STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - ST ALOISIUS	325 E BREWSTER ST HARVEY, ND 58341

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F 000	INITIAL COMMENTS The standard Medicare and Medicaid recertification survey started on 01/16/24 and concluded 01/18/24.	F 000		
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 staff interview, the facility failed to provide the necessary treatment/services to prevent and/or promote healing or worsening of a pressure injury for 1 of 3 sampled residents (Resident #63) observed with a pressure injury. Failure to identify/report a skin issue may result in the development/worsening of a pressure injury and delayed treatment of Resident #63's pressure injury. Findings include: Review of Resident #63's medical record occurred on all days of survey. Diagnoses	F 686	F686 1. On January 17th resident #63 had skin prep ordered as treatment to area on coccyx per standing order. LRD notified on 01-18-24. Reposition schedule implemented. Staff education was provided to nursing staff on the following dates regarding skin observations, reporting of findings and care of resident, use of PointClickCare EMR charting system to alert on skin condition and document. Mandatory nurses/CMA meeting on 01-25-24. Mandatory C.N.A. meetings on 01-23-24, 01-24-24 and 01-25-24.	2/16/24

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

Electronically Signed | 02/15/2024

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F 686	Continued From page 1 included dementia, Parkinson's disease, and diabetes. The admission Minimum Data Set (MDS), dated 12/23/23, identified at risk of developing pressure ulcers, required a pressure reducing device for chair, and no pressure ulcers/skin issues. The care plan stated, ". . . Potential for impaired skin integrity related to Bladder Incontinence, Bowel incontinence, Impaired Mobility . . . Inspect skin daily with cares and report any impairment." The record failed to show assessment, monitoring or documentation for a pressure injury since admission. On 01/17/24 at 9:57 a.m., a certified nurse aide (CNA) (#7) provided incontinence care for Resident #63. Observation showed a small black scab/injury to coccyx directly over a bony prominence surrounded by skin discoloration. The CNA indicated nursing was aware of this scab/injury. Observation of Resident #63 pressure injury occurred on 01/18/24 at 7:56 a.m. with an administrative nurse (#2) present. The administrative nurse (#2) agreed that it is an area of concern and reported being unaware of this skin issue. During an interview on 01/18/24 at 11:21 a.m., an administrative staff member (#1) stated she expected staff to follow facility procedures and report any skin concerns to nursing staff.	F 686	2. All residents have the potential to be affected. 3. Education was given at Nurse's meeting on 01-25-24 and C.N.A. meeting on 01-23-24, 01-24-24 and 01-25-24. Updated weekly resident assessment to include new specific assessment progress note section on 02-07-24 and policy updated. PointClickCare EMR charting system task in place to ask C.N.A. every shift for every resident if there is any skin condition concerns. If concern marked yes alert is sent to nurse dashboard. Nurse to monitor dashboard and clear when assessment completed. Implemented weekly skin meetings consisting of the IDT team to discuss residents with current skin issues, those who trigger for changes or concerns and progress note with interventions is put into PointClickCare EMR charting system. 4. QI will be implemented with ADON/QI nurses responsibile for 1. Monitoring skin alerts are followed up on per nursing. 2. Weekly nursing skin assessments are completed. 3. Interventions and treatments put in place when skin concerns are reported. QI to be completed weekly for four weeks, monthly for three months and quarterly for one year. ADON will report to the QI Committee at regular scheduled meetings. 5. 02-16-24	
F 744 SS=G	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		2/16/24

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F 744	Continued From page 2 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident interviews, the facility failed to provide appropriate dementia care and services for 1 of 1 sampled resident (Resident #65) with a diagnosis of dementia and wandering behaviors. Failure to adequately assess for necessary care and services, and monitor behaviors and implement effective behavior management interventions resulted in a decreased level of psychosocial well-being for Resident #65 as well as other residents affected by the behaviors. Findings include: The facility failed to provide a policy on dementia care. Review of Resident #65's medical record occurred on all days of survey. Diagnoses included dementia, psychotic and mood disturbance, anxiety and restlessness, and agitation. Current physician's orders included: * Seroquel (an antipsychotic) 50 milligrams (mg) by mouth three times a day (started on 12/29/23) related to dementia, psychotic and mood disturbance and anxiety. * Remeron (an antidepressant) 0.75 mg tablet by mouth one time a day (started on 01/17/24) related to restlessness and agitation.	F 744	F744 Resident #65 had care plan reviewed and revised on 01-19-24 and 02-06-24 to reflect current status as well as focus on person centered care. As part of behavior management intervention for resident #65 1:1 staffing utilized PRN, referrals to multiple dementia units had been sent out for small locked units with denials from all related to behaviors. Resident #65 had care plan reviewed and updated with individualization added to it. Motion sensor placed at exit of her room to alert staff when she left room so staff could monitor her where abouts, engage with resident, bring to activities, commons area, or to nurse's station for social stimulation. 2. All residents with dementia have the potential to be impacted. 3. Resident #65 had care plan updated and revised to reflect current needs and individualization on 01-19-24 and 02-06-24. Policies on care of the resident with dementia completed on 02-07-24. Staff to receive education on new policies on 02-08-24 and 02-09-24. Policy	

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F 744	Continued From page 3 Resident #65's current care plan stated, ". . . Focus . . . Alteration in thought process . . . and impaired communication related to Dementia . . . Interventions . . . Accept memory deficits . . . Assess individuals stress level . . . Call resident by name . . . Cue and supervise as needed . . . Repeat information . . . Give simple direct directions . . . Focus . . . Alteration in behavior as indicated by restlessness, insomnia, agitated, combative, easily annoyed and angered, has been noted to wander throughout the unit daily . . . Encourage resident to attend and participate in activities . . . NP [nurse practitioner] to consult . . . Secure care lock [device to notify staff if the resident attempts to exit the building] . . . [Resident's name] likes to carry rosary with her and it provides comfort . . . [Resident's name] loves animals and responds well to sitting with the animatronic cat . . . INTERESTS: her dog . . . Introduce resident to staff and residents. Show resident where activity calendar is in activity room, where activity board and menu are located in hallway and where activities will take place . . . Staff will do 1:1 visits as needed . . ." Resident #65's nurses' notes identified the following: * 01/03/24 at 11:29 a.m. ". . . Narrative: 12-28-23 @ [at] 18:10 [6:10 p.m.] Nurse was informed that this resident was in the room of another resident. She was found lying on the floor between the bed and the window. . . ." * 01/04/24 at 4:39 p.m. ". . . Resident removed her slip on and urinated on the side of her bed. She then wandered out to the common area. Writer assisted her back to her room and into the bathroom, cares provided. A new slip on [incontinent product] and pants put on. Resident	F 744	posted. Professional from the Alzheimer's Association came to St. Aloisius on 02-07-24 and provided a care consult on resident #65 and education to staff on dementia. interventions and person centered care. All staff assigned mandatory education on 01-20-24 through Health Care Academy on-line training titled "Understanding Dementia and Mental Health-Caring for the older adult in LTC" with a completion date required by 02-09-24. Education to C.N.A.s on use of PointClickCare EMR kardex for listings of inteventions on the care plan to promote person centered individual care provided to C.N.A.s January 23, 24, and 25th. PointClickCare EMR charting education provided to C.N.A.s on importance of documentation January 23, 24, and 25th when behaviors occur, reminder to chart all activities completed, personal cares and ways to help enhance the psychosocial well-being of the resident. CMS Hand in Hand 5 part module will be assigned to all nurses, C.N.A.s, activity professionals with the modules to be completed March and April. Professional from Alzheimer's Association to complete education and care consulation monthly x three months for	

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F 744	Continued From page 4 then pulled the pants and slipon [sic] down to her ankles and attempted to walk. Writer removed pants and underwear she had around her waist; put on the slip on. . . ." * 01/08/24 at 1:58 p.m. ". . . Resident has been wandering the unit most of shift. She has been going into other residents rooms and at times picking up items- she took and wore a pair of glasses . . ." * 01/08/24 at 10:03 p.m. ". . . Resident has wandered a lot this shift especially the first half of shift. She has been in numerous resident rooms going [sic] resident drawers and picking up personal items. . . ." * 01/09/24 at 4:48 a.m. ". . . Resident made a direct and concentrated attempt to exit through the new entrance. Two staff persons intervened to direct her away and back towards safety before she could get out. Resident became combative and started yelling. . . ." * 01/09/24 at 1:45 p.m. ". . . Resident has been in and out [sic] multiple residents rooms this shift. Resident was found rummaging through other residents belongs when she was in their rooms. Staff has assisted resident back to her room multiple times. Resident was in her room and voided on floor. When staff was cleaning up the urine, resident stated, "Is he still in here? CNA [certified nurse aide] said, there is no one else in here. Resident pointed to the urine on the floor and stated "that [expletive]". . ." * 01/09/24 at 3:12 p.m. ". . . Continually going into other Residents room this afternoon, other Residents are becoming upset. It is getting harder to redirect this Resident. . . ." * 01/09/24 at 3:27 p.m. ". . . Resident went into another Residents room and took his shoes, throwing them into hallway. . . ."	F 744	residents and to staff. Weekly the interdisciplinary team will meet to discuss and monitor patterns/trends in resident with behaviors. It will be titled weekly behavior meeting with review of residents with behaviors, residents scheduled to be seen by PMHNP, changes in psychotropic medications, etc. Behavior meeting notes will be made, referrals to PMHNP and review of care plan interventions and education to staff provided weekly on inteventions or changes as a result from these meetings. Residents with increased or new behaviors will have focused behavior charting initiated to identify patterns and trends. Social Service Director and MDS coordinator will be responsible for the QI audit of care plans to have person centered intervention and goals reflective of current status for residents with dementia and behaviors weekly x four weeks, monthly for three months then quarterly for one year. 4. Completion date 02/16/2024	

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F 744	Continued From page 5 * 01/09/24 at 6:40 p.m. ". . . Resident has been in and out of other residents rooms, removing items (ie: shirt). Moving furniture in the common area. Walked down towards the kitchen pulled down her pants and pooped on the floor. . . ." * 01/10/24 2:58 p.m. ". . . Resident wandered across the hall. She was found laying on top of the resident in bed 1 with her pants and slip-on between the door and the bed and urine in the trashcan [sic] next to it. Resident difficult to redirect to her room. . . ." * 01/11/24 at 1:54 a.m. ". . . Resident was found standing in room with her fists up. 2 staff entered room and calmed resident down. Resident had removed her pants and slip on. She then urinated next to the bed on the floor. She then placed her Christmas tree in the urine. Staff cleaned up the resident and the room. She was assisted back to bed. About 10 minutes later she wandered out to the common area. . . ." * 01/11/24 at 8:43 p.m. ". . . Resident has been wandering the unit throughout the shift. She is wandering into other resident's rooms and going through their belongings. She then went into a different residents room and laid down at the foot of the bed. Difficult to redirect. . . ." * 01/12/24 at 3:36 a.m. ". . . Resident is on contact precautions for Influenza, she has no concept of what this means. She exited her room and was found in [another room]. She had voided on the floor [in this room]. She was found sitting on the resident [in this room] having a bowel movement. . . ." * 01/12/24 at 8:31 a.m. ". . . Addendum: Visited with nursing staff [staff name] to confirm and resident appeared to be sitting at the foot end of the bed on residents leg. Other resident appeared unaware of situation of being	F 744		

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F 744	Continued From page 6 defecated on. . . ." * 01/16/24 at 11:12 p.m. ". . . Resident wandered this shift . . . assisted into bed twice and resident got up and went across the hall to another room. CNA found her with her pants down sitting on another residents bed. . . ." * 01/17/24 at 7:59 p.m. ". . . Resident wandering halls and into other resident's rooms. Swinging at anyone who attempts to redirect her. She wandered over to unit A Meadow Lane dayroom and sat in recliner and fell asleep. . . . she was found in a resident's bed up on A [unit A]. . . ." * 01/18/24 at 7:36 a.m. ". . . Resident wander [sic] out of her room and into the activity room around 430 [4:30 a.m.] and urinated on a chair. Staff assisted her back to her room and cleaned her up. She went back to bed for another hour then got up and wandered the unit. Resident is not willing to talkto [sic] writer and walks faster when writer attempts to talk to her. . . ." Review of Resident #65's activity logs showed only six 1:1 activities with Resident #65 in the last 30 days. Observations on all days of survey showed Resident #65 wandering throughout the facility including several resident rooms, therapy room, dining room, and other areas within the facility. During a confidential interview on 01/16/24 at 2:45 p.m. Resident A stated, "woken up a few nights ago" by Resident #65 who had entered the resident's room in the middle of the night. During an observation on the afternoon of 01/17/24 showed two CNAs (#4 and #5) entered Resident #31's room to assist her from bed.	F 744		

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F 744	Continued From page 7 Resident #65 followed the CNAs into the room. Resident #31 stated, "Oh that [expletive]. Get her out of here." The CNA (#4) stated, "Ok, ok, she's going," and assisted Resident #65 from Resident #31's room. The facility failed to assess and monitor patterns and trends of behaviors in an effort to minimize Resident #65's behaviors, recognize unmet needs, or prevent situations/triggers which may lead to behaviors or physical aggression toward staff and other residents. The facility failed to develop an effective behavior management program, consistently implement purposeful and meaningful activities in an attempt to manage the behaviors exhibited by Resident #65, evaluate the behavior management program on a continuous basis, and modify interventions as needed. The facility failed to ensure Resident #65 did not infringe upon the rights of others while still allowing her to achieve her highest level of well-being.	F 744		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 10 residents (Resident #55 and #60) observed during medication administration. Three medication errors occurred during staff	F 759	F759 Medication error rate greater than 10% 1. Staff education was provided to staff #8 identified in priming insulin pen for resident #55 and #60 on 01-19-24. Staff	2/16/24

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F 759	Continued From page 8 administration of 29 medications, resulting in an 10.14% error rate. Failure to properly prepare and administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the Prescribing information for NovoLog insulin, found at www.novo-pi.com/novolog.pdf) occurred on 01/18/24. This undated document, stated, "Instructions for use. . . E. Turn the dose selector to select 2 units. . . F. Hold your NovoLog FlexPen with the needle pointing up. . . G. Keep the needle pointing upwards, press the push-button all the way in. . . The dose selector returns to zero. . . ." Observation of medication administration on 01/16/24 at 4:25 p.m. showed a nurse (#8) prepared a Novolog insulin pen and a Novolog 70/30 insulin pen for Resident #55. The nurse (#8) applied a needle to each pen, removed the needle caps, and held each pen horizontally to prime. Observation of medication administration on 01/16/24 at 4:48 p.m. showed a nurse (#8) prepared a Novolog insulin pen for Resident #60. The nurse (#8) applied a needle, removed the needle cap, dialed the pen, and held the pen horizontally to prime. The nurse (#8) failed to prime the insulin pens vertically.	F 759	#8 demonstarted proper procedure 2. All residents receiving insulin have the potential to be affected. 3. Education was given at nurse's meeting on 01-25-24 on the priming of insulin pens along with visual example. Policy updated and reviewed by all nurses. Policy posted for all to see and placed in policy manual. 4. QI will be implemented with the DON and ADON responsible for observation of priming of the insulin pen weekly for four weeks, monthly for three months and quarterly for one year. DON/ADON will report to the QI committee at regular scheduled meetings. 5. 02-16-24	

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F 759	Continued From page 9 During an interview on 01/18/24 at 10:45 a.m., an administrative staff member (#1) confirmed the nurse failed to prime the insulin pens correctly.	F 759		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe and secure storage of controlled medications for 4 of 4 medication carts (Cart #1 and #2 on Unit A and Cart #1 and #2 on Unit B)	F 761	F761 Labeling and storage of drugs and biologicals 1. Immediate action - all schedule II-V medications were moved into a permanently affixed compartment that is	2/16/24

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F 761	Continued From page 10 and failed to lock 1 of 4 medication carts (Cart #2 on Unit B) observed during medication administration. Failure to store medications securely may result in unauthorized access to medications and/or medication errors. Findings include: Review of the facility policy titled "Medication Storage" occurred on 01/18/24. This policy, dated August 2021, stated, ". . . 1. General guidelines: a. All drugs and biologicals will be stored in locked compartments. . . c. During medication pass, medications must be. . . locked in the medication storage area/cart. . . ." Review of the facility policy titled "Medication Administration" occurred on 01/18/24. This policy, dated September 2021, stated, ". . . 5. The medication cart is used for medication pass. It is locked when not visualized. No medications are to be accessible on top of the cart. . . ." Observation of medication aide (MA) (#9) assigned to medication pass on Cart #1/Unit A on 01/16/2024 at 2:37 p.m. showed gabapentin (nerve pain medication) not under dual lock in the medication cart. Observation of MA (#10) and nurse (#8) assigned to medication pass on Cart #1 and Cart #2 on Unit B on the afternoon of 01/16/2024 showed controlled medications not under dual lock in the medication cart. Nurse (#8) stated, " The scheduled controlled drugs are in each person's section. It is the same in every med cart in this facility."	F 761	double locked. Policy revised on storage of schedule II-V medications. No residents were affected. Staff #8 was provided education on 01-19-24 to keep cart locked when not in view. Educated to not leave medications on top of cart. All nurses and C.M.A.s educated and reviewed policy of medication administration and locking of med cart at nurse and C.M.A. meeting on 01-25-24. Minutes of meeting and policy posted. 2. All medication carts have the potential to be impacted. 3. All nurses and CMA's were educated on the need to keep the medication cart locked, to not leave medications on the top of the cart when out of line of site during nurse/CMA meeting on 01-25-24. All II-V class drugs were moved into a permanently affixed compartment for storage that is double locked. Medication administration policy updated, reviewed and posted. Policy regarding the storage of biologicals updated, reviewed and posted. 4. QI monitor implemented and DON/ADON are responsible to monitor the medication carts to be locked, free of medications on top of cart and controlled substances are double locked weekly for one month, monthly for three months and quarterly for one year and report to the QI committee at scheduled meetings. 5. Date completed 02-16-24	

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	355037	A. BUILDING _____ B. WING _____	01/18/2024

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F 761	Continued From page 11 Observation of Cart #2 on Unit B occurred on 01/16/24 at 4:48 p.m. showed a nurse (#8) left a tube of Diclofenac gel (topical pain relief gel) on top of the unlocked medication cart and walked into Resident # 60's room.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, 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	F 880		2/16/24

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F 880	Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 880	F880 Infection Control	

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F 880	Continued From page 13 professional reference, policy review and staff interview, the facility failed to follow standards of infection control for 1 of 12 sampled residents (Resident #28) and 1 supplemental resident (Resident #39) observed during perineal cares and 1 of 1 sampled resident (Resident #65) on transmission-based precautions (TBP). Failure to follow infection control standards during perineal cares and with TBP has the potential to transmit infections to residents, staff, and visitors. Findings include: PERINEAL CARES Review of the policy/procedure titled "Perineal cares (Peri-Cares)" occurred on 01/18/24. This policy/procedure, dated June 2023, stated, ". . .Washes genital area, moving from front to back. . . dries genital area moving from front to back. . ." Review of Resident #39's medical record occurred on 01/17/23. Diagnoses include urinary incontinence, retention of urine, and history of urinary tract infection. During an observation on 01/16/24 at 12:58 p.m., a certified nurse aide (CNA) (#3) assisted Resident #39 with incontinence cares. The CNA (#3) wiped the resident's perineum from the back to the front three times. The CNA failed to provide proper perineal cares to prevent risk of infection to the resident. Review of Resident #28's medical record occurred on all days of survey. Diagnoses include urinary incontinence.	F 880	Peri Care 1. Individual staff #3 educated on 01-19-24 on proper peri care procedure. Observed C.N.A. #3 to complete proper peri care on 01-19-24. All staff educated on peri care during mandatory meetings on January 23, 24 and 25th. Updated peri care policy and meeting minutes posted. 2. All residents have the potential to be affected. 3. Staff education provided at mandatory meetings on January 23, 24 and 25th with review of proper peri care procedure. Policy posted and educational information. In addition, the infection control nurse will provide individual education to staff as needed during QI monitoring. 4. QI monitor implemented with infection control nurse or DON responsible to monitor peri care weekly for four weeks, monthly for three months and quarterly for one year. DON or IP will report to QI committee at scheduled meetings. 5. Completion date 02-08-24 F880 Infection Control 1. Resident was off isolation precautions on 01-16-24. 2. All residents have the potential to be affected. 3. Education to staff 02-08-24 regarding if resident noncompliant with isolation per policy to encourage and assist resident to wear a mask and to keep resident in low populated areas. Increasing staffing to 1:1 when able. Motion sensor used PRN	

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F 880	Continued From page 14 During an observation on 01/16/24 at 1:10 p.m., a certified nurse aide (CNA) (#3) assisted Resident #28 with incontinence cares. The CNA (#3) wiped the resident's perineum from the back to the front three times. The CNA failed to provide proper perineal cares to prevent risk of infection to the resident. During an interview on 01/18/24 at 11:21 a.m., an administrative nurse (#1) stated she expected staff to follow policy/procedures. TRANSMISSION BASED PRECAUTIONS Review of the facility policy titled "ISOLATION/TRANSMISSION BASED PRECAUTIONS" occurred on 01/18/24. This policy, dated June 2019, stated, ". . .It is our policy to take appropriate precautions including isolation to prevent transmission of infectious agents. . . . Contact Precautions: . . . Intended to prevent transmission of infectious agents, including epidemiolgically [sic] important micro-organisms, which are spread by direct or indirect contact with the resident or the resident's environment. . . ." The CDC guidance found at: https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm, dated 11/14/23. The guidance stated, ". . . Droplet Precautions should be implemented for residents with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a resident is in a healthcare facility. . . . Because residents with influenza may	F 880	to alert staff to resident exiting room. Policy updated to reflect additions when isolation is impacted by resident's cognition. 4. QI will be completed on any future resident on isolation precautions for one year to ensure policy is being followed if able, take resident to unoccupied Day Room for person centered activities. 5. Completion date 02-16-24	

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F 880	Continued From page 15	F 880		

continue to shed influenza viruses while on antiviral treatment, infection control measures to reduce transmission, including following Standard and Droplet Precautions, should continue while the resident is taking antiviral therapy. . . ."

- Review of Resident #65's medical record occurred on all days of survey and a physician's order, dated 01/12/24, for Oseltamivir Phosphate [antiviral medication] oral capsule 75 mg (milligrams) by mouth two times a day related to Influenza A.

Progress notes for Resident #65 showed the following:
* 01/11/24 at 4:55 p.m. ". . . [Doctor's name] notified of resident hoarse sounding in voice & [and] nasally sounding like coming down with an URI [upper respiratory infection]/cold. . . . Temp [temperature] check x2 [twice] with temporal [forehead] thermometer with readings of 99.9 and 100.2 [degrees Fahrenheit]. . . ."
* 01/11/24 at 6:03 p.m. ". . . [Resident #65's family name] updated . . . Positive for Influenza A. . . ."
* 01/11/24 at 8:43 p.m. ". . . Resident has been wandering the unit throughout the shift. She is wandering into other resident's rooms and going through their belongings. She then went into a different residents room and laid down at the foot of the bed. . . ."
* 01/12/24 at 3:36 a.m. ". . . Resident is on contact precautions for Influenza, she has no concept of what this means. She exited her room and was found in [another resident's room]. She had voided on the floor by [one of the beds]. She was found sitting on the resident [of the other

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F 880	Continued From page 16 bed] having a bowel movement. The facility failed to limit Resident #65's movement within the facility while isolation/TBP with Influenza A.	F 880		