STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	407 3RD AVE SE GARRISON, ND 58540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 08/08/21 and concluded 08/10/21.	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, and staff and resident interview, the facility failed to ensure the interdisciplinary team assess the appropriateness to self administer medications (SAM) for 1 of 1 sampled resident (Resident #2) with medications observed at the bedside. Failure to assess the resident's ability to SAM may result in medications errors or misuse of medications. Findings include: Review of the facility policy titled "Self-Administration of Medication" occurred on 08/10/21. This policy stated, ". . . Each resident has the right to self-administer medications only if an interdisciplinary team determines that it is clinically appropriate. . . . A Self-Medication Assessment will be completed on admission and reviewed quarterly if medications are being self-administered. . . . Drugs can be left at the patient's bedside and self-administered by the resident only if ordered by the Physician and the amount specified to be left at bedside. . . ."	F 554	1. Corrective Action 8/9/2021 Medication was removed from Resident #2 room and stored at the nurse's station until completion of self-administer medication assessment and order could be obtained from provider. Nursing Facility Manager provided education regarding requirements for having a self-administration of medication assessment that confirms that the resident has been deemed safe for self-administration of the medication. Resident # 2 was compliant and stated understanding. 2. Identification of Others 8/11/2021 A review resident charts was completed by the Nursing Facility Manager to identify residents who have medication orders for medications at the bedside, allowing resident to self-administer medications; this included scheduled medication, OTC (over the counter medications) and SO (standing	9/10/21

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

Electronically Signed | 09/03/2021

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F 554	Continued From page 1 Observation on the afternoon of 08/08/21 showed three bottles of eye drops (two Alaway and one Systane) and a bottle of nasal spray (Ayr) on Resident #2's bedside table. The resident stated she uses them as needed. The resident also carried an inhaler (Ventolin) in her pocket as she has a lot of respiratory issues, and it is her rescue inhaler. Resident #2's current physician's orders included: *Ayr Saline (sodium chloride) spray, 1 spray to both nares, Special Instructions: RESIDENT HAS BOTH NASAL GEL AND SPRAY- CAN KEEP AT BEDSIDE. As Needed *Ayr Saline Gel, Special Instructions: RESIDENT HAS BOTH NASAL GEL AND SPRAY- CAN KEEP AT BEDSIDE. As Needed *Alaway drops, 1 drop to each eye, Special Instructions: PRN (as needed) for itching or burning eyes. Pt (patient) to keep at bedside. *Ventolin aerosol inhaler, Special Instructions: 2 puffs every 4 hours as needed for SOB (shortness of breath) Resident #2's medical record lacked a self-administration of medications assessment, a physician's order for Systane eye drops, and an order allowing the resident to keep Ventolin in her room. During an interview on the afternoon of 08/09/21, a nurse manager (#2) stated she was unaware Resident #2 had an inhaler and Systane eye drops in her room, and the resident had them brought in from home. The nurse stated they did not do a self-administration assessment but the	F 554	order medication). 08/11/2021 Nursing Facility Manager initiated Nursing Observation: “Self-Administration of Medication” assessment to be completed no later than 09/10/2021 for all residents residing and not limited to just residents identified as having medications at the bedside to self-administer; to ensure that all residents have a self-administration of medication assessment completed to determine if the resident is capable of safely administering their medications. Residents identified as safe to self-administer medications will have a physician’s order whether resident is safe to self-administers medications, a care plan to be completed to identified if resident is capable to self-administer their medications, along with identifying what medications resident can self-administer, where medication will be stored, and resident education with return demonstration on understanding how to administer medication safely. 3. System Changes Nursing Facility admission packet to be updated no later than 9/10/2021 to include the following in writing: the facility policy and procedure for medication storage and self-administration, notice that all home medication brought into the facility throughout the resident’s stay are required to brought to the nurses station for medication verification, medications to	

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F 554	Continued From page 2 physician identified the resident may keep the eye drops and nasal spray at the bedside.	F 554	be stored at nurses station, until self-administration of medication assessment is completed with resident deemed safe for self-administration of the medication by interdisciplinary team, a provider order received for self-medication administration and indicating what medication can be left at the bedside. At admission to facility resident and resident representatives will be interviewed by Social Worker and/or Nursing Facility Manager/or Designee about resident's desire to self-administer medications and noted on Social Worker's admission form. F554 cont. On 8/24/2021 Nursing Facility Manager held a brief staff meeting with Nursing Facility staff who were available to attend to review state deficiencies from recent survey on 8/8/2021-8/10/2021. Review was not in-depth; as we had not received the POC and limited staff attendance. Nursing Facility Manager/designee will no later than 9/10/2021 will meet and educate licensed nursing staff and have sign in service sheet noting education on the following:	

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F 554	Continued From page 3	F 554	a. Nursing procedure to be followed for resident self-administration of medication, noting that residents requesting to self-administer medication will have a medication self-administration assessment completed to determine if safe for self-medication administration per IDT. b. Residents identified as safe to self-administer medications will be re-evaluated quarterly and with any change in condition and residents deemed safe to self-administer medications have a self- administration care plan developed, reviewed and revised as deemed appropriate. 4. Monitoring Nursing Facility Manager /designee will complete a QA study to ensure resident rooms are free from unsecured medication and chart review of resident medication orders, the approach to correct deficient practice related to the right to self-administer medication are consistently implanted and effective. QA Study to will be made across all new and current residents. The study will be conducted weekly for 3 months, 3 times a month for 3 months, and once a month for 6 months. The QA study results will be submitted and reviewed quarterly at the Quality Assurance meeting for further recommendations as needed.	

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F 554	Continued From page 4	F 554	5. Correction Date 09/10/2010	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.	F 578		9/10/21

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F 578	Continued From page 5 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the medical record for 1 of 13 sampled residents (Resident #17) accurately reflected the resident's Advanced Directive regarding code status. Failure to ensure the resident's medical record accurately reflected their wishes, limited emergency personnel from knowing the resident's wishes in the event of a medical emergency. Findings include: Review of Resident's #17's medical record occurred on all days of survey. The electronic health record face sheet and the nurses code status sheet identified full code status. A physician's order, dated 02/10/21,identified a code status as DNR/DNI (Do Not Resuscitate/Do Not Intubate). During an interview on 08/09/21 at 4:20 p.m., the nurse (#1) stated they have a binder on each medication cart with a paper sheet identifing residents' name and their code status. Resident #17's code status showed "Full Code". The nurse (#1) stated they can look on the face sheet of the electronic health record for the code status as well. During an interview on 08/10/21 at 2:45 p.m., an	F 578	1. Corrective Action 8/10/2021 Nursing Facility Manager reviewed Resident #17 Electronic Health Record and verified with provider written orders from 2/10/2021 and verified with LMSW that resident had requested change in code status at his care conference on 2/9/2021. Resident elected change in code status from Full Code to DNR/DNI and documentation was matching. Resident's code status was updated to reflect Resident #17 elective code status of DNR/DNI. 8/10/2021 Resident Code Status Reference Sheet located in nursing binders located on both medication carts were removed and will no longer be utilized as reference for nurses to check code status of residents; this eliminate the risk for error and safety to the resident. This eliminate needing to go to multiple areas update and to check resident code status. Nursing staff to utilize Electronic Health Record for code status verification. 2. Identification of Others 8/11/2021 a review resident charts was	

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F 578	Continued From page 6 administrative nurse (#2) confirmed staff incorrectly documented code status for Resident #17. The facility failed to ensure the code level status was consistent in all areas of the medical record.	F 578	completed by the Nursing Facility Manager to identify residents who code status in resident's orders, differenated from the code status sheet and code status orders. All Resident s medical records accurately reflected their code status wishes. Resident # 17 was the only chart with a discrepancy note and was immediately corrected. 3. System Changes At admission to facility resident and resident representatives will be interviewed by Social Worker and/or Nursing Facility Manager/or Designee about resident's wishes pertaining to code status choices upon admission, quarterly at resident's care conferences, and if there is a change in resident's health status. Health Provider will be notified when resident or resident representative has requested for a change in code status; an order will be obtained from provider and entered into resident's electectronic health record and resident's face sheet will be updated reflecting code status change, Code Status form will be updated and both order and code status form will be sent to provider for signature. Nursing staff completing code status orders will also complete a progress note noting changes. All process will be completed at time of code status change request.	

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F 578	Continued From page 7	F 578	On 8/24/2021 Nursing Facility Manager held a brief staff meeting with Nursing Facility staff who were available to attend to review state deficiencies from recent survey on 8/8/2021-8/10/2021. Review was not in-depth; as we had not received the POC and limited staff attendance. Nursing Facility Manager/designee will no later than 9/10/2021 will meet and educate licensed nursing staff and have sign in service sheet noting education on the following: a. 8/10/2021 Resident Code Status Reference Sheet located in nursing binders located on both medication carts were removed and will no longer be utilized as reference for nurses to check code status of residents; this eliminate the risk for error and safety to the resident. This eliminate needing to go to multiple areas update and to check resident code status. Nursing staff to utilize Electronic Health Record for code status verification. b. Nursing Protocol for Resident Code Status Change: Health Provider will be notified when resident or resident representative has requested for a change in code status; why the request for status change, an order will be obtained from provider and entered into resident's electectronic health record and resident's face sheet will be updated reflecting code status change, Code Status form will be updated and both code status order and code status form will be sent to provider for signature.	

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F 578	Continued From page 8	F 578	Nursing staff completing code status orders will also complete a progress note noting changes. All process will be completed at time of code status change request. 4. Monitoring Nursing Facility Manager /designee will complete a QA study of the residents electronic health record to ensure the approaches to correct deficient practice related to all residents medical records to accurately reflected residents code level status is consistent in all areas of the medical record. QA Study to will be made across all new and current residents. The study will be conducted weekly for 3 months, 3 times a month for 3 months, and once a month for 6 months. The QA study results will be submitted and reviewed quarterly at the Quality Assurance meeting for further recommendations as needed. 5. Correction Date 09/10/2010	
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 observation, record review, review of the Long-Term Care Facility Resident	F 641	1. Corrective Action For resident #14, a corrective action was	9/10/21

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F 641	Continued From page 9 Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 3 of 13 sampled residents (Resident #4, #12, and #14) and 1 supplemental resident (Resident #3). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI User's Manual, revised October 2019, pages A-24-25 stated, ". . . Check all conditions related to ID/DD [intellectual disability/developmental disability] status . . . OTHER ORGANIC CONDITION RELATED TO ID/DD Examples of diagnostic conditions include congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc. . . ." Review of Resident #14's medical record occurred on all days of survey. A Preadmission Screening and Resident Review completed on 10/15/20 identified no developmental or intellectual disability. An admission Minimum Data Set (MDS), dated 10/27/20, showed section A1550: other organic	F 641	obtained on 08/13/2021. The specific deficiency was corrected on 08/13/2021 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 10/27/2020 in order to correct miscoding of section A1550 (Other organic condition related to ID/DD). This correction was completed by the Licensed Master Social Worker and Nursing Facility MDS Coordinator. The corrected assessment was re-submitted and accepted by the state database on 8/16/2021 in Batch #8588. For resident #4, a corrective action was obtained on 08/13/2021. The specific deficiency was corrected on 08/13/2021 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 06/30/2021 in order to correct miscoding of section J1900 (one fall without injury and one fall with injury) state correct coding (one fall without injury). This correction was completed by the Nursing Facility MDS Coordinator. The corrected assessment was re-submitted and accepted by the state database on 8/16/2021 in Batch #8588. For resident #3, a corrective action was obtained on 08/13/2021. The specific deficiency was corrected on 08/13/2021 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 6/21/2021 in order to correct miscoding of section P0100A (Restraints). This correction was completed by the Nursing Facility MDS	

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F 641	Continued From page 10 condition related to ID/DD coded for Resident #14. The medical record lacked a medical diagnosis meeting the definition of other organic condition related to ID/DD. During an interview on 08/10/21 at 2:15 p.m., an administrative nurse (#3) agreed staff incorrectly coded the admission MDS. SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2019, page J-33 stated, ". . . Coding instructions for J1900 Determine the number of falls that occurred since . . . prior assessment . . . and code the level of fall-related injury for each. Code each fall only once. . . ." Review of Resident #4's medical record occurred all days of survey. A quarterly MDS dated 06/30/21 showed facility staff coded J1900 as one fall without incury and one fall with injury. The previous MDS was completed on 04/07/21. Resident #4's medical record identified a fall without injury on 04/27/21. The record lacked evidence of a fall with injury. During an interview on 08/10/21 at 2:15 p.m., an administrative nurse (#3) agreed staff incorrectly coded the MDS. SECTION P: RESTRAINTS The Long-Term Care Facility Resident Assessment Instrument User's Manual, revised	F 641	Coordinator. The corrected assessment was re-submitted and accepted by the state database on 8/16/2021 in Batch #8588. For resident #12, a corrective action was obtained on 08/13/2021. The specific deficiency was corrected on 08/13/2021 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 6/30/2021 in order to correct miscoding of section P0100A (Restraints). This correction was completed by the Nursing Facility MDS Coordinator. The corrected assessment was re-submitted and accepted by the state database on 8/16/2021 in Batch #8588. Corrective action for residents with the potential to be affected by the alleged deficient practice. 2. Identification of Others All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents will be conducted in order to identify any other resident who may have been affected by this alleged deficient practice. All current residents' most recent Minimum Data Set assessment will be reviewed in order to determine if the A1550, J1900, and P0100A was accurately coded.	

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F 641	Continued From page 11 October 2019, page P-1 defines a restraint as, "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." Page P-6 stated, "Bed rails used with residents who are immobile. If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint. . . ." - Review of Resident #3's medical record occurred on all days of survey. An admission MDS, dated 06/21/21, showed staff coded P0100A: bed rails used 2 days during the 7-day look-back period. Observation on all days of survey identified quarter rails on both sides of the bed, and Resident #3 dependent on staff for transfers. - Review of Resident #12's medical record occurred on all days of survey. An admission MDS, dated 06/30/21, showed staff coded P0100A: side rails used on a daily basis during the 7-day look-back period. Observation on all days of survey identified quarter rails on both sides of the bed, and Resident #12 dependent for transfers. During an interview on 08/10/21 at 2:15 p.m., an administrative nurse (#3) stated Residents #3 and #12 used the bed rails for assistance with repositioning and staff should not have coded them on the MDS.	F 641	These audits will be completed Licensed Master Social Worker (A1550) and Nursing Facility MDS Coordinator (J1900, P0100A) and will be completed no later than 09/10/2021. Any coding errors that are identified during the audit will be immediately modified and corrected and re-submitted to the state database. 3. System Changes LMSW will reeducate by reading the portions the MDS sections A of the RAI manual by 9/10/2021. MDS Coordinator will reeducate by reading the portions of the MDS sections A, J, P of the RAI manual by 9/10/2021. LMSW and MDS coordinator will complete the audits by 9/10/2021. LMSW and MDS Coordinator will complete the monitors as directed below. 4. Monitoring MDS Coordinator /licensed Master Social Worker will complete a QA study; monitoring accurate coding procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. QA Study to will be made across all new and current residents scheduled for. The study will be conducted weekly for 3 months, 3 times a month for 3 months, and once a month for 6 months. The QA study results will be submitted and reviewed quarterly at the Quality Assurance meeting for further	

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	355115	A. BUILDING _____ B. WING _____	08/10/2021

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F 641	Continued From page 12	F 641	recommendations as needed. 5. Correction Date 09/10/2010	
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. 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, professional reference, and staff interview, the facility failed to provide oxygen for 1 of 3 sampled residents (Resident #18) with an order for continuous oxygen. Failure to ensure facility staff provided continuous oxygen for Resident #18 per physician order may result in increased shortness of breath and other respiratory conditions. Findings include: Berman, Frandsen, and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, pages 1258 - 1259, stated, ". . . Oxygen therapy is prescribed by the primary care provider, who specifies the concentration, method of delivery, and depending on the method, liter flow per minute . . . Like any	F 695	1. Corrective Action 8/10/2021 Nursing Facility Manager reviewed Resident #18 Electronic Health Record and verified with provider written orders from 04/07/2021, verifying that resident oxygen orders reflect oxygen 2L/NC. Stickers were then place on resident's portable and room concentrators reflecting oxygen orders current setting 2L/NC and concentrators were set to appropriate settings. A sticker "Please DO NOT Change Setting" was also added to concentrator. 2. Identification of Others 8/11/2021 a review resident charts was completed by the Nursing Facility Manager to identify residents who receive oxygen therapy. Residents' concentrators are then inspected for appropriate oxygen	9/10/21

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F 695	Continued From page 13 medication, oxygen is not completely harmless . . . an inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. Excessive amounts of oxygen can lead to pulmonary tissue damage . . ." Review of Resident #18's medical record occurred all days of survey. The care plan stated ". . . has shortness of breathe and deconditioning related to COPD [chronic obstructive pulmonary disease] . . . Administer oxygen at 2 liters per nasal cannula via room or portable concentrator. . . ." A physician's order dated 04/07/21, stated, "Oxygen at 2 L/NC [liters per nasal cannula] continuously to keep [oxygen] sats > [saturations greater than] 90%" Observations identified: * 08/08/21 at 4:54 p.m., oxygen (O2) on at 3L/Nasal cannula (NC) via the portable concentrator. * 08/09/21 at 7:51 a.m., O2 on at 0.5L/NC via the room concentrator. * 08/09/21 at 9:49 a.m., O2 on at 3L/NC via the portable concentrator. * 08/10/21 at 9:23 a.m., O2 at 3L/NC via the portable oxygen concentrator to leave her room. Observation showed the room concentrator, which the resident used prior switching to the portable concentrator, set at 0.5L/NC. During an interview on 08/10/21 at 2:30 p.m., an administrative nurse (#2) stated the nurses set oxygen flow rate on the oxygen concentrators per physician orders and need to obtain a new order	F 695	order settings with all being in compliance with their oxygen orders. Stickers were then place on each resident's portable and room concentrators reflecting oxygen orders current setting and "Please DO NOT Change Setting". Under standing orders, charge nurses are allowed to apply oxygen to resident who are displaying shortness of breath, cyanosis, or hypoxia; oxygen orders for 2-4 l/NC or 5-7 l/per face mask (if no diagnosis for COPD) as needed for SOB, cyanosis, or hypoxia. 3. System Changes Charge nurses at the beginning of each shift will check and verify each resident's oxygen concentrators (portable and room machines) to confirm settings are set according to oxygen orders in electronic health record. Charge nurse will enter oxygen settings into the electronic MAR after verification, if correction action is needed related wrong setting, charge nurse will asset residents oxygen stats and respiratory status; residents' who are "normal" per the individual, settings will be set to correct settings, noting correction made in under residents' progress note. Resident noted to have "abnormal" status" charge nurse can adjust oxygen settings per orders under SO. Before a resident can be weaned off of oxygen therapy, a written oxygen order from a provider must be obtained, with	

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F 695	Continued From page 14 to adjust the flow rate.	F 695	parameters for weaning resident off of oxygen therapy. Licensed Nurses are only allowed to change residents' oxygen settings on oxygen concentrators. On 8/24/2021 Nursing Facility Manager held a brief staff meeting with Nursing Facility staff who were available to attend to review state deficiencies from recent survey on 8/8/2021-8/10/2021. Review was not in-depth; as we had not received the POC and limited staff attendance. Nursing Facility Manager/designee will no later than 9/10/2021 will meet and educate licensed nursing staff and have sign in service sheet noting education on the following: a. Review of Nursing Facility Standing Orders for Understanding orders, charge nurses are allowed to apply oxygen to resident who are displaying shortness of breath, cyanosis, or hypoxia; oxygen orders for 2-4 l/NC or 5-7 l/per face mask (if no diagnosis for COPD) as needed for SOB, cyanosis, or hypoxia. b. Charge nurses at the beginning of each shift will check and verify each resident's oxygen concentrators (portable and room machines) to confirm settings are set according to oxygen orders in electronic health record. Charge nurse	

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F 695	Continued From page 15	F 695	will enter oxygen settings into the electronic MAR after verification, if correction action is needed related wrong setting, charge nurse will asset residents oxygen stats and respiratory status; residents' who are "normal" per the individual, settings will be set to correct settings, noting correction made in under residents' progress note. c. Before a resident can be weaned off of oxygen therapy, a written oxygen order from a provider must be obtained, with parameters for weaning resident off of oxygen therapy. d. Licensed Nurses are only allowed to change residents' oxygen settings on oxygen concentrators. e. Stickers were then place on resident's portable and room concentrators reflecting oxygen orders current setting. A sticker "Please DO NOT Change Setting" was also added to concentrator. 4. Monitoring Nursing Facility Manager /designee will complete a QA study of residents' with oxygen concentrators (room & portable) to ensure the approaches to correct deficient practice related to incorrect resident oxygen concentrator settings to accurately reflect appropriate oxygen order settings with all being in compliance with provider oxygen order.	

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F 695	Continued From page 16	F 695	QA Study to will be made across all new and current residents. The study will be conducted weekly for 3 months, 3 times a month for 3 months, and once a month for 6 months. The QA study results will be submitted and reviewed quarterly at the Quality Assurance meeting for further recommendations as needed. 5. Correction Date 09/10/2010	
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	F 880		9/10/21

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F 880	Continued From page 17 standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of 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	F 880		

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F 880	Continued From page 18 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: THIS IS A REPEAT DEFICIENCEY FROM THE SURVEY COMPLETED ON 11/21/19 Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control standards for 3 of 13 sampled residents (Residents #6, #13 and #19). Failure to practice infection control related to hand hygiene, glove use during cares, and disinfection of multi-use lift equipment, has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of the facility policy, "HAND HYGIENE" occurred on 08/10/2021. This policy, dated June 2010, stated, "PURPOSE. . .To promote patient safety by preventing transmission of infection from one patient to another via the health care worker; and to remove transient bacteria on hands contaminated after the handling patients, objects, and surfaces. . . .3. Change gloves during patient care if moving from a contaminated body site to a clean body site. . . ." Review of the facility policy, "PATIENT MULTI-USE DEVICES" occurred on 08/10/21. This policy, dated February 2011, stated, "POLICY: as part of the Infection Control Prevention Program, all patient/resident multi-use medical devices must be disinfected between patient/resident uses. . . ."	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff perform hand hygiene or handwashing after removing gloves and after performing perineal care, in accordance with CDC guidelines. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance.	

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F 880	Continued From page 19 HAND HYGIENE - Observation on 08/09/21 at 10:43 a.m. showed two certified nursing assistants (CNAs) (#5 and #6) provided cares for Resident #6. The CNA (#6) completed perineal cares, disposed of the wet brief, and without removing soiled gloves, began applying a clean brief to Resident #6. The CNA (#5) removed soiled gloves, without performing hand hygiene, asked CNA (#6) for a new pair of gloves. The CNA (#6) with soiled gloves, removed a pair of gloves from his/her pocket and handed them to CNA (#5). The CNA (#5) then donned the pair of gloves without performing hand hygiene. The CNAs applied a clean brief and adjusted the resident's clothing. - Observation on 08/09/21 at 10:57 a.m. showed two CNAs (#5 and #6) provided cares for Resident #13. The CNA (#5) completed perineal cares, disposed of the brief soiled with bowel movement (BM), and without removing soiled gloves, opened the dresser drawer to remove a clean brief. The CNAs (#5 and #6) applied the clean brief and adjusted the resident's clothing. MULTI-USE EQUIPMENT DISINFECTION - Observation on 08/08/21 at 9:10 a.m. showed a CNA (#4) transferred Resident #19 from a wheelchair to the toilet and from the toilet to a recliner utilizing a sit-to-stand lift. After the transfers, the CNA (#4) removed the sit-to-stand lift from the room, placed it in the hallway, and failed to disinfect the equipment after resident use.	F 880	3. System Changes On or before 09/10/2021 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to complete hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, IP or suitable designee will ensure the following: a. All staff will receive education keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of certified nursing staff to ensure performance of proper hand hygiene, when indicated, in the course of their routine duties.	

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F 880	Continued From page 20 - Observation on 08/09/21 at 1:20 p.m. showed a CNA (#4) transferred Resident #19 from a wheelchair to a recliner utilizing the sit-to-stand lift. After the transferring, the CNA (#4) removed the sit-to-stand lift from the room, placed it in the hallway, and failed to disinfect the equipment after resident use. During an interview on 08/10/21at 2:34 p.m., an administrative nurse (#2) stated, "staff should use clean gloves during patient interaction, soiled gloves should be removed, hand hygiene should be performed, and staff should wipe equipment with sanitizing wipes between each patient."	F 880	Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 09/10/2021	