STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 11/14/22 and concluded 11/17/22.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		12/23/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/16/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and resident and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 3 of 21 sampled residents (Resident #21, #37 and #70) and 5 supplemental residents (#12, #18, #45, #46 and #60) observed during the survey. Failure to maintain a clean, comfortable, and sanitary environment does not provide a homelike living area for residents and fails to promote dignity Findings include: Review of the facility policy titled "Wheelchair Cleaning" occurred on 11/17/22. This policy, dated August 2022, stated, "Resident wheelchairs will be cleaned by staff weekly on bath days per CNA [certified nurse assistant] electronic tasking and prn [as needed]. . . ." Review of the facility policy titled "Supplies and Equipment, Nursing Services" occurred on 11/17/22. This policy, dated August 2022, stated, ". . . Equipment must be ready for use at all times of the day and night to serve the residents' needs. Care should be exercised in the handling and in the use of our equipment to prevent damage or breakage. . . . For repair of	F 584	1) Staff members involved in the care of resident #21, 37, 70, 12, 18, 45, 46, 60 were educated on the importance of making sure we provide a safe, clean, comfortable, and home like environment. Resident #12 door handle and hole in the wall fixed on 11/18/2022. Resident #18 wheelchair cushion replaced on 12/14/2022. Resident #21 wheelchair cleaned 11/20/2022. Resident # 37 wheelchair cleaned 11/20/2022 and left arm bolster, seat cushion and right back positioning wedge replaced 12/15/2022. Purple dried liquid drips to #37 wall adjacent to the head of the residents bed was cleaned on 12/15/2022 and wheelchair back fixed. Resident #45 wheelchair cleaned on 11/20/2022 and the wheelchair back and right arm rest replaced 12/15/2022. Resident #46 door frames and wall painted on 11/18/2022. Resident #60 white draw sheet was changed on 11/18/2022 when a bedding change was completed. Resident #70 wheelchair cleaned on 11/19/2022.	

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F 584	Continued From page 2 equipment, pull all faulty equipment and place work order on the intranet marking it as high priority." Observation on all days of survey showed the following: - Resident #12's inside room door handle fell off when used to open and closed, the handle needed to be placed back onto the door with each use. A hole in the wall where the door handle meets the wall. - Resident #18's right hip wheelchair bolster cushion worn with peeled/missing material on the outer covering. - Resident #21's wheelchair with white debris on the upper right top of chair, dry liquid streaks on the right armrest/cushion, and dry debris on the footrest cushion. - Resident #37's left arm bolster and right back positioning wedge on the resident's wheelchair worn with peeled/missing material on the outer covering, the repair patch on the wheelchair seat cushion peeling off, cracks present to the upper wheelchair back, both wheelchair wheels soiled, and purple dried liquid drips on the wall adjacent to the resident's head of bed. - Resident #45's wheelchair with dust and debris on the lower metal frame and both wheelchair wheels with white splatters that appeared as dried spilled milk. The vinyl of the wheelchair back and right arm rest with cracks. - Resident #46's room showed paint scuffed and scratched off the wall next to the bed. During an interview the morning of 11/16/22, Resident #46 stated, "I don't know what those marks are on the wall." - Resident #60's white chuck/draw sheet on top of his blankets with a dried gray colored stain and	F 584	2) All residents shave the potential to be affected. 3) A Mandatory all staff meeting will be held on December 21 and 22, 2022 to provide education on the importance of maintaining a clean, comfortable, and sanitary environment which includes cleaning of all wheelchairs as scheduled, checking wheelchairs for any cracks, making sure all wheelchairs cushions are intact, make sure residents wall are intact and door handles work, painting resident door frames as they become chipped. Reviewed policies titled," Wheelchair cleaning" and "supplies and equipment, nursing service." 4) Maintenance, and Director of Nursing or designee's will monitor to ensure wheelchair are being cleaned as per policy, monitor wheelchair for any cracks, and worn cushions, make sure door frames painted as needed, repair holes and fix door handles as they arise. monitoring will be done weekly times 4, monthly times 3, and then quarterly for one year. if concerns are identifies immediate corrective action will take place. DON and Maintenance will submit a report to the quarterly QA committee. 5) 12/23/2022	

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F 584	Continued From page 3 a fresh brown smear stain. - Resident #70's wheelchair with layer of dust on the spokes of the wheels, one spoke on the right wheel had dry liquid debris, and the metal frame under the wheelchair seat contained dust and debris. During an interview the morning of 11/17/22, an administrative staff (#1) reported staff are expected to clean resident wheelchairs and assistive devices weekly.	F 584		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary services for 2 of 21 sampled residents (Resident #37 and #42) and 10 supplemental residents (#2, #4, #14, #18, #39, #49, #52, #53, #82 and #83) who required assistance with activities of daily living (ADLs). Failure of facility staff to provide needed assistance for toileting/hygiene of residents may result in low self-esteem, skin breakdown, and/or urinary tract infections. Findings include: Information provided by the complainant indicated staff failed to provide toileting assistance for residents.	F 677	1) Staff members involved in the care of resident #2,4, 14, 18, 37, 39, 42, 49, 52, 53, 82. 83 were educated on the importance that residents are checked for toileted and changed according to their individualized care plan. 2) All residents who need assistance with toileting have the potential to be affected. 3) Mandatory all staff meeting will take place December 21, and 22, 2023 to provide education on the importance of check and changing and providing perineal care to all residents according to their individualized care plan. Reviewed policy titled "Incontinence Care". 4) The Director of Nursing or designee will monitor all residents that need help with toileting to make sure they are being	12/23/22

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F 677	Continued From page 4 Review of the facility policy titled "Incontinence Care" occurred on 11/17/22. This policy, reviewed January 2022, stated, "Residents who are incontinent are checked for toileting and changed according to their individualized toileting schedule and/or plan of care. Perineal care is provided to residents after each incontinent episode. . . ." Review of Resident's #2, #4, #14, #18, #37, #39, #42, #49, #52, #53, #82, and #83's medical records identified extensive to total assistance of one to two staff required for transfer, toileting, and personal hygiene. Observation on 11/15/22 of Resident's #2, #4, #14, #18, #37, #39, #42, #49, #52, #53, #82, and #83 showed the following: * The residents served breakfast, which began at 7:30 a.m. and ended at 9:00 a.m. * After breakfast, the resident's seated in their wheelchairs and pushed out to the Harmony unit lounge facing the television. * At 10:31 a.m., all 12 residents remained in their wheelchairs in the same location in the Harmony lounge. Nine of the 12 residents slept with their heads hanging down. * At 11:13 a.m., all 12 residents remained in their wheelchairs in the same location in the Harmony lounge facing the television. Without toileting, the staff began to take the residents to the dining room for lunch. During an interview on 11/16/22 at 5:15 p.m., an administrative nurse (#1) stated she expected facility staff to complete rounds every two hours including check/change and toileting of residents.	F 677	checked and changed according to their individualized care plan. The monitoring will be done weekly times 4, monthly times 3, then quarterly for one year. if concerns are identified immediate corrective action will be implemented. The DON or designee will report results to the QA committee on a quarterly basis. 5) 12/23/2022	

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F 677	Continued From page 5 During an interview the morning of 11/17/22, the administrative nurse (#1) stated she reviewed video footage on 11/15/22, after breakfast until lunch, and failed to confirm staff checked/changed or toileted Residents #2, #4, #14, #18, #37, #39, #42, #49, #52, #53, #82, and #83.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		12/27/21

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F 690	Continued From page 6 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. 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 perineal/catheter care in a manner consistent with standards of practice to prevent urinary tract infections (UTIs) for 2 of 2 sampled residents (Resident #37 and #42) observed receiving inappropriate perineal care. Failure to provide perineal care according to acceptable standards of practice placed residents at risk of developing urinary tract infections. Findings include: Review of the facility policy titled "Catheter Care" occurred on 11/17/22. This policy, reviewed January 2022, stated, ". . . clean the tube first at the urethral opening [opening where urine leaves the body], and away from the opening. Use only one downward stroke at a time, use a clean area of the cloth each time. Remainder of perineal care is done as usual . . ." Review of the facility policy titled "Perineal Care" occurred on 11/17/22. This policy, reviewed January 2022, stated, ". . . Females . . . cleanse perineum . . . Clean urethral meatus [opening] and vaginal orifice [opening] using clean portion of washcloth . . . with each stroke. . . . Males . . . Begin cleansing tip of penis and working	F 690	1) Staff members involved in care of resident #37, and 42 were educated on the correct way to perform catheter care and perineal care. 2) Residents who have a foley catheter or who require perineal care have the potential to be affected. 3) Mandatory All staff education will be held on December 21, and 22, 2022 to provide education on Catheter and Perineal care. Reviewed policies titled, "Catheter Care, and "Perineal Care." 4) The Director of Nursing or designee will monitor those resident with a catheter and those residents who require perineal care to ensure it is being performed correctly and done according to policy. The monitoring will be done weekly times 4, monthly times 3, the quarterly for 1 year. if concerns are identified immediate corrective action will be implemented. The DON or designee will report results of monitoring to the QA committee on a quarterly basis. 5) 12/23/2022	

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F 690	Continued From page 7 outward. . . . Cleanse the shaft of the penis, using downward strokes toward the scrotum. Use separate section of washcloth . . . with each stroke. . . ." - Review of Resident #37's medical record occurred on all days of survey. Diagnoses included a history of UTIs. The resident's care plan identified the resident as always incontinent of bowel and bladder and required extensive assistance of two staff members for toileting needs. Observation on 11/16/22 at 4:13 p.m. showed a certified nurse assistant (CNA) (#2) provided perineal cares to Resident #37 while in bed. The resident incontinent of urine. The CNA removed the resident's brief, used a washcloth to cleanse the resident's groin, and without folding the washcloth or obtaining a new washcloth, cleansed the frontal pubic area. The CNA (#2) failed to cleanse the urethral/vaginal areas. - Review of Resident #42's medical record occurred on all days of survey. Diagnoses included obstructive uropathy (obstruction of urine flow) and a history of UTIs. The resident's care plan identified the resident with an indwelling catheter, always incontinent of bowel, and required extensive assistance of two staff members for toileting needs. Review of Resident #42's medical record, from December 2021 through November 2022, showed the resident hospitalized with a UTI with urosepsis (infection of the bloodstream caused by a UTI) on 12/10/21, 01/23/22, 05/04/22 and 11/02/22.	F 690		

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F 690	Continued From page 8 Observation on 11/16/22 at 9:15 a.m. showed a CNA (#2) provided catheter/perineal cares to Resident #42 while in bed. The CNA used a washcloth to wipe the resident's catheter tubing, and without folding the washcloth or obtaining a new washcloth, wiped the penis tip, the scrotum/groin area, and then the penis shaft. During an interview on 11/17/22 at 9:03 a.m., an administrative nurse (#1) agreed staff failed to perform cares for Residents #37 and #42 according to the facility's policy or acceptable standards of practice.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, resident interview, and staff interview, the facility failed to provide proper respiratory treatment and care consistent with standards of practice and physician's orders for 2 of 4 sampled residents (Resident #40 and #56) receiving tracheostomy cares, suction, oxygen therapy, and nebulizer treatments. Failure to follow respiratory standards of practice may result in complications	F 695	1) Staff member involved in the care of resident #40 were educated on making sure to clean lary tube with liquid soap and water, use lubrication on lary tube prior to reinsertion, replace properly fitted new Velcro collar without the use of safety pin on lary tube as needed, rinse nebulizer equipment with water and place on a absorbent towel to dry and them put in a ziplock bag, follow order given by	12/27/22

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F 695	Continued From page 9 and compromise of the residents' respiratory status. Findings included: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 1308 & 1310, stated, ". . . Suctioning a Tracheostomy . . . Purposes: To maintain a patent airway and prevent airway obstructions. To promote respiratory function (optimal exchange of oxygen and carbon dioxide into and out of the lungs). To prevent pneumonia that may result from accumulated secretions. . . . Document relevant data. Record the suctioning . . . " Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 62, stated, ". . . Carrying Out a Physician's Order. Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 1311-1313, stated, ". . . Providing Tracheostomy Care . . . Equipment . . . Cotton twill ties or Velcro collar . . . Velcro Collar Method . . . Take the second piece of the collar around the back of the client's neck, keeping it flat. Have the client flex the neck and secure the two pieces	F 695	provider to make sure correct oxygen flow rate is given, make sure to document resident #40 prn use of oxygen and suctioning. Staff members involved in the care of resident #56 were educated on making sure to change oxygen tubing every Sunday night shift and label with the date it was changed. Velcro tracheostomy collar for resident #40 was changed on 12/15/2022. Provider contacted with order reviewed and updated by provider on 12/23/2022 to clean lary tube with water and soap. 2) All residents with a lary tube and any resident who uses oxygen, requires suctioning or require nebulizers have the potential to be affected. 3) Mandatory all staff meeting will be held on December 21, and 22, 2022 to educate staff on the importance of changing oxygen tubing every Sunday night and date tubing; educated on cleaning of lary tube, using lubrication to reinsert lary tube, proper way to clean nebulizer equipment, replacing a properly fitted Velcro collar without the use of safety pin(s), following provider orders in regards to oxygen flow, documenting prn oxygen flow, and suctioning. Reviewed policies titled, "Nebulizer Therapy" and " Oxygen Concentrator. 4) The Director of Nursing or designee will monitor residents with a lary tube to make sure the process is followed per	

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F 695	Continued From page 10 of the collar together with the Velcro, allowing space for one to two fingers between the collar and the client's neck. . . ." Review of the facility policy titled "Lary Tube Care" occurred on 11/17/22. This policy, dated August 2020, stated, ". . . ensure that residents who need respiratory care are provided such care consistent with professional standards of practice . . . Cleaning the Lary Tube [a tube to maintain an airway after a laryngectomy (surgical removal of the larynx)] . . . scrub the tube with a . . . soft bristle brush with warm water and mild soap. Rinse clean. . . . With insertion, only use a water-soluble lubricant to aid with placement." Review of the facility policy titled "Oxygen Concentrator" occurred on 11/17/22. This policy, reviewed January 2022, stated, ". . . Obtain physician's orders for the rate of flow and route of administration of oxygen . . . Turn the unit on to the desired flow rate . . . Cannulas and masks should be changed weekly or as necessary . . . " Review of the facility policy titled "Nebulizer Therapy" occurred on 11/17/22. This policy, dated May 2022, stated, ". . . Care of the Equipment. Clean after each use. . . . Disassemble parts after every treatment. Rinse the nebulizer cup and mouth piece [mask for Resident #40] with tap water. Shake excess water. Air dry on an absorbent towel. Once completely dry, store the nebulizer cup and mouth piece in a zip lock bag. . . ." - Review of Resident #40's medical record occurred on all days of survey. Diagnoses included tracheostomy status (a surgically	F 695	policy, will monitor those residents on nebulizer treatments to make sure they are cleaned and stored correctly, monitor resident on oxygen to make sure tubing is changed every Sunday night, monitor oxygen flow rate, monitor resident with prn orders for suctioning and oxygen to make sure correct documentation is done. Monitoring will be done weekly times 4, monthly times 3, then quarterly for one year. If concerns are identified immediate corrective action will take place. DON or designee will submit a report quarterly to the QA committee. 5) 12/23/2022	

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	355070	A. BUILDING _____ B. WING _____	C 11/17/2022

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created hole (stoma) in your windpipe), chronic respiratory failure (failure of lungs to oxygenate the blood), chronic obstructive pulmonary disease (COPD) (obstructive airflow in the lungs), and dependence on supplemental oxygen.

Physician's orders included the following:
* 02/04/22, "Larytube care: Remove tube from stoma and rinse with water then insert it back. . . . every 4 hours and as needed."
* 06/11/22, stated, "Oxygen at (2) L/min [liters per minute] with humidity via trach at bedtime and PRN as needed . . ."
* 06/11/22, "Albuterol Sulfate HFA Aerosol Solution . . . 1 inhalation via trach every 4 hours as needed for Shortness of breath . . ."
* 06/11/22, "Budesonide Suspension . . . 1 vial via trach two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE . . ."
* 07/26/22, "PRN [as needed] suctioning per residents request as needed for secretions . . ."

During an interview on 11/14/22 at 3:08 p.m., Resident #40 stated the following:
* "Some nurses don't use enough lubrication when they change it [Lary Tube] and it hurts when this happens."
* "Some nurses don't clean off all the soap when they clean it."
* Reported staff suctioned her "last night with her evening medications, around midnight, and again around 4:00 a.m."

Observations of Resident #40 showed the following:
* 11/14/22 at 3:08 p.m., two large bottles of clear liquid soap in the resident's bathroom with a sign on the mirror indicating only use to clean the Lary

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F 695	Continued From page 12	F 695		

Tube. A Velcro collar used to secure the Lary Tube in the stoma folded up behind the resident's neck and secured with a safety pin. When asked how long the facility staff have been using safety pins on her collar, the resident stated, "For quite a while."

* 11/15/22 at 9:11 a.m., A nurse (#10) removed, cleaned, and replaced the Lary Tube. The nurse failed to clean the tube with liquid soap and failed to use lubrication prior to inserting the tube into the resident's stoma. The nurse attached a new Velcro collar to the Lary Tube, folded the collar behind the resident's neck and secured it with a safety pin. The nurse provided suction per the resident's request. Observation prior to a nebulizer treatment showed a disassembled nebulizer cup and mask located directly on the bedside table. The staff failed to place the nebulizer equipment on an absorbent towel barrier and place the equipment in a zip-lock bag once dry.

* 11/16/22 at 8:19 a.m., The resident rested in bed attached to an oxygen concentrator with the liter flow set at 4L. When asked if she applies oxygen and/or adjusts the liter flow on the concentrator by herself, the resident stated, "No."

* 11/16/22 at 8:58 a.m., A nurse (#11) removed, cleaned, and replaced the Lary Tube. The nurse failed to clean the tube with liquid soap. The nurse attached the same Velcro collar to the Lary Tube, folded the collar behind the resident's neck and secured it with a safety pin. The nurse provided suction per the resident's request. Observation prior to a nebulizer treatment showed an assembled nebulizer cup and mask located directly on the bedside table. The staff failed to disassemble and rinse the nebulizer cup, rinse the mask, place the equipment on an

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F 695	Continued From page 13 absorbent towel barrier, and place the equipment in a zip-lock bag once dry. Review of Resident #40's November Medication Administration (MAR) lacked documentation for the suction the nursing staff provided on 11/14/22, 11/15/22 and 11/16/22. The MAR also lacked documentation for the PRN oxygen used on 11/16/22. The facility failed to complete the following for Resident #40: * Contact the prescriber regarding the order, dated 02/04/22, "Larytube care: Remove tube from stoma and rinse with water . . . " to ensure the order followed the facility's policy to cleanse the Lary Tube with mild soap. * Follow the physician's order for the correct oxygen flow rate and failed to document the residents PRN oxygen use and suctioning. * Provide a properly fitted tracheostomy collar. * Disassemble, rinse, place on an absorbent towel, air-dry the nebulizer medication cup and mask, and place the nebulizer equipment into a zip lock bag once dry. - Review of Resident #56's medical record occurred on all days of survey. Diagnoses included COPD. Physician orders included the following: * 02/15/21, "O2 [oxygen] via NC [nasal cannula] 3L/min, titrate to maintain sats [oxygen saturations] > [greater than] 90% every shift. . . ." * 02/28/22, "Change oxygen tubing, masks and label with date every Sunday night shift. . . ." Observation on all days of survey showed	F 695		

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F 695	Continued From page 14 Resident #56's oxygen tubing/nasal cannula labeled "10/31" (indicating the date the staff changed the tubing). The facility failed to change the oxygen tubing/nasal cannula per policy. During an interview on 11/17/22 at 10:23 a.m., an administrative nurse (#1) stated she expected staff to change oxygen tubing per facility policy.	F 695		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of	F 729		12/23/22

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F 729	Continued From page 15 a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on review of employee files and staff interview, the facility failed to ensure 1of 5 employees (Employee #1) reviewed completed nurse aide certification renewal every two years. Failure to verify certified nurse assistant (CNA) certification renewal has the potential to affect resident care. Findings include: Review of CNA employee files occurred on the morning of 11/17/22 and identified an expiration date of 09/21/20 on the Nurse Aide Registry form for Employee #1. During an interview on 11/17/22 at 10:30 a.m., an administrative staff member (#5) confirmed Employee #1's certification expired in 2020. The facility staff failed to ensure Employee #1 completed the certification renewal process prior to the expiration date and allowed a CNA to provide resident cares for over two years beyond the expiration date.	F 729	1) Human Resources and Nursing Administration educated on the importance of making sure we are checking all certified nurse aid licenses status upon hire to make sure all Certified nurse aides complete certification renewal process prior to expiration date. Employee #1 did complete certified nurse aid certification on 12/2/2022. 2) All certified nurse aides and anyone who holds a license that requires renewal has the potential to be affected. 3) Mandatory All staff meeting will be held on December 21 and 22, 2022 to provide education on the importance of making sure your certified nursing license is current and active 4) Human Resources or designee will monitor certified nursing license to make sure they are active weekly times 4, monthly times 3, the quarterly for one year. If concerns are identified immediate corrective action will take place. Human Resource or designee will submit a report to the quarterly QA committee.	

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755	5) 12/23/2022	12/23/22

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F 755	Continued From page 17 by: Based on record review, the facility failed to obtain routine, regularly scheduled medications for 1 of 21 sampled residents (Resident #40). Failure to ensure each resident receives routine, regularly scheduled medications has the potential for residents to suffer adverse health events and failure to establish and implement an effective policy/procedure regarding unavailable medications resulted in Resident #40 missing 61 doses of a scheduled inhaler and 3 doses of a scheduled oral medication. Findings include: The facility failed to provide a policy/procedure related to provider notification when a scheduled medication is not available from the pharmacy. Review of Resident #40's medical record occurred on all days of survey. Diagnoses included chronic respiratory failure (failure of the lungs to oxygenate the blood), chronic obstructive pulmonary disease (COPD) (obstructed airflow in the lungs), shortness of breath, and hypothyroidism (underactive thyroid). Review of Resident #40's physician's orders identified the following: * 11/30/21, "Albuterol Sulfate . . . Aerosol Solution [inhaler] . . . 1 puff . . . every 4 hours for COVID 19/pneumonia . . . D/C [discontinue] Date - 06/11/2022" * 12/02/21, "Levothyroxine Sodium Tablet Give 150 mcg [micrograms] by mouth one time a day for hypothyroidism . . . D/C Date - 01/17/2022" * 01/18/22, "Levothyroxine Sodium Tablet Give 175 mcg by mouth one time a day . . . D/C Date -	F 755	1) Staff members involved in the care of resident # 40 were educated on the importance of making sure resident #40 receives routine, regularly scheduled medications. 2) All residents have the potential to be affected. 3) mandatory all Staff meeting will be held on December 21 and 22, 2022 to provide education on making sure all residents receive routine, regularly scheduled medications as ordered by a provider. Education also given on new policy titled, " Unavailable Medications". 4) The Director of Nursing or designee will monitor resident #40 aan all other residents to ensure medications are given as prescribed. Monitoring will be done weekly times 4, monthly times 3, then quarterly for one year. If concerns are identified immediate corrective actions will be implemented. The DON or designee will report results of monitoring to the QA committee on a quarterly basis. 5) 12/23/2022	

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F 755	Continued From page 18 05/02/2022" Review of Resident #40's January 2022 - April 2022 medication administration record (MAR) and nursing progress notes showed the following: * 61 missed doses of Albuterol (16 doses from January 16-18, 35 doses from February 10-15, and 10 doses from April 26-28). The progress notes identified the medication as unavailable and "too soon to refill per pharmacy." * Three missed doses of Levothyroxine on January 18-20. The progress notes stated, "medication no longer in the [medication] cart, new dose increased by MD [medical doctor], awaiting delivery from pharmacy." The facility failed to notify Resident #40's provider or the prescribing provider when the albuterol inhaler and levothyroxine were unavailable from the pharmacy.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		12/23/22

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F 757	Continued From page 19 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure adequate monitoring of a medication for 1 of 2 sampled residents (Resident #44) who received coumadin (blood thinner). Failure to monitor a PT/INR level (prothrombin time and international normalized ratio-A blood test to measure a person's blood clotting time) may result in a blood level out of therapeutic range and does not allow the resident to maintain the highest practicable level of well-being. Findings include: Review of the facility policy titled "Physician Order-Ancillary Services" occurred on 11/16/22. This policy, revised February 2013, stated, ". . . When the physician Order is obtained . . . the order will be entered into . . . [electronic medical record (EMR)]. . . . After the Telephone/Verbal order from [sic] has been signed by the physician this will be scanned into the [EMR] and placed under the "misc" [miscellaneous] tab of the Resident's electronic medical record." Review of Resident #44's medical record occurred on all days of survey. Diagnoses included atrial fibrillation (irregular heart rhythm).	F 757	1)Staff members involved in the are of resident # 44 were educated on the importance of making sure lab draws (PT/INR) are done for specific medications (coumadin) are done per providers order. PT/INR for resident #44 was drawn on 11/14/2022 and provider notified that draw for 11/11/2022 was missed. 2) All residents who are on the blood thinner coumadin have the potential to be affected. 3) Mandatory All staff meetings will be held on December 21, and 22, 2022 to provide education on the importance of drawing PT/INR as ordered for those residents on the blood thinner coumadin. Reviewed policy titled, "Physician order-Ancillary Services." 4) The Director of Nursing or designee will monitor those residents on coumadin to ensure PT/INR are being drawn as ordered by providers. The monitoring will be done weekly times 4, monthly times 3, then quarterly for one year. If concerns	

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F 757	Continued From page 20 A faxed physician's order, dated 11/04/22, stated, "Take 3 mg [milligrams] of warfarin [coumadin] Nov [November] 5 & [and] Nov 6 and then resume regular warfarin dosing of 1.5 mg daily on Monday Nov 7. Recheck INR/PT in 1 week." The physician's orders in the EMR, dated 10/20/22, identified PT/INR every 14 days and the medication administration record (MAR) indicated the PT/INR to be completed on 11/17/22. The physician orders and MAR in the EMR lacked the 11/04/22 order to recheck PT/INR in one week. The medical record lacked evidence of a completed PT/INR in one week as ordered. During an interview on 11/15/22 at 4:37 p.m., a staff nurse (#9) stated the next PT/INR is scheduled for 11/17/22. When asked about the faxed physician's order dated 11/04/22, the nurse stated the PT/INR recheck should have been completed in one week, on 11/11/22. Facility staff failed to adequately monitor a medication and obtain a PT/INR on the date ordered by the physician.	F 757	are identified immediate action will be implemented. The DON or designee will report results of the monitoring to the QA committee on a quarterly basis. 5) 12/23/2022	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		12/23/22

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F 761	Continued From page 21 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer's instructions, and staff interview, the facility failed to ensure the safe and secure storage of drugs and biologicals in 1 of 2 medication carts (Harmony unit) reviewed. Failure to lock the medication cart when unattended may result in unauthorized access to medications. Findings include: Review of the programming guide for the M-Series Tech-Ready Medication Cart occurred on occurred on 11/17/22. The guide stated, ". . . To open: press user/supervisor code then the "ENTER" key. To close: Press the "LOCK" key . . . The locking system . . . is set to automatically re-lock after 5 minutes . . . Changing the Auto Re-lock open time . . . The new "OPEN TIME" will be active the next time you open the cart . . ."	F 761	1) Staff members specifically #11 were educated on the importance of making sure mediation carts are locked to ensure the safe and secure storage of drugs and biologicals. 2) All residents have the potential to be affected. 3) Mandatory all staff education will be held on December 21, and 22, 2022 to provide education on the importance of making sure medication carts are locked at all times when not in a nurses view so we can ensure all drugs and biologicals are safe and secure. 4) The Director of Nursing or designee will monitor medication carts to make sure they are locked at all times. The	

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F 761	Continued From page 22 Observation on 11/16/22 at 9:25 a.m. of the medication cart on the Harmony unit showed a nurse (#11) opened the cart via a keypad on top of the cart, prepared a resident's medications, and without pressing the cart's lock key, walked into the resident's room. After exiting the room, when asked if she locked the medication cart, the nurse stated, "It [the medication cart] automatically locks within a few seconds." When asked to check if the cart locked, the nurse (#11) pulled on a drawer, and confirmed the cart was unlocked. During an interview on 11/17/22 at 10:23 a.m., an administrative nurse (#1) stated it took three minutes for the medication cart on the Harmony unit to automatically lock when she checked it.	F 761	monitoring will be conducted weekly times 4, monthly times 3, and quarterly for one year. If concerns are identified immediate corrective action will be implemented. The DON or designee will report results to the quarterly QA committee. 5) 12/23/2022	
F 812 SS=L	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		12/27/22

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F 812	Continued From page 23 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer's guidelines, review of professional reference, and staff interview, the facility failed failure to ensure sanitization of dishware (utensils, dishes, pots/pan) used to serve residents, staff, and visitors in 1 of 1 kitchen. Failure to ensure the mechanical dishwashing machine maintains the correct hot water temperature required by manufacturer's directions to destroy pathogens may result in the spread of illness and/or foodborne illness to residents, visitors, or staff During the on-site recertification survey, the team determined a potential Immediate Jeopardy (IJ) situation existed on 11/16/22 at 9:50 a.m. The IJ potential resulted from observation of the dishwashing machine temperatures not being maintained at the manufacturer's recommendations. This finding placed residents in immediate danger due to the potential of spread of illness and/or foodborne illnesses from improper sanitization. * 11/16/22 at 10:02 a.m. - The survey team notified the director of nursing and dietary management of the IJ situation and requested they develop a plan for removal of the immediate jeopardy. * 11/16/22 at 10:10 a.m. During an interview with a dietary director (#6) she stated, "Unfortunately our machine temperatures may have been wrong for some time."	F 812	1) The Dietary Department Staff members involved in the dishwasher temperatures where educated on the importance of making sure dishes, pots/pans, and utensils are sanitized between uses. Hobart service was here 11/22/2022 and did service the dishwasher, they replaced solenoid valve, replaced hose, replaced pressure regulator valve, replaced vacuum breaker, replaced dishwasher skirts. Braaten Plumbing was also here on 11/16/2022 and 11/17/2022 found that plumbing in basement and ceiling of dishroom needed to be updated for connection to hot water heater for the unregulated water; They replaced copper pipes, press fittings, mixing valves, pipe insulation, loop hangers, all thread, and beam clamps on 12/13/2022. Dietary Staff Educated on 11/16/2022 on the policy titled, "Cleaning Dishes-Manual Dishwashing and policy titled," Cleaning Dishes/Dish Machine". Observation of each employee performing the procedure was observed by Dietary manager/Assistant. Dietary Staff utilized disposable dishware for all resident beginning on 11/16/2022 at 5pm until 11/20/2022 to supper with the exception of while plumbing work was being done on 3 sink area. Braaten was here on 11/17/2022 doing plumbing work	

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F 812	Continued From page 24 * 11/16/22 at 10:15 a.m. The survey team contacted the State Survey Agency (SSA) to report the findings and to discuss IJ. * 11/16/22 at 10:26 a.m. An administrative nurse (#8) verified the facility did not have any gastrointestinal illnesses in the facility. * 11/16/22 at 10:45 a.m. The facility submitted a written immediate action plan. * 11/16/22 at 5:05 p.m. - The facility provided a revised written plan of correction for the IJ. * 11/16/22 at 5:30 p.m. - The survey team reviewed and accepted the facility's version of the written plan of correction for the IJ. * 11/16/22 at 5:35 p.m. - The survey team removed and reduced the IJ situation from a scope/severity of L to a scope and severity of F. * 11/16/22 at 5:40 p.m. - The SSA notified the Centers for Medicare and Medicaid Services location of the immediate jeopardy was removed. Findings include: The FDA Food Code 2017 Annex 3 - Public Health Reasons, page 506, stated, "4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. The temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits . . . to ensure surfaces of multi-use utensils such as kitchenware and	F 812	so did not wash any dishes from 7:30am to 2pm until Braaten was completed. Started using dishwasher on 11/20/2022 at 4:10pm checked temperatures every hour times 4, then every 2 hours times 4, then every 4 hours times 4. 2) Anyone who eats at our facility both staff and residents, have the potential to be affected by a food borne illness. 3) Mandatory all Staff meetings will be held on December 21, and 22, 2022 to provide education on the importance of making sure the wash temperature is meeting the requirements, and the rinse temperature is meeting the requirement. Reviewed policies titled, " Cleaning Dishes/Dish Machine." 4) Dietary Manager will monitor dishwasher temperatures. The monitoring will be conducted daily times 2 at all times. If concerns are identified immediate corrective action will take place. Dietary Manager will submit a report to the quarterly QA committee. 5)12/23/2022	

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F 812	Continued From page 25	F 812		

tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning. The surface temperature must reach at least . . . 160 degrees F [Fahrenheit] as measured by an irreversible registering temperature measuring device to affect sanitization. . . ."

Manufacturer's guidelines (page 24) for dishwashing machine model CLCS66eN states ". . . Minimum Temperatures Using
High-Temperature Sanitizing for wash tank is 160 degrees Fahrenheit and for final rinse is 180 degrees Fahrenheit. . . ."

Review of the facility policy titled, "Cleaning Dishes/Dish Machine" occurred on 11/16/22, and stated ". . .Check the dish machine gauges throughout the cycle to assure proper temperatures. . . ."

Observations of the mechanical dishwasher currently in use in the main kitchen showed the following:
* 11/16/22 at 9:25 a.m., Upon the completion of the rinse cycle, the plate simulator (a type of irreversible temperature registering device) indicated a food-contact surface temperature of 152.4 degrees F (Fahrenheit). The temperature display on the outside of the dishwasher showed 157 degrees F during the wash cycle and 128 F during the rinse cycle.
* 11/16/22 at 9:35 a.m., wash temperature 155 degrees F and rinse temperature 135 degrees F; and plate simulator 152.4 degrees F.
* 11/16/22 at 9:51 p.m., wash temperature 155 F and rinse temperature 135 degrees F; plate simulator 152.5 degrees F. The facility's plate

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F 812	Continued From page 26 simulator registered 153.3 degrees F. During an interview on 11/16/22 at 10:00 a.m., an administrative staff (#4) and two dietary administrative staff (#6 and #7) agreed the dishwasher temperatures were a concern and the facility immediately implemented to paper and plasticware and the three-compartment sink method for dishwashing, rinsing, and sanitizing until the facility could resolve the issue. An administrative staff member (#7) demonstrated the correct use of the three-compartment sink method.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national	F 880		12/23/22

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F 880	Continued From page 27 standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 28 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 review of facility policy and staff interview, the facility failed to complete a water risk assessment for 1 of 1 year reviewed (2022). Failure to conduct the water risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system placed staff, residents, and visitors at risk of developing Legionella and other opportunistic infections. Findings include: Review of the facility policy titled "Bethel Lutheran Home Water Management Policy" occurred on 11/17/22. This policy, dated October 2022, stated, ". . . A risk assessment will be conducted . . . annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. . . . Data to be used for completing the risk assessment may include, but are not limited to . . . Legionella environmental assessment . . . Based on the risk assessment, control points will be identified. . . . The effectiveness of the water management program shall be evaluated no less than annually. . . ." Upon request on 11/17/22, the facility failed to provide a completed risk assessment for Legionella and other opportunistic waterborne pathogens as per the water management policy.	F 880	1. Corrective action: The facility will implement an appropriate risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. The infection preventionist (IP) in conjunction with applicable interdisciplinary team (IDT) members shall identify and implement a system to ensure for: control measures to be applied to address potential hazards at each control point. The IP, staff development coordinator (SDC), or designee, in conjunction with applicable IDT members, will: Educate on the correct procedure for implementation of water management activities to reduce the risk of Legionella and other opportunistic pathogens. 2. Identification of Others: The IP in conjunction with the applicable IDT members will review legionella guidelines from the CDC and/or other nationally accepted standards and develop action plans to address any newly identified water service changes. 3. System Changes: On or before 12/23/2022 the facility shall	

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F 880	Continued From page 29 During an interview on 11/17/22 at 10:36 a.m., administrative staff member (#4) confirmed the facility failed to complete the Legionella environmental assessment.	F 880	complete the following actions: The IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: Failure to implement the facility's water management program/risk assessment. The IP or suitable designee will ensure the following: a. Review and/or revise the facility policy on Water Management Program. b. Develop, implement, and complete a facility wide water system risk assessment. c. Educate all staff, including agency staff, on the principles of an effective water management program, including how Legionella and other water-borne pathogens grow and spread. 4. Monitoring: Weekly for no less than 12 weeks, the IP and/or applicable IDT members will conduct on-going monitoring to ensure, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include, but not limited to control measures, risk areas, and issues identified. 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	

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F 880	Continued From page 30	F 880	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: 12/23/2022	