STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY SENIOR LIVING ON COLUMBIA	2900 14TH AVE S GRAND FORKS, ND 58201

(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 02/28/22 and concluded on 03/03/22.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility policy, review of the facility's investigation, resident and staff interview, the facility failed to implement policies related to the investigation and reporting of abuse/neglect for 1 of 1 sampled resident (Resident #35) with an injury of unknown origin. Failure to recognize an injury of unknown origin as potential abuse/neglect and implement their investigation/reporting policy placed all residents at risk for abuse/neglect and possible injury. Findings include: Review of the facility policy titled "Prohibition and Prevention of Resident Abuse, Neglect, Exploitation, Mistreatment and Misappropriation	F 607	The report of the alleged violation for Resident #35 will occur by April 6, 2022. All residents could potentially be affected by not reporting alleged violations to the Department of Health. All staff will complete an educational module titled "How to Address Potential Abuse, Neglect, Mistreatment, Exploitation, Involuntary Seclusion, and Misappropriation of Resident Property" which also addresses Injuries of Unknown Origin by April 6, 2022. Upon review of the policy related to this matter, the checklist will be updated by April 6, 2022 to improve documentation of	4/6/22

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

Electronically Signed | 03/30/2022

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F 607	Continued From page 1 of Property" occurred on 03/02/22. This policy, revised 08/12/19, stated, ". . . Valley Senior Living will ensure that all alleged violations involving . . . mistreatment . . . are reported to the Administrator of the facility and to other officials (including to the State Survey Agency . . .) in accordance with State law through established procedures. . . . All alleged violations that . . . result in serious bodily injury will be reported immediately, but not later than 2 hours after the allegation is made. . . ." During an interview on 02/28/22 at 2:06 p.m. Resident #35 stated, "My pain is in my left hip, broke it 3 months ago. Girls that haven't worked with me before pulled on my sling. I said don't jerk me, but they were being 'butt heads' and would not listen. Doctor said it will heal by itself, but I'll always have pain." Resident #35 said he reported the incident to the charge nurse, "she said they put me in my chair the right way, and they said they did. She wouldn't listen so I dropped it". Review of Resident #35's medical record occurred on all days of survey. The current care plan stated, "I am totally dependent on 2 staff for transferring. Total mechanical body lift . . ." Review of Resident #35's progress notes identified the following: * 09/16/21 at 3:26 p.m., "Resident is reporting an increase in pain to Left stump. States he felt during reposition earlier today it may have got pulled on. Has been utilizing PRN [as needed] Tramadol which he reported has been somewhat effective." * 09/16/21 at 7:00 p.m., "Writer called to notified	F 607	reported incidents. It is the responsibility of the Director of Social Services to monitor compliance with this issue on an ongoing basis and provide a monthly report of concerns/grievances and reported alleged violations to the facility Quality Assurance and Performance Improvement team.	

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F 607	Continued From page 2 [sic] on-call Physician about resident's pain to both knees and that resident suggesting going to the hospital. But NP [nurse practitioner] did not see the need for resident going to the hospital since there was no redness, swelling or bruise to affected areas. One time dose of Tramadol 50mg [milligrams] order." * 09/17/21 at 9:35 a.m., "Received a call from [Facility Name] Dialysis nurse at approximately 0850 [8:50 a.m.] stating upon assisting resident from the wheelchair with the lift resident reported an increase amount of pain to the left stump. [Facility Name] Dialysis Nurse stated resident was assisted back down into wheelchair and was going to be transferred to [Facility Name] ER for further evaluation. Informed [Facility Name] Dialysis Nurse that resident had reported earlier the pain seemed to be better under control and no discomfort was noted with transfer from bed to wheelchair this morning. [Facility Name] Dialysis Nurse stated the total lift that they utilize are different than the total lift utilized here. [Facility Name] Dialysis nurse stated the total lifts here have 4 hooks and the total lifts utilized at Dialysis only have 2 hooks for the sling." * 09/17/21 at 1:52 p.m., "Received a call from [Facility Name] Dialysis Nurse at approximately 1352 [1:52 p.m.] and [Facility Name] Dialysis Nurse stated [Facility Name] ER was in touch with them and that resident was going to be admitted to the hospital for fracture of left femur." * 09/17/21 at 3:58 p.m., "Received a call from [Facility Name] ER Nurse at approximately 1530 [3:30 p.m.] that resident would be discharging from the ER and going straight to Dialysis. Per [Facility Name] ER Nurse resident [sic] due to the type of fracture resident has it is a non operative type of fracture and will heal on it's own.	F 607		

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F 607	Continued From page 3	F 607		

[Physician] updated regarding resident returning from ER after completing Dialysis."

Review of the dialysis note dated 09/17/21 at 2:57 p.m. stated, "patient arrived from [Facility Name] for his dialysis treatment. When checking [Resident #35] into dialysis, he informed staff that he was pulled on hard by two CNA's [sic] Thursday morning at the nursing home during a transfer. We attempted to Hoyer [total body mechanical lift] lift him into the dialysis chair today and just a small movement of his left stump to string the Hoyer pad up to our lift caused him severe pain in his left hip. Visiting with the patient, he agreed to have his left sided pain evaluated in ER [emergency room] prior to his dialysis treatment. Informed ER staff and [Facility Name] staff of the plan."

Review of the "Injury Observation" form dated 09/17/21 at 08:31 a.m., stated, "Fracture to left hip. Resident stated it could have occurred during repositioning or from how he was positioned in the wheelchair on 9/16. Classification of Injury - Injury of known or suspected source."

Review of an email regarding the investigation of Resident #35's fracture occurred on 03/03/22. This email, dated 09/17/21 at 5:39 p.m., stated, "[Nurse #4] and [Administrator #2] talked about [Resident #35] and his concern this afternoon that two aides at Valley Senior Living were the cause of his fracture from a transfer yesterday. He described the transfer, which was appropriate to his care plan, but he had pain from the transfer. He said the staff laughed about his pain which I don't have the context of the conversation

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F 607	Continued From page 4 they were in, but we need to ask the staff about. While this could be construed as an allegation of abuse, I don't see this as reportable because 1. The specific transfer was described by the resident as a transfer appropriate to the care plan. It had an outcome of pain. The reported laughing of CNAs needs to be asked about but is not an allegation of abuse, neglect, or mistreatment. 2. We do not know when the fracture occurred . . ." A provider note dated 09/20/21, stated, "the exact mechanism and time of the injury is unclear. He is attributing it to a particular staff during a particular transfer . . . he did not have any fall or specific trauma, and is not able to get himself out of bed without assistance . . ." Review of an Orthopedic Clinic Progress Note dated 09/22/21, stated, "[Resident #35] . . . who presents to the clinic today for left subtrochanteric femur fracture in setting of AKA [above the knee amputation]. DOI [date of injury] 9/16/21 after he was boosted in his wheelchair. During an interview on 03/03/22 at 9:45 a.m., two administrative staff (#2 and #3) confirmed the facility did not report the alleged violation of serious injury to the State Survey Agency. During an interview on 03/03/22 at 10:06 a.m., a nurse (#4) stated, "Resident #35 told me, "They pulled on the sling and when they did that, something hurt." The nurse (#4) demonstrated pulling up on the sling from behind the resident.	F 607		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		4/6/22

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F 692	Continued From page 5 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide/offer fluids to 4 of 12 sampled residents (Resident #58, #73, #151 and #161) observed during cares and/or required staff assistance for fluid intake. Failure to provide fluids and/or assistance with fluid intake may result in dehydration, constipation, and urinary tract infections. Findings include: Review of the facility policy titled "Hydration/Dehydration" occurred on 03/03/22. This policy, revised October 2021, stated, ". . .	F 692	1. Residents # 58, #73, #151, and #161 have been assessed for dehydration risk by the dietitians (LRDs) and care plans will be reviewed and updated as needed by April 6, 2022. 2. All residents in the facility have the potential to be affected by this practice. 3. An online learning module with posttest will be completed by all staff in regards to the hydration standard of offering fluids with each care interaction by April 6, 2022. 4. The Staff Development RN or designee will be responsible to complete a minimum of twenty-five audits weekly	

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F 692	Continued From page 6 The facility will offer each resident sufficient fluid intake to maintain adequate hydration. . . ." - Review of Resident #161's medical record occurred on all days of survey. Diagnoses included intellectual disability, legally blind, and hearing loss. An admission Minimum Data Set (MDS), dated 02/08/22, identified Resident #161 required extensive assist of one staff member for eating. The current care plan stated, ". . . I have an ADL [activity of daily living] self-care performance deficit r/t [related to] Activity Intolerance, Acute Respiratory Failure. . . . I need 1:1 [one to one] assistance with my meals. . . ." Observations showed the following: * 03/01/22 at 10:11 a.m. a CNA (certified nursing assistant) (#2) and a staff nurse (#3) provided toileting for Resident #161 and failed to offer fluids before or after cares. * 03/02/22 7:55 a.m. an unidentified staff member checked Resident #161's vital signs and no fluids available in the resident's room. * 03/02/22 2:50 p.m. a CNA (#4) and a staff nurse (#5) provided toileting for Resident #161 and failed to offer fluids before or after cares. * 03/02/22 3:05 p.m. a CNA (#6) entered Resident #161's room, answered the call light, and failed to offer fluids to the resident. - Review of Resident #58's medical record occurred on all days of survey. Diagnoses included impaired cognitive function related to Alzheimer's/Dementia, impaired visual function related to macular degeneration, and hearing loss. A quarterly MDS, dated 12/24/21, identified Resident #58 required total assist of one staff member for eating.	F 692	for twelve weeks, followed by twenty-five audits per month for the remainder of the twelve months. The results of this audit will be reported to the Staff Development RN who will report monthly to the QAPI team. The need for further audits will be determined at the discretion of the QAPI team.	

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F 692	Continued From page 7 The current care plan stated, ". . . I have Dementia . . . Anxiety . . . I require total assist with meals . . . I am at nutritional risk with potential for weight loss . . . dehydration . . . impairment to skin integrity r/t dementia . . . provide and serve honey thick liquids, supplements as ordered . . ." Observations of Resident #58 showed the following: * 03/01/22 at 10:40 a.m. Two CNA's (# 14 and #15) provided transfer and cares for Resident #58 and failed to offer fluids before or after cares. * 03/02/22 at 10:07 a.m. a CNA (#15) provided transfer and cares for Resident #58 and failed to offer fluids before or after cares. - Review of Resident #151's medical record occurred on all days of survey. Diagnoses included spastic quadriplegic cerebral palsy and intellectual disability. A quarterly MDS, dated 02/13/22, identified Resident #151 required total assist of one staff member for eating. The current care plan stated,". . . I need assistance with my ADL's r/t impaired mobility from Cerebral Palsy d/t [due to] spastic quadriplegia and contractures . . . EATING: I need staff assistance to eat my meals . . . provide and serve mechanical soft diet . . ." Observation on 02/28/22 at 03:05 p.m. showed two CNA's (#16 and #17) provide catheter cares and transfer Resident #151 from bed to the wheelchair. Observations showed fluids available however staff failed to offer fluids before or after cares.	F 692		

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F 692	Continued From page 8 - Review of Resident #73's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident, and dementia. A significant change MDS, dated 01/05/22, identified Resident #73 required extensive assist of one staff member for eating. The current care plan stated, ". . . I have an ADL self-care performance deficit r/t weakness and debility related to my CVA [cerebrovascular accident] . . . . EATING: I need staff assistance/supervision at meals. Please assist/cue me . . ." Observation on 03/01/22 at 9:05 a.m. showed two CNA's (#7 and #8) transferred Resident #73 to the bed and failed to offer fluids before or after cares. During an interview on 03/03/22 at 9:30 a.m., an administrative nurse (#10) stated it is the facility's expectation "to offer resident's fluids with cares."	F 692		
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	F 880		4/6/22

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F 880	Continued From page 9 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. (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	F 880		

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F 880	Continued From page 10 (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 professional reference, review of facility policy and staff interview, the facility failed to follow infection control practices for 5 of 35 sampled residents (Resident #46, #70, #124, #140, #151) and 2 supplemental residents (#32 and #121) observed during cares. Failure to follow standard infection control practices has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: TRANSMISSION BASED PRECAUTIONS Review of CDC (Centers for Disease Control and Prevention) guidance found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html, updated August 13, 2021, stated, "Reusable eye protection should [sic] cleaned and disinfected after each	F 880	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 are completing hand hygiene and changing gloves, when necessary, in accordance with CDC guidelines. (2) Ensuring staff are disinfecting equipment between multiple residents. (3) Ensuring staff entering and exiting a room on TBP donned, doffed, disinfected,	

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F 880	Continued From page 11 patient encounter. . . . Ensure appropriate cleaning and disinfection after each use if reusable face shields or goggles are used." Review of CDC guidance found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, updated February 2, 2022, stated, ". . . a NIOSH [National Institute for Occupational Safety and Health]-approved respirator or facemask is indicated for PPE [personal protective equipment] . . . during care of a patient on Droplet Precautions, they should be removed and discarded after the patient care encounter and a new one should be donned." - Review of Resident #124's medical record occurred on all days of the survey. The physician's order dated 02/25/22, stated, "Full Standard,Contact, Droplet Precautions . . ." Observation on 02/28/22 at 2:41 p.m. showed Resident #124's door open with an isolation cart outside the room. Signage on the resident's door indicated contact precautions and PPE to be worn by staff but failed to include droplet precautions. Observation on 02/28/22 at 4:31 p.m. showed a CNA (certified nursing assistant) (#6) removed her gloves and gown prior to exiting Resident #124's room and removed the N95 masks outside the room. The CNA failed to remove and disinfect her goggles. The CNA wearing the contaminated goggles entered another resident's room. Observation on 02/28/22 at 4:33 p.m. showed a	F 880	and disposed of or stored personal protective equipment (PPE), in accordance with CDC guidelines. (4) Ensuring staff discard contaminated items appropriately and use new, clean items when providing cares for residents. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff when hand hygiene and changing gloves must be performed. (2) Educate all staff when to disinfect equipment. (3) Educate all staff selecting, donning, doffing and disposing of PPE when entering a room on TBP. To verify each staff understands the procedure, each will perform a successful return demonstration of selecting, donning, doffing and disposing of PPE for providing cares in a droplet precaution room. (4) Educate all staff when items drop on the floor they are to be discarded appropriately and not used when providing cares for residents. 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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	355067	A. BUILDING _____ B. WING _____	03/03/2022

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F 880	Continued From page 12 CNA (#7) removed his gloves and gown prior to exiting Resident #124's room and removed the N95 masks outside the room. The CNA failed to remove and disinfect his goggles. The CNA walked down the hallway and interacted with staff while wearing the contaminated goggles. - Review of Resident #46's medical record occurred on all days of the survey. The physician's order dated 02/22/22, stated, "Full Standard,Contact, Droplet Precautions . . ." Observation on 02/28/22 at 3:40 p.m. showed Resident #46's door open with an isolation cart outside the room with signage indicating contact and droplet precautions and PPE to be worn by staff. Observation on 02/28/22 at 4:28 p.m. showed a certified nursing assistant (CNA) (#5) donned PPE and entered Resident #46's room to provide cares. The CNA removed his gloves and gown prior to exiting the room. The CNA failed to disinfect his goggles, dispose of the N95 mask or store it in an acceptable way, and apply a new surgical mask. The CNA walked down the hall and interacted with staff while wearing the contaminated goggles and N95 mask. Observation on 03/01/22 at 1:09 p.m. showed two CNAs (#8 and #9) donned PPE and entered Resident #46's room to provide cares. The CNAs removed their gloves and gowns prior to exiting the room and removed the N95 mask outside the room. When asked where to get disinfectant wipes to clean goggles, the CNA (#8) stated, "Well, we usually use the wipes from the lift, or we can use these wipes," indicating the bleach	F 880	3. System Changes On or before 04/06/2022 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 complete hand hygiene and changing gloves when necessary. b. Failure to disinfect equipment when used with multiple residents. c. Failure to follow TBP procedures when doffing PPE. d. Failure to discard contaminated items used when providing cares for residents. (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff on the importance of hand hygiene and changing gloves and when both tasks must be performed. b. Educate all staff on the importance of disinfecting equipment when used with multiple residents. c. Educate all staff on the importance of following TBP procedures when doffing PPE. d. Educate all staff on the importance of discarding contaminated items, and not utilizing them when providing cares for residents. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention	

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F 880	Continued From page 13 wipes in Resident #124's isolation cart. The CNA (#8) continued down the hall to store the lift while wearing the contaminated goggles and the CNA (#9) continued down the hall and interacted with a resident while wearing the contaminated goggles. Both CNAs failed to perform hand hygiene, failed to disinfect their goggles, and continued to wear the contaminated goggles. During an interview on 03/02/22 at 9:32 a.m., an administrative nurse (#1) stated she expects staff to disinfect eye protection, change face masks and perform hand hygiene for the appropriate infection upon leaving a transmission based precaution room and before performing another task. DRESSING CHANGE/HAND HYGIENE/PERINEAL CARES - Observation on 03/01/22 at 9:22 a.m. showed a nurse (#12) changed Resident #140's dressing to her sacrum. With donned gloves, the nurse removed the soiled dressing, used a wipe to clean bowel movement (BM) around the wound and without changing gloves, applied the new clean dressing. - Observation on 03/02/22 at 8:40 a.m. showed a CNA (#9) assisted Resident #70 with morning cares. During cares, the CNA dropped the washcloth on the bathroom floor, picked it up, and proceeded to wash the resident's perineal area with the same wash cloth. During an interview on 03/03/22 at 10:00 a.m., an administrative nurse (#13), stated she expected staff to follow standard infection control practices.	F 880	and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring 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) Observation of all staff performing hand hygiene and changing gloves when necessary. (2) Observation of all staff disinfecting equipment when used with multiple residents. (3) Observation of all staff following TBP procedures when entering and exiting an isolation room. (4) Observation of all staff discarding items appropriately when they become contaminated. 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	

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F 880	Continued From page 14 DISINFECTION OF EQUIPMENT Review of the facility policy titled "Cleaning and Disinfection of Resident-Care Items and Equipment" occurred on 03/03/22. This policy, revised August 2020, stated, " . . . Resident-care equipment, including reusable items and durable medical equipment, will be cleaned and disinfected according to current CDC [Center for Disease Control] recommendations for disinfections . . . Reusable resident care equipment will be decontaminated and/or sterilized between residents . . . " -Observation on 02/28/22 at 3:05 p.m. showed two CNAs (#16 and #17) utilized a total lift and transferred Resident #151 to bed to provide perineal cares. Following cares, the CNA (#17) removed the lift from the resident's room, and placed it in the hallway. The CNA failed to disinfect the lift. An unidentified CNA transported the contaminated lift into another resident's room. - Observation on 02/28/22 at 3:15 p.m. showed two CNAs (#16 and #17) used a total lift and transferred Resident #32 to bed to provide BM cares. One CNA (#16) remained gloved throughout cares, touching/moving the lift to the hallway and failed to clean the lift after use. An unidentified CNA transported the lift down the hall to another resident's room. - Observation on 02/28/22 at 4:14 p.m. showed two CNAs (#16 and #17) used a total lift and transferred Resident #121 to and from the bed to provide perineal cares. Following cares, the CNA (#17) removed the lift from the resident's room	F 880	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 04/06/2022	

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F 880	Continued From page 15 and placed it in the hallway. The CNA failed to disinfect the lift. During an interview on 03/03/22 at 8:15 a.m., an administrative nurse (#1) stated she expects staff to disinfect all lifts between each resident use.	F 880		