STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 09/12/22 and concluded 09/14/22.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide care and services to ensure proper skin care for 1 of 1 sampled resident (Resident #58) with non-pressure related skin impairment. Failure to obtain, clarify, follow physician's and standing orders related to skin impairments, and complete dressing changes as per standing orders may result in worsening skin impairment and delay change in treatment. Findings include: Review of the Facility policy titled ". . . Standing Orders" occurred on 09/14/22. This undated policy stated, ". . .Apply . . . Mepilex [absorbent foam] dressing . . . Check dressing every day and change every 3-7 days or when drainage is 2 times the size of the wound. Then change dressing following this protocol until area is	F 684	Resident #58's physician orders were corrected and updated on 9/14/2022. An e-mail was sent out to all licensed nurses on 9/13/2022 & 9/27/2022 regarding the need to ensure all physician orders contain all elements, who, what, when, where and why and the need to date & initial all dressings. 9/27/2022 Reminder cards were placed on all the desk top computers at all nurses stations to help guide order writing. Review records of residents with current dressing orders will be completed on 10/3/2022. Mandatory nurses/med tech meetings are	10/7/22

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

Electronically Signed | 10/03/2022

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F 684	Continued From page 1 healed. . ." Review of the facility policy titled "Medication Orders" occurred on 09/14/22. This policy, dated August 2018, stated ". . . STANDING ORDERS . . . Professional judgement is used in the initiation and administration of standing orders. The order is written following the procedure for verbal prescriber orders in accordance with the policy on prescriber medication orders. In indicating the source of the order, the abbreviation "s.o." [standing order] is used to indicate a standing order . . . The authorized prescriber countersigns all standing orders . . . New Verbal Orders: . . . Obtain prescriber signature within 48 hours. Place the signed copy on the designated page in resident's medical record. . . ." During an observation on 09/13/22 at 1:35 p.m., a licensed nurse (#7) completed a dressing change to Resident #58's left shin. The Mepilex dressing lacked a date to identify when staff placed it. The skin under the Mepilex showed two areas of red, excoriated skin. The nurse measured the red/excoriated area and documented a size of 8 cm (centimeters) x 3.5 cm. Review of Resident #58's medical record occurred on all days of survey. The current record lacked a physician's order for Mepilex. Resident #58's electronic treatment administration record (ETAR) identified "apply Mepilex to left shin weeping for protection" with documentation time of 2:00 p.m. and 10:00 p.m. The ETAR failed to identify frequency of dressing change.	F 684	scheduled for 10/6/2022 to review policies of physician orders, standing orders, and wound care protocol. The DON and/or her designee will complete QA on all new physician orders received & entered by licensed nurses weekly for no less than 12 weeks, then monthly for no less than 3 months, then quarterly times 2. If substantial compliance has been achieved and sustained at that time QA will be discontinued. All QA results will be shared with the QAPI committee quarterly.	

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F 684	Continued From page 2 The facility failed to initiate a standing order for the dressing change, obtain a physician signature for the standing order, clarify the frequency of the dressing change per the standing order, and failed to document when previous dressing was applied. During an interview on 09/13/22 at 4:30 p.m., an administrative nurse (#1) confirmed Resident #58's medical record lacked an order for the Mepilex and a complete standing order in the ETAR.	F 684		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and	F 803		10/7/22

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F 803	Continued From page 3 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, review of menus, and staff and resident interview, the facility failed to serve food according to prepared menus during 1 of 2 meals observed (the evening of 09/13/22). Failure to serve food according to menus may result in inadequate nutrition and weight loss. Findings include: Review of the facility policy titled "Portioning of Food" occurred on 09/14/22. This policy, dated August 2022, stated, ". . . The menus specify the size of portions. Portions are served as indicated to ensure adequate nutritional intake of the residents. . . ." Regarding the evening meals, confidential resident interviews identified the portions were "lean," and residents did not feel they got enough food. Observation of tray line in the unit 3 dining room on the evening of 09/13/22 identified staff served macaroni hotdish to residents using a 1/2 cup scoop. The menu identified the portion as 2/3 cup. During an interview on the morning of 09/14/22, a dietary supervisor (#3) stated residents have brought this issue up before, and staff should have used a 2/3 cup scoop.	F 803	Immediate education was done with employee working tray line the evening of 9/13/22 to educate him on how to use correct portion sizes for all diets and therapeutics listing serving sizes for all diets-requirement of F803 The Dietitian reviewed and updated policies on portion sizes, small and large servings. The Dietitian in collaboration with Dietary Manager reviewed and updated therapeutic menus listing portion sizes. Nutrition Services staff were educated at an in-service by Dietitian and Dietary Manager about policies, portion sizes for therapeutics, small and large portions. Portion sizes were demonstrated using scoops, ladles, and spoons. Questions were answered, and post-test done by those in attendance. Any nutrition staff that weren□t in attendance were in-serviced individually. Correct portion sizes and meal delivery will be monitored to assure adequacy of portions of food from nutrition services. Dietitian or designee will observe tray line weekly, for no less than 12 weeks, that portion sizes are adequate according to resident□s diet ordered.	

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F 803	Continued From page 4	F 803	Observations will be done across the different meals and tray lines. Observations of non-compliance or correction will be done with affected staff and a note to include all nutrition staff. Monthly monitoring will continue 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 compliant quarterly reporting for a total of 1 year monitoring or until approved by the QAPI committee and medical director.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		10/7/22

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F 812	Continued From page 5 by: Based on observation, review of facility policy, and staff interview, the facility failed to store food under sanitary conditions in 1 of 4 nutrition stations (Station 2). Failure to monitor refrigerator and freezer temperatures, and label, both resident snacks and food brought into the facility, with discard dates has the potential to result in foodborne illness to residents. Findings include: Review of the facility policy titled "Resident Food Storage" occurred on 09/14/22. This undated policy stated "Policy: Food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or resident's personal room refrigeration units will be monitored by designated facility staff for spoilage and safety. Procedure: . . . Food or beverages brought into the facility for resident consumption will be labeled and dated for monitoring food safety. . . . Foods in unmarked or unlabeled containers will be scrutinized and marked by designated facility staff with the current date the food item was brought to the facility for storage. Any suspicious or obviously contaminated food or beverage will be thrown away immediately. . . Designated facility staff will be assigned to monitor . . . refrigeration units for food or beverage disposal. All refrigeration units will have internal thermometers to monitor safe food storage temperatures. Units must maintain safe internal temperatures in accordance with state and federal standards for safe food storage temperatures. . . ." Observation of facility nutrition stations occurred	F 812	Food in freezer found undated was immediately discarded. Education was done at an all-staff meeting by Dietitian on 9/15/22 that Nutrition services would accept responsibility for taking daily temperatures of nourishment refrigerators on all the units. All staff are responsible for labeling resident food and beverages with name and date before storing it in nourishment refrigerators. Staff food will be stored in the breakroom refrigerator. No staff food will be stored with resident□s food. This includes education for F812.This information will be reviewed at the mandatory education for all CNA's and Nurses on 10/4/2022, 10/5/2022, & 10/6/2022. Dietitian and Dietary manager reviewed and updated nourishment policy. Laminated signs were posted in nourishment kitchens to remind all staff to label and date resident□s food and beverages. Recording form to record temperatures was updated to include a reminder to discard unlabeled or outdated food and beverages. Job tasks were updated that nutrition services staff will document daily temperatures when stocking fridges in the nourishment areas and throw expired or unlabeled foods and beverages. Staff were educated on these updates at Nutrition Services staff in-service on	

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F 812	Continued From page 6 on the morning of 09/14/22. Station 2's nutrition refrigerator/freezer log lacked temperatures for the following dates: *August 12th through August 21st *August 23rd through August 31st *September 1st through September 11th. Observation of the freezer showed a dessert dish of ice cream with an improper sized lid and a restaurant sandwich wrapped in paper inside a plastic restaurant bag. The ice cream and sandwich lacked a name and date. During an interview on 09/14/22 at 11:00 a.m., a dietary staff member (#2) stated the nutrition staff checked the temperatures and stocked the nutrition station fridges every day. When asked if the ice cream and sandwich should be labeled with a date and name the staff member responded "yes."	F 812	9/20/22. Nutrition staff have currently been monitoring for expired and unlabeled food, and are now taking the responsibility of recording daily refrigerator temperatures on all the units with updated recording forms. Refrigerator temperature logs will be monitored to assure accurate, daily temperatures are being taken and monitored. Dietitian or designee will QA nourishment refrigerator temperatures and contents for unlabeled items, weekly for no less than 12 weeks. Observations will be done in the different unit refrigerators/freezers and different shifts. Observations of non-compliance or correction will be done with unit staff note to include all staff. Monthly monitoring will continue 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 compliant quarterly reporting for a total of 1 year monitoring or until approved by the QAPI committee and medical director	
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.	F 880		10/7/22

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F 880	Continued From page 7 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of 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.	F 880		

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F 880	Continued From page 8 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed infection control practices during observations on 3 of 3 days of survey (September 12-14, 2022). Failure to follow infection control practices may result in the spread of infection within the facility. Findings include: Review of the facility policy titled "Enhanced Droplet Precautions" occurred on 9/14/22. This policy, dated July 2022, stated, ". . . Policy: . . . Residents suspected of or confirmed to have COVID-19 will be placed on Enhanced Droplet Precautions . . . Procedure: . . . Don an N95	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 entering and exiting a	

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F 880	Continued From page 9 facemask-cup mask in hand, place both straps to the front of the mask, place mask over face covering both nose and mouth. . . . Adjust nose piece to form a seal. Test seal by taking a deep breath, if mask collapses slightly, it is on correctly. Adjust as necessary . . . Doffing PPE [personal protective equipment] . . . Remove gloves immediately outside the room . . . taking care to not touch surfaces with the contaminated surface of the glove . . . perform hand hygiene . . . remove gown, break ties by pulling the neck area . . . place one hand on the neckline of the opposite shoulder and remove by turning it inside out taking care not to touch the contaminated outer surface of the gown . . . remove goggles . . . perform hand hygiene . . . PERSONAL PROTECTIVE EQUIPMENT USE - Observation on 09/12/22 at 1:38 p.m. showed a certified nurse aide (CNA) (#5) exited Resident #41's room in full PPE. The CNA wore her N95 mask over a surgical mask. The CNA removed and discarded her gloves and performed hand hygiene. She then pulled the sleeves of the gown over her hands, untied gown, rolled it into itself and discarded. After performing hand hygiene, the CNA removed her N95 by the straps, placed it into a paper bag and placed it on a table outside the resident's room. The CNA performed hand hygiene but failed to remove the surgical mask or sanitize her eye goggles before proceeding to another resident's room. During an interview on 09/14/22 at 2:35 p.m., an administrative nurse (#1) stated it is her expectation that N95 masks are to be applied directly to the staff members face, positioned	F 880	room on droplet precautions donned, doffed, and disposed of personal protective equipment (PPE), in accordance with CDC guidelines. (2) Ensuring staff perform hand hygiene or handwashing when donning PPE, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. (3) Ensuring staff follow infection control guidelines with medication preparation and administration regarding dropping of medication on top of the cart. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate on selecting, donning, doffing, and disposing of PPE when entering a room on droplet precaution isolation/quarantine procedures. To verify each of these/this staff understands the procedure, then each will perform a successful return demonstration of selecting, donning, doffing, and disposing of PPE for providing cares in a droplet precaution room. (2) Educate on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify this/these staff understands hand hygiene and	

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F 880	Continued From page 10 tightly over the nose and mouth and not over a surgical mask, and that goggles should be sanitized upon exiting an isolation room. - Observation on 09/14/22 at 08:43 a.m. showed a CNA (#4) enter Resident (#4 and #47's) room with enhanced droplet precautions in full PPE.The CNA (#4) exited the room in PPE carrying a meal tray and placed the meal tray on a cart outside the room then reentered the room wearing the same PPE and repeated the process with the other residents meal tray and failed to change PPE before reentering the room. During an interview on 09/14/22 at 09:05 a.m., an administrative nurse (#1) stated staff are expected to request assitance from another staff to remove trays from the residents rooms with enhanced droplet precautions. PERSONAL CARES Review of the facility policy titled "Bathing" occurred on 9/14/22. This undated policy stated, "Policy: It is the practice of this facility to assist residents with full body bathing to maintain proper hygiene and help reduce the risks of skin concerns and infectious processes. . . . Procedure: Bed Bath: . . . Using a basin of warm water, wet washcloth and allow resident to wash his/her own face, if able. Assist as needed. Dry area with towel . . . Move to the torso . . . Wash hands, arms, underarms, and chest and stomach areas. . . . Assist resident to turn to their side, wash back . . . Expose, wash, dry and lotion legs and feet. . . . Expose peri area. Wash and dry area. Assist resident to turn onto side, wash and dry buttock area. Assist resident to dress. . . ."	F 880	handwashing, this/these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing. (3) Educate staff passing medication of the correct infection control guideline to use when dropping medication on the cart or other areas beyond the medication cup. (4) Educate staff on correctly performing resident cares/hygiene. 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. 3. System Changes On or before 10/07/2022 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to select, don, and utilize the necessary PPE for droplet precautions isolation/quarantine room access, in accordance with CDC guidelines. b. Failure to complete handwashing or hand hygiene in accordance with CDC guidelines.	

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F 880	Continued From page 11 - Observation on 09/13/22 at 9:18 a.m., showed a CNA (# 4) perform a bed bath for Resident #70. The CNA performed hand hygiene and donned gloves. The CNA prepared a wash basin and placed the basin and clean wash cloths on the overbed table. After emptying the resident's catheter and without removing gloves or performing hand hygiene the CNA bathed the resident first washing and drying the resident's legs. The CNA returned the washcloth to the wash basin, removed the gloves, failed to perform hand hygiene, left the resident's room and returned with a tube of lotion. Without performing hand hygiene, the CNA donned gloves and applied lotion to the resident's legs. The CNA removed the resident's brief and performed perineal cares using a wet cloth from the wash basin, placed the cloth on the overbed table and applied barrier cream. The resident turned on his right side, the CNA washed the resident's buttocks, placed all washcloths into the wash basin, applied barrier cream to the buttocks, applied a clean brief, and pulled up the resident's pants. Using the same water and wash cloths from the wash basin, the CNA washed Resident #70's face, took a new cloth, wetted it in the wash basin, rinsed the resident's face and returned the cloths to the wash basin. Using the same cloths from the wash basin, the CNA completed the bed bath. The CNA failed to perform cares in the correct order (head to toe) and used the same basin of water to complete the bath. During an interview on 9/14/22 at 2:35 p.m., an administrative nurse (#1) stated she expected	F 880	c. Failure to ensure medications do not come in contact with an unclean surface prior to administering to a resident. d. Failure to perform personal cares/hygiene in an acceptable manor. 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, SDC, IP or suitable designee will ensure the following a. Educate all staff whose normal duties include entering resident rooms on the correct procedure for selecting, donning, using and doffing PPE when entering a droplet isolation/quarantine precaution room. This education will include the CDC's lesson on personal protective equipment developed for nursing home staff available at https://youtu.be/YYTATw9yav4. b. 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. c. All staff passing medication receive education on the infection control expectations when dropping a resident medication on to an unclean/contaminated surface. d. Educate staff performing resident cares/hygiene on appropriate techniques. (3) The facility leadership will contact the	

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	355084	A. BUILDING _____ B. WING _____	09/14/2022

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F 880	Continued From page 12 staff to perform bed baths from head to toe and follow facility policy. HAND HYGIENE Review of the facility policy titled "Hand Hygiene" occurred on 09/14/22. This policy, revised in February 2010, stated, ". . . All personnel are required to perform hand hygiene after each direct or indirect resident contact for which hand hygiene is indicated by accepted professional practice." - Observation on 09/12/22 1:14 p.m. showed a CNA (#8) donned gloves without performing hand hygiene. The CNA completed perineal cares, and without removing gloves or performing hand hygiene, applied a clean brief, dressed the resident, and assisted putting the resident back into the wheelchair. The CNA (#8) exited the room without removing the soiled gloves and performing hand hygiene HYGIENE CARES Review of the facility policy titled "Policy and Procedure" occurred on 09/14/22. This undated policy stated, ". . . Separate the labia . . . Clean from front to back with one stroke starting at the labia and moving outward. Use a clean area of disposable wash cloth for each stroke . . ." - Observation on 09/13/22 at 7:57 a.m. showed Resident #16 sitting on the toilet and CNA (#4) without gloves performing oral cares on resident. The CNA left the room without performing hand hygiene to retrieve deodorant. The CNA returned to the resident's room, and failed to perform hand	F 880	North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Monitoring of approaches to ensure infection control and prevention are effective will include: Weekly for no less than 12 weeks, the DON, IP, SDC 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 all staff types to ensure correct selection, donning, use and doffing of PPE when entering and exiting droplet precaution isolation/quarantine rooms. (2) Observations of all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. (3) Observations of medication staff to ensure proper medication preparation regarding infection control practices. (4) Observation of staff performing resident cares/hygiene to ensure the correct technique with emphasis on	

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F 880	Continued From page 13 hygiene and applied deodorant for Resident #16. The CNA (#4) failed to perform hand hygiene, donned gloves and performed perineal care. The CNA wiped from front to back, then back to front several times with the same washcloth. The CNA removed the gloves and exited room failing to perform hand hygiene. The CNA returned to the resident's room and failed to perform hand hygiene and applied a brief. Failure to perform proper hand hygiene and proper perineal care can lead to the spread of infections and urinary tract infections. MEDICATION ADMINISTRATION During observation of medication administration on 09/14/2022 at 11:07 a.m., a facility nurse (#6) dropped a medication on the medication cart during preparation. The nurse picked up the pill with a spoon, placed the pill into a medication cup and administered it to the resident. The facility nurse (#6) failed to discard and replace the contaminated pill. During an interview on 09/14/2022 at 11:20 a.m., an administrative nurse (#1) stated she expected staff to discard medication that fell on top of the cart.	F 880	bathing and perineal cares. 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 10/07/2022 On 9/15/2022 a memo was posted to all direct care staff. This memo contained information on PPE use in conjunction with Enhanced Droplet Precautions. Reminder provided that PPE must be removed in the isolation area. Upon initiation of isolation: Maintenance will tape off an area (approx. 4foot by 6foot) on the floor outside of an isolation	

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F 880	Continued From page 14	F 880	room to serve as a visual reminder to staff to not leave that area while in full PPE. This will be part of the setup of an isolation cart. Mandatory meetings for CNA's and Nurses will be held 10/4/2022, 10/5/2022, & 10/6/2022 to provide education on PPE using the https://youtu.be/YYTATw9yav4 video and policy review. During this education a return demonstration of donning and doffing PPE will be required. Upon initiation of isolation, QA will be started to ensure proper use of and donning/doffing of required PPE. On 9/14/2022 the DON provided education, demonstration and a return demonstration on bathing and peri cares with C.N.A. #4. On 9/14/2022 the DON provided education, demonstration and a return demonstration of glove use and proper hand hygiene during cares with C.N.A. #8. On 9/15/2022 a memo was posted to all direct care staff. This memo contained information on procedure of bathing, hand hygiene, and peri cares. On 9/27/2022 a new form was developed for validating skills of new CNAs to our facility. This form will be completed on all new LSH hires as well as new agency CNA□s that come into our building. The	

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F 880	Continued From page 15	F 880	form will be completed within 7 days. Mandatory meetings for all direct care staff will be held on 10/4/2022, 10/5/2022 & 10/6/2022. Topics will include Bathing policy, hand hygiene education including https://youtu.be/xmYMUly7qiE video, demonstration of hand hygiene and return demonstration by all direct care staff, & peri cares policy. On 9/14/2022 the DON reviewed infection control regarding medication administration with Nurse #6. All licensed nurses and medication aides will be educated on infection control during medication administration on 10/6/2022. Peri Cares/Hand Hygiene during cares/Bathing/Infection control during medication administration: Across all shifts and units The DON or her designee will complete QA weekly for no less than 12 weeks; then monthly for no less than 3 months; then quarterly for no less than 2 quarters. At the end of quarterly observations, if substantial compliance has been met, QA observations will be discontinued. All QA results will be shared quarterly with the QAPI committee. The DON had a telephone conference with a representative of Great Plains QIN on 9/30/2022. A fishbone RCA was completed. Findings: Low perception of risk and value and lack of in person	

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F 880	Continued From page 16	F 880	trainings regarding PPE, hand hygiene, and general infection control measures. Educational materials were supplied via e-mail on 9/30/2022.	