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 _____	C 05/16/2024

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 and complaint survey started on 05/13/24 and concluded 05/16/24.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		6/14/24

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

Electronically Signed | 06/05/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 2 of 5 sampled residents on oxygen (Resident #32 and #47). Failure to develop a comprehensive care plan limited staffs' ability to communicate needs and ensure the continuity of care. Findings include: Review of the facility policy titled "Care Plan, Comprehensive Interdisciplinary" occurred on 05/16/24. This policy, dated 03/2017, stated, ". . . The comprehensive care plan must describe the following: 1. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. . . . " - Review of Resident #32's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease, heart disease, and palliative care. Physician's	F 656	1. Care plans for Residents #32 and #47 were reviewed and updated for oxygen use on May 14, 2024. 2. All residents who use oxygen have the potential to be affected by this practice. 3. All care plans for residents with physician orders for oxygen will be reviewed and updated as appropriate by June 14, 2024. All Licensed Nurses will receive education about the process for developing a comprehensive care plan regarding oxygen use via online module completion and a post-test on the education provided by June 14, 2024. 4. The DONS or designee will conduct a random audit of all residents receiving oxygen therapy monthly for three months, followed by five random audits monthly for the next nine months. These audits will include a review of the resident's orders for oxygen and accuracy of the care plan. The DONS will report the results of the audits to the VC Quality	

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F 656	Continued From page 2 orders stated the following: ". . . O2 [oxygen] PRN [as needed] 1.5 Liters per nasal cannula for comfort as needed and every day shift daily. O2 sat [saturation] when PRN O2 orders are in place . . . O2 tubing to be changed every night shift . . . Change nasal cannula every night shift every 14 day(s) . . . and as needed . . ." Observations on all days of survey showed Resident #32 with oxygen on per nasal cannula at all times. Resident #32's current plan of care failed to identify oxygen use related to respiratory/cardiac diagnoses and palliative care. - Review of Resident #47's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease. Physician's orders stated the following: ". . . Check O2 sats every shift for prn oxygen use . . . 1 L/min [liter per minute] oxygen via nasal cannula continuously as needed for For [sic] O2 less than 90 or SOB [shortness of breath] . . ." Observations on 05/13/24 at 1:33 p.m. and 05/14/24 at 10:16 a.m. showed Resident #47 with oxygen. Review of Resident #47's annual Minimum Data Set (MDS), dated 02/20/24, identified oxygen use. The resident's current plan of care failed to identify O2 use. During an interview on 05/16/24 at 11:00 a.m., an administrative nurse (#1) confirmed staff are expected to include residents' use of oxygen on the plan of care.	F 656	Review Team monthly for the next twelve months.	

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to provide care and services to prevent the development of pressure ulcers for 1 of 8 sampled residents (Resident #165) with prevalon boots (used for pressure relief) as ordered by the provider. Failure to apply the pressure relief boots as ordered may result in the development/worsening of pressure ulcers. Findings include: Review of the facility policy titled "Standards of Care" occurred on 05/16/24. This policy, dated 05/01/24, stated, ". . . Additional pressure relief measures will be maintained for residents who are considered at risk for pressure injury. . . ." Review of Resident #165's medical record occurred on all days of survey. Diagnoses	F 686	1. The care plan and CNA Kardex for Resident #165 was updated on May 21, 2024 to read, “I need assistance to apply bilateral prevalon boots, on while in bed. Encourage me to wear them while in bed as I choose to not wear them at times.” 2. All residents who have orders for prevalon boots have the potential to be affected by this practice. 3. An audit for all residents who have prevalon boots was conducted on May 28, 2024 to ensure that the care plan was being followed for prevalon boot use and that the care plan and CNA Kardex clearly defined the usage for each resident. All Licensed Nurses and CNAs will receive education about the skin prevention protocol including prevalon boots and their importance via online module completion and a post-test by June 14,	6/14/24

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F 686	Continued From page 4 included a stage three pressure ulcer on the right ankle. The current care plan stated, "I have a potential impairment to skin integrity r/t [related to] Impaired [sic] mobility . . . I need assistance to apply bilateral prevalon boots, on while in bed. . . . " A provider's order, dated 11/13/23, stated, "Prevalon boot to BLE [bilateral lower extremities] for potential for high risk skin breakdown r/t immobility to be worn when in bed." Observations on 05/14/24 at 10:55 a.m. and 05/15/24 at 12:00 p.m. showed Resident #165 in bed without prevalon boots in place. The facility failed to implement pressure relief interventions for Resident #165 as ordered.	F 686	2024. 4.The DONS or designee will conduct an audit of all residents who wear prevalon boots monthly for three months followed by five resident audits monthly for the next nine months. The DONS will report the results of the audits to the VC Quality Review Team monthly for the next twelve months.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on record review and review of facility reported incident documents, the facility failed to provide adequate supervision and assistance devices to prevent accidents for 1 of 1 closed record (Resident #285) reviewed for a fall. Failure to use a gait belt and to provide adequate supervision resulted Resident #285 sustaining a fracture.	F 689	Supervision/Assistance with Transfers 1. Resident #285 is no longer residing in the facility. 2. All residents who require assistance of one person with a gait belt are at risk for this practice. 3. All CNAs are skills validated on gait belt use in a variety of scenarios upon orientation and annually. All Licensed	6/14/24

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F 689	Continued From page 5 Findings include: Review of Resident #285's medical record occured on 05/16/24. The care plan identified the following: ". . . Focus: I have an ADL [activities of daily living] self-care performance deficit r/t [related to] Activity intolerance following a hospital stay for weekend, near syncope . . . and chronic back pain r/t degenerative disc disease (Initiated on 07/12/23). . . . Interventions: AMBULATION: I am able to ambulate with assist of 1 staff with gait belt and FWW [front wheeled walker] . . . . PERSONAL HYGIENE: I require assistance by 1 staff with person hygiene, perineal and oral care. . . . TOILET USE: I need assist of 1 with toileting. . . . TRANSFER: I am able to transfer with assist of 1 with gait belt and my FWW. . . . Focus: I am at risk for falls r/t Deconditioning, incontinence, near syncope . . . Goal: I will not sustain serious injury . . . Interventions: Be sure my call light is in reach and encourage me to use it for assistance as needed. . . . I need a safe environment with even floors free from the spills and /or clutter, adequate reduced glare lighting . . . " Review of Resident #285's nurses notes identified the following: * 11/29/24 at 9:03 p.m.; " Resident was transferring to bed and lost balance fell and hit top of head. No injuries noted. Denies pain. . . . . Neuro [neurological] checks initiated. . . ." * 11/29/23 at 11:32 p.m.; ". . . Resident fell at 2016 [8:16 p.m.] . . . . [Name of physician] notified of fall and aware resident hit head. Neuro checks initiated. No injuries noted. Resident Alert and Oriented. Primary decision maker . . . notified of fall."	F 689	Nurses and CNAs will receive education about gait belt use via online module and will complete a post-test by June 14, 2024. 4. The Staff Development RN or designee will complete minimum of 30 Resident Service Audits per month. The Resident Service Audits evaluate a number of care related skills including proper gait belt usage. The Staff Development RN will report the results of the audits to the VC Quality Review Team monthly for the next twelve months. Supervision with Meals 1. Resident #165's care plan and CNA tasks were revised to reflect that fluids did not require one to one supervision on May 15, 2024. 2. All residents who require assistance with their snacks have the potential to be affected by this practice. 3. The Dietitians will audit the care plan and CNA tasks for all residents who have snacks to ensure accurate instructions are given to staff regarding level of supervision for food and drink by June 14, 2024. All Licensed Nurses and CNAs will receive education about providing the correct level of assistance for food and drink via online module and will complete a post-test by June 14, 2024. 4.The Licensed Registered Dietitians will audit the care plan and CNA tasks for all residents who have snacks to ensure accuracy every two weeks for three months and monthly for the next nine	

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F 689	Continued From page 6 * 11/30/23 at 2:30 a.m.; ". . . Resident got up to go to the bathroom around 1:30am. Reported pain 10 out of 10. When resident sat in wheelchair she started gagging and spitting up thick sputum. Reported of feeling funny but couldn't explain. Action: Gave Tylenol 500 mg [milligrams] PRN [as needed]. Called [Name of physician] and notified of change in status. Resident primary decision maker [name] was notified. . . . Resident sent to ER [emergency room] via wheelchair at 0208 [2:08 a.m.] . . . Response: [Name of physician] stated, "Send her in." [name of primary decision maker] stated, 'I'll go to the ER.' " * 11/30/23 at 7:23 a.m.; " . . . . Resident returned from ER at this time. Per report from ER resident has TLSO [thoracic-lumbo-sacral orthosis] brace. . . . " * 11/30/23 at 11:22 a.m.; "Resident Concern Progress Note . . . Resident had fall in room last evening and did not have gait belt on as care planned. Resident and CNA [certified nurse aide] reported that resident hit her head. No visible injury noted. At 1:30AM, resident woke up and vomited, provider updated and resident was sent to ER. . . . RN [registered nurse] notified daughter of fall and notified her of change in status when she went to the ER. Daughter met resident in ER. Initial findings regarding Resident concern: CNA did not follow care plan for transfer/ambulation. Resident was assessed in ER, CT scan showed compression fracture of T-9. . . . Resident returned to [nursing home]. . . ." Review of the Facility Reported Incident investigation identified a staff member assisted resident to the bathroom and the resident put the	F 689	months. The Staff Development RN or designee will observe the accuracy of the level of assistance provided to the care plan for 25 residents every other week for three months and 25 residents monthly for nine months. The LRD and Staff Development RN will report the results of their audits to the VC Quality Review Team monthly for the next twelve months.	

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F 689	Continued From page 7	F 689		

call light on when done. The staff member returned and assisted to pull her brief and pants up, then walked behind the resident to the sink where she was removed her dentures and put them away. The staff member left resident at the sink and moved to open the covers on resident's bed and set up her pillows. As the staff member turned around, the resident started to lean back and fell before he/she could get to her. The staff member did not have a gait belt on resident and reports that he/she didn't think the resident needed it.

The facility failed to ensure staff followed Resident #285's plan of care by utilizing a gait belt and this failure resulted in a fall and fracture.

2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision necessary to prevent accidents for 1 of 1 sampled resident (Resident #165) who required one to one supervision with meals. Failure to stay with the resident while eating as care planned places the resident at risk for choking.

Findings include:

Review of the facility policy titled "Care Plan, Comprehensive Interdisciplinary" occurred on 05/16/24. This policy, dated March 2017, stated, ". . . The services provided or arranged by the facility will meet professional standards of quality, be provided by qualified persons, and be culturally-competent and trauma-informed. . . ."

Review of Resident #165's medical record occurred on all days of survey. The current care

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F 689	Continued From page 8 plan stated, ". . . EATING: I am to eat all my meals out of bed in the upright position. Encourage me to go to the family room. I require 1:1 assist for meals d/t [due to] hx [history of] coughing with meals. . . . I am at increased nutrition risk r/t [related to] h/o [history of] CVA [cerebrovascular accident/stroke], aphasia, dysphasia [language disorder that affects speech production and comprehension], and FTT [failure to thrive]. . . . Provide and serve Regular diet with regular texture/thin liquids, breads and straws are ok per SLP [speech language pathology] 12/8/23. Resident does require assistance/observance at meals h/o of choking. . . . I have a history of swallowing problems. Report to the dietitian if I have any difficulty with chewing/swallowing my food. . . ." A task that is completed by care staff stated "NUTRITION - Snacks PM [afternoon] -encourage high calorie item; HS [bedtime] -choc milk or ice cream *needs 1:1 supervision-high choking risk." During an observation on 05/14/24 at 10:55 a.m., the certified nurse aide (CNA) (#7) placed a supplement shake with a straw on the resident's bedside table and left the resident unattended. During an interview on 05/15/24 at 1:51 p.m., the nurse (#5) stated the resident could reach the protein shake independently but would expect the CNA who gave the shake to stay with the resident.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		6/14/24

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F 690	Continued From page 9 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide appropriate toileting for 1 of 29 sampled residents (Resident	F 690	1. Resident #98 had a Foley catheter placed on May 24, 2024. 2. All residents who have a toileting	

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F 690	Continued From page 10 #98) who required staff assistance with toileting. Failure to provide toileting may result in a loss of dignity and placed residents at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and risk for fall and/or injuries. Findings include: Review of Resident #98's medical record occurred on all days of survey. Diagnoses included skin breakdown. The quarterly Minimum Data Set (MDS), dated 03/19/24, identified frequently incontinent of urine, extensive assist of two for toileting, and at risk for pressure ulcers. The current care plan stated, ". . . at risk for alterations to skin integrity . . . TOILET USE: I need assist of 2 with total lift . . . I am incontinent of bowel and bladder . . ." * Observation on 05/13/24 at 4:09 p.m. showed Resident #98 sitting in the wheelchair in her room with urine on the floor under the wheelchair. * Observation on 05/13/24 at 5:24 p.m. showed two certified nurse aides (CNAs) (#10 and #11) entered Resident #98's room and observed the resident's clothing, wheelchair, and floor wet with urine. The CNAs assisted Resident #98 with incontinence cares. Resident #98 stated she felt wet and uncomfortable. Review of the CNA toileting task report stated, staff need to assist Resident #98 with toileting every 3 hours from 4:00 a.m. to 10:00 p.m. Review of Resident #98's toileting task report, dated March 1st through May 15th, 2024,	F 690	schedule have the potential to be affected by the practice of the timing of assistance or inaccurate documentation related to toileting. 3. The RN Care Coordinators will review the plan of care for all residents with a toileting schedule by June 14, 2024. The RN Care Coordinators or their designees will audit the documentation to ensure the plan of care is followed by June 14, 2024. All Licensed Nurses and CNAs will receive education about toileting schedules and accurate documentation via online module and will complete a post-test by June 14, 2024. 4. The RN Care Coordinators or their designees will conduct an audit of all residents who have a toileting schedule for the appropriateness and accuracy of the toileting schedule every other week for three months and monthly for nine months. The DONS will report the results of the audits to the VC Quality Review Team monthly for the next twelve months.	

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F 690	Continued From page 11 identified 76 occasions where staff failed to assist the resident with toileting every three hours from 4:00 a.m. to 10:00 p.m. The log showed gaps of approximately 3.5 to 7 hours between staff assistance with toileting. During an interview on 05/14/24 at 2:49 p.m., an administrative nurse (#1) confirmed staff are expected to provide toileting assistance to all residents.	F 690		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of	F 849		6/14/24

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F 849	Continued From page 12 the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of	F 849		

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F 849	Continued From page 13 the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State	F 849		

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F 849	Continued From page 14 scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides	F 849		

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F 849	Continued From page 15 orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure residents' records contained the hospice election form for 1 of 5 sampled residents (Resident #79) receiving hospice services. Failure to obtain this document limits staff's ability to ensure coordination of care between the facility and the hospice. Findings include: Review of Resident #79's medical record occurred on all days of survey and identified Resident #79 elected Hospice services on 04/29/24. The medical record lacked the hospice election form. During an interview on 05/15/24 at 5:07 p.m., an administrative nurse (#1) confirmed the medical record for Resident #79 lacked the hospice election form.	F 849	1. The hospice election form for Resident 79 was scanned in on May 15, 2024 upon notification that is was not present in the medical record. The hospice election form for Resident 79 was completed by hospice staff on April 29, 2024 prior to the resident receiving hospice services. 2. All residents receiving hospice services have the potential to be affected by this practice. 3. The medical records for all residents receiving hospice services were audited on May 23, 2024 to ensure the presence of the hospice election form. The facility contract with the hospice agency indicates that hospice will provide information to the facility including the election form. Education on this standard will be provided to the Health Unit Coordinators who are responsible to scan in the information in a timely manner. 4. The DONS or designee will conduct an audit of the hospice information scanned	

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F 849	Continued From page 16	F 849	in the medical record of all residents receiving hospice services monthly for three months, followed by audits on the newly admitted residents to hospice monthly for the next nine months. The DONS will report the results of the audits to the VC Quality Review Team monthly for the next twelve months.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		6/14/24

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F 880	Continued From page 17 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for (2 of 21) sampled residents (Resident #49, and #154) and one supplemental resident (Resident #56) observed during personal cares. Failure to follow infection control standards related to hand hygiene and emptying of a urinary bag has the potential to spread infection throughout the facility and could transmit those infections to residents, staff, and visitors. Findings Include: Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 05/15/24. This policy, revised in May 2023, stated, ". . . all personnel shall follow the handwashing/hand hygiene procedures . . . 2. Before and after direct contact with residents. . . ." Review of the facility skills validation titled "Emptying Urinary Drainage Bag" occurred in 05/15/24. This skills validation, revised on February 2022, stated, ". . . 8. . . . Place graduate on paper towel. . . . 9. . . . Do not let spout or clamp touch the graduate. . . . 11. Place graduate on a paper towel on a flat surface. . . ." - Observation on 05/13/24 at 2:09 p.m., showed a certified nurse aide (CNA) (#2) carried his/her soiled gown out of an unidentified resident's room and placed it on a table outside of Resident #56's room. The CNA (#2) entered Resident 56's room to answer the call light, removed the resident's	F 880	1. CNAs #2 and 6 will be reeducated to follow appropriate standards related to hand hygiene and CNA #3 will be reeducated on emptying the urinary drainage bag by June 14, 2024. 2. All residents have the potential to be affected by lapses in hand hygiene. All residents with urinary catheters have the potential to be affected by improperly emptying the urinary drainage bag. 3. All CNAs and Licensed Nurses will receive education about infection prevention and control related to hand hygiene and emptying the urinary drainage bag via online module completion and a post-test by June 14, 2024. 4. The Infection Preventionist or designee will conduct ten random hand hygiene audits weekly for three months followed by five random audits weekly for the next nine months. The Infection Preventionist or designee will conduct ten random observations of emptying the urinary drainage bags monthly for three months followed by five random audits monthly for the next nine months. The Infection Preventionist will report the results of the audits to the VC Quality Review Team monthly for the next twelve months.	

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F 880	Continued From page 19	F 880		

shoes, and exited the room. The CNA (#2) re-entered the room with a mechanical lift and transferred the resident into bed. The CNA adjusted Resident #56's socks and blanket, placed the call light and a stuffed animal next the resident, offered the resident a drink then exited the room. The CNA (#2) failed to perform hand hygiene before entering and before exiting Resident #56's room.

- Observation on 05/14/24 at 10:19 a.m., showed a CNA (#3) placed a graduated container on Resident #154's bedding and failed to place a paper towel barrier under the container. The CNA held the entire urine collection bag inside the container and the spout, clamp, and leg bag touched the urine contents and the sides of the container. The CNA (#3) emptied the urine, rinsed and dried the graduate container, and placed it on Resident #154's dresser without a barrier between the container and dresser. The CNA (#3) failed to disinfect the catheter spout after it had touched the inside of the container.

During an interview on 05/16/24 at 12:32 p.m., an administrative nurse (#1) confirmed staff should have performed hand hygiene and followed proper procedures for emptying the catheter drainage bag.

- During an observation on 05/14/24 at 9:08 a.m., a CNA (#6) transferred Resident #49 from the recliner to the bath chair. Without wearing gloves, the CNA (#6) removed a wet brief from the resident and discarded it in the garbage. The CNA stated, "I should have had gloves on." Without performing hand hygiene, the CNA then wrapped a blanket around the resident, opened

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F 880	Continued From page 20 the resident's door, and wheeled the resident to the tub room. During an interview on 05/16/24 at 11:00 a.m. administrative nurse (#1) confirmed staff should perform hand hygiene after handling a wet brief.	F 880		