STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 10/31/22 and concluded on 11/03/22.	F 000		
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: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment/services to prevent skin breakdown and pressure ulcers for 1 of 1 sampled resident (Resident #14) reviewed for pressure ulcers. Failure to turn/reposition residents may result in worsening of existing pressure ulcers and additional skin breakdown/pressure ulcers. Findings include: Review of the facility policy titled "Terminal Care" occurred on 11/03/22. This policy, dated January 2021, stated, "Purpose: To assure residents	F 686	1. Education for nursing staff was provided in regards to proper repositioning of all residents including those receiving terminal cares. We will be unable to monitor resident #14, they passed away. 2. All residents will have Braden Scale assessment completed with the MDS process. Resident triggering moderate to high risk for skin breakdown on the Braden scale will be referred to therapy for evaluation of pressure relief devices. 3. Education at in-service 12/6/22 will be provided to Nurses and CNAs. Review of the pressure ulcer policy as well as	12/6/22

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

Electronically Signed | 11/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 686	Continued From page 1 receive appropriate care through the last stage of life. . . . If resident is immobile, change their position every two to three hours . . ." Review of Resident #14's medical record occurred on all days of survey. Physician's orders stated, ". . . 10/21/2022 SKIN TREATMENT mepilex [absorbent foam adhesive dressing] to coccyx Change 2 x wk [twice a week] . . . 10/29/22 SKIN TREATMENT: Apply Protective dressing to mid back change 2 x wk . . ." A significant change Minimum Data Set (MDS), dated 10/15/22, identified three Stage 2 (partial thickness loss of skin which presents as an abrasion or blister) unhealed pressure ulcers. Resident #14's care plan, stated, ". . . Stage 2 [pressure ulcer] Mid Spine 10/05/22 . . . Stage 2 coccyx 09/30/22 . . . 10/14/2022 Potential for End of Life. Disease progression. On Comfort Cares. . . ." Resident #14's pressure ulcer risk assessment, dated 10/14/22, stated, ". . . MOBILITY: Very limited-Makes occ. [occasional] slight changes in body/extremity position-can't make freq/signif [frequent/significant] changes alone . . . ADDITIONAL RISK FACTORS: . . . history of pressure areas . . . SCORE:14 . . . moderate risk for skin breakdown." Observations showed Resident #14 laid in bed in the same position as follows: * On 10/31/22, from 1:19 p.m. to 4:43 p.m. (approximately 3.5 hours), right side. * On 11/01/22, from 12:19 p.m. to 3:43 p.m. (approximately 3.5 hours), left side. * On 11/02/22, from 8:59 a.m. to 2:31 p.m.	F 686	terminal illness policy will be completed. Residents with pressure sores will be reviewed weekly and then again monthly at our interdisciplinary team meeting. See Agenda F686 4. Monitor of proper repositioning will be completed by PT/OT and DON or other designee on a weekly basis times 4 weeks then monthly X4. See F686	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 686	Continued From page 2 (approximately 5.5 hours), on back. During an interview on 11/02/22 at 2:35 p.m., an administrative nurse (#1) stated she expected facility staff to reposition Resident #14 every two to three hours.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure proper respiratory care for 1 of 1 sampled resident (Resident #1) with orders for continuous oxygen therapy. Failure to provide oxygen as ordered may complicate the resident's respiratory status. Findings include: Review of the facility policy titled "OXYGEN THERAPY-MASK AND NASAL CANNULA" occurred on 11/03/22. This policy, dated December 2020, stated, ". . . portable liquid tanks or e-cylinders are used for transportation of resident throughout facility . . . turn oxygen source to the prescribed flow . . . place cannula in resident's nose . . . check liter flow . . . to	F 695	1. Resident will receive proper oxygen therapy when using portable oxygen. Resident #1 was assessed and replacement portable oxygen has been ordered and implemented. 2. All residents requiring oxygen will be offered the portable oxygen concentrator which is a replacement product/transitioned to new tanks this month. The portable oxygen will be assessed to ensure it meets the needs of the resident. 3. Policy on portable oxygen concentrator will be reviewed at in-service 12/6/22 with nurses and CNAs. See Agenda F695	12/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 695	Continued From page 3 assure flow is correct and bottle is filled appropriately. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included shortness of breath and a recent history of COVID-19. Physician's orders stated, ". . . Administer oxygen 3.0 liter/min [minute] (per nasal cannula) continuous." Observation on 10/31/22 at 2:42 p.m. showed two certified nurse assistants (CNAs) (#2 and #3) transferred Resident #1 into a wheelchair. The CNA (#3) placed a nasal cannula attached to a portable oxygen tank on the back of the resident's wheelchair and proceeded to push Resident #1 to an activity. Assessment of the the oxygen tank showed it empty. Observation on 11/01/22 at 11:55 a.m. showed Resident #1 seated in the dining room, wearing a nasal cannula attached to a portable oxygen tank on the back of her wheelchair. Assessment of the portable oxygen tank showed the tank empty. The CNA (#4) stated, "It [portable oxygen tank] should have been filled before she was brought out to the dining room." During an interview on 11/02/22 at 2:35 p.m., an administrative nurse (#1) stated she expected facility staff to ensure portable oxygen tanks are full prior to resident use.	F 695	4. Monitor of portable oxygen fill/power level will be completed by DON or designee weekly X 4 weeks then monthly X4.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		12/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 812	Continued From page 4 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional literature, and staff interview, facility staff failed to prepare and serve foods under sanitary conditions in 1 of 1 kitchen. Failure to serve food in a sanitary manner may result in forborne illness to residents, staff, and visitors. Findings include: The "Food Code, U.S. Public Health Service, Food and Drug Administration," U.S. Department of Health and Human Services, 2017, page 78, stated, ". . . SINGLE-USE gloves shall be used for only one task . . . used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. . . ." Observations during the 11/01/22 and 11/02/22 noon meals showed a dietary staff member (#5)	F 812	1. No specific residents were found to have been affected by the deficient practice. All residents have the potential to be affected by improper sanitary practices by facility staff. 2. All residents of the facility have the ability to be affected by improper sanitary practices by dietary staff. The dietary manager will monitor dietary staff to assure they are following sanitary practices when preparing and serving food. 3. The dietary manager has met with employee #5 with review of proper handwashing and glove use with this employee. A mandatory all staff in-service is in place for 12/6/2022 with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 812	Continued From page 5 touched multiple surfaces (cupboard, drawer, and microwave handles and dietary meal cards) with gloved hands. With the same gloves, the staff member placed bread into and out of a toaster, and placed sandwiches onto the resident's meal plates. During an interview on 11/03/22 at 4:16 p.m., a dietary manager (#6) stated she expected the dietary staff member (#5) to use a utensil to serve the sandwiches for both meals.	F 812	review of policy at that time with all dining services staff. 4. The dietary manager will monitor dietary staff for proper handwashing and glove use three times a week for one month. Dietary staff will be monitored for proper handwashing technique and proper glove use during this time to assure that proper sanitary procedures are being followed. After one month, dietary staff will be monitored at least one time a week for three months followed by monthly audits. Monitoring will be documented.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the	F 880		12/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 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. §483.80(e) Linens.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and review of professional literature, facility staff failed to follow standards infection control standards for 1 of 6 sampled residents (Resident #3) and 1 supplemental resident (Resident #41) observed during transfers using a mechanical sit-to-stand lift. Failure to follow infection control standards related to disinfecting patient care equipment has the potential to transmit infections to other residents, staff, and visitors. Findings include: Review of guidelines found at https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf, updated May 2019, page 86, stated, ". . . Ensure that, at a minimum, noncritical patient-care devices are disinfected . . . after use on each patient . . ." Observations on 10/31/22 showed the following: * 2:39 p.m., Two certified nurse assistants (CNAs) (#2 and #3) transferred Resident #3 to the bathroom and then to a wheelchair using a mechanical sit-to-stand lift. After completion of the transfer, the CNAs failed to sanitize the lift prior to placing it in the hallway. * 2:56 p.m., Two CNAs (#2 and #3) transferred Resident #41 to the bathroom and then into a	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff have adequate knowledge of hygienic cleaning/disinfecting practices related to non-critical patient-care devices such as mechanical lifts. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate CNAs #2 and #3 and all other direct care staff on hygienic cleaning technique to prevent cross contamination related to non-critical patient-care devices such as mechanical lifts. To verify these staff understands the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 wheelchair using the same mechanical sit-to-stand lift used for Resident #3. After completion of the transfer, the CNAs again failed to sanitize the lift prior to placing it in the hallway.	F 880	training, the staff will complete a return demonstration of cleaning a lift in a hygienic manner using proper dwell times to achieve disinfection. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current nursing home guidelines from CDC and CMS related to cleaning/disinfection of non-critical patient care equipment. 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 12/06/2022 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 ensure cleaning of mechanical lifts was completed in a hygienic manner with appropriate dwell times to achieve disinfection 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9	F 880	designee will ensure the following: a. Educate all staff whose job duties include cleaning tasks on hygienic cleaning of patient-care equipment such as mechanical lifts including effective contact or dwell times for disinfectants used in the cleaning process. This education will include the CDC's lesson on cleaning available at https://youtu.be/t7OH8ORr5Ig. (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 direct care staff engaged in cleaning activities of patient-care equipment such as mechanical lifts to ensure cleaning and disinfection is completed in a hygienic manner and cleaning products are used in accordance with manufacturer instructions to achieve disinfection.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10	F 880	Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 12/06/2022 1. Shared Equipment will be properly cleaned to ensure correct infection control practices. Policy review with employees see example F888. Cleaning of shared equipment procedure will be reviewed at monthly meetings and will be included in annual employee competency review and new employee orientation. 2. All residents using shared equipment may be effected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	**100 ELM AVE NEW SALEM, ND 58563**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11	F 880	3. Review of cleaning shared equipment policy will be conducted at the in-service on 12/6/22 see agenda F888. 4. Contact to the North Dakota Quality Insurance Program was completed on 11/23/22 to inquire about assistance. Shared equipment monitor will be sent to the ND QIP for review. QIP has offered other resources to assist facility in proper infection control prevention. 5. Monitor of cleaning shared equipment will be completed weekly for a minimum of 12 weeks by IP, DON, or designee. Audit findings from monitor will be reviewed at monthly QA meetings.	