STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER POINTE A PROSPERA CO	3500 21ST ST SE MANDAN, ND 58554

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey, complaint, and facility reported incident investigation started on 10/16/23 and concluded 10/19/23. The facility was found in compliance with regulatory requirements for the complaint and facility reported investigations.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		11/23/23

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

Electronically Signed | 11/15/2023

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F 583	Continued From page 1 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to promote privacy and confidentiality of the medication administration records (MAR) on 2 of 6 units (300 and 400 unit) observed. Failure to promote resident privacy and lock computer screens may result in unauthorized viewing of resident records by other residents, visitors, or unlicensed staff. Findings include: Observations of computer screens on 10/17/23 showed the following: * At 8:26 a.m. to 8:37 a.m., an unattended computer at the nurse's station located in the 300 unit with the MAR opened and revealing a resident's picture, name, medications, and dosages. * At 8:42 a.m., a nurse (#4) left an unattended computer at the nurse's station located in the 400 unit with the MAR opened and revealing a resident's picture, name, medications, and dosages. During an interview on the morning of 10/19/23, an administrative nurse (#1) confirmed she expected staff to lock computer screens when unattended. The facility failed to promote privacy and	F 583	F-583- Confidentiality It is the intent of this facility to remain in compliance with F583, to ensure that resident□s confidentiality is maintained. All residents have the potential to be affected by this deficient practice. Standard of practice related to HIPPA, Confidentiality, and Privacy was reviewed with all staff on 11/9/23. Beginning the week of 11/13/23 the QI coordinator and/or her designee will complete QI monitoring of EMR (electronic medical records) computers utilizing the Audit tool entitled CQI Worksheet: Privacy/ Confidentiality of records. Random audits will be completed weekly X 4, then monthly X 2 to ensure that confidentiality is maintained. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and then summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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F 583	Continued From page 2 confidentiality of the residents' MARs when unattended by staff.	F 583		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623		11/23/23

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F 623	Continued From page 3 under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder	F 623		

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F 623	Continued From page 4 established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or their representative and/or the State Long Term Care Ombudsman written notice of transfer for 3 of 5 sampled residents (Resident #30, #47, and #68) with a hospital transfer. Failure to provide a written copy of the transfer notice does not allow the resident and/or their representative to make an informed decision regarding their rights or inform the Ombudsman of the transfer. Findings include: Review of the facility policy titled "Discharge And Transfer" occurred on 10/19/23. This policy,	F 623	F-623 □ Notice of Transfers It is the intent of this facility to remain in compliance with F-623 and provide all required notice of transfers. Residents noted to be affected by this deficient practice had no untoward affects and correction is not applicable. All residents who transfer out of the facility have the potential to be affected. The policy entitled Discharge and Transfer- Rehab/Skilled, Therapy and Rehab was reviewed and remains in place unchanged. The policy entitled Discharge and Transfer- Rehab/Skilled, Therapy and Rehab was reviewed with responsible	

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F 623	Continued From page 5 dated 12/27/22, stated, "Before a location transfers or discharges a resident, the location must: 1. Notify the resident and the resident's representative of the transfer or discharge and the reason for the move in writing . . . the location must send a copy of the . . . form to a representative of the Office of the State Long-Term Care Ombudsman . . ." - Review of Resident #30's medical record occurred on all days of survey and identified a hospital transfer on 08/04/23. The resident's medical record lacked evidence the facility provided a written notice/copy of the transfer form to the resident/representative or informed the State Ombudsman of the hospital transfer. - Review of Resident #47's medical record occurred on all days of survey and identified a hospital transfer on 08/07/23. The resident's medical record lacked evidence the facility provided a written notice/copy of the transfer form to the resident/representative or informed the State Ombudsman of the hospital transfer. - Review of Resident #68's medical record occurred on all days of survey and identified hospital transfers on 04/11/23 and 08/03/23. The resident's medical record lacked evidence the facility provided a written notice/copy of the transfer forms to the resident/representative or informed the State Ombudsman of the hospital transfers. During an interview on the afternoon of 10/18/23, an administrative staff member (#1) stated she was unable to produce a copy of Resident #47's transfer form for the hospital transfer on	F 623	staff on 11/9/23. Beginning the week of 11/13/23 the QI coordinator and/or her designee will complete QI monitoring of all notice of transfers weekly X 4, then monthly X 2 to ensure that compliance is maintained. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and then summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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F 623	Continued From page 6 08/07/23. During an interview on 10/19/23 at 1:52 p.m., an administrative staff member (#12) agreed Resident #30 and #68's medical records lacked transfer forms for their hospital transfers.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		11/23/23

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F 625	Continued From page 7 by: Based on record review and staff interview, the facility failed to provide a bed-hold notice to 1 of 5 sampled residents (Resident #30) with a transfer to the hospital. Failure to provide the facility's bed-hold notice does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: Review of Resident #30's medical record occurred on all days of survey and identified a transfer to the hospital on 06/17/23. The record lacked evidence the facility provided a bed hold notice to the resident and/or their representative. During an interview on 10/19/23 at 1:52 p.m., an administrative staff member (#12) confirmed Resident #30's medical record lacked a bed hold form for the hospital transfer on 06/17/23.	F 625	F625- Bedholds It is the intent of this facility to remain in compliance with F65 and obtain Bedholds with each qualifying occurrence. Residents noted to be affected by this deficient practice had no untoward affects and correction is not applicable. All residents who transfer out of the facility and remain out over the midnight hour have the potential to be affected. The policy entitled Bedhold □ Rehab/Skilled was reviewed and remains in place unchanged. The policy entitled Bedhold-Rehab/Skilled was reviewed with responsible parties on 11/9/23. Beginning the week of 11/13/23 the QI coordinator and/or her designee will complete QI monitoring of All qualifying occurrences that require Bedhold agreement weekly X 4, then monthly X 2 to ensure that compliance is maintained. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and then summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		11/23/23

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F 657	Continued From page 8 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 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 review and revise comprehensive care plans to reflect the current status for 2 of 25 sampled residents (Resident #39 and #81). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care and safety. Findings include: Review of the facility policy titled "Care Plan" occurred on 10/19/23. This policy, dated 09/22/22, stated, "The care plan will emphasize	F 657	F657 □ Care plan timing and revision It is the intent of this facility to remain in compliance with F 657 and provide timely revisions to care plans. Residents□ #39 and #81 were affected by this deficient practice. Care Plans for Residents #39 & #81 were reviewed and clarified for accuracy. All residents have the potential to be affected by this deficient practice. The policy entitled Care Plan was reviewed and remains in place unchanged.	

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F 657	Continued From page 9 the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will address the relationship of items or services required and facility responsibility for providing these services. . . . The interdisciplinary team will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition." - During an interview on 10/16/23 at 3:29 p.m., Resident #39 expressed concern of having to use a bed pan for toileting and lack of physical therapy, and stated, "I have these spells. They say I fall over." Review of Resident #39's medical record occurred on all days of survey. Diagnoses included orthostatic hypotension (excessive drop in blood pressure when an upright position is assumed) and syncope and collapse (fainting/passing out). The record showed Resident #39 as non-ambulatory, discharged from physical therapy on 09/07/23 due to drop in blood pressures with position changes, and use of a bed pan for safety related to syncopal episodes while on the toilet. Resident #39's care plan failed to address a problem, goal, or interventions related to orthostatic hypotension and/or syncope and their effects on the resident's activities of daily living (ADLs) and physical therapy. - Review of Resident #81's medical record occurred on all days of survey. Diagnoses included dysphagia (swallowing disorder).	F 657	All care plans were thoroughly reviewed to ensure accuracy. The Policy entitled Care Plan was reviewed with Responsible staff on 11/9/23. Beginning the week of 11/13/23 the QI coordinator and/or her designee will complete QI monitoring of random care plans for accuracy weekly X 4, then monthly X 2 to ensure that accuracy is maintained. Residents□ #39 and #81 will be included in this audit. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and then summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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F 657	Continued From page 10 A Speech Therapy note, dated 08/18/22, stated, ". . . Patient now is noted to have improved cooperation, and family is requesting ST [speech therapy] reassessment following bringing dentures to facility. . . . Upper and lower dentures present . . ." The Speech Therapy discharge summary, dated 10/13/22, stated, ". . . Patient additionally consistently spitting out dentures upon placement. . . ." The current care plan stated, "ORAL CARE: Assist of 2 for ADL. Has some of his own teeth." Observation on 10/17/23 at 9:29 a.m. showed the resident without dentures. During an interview on 10/18/23 at 1:48 p.m., an administrative staff member (#1) stated Resident #81 has a history of taking out the dentures and throwing them. The care plan failed to address Resident #81's dentures.	F 657		
F 658 SS=E	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, review of professional reference, and staff interview, the facility failed to follow professional standards of practice regarding medication administration for 19 of 20 unidentified residents on the 100 unit. Failure to follow professional standards for safe medication	F 658	F658 □ Professional Standards It is the intent of this facility to remain in compliance with F658 and provide the highest quality of professional standards. All Residents have the potential to be affected by this deficient practice.	11/23/23

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F 658	Continued From page 11 preparation and administration placed the residents at risk of receiving the wrong medication. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 838-840, stated, ". . . Administering Oral Medications . . . Organize the supplies. Gather the MAR(s) [medication administration records] for each client together so that medications can be prepared for one client at a time. Rationale . . . reduces the chance of errors. . . . Safety . . . Label all medications, medication containers, and other solutions . . . Note: Medication containers include syringes, medicine cups, and basins, Rationale: Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions being removed from their original containers and placed into unlabeled containers. . . ." Observation on 10/16/23 at 4:01 p.m. showed the 100 unit's medication cart with clear plastic medication cups located on top of the cart labeled with numbers 1 through 19. Medications were dispensed in most of the cups. When asked about the medications in the cups, a nurse (#13) stated she was getting her "OTC [over-the counter] meds [medications] ready." The nurse (#13) further stated, "I always do [pre-dish medications] or I wouldn't get my supper [medications] passed." During an interview on 10/19/23 at 9:04 a.m., an	F 658	The standard of practice for medication administration was reviewed. Education on the standard of practice for medication administration was reviewed with all staff with capabilities to administer medications on 11/9/23. Beginning the week of 11/13/23, the QI coordinator and/or her designee will complete QI monitoring of random medication passes weekly X 4, then monthly X 2 to ensure that compliance with this professional standard is maintained. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and then summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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F 658	Continued From page 12 administrative nurse (#14) stated she expected staff not to pre-dish medications.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and family and staff interview, the facility failed to provide assistance with activities of daily living (ADL) for 1 of 17 sampled residents (Resident #81) requiring substantial assistance with dressing or transfers. Failure to dress and assist the resident out of bed may result in decreased self-esteem and quality of life. Findings include: Review of the facility policy titled "Activities of Daily Living" occurred on 10/19/23. This policy, dated 11/29/22, stated, ". . . Policy. Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene. . . . ADLs are those necessary tasks conducted in the normal course of a resident's daily life. Included in these are the following: . . . 3. Dressing: Selecting, obtaining and putting on, fastening and taking off items of clothing . . . 4. Mobility: Transferring to or from a bed, chair or wheelchair, ambulating inside by . . . using wheelchair if seated." Review of Resident #81's medical record	F 677	F677 □ Activities of Daily Living It is the intent of this facility to remain in compliance by providing assistance with activities of daily living for each resident needing assistance. Resident #81 care plan was reviewed and updated for accuracy related to current condition. All residents needing assistance with dressing have the potential to be affected by this deficient practice. Their care plans were reviewed for accuracy. The policy entitled Activities of Daily Living □ Rehab/Skilled □ LTC was reviewed and remains in place unchanged. The Policy entitled Activities of Daily Living □ Rehab/Skilled □ LTC was reviewed with All Staff on 11/9/23. Beginning the week of 11/13/23 the QI coordinator and/or her designee will complete QI monitoring of random resident requiring dressing assistance weekly X 4, then monthly X 2 to ensure that compliance is maintained. Results of the QI monitoring will be reviewed as part of the monthly facility QI	11/23/23

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F 677	Continued From page 13 occurred on all days of survey. Diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (condition that causes weakness or paralysis on one side of the body) following cerebral infarction (stroke). A physician's order, dated 04/28/23, stated, "If resident is alert and awake at anytime during the day make sure and get him up for a few hours. one time a day for getting out of bed." The current care plan stated, "ADL's: The resident has an ADL self care performance deficit . . . DRESSING/GROOMING: Assist of 2 for ADL . . . TRANSFER: Assist of 2 and Hoyer [mechanical lift]. . . . Everyday after lunch offer resident to get dressed and out of bed to sit in hearth area or outside if nice. . . ." A progress note, dated 05/26/23, stated, ". . . She [family member] was wondering how much her Dad got up . . . She also brought him up some new clothes." During an interview on 10/17/23 at 11:28 a.m., a family member (#1) stated that she brought clothes to the facility but Resident #81 was in a night gown when she would come to visit. Family member (#1) stated Resident #81 likes to be outside, feel the weather, socialize and be around other people. She expressed concerns that Resident #81 stayed in bed all day and if the resident is left in his room too long, he gets depressed, causing an increase in antidepressants to compensate. Observation on 10/16/23 at 3:30 p.m. and 10/18/23 at 2:13 p.m. showed Resident #81 in bed in a hospital gown.	F 677	meetings and then summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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F 677	Continued From page 14 During an interview on 10/18/23 at 3:14 p.m., a nurse (#6) confirmed staff do not document the resident's refusal to get dressed. Facility staff failed to provide care to Resident #81 as ordered by the physician and/or as stated in the care plan.	F 677		
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	F 880		11/23/23

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F 880	Continued From page 15 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced	F 880		

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F 880	Continued From page 16 by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices on 2 of 2 units with Covid positive residents (Unit 500 and 600). Failure to follow infection control practices related to Personal Protective Equipment (PPE) has the potential to transmit infections to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Personal Protective Equipment (PPE)" occurred on 10/19/23. This policy, dated October 2022, stated, ". . . masks, eye protection or face shields to be worn whenever splashes, spray, spatter or droplets of blood or potentially infectious materials may occur and contaminate the employee's eyes, nose, or mouth . . . mask or face shield . . . fit flexible band to nose bridge . . . fit snug to face and below chin . . . place over face and adjust to fit . . ." Observations on 10/16/23 showed the following: * 12:13 p.m., a dietary aide (#8) entered Resident #97's room without wearing goggles or a face shield. A "Contact Precautions," stating to wear an N95 mask (a particle-filtering face mask), hung on Resident #97's door. * 12:18 p.m., a certified nurse aide (CNA) (#11) entered Resident #71's room without wearing goggles or a face shield. A "Droplet Precautions" sign hung on Resident #71's door. * 12:50 p.m., a dietary aide (#8) entered Resident #97's room without wearing goggles or a face shield.	F 880	F880 □ Infection Control It is the intent of this facility to remain in compliance with F880 and maintain approved infection control practices. Residents noted to be affected by this deficient practice had no untoward affects and correction is not applicable. All residents requiring transmission based precautions have the potential to be affected by this deficient practice. The policy entitled Personal protective equipment □ PPE was reviewed and remains in place unchanged. The policy entitled Personal protective equipment □ PPE was reviewed with all staff on 11/9/23. Beginning the week of 11/13/23 the QI coordinator and/or her designee will complete QI monitoring of random proper personal protective equipment as the current situation requires weekly X 4, then monthly X 2 to ensure that masks are worn properly. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and then summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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F 880	Continued From page 17 Observations on 10/17/23 of 500 and 600 units showed the following: * 8:13 a.m., a dietary aide (#9) on the 600 unit prepared food plates in the kitchenette while interacting with residents and staff wearing a surgical mask below his/her chin. * 8:17 a.m., a nurse (#6) on the 600 unit interacted with residents and staff wearing a surgical mask below his/her chin. * 09:36 a.m., a nurse (#6) on the 600 unit interacted with residents and staff wearing a surgical mask below his/her chin. * 11:20 a.m., a dietary aide (#9) on the 600 unit prepared resident food plates in the kitchenette and interacted with staff and residents wearing a surgical mask below his/her chin. * 11:35 a.m., a staff member entered the 500 unit and failed to appy a mask. * 3:20 p.m., a nurse (#6) on the 600 unit interacted with residents and staff wearing a surgical mask below his/her nose. Observations on 10/18/23 of the 600 unit showed the following: * 11:02 a.m., a nurse (#6) interacted with residents and staff wearing a surgical mask hanging from the ear. * 11:23 a.m., a dietary aide (#9) prepared food plates in the kitchenette while interacting with residents and staff wearing a surgical mask below his/her chin. During an interview on the morning on 10/19/23, an administrative nurse (#1) stated she expects staff to wear PPE appropriately when working with COVID positive residents and areas where they reside.	F 880		