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 _____	C 12/08/2022

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

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 12/05/22 and concluded 12/08/22. The concerns identified by the complainants were partially substantiated.	F 000		
F 568 SS=C	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interviews, the facility failed to provide a quarterly financial statement for 1 of 1 sampled resident (Resident #2) and 1 supplemental resident (Resident #22) reviewed for personal fund accounts. Failure to provide residents or their representatives with quarterly financial statements prevented the resident or representative from verifying transactions and fund balances. Findings include: Review of the facility policy titled "Trust Fund Account," dated April 2012, stated, ". . .	F 568	How will corrective action be accomplished for residents affected by deficiency? All residents/representatives with a facility resident trust account have been sent trust statements from January - March 31st, 2022, April - June 30th, 2022, and July - September 30th, 2022 as of 12/9/2022. The next statement that is set to be sent out is October - December 31st, 2022, this will be sent no later than January 3nd, 2023. How will facility identify other residents	12/9/22

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

Electronically Signed | 12/22/2022

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F 568	Continued From page 1 Statements showing the transactions and interests are sent out on a quarterly basis to the resident or the person they have designated for this. . . ." During interviews on the afternoon of 12/06/22, Resident #22, identified as cognitively intact, stated her son left money for her, but "if there was a statement it would go to him." Resident #2, identified with moderately impaired cognition, was unaware she had money in a personal fund account. During an interview on 12/06/22 at 2:22 p.m., a business office staff member (#4) stated she has never sent out a quarterly financial statement to the residents/representatives related to their trust funds, but the resident/representative "can call and check the balance at any time."	F 568	affected by deficiency? All residents/representatives with a trust account were identified as having been affected by deficiency. What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? The following corrective actions have been taken: as a means to ensure ongoing compliance we have implemented a procedure to send out resident trust account statements quarterly in the MBH Biller duties. How do we plan to monitor performance to ensure solutions are lasting? The plan of correction will be submitted by the MBH Biller to the Quality Assurance Committee to become a topic of the quarterly meeting to ensure that compliance is sustained and concerns are identified and addressed with the plan of action adjusted accordingly as needed. When will corrective action be completed? It was completed on 12/9/2022.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		12/21/22

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F 641	Continued From page 2 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/23/21. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 1 supplemental resident with a MDS review (Resident #1). Failure to accurately code the MDS does not allow each resident's assessment to reflect their current status/needs and may negatively affect the development of a comprehensive care plan and the care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2019, page K-5 to K-6 stated, ". . . Weight loss . . . From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago. . . . If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss . . . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. . . . Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. . . ."	F 641	How will corrective action be accomplished for residents affected by deficiency? The MDS which was submitted incorrectly will be corrected and resubmitted on 12/21/2022. How will facility identify other residents affected by deficiency? All residents' most recent MDS□s submitted will be reviewed for error in weight loss documentation. What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? This error was caused simply because the person submitting this section selected the wrong item and did not re-read the area before submitting. Moving forward, all employees who submit sections on MDS's will be responsible for double-checking all of their selections before submitting their sections. We have also implemented a new software titled SimpleLTC which will be used to essentially scrub all of our MDS's for any errors prior to submission. How do we plan to monitor performance to ensure solutions are lasting? Dietary manager will monitor MDS's	

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F 641	Continued From page 3 Review of Resident #1's medical record occurred on 12/05/22 and 12/06/22. A quarterly MDS, dated 11/06/22, identified a weight loss. Review of Resident #1's weight documentation showed a weight of 150 pounds on 10/13/22, 152 pounds on 09/07/22, and 158 pounds on 04/07/22 (1.32% weight change in 30 days and 5.06% weight change in 180 days). This is not indicative of a significant weight loss in 30 or 180 days. During an interview on 12/08/22 at 12:56 p.m., an administrative dietary staff member (#3) confirmed the facility staff inaccurately coded the MDS for weight loss.	F 641	which are submitted on a monthly basis for accuracy of weight-loss documentation. These findings will be reported to the QA Committee and quarterly QA meetings. When will corrective action be completed? Corrective action was completed as of 12/21/2022.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		12/20/22

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F 657	Continued From page 4 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/23/21. Based on observation, record review, policy review, and resident and staff interview, the facility failed to review and revise the comprehensive care plans to reflect the residents' current status for 2 of 12 sampled residents (Resident #2 and #10). Failure to update the care plans as needed may result in delayed treatment interventions and inadequate/inconsistent care delivery. Findings include: Review of the facility policy titled "Care Plan and Care Conference" occurred on 12/08/22. This policy, dated 02/09/17, stated, ". . . The Care Plan will [sic] completed in accordance with the State and Federal guidelines. . . . Each resident is assessed on a quarterly basis by the members of the Care Planning Team. The team members then meet to go over each assessment at least quarterly and at a minimum of two times per year. . . ." - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included non-pressure chronic ulcer of other part	F 657	How will corrective action be accomplished for residents affected by deficiency? Resident #10□s care plan was updated on 12/8/2022 to reflect recurrent of foot ulcers, and doctor's recommendation of wide-toe shoes, and also resident□s refusal. Resident #2□s care plan will be updated to reflect recent toe nail removal, and all interventions as recommended by medical provider. How will facility identify other residents affected by deficiency? Administrative nursing staff will review all residents' care plans to ensure all current treatments are included in care plan. What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? A Care Plan Binder was created and it is to be reviewed by CNA and nursing staff with each quarterly care plan	

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F 657	Continued From page 5 of right foot with unspecified severity and type 2 diabetes mellitus with other skin ulcer. Resident #10's physician's orders included: * 10/20/22, "For ulcer between right 4th and 5th toe apply iodine and 2x2 [two inch by two inch gauze pad] between toes every morning for 2 weeks if not improving schedule with Dr. [doctor] [name of podiatrist]." [discontinued 11/17/22] * 11/18/22, "use silicone spacer between 4th and 5th toe of right foot one time a day for ulcer" The podiatry consult, dated 11/16/22, stated, "dx [diagnosis] diabetic ulcer r. [right] 5th toe, hx [history] prior surgery r. 5th toe. no s/s [sign/symptom] infection, faint pulse bil [bilaterally], debrided ulcer today, shoes too narrow, causing condition to begin with likely. need wider shoes, use silicone spacer b/t [between] 4-5 toes r. may need surgery in office, f/u [follow-up] 1 month." During an interview on 12/05/22 at 3:57 p.m., Resident #10 stated she had a sore between her 4th and 5th right toes, now healed. The podiatrist told her to wear wider shoes, but she does not like them, but liked her current shoes which she thought fit well. Observation showed the resident's laced shoes appeared snug on her feet. During an interview on 12/08/22 at 12:53 p.m., an administrative nurse (#1) stated Resident #10's ulcer healed, the facility notified the resident and family of the podiatrist's recommendation for wider shoes, but the resident refused and family "is okay with that."	F 657	assessment, and as needed. Care plan reviews will occur on a scheduled basis (set based off of the MDS schedule) and will be completed by nursing staff and CNAs during report. Nursing staff will submit reviewed care plans to ADON/Care Coordinator who will review and update care plans as needed. How do we plan to monitor performance to ensure solutions are lasting? The ADON will ensure that care plan reviews are being done as set forth on the MDS schedule, and administrative nursing staff will meet on a weekly basis during our Risk meetings to discuss any changes/see if anything was missed. When will corrective action be completed? Corrective action was completed on 12/20/2022.	

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F 657	Continued From page 6	F 657		

During an interview at 12/08/22 at 1:33 p.m., an administrative nurse (#2) stated Resident #10's ulcer healed; the ulcer "tends to come and go." The nurse stated, "We are implementing care plan reviews to include CNAs [certified nurse aides] for their input to catch things that are being missed."

The current care plan stated, ". . . SKIN: I have potential for skin breakdown related to immobility, Diabetes, and dependence on staff for ADL [activities of daily living] cares. . . . I want my skin to remain intact. . . . Report to my doctor as indicated. . . . Assist with bathing and monitor skin frequently. Report any concerns to nurse/MD [medical doctor] as appropriate. . . ." Failure to include Resident #10's history of recurrent toe ulcers in the care plan, the podiatrist's recommendation for wider shoes, use of silicone toe spacers, or other pertinent interventions may result in future ulcer development.

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included type II diabetes mellitus.

A podiatry consult, dated 11/16/22 stated, "Chemical ablation [medical procedure that removes a layer of tissue] of all 10 toes [sic]."

Resident #2's physician's orders included: *11/16/22, "Cover toenails with 4x4 gauze daily and clean sock. No hard toe shoes. one time a day for Ablation of all 10 toenails until 11/30/2022." [completed 11/30/22]

The primary care provider note, dated 12/01/22

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F 657	Continued From page 7	F 657		

at 10:30 a.m., stated, ". . . Chief complaint: Re-check bilateral feet. . . . History of present illness: The patient is seen today resting comfortably in her wheelchair. The patient had chemical removal of all 10 of her toenails by podiatry two weeks ago. We are doing regular dressing changes and is seen today just to recheck these feet. She does state some mild discomfort with dressing changes, otherwise no pain noted. . . . Assessment: chronic dystrophic toenails, status post chemical matrixectomy [removing the growth area of the nail that is leading to the curved ingrown toenail]. . . . Plan: no sign of any active inflammation or infection currently. We will continue the dressing changes as recommended per podiatry, otherwise will continue to follow for regular scheduled rounds and sooner if any problems arise. . . ."

The progress notes stated the following:
* 12/1/2022 at 12:27 p.m., ". . . Dr. [name of primary care provider] here and assessed resident's toes due to Nursing staff voicing concerns. Toes continue to drain and large [sic] to right foot is quite red. Resident has increased pain in her toes also. Dr. [name] will consult Dr. [name of podiatrist] for any further instructions."
* 12/8/2022 at 9:26 a.m., ". . . Dressing change complete, drainage noted. Ace wraps applied."

During an interview on 12/05/22 at 12:46 p.m., Resident #2 stated her toenails were removed. The resident stated her toes were sore and that her stockings rubbed. She liked when they "wrapped" them, but she must ask for that. Observation showed the stockings had dried blood.

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F 657	Continued From page 8 The current care plan stated, ". . . SKIN/PRESSURE: I am at risk for skin breakdown due to intermittent incontinence and decreased mobility. . . ," The care plan lacked inclusion of the toenail removal and related interventions. Failure to include Resident #2's recent toenail removal as a new problem and develop/implement pertinent interventions may result in wound complications and pain for the resident. During an interview on 12/08/22 at 1:05 p.m., two administrative nurses (#1 and #2) agreed care plans should be updated when new problems are identified.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: UTI TREATMENT 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 2 sampled residents (Resident #23) with a urinary tract infection (UTI). Failure to	F 684	How will corrective action be accomplished for residents affected by deficiency? 1. Resident #23 has since completed her round of ordered antibiotics, so no corrective action can be taken to correct	1/5/23

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F 684	Continued From page 9 promptly treat a resident's urinary tract infection caused pain, discomfort, need for further treatments, and the potential for a serious bloodstream infection. Findings include: A review of the facility's "Suspected UTI Protocol Form" occurred on 12/08/22. This protocol, revised 09/30/2020, stated, ". . . With Catheter: MUST have TWO of the following symptoms, Fever 100.4 degrees Fahrenheit (F) or above, new or increased incontinence, urgency, dysuria [painful urination] foul smelling urine, chills, frequency, suprapubic or flank pain/tenderness, change or worsening of mental or functional status. If resident meets the criteria for UTI protocol, push fluids and administer UtyMax [a cranberry based supplement which provides the nutrients for the dietary management and prevention of recurrent urinary tract infections] BID [twice a day] for 72 hours. Symptoms shall be reassessed each shift for presence of the above symptoms. At the end of 72 hours IF symptoms persist, obtain a urinalysis and review results with physician. . . ." Review of the facility's policy titled "Lab and Radiology Services" occurred on 12/08/22. This policy, implemented December 2020 stated, ". . . 4. Results of lab and /or radiology are printed to the nurse's station printer, and results need to be relayed onto the provider to be reviewed." Review of Resident #23's medical record occurred on all days of survey. Diagnoses included: type 2 diabetes mellitus with diabetic chronic kidney disease, urinary incontinence,	F 684	this incident. 2. Staff have been educated that residents (Resident #2 in this incident) need to wear their TED hose as ordered by provider. They have also been educated that if the resident refuses to wear the TED hose, documentation needs to reflect this. How will facility identify other residents affected by deficiency? 1. Administrative nursing staff have reviewed residents' charts to ensure no lab results have been pending medical provider review for more than 24 hours. 2. Administrative nursing staff have done visual audits to ensure residents have their TED hose on if the nurse□s documentation states they do. What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? 1. We have updated our UTI Protocol Policy and UTI Protocol Form which will include a spot for nurses to document the date of culture completion and date of antibiotic start date. These forms will be monitored/reviewed by administrative nursing staff. Also will be holding a nurses' meeting to educate the nurses on the updated UTI Protocol Policy and educate them that all lab work needs to be followed up on by medical provider	

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F 684	Continued From page 10 presence of urogenital implants, and disorders of bladder. The current care plan stated, ". . . "Urinary: I am at risk for UTI's r/t [related to] placement of foley catheter. I want to remain free of UTI and other complications through review date. . . . I want staff to assist in performing catheter cares BID and as needed. . . . I want staff to encourage me to drink adequate amounts of fluid throughout the day. I want staff to monitor for s/sx [signs and symptoms] of UTI and report to nurse/MD [medical doctor] as indicated. Initiate UTI protocol when indicated per policy. . . ." During an interview on 12/05/22 at 1:20 p.m., Resident #23 stated she had a UTI and was on an antibiotic that "took them a while to start because they said they were waiting for the culture to come back." The resident reported a history of UTIs. Record review showed UTI treatment on 09/23/22 and 10/28/22 and frequent pain. Resident #23's progress notes showed the following: * 11/22/22 at 09:04 a.m., ". . . UTI Protocol completed and urine sample has been sent to the lab. Urine continues to be cloudy and foul smelling. Resident had complaint of suprapubic and flank pain on HS [hour of sleep]." * 11/22/22 at 2:35 p.m., ". . . Concern slip back from Dr. [name] . . . UA collected and sent to lab and results sent to Dr. [name]." * 11/22/22 at 3:40 p.m., ". . . Labs have been reviewed by Dr. [name]. He is waiting until the culture come [sic] back before new orders. . . ." * 11/29/22 at 12:10 p.m., ". . . Culture back and Dr. [name] reviewed and placed resident on Macrobid 100mg 2x daily times 5 days. . . ."	F 684	within 24 hours, and if needed treatment will be started within 24 hours of order. Administrative nursing staff, including DON and Infection Prevention Nurse will monitor UTI Protocol Forms to ensure these actions are being completed within appropriate time. 2. Education will be provided to nursing staff that they need to follow provider□s orders for TED hose use, and utilize appropriate documentation if the resident(s) is refusing TED hose use. Administrative nursing staff will complete visual audits of TED hose use, and appropriate documentation, weekly x 3 months, monthly x 3 months, and quarterly x 2 quarters. These findings will be reported to QA committee during quarterly QA meetings. How do we plan to monitor performance to ensure solutions are lasting? 1. Administrative nursing staff, including DON and Infection Prevention Nurse will monitor UTI Protocol Forms to ensure these actions are being completed within appropriate time. These findings will be reported to QA committee and quarterly QA meetings. 2. Administrative nursing staff will complete visual audits of TED hose use, and appropriate documentation, weekly x 3 months, monthly x 3 months, and quarterly x 2 quarters. These findings will be reported to QA committee during	

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(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 684	Continued From page 11 * 11/30/22 at 8:10 p.m., ". . . Resident very lethargic and moaning. Vital signs taken and BP [blood pressure] very low at 74/45, pulse 88, Temp 97.7, resp 24, O2 [oxygen saturation] 96%. Resident was just started on Macrobid for UTI. TC [telephone call] to on call provider [name] PA [physician's assistant] regarding situation. Orders received to give Bolus of 1 liter NS [normal saline] IV [intravenously] now. . . ." * 11/30/22 at 9:45 p.m., ". . . IV infusion complete. Vital signs are as follows, BP 87/42, Resp 20, Pulse 89, Temp 98.4, 93% O2 RA. Disconnected IV tubing from arm. TC to [name] PA with results . . ." * 12/01/22 at 6:23 a.m., ". . . Foley catheter changed as balloon had deflated. New 16FR indwelling foley catheter inserted with immediate return of urine. Urine dark yellow in color. . . . BP checked et [and] was 113/59-P [pulse] 88 . . . O2 sat 99% on RA [room air]." * 12/01/22 8:57 a.m., ". . . C/o [complained of] lower backpain and tylenol given at breakfast. Tearful at times. vitals-98.3-62-20 109/54 95% on room air. Remains in bed per request. Appetite fair. On antibiotic therapy and no adverse reaction noted. Fluids encouraged. Foley catheter draining dark yellow urine." * 12/01/22 at 11:34 a.m., ". . . Resident was seen by Dr. [name] for C/O back pain. Last evening had a very low BP and received fluids. Resident has not felt well the last couple of days and has been in bed. Order for CBC [complete blood count] and a CMP [comprehensive metabolic panel]. . . ." * 12/02/22 at 2:28 a.m., ". . . Resident in better spirits during HS cares. No crying noted and states she had said she wanted to die but if she thinks she is doing better she will feel better. She	F 684	quarterly QA meetings. When will corrective action be completed? 1. Nurses' meeting will be held on January 5th, 2023. Education will occur then and actions will start immediately following.	

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	355044	A. BUILDING _____ B. WING _____	C 12/08/2022

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F 684	Continued From page 12	F 684		

states that she is feeling better and would like to play on tablet and sit in wheelchair. Urine continues to be dark amber in color. No sediment noted. No s/s of ADR [adverse drug reaction] noted to starting macrobid. vitals WNL[within normal limits]."

Record review identified the urine culture report as "final" on 11/24/22; however, facility staff failed to implement interventions until 11/29/22 (five days later).

The facility failed to follow up on labs and treatment for a resident with a history of UTIs. This delay in treatment caused Resident #23 to experience pain, other symptoms of an infection, and the need for IV fluids.

WOUND ASSESSMENT AND TREATMENT

2. Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to provide treatment and care in accordance with professional standards for 1 of 1 sampled residents (Resident #2) with edema (excess fluid accumulation in the body tissues) and a new surgical wound. Failure to utilize compression stockings or wraps as ordered for edema and assess wounds may result in worsening edema, skin breakdown, or infection.

Findings include:

Review of facility policies occurred on 12/08/22. The "Elastic Stocking/Anti-Embolism/Ted Hose Policy," dated December 2020, stated, ". . . A provider's order must be obtained. Ted hose should be applied in the morning and taken off at

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F 684	Continued From page 13 bedtime unless otherwise ordered." The "Wound Treatment Management Policy," dated December 2020, stated, ". . . Policy: to promote wound healing of various types of wounds. . . In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. . . . Wounds will be assessed weekly, every Tuesday, and documented on the wound Assessment Sheet within the Wound Binder at the nurse's station. Any concerns will be forwarded to the provider. . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included chronic diastolic (congestive) heart failure and type 2 diabetes mellitus. The facility completed a significant change Minimum Data Set (MDS) on 11/07/22 for weight gain and the addition of a diuretic. The current care plan stated, ". . . Excess Fluid Volume: I am at risk for edema. . . I want to have minimal edema and any presence of edema to be well managed. . . . I need assisted [sic] with putting on my ted stocking/ace wraps in the morning and off at bedtime. . . ." Interviews and observations showed the following: * 12/05/22 at 12:46 p.m., Resident #2 stated her toenails were removed. The resident stated her toes were sore and that her stockings rubbed on them. She liked when they "wrapped" them, but she must ask for that. Observation showed dried blood on her stockings, and no compression stockings or wraps on lower extremities. * 12/05/22 at 03:50 p.m., two nurses (#10 and #11) applied dressings to Resident #2's toes per her request. The nurse (#11) stated, "you must've	F 684		

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F 684	Continued From page 14 been up a lot today your feet are more swollen." Observation showed no compression stockings or wraps on the resident's lower extremeties and the presence of edema. * 12/06/22 at 11:40 a.m., no compression stockings or wraps present on Resident #2's lower extremities. * 12/07/22 at 3:20 p.m., no compression stockings or wraps present on Resident # 2's lower extremities. Orders included: 08/15/22, "TED stocking/ace wraps to bilateral lower extremities [BLE], on in am, off in pm every day and evening shift for edema." 11/16/22, "Cover toenails with 4x4 [size of gauze dressings] gauze daily and clean sock. No hard toe shoes. One time a day for Ablation (medical procedure that removes a layer of tissue) of all 10 toenails until 11/30/2022." [Completed 11/30/22] The primary care provider note, dated 12/01/22 at 10:30 a.m., stated, ". . . Chief complaint: Re-check bilateral feet. . . . The patient had chemical removal of all 10 of her toenails by podiatry two weeks ago. We are doing regular dressing changes and is seen today just to recheck these feet. She does state some mild discomfort with dressing changes, otherwise no pain noted. We will continue the dressing changes as recommended per podiatry, otherwise will continue to follow for regular scheduled rounds and sooner if any problems arise. . . ." Resident #2's treatment administration record (TAR) showed staff applied the TED hose on	F 684		

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F 684	Continued From page 15 December 5, however, observation showed no TED hose in place. On December 6 and 7, facility staff documented a "9" on the TAR indicating "other" and to refer to the progress notes." The record lacked documentation in the progress notes. Review of Resident #2's medical record lacked weekly wound assessments as per policy. The record also lacked documentation for not applying the compression stockings or wraps. During an interview on 12/08/22 at 01:05 p.m., two administrative staff (#1 and #2) stated they expected staff to document wound assessments in the progress notes. They also stated that if staff document a "9" in the TAR, they expected staff to document the reason in a progress note.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §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: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 6 sampled residents (Resident #4) and 1 supplemental resident (Resident #1) observed during a pivot transfer. Failure to utilize a gait belt	F 689	How will corrective action be accomplished for residents affected by deficiency? CNA and Nurses' meeting will be held and education will be provided on the safety of transfers and pivot transfers	1/5/23

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F 689	Continued From page 16 during transfers places residents at risk of an accident and/or injury. Findings include: Review of the facility policy titled "Use of Gait Belt Policy at Mountrail Bethel Home" occurred on 12/07/22. This policy, dated December 2020, stated, ". . . It is the policy of Mountrail Bethel Home to use gait belts with residents that need assistance to ambulate or transfer for the purpose of safety. . ." - Review of Resident #4's medical record occurred on all days of survey. The care plan stated, ". . .TRANSFERS: I transfer with assistance of 2 staff or Hoyer lift or standing lift . . ." Observations of Resident #4 showed the following: * 12/06/22 at 8:53 a.m., two certified nursing assistants (CNAs) (#5 and #6) transferred the resident from the Broda [specialized mobility] wheelchair to the bed. The CNAs lifted the resident under each arm to pivot transfer. * 12/06/22 at 11:13 a.m., two CNAs (#5 and #7) transferred the resident from the bed to the Broda wheelchair. The CNAs lifted the resident under each arm to pivot transfer. * 12/06/22 at 4:11 p.m., two CNAs (#5 and #8) transferred the resident from the bed to the Broda wheelchair. The CNAs lifted the resident under each arm to pivot transfer. A gait belt hung on a hook outside the bathroom door. Staff failed to use the gait belt during each observed transfer.	F 689	policy. All staff will be educated on gait belts and that gait belts must be used with any resident with an assistive device and with all transfers. Staff will also be educated that they shall not lift residents under the arms to perform a transfer. How will facility identify other residents affected by deficiency? Visual audits of resident transfers will be completed. What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? Continued education will be given to CNAs and nurses on resident transfers and gait belt use, and visual audits of transfers/gait belt use will be completed by administrative nursing staff. 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. Findings will be reported to the QA committee and quarterly QA meetings and education will be provided to staff on-site. When will corrective action be completed?	

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F 689	Continued From page 17 -Review of Resident #1's medical record occurred on all days of survey. The care plan stated, ". . . FALLS . . . I require Ax2 [assistance of two staff] for pivot transfer or the use of stand-lift. . ." Observation on 12/06/22 at 10:06 a.m., showed two CNAs (#5 and #7) transferred Resident #1 from the Broda wheelchair to the recliner chair. The CNAs lifted the resident under each arm to pivot transfer. Staff failed to use a gait belt during the transfer. During an interview on 12/08/22 at 1:57 p.m., two administrative nurses (#1 and #2) stated they expected staff to use the gait belt during all assisted transfers and staff should not lift residents under the arms to perform a transfer.	F 689	Nurses' meeting will be held on January 5th, 2023. Education will occur then and actions will start immediately following.	
F 725 SS=L	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		12/8/22

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F 725	Continued From page 18 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on review of the Payroll Based Journal (PBJ) Staffing Data Report, information from the complainant, review of nurse staffing schedules, and staff interview, the facility failed to provide the services of a licensed nurse for 24 hours a day, seven days a week, on 48 of 168 days of nursing schedules (June 26-December 10, 2022) reviewed. Failure to schedule a nurse 24 hours a day may result in inefficient or lack of coordination of care/services, limited ability to promptly respond to residents' needs or administrative concerns, and could lead to confusion and/or an adverse outcome in an emergency; therefore, endangering residents' health, safety and well-being. During the on-site recertification and complaint survey, the team determined a potential Immediate Jeopardy (IJ) situation existed on 12/07/22 at 4:19 p.m. The IJ potential resulted from review of the nurse staffing schedules indicating lack of licensed nurse coverage 24 hours a day. This finding placed residents in immediate danger due to the lack of a licensed nurse present to assess and manage resident health and safety.	F 725	How will corrective action be accomplished for residents affected by deficiency? Facility will have a licensed nurse scheduled and working at the facility 24 hours per day, 7 days per week. How will facility identify other residents affected by deficiency? n/a What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? An administrative nursing staff, not involved in the MBH nursing scheduling, will audit the nursing schedule to ensure a licensed nurse is schedule to work at MBH 24/7. How do we plan to monitor performance to ensure solutions are lasting?	

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F 725	Continued From page 19 * 12/07/22 at 1:45 p.m., During an interview, an administrative nurse (#9) and an administrative staff member (#13) stated the practice to staff a medication aide in place of a nurse from 6:00 p.m. to 10:00 p.m. started sometime in the past year per a prior administrative staff member's suggestion, so management or other nurses would not have to cover those hours. They stated the hospital emergency room (ER) nurses were available to call if needed. The administrative staff member (#13) stated, "We have changed that practice now, and will never staff that way again. We have fixed the schedule right away." * 12/07/22 at 4:19 p.m., The survey team contacted the State Survey Agency (SSA) to report the findings and discuss potential IJ. * 12/07/22 at 5:15 p.m., The SSA contacted the survey team after discussion with the CMS (Centers for Medicare & Medicaid Services) location and verified the presence of IJ. * 12/07/22 at 5:28 p.m., The survey team notified the assistant director of nursing (ADON), who notified the administrator and director of nursing by phone/email, of the IJ situation, provided them with the IJ template, and requested they develop a plan for removal of the immediate jeopardy. * 12/07/22 at 6:44 p.m., The ADON presented the IJ removal plan which the survey team reviewed and accepted. The ADON stated the current schedule ended on 12/10/22 and there were no medication aides scheduled to work alone for that time period. Review of the schedule confirmed this statement.	F 725	Schedules will be audited weekly x 3 months, monthly x 3 months and quarterly x 2 quarters. If there are missing nursing hours identified, the appropriate personnel will be notified immediately. Findings will be reported to QA committee and quarterly QA meetings. When will corrective action be completed? Corrective action was completed on 12/8/2022.	

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F 725	Continued From page 20 * 12/08/22 at 10:13 a.m., The survey team verified the facility carried out the IJ removal plan and the survey team removed and reduced the IJ situation from a scope/severity of L or a scope/severity of F. * 12/08/22 at 2:58 p.m., The SSA notified the CMS location of the removal of IJ. Findings include: Review of the PBJ Staffing Data Report, for the quarter of July 1 - September 30, 2022, showed the facility triggered for "Failed to have Licensed Nursing Coverage 24 Hours/Day" on four days. Information provided by the complainant stated concern for cares and assessments of residents as the complainant noted only a medication aide and certified nurse aides scheduled at night, but no nurse. The facility provided a copy of the nurse staffing schedules for the time period of June 26 - December 10, 2022. A review of the schedules identified 48 days the facility scheduled a medication aide instead of a licensed nurse during a portion of the 24-hour day. The facility lacked nurse coverage from 6:00 p.m. to 10:00 p.m. on 45 days and from 7:00 p.m. to 10:00 p.m. on three days. The last day scheduled without a nurse for 24 hours was 12/03/22. Medical record review of the past four months identified six of 12 sampled residents (Resident #18, #24, #25, #27, #28, and #29) with falls with or without injuries, a resident (#29) on	F 725		

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F 725	Continued From page 21 intravenous (IV) antibiotics per a PICC line (peripherally inserted central catheter, a form of IV access) who pulled out the PICC line twice, two residents (#21 and #28) with wander guards of which one resident eloped, and one resident on comfort cares who expired. The nurse staffing schedule showed at the time of the resident's death, only one medication aide and five certified nurse aides scheduled, with one administrative nurse on-call. During an interview on 12/07/22 at 5:28 p.m., the ADON stated when a medication aide was scheduled without a nurse present, the medication aide was supposed to call one of the nurse managers before contacting a hospital nurse. The ADON stated, "I don't think the ER nurse ever had to come over" to the facility. "We would help per phone or come in." During an interview on 12/07/22 at 6:09 p.m., a certified nurse aide/medication aide (#14) who worked evenings and nights, stated the last time she worked without a nurse present was last week from 6-10 p.m. "We were told that a nurse from the hospital was available if needed, but were told to call the nurse on-call first. The medication aide clarified the on-call nurse as the facility director of nursing (DON), ADON, or other nurse manager. She stated she never called a hospital nurse for assistance as she always called the DON or ADON first, for example, when a resident needed an as-needed (PRN) medication or questions from family members.	F 725		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse	F 727		12/8/22

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F 727	Continued From page 22 §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/23/21. Based on review of the Payroll Based Journal (PBJ) Staffing Data Report, policy review, review of nurse staffing schedules, and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for six days of the 100-day period from 08/27/22 to 12/04/22. Failure to ensure sufficient, qualified nursing staff are available on a daily basis has the potential to affect the health and safety of all the residents residing in the facility. Findings Include: Review of the facility policy titled "RN Coverage" occurred on 12/07/22. This policy, dated 03/16/06, stated, ". . . a Registered Nurse will be on duty for 8 consecutive hours every 24 hours. Mountrail Bethel Home will define the 24 hour	F 727	F-727 How will corrective action be accomplished for residents affected by deficiency? Facility will ensure there is an RN scheduled to work directly at MBH at least 8 hours per day, 7 days a week. How will facility identify other residents affected by deficiency? n/a What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? An administrative nursing staff, not involved in the MBH nursing scheduling, will audit the nursing schedule to ensure a registered nurse is scheduled to work at	

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(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 727	Continued From page 23 period of time from 0600-0600." Review of the PBJ Staffing Data Report, for the quarter of July 1 - September 30, 2022, showed the facility triggered for "No RN Hours" on four different days. The facility provided a copy of the nurse staffing schedules for the time period of June 26 - December 10, 2022. A review of the schedules showed the facility designated RN coverage with an RN scheduled the same shift in the hospital on six weekend days: August 27 and 28, September 25, October 9 and 23, and December 4, 2022. During an interview on 12/07/22 at 10:15 a.m., three administrative nurses (#1, #2, and #9) stated they staffed 8-hour RN coverage with a hospital Emergency Room RN only as a last resort. The hospital RN was available to call for questions/assistance, but was not physically present in the skilled nursing facility as required. They agreed assigning a hospital RN does not meet the requirement for 8-hour RN coverage.	F 727	MBH at least 8 hours/day, 7 days a week. How do we plan to monitor performance to ensure solutions are lasting? Schedules will be audited weekly x 3 months, monthly x 3 months and quarterly x 2 quarters. If there are missing nursing hours identified, the appropriate personnel will be notified immediately. Findings will be reported to QA committee and quarterly QA meetings. When will corrective action be completed? Corrective action was completed on 12/8/2022.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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 a medication error rate of less than five	F 759	How will corrective action be accomplished for residents affected by deficiency?	1/5/23

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	355044	A. BUILDING _____ B. WING _____	C 12/08/2022

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F 759	Continued From page 24 percent for 2 of 5 residents observed during medication administration (Resident #10 and #32). Two medication errors occurred during staff administration of 32 medications, resulting in a 6% error rate. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 12/07/22. This policy, dated December 2020, stated, ". . . Attach safety pen needle . . . Prime the insulin pen: a. Dial 2 units by turning the dose selector clockwise. b. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. . . ." Review of the facility policy titled "Medication Administration" occurred on 12/07/22. This policy, dated December 2020, stated, ". . . Review MAR [Medication Administration Record] to identify medications to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. . . ." Observation of medication pass showed the following: * 12/06/22 at 11:40 a.m., a nurse (#10) attached a needle to Resident #10's Novolog insulin flex pen, dialed the dose to two units, held the pen horizontally and pushed the button to expel the air. The nurse then dialed the dose selector to	F 759	1. Education has been provided to nursing staff on our Insulin Pen policy and how to appropriately administer insulin via insulin pens. 2. Staff has been educated on the importance of identifying the correct dose of medication, and the appropriate medication dose has been ordered for Resident #32. How will facility identify other residents affected by deficiency? 1. Other residents who use insulin pens have been identified as other residents possibly affected. 2. Pharmacy staff reviews residents' prescription orders to ensure they are getting the appropriate prescriptions to match the order. Administrative nursing staff will review the residents' over-the-counter orders to ensure they are getting the appropriate dose. What measures will be put into place or systemic changes made to ensure that deficient practice will not reoccur? 1. Meeting will be held on 1/5/2023 where Nurses and CMAs will be educated on the Insulin Pen policy, and education will be provided specifically on priming the insulin pens. 2. Meeting will be held on 1/5/2023	

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F 759	Continued From page 25 three units prior to administering the insulin to Resident #10. The nurse failed to hold the insulin pen upright to prime it or watch for a drop of insulin at the tip of the pen. * 12/07/22 at 8:20 a.m., a nurse (#12) administered magnesium oxide 400 milligrams (mg) from a stock bottle to Resident #32. The medical record showed the order for the resident's magnesium oxide stated "500 mg." The nurse gave an incorrect dose of magnesium oxide to Resident #32. During an interview on 12/07/22 at 3:32 p.m., a nurse (#12) verified 500 mg as the correct magnesium oxide dose. During an interview on 12/07/22 at 3:43 p.m., an administrative nurse (#1) stated staff should prime insulin pens with 2 units, pointing the pen upward.	F 759	where Nurses and CMAs will be educated on the 5 rights of medication administration. How do we plan to monitor performance to ensure solutions are lasting? 1. Visual audits will be completed by administrative nursing staff on insulin pen use weekly x 3 months, monthly x 3 months and quarterly x 2 quarters. Education, if needed, will be provided on-the-spot and all findings will be reported to QA committee and quarterly QA meetings. 2. Random medication passes will be audited by administrative nursing staff x 3 months, monthly x 3 months and quarterly x 2 quarters. Education, if needed, will be provided on-the-spot and all findings will be reported to QA committee and quarterly QA meetings. When will corrective action be completed? 1. Nurse□s meeting will be held on January 5th, 2023. Education will occur then and actions will start immediately following.	
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	F 880		12/31/22

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F 880	Continued From page 26 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 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	F 880		

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F 880	Continued From page 27 (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: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 1 of 6 sampled residents (Resident #4) observed during perineal care. 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	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. 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	

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F 880	Continued From page 28 12/07/22. 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 . . . Before applying and after removing personal protective equipment (PPE), including gloves. . . When, during resident care, moving from a contaminated body site to a clean body site. . . After assistance with personal body functions (e.g., elimination, hair grooming, smoking) . . ." Observation of Resident #4 showed the following: * 12/06/22 at 8:53 a.m., two certified nursing assistants (CNAs) (#5 and #6) transferred the resident from the wheelchair to bed and completed perineal cares. One CNA (#5) cleansed the rectal area with disposable wipes. The CNA (#5) removed her gloves, applied new gloves, assisted the CNA (#6) to place brief, and adjusted the resident's pants. The CNA (#5) removed her gloves, applied new gloves, and covered the resident with a blanket. The CNA (#5) failed to perform hand hygiene after cleansing the resident's rectal area and between glove use. *12/06/22 at 11:13 a.m., two CNAs (#5 and #7) completed perineal cares. One CNA (#5) lowered the resident's pants, removed the brief, cleansed the perineal area with a disposable wipe, and removed her gloves. The CNA (#5) applied new gloves, assisted the CNA (#7) to place brief, and removed her gloves. The CNA (#5) failed to perform hand hygiene after cleansing the resident's perineal area and between glove use. *12/06/22 at 4:11 p.m., two CNAs (#5 and #8)	F 880	for: (1) Ensuring staff perform hand hygiene or handwashing after removing gloves and during/after performing perineal care, in accordance with CDC guidelines. 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. Identification of Others The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) 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 12/31/2022 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis	

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F 880	Continued From page 29 completed perineal cares. One CNA (#8) cleansed the resident's rectal area with a disposable wipe, placed a new brief on the resident, removed her gloves, donned new gloves, and continued to assist CNA (#5) with dressing of the resident. The CNA (#8) failed to perform hand hygiene after cleansing the resident's rectal area and between glove use. During an interview on 12/08/22 at 1:57 p.m., two administrative nurses (#1 and #2) confirmed staff failed to follow the facility's policy regarding hand hygiene.	F 880	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 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:	

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F 880	Continued From page 30	F 880	(1) Observations of all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and 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 12/31/2022	