DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 3, 2023

Administrator
Sterling Park Health Care Center
142 North First Street
Waite Park, MN 56387

Re: Reinspection Results
Event ID: 24BN12

Dear Administrator:

On September 19, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 9, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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October 3, 2023

Administrator
Sterling Park Health Care Center
142 North First Street
Waite Park, MN 56387

RE: CCN: 245375
Cycle Start Date: August 9, 2023

Dear Administrator:

On September 19, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245375	A. BUILDING: _____ B. WING _____	8/9/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK HEALTH CARE CENTER	**142 NORTH FIRST STREET WAITE PARK, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 851	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to submit complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data, during 1 of 1 quarter reviewed (Quarter 2), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include:

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245375	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 8/9/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK HEALTH CARE CENTER	**142 NORTH FIRST STREET WAITE PARK, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 851	Continued From Page 1 Review of the Payroll Based Journal (PBJ) Casper Report 1705D identified the following dates triggered for review: 1/28/23, 1/29/23, 2/4/23, 2/12/23, 2/18/23, 2/19/23, 2/24/23, 2/25/23, 2/26/23, 3/1/23, 3/3/23, 3/4/23, 3/7/23, 3/11/23, 3/12/23, 3/17/23, 3/18/23, 3/19/23, 3/27/23, and 3/30/23 for failure to have licensed nurse coverage 24 hours per day. Review of applicable nursing staff's timecards on the above-mentioned dates identified licensed nursing staff had worked 24 hours each day, therefore the data submitted in the PBJ to CMS was inaccurate. Interview with the Executive Director (ED) on 8/9/23 identified due to nursing schedules of 12 hour shifts with a half hour break automatically removed from the employee shift it appears the nurse only was working 11.5 hours, therefore data submitted through PBJ specifications established by CMS was inaccurate. There was no policy related to PBJ entries available by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING _____ B. WING _____	C 08/09/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/7/23 through 8/9/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/7/23 through 8/9/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54388966C (MN00091535). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		9/8/23

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

Electronically Signed | 09/05/2023

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 880	Continued From page 1 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 2 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control practices regarding disinfection of mechanical Hoyer lifts for 3 of 6 residents (R10, R12 and R22) who utilized a multiple-resident use lift. R10's quarterly Minimum Data Set (MDS) dated 5/31/2023, identified that R10 was a total assist of two staff with transfers and required the use of a total body mechanical lift.	F 880	1. In continuing compliance with F 880, Infection Control. Sterling Park Senior Living will ensure that all multi-use resident lifting equipment is cleaned/disinfected between each resident use. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated by 9/1/2023 on the proper procedure for cleaning/disinfecting resident lifts.	

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F 880	Continued From page 3 R12's quarterly MDS dated 6/15/2023, identified that R12 was an extensive assist of two staff with transfers and required the use of a total body mechanical lift. R22's quarterly MDS dated 6/8/2023, identified that R22 was an extensive assist of two staff with transfers and required the use of a total body mechanical lift. During observation on 8/8/23 at 10:47 a.m., nursing assistant (NA)-A brought a mechanical Hoyer lift into R22's room to transfer R22 from wheelchair to commode. After assisting R22, NA-A brought mechanical Hoyer lift out into hallway and failed to disinfect the lift. NA-A then took lift into R10 and R12's room. R10 and R12 were assisted from their beds to their wheelchairs with assistance of the mechanical Hoyer lift. NA-A brought lift out to the hallway and failed to once again disinfect the mechanical Hoyer lift with sanitizing wipes before leaving hallway. On 8/8/23, at 10:57 a.m., the container of gray Sani-wipes, that was located on mechanical Hoyer lift, was found to have the cover off the container and the wipes that were present in the container were completely dry. When interviewed on 8/8/23 at 11:08 a.m., NA-A stated that the mechanical Hoyer lifts are disinfected every night with a cloth and a spray, but that there are also wipes available. NA-A then stated that they use the gray top Sani-wipes to wipe down the lift in-between residents. NA-A stated that she did not use the wipes, located on the lift, to disinfect lift in between the three residents. NA-A confirmed that the container of	F 880	3. The Director of Nursing or designee will audit each shift weekly x 4 weeks for compliance for lift cleaning/disinfecting. 4. As part of Sterling Park Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community s QA Process.	

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F 880	Continued From page 4 wipes, located on lift, were dry. NA-A took the container of dry wipes off the lift and stated that she was going to go and get more before they transfer anyone else. When interviewed on 8/8/23 at 11:35 a.m., assistant director of nursing (ADON) stated the process and expectation is to disinfect the mechanical lifts between each resident use. Staff are to use the Sani-wipes, that are present on each lift, to disinfect lift. ADON stated that the disinfection of the lifts is important for standard and transmission-based precautions and primarily infection control, to prevent the spread of infection. The Infection Control Equipment Cleaning/Disinfecting policy dated 10/19/22, identified the multiple us items will be cleaned and disinfected between each resident use: mechanical lifts.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative	F 883		9/8/23

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F 883	Continued From page 5 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F 883		

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F 883	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R13, R24 and R31) were offered or received the pneumococcal vaccine (PCV20) in accordance with the Center for Disease Control (CDC) recommendations. Findings include: The CDC's PneumoRecs VaxAdvisor identified: -based on shared clinical decision-making, decide whether to administer one dose of PCV20 at least 5 years after the last pneumococcal vaccine dose. Regardless of whether PCV20 is administered, their pneumococcal vaccinations are complete. The CDC's Pneumococcal vaccine timing for adults identified: -together, with the patient, vaccine providers may choose to administer PCV20 to adults 65 years and older who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSC23 at or after the age of 65 years old. R13's face sheet, identified she was 70 years old and admitted in August 2021. R13 had no allergies to vaccines or contraindications to vaccine listed. R13's immunization report, identified R13 had previously received the PCV23 on 10/3/2018 and the PCV13 on 1/2/2018. R13's medical record lacked evidence the recommended pneumococcal (PCV20) vaccination was offered or received.	F 883	1. In continuing compliance with F 883, Influenza and Pneumococcal Vaccines Sterling Park Senior Living has offered the PCV20 to R13, R24, and R31 and completed and audit on all other residents for eligibility for PCV20 on 8/28/2023. 2. To correct the deficiency and to ensure the problem does not recur all Nurses were educated by 9/7/2023 on the eligibility requirements for PCV20. 3. The Director of Nursing or designee will audit all new residents weekly for 4 weeks to ensure they are offered PCV20 as appropriate. 4. As part of Sterling Park Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community s QA Process.	

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F 883	Continued From page 7 R24's face sheet, identified she was 80 years old and admitted in August 2022. R24 had no allergies to vaccines or contraindications to vaccine listed. R24's immunization report, identified R24 had previously received the PCV23 on 9/15/2010 and the PCV13 on 11/18/2015. R24's medical record lacked evidence the recommended pneumococcal (PCV20) vaccination was offered or received. R31's face sheet, identified she was 74 years old and admitted in July 2023. R31 had no allergies to vaccines or contraindications to vaccine listed. R31's immunization report, identified R31 had previously received the PCV23 on 12/3/2012 and the PCV13 on 8/2/2018. R31's medical record lacked evidence the recommended pneumococcal (PCV20) vaccination was offered or received. When interviewed on 8/9/23 at 11:36 a.m., infection preventionist (IP) stated when a resident is admitted to the facility, they go through an admission event, where the immunization record is reviewed. If resident is eligible for a vaccine, the physician would be notified to get an order and once order is received, order would be entered into the electronic health record. IP stated R4, R17, R24 and R35 were not offered the PCV20. The Pneumococcal vaccine policy dated 10/19/2022, identified that all resident's will be	F 883		

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F 883	Continued From page 8 provided the opportunity and encourage to receive the pneumococcal vaccinations. On admission each resident will be questions regarding history of receiving the pneumococcal vaccinations. Each resident will be educated and offered the pneumococcal vaccine if they have never had the vaccine.	F 883		

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	00643	A. BUILDING: _____ B. WING _____	08/09/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/7/2023-8/9/2023, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H54388966C (MN00091535). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00643	A. BUILDING: _____ B. WING _____	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK HEALTH CARE CENTER	142 NORTH FIRST STREET WAITE PARK, MN 56387

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's	21426		9/19/23

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21426	Continued From page 3 Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 6 sampled employees received the required two-step tuberculin skin test (TST), and it was given timely. Findings include: Community Life (CL)-A record identified a hire date of 2/7/23. CL-A's record showed that the second TST was not administered within the required 21 days. Second TST was administered 31 days after administration of first TST. When interviewed on 8/9/23 at 11:36 a.m., assistant director of nursing (ADON) stated that employee's tuberculin (TB) screening is completed on hire, and TST Step 1 would be administered on the date of hire. The new employee would then receive TST Step 2, 10 -14 days after administration of first TST but no more than 21 days, unless there is a national shortage or other concerns. ADON stated that the	21426	1. The facility has completed an audit of all staff TB's to ensure compliance on 9/7/2023. Any staff found to have a TB out of compliance will re-start the 2 step process or complete a 1 step blood test alternative. 2. Education was completed with all nurses regarding the appropriate time frame for administering the 2 step TB by 9/7/2023. 3. DON and/or Designee will complete weekly audits for 8 weeks of all new hire employees for TB compliance.	

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21426	Continued From page 4 tuberculin screening an/or test is important to verify that no tuberculosis enters the facility as there are high-risk residents residing in facility. Additionally, ADON confirmed that E-1's second step was not administered in the correct timeframe. The TB Employee Screening policy dated 10/19/23, identified that all staff shall receive baseline TB screening upon hire. Consisting of two components: a. completing questionnaire for current symptoms. b. using a 2-step TST or a single IGRA to test for infection with M. tuberculosis. The tuberculosis screening for healthcare workers dated 5/24/22, directed that Step 1 be given and read prior to employment and that step two can be given after beginning employment and must be given within 7-14 days after the first test is administered. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring.	21426		

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21426	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21426		