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	355037	A. BUILDING _____ B. WING _____	C 09/15/2021

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SMP HEALTH - ST ALOISIUS	**325 E BREWSTER ST HARVEY, ND 58341**

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification and complaint survey started on 09/13/21 and concluded 09/15/21.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to ensure residents could safely self-administer medications for 1 of 1 sampled resident (Resident #45) observed with medication at the bedside. Failure to obtain a physician's order for the resident to self-administer medications (SAM) and evaluate/re-evaluate the resident's ability to safely self-administer medications may result in a medication error and/or harm to a resident. Findings include: Review of the policy titled "Self Administering Medications" occurred on 09/15/21. This policy, dated June 20, 2019, stated, ". . . The Interdisciplinary team will determine who is responsible for storage location and documentation of self administration of medication on an individual basis. This will be documented on the resident's care plan . . . A Physician's order will be required to self administer medication."	F 554	1. Resident #45 not willing to participate in self-administration of medication assessment process. Resident has been working towards discharge home with services. This is planned for October 4, 2021. Nurses were educated on proper procedure of medication administration which included not leaving medications at bedside without resident being deemed able to self-administer medication. Nursing staff and CMAs were educated through communication board on September 22, 2021 to not leave medications in resident rooms. Medication Administration policy was updated to include nurses to observe residents to take medications. All CNAs and CMAs were educated on policy at staff meeting on September 22, 2021. 2. All residents receiving medication have the potential to be impacted. 3. The Medication Administration policy was updated to specifically state nurse is to observe resident to take medications. All nurses and CMAs were educated at	10/8/21

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

Electronically Signed | 09/30/2021

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F 554	Continued From page 1 Observation on 09/13/21 at 10:43 a.m. identified a medication cup on the resident's bedside stand containing 2 white pills. During interview, Resident #45 stated the cup contained Tylenol and to leave the medication where it was. Review of Resident #45's medical record occurred all days of survey. Physician's orders identified "Tylenol Tablet 325 MG (milligrams) give 2 tablets by mouth every 4 hours as needed for Pain; Elevated Temperature," and "Tylenol Tablet 325 MG 2 tablet by mouth two times a day for Pain; Comfort scheduled for 9:00 a.m. and 9:00 p.m.." Review of September's medication administration record (MAR) identified the resident did not receive an as needed (PRN) dose of Tylenol on 09/13/21, and the last scheduled dose of Tylenol was given at 9:00 a.m. The record lacked a physician's order for self-administering of medication (SAM), an assessment for self-administering medication, and a problem related to SAM on the care plan. During an interview on 09/14/21 at 3:02 p.m., a facility nurse (#1) confirmed facility staff should not leave medication in Resident #45's room.	F 554	Nurse's Meeting on new policy and proper procedure September 22, 2021. 4. A QI monitor was put in place to observe for proper administration of medication to be completed weekly for four weeks and monthly for three months and quarterly thereafter for one year. The DON or assigned designee will be responsible and results will be reported at facility Quality Assurance meetings.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		10/8/21

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F 758	Continued From page 2 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced	F 758		

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F 758	Continued From page 3 by: Based on record review, facility policy review, and staff interview, the facility failed to monitor and assess the continued need for psychotropic medications for 2 of 2 sampled residents (Resident #38, and #68) with as needed (PRN) psychotropic medications. Failure to limit PRN antipsychotic medication orders to 14 days and ensure the physician evaluates residents prior to renewal may result in the residents receiving unnecessary medications and experiencing adverse reactions. Findings include: Review of the facility's policy titled "Use of Psychoactive Drugs" occurred on 09/15/21. This policy, dated April 2018, stated, ". . . Procedure: " . . . PRN orders for psychotropic drugs are limited to 14 days, except as provided if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. He or she should document their rationale in the resident's medical record and indicate the duration for the PRN order . . ." - Review of Resident #38's medical record occurred on all days of survey. Diagnoses included dementia with behavior disturbance. The record identified a physician order, dated, 07/14/21, "Lorazepam [antianxiety medication] Tablet 0.5 MG [milligrams]. Give 0.5 tablet by mouth as needed for severe restlessness related to unspecified dementia with behavioral disturbance." - Review of Resident #68's medical record	F 758	1. Resident #38 and #68 were impacted by this deficient practice. Both residents had prn psychoactive medications re-evaluated on September 15, 2021. 2. All residents who are on prn psychoactive medications have the potential to be impacted. 3. All residents who are on prn psychoactive medications have the potential to be impacted. Nursing staff was educated on September 22, 2021 at Nurse's Meeting on proper procedure and regulation requirements. Psychoactive Medication policy was updated to reflect new interventions put in place to help prevent 14 day re-evaluation from being missed. When prn psychoactive medication orders are obtained, order will reflect needed re-evaluation and an alert will be entered into the ETAR to alert nurse of re-evaluation due on that date. 4. DON will be responsible for QI to ensure re-eval of prn psychoactive medications. QI will be completed weekly for four weeks, monthly for three months and quarterly thereafter for one year.	

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F 758	Continued From page 4 occurred on all days of survey. Diagnoses included anxiety and dementia. The record identified a physician order, dated 08/20/21, "Lorazepam Tablet 0.5 mg. Give 1 tablet by mouth as needed for anxiety." The medical record lacked a physician's order to discontinue the PRN Lorazepam after 14 days or re-evaluate Resident #38 and #68's need for continued use. During an interview on 09/15/21 at 3:00 p.m., a supervisory nurse (#1) confirmed the facility staff failed to discontinue or re-evaluate the need for Resident #38 and #68's Lorazepam.	F 758		
F 812 SS=E	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	F 812		9/30/21

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F 812	Continued From page 5 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, and staff interview, the facility failed to prepare and serve food under sanitary conditions during 2 of 3 days of meal service observations (09/13/21 and 09/14/21) for Unit B. Failure to follow proper hand hygiene and glove use during meal tray service has the potential to result in foodborne illness to residents. Findings include: Review of the facility policy titled "Gloves" occurred on 09/14/21. This policy, dated March 2016, stated, ". . . Food preparation shall be done using sanitary precautions . . . Hands should never touch food in ready-to-eat form . . . Gloves shall be worn when coming into contact with food during food preparation and serving . . . Gloves shall be taken off, discarded and hands washed before going to another task." Review of the facility policy titled "Food Service Glove Use" occurred on 09/15/21. This policy, revised February 2021, stated, ". . . Gloves will be worn when handling ready to eat foods and while serving meals . . . Hands will be washed before putting on clean gloves . . . Gloves will be taken off, hands washed and clean gloves put on after touching possible unclean surfaces. . . ." Observations showed the following: * 09/13/21 at 11:38 a.m. - A dietary staff member (#2) wore gloves while prepping meal trays, opened the freezer door with gloved hand, and took a piece of bread from the bread bag with the	F 812	1. The CDM and Dietitian have educated staff on proper hand hygiene and glove use. 2. Staff will practice proper hand hygiene and glove use while preparing and serving meals. 3. The CDM and Dietitian will continue to educate staff on proper hand hygiene and glove use and will observe staff during serving at least three times per week. 4. A QI monitor on proper hand hygiene and glove use will be performed three times weekly for one year to ensure that staff are practicing proper hand hygiene and glove use. The results will be reported to the QI Committee at regularly scheduled meetings. 5. Corrective action was taken on September 14, 2021 after meeting with one of the surveyors. Correct action continued through September 29, 2021 until all dietary staff were re-educated on proper practice for hand hygiene and glove use.	

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F 812	Continued From page 6 same gloved hand. * 09/13/21 at 11:49 a.m. - A dietary staff member (#2) wore gloves while prepping meal trays, fixed placement of face mask, and took piece of bread from the bread bag with the same gloved hand. * 09/14/21 at 7:46 a.m. - A dietary staff member (#3) wore gloves while prepping meal trays, opened the fridge door, then picked up a piece of toast to butter using the same hand. * 09/14/21 at 7:55 a.m. - A dietary staff member (#4) wore gloves while transporting a cart into the kitchenette. The staff member wiped her gloved hands with a wet cloth, picked up a banana, cut off the ends, and placed it on a resident tray. The staff member touched a cupboard door, wiped gloved hands with a wet cloth, and continued prepping trays using the same gloved hand. * 09/14/21 at 8:00 a.m. - A dietary staff member (#3) wore gloves while prepping meal trays. The staff member removed a bagel from its wrapper and sliced it, touched trays, removed a piece of bread from the bread bag, placed it in a toaster, touched cereal container, removed the bread from the toaster, and touched plates using the same gloved hand. During an interview on the morning of 09/15/21, a dietary manager (#5) stated she expected staff to wash their hands and change gloves when gloves are contaminated or switching tasks.	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	F 880		10/8/21

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F 880	Continued From page 7 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: (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	F 880		

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F 880	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 7 sampled residents (Resident #8, #23, and #38) and 1 supplemental resident (Resident #59) during observation of perineal cares and mechanical lift transfers. Failure to practice infection control related to hand hygiene and glove use and disinfecting equipment has the potential for transmission of communicable diseases and infections to residents and staff. Findings include:	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for:	

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F 880	Continued From page 9 Staff failed to provide a copy of the policy addressing disinfecting equipment. Review of the facility policy, "Hand Hygiene" occurred on 09/15/21. This policy, revised 03/22/21, stated, ". . . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residence [sic], and visitors. . . . Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. . . . Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. . . . After handling items potentially contaminated with body fluids . . . During resident care, moving from a contaminated body site to a clean body site . . . after assistance with personal body functions . . ." Observations showed the following: * 09/13/21 at 3:24 p.m., two certified nursing assistants (CNA #5 and #6) transferred Resident #23 from the bed to her wheelchair with a Hoyer (full body mechanical lift). The CNAs placed the lift in the hallway to use with another resident and failed to disinfect the lift. * 09/13/21 at 3:56 p.m., two CNAs (#5 and #6) transferred Resident #38 from the bed to his wheelchair with a Hoyer. The CNAs failed to disinfect the lift after use. * 09/14/21 at 8:57 a.m., a CNA (#3) changed Resident #8's brief soiled with urine and performed perineal care, then cleansed the resident's back and assisted with pants. The CNA (#3) failed to perform hand hygiene and change gloves between tasks. * 09/14/21 at 11:40 a.m. a CNA (#3) changed Resident #59's brief soiled with feces and	F 880	(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. 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. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 10/08/2021 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to complete hand hygiene and changing gloves when necessary. b. Failure to disinfect equipment when used with multiple residents.	

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F 880	Continued From page 10 performed perineal care. The CNA transferred the resident with a Hoyer, touching the lift sling, lift handles, and hand controls with contaminated gloves. The CNA (#3) failed to perform hand hygiene and change gloves between tasks and disinfect the lift equipment between residents. During an interview on 09/15/21 at 3:05 p.m., an administrative nurse (#2) confirmed she expects staff to perform hand hygiene and change gloves after providing cares and disinfect lift equipment between residents.	F 880	(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. (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 and control within the facility through quality assurance process improvement (QAPI) methods. This was completed on September 29, 2021. 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. Observations will be made across all shifts and neighborhoods/units.	

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F 880	Continued From page 11	F 880	Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 10/08/2021	
F9999	FINAL OBSERVATIONS Based on record review, facility investigation report review, and staff interview, the complaint issues investigated in conjunction with the standard Medicare/Medicaid survey were not substantiated.	F9999		