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 _____	C 12/19/2024

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

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 12/16/24 and concluded 12/19/24. The issues identified by the complainant were found to be in compliance with regulatory requirements.	F 000		
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the coverage of 1 of 1 surety bond provided the required coverage of all personal funds for residents who deposited money with the facility. Failure to ensure the security bond covered all funds entrusted to the facility may result in the residents suffering financial losses secondary to the facility failing to hold, safeguard, manage, and/or account for their funds. Findings included: Review of the facility policy titled "Resident Trust Funds" occurred on 12/19/24. This policy, dated November 2000, stated, ". . . The facility maintains a security bond to protect the resident's funds. . . ." During an interview on 12/18/24 at 3:33 p.m., a business office staff member (#14) reported the residents' trust fund account currently contained	F 570	On 12/18/2024 insurance provider was notified and provider increased surety bond to cover $11,000. On 1/7/2025 bond coverage was increased to $20,000. Any resident trust account could be impacted by this deficient practice. Copy of bond coverage amount will be stored with statements for the resident trust account for accessibility. Administrator, or designee, will monitor resident trust accounts monthly to ensure the amount in the account does not exceed bond coverage. Goal for audits will be 100% compliance. Results of these audits will be shared with the QA committee on a quarterly basis.	1/23/25

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

Electronically Signed | 01/17/2025

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F 570	Continued From page 1 $10,138.13. An administrative staff member (#1) showed the surveyor an insurance document, with an effective date of 03/11/23, which showed a bond limit of $10,000.00. The facility failed to implement a system ensuring they maintained a surety bond that covered all personal funds entrusted to the facility.	F 570		
F 641 SS=D	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 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 18 sampled residents (Resident #24 and #35) and 1 supplemental resident (Resident #40). Failure to accurately code 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 N: MEDICATIONS The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2024, page N-7 stated, ". . . N0415G1. Diuretic: Check if a diuretic medication was taken by the resident at any time	F 641	The MDS dated 3-26-24 for resident #24 was modified on 12-18-24 under Section O: Special Treatments, Procedures, and Programs O0110K1 was coded "Yes" reflecting that resident #24 is receiving hospice care. The MDS dated 9-30-24 for resident #24 was modified on 12-18-24 under Section N: High-Risk Drug Classes: Use and Indication N0415G1 reflecting that resident #24 had taken a diuretic and N0415G2 as "Yes" reflecting that an indication is noted. The MDS dated 10-28-24 for resident #40 was modified on 1-13-25 under Section O: Special Treatments, Procedures, and Programs O0110K1 was coded "Yes" reflecting that resident #40 is receiving hospice care. The MDS dated 11-13-24 for resident #35 was modified on 1-13-25 under Section O: Special Treatments, Procedures, and	1/23/25

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F 641	Continued From page 2 during the 7-day look-back period . . ." - Review of Resident #24's medical record occurred on all days of survey. Medications included and identified Furosemide (a diuretic) daily. Review of the quarterly MDS, dated 09/30/24, showed the facility failed to code diuretic use. SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS The Long-Term Care Facility RAI User's Manual, revised October 2024, pages O-3, O-4, and O-7, stated, ". . . Coding Instructions for Column b. While a resident. Check all treatments, procedures, and programs that the resident received or performed . . . within the last 14 days. . . . O0110C1, Oxygen therapy. Code continuous or intermittent oxygen administered via mask, cannula, etc. . . . O0110K1, Hospice care. Code residents identified as being in a hospice program . . ." - Review of Resident #24's medical record occurred on all days of survey. A physician's order, dated 03/13/24, stated, "Admitted to Hospice . . ." Review of the significant change MDS, dated 03/26/24, showed the facility failed to code hospice services. - Review of Resident #40's medical record occurred on all days of survey. Physician's orders identified the resident admitted to hospice services on 10/21/24. Review of the significant change MDS, dated 10/28/24, showed the facility failed to code hospice services.	F 641	Programs O0110C1 was coded "Yes" reflecting that resident #35 used oxygen therapy. The MDS Coordinator and Nurse Mangers were educated in coding the MDS sections "N" and "O" 12-18-24. A review of SCSA MDS related to hospice admission for all residents currently on hospice services has been completed for accuracy on Section "O". A review of the most recent MDS for all residents requiring oxygen use has been completed for accuracy on Section "O". A review of the most recent MDS for all residents taking a diuretic has been completed for accuracy on Section "N". QA will be completed weekly for accuracy of scoring of the MDS under sections "N" and "O" under the direction of the Director of Nursing until 100% compliance has been achieved. Director of Nursing or designee will complete audits on Sections "O" and "N" weekly until compliance has been achieved. After compliance has been achieved, periodic QA studies, not less than monthly for six months, will be completed to assure compliance has been maintained. The results of these audits will be reported to the QA Committee on a quarterly basis.	

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F 641	Continued From page 3 - Review of Resident #35's medical record occurred on all days of survey. A physician's order, dated 05/31/24, stated, " . . . Oxygen 2L [liters per minute] via NC [nasal cannula] PRN [as needed] to keep sats [oxygen saturation level] greater than 90% . . ." A quarterly MDS, dated 11/13/24, showed the facility failed to code oxygen use. The resident's medication administration record (MAR), dated 10/30/24 to 11/13/24, identified oxygen use. During an interview on 12/18/24 at 4:25 p.m., an administrative nurse (#3) confirmed staff miscoded the MDS's.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		1/23/25

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F 657	Continued From page 4 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 2 of 18 sampled residents (Resident #1 and #35). Failure to update care plans limited the staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 12/19/24. This policy, dated 11/17/16, stated, ". . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment . . . " - Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, ". . . Potential for bleeding related to anticoagulant [medicine that increases the time for blood to clot] use. . . . Apixaban [blood thinner] as ordered by MD [medical doctor] . . ." Review of the October 2024 Electronic Medication Administration Record (eMAR) showed the provider discontinued Apixaban on 10/30/24. During an interview on 12/18/24 at 10:26 a.m., an	F 657	Resident #1's care plan was revised on 12-18-24 and potential for bleeding related to anticoagulant entry was resolved. Resident #35 was provided education on improper oxygen use risks on 12-17-24. Resident #35's care plan was reviewed and history of self-regulating oxygen flow rate and education regarding risks of improper use of oxygen were added. All resident care plans have the potential to impacted by this deficient practice. A review of the care plans for all residents who use oxygen and/or are prescribed anticoagulants was completed on 1-13-25. Reviewed Comprehensive Care Plan and Reviewing and Revising the Care Plan policies on 1-10-25, no revisions were made. Comprehensive Care Plan and Reviewing and Revising the Care Plan policies will be reviewed and education will be provided on care planning to all licensed	

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F 657	Continued From page 5 administrative nurse (#2) confirmed staff failed to revise Resident #1's care plan following the discontinuation of the anticoagulant. - Review of Resident #35's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disorder (COPD) (restricted airflow in the lungs), shortness of breath, and chronic heart failure (CHF). A physician's order, dated 05/31/24, stated, "Oxygen 2L [liters per minute] via NC [nasal cannula] PRN [as needed] to keep sats [oxygen saturation level] greater than 90% . . ." A quarterly MDS, dated 11/13/24, identified the resident as cognitively intact and independent with activities of daily living. During an interview on 12/17/24 at 9:23 a.m., Resident #35 stated he/she uses oxygen when "I feel winded." The resident confirmed he/she independently uses the oxygen concentrator and portable oxygen tank, and stated, "I sometimes turn it [the meter flow] up until it pops to clear out the tube and then turn it back down." Resident #35's care plan failed to include Resident #35's independent use of oxygen and education on the risks of this practice. During an interview on 12/17/24 at 4:31 p.m., an administrative nurse (#2) confirmed Resident #35 removes and applies their own oxygen, and stated, "They [facility staff] have educated [resident] on oxygen."	F 657	nursing staff on 1-16-25 at the nurse's meeting. All care plans will be entered into Point Click Care and paper copies will be destroyed to ensure accessibility of up to date care plans for staff. All Care cards will be available on the Kardex located in PCC. 10 random care plan audits will be completed weekly by the Director of Nursing, or designee until 100% compliance is achieved. After compliance has been achieved, periodic QA studies, not less than monthly for 6 months, will be completed to assure compliance has been maintained. The results of these audits will be reported to the QA committee on a quarterly basis.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		1/23/25

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F 658	Continued From page 6 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 observation, record review, review of manufacturer's instructions for use, and staff interview the facility failed to ensure staff followed standards of practice for 2 of 2 residents (Resident #33, and #235) who required rapid acting insulin. Failure to administer rapid acting insulin within the time specified by the manufacturer may result in a hypoglycemic (low blood sugar) reaction. Findings include: Prescribing information for Humalog insulin (a raid acting insulin), found at https://www.humalog.com, stated, "Administer HUMALOG . . . within 15 minutes before a meal or immediately after a meal. . . ." Prescribing information for Novolog insulin, found at https://www.novolog.com, stated, "Novolog is a rapid-acting insulin . . . Novolog starts acting fast. Eat a meal within 5-10 minutes after taking it. . . ." - Review of Resident #235's medical record occurred on 12/18/24. Current physician's order included Humalog insulin 50 units three times a day. During an interview on 12/18/24 at 5:16 p.m., a nurse (#15) stated she checked Resident #235's blood sugar at 4:45 p.m., obtained a blood	F 658	Nurse #15 was educated on proper rapid-acting insulin administration on 12-18-24. All licensed nursing staff will be educated on proper rapid-acting insulin administration on 1-16-25. Medical record review for resident #33 and resident #235 were completed by DON on 1-10-25. No ongoing adverse effects noted from improper insulin administration. Any resident receiving insulin could be impacted by this practice. A review of the medical record for all residents who are prescribed rapid acting insulin was completed on 1-13-25. No adverse health effects related to improper insulin administration were noted. All diabetic residents are indicated by a yellow-colored meal ticket. Yellow-colored tickets are served meals first. All CNA staff will be provided education regarding diabetic residents and dining on 1-14-25. Dietary staff will be provided education regarding diabetic residents and dining on	

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F 658	Continued From page 7 glucose reading of 125 milligrams/deciliter (mg/dl), and administered 50 units of Humalog. Observation on 12/18/24 of Resident #235 showed the following: * 5:17 p.m., at a table in the dining room. * 5:37 p.m., received two glasses of juice at the table. (52 minutes later) * 5:48 p.m., received the evening meal (one hour and 3 minutes after receiving a rapid acting insulin). - Review of Resident #33's medical record occurred on all days of survey. Current physician's order included, Aspart (Novolog Insulin) 30 units in the evening and hold if resident does not eat. Observations on 12/18/24 showed the following: * 5:00 p.m., a nurse (#15) administered 30 units of Novolog to Resident #33. * 5:28 p.m., Resident #33 received her evening meal. (28 minutes after receiving a rapid acting insulin). During an interview on 12/19/24 at 10:26 a.m., an administrative nurse (#2) stated she expected staff to serve a meal within 15 minutes of administering a rapid acting insulin.	F 658	1-15-25 and 1-16-25. QA will be completed twice weekly for no less than four weeks by Director of Nursing, or designee, on the administration of fast-acting insulin and timing to ensure meal is served within 15 minutes of administration or that rapid-acting insulin is administered immediately after a meal. Observations will be made across shifts with a meal and for all units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on QA monitoring forms. After four weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to weekly for 4 weeks then monthly for no less than three months. All monitoring results will be reported quarterly to the QA committee.	
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	F 689		1/23/25

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F 689	Continued From page 8 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to properly utilize assistive devices necessary to prevent accidents and/or injury for 1 of 3 sampled residents (Resident #75) observed during transfers. Failure to utilize a gait belt during transfers placed the resident at risk for falls and/or injury. Findings include: Review of the policy titled "Gait belt For Transfers" occurred on 12/19/24. This policy, dated September 2002, stated, ". . . Gait belts are provided to assist staff to safely transfer or ambulate residents. . . ." Observation on 12/18/24 at 8:44 a.m., showed a certified nurse aide (CNA) (#11) provided personal cares to Resident #75. After personal cares were provided, the CNA (#11) placed both hands on the resident's buttocks to assist the resident to sit in the wheelchair. The CNA failed to utilize a gait belt during the transfers. Review of Resident #75's medical record occurred on all days of survey. The care plan, dated 11/16/24, stated, ". . . Assist of 1 with gait belt for transfers. . . ." The facility failed to ensure staff followed Resident #75's plan of care and use a gait belt during transfers.	F 689	CNA #11 was provided education on gait belt use on 12-19-24. Gait belt was immediately placed in resident #75□s room on 12-19-24. All residents who transfer with the assistance of staff and a gait belt are at risk of being impacted by this practice. Gait belt policy reviewed on 1-13-25 and no changes were made. All CNA staff will be in-serviced on 1-14-25 proper gait belt use and will complete a skill validation. All licensed nurses will be provided education on 1-16-25 on proper gait belt use. On 12-19-24, all rooms of residents that transfer or ambulate with assistance x 1-2 staff were checked to ensure a gait belt was present. QA will be completed twice weekly for no less than six weeks by Director of Nursing or designee on the use of a gait belt for transfers and/or ambulation. Observations will be made across all shifts on all units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be	

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F 689	Continued From page 9	F 689	documented on QA monitoring forms. After six weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to weekly x 6 weeks then monthly for no less than three months. All monitoring results will be reported quarterly to the QA committee.	
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 by: Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure food is served and stored in accordance with professional standards for food service sanitation	F 812	Impacted freezer was defrosted on 12/16/24 by maintenance staff. Staff member #13 was provided education regarding the use of gloves and hand hygiene on 12/19/24.	1/23/25

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F 812	Continued From page 10 in 1 of 1 kitchen (main kitchen). Failure to ensure a reach-in freezer remains free of frozen water/condensation and ensure proper glove usage when serving ready-to-eat foods has the potential to result in foodborne illness and may result in adverse consequences for residents, visitors, and staff. Findings include: Review of the facility policy titled "USE OF PLASTIC GLOVES" occurred on 12/19/24. This policy, dated 2005, stated, ". . . If used, single use gloves shall be used for only one task . . . used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. . . . ANYTIME A CONTAMINATED SURFACE IS TOUCHED, THE GLOVES MUST BE CHANGED. . . ." The 2022 Food and Drug Administration (FDA) Food Code, page 81, stated, ". . . 3-305.11 Food Storage. . . . FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination . . ." Annex 3 Page 384, stated, ". . . 3-305.12 Food Storage, Prohibited Areas. Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate . . . can be sources of microbial contamination for stored food. . . ." Observation on 12/16/24 at 1:37 p.m. showed a large amount of ice build-up on the back wall of a reach in freezer extending from the top to the bottom floor of the freezer, ice accumulation on top of a box containing ice cream bars and several closed boxes placed on top of the ice	F 812	Any of the kitchen freezers could be impacted by this practice. All kitchen staff could have potential to be impacted by improper hand hygiene. Glove and hand hygiene policies for kitchen staff were reviewed on 1/9/25 by Director of Nutrition Services. No updates were made at this time. Policy for defrosting freezers was developed on 1/15/25. Freezer checks were added to weekly maintenance schedule. Education done with dietary staff on ice buildup in freezers, hand hygiene, and glove use on 1/15/25 and 1/16/25. All dietary staff demonstrated proper handwashing and glove use at this time. Director of Nutrition Services, or designee, will perform weekly audits of meal services for a minimum of twelve weeks or until compliance is achieved and sustained. At this point audits of meal service will decrease to monthly for a minimum of nine months. Maintenance Director, or designee, will perform weekly checks of freezers to ensure there is no ice buildup for a minimum of twelve weeks. At this point audits may decrease to monthly and will continue as part of routine maintenance checks. The results of the meal service audits and the freezer audits will be reported to the QA committee on a quarterly basis.	

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	355084	A. BUILDING _____ B. WING _____	C 12/19/2024

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F 812	Continued From page 11 build-up on the bottom of the freezer. When asked about the ice accumulation, a dietary manager (#12) stated, "I am not sure why this happens. Maintenance takes care of this for us. I guess it's that time again." Observation of the tray line in the main kitchen on 12/17/24 at 12:00 p.m. showed a dietary staff member (#13) wore gloves while using utensils to dish food onto residents' plates. The staff member removed a food item from a warming oven, pushed a plate warmer cart out of his/her way, and without changing gloves, reached into a bag and placed bread onto a resident plate. The staff member (#13) failed to change gloves after touching non-food areas and before handling ready-to-eat food.	F 812		
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,	F 880		1/23/25

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F 880	Continued From page 12 visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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. (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.	F 880		

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F 880	Continued From page 13 §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, record review, policy review, and staff interview, the facility failed to follow standards of infection control and prevention for 4 of 18 sampled residents (Resident #2, #33, #75, and #236) and 2 supplemental residents (#9 and #43) observed. Failure to practice infection control standards related to enhanced barrier precautions (EBP), transmission-based precautions (TBP), and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Enhanced Droplet Precautions" occurred on 12/19/24. This policy, dated July 2022, stated, "Residents suspected of or confirmed to have COVID-19 will be placed on Enhanced Droplet Precautions . . . Doffing [removing] PPE [personal protective equipment] . . . Remove gloves immediately outside the room. Take care to not touch the contaminated surface of the glove. Perform hand hygiene. Remove gown . . . Remove goggles. . . . Remove N95 mask. . . Perform hand hygiene . . ."	F 880	CNA #9 was in-serviced on proper Enhanced Barrier Precautions procedures on 12-17-24. CNA #10 and CNA #11 were in-serviced on proper hand hygiene procedures 12-18-24. CNA #10 and CNA #11 were in-serviced on proper PPE doffing procedures on 12-19-24. The Nurse Manager received education on 12/19/24 regarding the immediate intervention required for observed policy noncompliance. Nurse #15 was in-serviced on proper glucometer cleaning and disinfection procedures on 12-19-24. All residents could potentially be impacted by this deficient practice. Hand hygiene policy reviewed on 1-13-25. No revisions made.	

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F 880	Continued From page 14 Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 12/19/24. This policy, dated April 2024, stated, ". . . PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . . . High-contact resident care activities include: . . . dressing . . . transferring . . . changing briefs . . ." Review of the facility policy titled "Standard Precautions" occurred on 12/19/24. This policy, dated December 1996, stated, "Standard Precautions incorporates previous CDC [Centers for Disease Control] recommendations for universal precautions, patient care equipment . . . The major emphasis is on the use of gloves and other protective equipment, devices, and controls to prevent or reduce hand, skin, and mucous membrane contact with blood and other potentially infectious materials. . . . Standard Precautions should be used for all residents at all times . . . The precautions apply to . . . feces . . .Gloves should be worn for . . . handling items or surfaces soiled with these substances . . . Hands should be washed immediately after gloves are removed. . . . Gowns should be worn during procedures . . . when soiling with these substances is likely . . ." -Review of Resident #2, #43, and #236's medical records occurred on all days of survey and identified diagnoses of Covid-19 infection. Observation on 12/16/24 at 2:30 p.m., showed a certified nurse aide (CNA) (#9) exited Resident #43 and #236's shared room wearing PPE and carrying two used drinking glasses. The CNA (#9) set the two glasses on a table outside of the residents' room, removed her PPE and placed	F 880	Glucometer Disinfection policy reviewed and was updated on 1-13-25. All licensed nursing staff will be provided education on policy changes on 1-16-25. Enhanced Barrier Precautions policy was reviewed on 1-13-25. No revisions made. Signage was placed at each nurse's station on 12-31-24 outlining the steps for cleaning and disinfecting shared resident equipment after each use. DONNING/DOFFING PPE signage updated on 12-31-24 with "Do not leave immediate area with PPE on". Enhanced Barrier Precautions signage was updated on 12-31-24 for clarity on high contact resident care activities. All CNA staff will be in-serviced on 1-14-25 on proper hand hygiene, enhanced barrier precautions, and doffing and complete a skills validation. All licensed nursing staff will be provided education on 1-16-25 regarding Enhanced Barrier Precautions, Hand hygiene, Doffing of PPE, and Glucometer cleaning and disinfection. QA will be completed twice weekly for no less than six weeks by Director of Nursing, Nurse Managers, or designee on the hand hygiene, doffing PPE, glucometer cleaning and disinfection, and enhanced barrier precautions procedures.	

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F 880	Continued From page 15 the glasses in the container with the dirty dishes. The CNA applied PPE and returned to the resident's room. The CNA failed to perform hand hygiene after removing PPE and before re-entering the resident's room. Observation on 12/18/24 at 10:20 a.m., showed a CNA (#10) exited Resident #2's room wearing PPE, and carried a meal tray down the hall, past the nurse's station and another resident, and placed the tray on a cart designated for dirty dishware. The CNA returned to the bin located outside the resident's room, removed her PPE and completed hand hygiene. During an interview on 12/19/24 at 10:55 a.m., an administrative staff member (#2) confirmed she expected staff to remove PPE and perform hand hygiene after leaving a Covid-19 positive room and before completing other tasks. - Review of Resident #75's medical records occurred on all days of survey. The care plan stated, "Potential for UTI [urinary tract infection] related to indwelling foley catheter. . . . Enhanced Barrier Precautions in place. . . ." Observation on 12/18/24 at 8:44 a.m., showed a CNA (#11) providing high-contact resident cares including changing the resident's brief, dressing, and transferring Resident #75. The CNA failed to wear a gown during the high-contact resident care. - Review of Resident #9's medical record occurred on 12/17/24 and identified EBP. Observation on 12/17/24 at 2:35 p.m. showed	F 880	Observations will be made across shifts all shift on all units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on QA monitoring forms. After six weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to weekly x 6 weeks then monthly for no less than three months. All monitoring results will be reported quarterly to the QA committee.	

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F 880	Continued From page 16 two CNAs (#10 and #11) performed hand hygiene, applied gowns and gloves, and changed Resident #9's brief soiled with bowel movement (BM). The CNA (#10) removed the resident's brief, cleansed the perineal area, removed her gloves and without performing hand hygiene, applied clean gloves. The CNA (#11) cleansed the resident's hands of BM, removed her gloves and without performing hand hygiene, applied clean gloves. Both CNAs applied a clean brief and clean linens to the resident's bed. The CNAs (#10 and #11) failed to perform hand hygiene after removing soiled gloves and before performing other tasks. - Observation on 12/19/24 at 5:00 p.m. showed a nurse (#15) entered Resident #33's room and without performing hand hygiene, donned gloves, checked the resident's blood sugar, removed the gloves, and again without performing hand hygiene, exited the resident's room. At the nurses' station, the nurse (#15) placed the glucometer on top of the medication cart, obtained an alcohol wipe and gloves from the cart, and returned to Resident #33's room. The nurse donned gloves without performing hand hygiene, administered insulin, exited the room and threw the gloves in the trash can. The nurse failed to perform hand hygiene throughout the observation. During an interview on 12/19/24 at 10:55 a.m., an administrative staff member (#2) confirmed staff should perform hand hygiene between glove changes.	F 880		