STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - AVE MARIA	501 19TH ST NE JAMESTOWN, ND 58401

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started 08/02/21 and concluded 08/05/21.	F 000		
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: Based on record review, review of the facility's investigative report, and staff interview, the facility failed to provide appropriate and sufficient supervision to prevent accidents for 1 of 1 sampled resident (Resident #88) who fell during a full body mechanical lift transfer and sustained a serious injury. Failure to safely utilize a mechanical lift resulted in Resident #88 falling from the lift and sustaining a serious injury, and placed all residents requiring this type of transfer at risk for falls and/or injury. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: Review of Resident #88's medical record occurred on August 2-5, 2021. Diagnoses included dementia, major depression, psychosis, cerebrovascular accident (CVA) with left hemiparesis (partial paralysis), and long term use	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 08/19/2021

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F 689	Continued From page 1	F 689		

of an anticoagulant (blood thinner). The quarterly Minimum Data Set (MDS), dated 01/13/21, identified total dependance on two or more staff members for transfers.

The care plan identified, ". . . [Resident #88] has an ADL [activity of daily living] Self Care Performance Deficit . . . [and is] at risk for falls r/t [related to] CVA with (L) [left] hemiparesis . . . [Resident #88] requires total assist with hoyer [full body mechanical lift] lift. . . ."

Resident #88's EZ Way sling sizing chart identified, "It is important that the base of the sling be positioned two inches below the tailbone and the top of the sling be parallel with the top of the shoulder line (base of neck). . . . Sling Color Coding System: Green XL [extra large] . . . Maximum distance from patient's tailbone to base of neck 29" [inches] . . ."

A progress note, dated 01/29/21 at 7:59 p.m., identified, ". . . author notified of fall, upon entry to room 2 staff present, resident sustained fall during transfer, upon assessment resident on floor with head resting against closet, sitting on buttocks with legs in front. . . . during assessment resident was alert, range of motion to lower extremities per residents usual. No no-verbal signs of pain, abrasion to right lower back, hematoma with small laceration to right back of head. Pupils 3, PERLA [normal oculomotor functions]. Resident taken to [facility] ER [emergency room] by ambulance for evaluation of injuries. . . ."

A hospital admission history and physical, dated 01/29/21, identified, "[Resident #88] . . . fell

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F 689	Continued From page 2	F 689		

during transfer with hoyer lift and hit his head. His scalp hematoma and CT scan shows interhemispheric hemorrhage. He is on coumadin and aspirin due to h/o [history of] CVA, atrial fibrillation. No neurologic change. Needs admission tonight for observation and repeat CT [cat scan of brain] in AM. . . ."

The progress notes identified the following:
* 01/30/21 at 8:54 p.m., ". . . Returns back to [facility] this evening at 5:40 p.m. following hospitalization d/t [due to] yesterday's fall from hoyer lift. Small brain bleed noted in CT upon admittance to [hospital] yesterday and another done today with no change, provider feels comfortable sending back. No skull fracture. . . . Responds normally at this time. . . . Refuses anything oral this evening other then a few sips of liquids. . . ."
* 01/31/21 at 1:48 p.m., ". . . Does open eyes . . . Does not holler out but is responsive."
* 01/31/21 at 4:06 p.m., "Resident is alert and oriented, he has been very tired and lethargic during shift. . . . Contusion to back of head is scabbed over with no drainage noted. . . ."
* 01/31/21 at 9:37 p.m., ". . . Is sitting in recliner this evening does respond to staff with simple words like 'no' when staff in room attempting to give evening meds [medications] and purses lips closed tightly but is fairly sleepy as well. Does decline evening meds along with supper, takes some sips of drink of equal roughly 120 mls [milligrams] of fluids . . ."
* 02/01/21 at 3:51 a.m., ". . . Resident doesn't respond per normal self, appears to be asleep but with eyes partially open. . . ."
* 02/02/21 at 3:15 a.m., "Resident is awake intermittently with little to no engagement with

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F 689	Continued From page 3	F 689		

staff. . . . No oral intake this shift. . . ."
* 02/03/21 at 8:44 a.m., "resident is alert and will speak to staff saying 'I do not want that' when staff attempt to feed him breakfast. . . ."
* 02/03/21 at 10:07 p.m., ". . . Resident does not respond with questions asked but does open his eyes with verbal stimulus. Author then asked if [family member] would like to get hospice involved at this time . . ."
* 02/04/21 at 6:03 p.m., "Is now admitted to [hospital] Hospice. . . ."
* 02/07/21 at 10:12 a.m., "Resident remains unresponsive. . . ."
* 02/08/21 at 3:09 p.m., "Author walked into room to check on resident and noted that resident was not breathing at 2:50 p.m. . . ."

The facility's "Final Investigation Report" identified, ". . . the nurse manager identified [certified nurse assistant (CNA) (#14)] had not followed the resident's care plan and chose to use a size large sling instead of an x-large sling as noted on the resident's care plan. . . . A copy of the Hoyer sling sizing chart was in the resident's folder in the bathroom available to all staff. Staff are trained to check the routine care sheets each shift for any changes. . . . [CNA (#14)] was suspended immediately after the incident occurred and the facility will be terminating [his] employment. . . ."

During an interview on 08/05/21 at 1:15 p.m., two managerial nurses (#2 and #15) reported, "The sling did not cover part of his buttocks. It was higher up on his back because they used the wrong sized sling. We went over sling size and positioning [during all staff meetings on February 10 and 25, 2021 and March 3, 4, 11, 14, and 29,

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F 689	Continued From page 4 2021]. Staff members who didn't attend the meeting read the notes. They were required to read the notes and watch the video of the meeting." Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented the corrective action for the resident affected by the deficient practice by: * Completing an investigation with interviews of staff who assisted with the transfer on 01/29/21, * Determining CNA (#14) failed to safely utilize an x-large sling resulting in Resident #88 falling from the Hoyer lift and sustaining a serious injury, and * Suspending CNA (#14) immediately after the incident and later terminating his employment. The facility put measures in place to ensure the deficient practice does not recur by: * Providing education to all nursing staff on February 10 and 25, 2021 and March 3, 4, 11, 14, and 29, 2021 ensuring utilization of appropriately sized slings for Hoyer lift transfers and * Auditing Hoyer lift transfers starting on 01/29/21. The facility completed audits through 03/15/21. The survey team determined a deficient practice existed on 01/29/21. The facility implemented corrective action on 01/29/21, provided staff education on February 10 and 25, 2021 and March 3, 4, 11, 14, and 29, 2021, and audited Hoyer lift transfers through 03/15/21.	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		8/24/21

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F 692	Continued From page 5 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of facility policy, the facility failed to offer fluids to 4 of 14 sampled residents (#47, #53, #68, and #80) who required staff assistance for fluid intake and/or are at risk for dehydration or urinary tract infections (UTIs). Failure to provide assistance with fluid intake may result in dehydration, constipation, and UTIs. Findings include: Review of the facility policy titled "Standards of Care" occurred on 08/05/21. This policy, revised April 2021, stated, ". . . Encourage and offer	F 692	F692 Nutrition/Hydration Status Maintenance 1. On 08/18/2021, residents #47, #53 and #68 were assessed by Licensed Dietitian and Licensed Nurse to ensure these residents are receiving sufficient fluid intake to maintain proper hydration and health. All above listed residents were found to have sufficient fluid intake. Resident #80 was unable to be assessed as he passed away on 8/15/2021 on hospice. 2. Any resident that requires assistance with fluid intake has the potential to be affected by failure to offer sufficient fluid	

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F 692	Continued From page 6 fluids with each contact . . ." - Review of Resident #47's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, depression, and diabetes mellitus. The current care plan identified, ". . . Urinary incontinence r/t [related to] Dx [diagnosis] of dementia At risk for UTI r/t urinary incontinence . . . Encourage fluids . . ." Observation on 08/03/21 at 3:36 p.m. showed two Certified Nursing Assistants (CNAs) (#6 and #7) provided perineal care, changed brief, and transferred Resident #47 to his/her wheelchair. The CNAs (#6 and #7) failed to offer or encourage fluids. -Review of Resident #53's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, major depression, and urinary incontinence. The current care plan identified, ". . . risk of dehydration . . . provide > [greater than] 400 ml [milliliters] water in room . . . At risk for UTI r/t urinary incontinence . . . Encourage fluids . . ." Observation on 08/03/21 at 9:30 a.m. showed a CNA (#8) provided perineal care, changed brief, transferred Resident #53 to chair, and failed to offer or encourage fluids. -Review of Resident #68's medical record occurred on all days of survey. Diagnoses included femur fracture, vascular dementia with behavioral disturbances, and urine retention. The current care plan identified, ". . . Urinary incontinence r/t Decreased mobility . . . will be free of UTI . . . Encourage fluids . . ."	F 692	intake to maintain proper hydration and health. 3. Nursing staff have been educated on the necessity of offering fluids with each contact at both the CNA meeting on 08/12/2021. Further education will be provided at nurses meeting on 08/19/2021 and at an all-nursing staff meeting on 08/20/2021 and 08/23/2021. 4. A QA tool has been developed and beginning 08/09/2021 a random audit of ten residents will be completed weekly for twelve weeks then monthly thereafter ongoing by QAPI Manager, Nurse Manager or designee to ensure that residents are offered sufficient fluid intake to maintain proper hydration and health. The results will be discussed at the monthly QAPI meetings with action and follow-up completed as necessary. 5. 08/24/2021	

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F 692	Continued From page 7 Observation on 08/03/21 at 10:27 a.m. showed a CNA (#9) and a licensed nurse (#10) transferred Resident #68 to a shower chair, placed the shower chair over the toilet, provided perineal care, and transferred to a chair. The CNA (#9) and a licensed nurse (#10) failed to offer or encourage fluids. - Review of Resident #80's medical record occurred on all days of survey. Diagnoses included dementia, open wounds, and urinary retention. The current care plan identified, ". . . Urinary incontinence r/t Decreased mobility . . . will be free of UTI . . . Encourage fluids . . . has an ADL (activities of daily living) Self Care [sic] Performance Deficit r/t Dementia . . . EATING: [Resident #80] requires extensive assist of one . . ." Observation on 08/02/21 at 3:42 p.m. showed two CNAs (#16 and #17) provided perineal care, changed the brief, and failed to offer or encourage fluids to Resident #80. Observation on 08/03/21 at 9:28 a.m. showed two CNAs (#18 and #19) transferred Resident #80 from the wheelchair to the bed, provided perineal care, changed the brief, provided oral care, lowered the bed, positioned the resident on his/her side, and failed to offer or encourage fluids. During an interview on 08/05/21 at 10:45 a.m., an administrative nurse (#5) agreed the staff should offer and encourage fluids with each contact.	F 692		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/24/21

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F 880	Continued From page 8 §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 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;	F 880		

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F 880	Continued From page 9 (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: F880 IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 11/14/19 and 10/21/20. 1. Based on observation, review of facility policy, review of manufacturer's directions, review of professional reference, and staff interview, the facility failed to ensure staff followed standard	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.	

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F 880	Continued From page 10 infection control practices for 1 of 1 resident (Resident #1) observed receiving a blood glucose test with a shared blood glucose meter and has the potential to affect other residents in the facility. Failure to clean and disinfect shared glucose meters with the appropriate disinfectant has the potential to cause cross-contamination and may result in the transmission of blood-borne pathogens to other residents. During the recertification survey, the team determined a potential Immediate Jeopardy (IJ) situation existed on the evening of 08/04/21. The IJ potential resulted from observation of a medication aide (MA) (#4) disinfecting a shared blood glucose meter with alcohol wipes. These findings placed residents in immediate danger due to the potential for cross contamination with a blood-borne pathogen and the need for education on the appropriate/effective disinfectant to use to for a shared blood glucose meter. * 08/04/21 at 6:02 p.m., 6:14 p.m., and 6:58 p.m. - The survey team contacted the management staff at the State Survey Agency (SSA) to report the findings and to discuss a potential IJ situation. * 08/04/21 at 7:30 p.m. - The survey team notified the Assistant Administrator and Director of Nursing of the IJ situation and requested they develop a plan for abatement of the immediate jeopardy. * 08/04/21 at 8:45 p.m. - The facility provided a written plan of correction (via email) for the IJ.	F 880	The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff use the appropriate disinfectant to clean glucose meters used for multiple residents. The individual CMA was educated immediately on the appropriate disinfectant to use on blood glucose meters used for multiple residents. All other licensed staff and medication assistants working at the time of the citation were educated immediately also. The facility immediately discarded the blood glucose meter and replaced it with a new meter. All licensed nursing staff and medication assistants were educated immediately by text on 08/04/21 using the facility's mass messaging system and will sign acknowledgement before their first shift back confirming they were educated. Proper cleaning instructions were placed in each nurses' station and on each medication cart on 08/04/21. The facility updated the policy for 'Testing Blood Glucose and Meter Use' to specify that Oxivir wipes are the appropriate disinfectant to clean the meters. (2) Ensuring staff perform hand hygiene or handwashing after removing gloves, after performing perineal care and after leaving a resident's room, in accordance with CDC guidelines. 2. Identification of Others	

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F 880	Continued From page 11 * 08/05/21 at 11:12 a.m. - The SSA notified the regional office of the immediate jeopardy situation. * 08/05/21 at 1:48 p.m. - The survey team reviewed and accepted the facility's revised version of the written plan of correction for the IJ. * 08/05/21 at 1:58 p.m. - The survey team determined the IJ situation at a scope/severity of K was abated and reduced to a scope and severity of E. * 08/05/21 at 3:01 p.m. - The SSA notified the regional office of the immediate jeopardy abatement. Findings include: Review of The Food and Drug Administration's (FDA) guidance for manufacturers regarding appropriate products and procedures for cleaning and disinfection of blood glucose meters, from the FDA's website (http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/ucm227935.htm), stated, "Point of care blood testing devices such as blood glucose meters should be used only on one patient and not shared. If dedicating blood glucose meters to a single patient is not possible, the meters must be properly cleaned and disinfected after every use following the guidelines provided in device labeling. . . . The disinfection . . . should be effective against HIV, Hepatitis C, and Hepatitis B virus. Outbreak episodes have been largely due to transmission of Hepatitis B and C viruses. However, of the two, Hepatitis B virus is the most	F 880	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. (1) All residents who have blood glucose monitoring performed by staff have the potential to be affected by failure to use the appropriate disinfectant on glucose meters used on multiple residents. (2) All residents have the potential to be affected by failure of staff to perform hand hygiene in accordance with CDC guidelines. 3. System Changes On or before 09/02/2021 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 clean shared glucose meters with the appropriate disinfectant. b. Failure to complete hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf	

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F 880	Continued From page 12 difficult to kill. Please note that 70% ethanol solutions are not effective against viral bloodborne pathogens and the use of 10% bleach solutions may lead to physical degradation of your device." Observation on 08/04/21 at 4:55 p.m. on Unit D showed a MA (#4) used a glucose meter to check Resident #1's blood glucose in the nurses station. The MA (#4) stated there is one glucose meter for residents on Unit D. After using the glucose meter, observation showed the MA (#4) wiped the meter with alcohol wipes. When asked what he/she used to clean the glucose meter, the MA (#4) confirmed he/she used alcohol wipes. During an interview on 08/04/21 at 5:35 p.m. with an administrative nurse (#1) and a managerial nurse (#2) regarding what disinfectant staff use for the shared glucose meters, the managerial nurse (#2) stated the facility instructed/trained staff to use Oxivir wipes. Review of the facility policy titled "Testing Blood Glucose and Meter Use" occurred on 08/04/21 at 5:40 p.m. This policy, dated February 2021 stated, "POLICY: The Blood Glucose Monitoring System will be set up and cared for as directed by the Manufacturer's Users Manual as required. . . . Procedure: . . . 7. Clean the meter using a sanitizer wipe in accordance with product dwell time and allow to air dry. " The policy failed to clearly state the type of "sanitizer wipe" to disinfect the glucose meter. Review of the Manufacturer's User Manual for the 'Easy Touch Glucose Monitoring System'	F 880	(2) The DON, IP or suitable designee will ensure the following: a. All nurses and medication assistants will receive education regarding updated policy on cleaning shared glucose meters with the appropriate disinfectant. The facility contacted the manufacturer of the glucose meter on 08/05/21 who stated the meter should be cleaned with a disinfectant that is 'virucidal, bactericidal, tuberculocidal, and fungicidal.' The facility's current disinfectant, Oxivir, meets these criteria. b. All staff will receive education regarding keeping hands clean between tasks, contacts with potentially contaminated surfaces, and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, 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) QA monitoring tool for blood glucose meter cleaning developed by facility. The QAPI Manager, nurse manager, or designee will perform random audits weekly of all residents who receive blood glucose monitoring for 12 weeks and monthly thereafter to ensure that appropriate disinfectant is being used to	

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F 880	Continued From page 13 occurred on 08/04/21 at 5:45 p.m. The manual stated, ". . . Care and Storage . . . 4. When cleaning the meter, gently wipe the exterior surface using a damp soft cloth. . . . For healthcare professionals using this system on multiple patient [sic], please be aware that all items that come in contact with human blood should be handled as potential biohazards. Users should follow the guidelines for prevention of blood-borne transmittable disease in a healthcare setting for potentially infectious human blood specimens as recommended in the National Committee for Clinical Laboratory Standards, Protection of Laboratory Standards, Protection of Laboratory Workers from Instrument Biohazards and Infectious Disease Transmitted by Blood, Body Fluids and Tissue: Approved Guideline. . . ." During an interview on 08/04/21 at 6:12 p.m., an administrative nurse (#1) and managerial nurse (#12) reported the medication aid (#4) began his shift at 2:30 p.m. and had only checked one resident's glucose level. The resident resided on Unit D. During an interview on 08/04/21 at 6:41 p.m., a licensed nurse (#11) on Unit C stated, "There is a shared MA for Units C and D who will check five residents' blood sugars on Unit C using the same meter for all residents on this unit when he/she gets done on Unit D." Review of the physician's orders for the five residents on Unit C with blood glucose orders identified three of these five residents (#47, #52, #100) had the potential to be exposed to contamination from an improperly	F 880	clean the glucose meter. (2) Observations of certified nursing staff to ensure performance of proper hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring 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 F880 Infection Prevention & Control 1. The facility will ensure that staff use the appropriate disinfectant to clean glucose meters used for multiple	

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F 880	Continued From page 14 cleaned/disinfected glucose meter had the MA (#4) not been notified and instructed on the use of the appropriate disinfectant wipe. Failure to clean and disinfect shared glucose meters with the appropriate disinfectant after each resident has the potential to cause cross-contamination and may result in the transmission of blood-borne pathogens to other residents. 2. Based on observation, policy review, and staff interview, the facility failed to ensure staff followed standard infection control practices for 2 of 21 sampled residents (Resident #31 and #80) observed during resident cares. Failure to follow standard infection control practices related to hand hygiene may result in the spread of infection to residents, staff, and visitors. Findings Include: Review of the facility policy titled "Hand Hygiene" occurred 08/05/21. This policy, revised May 2021, stated, ". . . HAND HYGIENE SHOULD BE PRACTICED: . . . b. Before and after caring for each resident. . . . m. Before applying and after removing gloves. . . HAND WASHING SHOULD BE DONE: a. After any exposure to blood and/or body fluids. . . ." - Observation on 08/2/21 at 3:47 p.m., showed two certified nurses aides (CNAs) (#16 and #17) provided cares for Resident #80. The CNA (#16) removed a brief soiled with stool, performed perineal care, applied a clean brief, and without removing gloves or performing hand hygiene, turned off the pressure on the pressure relieving	F 880	residents. The individual CMA was educated immediately on the appropriate disinfectant to use on blood glucose meters used for multiple residents. All other licensed staff and medication assistants working at the time of the citation were educated immediately also. The facility immediately discarded the blood glucose meter and replaced it with a new meter. All licensed nursing staff and medication assistants were educated immediately by text on 08/04/2021 using the facility's mass messaging system and will sign acknowledgement before their first shift back confirming they were educated. Staff did sign acknowledgement of receiving education prior to first shift back. Proper cleaning instructions were placed in each nurses' station and on each medication cart on 08/04/21. The facility updated the policy for 'Testing Blood Glucose and Meter Use' to specify that Oxivir wipes are the appropriate disinfectant to clean the meters. 2. All residents who require blood glucose monitoring have the potential to be affected by failure to use the appropriate disinfectant on glucose monitoring meters used on multiple residents. 3. 1a) A root cause analysis was completed by the Interdisciplinary Team and it was determined that the CMA was unclear on the appropriate disinfectant to clean the blood glucose meters because the facility’s policy was not specific as to	

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F 880	Continued From page 15 mattress, placed the hoyer sling under the resident and transferred Resident #80 to the wheelchair with the hoyer lift. The CNA (#16) removed her gloves, placed the resident's glasses, made the bed, and transferred Resident #80 to the nurses station without performing hand hygiene. - Observation on 08/2/21 at 4:58 p.m., showed a CNA (#16) apply a gait belt and assisted Resident #31 from the bed to the wheelchair. The CNA (#16) combed the resident's hair and transferred her to the dining room without performing hand hygiene. During an interview on 08/05/21 at 10:05 a.m., an administrative nurse (#20) stated she expected staff to perform hand hygiene after glove removal, after perineal cares and after exiting resident rooms.	F 880	the appropriate disinfectant. Therefore, on 08/04/2021 the facility updated the policy for Testing Blood Glucose to specify that Oxivir is the appropriate disinfectant to clean the meters. 2a) All nurses and medication assistants will receive education regarding the updated policy on cleaning shared glucose meters with the appropriate disinfectant. The facility contacted the manufacturer of the glucose meter on 08/05/2021 who stated the meter should be cleaned with a disinfectant that is 'virucidal, bactericidal, tuberculocidal, and fungicidal.' The facility's current disinfectant, Oxivir, meets these criteria. Further education on using appropriate disinfectant to clean glucose monitoring meters was provided on 08/5/2021 to Certified and Licensed Nursing staff on-duty. The facility's glucose monitoring device's manufacturer, MHC Medical Products, LLC, was contacted via telephone on 08/4/2021 at 7:58 pm; however, it was outside of business hours. Director of Nursing and/or designee contacted the manufacturer again on 8/5/2021 and it was found that the Oxivir wipes meet the criteria as it is a virucidal, bactericidal, tuberculocidal and fungicidal. Licensed and Certified nursing staff have been educated on the appropriate disinfectant to be used to clean the glucose meter used for multiple residents at the CNA/CMA meeting on 08/12/2021. Further education will be	

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F 880	Continued From page 16	F 880	provided at nurses' meeting on 08/19/2021 and at an all-nursing staff meeting on 8/20/2021 and 8/23/2021. Laminated cleaning instructions were placed on all blood glucose monitoring kits on 8/18/2021 to state the appropriate disinfectant to clean glucose monitoring meters. 4. A QA monitoring tool has been developed beginning 08/4/2021 weekly for twelve weeks and monthly thereafter for no less than three months which will include an audit of all residents requiring blood glucose monitoring and will be completed by the QAPI Manager, nurse manager, or designee to ensure that appropriate disinfectant is being used to clean the glucose meter. 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. 08/24/2021 F880 Infection Prevention & Control 1. Ensuring staff perform hand hygiene or handwashing after removing gloves, after performing perineal care, and after leaving a resident's room, in accordance with CDC guidelines. 2. All residents have the potential to be affected by the failure of staff to perform hand hygiene or handwashing after	

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F 880	Continued From page 17	F 880	removing gloves, after performing perineal care and after leaving a resident's room, per AMV policy and in accordance with CDC guidelines. 3. b) A root cause analysis was completed by the Interdisciplinary Team and was determined that the CNA did not follow AMV policy regarding hand hygiene. All staff received education regarding keeping hands clean between tasks, contact with potentially contaminated surfaces, and between residents at CNA meeting on 08/12/2021. Education including the CDC's lesson on clean hands at https://youtube/xmYMUly7qiE was sent to all staff via Everbridge on 08/18/2021 and staff will sign acknowledging they have reviewed this education. Further education will be provided at nurses' meeting on 8/19/21 and at an all-nursing staff meeting on 8/20/2021 and 8/23/2021. 4. A QA tool has been developed and began on 8/9/2021 a random audit of ten residents will be completed weekly for twelve weeks then monthly thereafter ongoing by QAPI Manager, Nurse Manager or designee to ensure that staff perform hand hygiene or handwashing after removing gloves, after performing perineal care and after leaving a resident's room, in accordance with CDC guidelines. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for	

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F 880	Continued From page 18	F 880	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. 8/24/2021	