STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	08/13/2014

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WEDGEWOOD MANOR	804 MAIN ST W CAVALIER, ND 58220

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 08/11/14 and completed on 08/13/14, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review.	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F278 To ensure the MDS Assessment is coded correctly to provide an accurate assessment of Resident #2, #3, #4, #5, #6, and #7's turning/repositioning program and #2's toileting program and any other residents that may be affected: The MDS staff responsible for coding these portions of the MDS will attend a workshop on "Understanding Coding and Scheduling Requirements" at the Fall LTC Convention on 9/16/14 and 09/17/14 with a focus on the coding of the MDS 3.0 section by section which includes question M1200C on Turning and Repositioning Programs and question H0200 on Urinary Toileting Programs. Repositioning Programs for Resident #2, #3, #4, #5, #6, And #7 and all residents on a repositioning program will be reviewed to ensure their programs are individualized to specify interventions and frequency of the repositioning programs. Resident #2's toileting program will be reviewed and revised to meet individual needs. Care plan's for Resident # 2, 3, 4,5,6, and 7 will be reviewed and updated to address individual needs for repositioning and	09/17/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patti Johnson	Administrator	09/03/2014

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 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 6 of 9 sampled residents (Resident #2, #3, #4, #5, #6, and #7) coded with a turning/repositioning program and 1 of 1 sampled resident (Resident #2) coded for a toileting program. Failure to code portions of the MDS correctly does not provide an accurate assessment of a resident's current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, May 2013, stated the following: * Page H-6 (Urinary Toileting Program), stated, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated . . . A toileting program does not refer to: -simply tracking continence status, -changing pads or wet garments, and -random assistance with toileting or hygiene . . ." * Page M-38 stated, "M1200C Turning/Repositioning Program: The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [such as] reposition on side, pillows between knees) and frequency (e.g. every 2 hours). Progress notes, assessments, and other documentation (as	F 278	address changes to Resident #2's toileting plan. The MDS's for Resident #2, 3, 4,5, 6,and 7 will be corrected and resubmitted as per instructions identified in Chapter 5 of the Long Term Care Facility RAI User's Manual. Each resident's care plan will be reviewed by the Interdisciplinary Team quarterly, annually, with a hospital return, and any significant change in status review to ensure appropriate individualized repositioning and toileting programs. Monitoring of compliance of individualized repositioning programs for Resident #2, 3, 4, 5, 6, and 7 and Resident # 2's toileting program will also include a random sample of residents to ensure 20% of the facility population based on the current daily census of residents. QA monitoring will be completed weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues that are identified and immediate corrective action will occur. The DON or designee will submit a report of the monitoring results to the QA Coordinator during the scheduled monthly QA Meeting.	09/17/14 09/17/14 09/17/14

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F 278	Continued From page 2 dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention." - Review of Resident #2's medical record occurred on all days of survey. Observations showed Resident #3 continuously walked about the facility, both independently and with hand-held assistance from a staff member. The significant change MDS, dated 06/07/14, identified a toileting program and a turning/repositioning program. The Care Area Assessment (CAA), dated 06/13/14, stated, ". . . She requires extensive assistance with toileting and is frequently incontinent at this time. A bladder and bowel elimination evaluation pattern was put out and no improvement noted with prompted toileting. She is not always compliant to using the bathroom or accepting assistance. Then a check and change is done . . ." Resident #2's current care plan stated, "Elimination . . . Routine toileting program as allows . . . Bed Mobility: Independent . . . Skin . . . Monitor and que [sic] for repositioning q [every] 2 hrs [hours]. Staff to Encourage to shift positions as able. Frequently able to change positions independently . . ." Resident #2's "Repositioning Schedule every 2 hours" showed staff initialed the form every two hours even though observation and record review identified Resident #2 as independent. Resident #2's medical record failed to identify a specific and individualized toileting program and turning/repositioning program.	F 278		

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F 278	Continued From page 3 - Review of Resident #3's medical record occurred August 11-13, 2014. A significant change MDS, dated 08/01/14, identified the resident at risk for pressure sores, having a current pressure sore, and on a turning/repositioning program for skin and ulcer treatment. Review of the resident's "Repositioning Schedule every 2 hours" showed staff turned the resident every two hours but failed to identify which side the staff positioned the resident on as indicated on the form. - Review of Resident #4's medical record occurred August 11-13, 2014. A quarterly MDS, dated 07/13/14, identified the resident at risk for pressure sores and on a turning/repositioning program for skin and ulcer treatment. Review of the Resident #4's "Repositioning Schedule every 2 hours" showed facility staff failed to reposition the resident every two hours and when staff did reposition him, staff failed to identify the position (right side, left side, etc), as indicated on the form. - Review of Resident #7's medical record occurred 08/13/14. A quarterly MDS, dated 06/01/14, identified the resident at risk for pressure sores and on a turning/repositioning program for skin and ulcer treatment. The facility failed to provide evidence of a documented, individualized turning/repositioning program. - Review of Resident #5's medical record occurred August 11-13, 2014. A significant change MDS, dated 07/14/14, identified a turning/repositioning program for skin and ulcer treatment. Resident #5's current care plan stated, ". . . Skin . . . Reposition at least every 2 hours -	F 278		

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F 278	Continued From page 4 does self reposition . . ." The "Repositioning Schedule every 2 hours" lacked evidence staff implemented an individualized repositioning program for Resident #5. - Review of Resident #6's medical record occurred August 11-13, 2014. A significant change MDS, dated 07/11/14, identified a turning/repositioning program for skin and ulcer treatment. The current care plan stated, ". . . Skin . . . Reposition at least every 2 hours . . ." The medical record lacked evidence staff re-evaluated the current program for effectiveness. During an interview on the afternoon of 08/13/14, two MDS coordinators (#6 and #7) agreed the turning/repositioning programs for Resident #2, #3, #4, #5, #6, and #7 were not specific and individualized.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to follow professional standards of care related to indwelling catheters for 1 of 4 sampled residents (Resident #1) and 1 of 1 closed medical record reviewed (Resident #10). Failure to follow physician's orders related to changing the catheter monthly has the potential for urinary tract	F 281	F281 To ensure services provided or arranged by the facility meet professional standards of quality the facility will ensure physician orders are followed related to the catheterization of Resident #1 and any other residents that has an indwelling catheter in place that may be affected: The facility will hold an in-service on entering catheterization physician orders into the EMR and on the facility policy regarding catheterization will be given to Licensed Nursing Staff on 09/11/14. The facility will review all physician orders regarding	09/17/14

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F 281	Continued From page 5 infections (UTIs). Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 73-75, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." - Resident #1's medical record, reviewed on all days of survey, identified an admission date of 06/16/14 for rehabilitation services for a pelvic fracture. Diagnoses included urinary retention (indwelling catheter placed prior to admission), a current UTI, and history of a UTI (06/25/14). A physician's order stated, "CHANGE FOLEY [catheter] MONTHLY (EVERY 30 DAYS)". The medical record failed to identify facility staff changed Resident #1's foley catheter at anytime since her admission. - Resident #10's closed medical record, reviewed on 08/13/14, identified an admission date of 05/27/14. Diagnoses included muscle weakness and anxiety. A physician's order stated, "CHANGE FOLEY [catheter] MONTHLY (EVERY 30 DAYS)". The medical record identified facility changed the catheter on 07/20/14 (24 days after the physician's order stated to change the catheter). The facility removed Resident #10's catheter on 08/03/14 and she returned to her home on 08/04/14. During an interview on the afternoon of 08/13/14, an administrative nurse (#4) agreed the facility staff failed to follow physician's orders related to	F 281	catheterizations to ensure individualized orders are carried out. The facility will develop a plan monthly to review that catheterizations have been completed as per the individual resident's plan of care and physician order. QA monitoring will be completed on Resident #1 and any resident with an indwelling catheter by a designated RN weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues and immediate corrective action will occur. The RN or designees will submit a report of the monitoring results to the QA Coordinator during the scheduled monthly QA meeting.	09/17/14

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F 281	Continued From page 6 changing Resident #1 and #10's catheters monthly.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 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 necessary care and services to manage constipation for 1 of 1 sampled resident (Resident #2) who required as needed (PRN) medications for constipation. Failure to implement less invasive interventions to manage constipation may have resulted in this resident receiving unnecessary suppositories and enemas. Findings include: Review of the facility policy titled "Bowel Protocol" occurred on 08/13/14. This policy, dated May 2014, stated, ". . . For Residents prone to hard stools or Constipation Problems the following guidelines apply: . . . B. Nursing to initiate fiber juice. C. Refer to dietary manager or LRD [Licensed Registered Dietician] for further dietary interventions. D. If the above are unsuccessful, Standing orders	F 309	F309 To ensure that each resident receives and the facility provides the necessary care and services to manage constipation for Resident #2 and any of the other residents that are in the facility at risk for constipation and to provide less invasive interventions to manage constipation the facility will reassess Resident # 2's plan of care and make the necessary interventions to provide the least invasive measures to promote the highest practicable physical, mental, and social well-being. The facility will reeducate Nursing Staff and Dietary Managers on the facility bowel protocol on 09/11/14. Every resident of the facility will have their bowel programs reviewed on admission, quarterly, annually, with a hospital return or any significant change. The facility will assign a designated RN to review bowel programs monthly to ensure that individual resident needs are met and the facility Bowel Program Policy is followed. QA monitoring of Resident #2 and a random sample of 20% of the facility population based on the current daily census will occur weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year by the RN or designee. Any issues identified will be reported to the Administrator and immediate	09/17/14 09/17/14 09/17/14

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F 309	Continued From page 7 for bowel management will be followed on the evening of the second day without a BM [bowel movement]. The resident will be placed on the toilet the morning of the third day to empy [sic] the bowel & aid in establishing a normal bowel evacuation pattern. E. If standing orders is unsuccessful, the nurse will insert a suppository rectally in the morning of the third day . . ." The "Wedgewood Manor PRN Orders" stated, ". . . Bowel Management: 1) MOM [Milk of Magnesia] 30 milliliters oral daily as needed 2) Bisacodyl Supp [suppository] 10 milligrams Rectal daily as needed. 3) Fleets enema rectal daily as needed. 4) Senna S i-ii [one to two] oral as needed. 4) [sic] Follow facility bowel management protocol as needed for hard to manage constipation. . . ." Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included constipation. Daily medications for prevention of constipation included Miralax and Senna S. PRN medications included MOM, bisacodyl suppository, and fleets enema. Dietary interventions included a high fiber juice three times a day. Resident #2's current care plan identified a problem of constipation and stated, "Res [Resident] will have a normal BM at least every 3 days [for] 3 mos [months] . . . Nutrition: . . . High fiber juice 4oz [ounces] tid [three times a day] . . . crushed prunes tid . . ." Review of Resident #2's "Bowel Movement Roster" and Medication Administration Record (MAR) from May 01 to August 12, 2014 identified the following:	F 309	corrective action will occur. The RN or designee will submit a report of the monitoring results to the QA Coordinator during the scheduled monthly QA Meeting.	

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F 309	Continued From page 8 * Five times - no BM for two days and the facility administered a suppository with results. * No BM for three days and the facility administered a suppository with results. * No BM for one day and the facility administered both MOM and a suppository with results. * No BM for one day and the facility administered MOM without results. The resident went two more days without a BM and the facility administered a fleets enema with results. * Had a BM on 05/31/14 and the facility administered a suppository on 06/01/14 with results. * Had a BM on June 8th, 9th, and 10th and the facility administered a fleets enema on June 11th with results. The above occurrences showed the facility staff failed to attempt a less invasive intervention (MOM) prior to the administration of a suppository or fleets enema; failed to follow the facility policy as to when to administer a PRN medication; and administered a PRN medication even though Resident #2 had regular bowel movements. During an interview on the afternoon of 08/13/14, an administrative nurse (#4) agreed nursing staff did not follow the facility policy related to bowel management for Resident #2.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 To ensure the resident environment remains as free as possible from accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents to Resident #6 and any resident that utilizes a mechanical lift and has the potential to	

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F 323	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff used mechanical lifts appropriately for 1 of 2 sampled residents (Resident #6) observed transferring with a sit-to-stand lift. Failure to ensure staff used a mechanical lift appropriately placed Resident #6 at risk for falls and/or injury. Findings include: Review of the facility's policy titled "Policy on Safe Resident Lifting, Repositioning, and Transporting" occurred on the afternoon of 08/13/14. This undated policy stated, ". . . The resident's chart will indicate the need to use mechanical equipment or transfer aids during lifting or repositioning procedures. Staff are to report any changes in the ability of the resident to complete the transfer with their current orders or any pain noted during the transfer to their Charge nurse. . . ." Review of Resident #6's medical record occurred on August 11-13, 2014. Diagnoses included dementia, arthropathy (arthritis), and osteoarthrosis. The significant change Minimum Data Set (MDS), dated 07/11/14, identified severely impaired cognition and extensive assistance of two persons for transfers. The current care plan stated, " . . . Weight Bearing Restrictions . . . Bears weight poorly L) [left] leg stand aid with 2 assist - Hoyer [full body	F 323	be affected: The facility will review it's policy on "Safe Resident Lifting, Repositioning, and Transporting." Direct care staff will need to complete a return demonstration to an assigned Facility Trainer that shows they are following facility policy on use of stand lifts. Direct care staff will review the video on use of the stand lifts based on manufacturer's guidelines. Flex time employees and agency employees will complete this training as part of the orientation process as they are scheduled to work. On 08/14/14 an OT evaluation was completed on Resident # 6's ability to transfer using the stand lift and appropriate adjustments have been made to Resident# 6's plan of care to meet his individual needs. QA Monitoring will occur on Resident #6 and a random sample of residents of at least 50% of the population that utilize stand lifts will be monitored weekly x 3 months, monthly x 3 months and quarterly thereafter x 1 year. The Administrator will be notified of any issues and immediate corrective action will occur. The RN or appropriate designee will report to the QA Committee at their regularly scheduled monthly meetings.	09/17/14 09/17/14

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F 323	Continued From page 10 mechanical lift] as needed . . . Transfers . . . Assist required AO2 [assist of 2] stand aid from bed to w/c [wheelchair], w/c to toilet use technique to prevent any friction/shearing. Hoyer lift assist as needed . . ." Observations of Resident #6 showed the following: *08/12/14 at 9:25 a.m., two certified nursing assistants (CNAs) (#1 and #2) repositioned Resident #6 using a sit-to-stand lift. The resident did not bear weight and was in a seated position as he was suspended from the harness. As the harness straps pulled upward into Resident #6's axillae (armpits), his shoulders raised to ear level. *08/12/14 at 2:30 p.m., two CNAs (#1 and #3) repositioned Resident #6 using a sit-to-stand lift. The CNA (#1) stated, "That's good" before the resident's knees were fully extended. As the harness straps pulled upward into Resident #6's axillae (armpits), his shoulders raised to ear level. When asked how he was doing at that point, the resident stated, "It's either that or fall down. I guess I did better than the first time." *08/12/14 at 4:20 p.m., two CNAs (#1 and #3) repositioned Resident #6 using a sit-to-stand lift. The resident did not bear weight and was in a seated positioned as he was suspended from the harness. As the harness straps pulled upward into Resident #6's axillae (armpits), his shoulders raised to ear level. The CNA (#1) stated, "He can't go higher." During an interview on the afternoon of 08/13/14, an administrative nurse (#4) confirmed CNAs should notify a charge nurse, who would immediately assess the need for a Hoyer lift, if the resident does not bear weight.	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 F 441 SS=D	Continued From page 11 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	F441 To ensure the facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection to Resident # 3 and any resident in the facility that may be affected receives assistance with perineal care and proper handling of linens: the facility will reeducate staff on hand hygiene, proper use of gloves, and handling of linens. The facility has purchased an educational video called "Infection Control Skills for the Care Provider" which focuses on infection control practices geared toward Certified Nursing Assistants. This video will be presented at the scheduled meetings. The facility at the scheduled meetings. The facility will monitor care provided to Resident # 3 to ensure that infection control policies are followed. The Infection Control Nurse or designee will also monitor 20% of the facility population based on the current daily census to ensure that infection control practices such as hand hygiene, proper use of gloves, and handling of linens is completed properly. QA Monitoring will occur weekly x 3 months, monthly x 3 months, and quarterly thereafter x 1 year. Any issues identified will be reported to the Administrator and immediate corrective will occur. The Infection Control Nurse or appropriate designee will submit a report	09/17/14 09/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	804 MAIN ST W CAVALIER, ND 58220

(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 441	Continued From page 12 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JULY 18, 2013. Based on observation, staff interview, and review of facility policy, the facility failed to follow standard infection control practices for 1 of 1 sampled resident (Resident #3) observed during morning cares including perineal care with incontenence of stool. Failure to perform hand hygiene following perineal cares and to properly handle soiled linen has the potential to cause or spread an infection within the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 08/13/14. This policy, dated 2009, stated, "PURPOSE: To decrease the risk of transmission of infection by appropriate hand hygiene. . . . I. HANDWASHING When hands are visibly dirty or contaminated with proteinaceous material, are visibly soiled with blood or other body fluids . . ." Review of the facility policy titled "Using Gloves" occurred on 08/13/14. This policy, dated 2009, stated, "PURPOSE: To provide guidelines for the use of gloves for resident and employee protection. . . . E. Perform hand hygiene after removing gloves. . . ." Review of the facility policy titled "Laundry Services" occurred on 08/13/14. This policy, dated 2009, stated, "POLICY: . . . A. Soiled linen should be handled as little as possible and with a	F 441	to the QA Coordinator at the monthly meeting.	

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F 441	Continued From page 13 minimum of agitation to prevent gross microbial contamination of the air and of persons handling the linen. . . . B. All soiled linen should be bagged or put into carts at the location where used . . . All staff use standard precautions in handling linen, therefore all linen is handled in the same manner. . . ." - Observation on 08/12/14 at 10:13 a.m., showed two certified nurse aides (CNAs) (#2 and #5) provided morning care for Resident #3. The CNA (#5) removed the resident's nightclothes, looked for a place to put them, and then placed them on the floor next to the bed. One CNA (#5) provided frontal perineal care. After providing perineal care, and wearing the same gloves, the CNA (#5) manipulated multiple types of personal care products on the over bed table before obtaining a cream used for rectal care. As the CNA (#5) provided rectal cleansing, she identified the need for disposable wipes to cleanse stool. The CNA (#5), wearing the same gloves, reached into an open drawer two to three feet from the head of the bed and pulled out a package of disposable wipes. The CNA (#5) pulled wipes from the package and when finished closed the package and put the package with the other care products on the over bed table. The CNA (#5) removed one glove, failed to perform hand hygiene, and using her ungloved hand opened multiple drawers looking for a disposable chux to place under Resident #3. Not finding one, the CNA (#5) left the room with one glove on and without performing hand hygiene. On return to Resident #3's room, the CNA (#5) failed to perform hand hygiene before applying a pair of gloves and continued care for Resident #3. At the end of care the CNA (#5) picked up the nightclothes, added towels from the care provided and tucked them	F 441		

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F 441	Continued From page 14 under one of her arms. The CNA (#5) moved the bundle of clothes/towels from one arm to the other as she applied gloves, collected the wash basin, placed the supply of care products and package of wipes in the wash basin and placed the care products into the bottom drawer of a small dresser. The CNA (#5) removed the gloves and without performing hand hygiene left Resident #3's room with the bundle of clothes/towels. The CNA (#5) failed to perform hand hygiene, and handle linen per facility policy. During an interview on the afternoon of 08/13/14, an administrative nurse (#4) agreed staff members failed to use gloves and handle linen appropriately.	F 441		