STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	R-C 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

(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 An on-site revisit survey, started on 07/12/21 and concluded 07/13/21, was conducted to determine compliance with deficiencies identified during the 05/24/21 survey.	{F 000}		
{F 558} SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON JULY 12-13, 2021, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 05/24/21 CMS-2567. Based on observation and record review, the facility failed to provide reasonable accommodation of needs for 1 of 12 sampled residents (Resident #17). Failure to have commonly used items within the resident's reach may place the resident at risk for falls. Findings include: Review of Resident #17's medical record occurred on all days of survey. Diagnoses included Parkinson's Disease. The current care plan, revised on 06/23/21, stated, ". . . At risk for falls due to: History of falls, impaired balance/poor coordination . . . ensure trash can is	{F 558}	F558 - Accommodations of Needs Resident #17 bedside table was placed next to bed with indicated items placed within reach on 7/13/21. Care plan reviewed with resident representative and updated with current preferences by 7/29/21. Tape for visual cuing was placed on the floor mat outlining where resident prefers bedside table to be placed with frequently used items within reach. Facility in house residents with reduced mobility have the potential to be affected by the alleged practice. Facility residents with reduced mobility will have care plans reviewed and updated for call lights and other items indicated by the resident to be left within reach, starting on 7/21/21. Facility staff re-educated by Director of Nursing or designee on leaving items within reach upon completion of cares,	7/30/21

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

Electronically Signed | 07/27/2021

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{F 558}	Continued From page 1 next to resident's bed within reach . . . have commonly used articles within easy reach. Remote control, glasses, box of Kleenex, clip boards and something to write with . . . non-slip surface on tray table to prevent dropping commonly used items . . ." Observations of Resident #17 showed the following: * 07/12/21 at 11:55 a.m., the resident lying in bed with the trash can set at the foot of the bed, a tray table with a glass of water not within reach, a Kleenex box upside down on the bedside floor mat. * 07/12/21 at 5:26 p.m., the resident lying in bed with the trash can set between the foot of the bed and the recliner. * 07/13/21 at 8:07 a.m., the resident lying in bed with a glass of water and a Kleenex box on the tray table not within reach. * 07/13/21 at 12:10 p.m., the resident seated in a Broda chair (specialized wheelchair) in his room with the trash can out of reach by the foot of his bed and a Kleenex box and a spilled cup of water on the floor. * Observations on all days of survey showed the remote control, a clip board or something to write with, and glasses not available to Resident #17 and the tray table lacked a non-slip surface on its top. The facility failed to provide reasonable accommodation of needs as care planned placing Resident #17 at risk for injury related to falls.	{F 558}	notifying nurse if plan of care needs to change based on identified concerns, and documentation of non-compliance, starting 7/19/21. Facility staff will be audited by the Director of Nursing or designee in real time during care to ensure competency to ensure items within reach prior to exiting resident rooms. Audits will be conducted 5 times per week for 12 weeks, then weekly for three months or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	
{F 641} SS=D	Accuracy of Assessments CFR(s): 483.20(g)	{F 641}		7/30/21

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{F 641}	Continued From page 2 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON JULY 12-13, 2021, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 05/24/21 CMS-2567. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 12 sampled residents (Resident #17 and #18). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI Manual, revised October 2019, page M-35 states, ". . . M1200C Turning/Repositioning Program. The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the	{F 641}	F641 - Accurate MDS Resident #17 and Resident #18 Section M of MDS modified in Section M1200C and correction submitted on 7/15/21 by Resident Care Management Director. Facility residents have the potential to be affected by the alleged practice. Facility residents Section M of most recent MDS submission has been reviewed, by Resident Care Management Director as this is whom completes and submits MDS and if need corrections completed and resubmitted on 7/15/21. Education provided to Resident Care Management Director by Director of Clinical Reimbursement by 7/29/21 by Director of Clinical Reimbursement on the documentation required to code Section M. Audits of Section M will be conducted by the Director of Clinical Reimbursement prior to MDS submissions for Section M coding and documentation. Audits will continue for 12 weeks prior to each submission or until substantial compliance is maintained, then weekly for 3 months or until substantial compliance is maintained. Audit results will be brought to QAPI for review and recommendations.	

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{F 641}	Continued From page 3 turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention. . . ." The facility failed to provide a policy. - Review of Resident #17's medical record occurred on all days of survey. Diagnoses included Parkinson's Disease. A significant change MDS, dated 06/17/21, identified Section M1200C coded for a turning/repositioning program. - Review of Resident #18's medical record occurred on all days of survey. The resident's care plan indicated comfort cares. A quarterly MDS, dated 6/13/21, identified Section M1200C coded for a turning/repositioning program. Resident #17 and #18's records lacked specific interventions related to the turning/repositioning program. During an interview on 07/13/21 at 2:38 p.m., administrative staff (#3) agreed Resident #17 and #18's medical records lacked specific documentation to meet the RAI Manual's definition of a turning/repositioning program.	{F 641}		
{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:	{F 658}		7/30/21

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{F 658}	Continued From page 4 Based on observation, review of professional reference, review of the facility notification tool, record review, and staff interview, the facility failed to follow professional standards of practice for 1 of 12 sampled residents (Resident #18). Failure of the nursing staff to report a change in Resident #18's skin condition to the nurse placed the resident at risk for adverse health effects. Findings include: Hedmar, Fuzy, and Rymer's "Nursing Assistant Care Long-Term Care," 4th edition, Hartman Publishing, page 14, Fig 2-9, stated, "The chain of command describes the line of authority in a facility and helps ensure that each resident receives proper care. . . . Nursing Assistants (NAs, CNAs [certified nursing assistants]) . . . observe and report any changes in residents' conditions and abilities [to the] Staff Nurses . . ." Review of the form titled "Stop and Watch Early Warning Tool" occurred on 07/13/21. This form, dated June 2018, stated, "If you have identified a change while caring for or observing a resident/patient please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can. . . . C-Change in skin color or condition . . ." Observation on 07/12/21 at 5:55 p.m. during cares, showed Resident #18 with swollen genitalia. The CNA (#6) recognized the skin change and stated, "We [CNA #6 and #7] need to tell [first name of nurse on duty] that it's [the resident's genitalia] quite swollen again." Review of Resident #18's medical record	{F 658}	F658 □ Professional Standards Resident #18 had change of condition assessed by RN and physician notified. Per RN assessment, resident remains at baseline. MD notified of resident #18 current condition on 7/21/21. Facility residents have the potential to be affected by the alleged practice. Facility residents assessed by facility nurse for changes of condition on 7/21/21. Notifications completed to MD and Responsible party if changes noted. Facility nursing staff re-educated by Director of Nursing or designee starting 7/19/21 on notifications and documentation when identifying potential changes in condition, including CNAs to use eInteract Stop and Watch tool for documentation of observed changes and report change to floor nurse. Licensed Nurse receives verbal notice of change of condition from the CNA and eInteract Stop and Watch prompt of documented changes noted by Certified Nursing assistants. Licensed Nurse will complete change of condition observation of the resident and update resident representative, physician, and nursing management of changes in condition. Nursing management to review documentation for changes of condition and review with IDT in morning meetings. Audits on changes of conditions observed and documented by facility nursing staff will be completed 5 times per week and	

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{F 658}	Continued From page 5 occurred on all days of survey. The record lacked documentation regarding a change in skin condition. During an interview on 07/13/21 at 9:03 a.m., the staff nurse (#9) on duty both days, stated the CNAs (#6 and #7) failed to notify her in regards to Resident #18's change in skin condition. During an interview on the afternoon of 07/13/21, a management staff member (#3) stated the facility educated CNAs to verbally report or fill out a Stop and Watch form and give it to the nurse when any change in a resident's condition is observed. The CNAs (#6 and #7) failed to report the observed change in skin condition to the nurse and placed Resident #18 at risk for adverse health effects.	{F 658}	will include interview of floor staff to verify change of condition reported. Audits will be completed for 12 weeks by the Director of Nursing or designee, then twice weekly for 3 months or until substantial compliance is maintained. Audits will be brought to QAPI for review and recommendations.	
{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: DURING THE ON-SITE REVISIT COMPLETED ON JULY 12-13, 2021, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 05/24/21 CMS-2567 Based on observation, record review, and resident and staff interview, the facility failed to provide Activities of Daily Living (ADL) assistance	{F 677}	F 677 - ADLs Resident #10, #18 and #97 toenails and fingernails were cared for on 07/13/2021 and nail care schedules were updated in POC or on MD orders for these residents by Director of Nursing or designee. Facility residents have the potential to be	7/30/21

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{F 677}	Continued From page 6 to 3 of 12 sampled residents (Resident #10, #18, and #97) who required staff assistance for nail care. Failure to provide routine and as-needed finger and toenail care may result in unkempt nails and increased potential for residents to suffer scratches or skin tears from long or jagged nails. Findings include: - Review of Resident #10's medical record occurred on July 12-13, 2021. The Treatment Administration Record (TAR) stated, "Nail care, both hands and Feet one time a day every 30 day(s) for safety -Start Date 03/25/2021 1900 [7:00 p.m.] HS [hour of sleep]." The TAR showed staff completed Resident #10's nail care on 06/23/21, 18 days ago. Observation on 07/12/21 at 12:05 p.m. showed Resident #10's fingernails, excluding the thumbs, grown past the edge of his fingertips. The left second fingernail contained a rough jagged edge. The resident stated staff cut his nails about once a month. - Review of Resident #18's medical record occurred on July 12-13, 2021. A physician's order, dated 03/25/21, stated, "Nail care, both hands and feet one time a day every 30 day(s) for safety . . ." The TAR showed staff completed Resident #18's nail care on 06/23/21, 18 days ago. Observations on 07/12/21 at 11:40 a.m. and at 5:55 p.m. and on 07/13/21 at 12:18 p.m., showed Resident #18's toenails approximately 1/4 inch past the tip of the toes to both feet.	{F 677}	affected by this practice. Audit completed on 7/13/2021 included facility residents and finger and toe nail care was provided, if indicated or IDT to assist in setting up podiatrist as needed. Review of resident task lists and orders completed and updated to include nail care on a specific day of the week. Updates were completed on 07/14/2021 by Director of Nursing or Designee. Documentation of diabetic nail care to be completed in TAR and documentation of routine nail care to be completed by CNAs in POC tasks. Director of Nursing or designee began providing re-education to nursing staff on 7/19/21 on completing and documenting nail care as it is completed in POC tasks or TARs as indicated. Director of Nursing or designee will audit compliance with toe and fingernail care for four residents weekly for four weeks, then three residents weekly for four weeks, then two residents weekly for four weeks, then one resident weekly for four weeks. Audits will be submitted to the QAPI committee for review and recommendations.	

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{F 677}	Continued From page 7 - Review of Resident #97's medical record occurred on 07/12/21. Diagnosis included dementia. Observation on 07/12/21 at 11:47 a.m. showed Resident #97's fingernails were long with partially worn off nail polish. During an interview on 07/13/21 at 12:18 p.m., an administrative staff member (#3) agreed the residents' current physicians' orders to provide monthly nail care does not correspond with the facility's current plan to provide weekly nail care during the residents' baths or as needed. The facility failed to ensure staff provided the residents with timely nail care.	{F 677}		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED	{F 686}	F686 - Pressure Ulcers	7/30/21

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{F 686}	Continued From page 8 ON JULY 12-13, 2021, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 05/24/21 CMS-2567. Based on observation, record review and review of the facility policy, the facility failed to provide the necessary treatment and services to prevent the development of pressure ulcers for 1 of 3 sampled residents (Resident #17) who wear padded boots. Failure to consistently implement the padded boots may result in skin breakdown and/or the development of pressure ulcers. Findings include: Review of the facility policy titled "Heel Protectors" occurred on 07/13/21. This policy, dated 2016, stated, "BASIC RESPONSIBILITY Licensed Nurse, Certified Nursing PURPOSE To provide comfort and protection of skin. To prevent skin irritation and pressure. To prevent break in skin integrity. . . ." - Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, ". . . At risk for alteration in skin integrity related to: impaired mobility . . . Prevalon boots [padded boots] bilateral [both] feet at all times. Check for placement as resident kicks boots [sic] with care and rounds. . . ." Observations of Resident #17 showed the following: * 07/12/21 at 11:55 a.m., the resident lying in bed without the Prevalon boots on. Both boots sat on the recliner seat in his room. * 07/12/21 at 5:26 p.m., two CNA's (#6 and #7)	{F 686}	Resident #17□s prevalon boots were re-evaluated on 7/19/21 as resident was, due to lower extremity movement, removing the prevalon boots. Facility began trial use of alternate protectors on bilateral heels to promote compliance starting on 7/19/21, care plan updated. Resident representative and physician in agreement with plan of care. Facility residents care planned for use of prevalon boots have the potential to affected by the alleged practice. Facility audited resident care plans for use of prevalon boots and reviewed documentation for compliance or refusals. If indicated, residents interviewed on care plan preferences regarding use of prevalon boots, care plans updated by 7/29/21. Facility nursing staff was re-educated by the Director of Nursing or designee on documentation and intervention when observations are made of resident refusals of prevalon boots and skin protection in general, starting on 7/19/21. Audits of prevalon boots placed on residents will be conducted by the Director of Nursing or designee 5 times per week for 12 weeks, then twice weekly for 3 months or until substantial compliance is maintained. Audit results will be reviewed by the QAPI committee for recommendations.	

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{F 686}	Continued From page 9 providing cares to the resident lying in his bed without the boots on. Both boots sat on the recliner seat. After cares were completed, both CNAs left the room without placing the boots on the resident. * 07/13/21 at 8:07 a.m., the resident lying in bed with one boot on his right foot and the other boot lying on the recliner seat in his room. * 07/13/21 at 12:10 p.m., the resident seated in his Broda chair (specialized wheelchair) with one boot on his right foot and the other boot lying on the recliner seat in his room. Failure to ensure Resident #17 had Prevalon boots on both feet at all times increased the risk for development of skin breakdown and/or pressure ulcers.	{F 686}		
{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,	{F 880}		7/30/21

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{F 880}	Continued From page 10 visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	{F 880}		

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MINOT HEALTH AND REHAB, LLC	**600 S MAIN ST MINOT, ND 58701**

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{F 880}	Continued From page 11 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON JULY 12-13, 2021, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 05/24/21 CMS-2567. 1. HAND HYGIENE Based on observation, policy review, and staff interview, the facility failed to ensure staff followed standard infection control practices for 2 of 12 sampled residents (Resident #51 and #347). Failure to follow standard infection control practices related to hand hygiene and wound care may result in the spread of infectious agents to residents, staff, and visitors. Findings include: Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 07/13/21. This policy, dated August 2019, stated, ". . . Wash hands . . . Before and after resident contact . . . After removing gloves . . . Before handling clean or soiled dressings, gauze pads, etc. . . ." Review of the facility policy titled "Dressing	{F 880}	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff entering and exiting a room on droplet precautions donned, doffed disposed of personal protective equipment (PPE), in accordance with CDC guidelines. (2) Ensuring staff hand hygiene or handwashing when donning PPE, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines.	

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{F 880}	Continued From page 12 Change, Clean" occurred on 07/13/21. This policy, dated June 2017, stated, ". . . Put on second pair of disposable gloves . . . Apply prescribed medication . . ." - Observation on 07/12/21 at 2:37 p.m. showed a licensed nurse (#5) performed a dressing change to Resident #347's left heel. The nurse, with ungloved hands, opened a sterile dressing package and poured Dakin's solution (used to treat skin and tissue infections) into a medication cup. The nurse removed a sterile gauze from the package and placed it into the Dakin's solution. Without performing hand hygiene, the nurse donned gloves and placed the Dakin's soaked gauze on Resident #347's wound, covered it with a dry gauze pad, and completed the dressing change. The nurse failed to wear gloves while he/she picked up and placed the gauze pad into the Dakin's solution and failed to perform hand hygiene prior to donning gloves. - Observation on 07/13/21 at 9:05 a.m. showed a certified nursing assistant (CNA) (#2) donned gloves, assisted Resident #51 onto the toilet, removed the soiled brief, wiped bowel movement (BM) from Resident #51's legs and removed the gloves. Without performing hand hygiene, the CNA donned clean gloves, obtained a clean brief and pants from the closet, removed the resident's soiled pants, and without removing his/her gloves applied the clean brief and pants. The CNA (#2) failed to perform hand hygiene between glove changes and failed to remove soiled gloves and perform hand hygiene prior to contact with clean objects. During an interview on 07/13/21 at 2:52 p.m., two	{F 880}	The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff on selecting, donning, doffing and disposing of PPE when entering a room on droplet precaution isolation/quarantine procedures. To verify each of these/this staff understands the procedure, the each will perform a successful return demonstration of selecting, donning, doffing and disposing of PPE for providing cares in a droplet precaution room. (2) Educate all staff on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify these staff understands hand hygiene and handwashing, these staff will perform a successful return demonstration of identifying the need and correct 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 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	

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{F 880}	Continued From page 13 administrative nurses (#3 and #4) agreed they expected staff to follow standard infection control practices with proper hand hygiene and wound care. 2. TRANSMISSION BASED PRECAUTIONS Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow infection control standards for 1 of 12 sampled residents (Resident #29) and 4 supplemental residents (Resident #2, #3, #73, and #84) on isolation precautions related to suspected COVID-19 status. Failure to close doors and properly utilize personal protective equipment (PPE) for residents on isolation/transmission-based precautions has the potential to spread the COVID-19 virus to other residents, personnel, and visitors. Findings include: Review of The Centers for Disease Control and Prevention (CDC) guidance for PPE use, found at: https://www.cdc.gov, stated, "Donning (putting on the gear): . . . 2. Perform hand hygiene using hand sanitizer . . . Doffing (taking off the gear): . . .6. Remove and discard respirator (or facemask if used instead of respirator) . . . 7. Perform hand hygiene after removing the respirator/facemask . . . Eye Protection . . . Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. . . ." Review of The Centers for Disease Control and Prevention (CDC) guidance for managing Residents with Suspected or Confirmed SARS-CoV-2 Infection (COVID-19), found at:	{F 880}	On or before 08/07/2021 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to select, don and utilize the necessary PPE for droplet precautions isolation/quarantine room access, in accordance with CDC guidelines. b. 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. 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. 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	

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{F 880}	Continued From page 14 https://www.cdc.gov, stated, ". . . it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. . . ." - Review of Resident #2's medical record occurred on 07/12/21. The care plan identified Resident #2 as a close contact for COVID-19 and the facility initiated contact/droplet precautions on 06/30/21. Observations of Resident #2 showed the following: * 07/12/21 at 12:01 p.m., the room door open with contact and droplet isolation signage on the door and an isolation cart in front of the room. * 07/12/21 at 3:33 p.m., the room door open and the call light on. A certified nursing assistant (CNA) (#1) entered the room wearing goggles and a surgical mask. The CNA failed to perform hand hygiene prior to entering the room, failed to don a gown and gloves, turned off the call light, and spoke with the resident. The CNA exited the room and failed to perform hand hygiene, change/discard the surgical mask, and disinfect his/her goggles. * 07/13/21 at 7:57 a.m., the room door open. An administrative staff member (#8) exited the room after delivering the resident's breakfast tray. The staff member failed to change/discard the surgical mask, disinfect his/her goggles, and close the door. - Review of Resident #3's medical record occurred on 07/12/21. The care plan identified Resident #3 as a close contact for COVID-19 and the facility initiated contact/droplet precautions on 06/30/21.	{F 880}	https://youtu.be/xmYMUly7qiE. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via 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 correct selection, donning, use and doffing of PPE when entering and exiting droplet precaution isolation/quarantine rooms. (2) 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	

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{F 880}	Continued From page 15 Observations of Resident #3 showed the following: * 07/12/21 at 11:53 a.m., the room door open with contact and droplet isolation signage on the door and an isolation cart in front of the room. * 07/12/21 at 12:23 p.m., the room door open. Resident #3 sitting in his/her wheelchair eating lunch. - Review of Resident #29's medical record occurred on all days of survey. A physician's order, dated 06/30/21, stated, "Droplet precautions due to post contact with covid positive person . . ." Observations of Resident #29 showed the following: * 07/12/21 at 11:49 a.m., an open room door with contact and droplet isolation signage on the door and an isolation cart in front of the room. * 07/12/21 at 3:24 p.m., two CNAs (#6 and #7) exited the resident's room and failed to change/discard surgical masks or disinfect their goggles. * 07/12/21 at 5:25 p.m., the room door open. * 07/12/21 at 6:10 p.m., the room door open. * 07/13/21 at 8:00 a.m., an unidentified staff entered the resident's room without donning gloves. * 07/13/21 at 8:07 a.m., the room door open. * 07/13/21 at 2:20 p.m., a CNA (#1) provided cares to the resident without a gown. - Observations of Resident #73 showed the following: * 07/12/21 at 11:49 a.m., an open room door with contact and droplet isolation signage on the door	{F 880}	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.	

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{F 880}	Continued From page 16 and an isolation cart in front of the room. * 07/12/21 at 12:11 p.m., an unidentified staff member exited the room and failed to change/discard the surgical mask, disinfect his/her goggles, and close the door. - Review of Resident #84's medical record occurred on 07/12/21. The care plan identified Resident #3 as a close contact for COVID-19 and the facility initiated contact/droplet precautions on 06/30/21. Observations of Resident #84 showed the following: * 07/12/21 at 12:10 p.m., the room door with contact and droplet isolation signage on the door and an isolation cart in front of the room. A staff nurse (#5) exited the room and failed to change/discard the surgical mask and disinfect his/her goggles. * 07/12/21 at 2:15 p.m., the room door open. * 07/12/21 at 6:35 p.m., the room door open. During an interview on 07/12/21 at 12:03 p.m., staff members (#9 and #12) stated the residents on precautions throughout the facility are on precautions due to exposure to a positive staff member. During an interview on 07/13/21 at 2:52 p.m., two administrative nurses (#3 and #4) stated they expected staff to don proper PPE when entering or working in an isolation room, change/discard surgical masks and disinfect eye goggles upon exit from an isolation room, and ensure doors to isolation rooms remained closed.	{F 880}		