STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355114	A. BUILDING _____ B. WING _____	02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH DAKOTA VETERANS HOME	1600 VETERANS DRIVE LISBON, ND 58054

(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 02/16/21 and concluded on 02/18/21.	F 000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §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 staff interview, the facility failed to obtain a current physician's order for a powder/barrier cream for 1 of 2 sampled residents (Resident #26) with skin breakdown. Failure to obtain a current order for the powder/barrier cream may result in adverse consequences and ineffective management of a resident's condition. Findings include: Review of the facility policy titled "Physician Orders" occurred on 02/18/21. This policy revised May 2014, stated, ". . . . All residents of this facility shall be accompanied by physician's orders adequate to provide immediate and essential care to the resident consistent with the resident's mental and physical status . . . All orders will be entered in the electronic medical record . . . Orders will be acknowledged and cosigned . . . orders will be electronically sent for signature . . . automatic discontinue of standing orders after 30 days if Medical Provider has not	F 658	1. Action taken for resident(s) found to have been affected include: Related to how the North Dakota Veterans Home electronic medical record system functions, for each individual resident, the Standing Orders is approved and signed by the Medical Provider on a paper format. That signed Standing Order is then scanned into the resident's medical record. Therefore, it does not show up in the "Physician order" section unless initiated as an individual order. Resident #26 had a signed Standing Order Protocol in their medical record that was current and was signed by the medical provider. Those signed standing orders included the following: a. May use approved standing orders. b. Stoma powder to affected area BID and PRN. Apply small amount topically to affected area followed by skin protectant BID PRN. Discontinue when healed. *If no improvement after 7 days contact MD. For Resident #26, the use of stoma powder has been initiated as an individual order into the electronic health record.	

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

Administrator 3/10/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 specifically renewed . . . each medication order must have a route, dose, frequency and related diagnosis . . . if any of this information is incomplete, the deficiency should be corrected by a call to the prescriber before meds [medications]/treatments administered . . ." Review of Resident #26's medical record occurred on all days of the survey. Diagnoses included multiple sclerosis, history of skin breakdown to coccyx and superficial open area to left inner buttocks. The current care plan stated, ". . . red rash, excoriated to buttocks, denuded area to bilateral sides of rectum . . . stoma powder and zinc to open/red areas to buttocks . . . " Observation on 02/17/21 at 10:47 a.m., showed two certified nursing assistants (CNA's) (#11 and #12) apply stoma powder and zinc barrier cream to Resident #26's after providing toileting cares. During an interview on 02/17/21 at 11:37 a.m., a nurse (#8) agreed Resident #26's medical record lacked physician orders for the stoma powder and zinc barrier cream, and indicated direct staff have been applying the powder and barrier cream "for a few days now". The nurse (#8) acknowledged staff failed to obtain a physician order for skin breakdown. During an interview on 02/17/21 at 1:20 p.m., Resident #26 stated his skin broke down "around last Friday [02/12/21] and reported staff applied the powder and zinc "on and off" throughout the weekend. During an interview on 02/18/21 at 11:15 a.m., an	F 658	2. Identification of other residents having the potential to be affected was accomplished by: a. Facility has determined that all residents have the potential to be affected. b. All current resident charts will be reviewed to ensure standing orders in use have been initiated to show visibility. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: a. NDVH policy, Nursing Services-Skilled Care, Physician Orders, Completion of, will be reviewed and revised to include procedure for standing orders. b. In-service educator will provide education to nursing staff to include revised policy: Physician Order, Completion of, and a review of transcription and submission of physician orders. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: a. Nursing management team will monitor the provision of services ordered and provided for residents on his/her respective unit (13 residents), 4 records per week for one month then 2 records every two weeks for two months.	

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F 658	Continued From page 2 administrative nurse (#6) indicated staff should follow the facility's policy and stated, "they are working on it". The facility failed to obtain a current physician's order for Resident #26's skin breakdown.	F 658	b. Audit records will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date:	4-9-2021
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure 2 of 2 sampled residents (Resident #1 and #12) received care and services necessary to attain the highest degree of safety possible while being fed a modified diet and drinking thickened liquids. Failure of staff to know a resident's prescribed diet, provide appropriate thickened liquids, and provide meal assistance has the potential to negatively impact residents overall swallow safety and placed Resident #1 and #12 at risk for aspiration. Findings include: Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 137-138, and educational handouts, identified, ". . . Thin liquids	F 684	1. Action taken for resident(s) found to have been affected include: a. Kitchen staff have been instructed to prepare all food items to the consistency ordered prior to leaving the kitchen. b. Staff involved have been educated on locations where they can see the residents plan of care that included diet/consistency and assistance the resident requires. c. Resident #12 does not have an order for "Frazier (Free) Water Protocol" , that information was added to shift report to be passed on. d. Designated staff to provide meal supervision for resident #12. 2. Identification of other residents having the potential to be affected was accomplished by: a. The facility determined that all residents with orders for consistency modification and/or requiring supervision during meals have the potential to be affected.	

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F 684	Continued From page 3 are the hardest thing to control in the mouth and keep together in a bolus. It is easier to aspirate thin liquids as they travel through the throat past the larynx [area of the throat involved in breathing, producing sound, and protecting the airway during a swallow] because they break apart and some of the liquid can fall into the larynx. Thickened liquids are easier to keep together as a cohesive bolus. Thickened liquids also move more slowly through the pharynx [area of the throat that carries air to the larynx and food to the stomach], giving the larynx more time to close and protect the airway. . . . Patients with pharyngeal problems who are at risk for aspiration sometimes have more difficulty with thinned, runny purees because the disordered mechanism cannot respond in time with sufficient control to protect the airway. . . . we make recommendations for foods to be one texture only because it's harder to manipulate something in the mouth with two textures . . ." - Review of Resident #1's medical record occurred on all days of survey. The record identified diagnoses including transient ischemic attack (TIA)/cerebral infraction (stroke), aphasia (communication impairment) with left-sided hemiparesis (weakness/paralysis on one side of the body), oropharyngeal dysphagia (swallowing impairment), reflux (when stomach acid flows upward/irritating the lining), and history of pneumonia. The quarterly Minimum Data Set (MDS), dated 02/01/21, identified Resident #1 has a feeding tube and required a mechanically altered diet for all oral intake. The physician's orders and current care plan further identified Resident #1 required a puree diet with honey-thickened liquids.	F 684	3. Actions taken/systems put into place to reduce the risk of future occurrence include: a. NDVH policy, Dietary Services Tray Cards – Skilled Unit, will be reviewed and updated to ensure it provides clear guidance to employees. b. NDVH policy, Appropriate Health Care will be reviewed and updated to ensure it provides clear guidance to employees. c. Nurses will ensure the plan of care is followed to include appropriate supervision and interventions are implemented. d. In-service educator and Dietary Mangers will provide instruction to NDVH Nurses, Certified Nursing Assistants, Activities and Social Services. To included updated policies, Therapy communication sheet, and education on "Texture/ Liquid Modification and Specific Needs with Meals and Feeding". e. In-service educator will provide education to Certified Nursing Assistants on locations and content of the CNA care plans.	

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F 684	Continued From page 4 On 02/17/21 at 5:00 p.m., observation showed a certified nursing assistant (CNA) (#2) squirting a liquid thickening agent into the banana dessert on Resident #1's tray. The CNA (#2) failed to look at the label to determine the correct amount of thickening agent required. After adding/mixing two squirts of the thickener, the CNA (#2) stated, "I think that is good enough." When asked questions pertaining to the consistency of the dessert, the CNA (#2) squirted/mixed more thickener into the dessert until it reached a honey consistency. When asked questions pertaining to Resident #1's diet, the CNA (#2) stated, "I'm not sure what his diet is. I think pureed." The CNA (#2) and an unidentified dietary staff member then located Resident #1's meal ticket which indicated a pureed diet with honey-thickened liquids. Facility staff failed to ensure they knew the resident's current diet order and thickened the foods/liquids to the appropriate consistency prior to serving them to the resident. - Review of Resident #12's medical record occurred on all days of survey. The record identified diagnoses including TIA/stroke, dysphagia, reflux, and generalized muscle weakness. A physician's order, dated 02/04/21, stated, "Nectar thickened liquids." Review of the current care plan showed, ". . . 1:1 supervision during meal times . . . needs cueing and reminders often throughout meal service . . . mechanical soft with nectar thick liquids . . . encourage to alternate with fluids in between bites . . ."	F 684	4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: a. Dietary managers and nursing management team will complete random weekly audits: i. Residents will be observed during meal/snack times. -To ensure adequate supervision and assistance is provided. -To ensure receive prescribed diet. -To ensure receive appropriate thickened liquids. ii. To be completed 2x/week per house for one month and then weekly per house for two months. b. Audit record will be reviewed by the QAPI Committee until sch time consistent substantial compliance has been achieved as determined by the committee. 5. Correction Action Completion Date:	4-9-2021

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F 684	Continued From page 5 A swallow study, completed 02/04/21, stated, ". . . With thin liquids there was penetration and a tiny amount of aspiration. . . . Solids were swallowed after a delay in initiation of the swallowing mechanism . . . Thin liquids are unsafe. Nectar thickness liquids were safe." Observations of Resident #12 showed the following: * 02/16/21 during the noon meal, staff sat down at the table intermittently assisting the resident during the meal. Resident #12 held fluids in her mouth for a while prior to swallowing them. * 02/17/21 at 9:31 a.m., Resident #12 asked for a drink of water. The CNA (#13) provided water from the resident's bathroom sink without thickening it. The resident held the water in her mouth for a while before swallowing it. At 9:36 a.m., Resident #12 requested another drink of water. Again, the CNA (#13) provided water from the resident's bathroom sink without thickening it. The resident held the water in her mouth for a while and swallowed after CNA (#13) prompted her to do so. * 02/17/21 at 9:54 a.m., Resident #12 sat at the breakfast table with a large glass of orange juice. The orange juice appeared thick in the middle and watery on top and on the sides (two consistencies). * 02/17/21 during the breakfast and supper meals, staff sat down at the table intermittently assisting Resident #12 during the meal. Resident #12 held fluids in her mouth for a while prior to swallowing them. During a kitchen tour on 02/18/21 at 9:55 a.m., when asked how staff know the resident's prescribed diet and the amount of assistance	F 684		

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F 684	Continued From page 6 he/she requires during meals, a dietary supervisor (#1), stated, "Diets and liquids are on the residents tray cards and amount of assistance residents need during meals is listed on the touch screen [a computer screen located on the wall for staff access] and tells them. They can also see a resident's whole care plan on the touch screen." During an interview on 02/18/21 at 10:58 a.m., when asked the definition of one-to-one (1:1) supervision during meals, the dietary supervisor (#1), stated, "Staff to sit down with the resident the whole meal." The facility failed to thicken and/or appropriately thicken Resident #12's dessert/fluids as ordered and failed to provided one-to-one supervision at meals as care planned.	F 684		
F 689 SS=D	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 observation, review of the facility policy, review of chemical Safety Data Sheets (SDS), and staff interview, the facility failed to ensure an environment free of accident hazards on 2 of 4 households (Freedom and Peace). Failure to store chemicals in a locked/secured	F 689	1. Action taken for resident(s) found to have been affected include: a. The administrator replaced the broken lock on 2-17-2021 . b. Dietary manager on 2-17-2021 removed container of Dawn dish soap from unlocked area. c. The area of concern was inspected for any other locks not functioning and that all items required to be locked were stored in such a manner. 2. Identification of other residents having the potential to be affected was accomplished by: a. Facility believed that all residents have the potential to be affected. b. All required locks in households were inspected for proper functioning.	

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F 689	Continued From page 7 area placed the residents in these households at risk for injury. Findings include: Review of the facility policy titled "Chemical Use and Safety" occurred on 02/18/21. This policy, revised 12/20/19, stated, ". . . All chemicals are to be stored properly and kept in a locked area. Containers of chemical will not be left unattended. . . ." Observations on all days of survey showed, at various times, unaccompanied residents wandering in the Freedom and Peace households. A tour of the open kitchenette areas in the Freedom and Peace households occurred on the morning of 02/18/21 with a dietary supervisor (#1). Observation on the Freedom household showed an unlocked under sink cupboard with a broken lock containing a bottle of Virex (an all-purpose disinfectant cleaner) and a bottle of Ecolab 146-Quat Sanitizer, and an unlocked upper cupboard containing a bottle of liquid Dawn dish soap. Observation on the Peace household showed an unlocked upper cupboard containing an unlabeled container of what the dietary supervisor identified as Dawn dish soap. Review of the SDS sheets for the chemicals showed: * Liquid Dawn Dish Soap: Causes eye irritation * Virex: Causes serious eye irritation * Ecolab 146-Quat Sanitizer: Harmful if swallowed. Causes severe burns and eye damage.	F 689	c. All households inspected to ensure substances/chemicals required to be stored in locked area were stored in a safe place. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: a. Paper format for reporting needed repairs has been replaced with an on-line program. Program has been loaded on all computer and tablets that staff use for communication and documentation. b. Locks identified as frequent use and high risk for failure will be replaced with a locking system that has increased functionality for use and reliability. c. NDVH policy Chemical Use and Safety was reviewed. d. IT designee and In-service Educator will instruct all employees on use of on-line workorder program and new locks. All staff will be in-serviced on the policy and procedure of the NDVH policy, Chemical Use and Safety. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: a. The Housekeeping team and/or Nurse managers will conduct checks of locks to ensure are in proper working order, one house per week. b. The Housekeeping team and/or Nurse managers will conduct routine checks of unlocked areas in resident households to ensure all substances/chemicals are stored appropriately, one house per week.	

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F 689	Continued From page 8 During an interview on 02/18/21, the dietary manager (#1) stated, "The chemicals should be labeled and stored in a locked cupboard. I didn't know this lock was broken." Failure to store chemicals on the Freedom and Peace households in locked cupboards placed the residents at risk for injury.	F 689	c. Audit records will be reviewed by the QAPI Committee and will continue until such time consistent substantial compliance has been achieved as determined by the committee. Correction action completion date:	4-9-2021
F 880 SS=D	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,	F 880	1. Immediate action taken for resident(s) found to have been affected include: a. Residents identified for meeting need for Droplet Precautions; placed in precautions immediately with signage placed outside of door and: i. Signage for droplet precautions updated to include use of N95 mask and needed for door to be close. Staff educated on updated requirements and signage. ii. Education on N-95 Instructions for Droplet Precautions reviewed and provided for staff. iii. Ensure staff entering and exiting a room on droplet precautions donned, doffed disposed of PPE in accordance with CDC guidelines. iv. Door to room remain closed and staff consistently assist residents to keep the doors to their room closed per CDC guidelines. 2. Identification of other residents having the potential to be affected was accomplished by: a. Facility believed that all residents have the potential to be affected. b. Algorithm for when droplet precautions is needed; made and distributed to staff.	

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F 880	Continued From page 9 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 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	F 880	3. Actions taken/systems put into place to reduce the risk of future occurrence include: a. Root cause analysis was completed on failure to post appropriate signage to include the appropriate PPE required for droplet precautions. b. All staff whose normal duties include entering residents' room will be educated on selecting, donning, doffing, and disposing of PPE when entering a room on droplet precautions isolation/quarantine procedures. This education will include CDC's lesson on personal protective equipment developed for nursing home staff and staff will complete the QSEP – CMS Target COVID-19 for Frontline Nursing Home Staff. Education will include the importance of assisting residents to keep the door to their rooms closed. c. North Dakota Quality Improvement Organization will be involved with improving infection prevention and control within NDVH through quality assurance process improvement. Meeting dated is scheduled for Monday March 22nd. d. Current ND DoH and CDC guidelines have been provided for staff. With future updates, the new information will be provided in red print to assist with identification of changes. e. Nurse Managers to review all hospital returns and new admissions and assure initiation of Droplet Precautions when indicated. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: a. Weekly observation monitoring for no less than 12 weeks will be conducted to ensure:	

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(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 880	Continued From page 10 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional references, and staff interview, the facility failed to follow infection control standards for 2 of 2 sampled residents (Resident #90 and #91) placed on isolation precautions due to their unknown COVID-19 status. Failure of the facility to place newly admitted/re-admitted residents on droplet precautions and ensure staff wear N95 masks when entering their rooms and the doors to their rooms remain closed, may result in residents and staff being exposed to COVID-19 (a viral infection) or other healthcare-associated infections. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance for PPE use, found at: https://www.cdc.gov, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 02/23/21, stated, ". . . The PPE [personal protective equipment] recommended when caring for a patient with suspected or confirmed COVID-19 includes the following . . . Put on an N95 respirator . . . Put on eye protection . . . Put on clean, non-sterile gloves . . . Put on a clean isolation gown upon entry into the patient room . . . " - Review of Resident #90's medical record occurred on all days of survey. The progress note, dated 02/02/21, identified, "Resident returned following hospital stay at [Hospital] for	F 880	i. Appropriate signage to include the specific personal protective equipment (PPE) required for droplet precautions. ii. Observation of all staff types to ensure correct selection, donning, use and doffing of PPE when entering and exiting droplet precaution isolation/ quarantine rooms. iii. Observation of households to determine if staff are ensuring the doors to the resident's rooms remain closed. When indicated. b. Observations will be made across all shifts and households. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. c. After 12 weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. i. Monthly monitoring will be continued for no less than 3 months. d.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 3 consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. Correction action completion date:	4-9-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355114	A. BUILDING _____ B. WING _____	02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH DAKOTA VETERANS HOME	1600 VETERANS DRIVE LISBON, ND 58054

(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 880	Continued From page 11 discharged diagnoses: acute CVA [cerebral vascular accident] . . ." Observation on 02/16/21 at 5:00 p.m. showed an "Enhanced Precautions" sign and isolation cart outside Resident #90's door. The door to his room was wide open, and Resident #90 was observed laying on his bed. At 5:07 p.m., a certified nursing assistant (#3), wearing a surgical mask, face shield, gown, and gloves, entered Resident #90's room carrying his afternoon snack. - Review of Resident #91's medical record occurred on all days of survey. The progress note, dated 02/05/21, identified, "Resident is a . . . gentleman admitted to [Facility] skilled unit [room] following inpatient stay at [Hospital] following [a surgical procedure] . . ." Observation showed the following: * 02/16/21 at 1:22 p.m., An "Enhanced Precautions" sign and isolation cart outside Resident #91's door. The door to his room was wide open. * 02/16/21 at 4:02 p.m., An "Enhanced Precautions" sign and isolation cart outside Resident #91's door. The door to his room was wide open. * 02/17/21 at 5:25 p.m., An "Enhanced Precautions" sign and isolation cart outside Resident #91's door. The door to his room was wide open. During an interview on 02/17/21 at 10:12 a.m., when asked questions regarding "Enhanced Precautions" requirements, a nurse (#4) stated, "Oh, the doors are usually closed. They should	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: Ensuring appropriate signage to include the specific personal protective equipment (PPE) required for droplet precautions. a. Ensuring staff entering and exiting a room on droplet precautions donned, doffed disposed of PPE, in accordance with CDC guidelines. b. Ensuring staff consistently assist residents to keep the doors to their rooms closed, in accordance with guidelines from the CDC. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: a. Educate staff on appropriate signage for droplet precautions. b. Educate all direct care staff on selecting, donning, doffing, and disposing of PPE when entering a room on droplet precaution isolation/ quarantine procedures. c. Educate all staff on the importance of assisting residents to keep the doors to their rooms closed.	

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F 880	Continued From page 12 have been closed." During an interview on 02/18/21 at 8:15 a.m., an administrative staff member (#6) reviewed the "Enhanced Precautions" sign outside Resident #91's room and reported the sign failed to direct staff to close the doors. She confirmed "the doors should be closed."	F 880	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 The facility shall complete the following actions: 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 post appropriate signage to include the appropriate PPE required for droplet precautions. b. Failure to select, don and utilize the necessary PPE for droplet precautions isolation/quarantine room access, in accordance with CDC guidelines. c. Failure to assist residents to keep the doors to their rooms closed. (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff whose normal duties include entering resident rooms on the correct procedure for selecting, donning, using and doffing PPE when entering a droplet isolation/quarantine precaution room. This education will include the CDC's lesson on personal protective equipment developed for nursing home staff available at https://youtu.be/YYTATw9yav4. b. Educate all staff on the importance of assisting residents to keep the doors to their rooms closed. c. The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and	

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F 880	Continued From page 13	F 880	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 observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: a. Appropriate signage to include the specific personal protective equipment (PPE) required for droplet precautions. b. Observations of all staff types to ensure correct selection, donning, use and doffing of PPE when entering and exiting droplet precaution isolation/quarantine rooms. c. Observe common areas of the building to determine if staff are ensuring the doors to the resident's rooms remain closed. 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 03/25/2021	