STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. BUILDING _____ B. WING _____	R-C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE STANLEY, ND 58784**

(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 01/24/23 and concluded 01/25/23, was conducted to determine compliance with deficiencies identified during the recertification and complaint survey completed on 12/08/22.	{F 000}		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice regarding medication administration for 3 of 3 sampled residents (Residents #4, #5, and #6) and 10 supplemental residents (Resident #12, #13, #14, #15, #16, #17, #18 #19, #20, and #21) observed during medication pass. Failure to disinfect the rubber seal of insulin pens increases the risk of infection to residents and failure to follow standards for safe medication preparation and administration placed all residents at risk of receiving the wrong medication. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 01/25/23. This policy, dated December 2020, stated, ". . . Remove the pen cap from the insulin pen. b. Wipe the rubber seal with an alcohol pad. . . ."	F 658	How will corrective action be accomplished for residents affected by deficiency? Staff were educated at a nurse/CNA/CMA meeting on 2/2/2023 on the appropriate insulin pen preparation/administration and on medication administration policy which does not include pre-dishing medications. How will facility identify other residents affected by deficiency? All residents who receive insulin, or who receive medications were possibly affected by this deficiency. What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? Administrative nursing staff will be auditing nurses and CMAs to ensure proper insulin pen preparation and to	2/2/23

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

Electronically Signed | 02/06/2023

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F 658	Continued From page 1 Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 838-840, stated, ". . . Administering Oral Medications . . . Organize the supplies. Gather the MAR(s) [medication administration records] for each client together so that medications can be prepared for one client at a time. Rationale . . . reduces the chance of errors. . . . Safety . . . Label all medications, medication containers, and other solutions . . . Note: Medication containers include syringes, medicine cups, and basins, Rationale: Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions being removed from their original containers and placed into unlabeled containers. . . ." - Observations on 01/24/23, while nursing staff prepared insulin pens, showed the following: * At 11:35 a.m., a staff nurse (#11) failed to disinfect the rubber seal on Resident #19's Humalog insulin pen prior to attaching the needle. * At 11:41 a.m., a staff nurse (#3) failed to disinfect the rubber seal on Resident #12's Novolog insulin pen prior to attaching the needle. * At 11:57 a.m., a staff nurse (#3) failed to disinfect the rubber seal on Resident #13's Humalog insulin pen prior to attaching the needle * At 12:07 p.m., a staff nurse (#3) failed to disinfect the rubber seal on Resident #14's Novolog insulin pen prior to attaching the needle. - Observation of medication pass on 01/24/23 at 11:35 a.m. with a staff nurse (#11) showed the	F 658	ensure medications are not being pre-dished. This auditing will occur weekly x 12 weeks, monthly x 3 months, and quarterly x 2 quarters. Education will be provided on-the-spot when needed. How do we plan to monitor performance to ensure solutions are lasting? Same as above.	

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F 658	Continued From page 2 following medications in unlabeled cups located in each resident's drawer in the medication cart: * Resident #5 - Tylenol (pain reliever) and Lasix (diuretic) * Resident #6 - Lasix (medication cup tipped on its side in the drawer) * Resident #20 - Lasix and Potassium (potassium supplement) * Resident #21- Probiotic (replaces microorganisms found in the stomach), Tylenol, and Tramadol (pain reliever) - Observation of medication pass on 01/24/23 at 12:09 p.m. with a staff nurse (#3) showed the following medications in unlabeled cups located in each resident's drawer in the medication cart: * Resident #4, Bumetanide (diuretic) * Resident #13, Lasix and Ocuvite (eye vitamin) * Resident #14, Lasix * Resident #15, Hydralazine (treats high blood pressure) * Resident #16, Sodium Chloride (sodium supplement) and Tramadol * Resident #17, Ativan (reduces anxiety) * Resident #18, Immodium (slows down muscle contractions in the stomach) and Gabapentin (treats neuropathic pain) During an interview on 01/25/23 at 11:30 a.m., an administrative nurse (#1) stated she expected staff to disinfect the rubber seal on insulin pens prior to attaching needles and pre-dishing of medications is not the facility's policy.	F 658		
{F 689} SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	{F 689}		2/2/23

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{F 689}	Continued From page 3 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON JANUARY 24-25, 2023, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 12/08/22 CMS-2567. Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 4 of 11 sampled residents (Residents #8, #9, #10 and #11). Failure to provide supervision of certified nurse aides (CNAs) by a licensed nurse regarding resident transfer modes and failure to utilize safe/proper technique during transfers may result in unnecessary pain, falls and/or injury for residents. Findings included: Review of the North Dakota Administrative Code (NDAC) online at www.ndlegis.gov/information/acdata/pdf/54-05-02.pdf stated, ". . . Standards related to registered nurse scope of practice. . . . Develop a plan of care based on nursing assessment and diagnoses that prescribe interventions to attain expected outcomes. 5. Revise nursing interventions consistent with the client's overall health care plan. . . . ."	{F 689}	How will corrective action be accomplished for residents affected by deficiency? Physical Therapy has updated all resident care plans to currently fit one primary way to transfer/mobilize with staff, unless otherwise specified by therapist. In the custom interventions section, therapist has assessed and cleared various lifts that the resident is appropriate to use in various situations, per nurse discretion. Nurses and CMAs have been educated on 2/2/2023 that all residents now have one primary way they should transfer, per their care plan. If the resident is feeling weak/not transferring well, the nurse should be notified so they can complete an assessment and determine a different method of transfer. Nurses have been educated that this needs to be documented in a progress note in Point Click Care. How will facility identify other residents affected by deficiency? All residents' care plans have been reviewed and updated with one primary method of transfer. What measures will be put into place or	

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{F 689}	Continued From page 4 Review of the NDAC online at www.ndlegis.gov/information/acdata/pdf/33-43-01.pdf stated, ". . . 33-43-01-12. Supervision and delegation of nursing interventions. An individual on the department's nurse aide registry [CNA] may perform nursing interventions which have been delegated and supervised by a licensed nurse. . . ." - Review of Resident #8's medical record occurred on all days of survey. The current care plan stated, ". . . PHYSICAL THERAPY . . . I transfer with assistance of 2 staff or Hoyer lift [full body mechanical lift] or standing lift [sit-to-stand lift] prn [as needed]. I may stand independently or with 1-2 staff assist, as my needs vary day to day. . . ." The current CNA pocket resident care card stated, "Transfer: A2 Gaitbelt [assistance of two staff with a gaitbelt]. Ambulation: SL [sit-to-stand lift], X2 [two staff] Pivot . . ." Observations on 01/24/23 of Resident #8 showed the following: * At 1:18 p.m., two CNAs (#5 and #6) attempted to transfer the resident from a Broda chair (specialized wheelchair) to a recliner utilizing a mechanical sit-to stand lift. The resident was restless, agitated, and unable to follow commands. The CNA (#5) began to raise the resident without the resident's feet/legs properly positioned (the stand lacked leg straps) and without the resident grasping onto the stand handles. As the lift raised, the resident leaned back into the sling with his legs in the air. The CNA (#5) then lowered the resident back into the Broda chair, and stated, "We will try again in 30 minutes so he can calm down. We don't want him	{F 689}	systemic changes made to ensure that deficient practice will not reoccur? Therapist will reassess appropriateness of indicated lifts at each resident's MDS or when there is concern with the resident's ability to transfer. Care plans will be updated to reflect any changes, reassessment will be documented, and nursing staff will be notified. CNA staff is to notify Nursing staff, who is to assess resident, when there is a concern with primary transfer and use their discretion as to whether the other previously cleared lift(s) is/are appropriate or if another lift is indicated. Nurse is to then document any use of lifts other than the primary one approved for each resident. Therapy will be notified and will complete re-assessment of resident if there are continued concerns with primary transfer or if the resident is needing to use other indicated lift(s) more frequently. How do we plan to monitor performance to ensure solutions are lasting? Visual audits of resident transfers/gait belt use will be completed by administrative nursing staff weekly x 3 months, monthly x 3 months and quarterly x 2 quarters. Audits will include making sure staff are using correct transfer method (pivot, mechanical lift, hoyer, etc.) as identified in the resident's care plan. Findings will be reported to the QA committee and quarterly QA meetings and education will be provided to staff on-site.	

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{F 689}	Continued From page 5 to fall." * At 2:15 p.m., a CNA (#8) placed a gait belt around the resident's waist while he sat in a Broda chair. Two CNAs (#8 and #9) assisted the resident to stand, pivoted the resident, sat him on the edge of the bed, and then laid him down. During the pivot transfer, the resident did not move his feet, his shoes stuck to the floor, and both feet/ankles twisted. - Review of Resident #9's medical record occurred on all days of survey. The current care plan stated, ". . . PHYSICAL THERAPY . . . I transfer . . . with assist of 1 staff . . . my 4WW [four-wheeled walker]. . . . " The current CNA pocket resident care card stated, ". . . Transfer: A1[assist of one staff] w/ [with] Gaitbelt. . . ." Observation on 01/24/23 a 12:46 p.m. showed two CNAs (#4 and #5) placed a gait belt around Resident #9's waist while he sat in his wheelchair. While assisted the resident to stand, both CNAs grabbed onto the gaitbelt with the CNA (#4) pulling underneath the resident's right arm with her arm. The CNAs then pivoted the resident into a recliner. - Review of Resident #10's medical record occurred on all days of survey. The current care plan stated, ". . . PHYSICAL THERAPY: I transfer with mechanical standing lift and assist of 1 but may pivot-transfer with assist of 2 staff. . . . I may use a hoyer lift PRN with assist of 2 staff when too tired or unable to participate with mechanical standing lift. . . ." The current CNA pocket care guide stated, ". . . Transfer: A1, A2 Pivot w/ Gaitbelt. Ambulation: SL PRN . . ."	{F 689}	Physical Therapist will monitor care plans quarterly (whenever a resident has an MDS due) to ensure they reflect the safest mode of transfer for each resident. Physical Therapist will monitor progress notes in PCC weekly to ensure nursing staff is putting in documentation any time an alternative lift/transfer method was used on a resident other than their primary method. Physical Therapist will report results to QA committee at quarterly QA meetings and education/feedback will be provided to staff as needed.	

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{F 689}	Continued From page 6	{F 689}		

Observation on 01/24/23 at 12:58 p.m. showed two CNAs (#4 and #5) placed a gait belt around Resident #10's waist while seated in a wheelchair. During the transfer, both CNAs grabbed onto the gaitbelt with the CNA (#4) pulling underneath the resident's right arm with her arm. Both CNAs then physically lifted the resident from her wheelchair and placed her into a recliner.

- Review of Resident #11's medical record occurred on all days of survey. The current care plan stated, ". . . PHYSICAL THERAPY: I transfer with assist of 2 with the mechanical standing lift or hoyer lift, as my needs vary day to day. . . ." The current CNA pocket resident care guide stated Transfer: A2 Ambulation: SL . . ."

Observation on 01/24/23 at 1:08 p.m. showed two CNAs (#4 and #5) utilized a mechanical sit-to-stand to transfer Resident #11 from his wheelchair to bed.

During an interview on 01/25/23 at 8:28 a.m., a physical therapist (#10) stated therapy staff assess residents upon admission and they complete reassessment "if the nursing home staff ask." When asked about the therapy department listing multiple modes for transfers and ambulation on assessment recommendations, the therapist stated the CNAs and nurses together can make the decision on which method to use based on how the resident is doing that day "and if they [nursing staff] want to reassess or remove one method, we will come and do that."

During interviews on 01/25/23 at 8:41 a.m. and

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{F 689}	Continued From page 7 8:44 a.m., two CNAs (#7 and #9) stated they use their pocket care guides when deciding what method to transfer a resident and they do not confer with a nurse prior to using the different transfer methods listed on the resident care cards. During an interview on 01/25/23 at 8:52 a.m., an administrative staff member (#1) stated the CNAs can make the decision on the best method of transfer for a resident based on how the resident is feeling/doing that day "because it is care planned [various transfer methods]" and agreed staff should not lift residents under their arms while transferring.	{F 689}		
F 761 SS=E	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 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	F 761		2/2/23

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F 761	Continued From page 8 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, review of facility policy, and staff interview, the facility failed to accurately label multi-dose insulin pens for 2 of 11 sampled residents (Resident #6 and #7) and two supplemental residents (Resident #13 and #19) and failed to ensure safe and secure storage of drugs and biologicals for 1 of 1 unlocked medication cart. Failure to label multi-dose insulin pens with the open date and ensure the insulin pens have the correct label increases the risk of residents receiving outdated medications with reduced efficacy and/or the wrong dose of medication. Failure to lock the medication cart may result in unauthorized access to medications. Findings include: INSULIN PENS - Observations on the morning of 01/24/23 showed the following insulin pens in the medication cart lacked an open date: * Resident #6, Novolog * Resident #7, Novolog and Levemir * Resident #13, Humalog * Resident #19, Humalog During an interview on 01/25/23 at 11:30 a.m., an administrative nurse (#1) confirmed she expected staff to label the insulin pens with an open date.	F 761	How will corrective action be accomplished for residents affected by deficiency? Education was provided to all nurses and CMAs at an in-service on 2/2/2023. Education included: all staff need to be putting open dates on insulin pens, eye drops, etc. whenever they are opening a new pen/vial. Any time a dose is changed for insulin, pharmacy needs to be notified and a new/appropriate label needs to be placed on the insulin pen. The medication cart always needs to be locked if the nurse is not within seeing distance of it. How will facility identify other residents affected by deficiency? All residents were at risk for being affected by this deficiency. What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? Education was provided, and auditing will be performed. How do we plan to monitor performance to ensure solutions are lasting? Auditing of: open dates on insulin pens, appropriate labels on insulin pens and locking of medication carts will be	

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F 761	Continued From page 9 - Observation on 01/24/23 at 11:57 a.m. showed Resident #13's insulin pen label stated to administer 12 units of Humalog before each meal. The order in the resident's MAR (medication administration record) stated, "HumaLOG KwikPen . . . Inject as per sliding scale . . . subcutaneously before meals and at bedtime . . ." When asked which insulin order is correct, the staff nurse (#3) stated the sliding scale order is correct and further stated the nursing staff failed to get an updated label for the pen after Resident #13 returned from the hospital "about a week ago." MEDICATION CART Review of the facility policy titled "Medication Storage Policy at Mountrail Bethel Home" occurred on 01/24/23. This policy, dated December 2020, stated, ". . . All drugs and biologicals will be stored in locked compartments (i.e. medication carts . . .)" Observation of medication pass occurred on 01/24/23 at 11:35 a.m. with a staff nurse (#11). The staff nurse (#11) entered three different resident's rooms to administer medications and failed to lock the medication cart. While in the residents' rooms the medication cart remained out of the nurse's view. During an interview on 01/25/23 at 11:30 a.m., an administrative nurse (#1) confirmed she expected staff to lock the medication cart when in a resident's room.	F 761	done on a weekly basis x 12 weeks, monthly basis x 3 months and quarterly basis x 2 quarters.	

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{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, 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	{F 880}		2/17/23

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{F 880}	Continued From page 11 infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON JANUARY 24-25, 2023, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 12/08/22 CMS-2567. Based on observation, review of facility policy,	{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)/unit(s) identified in the deficiency.	

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{F 880}	Continued From page 12 and staff interview, the facility failed to follow infection control practices for 3 of 5 sampled residents (Resident #1, #3 and #11) observed during cares. Failure to follow infection control practices related to hand hygiene has the potential to transmit infections to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Hand Hygiene Policy at Mountrail Bethel Home" occurred on 01/25/23. This policy, dated December 2020, stated, ". . . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. . . . Hand hygiene is indicated and will be performed . . . Between resident contacts . . . Before applying and after removing personal protective equipment (PPE), including gloves . . . After assistance with personal body functions . . ." Observations on 01/24/23 showed the following: - At 12:38 p.m., two certified nursing assistants (CNAs) (#4 and #5) assisted Resident #11 to stand utilizing a mechanical sit-to-stand lift. The CNAs (#4 and #5) removed the resident's brief and the CNA (#5) provided perineal cares. The CNA (#5) changed her gloves and both CNAs applied a new brief, pulled the resident's pants up and laid him in his bed. The CNA (#5) doffed her gloves, and without performing hand hygiene, placed a Kleenex box and glass of water on the resident's overbed table, clipped a call light to the resident's blanket, moved the overbed table beside the resident's bed, and gave him a drink of water. The CNA (#5) then performed hand	{F 880}	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 perform hand hygiene or handwashing after removing gloves during/after performing perineal care, and before exiting the resident's room in accordance with CDC guidelines. (2) Ensure staff encourage residents to perform hand hygiene or handwashing after using the bathroom. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff on correctly completing hand hygiene after changing tasks, after removing gloves, and before touching items that potentially contaminate 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 procedure for performing hand hygiene and handwashing. (2) Educate all staff on the importance of offering and assisting residents with hand hygiene after using the bathroom. 2. Identification of Others The IP and DON, in conjunction with the applicable interdisciplinary team (IDT)	

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{F 880}	Continued From page 13 hygiene before exiting the room. - At 1:30 p.m., two CNAs (#6 and #7) pivot transferred Resident #1 onto the toilet. After voiding, the resident attempted to cleanse his own perineal area. The CNA (#7) finished cleansing the resident, and then both CNAs placed a new brief on the resident, pulled up his pants, and transferred him back into the wheelchair. Without offering the resident hand hygiene, the CNAs pushed the resident out of his room and transferred him into a recliner in the common lounge area. - At 3:52 p.m. a CNA (#8) assisted Resident #3 on and off the toilet. After voiding, Resident #3 cleansed her own perineal area, the CNA (#8) assisted the resident with her brief and clothing and to the hallway for a walk. The CNA (#8) failed to offer Resident #3 the opportunity for hand hygiene after toileting and failed to perform hand hygiene before exiting the resident's room. During an interview on 01/25/23 at 11:30 a.m., an administrative nurse (#1) confirmed she expected staff to offer the resident hand hygiene after toileting, perform hand hygiene after glove changes, and before exiting the resident's room.	{F 880}	members, will review current nursing facility guidelines for hand hygiene 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 02/17//2023 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 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 in regard to keeping hands clean between tasks, and contacts with objects/persons that has the potential for cross contamination. This education will include the CDC's lesson on clean hands available at 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	

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{F 880}	Continued From page 14	{F 880}	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. (2) Observation of all staff offering and assisting residents to perform hand hygiene after using the bathroom. Observations will be made across all shifts and 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	

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{F 880}	Continued From page 15	{F 880}	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 02/17/2023 How will corrective action be accomplished for residents affected by deficiency? Staff education was provided to nurses and CNAs on appropriate hand hygiene. Reviewed the policy and completed a hand hygiene training at staff meeting on 2/1/2023. Will also continue with weekly auditing and education as needed. Created a new policy titled Resident Hand Hygiene Policy to reflect how staff should be assisting residents with hand hygiene, and also provided education to staff on this. How will facility identify other residents affected by deficiency? All residents are at risk for being affected by this. What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? Continued auditing and education. Continued access to hand sanitizer in all areas.	

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{F 880}	Continued From page 16	{F 880}	How do we plan to monitor performance to ensure solutions are lasting? Visual auditing weekly x 12 weeks, monthly x 3 months, quarterly x 2 quarters and continue with annual education on hand hygiene.	