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	355052	A. BUILDING _____ B. WING _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	**108 E NYHUS AVE MCVILLE, ND 58254**

(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 and complaint started 10/18/21 and concluded 10/20/21.	F 000		
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;	F 623		11/24/21

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

Electronically Signed | 11/18/2021

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F 623	Continued From page 1 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, 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	F 623		

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F 623	Continued From page 2 agency responsible for the protection and advocacy of individuals with a mental disorder 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 and staff interview, the facility failed to provide the resident and/or resident's representative with the appropriate Notice of Transfer or Discharge for 1 of 1 closed records (Resident #131) discharged to another facility. Failure to provide a Notice of Transfer or Discharge with appeal information does not allow the resident and/or representative to make an informed appeal decision. Findings include: Review of Resident #131's medical record occurred October 19, 2021. The record identified	F 623	1. Corrective action has been taken to correct this deficient practice. An updated policy has been completed and reviewed. Licensed nursing staff and Social Service staff has received education on when, how and why complete a transfer discharge form. The appeals process was be explained and the importance of informing the resident/resident representatives of their rights. 2. With this deficient practice, all residents have the potential to be affected. Every resident has the potential to be discharged or transferred out of the	

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F 623	Continued From page 3 the facility discharged the resident to another facility on August 23, 2021. Review of the discharge form provided to the family identified it lacked information regarding the right to appeal. During an interview on 10/20/21 at 10:26 a.m., the facility social worker (#1) confirmed the Notice of Transfer or Discharge given to the family lacked appeal information.	F 623	facility. 3. Updated policy is in place and reviewed with Licensed Nursing Staff and Social Service Staff. Review of where the forms for Transfer and Discharge are kept at the nurses' station. Review of how to fill out the forms and who needs to be notified and the timeline of the appeal process have been included in the staff meetings. QA process will follow with each transfer or discharge from the facility by monitoring if the correct form and information was given to either the resident or resident representative. Travel staff nurse duties information sheet has been updated to include where the process and procedure of Transfer and Discharge forms. 4. QA process has begun by Social Service department with each transfer/discharge from the facility to monitor that forms were given to the resident/representative. QA will identify type of transfer/discharge, correct information marked on the forms. Appeals process recognized and explained and timely faxing of form to the North Dakota States Ombudsman program. This QA process will be ongoing until 100% compliance is achieved. Once achieved, QA will be placed on a yearly rotation for Quality Assurance Process. All new hires in Licensed Nursing staff and Social Service departments will be informed of the Transfer and Discharge process. 5. This deficient practice will be corrected by 11-24-2021. Staff education will be completed by 11-24-2021.	

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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 accurate coding of the Minimum Data Set (MDS) for 1 of 13 sampled residents (Resident #22). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2019, page N-6 stated, ". . . N0410A, Antipsychotic: Record the number of days an antipsychotic medication was received by the resident at any time during the 7-day look-back period . . ." and pages O-5 and O-39 stated, ". . . Coding instructions for O0100K, Code residents identified being in a hospice program . . . Check all of the following treatments, procedures, and programs that were performed during the last 14 days. . . . 2. While a resident . . . K. Hospice care . . ." Review of Resident #22's medical record occurred on all days of survey. Review of the September 2021 medication administration record identified the resident received Seroquel,	F 641	1. Resident #22 was reassessed on 10/20/21 to include the use of antipsychotic medications in Section N of the MDS and well as Section O0100. After record review of resident # 22 MDS it was noted that Section N and Section O of the MDS was miscoded. MDS coordinator reviewed resident chart at this time. A correction MDS was completed to update resident current MDS medication classification list. MDS was sent to CMS and State on 10/21/2021. Correction MDS was accepted into the QIES system without error. 2. The facility has determined that all residents have the potential to be affected as all residents residing in this LTC facility have MDS assessments completed. 3. The MDS coordinator reviewed those residents whom receive antipsychotic medications and whom have Special Programs on their MDS assessments within the past year for proper coding in sections N and O of the MDS. No further discrepancies where noted on their MDS assessments within the past year. The MDS coordinator updated and reviewed the policy Conducting an Accurate Resident Assessment. This policy was also reviewed by the IDT including but not	11/24/21

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F 641	Continued From page 5 an antipsychotic medication, 12.5 mg (milligrams) twice a day since 02/20/21. The record also identified Resident #22 elected Hospice on 05/04/21. Review of the quarterly MDS, dated 09/13/21, failed to identify the use of antipsychotic medication or that the resident received hospice care. During an interview on 10/20/21 at 11:54 a.m., a management staff member (#8) acknowledged he/she failed to code antipsychotic medication use and Hospice services.	F 641	limited to Social Services Manager, DON, Dietary Manager, QA Manager and Administrator. As, a group we reviewed and discussed the importance of identifying the use of antipsychotic medications and the effect it may have on the residents. Furthermore, noting why coding this on the MDS represents a holistic plan of care for the residents in which we serve. 4. The MDS coordinator and QA Manager will conduct a random MDS audit of two (2) residents per week X 4 weeks and one (1) resident biweekly X 1 month to ensure accurate coding of the MDS. Furthermore, those receiving antipsychotic medications will be audited upon their next upcoming MDS. These residents and their medical records will be assessed to ensure that proper coding in relation to their antipsychotic medication use and their enrolled special programs is identified. These random audits began on November 1st, 2021. Findings of these audits will be discussed with the Resident Council. 5. 11/24/2021. This plan of correction will be monitored at the Quality Assurance meetings monthly x 3 months. All future MDS assessments for those residents whom already reside in facility will have been observed by Feb 1st 2022 or until such time consistent substantial compliance has been met.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		11/10/21

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F 758	Continued From page 6 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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F 758	Continued From page 7 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility policy, and staff interview, the facility failed to monitor and assess the continued need for psychotropic medications for 2 of 2 sampled residents (Resident #1 and #22) reviewed for psychotropic medication use. Failure to monitor residents for tardive dyskinesia (abnormal involuntary movements) may result in the resident receiving unnecessary medications and experiencing adverse reactions related to their use. Findings include: Review of the facility policy titled "Tardive Dyskinesia Monitoring" occurred on 10/20/21. This policy, dated June 2015, stated, " . . . One of the side effects that can develop as a result of receiving certain medications is abnormal voluntary movements or tardive dyskinesia (TD). The Abnormal Involuntary Movement Scale (AIMS) is used to detect this side effect. . . . Residents who are receiving medication that puts them at risk of developing TD will have periodic and ongoing screening. . . . Medications that may cause TD are: Antipsychotics . . . . once an order for either a scheduled or PRN [as needed] medication is received for the medications . . . an AIMS will be completed prior to the initiation of	F 758	1. Corrective actions for Resident #1 not having AIMS assessments done timely, per policy, include having an AIMS assessment done on 11/10/21, and being put on an assessment schedule according to her assessment dates, and any dose adjustments. Corrective actions for Resident #22 not having AIMS assessments done timely, per policy, include having an AIMS assessment done on 11/10/21, and being put on an assessment schedule according to her assessment dates, and any dose adjustments. Also, a designated nurse (Resident Care Coordinator) has been assigned the role of carrying out these assessments. 2. Any resident who receives a psychotropic medication is at risk for associated abnormal involuntary movements and has the potential to be affected by this deficient practice. 3. Nursing staff have been given the Tardive Dyskinesia Monitoring policy for review, and have been informed that the Resident Care Coordinator will be responsible for carrying out these assessments, per policy. 4. The Director of Nursing (DON) will be	

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F 758	Continued From page 8 the drug. All residents receiving drugs which put them at risk will have an assessment conducted every 6 months . . . if a dosage of the medication is changed, the resident will be assessed in 2 weeks and again in 2 months. The assessment will be completed every 6 months after that time. . . ." - Review of Resident #1's medical record occurred on all days of survey. The current physician's orders identified Seroquel (an antipsychotic) 12.5 mg (milligrams) at bedtime, initiated on 09/24/20, and increased to 25 mg at bedtime on 12/14/20. The record further identified staff last completed an AIMS assessment on 09/24/20 (over a year ago). - Review of Resident #22's medical record occurred on all days of survey. Current physician's orders identified Seroquel 12.5 mg at bedtime, initiated on 02/11/21, increased to 12.5 mg twice a day on 02/20/21, and then increased to 25 mg twice a day on 09/29/21. The record further identified staff did not complete an AIMS assessment since the Seroquel started on 02/11/21. During an interview on the afternoon of 10/20/21, an administrative nurse (#4) acknowledged staff did not complete Resident #1 and #22's AIMS assessments timely and per the facility policy.	F 758	responsible to monitor AIMS assessment completion. The Resident Care Coordinator has compiled a list of residents who are on psychotropic medications, and has a copy of the Tardive Dyskinesia Monitoring policy and the MDS assessment schedule. The DON will monitor monthly for six months, then quarterly for another six months, to ensure fulfillment of AIMS assessment requirements. Any assessments that might have been missed will be done immediately. The DON will report audit results at Quality Assurance monthly and quarterly meetings for a period of 12 months. 5. Corrective action was initially done on 10/25/21, when this was discussed with licensed nurses at a nursing department meeting. On 11/10, Resident #1 and #22 had an AIMS assessment. QA monitoring will be done as noted in #4 above.	
F 761 SS=D	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	F 761		11/24/21

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F 761	Continued From page 9 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. §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, policy review, professional reference, and staff interview, the facility failed to properly store and secure medications for 1 of 1 medication cart and 1 of 2 days of observation during medication pass (10/20/21). Failure to store all medications securely may result in unauthorized access to medications. Failure to discard expired medications increases the risk of residents receiving medications with reduced efficacy. Finding include: Review of the facility policy titled "Medication Administration" occurred on 10/20/2021. This	F 761	1. Corrective action for insulin storage deficiencies included disposal and replacement of the insulin vial and two pens that were at 30 days past opened date. Corrective action for medication cart keys: Nurse was initially instructed to keep keys in her pocket, or, if using entry code, in med cart drawer, and reminded subsequently. 2. All residents who receive insulin have the potential to be affected by not disposing of opened insulins after 28 days. Any resident or staff member could be	

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F 761	Continued From page 10 policy, revised January 2020, stated. ". . . Identify expiration date. If expired, notify nurse manager. . . . The medication cart should be locked when left unattended. . . ." Review of the facility policy titled "Insulin administration" occurred on 10/20/21. This undated policy, stated, ". . . Label each vial: Label with date opened, Label when to discard (28 days). . . ." Review of insulin storage information found at www.fda.gov, stated. ". . . Insulin in products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated . . . for up to 28 days and continue to work. . . ." Observation of the medication cart on 10/20/21 at 10:59 a.m., identified the following: * One open vial of insulin dated 09/21/21 (30 days after open date), and currently being used. * Two insulin pens dated 09/20/21 (30 days after open date) and currently being used. During an interview on 10/20/21 at 11:10 a.m., a facility nurse (#5) confirmed insulin vials and pens were only good for 28 days, then staff should discard. During an interview on 10/20/21 at 11:55 a.m., an administrative nurse (#4) confirmed insulin vials are only good for 28 days after opening. Observations of medication administration on 10/20/21 with a facility nurse (#1) identified the following: * 10/20/21 at 11:38 a.m., the nurse left the	F 761	affected by the medication cart being left open and unattended, or left locked but with keys openly accessible. 3. Nurses have been given the Insulin Administration and Medication Administration Policies for review, and have been informed that insulin vials and pens are to be discarded after 28 days; and that keys are to be kept in nurse□s pocket or in locked med cart drawer (if using entry code system) at all times, and cart is to be kept locked when unattended. 4. The Director of Nursing (DON), or designee, will be responsible to monitor insulin container dates and medication security. These will both be monitored weekly for six weeks, biweekly for six weeks, then monthly for six months. Any concern will be addressed with individual nurse, with increased auditing done if needed. The DON will report audit results at Quality Assurance monthly meetings through September, and at quarterly meetings for the duration of 2022. 5. Corrective action continued on 10/25/21, when these issues were discussed with licensed nurses at a nursing department meeting/in-service. This will be completed by 11/24/21. QA monitoring will be done as noted in #4 above.	

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F 761	Continued From page 11 medication cart unlocked in the hallway with the key ring (containing multiple keys) in the lock, and entered the dining room to administer medication. The nurse failed to keep the medication keys secure from residents and staff. * 10/20/21 at 11:46 a.m., the nurse locked the medication cart (located in the open hallway), placed the medication cart keys (containing multiple keys), on top of the cart in open view, then entered the dining room to pass medication, returned to the cart, dished up medication for another resident, returned to the dining, again left the keys on top of the medication cart in plain view. The nurse failed to keep the medication keys secure from residents and staff. * 10/20/21 at 11:52 a.m., the nurse locked the medication cart, placed the keys on top of the medication cart under a towel, left the cart unattended in the hallway near the nurses station, then left the cart unattended to complete other duties. The medication cart was not in view of the nurse at all times. During an interview on 10/20/21 at 11:55 a.m., and administrative nurse (#4), stated nursing staff are to keep their keys in their pockets, not on top of the medication cart when left unattended.	F 761		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population	F 801		12/10/21

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F 801	Continued From page 12 in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not	F 801		

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F 801	Continued From page 13 employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure 1 of 1 dietary manager (#9) obtained the proper qualifications to serve as the director of food and nutrition services. Failure to ensure staff have the qualifications to carry out the functions of food and nutrition services has the potential to result in foodborne illness to residents, staff, and visitors. Findings include:	F 801	Nelson County Health System was notified of the 1135 waiver for this requirement on 12/7/2021.	

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F 801	Continued From page 14 During an interview on 10/20/21 at 12:54 p.m., a dietary manager (#9) stated she started the certified dietary manager's (CDM) course in March 2020 and has not yet completed the course. The facility failed to ensure the dietary manager (#9) completed the required education for a CDM, certified food service manager, or a national certification for food service management and safety from a national certifying body.	F 801		
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;	F 880		11/24/21

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F 880	Continued From page 15 §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 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.	F 880		

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F 880	Continued From page 16 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control standards for 4 of 9 sampled residents (Resident #9, #16, #20, and #22) observed during cares. Failure to follow infection control practices for hand hygiene and glove use related to treatments and perineal care has the potential to spread infection from one body site to another and within the facility. Findings include: Review of the facility policy/procedure titled "DRESSING CHANGE - NON-STERILE" occurred on 10/20/21. This policy, dated February 2018, stated, "Procedure: . . .*Don gloves *Remove old dressing, discard in plastic bag *Remove gloves wash hands, don clean gloves *Cleanse area with prescribed cleaning solution *Apply any prescribed medication(s) *Apply new dressing as ordered, secure with tape as needed *Remove gloves, wash hands . . ." Review of the facility policy/procedure titled "HAND WASHING SPECIFICS" occurred on 10/20/21. This policy, dated January 2015, stated, ". . . WHEN SHOULD YOUR HANDS BE WASHED? . . . 2. Before entering and leaving the patient/resident unit. 3. Before, between and after all physical contacts with the patient/resident. . . . 7. After handling used dressings . . ."	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 staff hand hygiene or handwashing when moving between tasks and residents, after removing gloves, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will educate all staff on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify this/these staff understands hand hygiene and handwashing, this/these staff will perform a successful return demonstration of identifying the need and correct	

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F 880	Continued From page 17 - Observation on 10/18/21 at 2:54 p.m. showed a nurse (#1) provided wound treatments for Resident #16. The nurse (#1) donned gloves to remove an existing dressing, opened a new tube of medication, applied the medication to sores on the side of his foot, fifth and fourth toes (with the tube touching the resident's skin), and applied a clean dressing over the area. The nurse (#1) then moved to a wound on the heel of the same foot, opened the new dressing, applied medication from the same tube to the new dressing, removed the existing dressing, and applied the prepared dressing. The nurse (#1) failed to remove his/her gloves and perform hand hygiene between removing the old dressing/applying the new dressing. The nurse (#1) moved to another treatment for Resident #16. The nurse changed gloves without performing hand hygiene, emptied the resident's urine drainage bag, and disposed the contents into the toilet. The nurse changed gloves, and without performing hand hygiene, irrigated the resident's catheter using sterile supplies. - Observation on 10/18/21 at 3:54 p.m. showed two certified nursing assistants (CNAs) (#3 and #10) performed perineal cares while Resident #22 lay in bed. Without removing her gloves and performing hand hygiene, the CNA (#3) adjusted the resident's clothing, hooked the sling to a full body lift, transferred the resident to the wheelchair, placed a blanket and eye glasses on the resident, and provided the resident water. - Observation on 10/19/21 at 9:53 a.m. identified two CNAs (#3 and #7) provided perineal cares	F 880	procedure for performing hand hygiene and handwashing. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current 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 11/24/2021 the facility shall complete the following actions: 1. The DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to failure to complete handwashing or hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf 2. The DON, SDC, IP or suitable designee will ensure the following: a. 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.	

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F 880	Continued From page 18 and transferred Resident #20. The CNA (#3) failed to complete hand hygiene after removing her gloves and before leaving the resident's room. - Observation on 10/19/21 at 12:50 p.m., showed two CNAs (#2 and #3) provided perineal care for Resident (#9). The CNAs failed to perform hand hygiene as they left Resident #9's room.	F 880	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 observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of 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	

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F 880	Continued From page 19	F 880	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 11/24/2021	
F9999	FINAL OBSERVATIONS Based on record review and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		