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 _____	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 09/26/22 and concluded 09/29/22	F 000		
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 persons in the facility;	F 880		11/3/22

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

Electronically Signed | 10/14/2022

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F 880	Continued From page 1 (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, review of facility policy, and staff and resident interviews, the facility	F 880	1. Corrective Action The facility will immediately implement an	

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F 880	Continued From page 2 failed to follow standards of infection prevention and control for 3 of 20 sampled residents (Resident #17 #48, and #76) and 2 supplemental residents (Resident #8 and #71). Failure to follow infection control standards related to disinfecting equipment and performing aerosol-generating procedures has the potential to transmit infections to other residents, staff, and visitors. Findings include: DISINFECTING SHARED EQUIPMENT: Review of the facility policy titled "Infection Prevention and Control Program" occurred on 09/28/22. This policy, revised July 2022, stated, ". . . All shared items and equipment will be cleaned in between uses using Disinfecting wipes/spray per facility protocol. . ." - Observation on 09/26/22 at 4:50 p.m. showed two certified nurse assistants (CNAs) (#3 and #4) used a mechanical lift and transferred Resident #8 from the bed to the wheelchair. Upon completion of the transfer, the CNA (#3) removed the lift from the room and took the lift into another resident's room for use. The CNA (#3) failed to disinfect the mechanical lift after use and prior to entering another resident room. - Observation on 09/26/22 at 5:01 p.m. showed two CNAs (#2 and #3) used a mechanical lift and transferred Resident #48 from the bed to the wheelchair. Upon completion of the transfer, the CNA (#3) removed the lift from the room and placed it in a storage area by the nurse's station. The CNA (#3) failed to disinfect the mechanical lift after use.	F 880	appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff have adequate knowledge of hygienic cleaning practices of resident care items and equipment to correctly disinfect mechanical lifts between resident use. (2) Ensure staff have adequate knowledge of following precautions during aerosol-generating procedures. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff on correct disinfecting practices for all reusable equipment. To verify this/these staff understands correct disinfection, this/these staff will perform a successful return demonstration of identifying the need and correct procedure for disinfecting of reusable equipment. (2) Educate all staff on appropriate precautions during aerosol-generating procedures. 2. Identification of Others	

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F 880	Continued From page 3 - Observation on 09/27/22 at 10:16 a.m. showed a CNA (#5) and a staff nurse (#6) used a mechanical lift and transferred Resident #17 from the chair to the bed. Upon completion of the transfer, the CNA removed the lift from the room and placed it in the hallway. The CNA (#8) failed to disinfect the mechanical lift after use. - Observation on 09/27/22 at 10:30 a.m. showed two CNAs (#7 and #8) used a mechanical lift and transferred Resident #17 from the bed to the wheelchair. Upon completion of the transfer, the CNA (#8) failed to disinfect the mechanical lift after use and prior to entering another resident room. - Observation on 09/27/22 at 1:19 p.m. showed two CNAs (#7 and #8) used a mechanical lift and transferred Resident #76 from the wheelchair to the bed. Upon completion of the transfer, the CNA (#7) removed the lift from the room and placed the lift in the hallway. The CNA (#7) failed to disinfect the mechanical lift after use. - Observation on 09/27/22 at 2:07 p.m. showed two CNAs (#2 and #3) used a stand lift and transferred Resident #8 from the wheelchair to the bed. Upon completion of the transfer, the CNA (#3) removed the lift from the room and placed it in a storage area by the nurse's station. The CNA (#3) failed to disinfect the mechanical lift after use. During an interview on 09/29/22 at 9:55 a.m., an administrative nurse (#1) stated it is her expectation that the staff sanitize the mechanical lifts as per policy.	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. All residents who utilize shared equipment have the potential to be affected by the deficient practice. Those who come in contact with aerosol-generating procedures have the potential to be affected by the deficient practice. 3. System Changes The facility has put in place the following systemic changes including 1) placing Oxivir wipe holders directly on the lifts to make them more visible and 2) the instructions for the aerosol-generating procedure have been added to medication administration record. On or before 11/03/2022 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure cleaning of reusable	

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F 880	Continued From page 4 BREATHING TREATMENTS: Review of the facility policy titled "Infection Control" occurred on 09/28/22. This policy, revised September 2022, stated, ". . . Avoid aerosol-generating procedures . . . if required, take the following precautions: Perform in private room, if possible, with door closed during and after procedure for 30 minutes. Staff wear a surgical mask and eye protection. . . ." Observation on 09/26/22 at 1:19 p.m. showed Resident #71's room door open and the resident seated in a recliner chair receiving a breathing treatment. The resident's door lacked signage for aerosol precautions. During an interview on 09/26/22 at 2:03 p.m., Resident #71 reported the staff bring the medication for the nebulizer machine to the room, and she completes the breathing treatment. Resident #71 stated, "I have COPD [chronic obstructive pulmonary disease] and get four treatments a day." Observation on 09/27/22 at 8:42 a.m. showed signage on Resident #71's door. The sign indicated, "STOP ATTENTION: Nebulizers are given in this room. MUST wear mask and eye protection in this room during and for 30 MINUTES after administration. Door MUST remain closed during this time. . . ." Observation on 09/27/22 at 9:34 a.m. showed a medication assistant (MA) (#9) in Resident #71's room administering a breathing treatment. The MA failed to wear eye protection and close the door while interacting with the resident. At 9:35	F 880	equipment was completed in a hygienic manner with appropriate dwell times to achieve disinfection in accordance with CDC guidelines and cleaning product manufacturer instructions. b. Failure to follow the correct precautions when administering aerosol-generating medications/treatments. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf A root cause analysis was completed by the Interdisciplinary Team in conjunction with the ND Quality Improvement Organization. (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff whose job duties include hygienic cleaning procedures including effective contact or dwell times for disinfectants used on reusable equipment. This education will include the CDC's lesson on cleaning available at https://youtu.be/t7OH8ORr5Ig. b. Educate staff on following infection control precautions and personal protective equipment (PPE) use when administering aerosol-generating medications/treatments. All staff received education regarding the correct disinfecting practices for all	

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F 880	Continued From page 5 a.m., the MA exited the resident's room, the door remained open, and the breathing treatment continued. During an interview on 09/29/22 at 9:50 a.m., an administrative nurse (#1) stated she expected staff to wear eye protection and keep the room door closed during and after a breathing treatment.	F 880	reusable equipment including watching the CDC's video lesson on cleaning during an all staff meeting on 10/13/2022. The CDC ' s video lesson on cleaning was also sent to all staff via Everbridge on 10/13/2022 and staff will sign acknowledging they have reviewed this education. Further education will be presented at the nurses ' meeting on 10/20/22 regarding a) the proper cleaning of reusable equipment and b) the appropriate precautions during aerosol-generating procedures. Education will also be provided at the CNAs meeting on 10/27/22 specific to the proper cleaning of reusable equipment and b) the appropriate precautions during aerosol-generating procedures. (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. The facility leadership contacted the North Dakota Quality Improvement Organization on 10/11/2022 which resulted in a scheduled meeting on 10/13/2022. The facility leadership including the CEO, DON, and nurse manager team met with the QIO on 10/13/2022 and discussed ways to improve infection prevention and control	

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F 880	Continued From page 6	F 880	within the facility. 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) Observations of staff types to ensure performance of proper equipment disinfection, in the course of their duties. (2) Observations of staff types to ensure proper infection control practices and PPE use when administering aerosol-generating medications/treatments. 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. A QA tool has been developed and began the week of 10/10/2022. 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	

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F 880	Continued From page 7	F 880	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 11/03/2022	