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GOOD SAMARITAN SOCIETY - CHEYENNE COUNTY	820 S DENISON STREET ST FRANCIS, KS 67756

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigations #133812 and #133728.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		

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

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from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 25 residents. The sampled included 14 residents. Based on observation, record review and interview, the facility failed to promote dignity during dining services for 3 residents. (#15, #21, #125)

Findings included:

- On 10/30/18 at 11:16 AM, observation during the noon meal revealed Nurse Aide N assisted Resident #21 to eat while standing over him/her and giving the resident bites of food. Observation revealed Nurse Aide N then went around the same table and stood over Resident #125 and assisted him/her with his/her meal.

On 10/30/18 at 12:29 PM, Dietary Staff BB verified the above observation and stated staff should sit down when assisting the residents with their meals.

On 10/30/18 at 5:00 PM, Administrative Nurse D stated staff should sit at the same height as the resident, when assisting them with meals.

The facility's 9/2017 Dining Service Standards policy documented residents should receive assistance from employees in a dignified manner.

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The facility's 1/2007 Resident Rights policy documented residents had a right to a dignified existence, self determination, and communication, with and access to, persons and services inside and outside the facility.

The facility failed to promote dignity for Resident #21 and Resident #125, when staff stood over them, while assisting them to eat, placing them at risk for an undignified experience.

- On 10/30/18 at 12:19 PM, Dietary Staff CC yelled across the dining room, to staff on the opposite side, "someone needs to come and assist Resident #15, because he/she needs to use the bathroom", while other residents were present.

On 11/5/18 at 1:11 PM, Administrative Nurse D stated when staff relay information to other staff regarding the resident's need for assistance with toileting, they should keep the information quiet, to promote dignity for the resident.

The facility's 9/2017 Dining Service Standards policy documented residents should receive assistance from employees in a dignified manner.

The facility's 1/2007 Resident Rights policy documented residents had a right to a dignified existence, self determination, and communication, with and access to, persons and services inside and outside the facility.

The facility failed to promote dignity for Resident #15, when staff yelled across the dining room private information, in settings where others could overhear, placing the resident at risk for embarrassment.

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 25 residents. Based on observation, interview, and record review, the facility failed to provide a safe environment, free of accident hazards, for 3 of 25 residents, identified by the facility as cognitively impaired, independently mobile. Findings included: - On 10/30/18 at 8:24 AM, observation revealed the stove top in the beauty shop/activity area was operable and accessible. Further observation revealed no staff or residents in the area. On 10/30/18 at 10:15 AM, Administrative Nurse D reported the facility had 3 cognitively impaired, independently mobile residents who resided the facility. On 11/5/18 at 8:25 AM, Administrative Staff A verified the observation and stated he/she was unsure the last time the staff used the stove. The facility's 4/2016 policy for Safety Practices for Activity Services instructed staff to ensure that stoves/ranges are disconnected from electrical	F 689		

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power by a keyed safety switch or circuit breaker when not in use by activity staff members.

The facility failed to disconnect the electric stove in the activity area when not in use to ensure a safe, hazard free environment for the 3 cognitively impaired, independently mobile residents who reside in the facility.

- On 10/30/18 at 8:46 AM, observation during initial tour revealed an unlocked, unsupervised, therapy room, with an unlocked cabinet above the sink, and a 160 count container of Sani cloth (disinfectant) wipes. The label documented the wipes cause moderate eye irritation, avoid contact with eyes, wash hands thoroughly with soap and water after handling, before eating, drinking, chewing gum, using tobacco, or using the toilet.

On 10/30/18 at 8:50 AM, Dietary Staff BB verified the finding above, stated the wipes should be locked up, and placed them in the locked housekeeping closet.

On 10/30/18 at 10:15 AM, Administrative Nurse D identified the facility had 3 cognitively impaired independently mobile residents who resided in the facility.

On 10/30/18 at 5:00 PM, Administrative Nurse D stated staff should keep the sani cloth wipes locked up.

The facility's March 2016 Procurement and Storage of Equipment, Products and Supplies policy documented the facility should ensure that all products (chemicals and disinfectants) are labeled and stored in a manner that eliminates

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F 689	Continued From page 5 risk of improper use, contamination, inhalation, skin contact or personal injury. The facility failed to ensure the environment remained as free of accident hazards as is possible, by leaving a container of sani wipes in an unlocked cabinet, placing the 3 cognitively impaired independent mobile resident's at risk for injury.	F 689		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able	F 726		

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to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:
The facility had a census 25 residents. The sample included 14 residents. Based on record review and interview the facility failed to conduct and/or implement nursing competencies required for residents' care needs, as identified through resident assessments and plan of care.

Findings included:

- The facility's assessment for the Nursing Service policy and procedure for Competency Validation Process of clinical skills, recorded this process was under review, and staff designee for nursing services competency validation would be completed by Administrative Nurse D, Administrative Nurse E, and Direct Care Staff M.

On 11/5/18 at at 12:16 PM, Administrative Nurse D stated the facility's competency validation process was an area of weakness and had only conducted competencies after a recent incident of which the facility reported to the state agency. Administrative Nurse D stated the facility recently hired new personnel and planned to implement the competency validation process.

The facility's Competency Validation Process policy, dated 11/2017, documented the competency process will be completed annually at a minimum, and more often when training needs are identified. The facility will review past survey reports, resident assessments, plans of care, the diagnosis/acuity of the residents in the

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F 726	Continued From page 7 building, and skills of both licensed and non-licensed employees, to create a list of clinical skills specific to the facility. By using analysis in the learning and development policies and procedures, the competency validation process will be based in the identified clinical skill training issue, type of training need, priority of risk, and measurable outcome. The process will help determine the specific clinical skills that need to have competency performance validation. The facility failed to implement a competency validation program placing the residents who reside in the facility at risk of receiving improper specific clinical skilled care and safety needs.	F 726		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		

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minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 24 residents. The sample included 14 residents, of which 5 were reviewed for unnecessary drug use. Based on observation, interview, and record review the facility failed to follow up on the consultant pharmacist's recommendations to obtain a risk versus benefit rationale for the continued use of Risperdal (antipsychotic medication), and Zoloft (antidepressant medication-class of medications used to treat mood disorders and relieve symptoms of depression) for 1 of 5 sampled residents. (#20)

Findings included:

- Resident #20's medical record documented the facility admitted him/her on 5/24/18.

The (POS) Physician Order Sheet, dated 9/18/18, documented diagnoses of anxiety disorder (a

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mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), insomnia (inability to sleep), restlessness, and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).

The significant change (MDS) Minimum Data Set assessment, dated 9/17/18, documented the resident had severe cognitive impairment with a (BIMS) Brief Interview for Mental Status score of 7. The MDS documented the resident rejected care 1-3 days of the look back period, required limited staff assistance with eating, and extensive staff assistance with all other (ADLs) activities of daily living. The MDS documented the resident received antipsychotic, antidepressant, antibiotic, diuretic and opioid medications. The MDS documented the resident received antipsychotics on a routine basis, no (GDR) Gradual Dose Reduction, and the physician had not documented a GDR as clinically contraindicated.

The 9/17/18 (CAA) Care Area Assessment summary for cognition documented the resident's cognition score decreased from a 12 to a 7, he/she became confused and at times thought he/she needed to go home to take care of a disabled family member.

The CAA for antipsychotic use documented the resident received antipsychotic and antidepressant medications and could cause a potential for falls or increase in sleepiness.

The 8/22/18, revised 9/25/18, care plan directed

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staff to cue, reorient and supervise the resident as needed, due to the resident became very confused during late evening and night time hours. The care plan directed staff to monitor, document, and report to the health care provider, any changes in cognitive function, and to educate the resident and family about risks, benefits, potential side effects, and/or toxic symptoms of medications.

The physician's orders directed staff to administer the following medications to the resident:
Risperdal, 0.5 (mg) milligrams, at bedtime, for restlessness and agitation, initiated 9/10/18.
Zoloft, 100 mg, every morning, for depression, initiated 5/26/18.

The facility's 9/10/18 fax to the physician requested a diagnosis for the use of Risperdal. The physician wrote a diagnosis of insomnia or agitation.

The facility's consultant pharmacist reviews documented the following:
9/10/18, recommend a review of Zoloft, and the physician responded: no change, resident doing well on the current regimen.
10/18/18, inappropriate diagnosis for Risperdal use, and the physician responded: no change, resident doing well on current regimen.
The physician's response to the pharmacist's recommendations lacked a rationale or reasonable explanation for the continued use of the psychoactive medications.

On 10/30/18 at 5:00 PM, observation revealed the resident sat in his/her wheelchair at a dining table with a black immobilizer boot on his/her left foot. The resident stated he/she fell about 3-4 weeks

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F 756	Continued From page 11 ago. On 10/31/18 at 2:20 PM, Nurse M stated the resident became agitated during the evening shift, and at times refused cares. Nurse M stated he/she was unsure if the resident had insomnia at night, but in the morning, the resident refused medication at times. On 11/5/18 at 1:15 PM, Administrative Nurse D verified the staff had not followed up with the physician regarding the pharmacist recommendations for a reasonable explanation of why the risks outweighed the benefits of the physician ordered medications. The facility's 9/2012 policy for Pharmaceutical Services documented the licensed pharmacist would provide consultation on all aspects of pharmacy services. The policy recorded the pharmacist would report any irregularities to the attending physician or the director of nursing services and those reports must be acted upon and follow up documentation retained. The facility failed to follow up on the consultant pharmacist's recommendations to obtain a risk versus benefit rationale for Resident #20's continued use of Risperdal and Zoloft, placing the resident at risk for adverse side effects related to the use of psychotropic drugs.	F 756		
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-	F 757		

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F 757	Continued From page 12 §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 §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: The facility had a census of 24 residents. The sample included 14 residents, of which 5 were reviewed for use of unnecessary medications. Based on observation, interview, and record review the facility failed to ensure 1 of 5 sampled resident's was free from unnecessary drug use. Resident #20 received Risperdal (antipsychotic medication), and Zoloft (antidepressant medication-class of medications used to treat mood disorders and relieve symptoms of depression). Findings included: - Resident #20's medical record documented the facility admitted him/her on 5/24/18. The (POS) Physician Order Sheet, dated 9/18/18, documented diagnoses of anxiety disorder (a	F 757		

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mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), insomnia (inability to sleep), restlessness, and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).

The significant change (MDS) Minimum Data Set assessment, dated 9/17/18, documented the resident had severe cognitive impairment with a (BIMS) Brief Interview for Mental Status score of 7. The MDS documented the resident rejected care 1-3 days of the look back period, required limited staff assistance with eating, and extensive staff assistance with all other (ADLs) activities of daily living. The MDS documented the resident received antipsychotic, antidepressant, antibiotic, diuretic and opioid medications. The MDS documented the resident received antipsychotics on a routine basis, no (GDR) Gradual Dose Reduction, and the physician had not documented a GDR as clinically contraindicated.

The 9/17/18 (CAA) Care Area Assessment summary for cognition documented the resident's cognition score decreased from a 12 to a 7, he/she became confused and at times thought he/she needed to go home to take care of a disabled family member.

The CAA for antipsychotic use documented the resident received antipsychotic and antidepressant medications and could cause a potential for falls or increase in sleepiness.

The 8/22/18, revised 9/25/18, care plan directed

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staff to cue, reorient and supervise the resident as needed, due to the resident became very confused during late evening and night time hours. The care plan directed staff to monitor, document, and report to the health care provider, any changes in cognitive function, and to educate the resident and family about risks, benefits, potential side effects, and/or toxic symptoms of medications.

The physician's orders directed staff to administer the following medications to the resident:
Risperdal, 0.5 (mg) milligrams, at bedtime, for restlessness and agitation, initiated 9/10/18.
Zoloft, 100 mg, every morning, for depression, initiated 5/26/18.

The facility's 9/10/18 fax to the physician requested a diagnosis for the use of Risperdal. The physician wrote a diagnosis of insomnia or agitation.

The facility's consultant pharmacist reviews documented the following:
9/10/18, recommend a review of Zoloft, and the physician responded: no change, resident doing well on the current regimen.
10/18/18, inappropriate diagnosis for Risperdal use, and the physician responded: no change, resident doing well on current regimen.
The physician's response to the pharmacist's recommendations lacked a rationale or reasonable explanation for the continued use of the medications.

On 10/30/18 at 5:00 PM, observation revealed the resident sat in his/her wheelchair at a dining table with a black immobilizer boot on his/her left foot. The resident stated he/she fell about 3-4 weeks

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F 757	Continued From page 15 ago. On 10/31/18 at 2:20 PM, Nurse M stated the resident became agitated during the evening shift, and at times refused cares. Nurse M stated he/she was unsure if the resident had insomnia at night, but in the morning, the resident refused medication at times. On 11/5/18 at 1:15 PM, Administrative Nurse D verified the staff had not followed up with the physician regarding the resident's continued use of Zoloft and Risperdal. The facility's 6/2017 Psychotropic Medication policy documented each resident's drug regimen must be free from unnecessary drugs when used without adequate indications for its use. The facility failed to ensure Resident #20 was free from unnecessary drug use, placing the resident at risk for adverse side effects related to the use of the medications.	F 757		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: The facility had a census of 25 residents, of	F 804		

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which 2 residents received a pureed diet. Based on observation, record review and interview the facility failed to prepare food by methods that conserved the nutritive value for 2 of 2 residents with an ordered pureed textured diet.

Findings included:

- Observation of meal preparation for 2 pureed meals on 10/31/18 at 11:35 AM, revealed Dietary Staff DD spooned 10 (1/2 ounce) meatballs into a blender and added an unmeasured amount of tomato juice, then blended to the consistency of mashed potatoes. Dietary Staff DD retrieved a new blender container, spooned 1/2 cup of scalloped potatoes x 2 servings into the container, added an unmeasured amount of milk from a gallon a jug into the container, blended to consistency of mashed potatoes, placed in a small bowl and placed in the steam table. Dietary Staff DD took a clean blender container, placed 1/2 cup x 2 servings of cooked green beans into the container, then blended to consistency of mashed potatoes, spooned into a small bowl, and placed into the steam table. Dietary Staff DD verified he/she did not have a recipe to follow, and just slowly adds liquid to food items to make them the right consistency. When the surveyor questioned Dietary Staff DD about bread for the resident, he/she placed a slice of bread in a bowl and poured an unmeasured amount of milk over the bread.

On 10/31/18 at 11:55 AM, Dietary Manager EE stated the facility had no recipes for pureed items.

The facility's 12/2017 Texture-Altered Diets policy documented the pureed diets are prepared and plated to maximize the visual impact and dining

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F 804	Continued From page 17 experience. Special preparation techniques and recipes are used whenever possible, including puree food molds. The puree process is used as the standardized process for the preparation and service of pureed foods unless a standardized pureed recipe is available for the menu item. The facility failed to prepare pureed food by methods that conserved the nutritive value, for 2 residents who received a pureed textured diet, placing them at risk for not having their nutritional needs met.	F 804		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

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F 880	Continued From page 18 §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 infection. §483.80(f) Annual review.	F 880		

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The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

The facility had a census of 25 residents. The sampled included 14 residents. Based on observation, record review and interview, the facility failed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections, by not changing gloves during perineal care (cleansing the genitals and anal area) for 3 of 14 sampled residents (#1, #4, and #5), improper cleaning of contact isolation room for Resident #10, who had Clostridium Difficile (contagious bacteria characterized by foul smelling frequent bowel movements) and not wearing appropriate personal protective equipment while assisting Resident #10 with eating.

Findings included:

- On 10/30/18 at 12:23 PM, observation revealed Nurse Aide O sat in Resident #10's contact isolation room, in the resident's wheelchair, and not wearing a personal protective gown. Nurse Aide O assisted the resident to eat, walked around the resident's room and threw the resident's plate and silverware into the trash. Nurse Aide O washed his/her hands and left the resident's room.

On 10/31/18 at 9:03 AM, Nurse Aide Q entered Resident #4's room and Resident #4 was on a bed pan. Nurse Aide Q turned on the call light for assistance and Nurse Aide O entered Resident #4's room. Both staff applied gloves and Nurse Aide Q assisted the resident to turn to his/her left

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side and provided premoistened incontinent wipes to Nurse Aide O who provided perineal care to the resident. Nurse Aide O removed the bed pan and with the soiled gloves, opened a bag and retrieved a new incontinent brief. Nurse Aide O, with the same soiled gloves, assisted Nurse Aide Q to position the resident, applied the new brief, adjusted the resident's clothing and left leg splint, then positioned the resident to the center of the bed. Nurse Aide O, with the same soiled gloves, placed the resident's call light next to the resident, adjusted the head of the bed, bagged the trash and the bed pan, and removed his/her soiled gloves. Nurse Aide O then washed his/her hands.

On 10/31/18 at 9:03 AM, observation revealed Nurse Aide N obtained a new incontinent brief and premoistened incontinent wipes and told Resident #1 he/she was going to provide perineal care. Nurse Aide N provided perineal care and with the same soiled gloves, placed and fastened a new incontinent brief under Resident #1, and removed his/her soiled gloves.

On 10/31/18 at 10:58 AM, observation revealed Nurse Aide N assisted Resident #5 to the bathroom, applied gloves, pulled down the resident's pants and incontinent brief and Resident #5 sat down on the toilet. Nurse Aide N removed the resident's incontinent brief, which was slightly soiled with urine, threw it into the trash can, and removed his/her soiled gloves. Nurse Aide N gathered a new incontinent brief and premoistened incontinent wipes, hooked the new incontinent brief on the resident and placed the wipes on the back of the toilet. Nurse Aide N assisted the resident to stand up, provided perineal care, and with soiled gloves, assisted the

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resident to pull up his/her incontinent brief and pants and then removed the soiled gloves.

On 10/31/18 at 4:40 PM, Nurse Aide O and Nurse Aide P assisted Resident #5 to the bathroom and applied gloves. Nurse Aide O pulled down the resident's pants, removed the resident's incontinent brief, which was soiled with urine, threw it into the trash, and with soiled gloves, obtained a new incontinent brief and placed it on the resident. After removing his/her soiled gloves, Nurse Aide O applied a new pair of gloves. Nurse Aide O gathered premoistened incontinent wipes and both staff assisted the resident to stand up. Nurse Aide O provided perineal care to the resident, and with soiled gloves, assisted the resident to pull up his/her incontinent brief and pants, and adjusted the resident's shirt. Nurse Aide O then removed his/her soiled gloves, threw them into the trash, and washed his/her hands.

On 10/31/18 at 4:45 PM, Nurse Aide O verified he/she should have removed his/her soiled gloves after providing perineal care to the resident.

On 11/5/18 at 4:07 PM, Administrative Nurse D stated he/she expected staff to change gloves after providing perineal care for a resident.

The facility's Perineal care policy, dated 10/2017, instructed staff to removed soiled gloves after providing perineal care to the residents, use hand sanitizer or wash with soap and water to cleanse hands, and put on clean gloves to apply a clean pad and/or clothing.

The facility failed to provide a safe, sanitary, and comfortable environment to help prevent the

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development and transmission of infections, by not changing gloves during perineal cares and continued to provide care for 3 residents, #1, #4, and #5, placing the residents at risk for infection.

- On 11/1/18 at 11:45 AM, observation revealed Housekeeping Staff U cleaned Resident #10's bathroom, who's room was in isolation. Housekeeping Staff U sprayed the sink and toilet well with Steriplex Sporicide, waited 2 minutes, then used a moist cloth to wipe the Sporicide off the sink, with the same cloth, he/she wiped off the toilet seat, lid, and rim. The Steriplex Sporicide bottle stated a 5 minute dry time. Housekeeping Staff U placed the moist cloth in a bag.

On 11/5/18 at 1:15 PM, Administrative Nurse D verified the housekeeping staff should follow the Sporicide directions and wait five minutes to allow the disinfectant to work.

The facility's Clostridium Difficile policy, dated 10/2017, documented staff are to use gowns and gloves when entering the room, when providing care, and use an appropriate sporicidal solution for cleaning surfaces in the room.

The facility failed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections, by improperly cleaning the contact isolation bathroom and by not wearing appropriate personal protective equipment in the contact isolation room, placing the residents at risk for receiving an infection.