STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	C 10/21/2021

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GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 58251

(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 and complaint survey started on 10/18/21 and concluded 10/21/21.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 1 supplemental resident (Resident #23) reviewed for falls. Failure to accurately complete the MDS does not allow the resident's assessment to reflect their current status/needs and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2019, page A-7 stated, ". . . Coding Instructions for A0310E, Is This Assessment the First Assessment (OBRA, Scheduled PPS, or OBRA Discharge [types of assessments]) since the Most Recent Admission/Entry or Reentry? * Code 0, no: if this assessment is not the first of these assessments since the most recent admission/entry or reentry. * Code 1, yes: if this assessment is the first of	F 641	1) On 10/19/2021 MDS Staff did complete a modification to Section A0310 and did successfully resubmit this for resident #23. 2) A second MDS was in process of being sent but still pending. This was corrected and resubmitted. 3) Both MDS Corrections were made within 30 minutes while survey was still on site. 4) Education will be provided to the MDS Coordinators by 11/18/2021 to review MDS Section A310E and correct completion of that section. 5)Checklist will be updated to include review of the MDS for all re-admissions who were hospitalized after a fall with injury. All re-admission records will be reviewed for accuracy using audit tool before submission to CMS.	11/18/21

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

Electronically Signed | 11/12/2021

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F 641	Continued From page 1 these assessments since the most recent admission/entry or reentry. . . ." Pages J-27-28 stated, "J1700. Fall History on Admission/Entry or Reentry: Complete only if A0310A = 01 or A0310E = 1 . . . Coding Instructions for J1700A, Did the Resident Have a Fall Any Time in the Last Month Prior to Admission/Entry or Reentry? * Code 0, no: if resident and family report no falls and transfer records and medical records do not document a fall in the month preceding the resident's entry date item. * Code 1, yes: if resident or family report or transfer records or medical records document a fall in the month preceding the resident's entry date item. . . ." Review of Resident #23's medical record occurred on 10/19/21. A re-admission note, dated 06/21/21, stated, ". . . Reason resident was hospitalized or received services at a hospital: Fell 2x [times] in nursing home on 6/16/21. Conditions and complications treated during most recent hospitalization: closed fracture of trochanter of left femur, closed hip fracture, . . ." A significant change MDS, dated 06/27/21, showed staff failed to code section A0310E as the first assessment since re-admission and therefore were unable to code the MDS for a fall with a fracture. During an interview on 10/21/21 at 10:41 a.m., an MDS nurse (#7) stated she "probably" coded the MDS incorrectly as she thought the discharge return anticipated MDS was the first MDS since re-admission.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		11/18/21

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F 658	Continued From page 2 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. 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 follow professional standards of practice for 1 of 1 sampled resident (Resident #27) with a skin impairment. Failure to assess, monitor, or document skin impairments may result in worsening signs/symptoms and/or delayed treatment. Findings include: Review of the facility policy titled, "Skin Assessment Pressure Ulcer Prevention and Documentation Requirements" occurred on 10/20/21. This policy, dated 04/21/21, stated, ". . . An abrasion is a wound caused by superficial damage to the skin, no deeper than the epidermis. If a bruise, contusion, abrasion, or skin tear is observed on a resident, this should be reported to the nurse immediately. The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation UDA [user-defined assessment] . . ." During an interview on 10/19/21 at 1:15 p.m., Resident #27 stated, "I have an open area on my buttock from sitting on the toilet too long." Review of Resident #27's medical record	F 658	1) Skin Assessment wound UDA for resident #27 has been completed. 2) All residents skin has been assessed and appropriately documented in the wound data collection UDA as appropriate. 3) Education will be provided by DNS to all Licensed Staff to follow GSS Policy, "Skin Assessment Pressure Ulcer Prevention and Documentation Requirements." Education to be completed by 11/18/2021. Skin observation UDA will be added to the TAR for residents with wounds to alert licensed nurse of required UDA. DNS or Designee will review resident dashboards during clinical morning huddle to ensure skin assessment UDA completed at least weekly for residents with wounds. 4) DNS or Designee will audit wound documentation 1X per week for 8 weeks; bimonthly for 8 weeks, and 1X per month for 2 month and to report audit results to QAPI Committee.	

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F 658	Continued From page 3 occurred on all days of survey. A physician's order, dated, 07/12/21 stated, "Mepilex foam dressing to left thigh shearing. Change every 3-5 days. D/C [discontinue] when resolved. Every 96 hours for skin shearing AND every 24 hours as needed when soiled or not intact." Review of the Treatment Administration Records (TAR) for the months of July, August, September, and October 2021 showed the nurses completed the dressing change every fourth day since 07/13/21. The progress notes for the months of July, August, September, and October 2021 lacked documentation of the size, appearance, or progress towards healing of the abrasion on Resident #27's left thigh. Observation 10/19/21 at 4:01 p.m., showed the licensed nurse (#10) removed the Mepilex dressing from Resident #27's left thigh abrasion. The pad of the dressing contained spots of dark drainage. During an interview on 10/20/21 at 1:55 p.m., when asked for assistance to locate Resident #27's skin observation UDAs related to the left thigh skin abrasion from 07/12/21 to present, a licensed nurse (#7) identified the medical record lacked skin assessment/observation UDAs for Resident #27's left thigh skin abrasion. During an interview on 10/20/21 at 3:45 p.m., an administrative nurse (#2) reported she expected nursing staff to monitor, assess, and document weekly on the condition of a wound.	F 658		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff.	F 725		11/18/21

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F 725	Continued From page 4 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, and resident, group, and staff interviews, the facility failed to assure sufficient nursing staff and related services are available at all times to meet the residents' needs for 9 of 12 sampled residents (Resident #6, #7, #10, #12, #13, #14, #15, #19, and #27) and 3 supplemental residents (Resident #21, #22, and #180) who required staff assistance for bathing. Failure to provide sufficient staffing does not	F 725	1) New process put into place on 10-18-2021. This has been corrected for residents #6, #7, #10, #12, #13, #14, #15, #19, and # 27. 2.) This new process has a designated bath aide to give bath/shower per resident preference at least 1X per week. Baths will be completed on the day shift Monday through Friday. Any baths unable to be completed on day shift will be completed	

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F 725	Continued From page 5 promote resident rights and physical, mental, and psychosocial well-being. Findings include: The information provided by the complainant indicated the facility did not have sufficient staff to provide care to the residents. - During a resident interview on 10/18/21 at 4:07 p.m., Resident #15 reported he has missed a few weeks of baths and stated, "Sometimes it's two or three weeks in a row, they [baths] are supposed to be weekly." Review of Resident #15's medical record occurred on all days of survey. The current care plan stated, "The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] weakness, gait instability E/B [evidenced by] need for assist. . . . BATHING: Resident requires extensive assist of 1. . . ." The current "Bath Weight List" identified the facility scheduled Resident #15 for a weekly bath on Thursdays. Bathing records dated 08/01/21-10/19/21, identified staff failed to bathe Resident #15 on nine of 12 scheduled bath days. - During a resident interview on 10/18/21 at 1:04 p.m., Resident #10 reported there was "not enough staff, only two aides this morning for everybody. There is no bath aide, I've gone a month without a bath. They pull the bath aide to the floor if they are short staffed."	F 725	on the evening shift of the same day. 3) All CNA'S and Licensed Staff will be educated by DNS on the importance of routine bathing of the residents by 11-18-2021. 4) DNS or Designee to audit 1X per week for 8 weeks, 2X per month, and 1X per month for 2 months. Report audits to QAPI Committee monthly.	

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F 725	Continued From page 6	F 725		

Review of Resident #10's medical record occurred on all days of survey. The current care plan stated, "The resident has an ADL self care performance deficit R/T weakness, fall at home, recent hospitalization E/B need for assist. . . . BATHING: Resident requires extensive assist of 1. . . ."

The current "Bath Weight List" identified Resident #10 scheduled for a weekly bath on Mondays.

Bathing records dated 08/01/21-10/20/21, identified staff failed to bathe Resident #10 on two of 12 scheduled bath days.

- During a resident interview on 10/19/21 at 1:43 p.m., Resident #21 reported having three baths since admission.

Review of Resident #21's medical record occurred on all days of survey. The current care plan stated, "The resident has an ADL self care performance deficit R/T weakness E/B need for assist. . . . BATHING: Resident requires limited assist of 1. . . ."

The current "Bath Weight List" identified Resident #21 scheduled for a weekly bath on Fridays.

Bathing records, dated 09/01/21-10/20/21, identified staff failed to bathe Resident #21 on three of seven scheduled bath days.

- During a resident interview on 10/19/21 at 1:43 p.m., Resident #22 reported having only one bath since admission.

Review of Resident #22's medical record

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F 725	Continued From page 7	F 725		

occurred on all days of survey. The current care plan stated, "The resident has an ADL self care performance deficit R/T weakness E/B need for assist. . . . BATHING: Resident requires limited assist of 1. . . ."

The current "Bath Weight List" identified Resident #22 scheduled for a weekly bath on Fridays.

Bathing records, dated 09/01/21-10/20/21, identified staff failed to bathe Resident #22 on five of six scheduled bath days.

- Facility staff provided the current bath list on 10/20/21. This list identified which day of the week each resident received their weekly bath (tub, whirlpool, or shower). Review of certified nursing assistant (CNA) bathing documentation showed the number of times the facility staff failed to provide a bath in the four weeks from 09/21/21/ to 10/20/21 as follows:
* Resident #6 - three
* Resident #7 - four
* Resident #12 - four
* Resident #13 - two
* Resident #14 - two
* Resident #19 - two
* Resident #27 - two
* Resident #180 - four

During the group interview on 10/20/21 at 10:00 a.m., when asked about receiving baths as scheduled, Resident #180 stated, "There isn't enough staff. I've been trying to get my hair washed for two weeks. They say they are 'always going to do it' but don't, they are using dry shampoo, but I can't stand it anymore. I was okay with a bed bath, but I really want my hair

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F 725	Continued From page 8 washed." During an interview on 10/20/21 at 11:10 a.m., a CNA (#4) stated the facility recently started with one scheduled bath aide again and they follow the bath list, if there is no bath aide due to staffing etc., then the CNAs may try to offer baths at alternate times such as evenings, or alternate days but this may not cover all missed baths. During an interview on 10/20/21 at 2:30 p.m., administrative staff (#1 and #2) stated residents receive one bath a week, with the exception of one or two residents. The previous bath aide quit effective the first of August. There were numerous different things trialed to replace the position without success. They agreed the facility did not maintain staffing to a level where resident baths were given as scheduled from August forward.	F 725		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		11/18/21

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F 732	Continued From page 9 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of staffing reports, and staff interview, the facility failed to ensure posting of accurate and complete staffing information on 4 of 4 days of survey (October 18-21, 2021). Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift. Findings include: Observation of the daily staffing report showed the following: * 10/18/21 - Incomplete data for nurses and no data for certified nursing assistants (CNAs).	F 732	1) A new staffing information sheet was initiated on 10-27-2021 which clearly indicates the hours for RNS, LPNS, CNAS, that are scheduled for the day, along with total hours per category and resident census. 2) CNA'S were educated on 11-10-21 and Licensed Staff were educated on 11-11-21 by DNS and Ancillary Staff were educated on 11-9-2021 by Administrator. 3) DNS or Designee to audit this form daily to monitor posting is visible and ensure posting for accuracy for 14 days, weekly for 6 weeks, and 1x per month for 2 months. DNS or Designee to report	

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F 732	Continued From page 10 * 10/19/21 - No current report posted. * 10/20/21 - No current report posted. * 10/21/21 - Incomplete data for nurses and CNAs. The facility failed to post the required daily census/staffing report on two of the four days observed and on the other two days, the facility failed to identify all the RNs, LPNs, and CNAs scheduled who were directly responsible for resident care per shift. During an interview on 10/21/21 at 3:10 p.m., a nurse administrator (#2) stated night shift staff duties included posting the daily staffing sheet, which should list the number of residents in the building and the scheduled hours of RNs, LPNs and CNAs. The nurse agreed the staffing sheet was inaccurate.	F 732	audit results to the QAPI Committee monthly.	
F 761 SS=E	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.	F 761		11/18/21

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F 761	Continued From page 11 §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 correctly label, store, and discard medications/biologicals in 2 of 2 medication storage areas (medication cart and medication room). Failure to correctly label medication, properly store/secure refrigerated medication, and discard expired medication/blood glucose strips increases the risk of residents receiving outdated or improperly temperature-controlled medications with reduced efficacy, inaccurate dose of medications, inaccurate test results, and may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Medications: Acquisition Receiving Dispensing and Storage" occurred on 10/21/21. This policy dated, 12/28/20, stated, ". . .The location will routinely check for expired medications and necessary disposal will be done . . . Refrigerators holding medications (such as insulin, etc.) will be kept between 36 degrees F [Fahrenheit] and 46 degrees F. . . . Check refrigerator temperatures daily. . . . Controlled drugs (Schedule II) and other drugs subject to possible abuse will be	F 761	1) All Nursing will be educated by DNS on the GSS Policy "Medications: Acquisition/Receiving/Dispensing and Storage" by 11-18-2021. 2) A duty list has been revised to ensure Nursing Staff is a) checking the fridge for expired medications weekly b) checking the E-KIT for expired medications-order to pharmacy to replace expired medications complete weekly c) checking the OTC drugs for expired medications weekly d) checking medication cart for properly stored medications-open dates weekly, proper labels on medicine containers e) daily monitoring of the refrigerator temperature and proper documentation f) ensure storage of scheduled 2 medications are securely locked per policy g) weekly check of supplies and discard expired items 3) Pharmacy consultant will check E-Kit and Medication Carts quarterly for expired medication for expired medications and include in the report to the facility.	

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F 761	Continued From page 12 stored in separate, locked, permanently fixed compartments . . . If the medication requires refrigerator, these need to be locked in a separate container. . . ." - Observation of the medication cart on 10/21/21 at 9:40 a.m. with a licensed nurse (#9) identified a resident's Ventolin Inhaler (bronchodilator) with an expiration date of September 2021. A resident's bottle of Brimonidine eye drops (treatment for glaucoma) lacked a pharmacy label or directions for its use. - Observation of the medication room occurred the morning of 10/21/21 with a licensed nurse (#9) and showed the following: * An unlocked medication refrigerator with a separate unlocked container, located on the bottom shelf, containing one 30 milliliter multidose vial of Lorazepam (antianxiety). * Review of the refrigerator temperature logs for the month of October 2021 showed facility staff failed to check the refrigerator temperature for 6 of the past 20 days. * An unlocked refrigerator located on the floor in the medication room contained miscellaneous beverages and a resident's box of individual dosed Perforomist Nebulization Solution. * A cabinet contained eight boxes of Assure Platinum blood glucose test strips with an expiration date of 09/17/21. * The Emergency kit (E-kit) contained 6 tablets of Metolazone (diuretic), expired June 2021; 11 tablets of Ciproflaxacin (antibiotic), 10 tablets of Furosemide (diuretic), 25 vials of Haldol (antipsychotic), and 5 tablets of Odansetron (antiemetic), expired July 2021; 6 tablets of Bactrim (antibiotic) and an Albuterol inhaler	F 761	4) DNS or Designee to audit 1X per week for 8weeks; 2X per month for 2 months; and 1X per month for 2 months. Audit results will be reported to QAPI Committee until Committee determines compliance has been met.	

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F 761	Continued From page 13 (bronchodilator), expired August 2021; and 3 tablets of Azithromycin (antibiotic), expired September 2021. During the observation of the medication room, the licensed nurse (#9) stated, "All refrigerated medications should be stored in the medication refrigerator and the refrigerator locked when not in use." When asked if the temperature of the refrigerator located on the floor is monitored, the licensed nurse (#9) replied "no". During an interview on 10/21/21 at 12:00 p.m., an administrative nurse (#2) stated the facility is working on a process for regular monitoring of medications and expiration dates and confirmed the facility staff should have removed and replaced the expired medications and blood glucose test strips.	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	F 880		11/18/21

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F 880	Continued From page 14 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 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	F 880		

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F 880	Continued From page 15 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, review of professional literature, and staff interview, the facility failed to follow infection control standards for 3 of 12 sampled residents (Resident #6, #10, and #179) and 1 supplemental resident (#16). Failure to follow infection control practices for hand hygiene, personal protective equipment (PPE), ostomy care, and during linen handling/storage has the potential to transmit infections to other residents, staff, and visitors. Findings include: HAND HYGIENE Review of the facility policy titled "Hand Hygiene and Handwashing" occurred on 10/21/21. This policy, revised 04/06/21, stated, ". . . The goal is to prevent the spread of infection between residents . . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands: . . . After having contact with body fluids, . . . After removing gloves. . . ."	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: (1) Ensuring staff have adequate knowledge of proper use of graduates to empty ostomy/catheters to avoid contamination of surfaces and resident food/water and personal items. (2) Ensuring staff consistently handle soiled/contaminated linen/laundry, in accordance with guidelines from the CDC. (3) Ensuring staff store linen and other items in accordance with current nursing	

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F 880	Continued From page 16 - Observation on 10/19/21 at 8:32 a.m. showed a certified nursing assistant (CNA) (#5) donned gloves, removed Resident #16's urine soaked brief, performed perineal cares, and removed the soiled gloves. Before performing hand hygiene, the CNA (#5) placed a clean brief, applied lotion to Resident #16's back, dressed the resident, applied a gait belt, and transferred the resident to the wheelchair using the stand aid. The CNA failed to complete hand hygiene after performing perineal cares and prior to completing other tasks. - Observation on 10/19/21 at 9:52 a.m. showed a CNA (#3) assisted Resident #10 to change a urine soaked brief and pants. The CNA (#3) donned gloves, removed the soiled brief and pants, and applied a clean brief and pants. The CNA (#3) removed her gloves. The Resident #10 stated his socks were also wet. Without donning gloves, the CNA (#5) removed the wet socks and applied clean socks to the resident's feet. The CNA (#3) bagged the soiled linen and garbage and exited the resident's room without performing hand hygiene. PPE Review of the Centers for Disease Control and Prevention (CDC) guidance found at: https://www.cdc.gov, updated Sept. 10, 2021, ". . . Source control options for HCP [healthcare personnel] include: . . . A well-fitting facemask. . . . Textile (cloth) covers that are intended primarily for source control. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel. . . ."	F 880	facility guidelines from the CDC. (4) Ensuring staff hand hygiene or handwashing when donning/doffing gloves, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. 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 11/18/2021 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 of staff to properly use a graduate to empty an ostomy/catheter to avoid contamination of surfaces, resident food/drink, personal items. b. Failure of staff to properly handle and transport contaminated linen. c. Failure of staff to properly store clean linen. d. Failure to complete handwashing or hand hygiene in accordance with CDC guidelines.	

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F 880	Continued From page 17 Observation on 10/19/21 at 1:50 p.m. showed a CNA (#6) wore a cloth face covering, not a surgical mask, while she completed a bed bath on Resident #179. Observation on 10/19/21 at 2:46 p.m. showed a CNA (#6) wore a cloth face covering, not a surgical mask, as she assisted a CNA (#8) to reposition Resident #179. OSTOMY CARE Observation on 10/20/21 at 8:31 a.m. showed a CNA (#5) emptied Resident #179's ileosotomy (surgical opening into the small intestine to drain bowel contents) bag into a graduate (collection container). The CNA (#5) placed the graduate with a small amount of bowel movement on the bedside stand next to an open glass of ice and water. During an interview on 10/21/21 at 4:10 p.m., an administrative nurse (#1) stated she expected all staff to change into a surgical mask upon entry into the facility. She expected staff to perform hand hygiene after removing gloves and not to place used graduates next to food or water. LINEN HANDLING/STORAGE Review of the Centers for Disease Control and Prevention (CDC) guidance found at: https://www.cdc.gov/hai/prevent/resource-limited/laundry.html, updated 03/27/20, "Best practices for linen (and laundry) handling: . . . Never carry soiled linen against the body. Always place it in the designated container. . . ."	F 880	Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate on the correct procedure for use of graduates to empty ostomy/catheters to avoid contamination of surfaces and resident food/water and personal items. b. Educate on the correct procedure for handling soiled/contaminated linen/laundry. c. Educate on storage of linen and other items in the linen storage rooms. d. All staff will receive education 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. (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. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via	

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F 880	Continued From page 18 Observation on 10/19/21 at 9:38 a.m. showed two CNAs (#3 and #5) assisted Resident #6 to transfer from the bed to the wheelchair. One CNA (#3) removed the soiled bedding from Resident #6's bed and without placing the bedding in a linen bag or container, placed the linens on a chair. A moment later the CNA (#3) picked up the soiled linens, carried them next to her body to the soiled utility room, and placed them in a laundry container with a lid. Failure to transport soiled linen appropriately may lead to contamination of the resident's chair and staff's clothing and spread of infection to staff and residents.	F 880	observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observe direct care staff use a graduate to empty an ostomy/catheter to avoid contamination of surfaces, resident food/drink, personal items. (2) Observations of all staff types to ensure correct procedure for handling soiled/contaminated linen/laundry. (3) Observations of linen storage rooms for storage of linen and other items. (4) Observations of all staff types to ensure performance of proper handwashing and 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	

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F 880	Continued From page 19	F 880	three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 11/18/2021 1) An RCA meeting commenced on 11-09-2021 to analyze root cause of gaps noted in the Infection Prevention Process. 2) Education will be provided by 11-18-2021 to all CNA'S and Licensed Staff by DNS and all Ancillary Staff by Administrator regarding Proper Handwashing, Proper Masks usage in the work environment, and appropriate use of linen bags. 3) Nursing staff will be educated regarding proper procedure for emptying a catheter bag or ostomy bag maintaining effective infection control practices. 4) Further education will be provided by DNS regarding maintaining infection control practices with the storage of linens to all CNA'S and Licensed Staff by DNS and Ancillary Staff by the Administrator. 5) Audits will be completed by DNS or Designee as followed to evaluate the effectiveness of the education provided. a) Linen bag usage 1X per week for 2 months; 2X per month for 2 months; and 1X per month for 2 months. b) Handwashing Audits 5 Staff per week for 4 weeks; 5 staff 2X per week for 8 weeks; 5 staff 1X per month for 2 months; Staff from all disciplines will be included in this audit process.	

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F 880	Continued From page 20	F 880	c) Appropriate mask use audits 5 staff per week for 4 weeks; 5 staff 2X per week for 8 weeks; and 5 staff 1X per month for 2 months; Staff from all disciplines will be included in this audit process. d) Emptying ostomy or catheter bags audit 2 observations per week for 4 weeks; 2 observations per month for 2 months; 2 observations per month for 2 months. e) Linen closets to ensure no items are on the floor. Halls 1, 2, and 3 will be audited 1X per week for 2 months; 1X per month for 2 months. f) All Audit Results will be discussed at monthly QAPI Committee Meetings.	