STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355066	A. BUILDING _____ B. WING _____	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WISHEK LIVING CENTER	**400 S 4TH ST WISHEK, ND 58495**

(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 started on 12/13/21and concluded on 12/15/21.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623		1/18/22

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

Electronically Signed | 01/12/2022

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F 623	Continued From page 1 allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and	F 623		

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F 623	Continued From page 2 advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or their representative and/or the State Long Term Care Ombudsman written notice of transfer for 2 of 5 residents (Resident #35 and #37) with a recent hospital transfer. Failure to provide a notice of transfer does not allow the resident and/or their representative to make informed decisions regarding their rights or inform the Ombudsman of the transfer. Finding include: Review of the facility policy titled "GUIDE FOR IMPLEMENTATION OF TRANSFER OR	F 623	F623 1. Corrective Action: Regarding residents #35 and #37, protocol regarding the Notice of Transfer for Hospitalization form was reviewed with social services that a written copy of this form must be provided to the resident/their representative and to the State Ombudsman. 2. Identification of Others: All residents being transferred or discharged from the facility are potentially affected by this deficient practice. 3. System Changes: Current policy will be reviewed with social	

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F 623	Continued From page 3 DISCHARGE REQUIREMENTS" occurred on 12/15/21. This policy, revised December 2016, stated, ". . . The original notice must be given to the resident, with a copy given to the resident's representative(s) . . . A copy of the notice must be sent to a representative of the Office of the State Long-Term Care Ombudsman . . ." - Review of Resident #35's medical record occurred on all days of survey. The record identified a hospitalization October 30-November 3, 2021, and staff notified his representative per telephone of the transfer. - Review of Resident #37's medical record occurred on all days of survey. The record identified a hospitalization November 3-9, 2021, and staff notified his representative per telephone of the transfer. Resident #35 and #37's medical records lacked evidence the resident/his representative received a written notice/copy of the transfer form and/or lacked evidence the facility informed the State Ombudsman of the hospital transfers. During an interview on 12/15/21 at 12:23 p.m., a managerial nurse (#1) stated the social service staff is responsible for providing a written copy of the transfer form to the resident/their representative and to the State Ombudsman.	F 623	services staff and education will be provided that a copy of the transfer forms must be provided to the resident/his representative and the State Ombudsman for all hospital transfers. 4. Monitoring: QA nurse or DON will review charts of hospitalized residents weekly x4, monthly x2, and quarterly x3. If irregularities are noted, further education will be provided to that staff member immediately. Results will be reviewed quarterly by the QA committee. QA monitoring will begin 1/19/22. 5. Correction Date: Correction action/education will be completed by 1/18/22.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital	F 625		1/18/22

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F 625	Continued From page 4 or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) 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 provide a written copy of the bed hold notice to the resident or their representative upon transfer for 4 of 5 sampled residents (Resident #26, #35, #37 and #44) with a recent hospital transfer. Failure to provide a bed hold notice does not allow the resident or their representative to make informed choices regarding their rights. Findings include:	F 625	F625 1. Corrective Action: Regarding residents #26, #35, #37, and #44, reviewed and updated bed hold policy stating the need to notify the resident/representative of bed hold policy immediately or within 24 hours of transfers to hospital and document that this was completed. 2. Identification of Others: All residents have the potential to be affected by this deficient practice.	

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F 625	Continued From page 5 Review of the facility policy titled "BED HOLD POLICY AND PROCEDURE" occurred on 12/15/21. This policy, revised November 2016, stated, ". . . [facility] will advise and inform all residents and their responsible parties of its Bed-Hold Policy . . . each time a resident is admitted to a hospital . . . the resident or their representative is requested to immediately notify the Facility of their bed-hold decision. . . ." - Review of Resident #26's medical record occurred on all days of survey. The record identified a hospitalization on 12/11/21, and staff notified his representative per telephone of the transfer. - Review of Resident #35's medical record occurred on all days of survey. The record identified a hospitalization October 30-November 3, 2021, and staff notified his representative per telephone of the transfer. - Review of Resident #37's medical record occurred on all days of survey. The record identified a hospitalization November 3-9, 2021, and staff notified his representative per telephone of the transfer. - Review of Resident #44's medical record occurred on all days of survey. The record identified a hospitalization November 14-15, 2021, and staff notified her representative per telephone of the transfer. Resident #26, #35, #37 and #44's medical records lacked evidence the residents/their representatives received a written copy of the bed hold notice and lacked documentation the	F 625	3. System Changes: Education will be provided to nursing that the resident/their representative must be notified of the bed hold policy immediately upon discharge/transfer to the hospital, or within 24 hours. 4. Monitoring: QA nurse or DON will review charts of any residents out for over 24 hours weekly x4, monthly x2, and quarterly x3. If irregularities are noted, further education will be provided to that staff member immediately. Results will be reviewed quarterly by the QA committee. QA monitoring will begin 1/19/22. 5. Correction Date: Corrective action/education will be completed by 1/18/22.	

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F 625	Continued From page 6 residents/their representatives accepted or denied the bed hold. During an interview on 12/15/21 at 12:23 p.m., a managerial nurse (#1) stated the social service staff is responsible for providing a written copy of the bed hold notice to the resident/their representative and documenting in the medical record whether they accepted or denied the bed hold.	F 625		
F 684 SS=D	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: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 4 sampled residents (Resident #13 with a skin injury. Failure to identify a skin injury/condition in a timely manner resulted in delayed treatment and may result in worsening of the skin injury/condition. Findings include: Review of the facility policy titled "Guidelines for Skin Assessment and Prevention" occurred on 12/15/21. This policy, revised November 2013,	F 684	F 684 1. Corrective Action: Regarding resident # 13, administrative nurse #1 immediately assessed and dressed the wound as well as followed our policy regarding wound assessment and documentation upon being notified of the skin injury. 2. Identification of Others: All residents are potentially affected by this deficient practice. 3. System Changes: We will continue to follow our current policy regarding skin issues which states	1/18/22

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F 684	Continued From page 7 stated, ". . . all residents will be assessed for the risk of skin impairment using the Braden scale assessment form [a tool that predicts the risk for developing a pressure ulcer or skin injury]. This will be completed . . . quarterly. . . . Residents who score 15 or below [indicating mild to moderate risk] on the Braden Scale will have a full body skin inspection completed by the nurse weekly with their bath. Any findings will be documented in the residents' electronic medical record and interventions will be implemented per facility protocol. . . . All residents will have a skin check weekly with their bath to be completed by the bathe aid. Any skin issues will be reported immediately to the nurse for further assessment and treatment if needed. The nurse will document the findings in the electronic medical record . . . CNA's [certified nurse aides] will inspect the resident's skin condition with all cares. Any adverse findings are reported to the nurse immediately. . ." Review of Resident #13's medical record occurred on all days of survey. A physician's order, dated 10/12/18, stated, "Weekly skin assessments due to Braden score of 14". The record showed Resident #13 received weekly baths. Observation on 12/14/21 at 9:26 a.m. showed a circular scab on the top of Resident #13's right great toe. Resident #13's medical record lacked evidence of a report or documentation of a right great toe skin injury and/or treatment. During an interview on 12/14/21 at 2:29 p.m., a	F 684	that staff are to report to a nurse any skin issues that are noted. We will also continue to follow our policy that states a Braden Risk Assessment will be completed and any resident scoring below 15 will be placed on a weekly skin check to be done by the nurse. Will educate staff regarding our current policies on skin issues and proper reporting at the next nurse and CNA meetings. Nurses meeting is scheduled for 1/17/22 and CNA meeting is scheduled for 1/18/22. 4. Monitoring: QA nurse or DON will complete a random skin inspection on 2 residents weekly x4, monthly x2 and quarterly x3. If irregularities are noted, further education will be provided to that staff member immediately. Results will be reviewed quarterly by the QA committee. QA monitoring will begin 1/19/22. 5. Correction Date: Corrective action/education will be complete by 1/18/22	

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F 684	Continued From page 8 managerial nurse (#1) stated he/she was not aware of a skin injury to Resident #13's right great toe and performed an assessment. At 3:09 p.m., the managerial nurse (#1) confirmed a skin injury/scab present on Resident #13's toe. The facility staff failed to identify and/or provide treatment for Resident #13's right great toe skin injury/condition.	F 684		
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 §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	F 761		1/18/22

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F 761	Continued From page 9 by: MEDICATION STORAGE 1. Based on observation, review of professional reference, and staff interview, the facility failed to store all medications in a secure manner in 1 of 3 medication carts (East). Failure to store all medications securely may result in unauthorized access to medications and/or medication errors. Findings include: Review of the professional nursing procedure reference, ". . . Lippincott's Nursing procedures, sixth edition, pages 3-4, ". . . verify the medication is being administered at the proper time . . . to reduce the risk of medication errors . . . never return unwrapped medications to containers . . . instead, dispose of them and return to pharmacy . . ." Observation on 12/15/21 at 08:41 a.m., showed an unlabeled medication in a cup in the top drawer of the East medication cart. The medication aide (#11) stated she removed the medication from the medication cartridge for Resident (#3) at an unscheduled time and stated she planned to dispense the medication to the resident later. During an interview on 12/15/21 at 11:15 a.m., an administrative nurse (#1) stated the medication aide (#11), failed to follow acceptable practices for administering and storing medications. EXPIRED MEDICATIONS	F 761	F 761 Expired Medications 1. Corrective Action: Regarding all residents affected in this deficient practice, all medications were checked upon notice of the expired medication and all expired medications were removed from the area and placed in the box to be destroyed. 2. Identification of Others: All residents are potentially affected by this deficient practice. 3. System Changes: A new sign off sheet has been made and placed in the medication room for the nurse to sign off weekly that all medications were checked. We will also re-educate the nurses at the next nurses meeting scheduled for 1/17/22. 4. Monitoring: QA nurse or DON will check at least 10 medications for expiration dates weekly x4, monthly x2, and quarterly x3. If irregularities are noted, further education will be provided to that staff member immediately. Results will be reviewed quarterly by the QA committee. QA monitoring will begin 1/19/22. 5. Correction Date: Corrective action/education will be completed by 1/18/22. Medication Storage 1. Corrective Action: Regarding resident #3, the medication was immediately destroyed and a new medication was taken from the cartridge	

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F 761	Continued From page 10 2. Based on observation, review of facility policy, and staff interview, the facility failed to properly store medications in 1 of 1 medication storage areas. Failure to discard expired medications increases the risk of receiving outdated medications with reduced efficacy. Finding include: Review of the policy titled "DISPOSITION OF MEDICATIONS" occurred on 12/15/21. This undated policy stated, ". . . The consulting pharmacist, Director of Nursing/RN (registered nurse) in charge of key are responsible for the proper disposal of drugs no longer eligible for use, such as those that have expired . . . all expired narcotics are to be recorded on a Drug destruction Log . . ." Review of the double locked narcotic cabinet in the medication storage room occurred on 12/15/21 at 10:30 a.m. with two nurses, (#12 and #13). Observation showed 30-1 mg (milligram) tablets of Ativan (an antianxiety medication) with an expiration date of 10/31/21 and 30-5/325 mg tablets of Hydrocodone (a narcotic) with an expiration date of 11/03/21. During an interview on 12/15/21 at 11:15 a.m., an administrative nurse (#1) agreed facility staff should have destroyed the expired medications.	F 761	at the properly scheduled time of administration. 2. Identification of Others: All residents are potentially affected by this deficient practice. 3. System Changes: Standards of practice for medication administration will be reviewed at the nurse/CMA meeting which is scheduled for 1/17/22. 4. Monitoring: QA nurse or DON will check medication carts of medications being improperly stored weekly x4, monthly x2, and quarterly x3. If irregularities are noted, further education will be provided to that staff member immediately. Results will be reviewed quarterly by the QA committee. QA monitoring will begin 1/19/22. 5. Correction Date: Corrective action/education will be completed by 1/18/22.	
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of	F 803		1/18/22

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F 803	Continued From page 11 residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility menus and staff interview, the facility failed to serve food according to prepared menus during 1 of 1 observation of tray line (noon meal on 12/14/21). Failure to serve food according to the serving size on the menu has the potential to place residents at risk for inadequate nutrition and unplanned weight loss/gain. Findings include: Observation of the noon meal tray-line on 12/14/21 showed the following portion sizes served to residents on a regular diet:	F 803	F 803 1. Corrective Action: Regarding all residents affected in this deficient practice, proper serving sizes have been reviewed and a new policy has been created which includes use of new colored scoops that correspond with a color coded chart that demonstrates the correct serving sizes, according to color. Color coding will also match color codes on resident dietary table cards. 2. Identification of Others: All residents have the potential to be affected by this deficient practice.	

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	355066	A. BUILDING _____ B. WING _____	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WISHEK LIVING CENTER	400 S 4TH ST WISHEK, ND 58495

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F 803	Continued From page 12 Beef Tips: 4-ounce ladle Fried Potatoes: #16 scoop (1/4 cup) Cheesy Beans: 3-ounce ladle (3/8 cup) Review of the menu identified the following portion sizes for a regular diet: Beef Tips: 3 ounces Fried Potatoes: 1/2 cup Cheesy Beans: 1/2 cup During an interview on 12/15/21 at 10:37 a.m., two administrative dietary staff members (#3 and #4) confirmed staff should follow the menu for correct serving sizes.	F 803	3. System Changes: Colored scoop size chart will be placed next to the serving line along with the menu which lists the portion size needed for that meal. Education was provided to dietary staff on how to use the color coded chart and proper portion sizes on 1/5/22. Scoop size procedure was also added to orientation process for new employees. 4. Monitoring: Dietary manager, QA nurse, or designee will observe a meal administration weekly x4, monthly x2, and quarterly x3. If irregularities are noted, further education will be provided to that staff member immediately. Results will be reviewed quarterly by the QA committee. QA monitoring will begin 1/19/22 5. Correction Date: Corrective action will be completed by 1/18/22	
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:	F 880		1/18/22

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F 880	Continued From page 13 §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 (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	F 880		

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F 880	Continued From page 14 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 ensure staff followed standard infection control practices for 3 of 9 sampled residents (Resident #2, #6, and #45) observed transferred with a mechanical lift and for 5 of 6 fans observed in the kitchen. Failure to follow standard infection control practices related to cleaning mechanical lifts and cleaning of fans has the potential to spread infections within the facility. Findings include: MECHANICAL LIFTS Review of the facility policy titled "Cleaning and Disinfection of Resident-Care Equipment" occurred on 12/15/21. This policy, implemented 01/26/20, stated, ". . . Multiple-resident use equipment shall be cleaned and disinfected after each use. . . ."	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of z483.80 for the affected residents identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff are disinfecting equipment between multiple residents. (2) Ensuring staff are cleaning all fans/grates in the kitchen according to the cleaning schedule. The DON, IP, in conjunction with applicable IDT members, will: (1) Educate staff when to disinfect	

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F 880	Continued From page 15 - Observation on 12/14/21 at 10:35 a.m. showed two CNAs (#5 and #6) transferred Resident #6 into the wheelchair utilizing a Hoyer lift (full body mechanical lift). The CNAs (#5 and #6) failed to sanitize the lift prior to exiting the room. - Observation on 12/15/21 at 1:53 p.m. showed two CNAs (#9 and #10) transferred Resident #45 into the wheelchair utilizing a Hoyer lift. The CNAs (#9 and #10) failed to sanitize the lift prior to exiting the room and pushing it into the hallway. - Observation on 12/15/21 at 2:06 p.m. showed a CNA (#10) transferred Resident #2 into the wheelchair utilizing a stand lift. The CNA (#10) failed to sanitize the lift prior to exiting the room, pushing it into the hallway, and entering another resident's room with the same lift. FANS Observation in the kitchen on 12/15/21 at 10:30 a.m. showed an accumulation of dust/dirt on the fan blades and grates on the following: * One fan above the three-compartment. * Two fans in the dish machine room. * One fan above a counter in the kitchen. * One fan below a reach-in cooler in the food preparation area. During an interview on 10/15/21 at 10:45 a.m., two administrative dietary staff members (#3 and #4) stated staff are expected to clean the fans weekly.	F 880	equipment between use with multiple residents. (2) Educate staff to clean all fans/grates in the kitchen according to the cleaning schedule. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 01/18/2022 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to disinfect equipment between use with multiple residents. b. Failure to clean the fans/grates in the kitchen according to the cleaning schedule. (2) The DON and IP in conjunction with applicable IDT members will ensure the following: a. Educate all staff on the importance of disinfecting equipment when used with multiple residents b. Educate all staff on the importance of	

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F 880	Continued From page 16	F 880	cleaning fans/grates in the kitchen according to the cleaning schedule so that dirt does not blow onto food and/or clean dishes. 4. Monitoring (1) DON, IP, or applicable IDT member will observe staff disinfecting equipment when used with multiple residents weekly x4, monthly x2, and quarterly x3. If irregularities are noted, further education will be completed with that staff member immediately. (2) DON, IP, or applicable IDT member shall do onsite inspection of fans/grates in the kitchen to ensure cleaning schedule is being followed. If irregularities are noted, further education will be completed with that staff member immediately. Results will be reviewed quarterly by the QA committee. QA monitoring will begin 1/19/22 5.Correction Date Corrective action will be complete and in place by 1/18/22	