STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 09/16/18 and concluded on 09/19/18.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise	F 657	1. Actions taken for the residents found to have been affected: Care plans for	10/22/18

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

Electronically Signed | 10/04/2018

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F 657	Continued From page 1 the comprehensive care plan to reflect the current status for 2 of 13 sampled residents (Resident #27 and #32). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #27's medical record occurred on all days of survey. Diagnoses included chronic atrial fibrillation and cerebral infarction. Current physician's orders identified Warfarin (a medication used to thin the blood) prescribed daily. Resident #27's current care plan failed to address the use of this medication. During an interview on 09/19/18 at 12:15 p.m., an administrative nurse (#3) confirmed the medication should be addressed on the care plan. - Review of Resident #32's record occurred on all days of the survey. The current Resident Activities of Daily Living Sheet (ADLs) identified Resident #32 required the assistance of 1 staff member for transfers and ADLs, mobile with a wheelchair (wc) or walker (w) and ambulated (walked) independently. Observation on 09/17/18 at 2:04 p.m., showed a certified nurse assistant (CNA) (#2) responded to Resident #32's call light and assisted the resident from the bed to the toilet using a gait belt and a wheeled walker.	F 657	resident #27 and #32 were reviewed and updated before surveyors left the building on 9/19/18. 2. Identification of other residents having the potential to be affected: All residents have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce risk of future occurrence: A review and re-education session for nurses on their role in the care plan process and importance of timeliness of revisions will be included in the skills fair to be held October 10th being conducted by the Nursing Servicers Coordinator. 4. How the corrective actions will be monitored to ensure the practice will not recur: Quality Assurance will be completed by the Nursing Services Coordinator or her designee to ensure care plans reflect the current status of residents and will be done once/week for four weeks, monthly for two months, and quarterly thereafter until deemed not needed by the QAPI committee. The QA will include 5 residents who have any of the following indicators: Coumadin, ADL assistance, transfer assist, skin tears, behavior care planning. The results of these QA's will be reviewed by the QAPI committee.	

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F 657	Continued From page 2 Review of Resident #32's most recent care plan stated, ". . . I continue to be independent in my room with ambulation. . . ." The care plan failed to accurately reflect the level of assistance Resident #32 required with mobility, transfers, and ADLs. Review of Resident #32's progress notes, dated September 2018, showed the resident had physical and verbal behaviors toward other residents and staff. The care plan failed to address the resident's behaviors and identify appropriate interventions to keep the resident safe and functioning at her best. During an interview on 09/18/18 at 3:30 p.m., an administrative nurse (#3) agreed the resident's care plan failed to identify interventions for the resident's behaviors. Observation on 09/17/18 at 2:00 p.m., showed a dressing to Resident #32's front shin on her right leg during morning cares. Review of Resident #32's most recent skin assessment, dated 08/28/18, stated the resident had a skin tear on the shin of her right leg. The resident's treatment administration record (TAR) for the months of August and September 2018 failed to show a treatment or dressing change for the skin tear. During an interview on 09/19/18 at 9:25 a.m., a staff nurse (#6) stated the resident did have a dressing on her right shin for a skin tear and that	F 657		

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F 657	Continued From page 3 staff should have added it to the TAR.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to administer medications in accordance with acceptable standards of practice for 1 of 1 sampled resident (Resident #31) who spit out her medications. Failure to retrieve the medication from the floor provided an unsafe environment and had the potential to result in adverse effects, if consumed, by a resident or visitors. Findings include: Review of the facility policy titled "MEDICATION: ORAL ADMINISTRATION" occurred on 09/18/18. This policy, revised November 2017, stated, ". . . Administration of oral medications will be done in a safe and professional manner . . . Medications will be given according to the professional nursing standards of practice . . . Direct resident care and safety is a priority. . . ." Observation of medication pass occurred on 9/17/18 at 9:16 a.m., a staff nurse (#8) prepared medications for Resident #31, placed them in a medication cup, and went to the dining room where the resident was sitting in her wheelchair	F 658	1. Actions taken for the resident found to have been affected: The resident (#31) was not affected by this incident as she refused all medications. An incident report was completed and the nurse involved will be coached prior to her next day worked. 2. Identification of other residents having the potential to be affected: All residents have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce risk of future occurrence: A review and re-education session for nurses on proper medication administration will be included in the skills fair to be held October 10th being conducted by the Nursing Services Coordinator. 4. How the corrective actions will be monitored to ensure the practice will not recur: Quality Assurance will be done by the Nursing Services Coordinator or her designee by monitoring medication administration on 5 residents once/week for four weeks, monthly for two months, and quarterly thereafter until deemed no	10/22/18

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F 658	Continued From page 4 next to a small couch and end table. The staff nurse scooped up 3 to 4 medications with a plastic spoon and raised the spoon to the resident's lips. The resident opened her mouth, took the pills, and attempted to swallow them with the water the nurse had given her, then shook her head, and spit them out. The nurse caught some of the pills with a tissue. This surveyor observed one pill fall to the floor. The nurse returned to the medication room without retrieving the medication from the floor. At approximately 11:20 a.m., this surveyor moved the end table and found a small, mint colored, scored, oblong pill and reported it to administrative nurse (#2). During an interview on 9/17/18 at 11:25 a.m., an administrative nurse (#3) agreed the staff nurse should have retrieved the medication from the floor at the time it had fallen.	F 658	longer needed by the QAPI committee. The results of these QA's will be reviewed by the QAPI committee.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care and services in a manner to maintain the highest practicable well-being for 1 of 1 sampled resident	F 684	1. Actions taken for the residents found to have been affected: A note written by the Nursing Services Coordinator was placed in the communication record on	10/22/18

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F 684	Continued From page 5 (Resident #32) observed physically shivering and verbally indicating she was cold. Failure to implement intervention to provide a comfortable environment for the resident may result in the resident experiencing unnecessary discomfort. Findings include: Review of Resident #32's medical record occurred on all days of the survey. The current care plan identified, ". . . I enjoy having a warm blanket wrapped around me as I get cold easily . . . I enjoy having a towel wrapped around me as I get cold. . . ." Observation on 09/17/18 at 2:04 p.m., showed a certified nursing assistant (CNA) (#2) transferred Resident #32 to the toilet and performed personal cares. Resident #32 verbalized she was cold. The CNA did not respond. The resident started shivering and again stated she was cold. The CNA (#2) stated she would try to hurry. At 2:30 p.m., 26 minutes after being seated on the toilet, the CNA completed the resident's cares. The CNA failed to provide a blanket or towel for Resident #32's comfort. Observation on 09/18/18 at 8:39 a.m., showed Resident #32 sitting in the therapy room sleeping in her wheelchair with her jacket on and her sleeves pulled over her hands. An unidentified therapy aid asked the resident if she was cold, and she responded "yes". The therapy aid did not respond. After performing various exercises, the resident returned to her wheelchair, and again pulled on her coat sleeves to cover her hands and held the opening at the jacket neck with her	F 684	9/19/18 and reviewed at shift-to-shift report for the following 7 days. The note included information about resident #32's need to be covered well and kept warm when doing care or providing other services and to be aware of where she is in the environment for her comfort (i.e. not near a ceiling fan). 2. Identification of other residents having the potential to be affected: All residents have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce risk of future occurrence: A review and re-education session for nurses, medication aides, C.N.A's, and restorative care aides on ensuring resident comfort and being observant and aware of what is in the environment that could cause discomfort will be included in the skills fair to be held October 10th coordinated by the Nursing Services Coordinator. A discussion on this information will also be completed on October 11th with the contract therapy staff. 4. How the corrective actions will be monitored to ensure the practice will not recur: Quality Assurance to ensure residents are comfortable in their environment and that their current needs are met will be completed by observing 5 residents once/week for four weeks, monthly for two months, and quarterly thereafter until deemed not needed by the QAPI committee. The Nursing Services Coordinator or her designee will complete the QA and the results of these QA's will	

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F 684	Continued From page 6 left hand. Observation showed Resident #32 visibly shaking. The resident did not actively participate in the remainder of her therapy. Resident #32 clinched her jaw and kept her eyes closed. At 8:52 a.m. the therapy aid arrived with a warm blanket for the resident, wrapped it around her, and transferred her to the dining room for breakfast. The aid parked the resident's wheelchair underneath a ceiling fan on high speed. At 9:12 a.m., an unidentified staff member arrived in the dining room and asked the resident if she was ready for breakfast. Resident #32 stated "no". The unidentified aid took the resident to her room and notified a CNA the resident wanted to lay down. During an interview on 09/18/18 at 3:30 p.m., an administrative nurse (#3) agreed Resident #32 was care planned to have a blanket as that she is often cold.	F 684	be reviewed by the QAPI committee.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		10/22/18

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F 686	Continued From page 7 by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/02/18 Based on observation, record review, facility policy and procedure, and staff interview, the facility failed to provide the necessary care and services to prevent the development and promote healing of pressure ulcers for 1 of 1 sampled resident (Resident #27) with a current pressure ulcer. Failure to consistently use interventions to prevent and heal the pressure ulcer may result in further skin breakdown. Findings include: Review of the facility policy titled "Skin Treatment: Protocols" occurred on 09/19/18. This policy/procedure, dated February 2018, stated, ". . . 3. To identify actual or possible cause of alteration in skin integrity and prevent the occurrence. . . . PRESSURE REDUCING CHAIR CUSHION GUIDELINE Appropriate pressure reducing cushions for chairs (including chairs and wheelchairs) Refer to BRADEN [a skin assessment tool] to determine which cushion is appropriate. . . . STAGE I . . . 4. Assess for contributing factors . . . May consult with OT [occupational therapy] to add pressure relieving measures to plan of care as appropriate. - Pressure relieving seat in wheelchair - Pressure relieving mattress to bed . . ." Review of Resident #27's medical record occurred on all days of survey. An admission Minimum Data Set, dated 07/16/18, identified a risk for pressure ulcers, no pressure ulcer present, and intact cognition.	F 686	1. Actions taken for the residents found to have been affected: A second cushion was put into place for resident #27 so one cushion can be kept in her wheelchair and the second in her recliner, thus reducing the possibility of the human error of forgetting to move the cushion from chair to chair. Resident #27 was also seen on 10/3/18 by the wound nurse who reviewed and revised her plan of care. 2. Identification of other residents having the potential to be affected: No other residents have pressure sores at this time. 3. Actions taken/systems put into place to reduce risk of future occurrence: A review and re-education session for nurses, medication aides, C.N.A's, and restorative care aides on their role in providing skin care, preventive measures, and ensuring the plan of care measures to prevent skin break down are followed will be included in the skills fair to be held October 10th conducted by the Nursing Services Coordinator. 4. How the corrective actions will be monitored to ensure the practice will not recur: Quality Assurance to ensure residents with pressure ulcers have appropriate cushions and that they are in place will be done once/week for four weeks, monthly for two months, and quarterly thereafter until deemed not necessary by the QAPI committee. This will be completed by the Nursing Services Coordinator or her designee and the QA sample will include all residents with	

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F 686	Continued From page 8 The current care plan, dated 9/17/18, stated, ". . . I have potential problem of skin break down. problem area Coccyx. I currently have a stage two pressure ulcer to the area . . . I be [sic] reminded to reposition per standard care from w/c [wheelchair], recliner to bed. when in bed turn on my sides . . . I will have zinc based protective cream applied to my coccyx AM and PM care until healed or different TX [treatment] noted." The care plan lacked the information about the roho cushion and that the resident slept in her recliner. Review of Resident #27's progress notes identified the following: *08/28/18 6:36 a.m., ". . . Type of ulcer: . . . pressure Stage Ulcer: . . . II [2] Location: coccyx Size: . . . 0.4 cm [centimeters] round depth 0.1. . . Plan of treatment/ change needed?: zinc cream apply bid [twice a day] for 7 days and on sides when in bed." *08/30/18 12:46 p.m., ". . . Nursing informed OT pt [patient] has a pressure area. OTR [occupational therapy registered] provided pt with a roho [pressure relief cushion] cushion and fitted to pt. . . ." *09/16/18 9:13 a.m. ". . . Wound to coccyx appears to have no change in size. . . ." The next progress note to address the pressure ulcer was approximately 2 weeks later. *09/18/18 9:15 a.m., ". . . area to coccyx measures 0.9 x [times] 0.9 cm, skin turgor is good, wound bed has granulation and a small amount of slough in the middle of wound, no drainage noted, no odor, surrounding tissue is intact and pink."	F 686	pressure sores. The results of these QA's will be reviewed by the QAPI committee.	

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F 686	Continued From page 9 The following observations and interviews occurred: *09/17/18 at 09:35 a.m., observation showed no pressure relief cushion in Resident #27's recliner and a non-medical cushion in her wheelchair. The resident had transferred from the wheelchair, used the bathroom, and transferred into the recliner in her room. A certified nurse assistant (CNA) (#10) reported the resident has a roho cushion in her recliner and wheelchair, but it was not here at the present time. *09/18/18 at 8:51 a.m., observation showed Resident #27 sitting in her recliner in her room and the roho cushion in her wheelchair. When asked about her bed, the resident stated, "I sleep in my recliner." *09/18/18 at 9:10 a.m., observation showed a CNA (#9) applied a gait belt and assisted the resident to stand up from the recliner. The recliner lacked a cushion. A staff nurse (#5), present in the room, assessed the resident's pressure ulcer. During interview, when asked about the cushion, the nurse (#5) stated, "it [the cushion] should be in her recliner." *09/19/18 at 8:48 a.m., observation showed the resident in the bathroom with a CNA (#4). The wheelchair in the corner of the room contained the roho cushion. The CNA stated, "the cushion was not under the resident this morning." Resident #27 confirmed she slept in the recliner all night. During an interview on 09/19/18 at 09:16 a.m., an administrative nurse (#3) when asked about the use of the pressure relieving cushion, reported it is a standard of care "for the cushion to follow the resident."	F 686		

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F 686	Continued From page 10 Failure to routinely assess, monitor and measure an existing pressure ulcer and ensure consistent implementation of interventions may result in delayed healing or the development of new pressure ulcers.	F 686		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are	F 755		10/22/18

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F 755	Continued From page 11 in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to establish a system to account for all controlled medications awaiting destruction in 1 of 1 cabinets holding narcotics for disposal. Failure to assure all controlled medications are accounted for until destruction has the potential for medication loss and/or diversion. Findings include: Observation of the main medication room occurred on 09/18/18 at 10:17 a.m. with a staff nurse (#5) and showed a locked box containing several blister packs of controlled medications designated for destruction. The nurse (#5) stated when a narcotic is put into the locked box the number of pills remaining in the pack is written on the card and the date. We do not keep a list of what is sent to the pharmacy. The nurse stated the key for the locked box is kept in the top drawer of the locked main medication cart. During an interview on 09/19/18 at 8:50 a.m., an administrative nurse (#3) stated the facility had no process in place to record or verify the controlled medications stored prior to destruction.	F 755	1. Actions taken for the residents found to have been affected: A system to account for all controlled medications was put into place using the ND Pharmacy destruction log (which inventories the medications waiting to be destroyed) prior to the surveyors exit from the building on 9/19/18. 2. Identification of other residents having the potential to be affected: No residents were affected. 3. Actions taken/systems put into place to reduce risk of future occurrence: When the log was put into place, nurses were instructed by the Nursing Services Coordinator on the new process at shift-to-shift report beginning on 9/19/18 and for the following 7 days. 4. How the corrective actions will be monitored to ensure the practice will not recur: Quality Assurance will be completed by the Nursing Services Coordinator or her designee to ensure that all narcotics in the destruction box and the log match. The QA will be done once/week for four weeks, monthly for two months, and quarterly thereafter until the QAPI committee deems it not necessary. The results of these QA's will be reviewed by the QAPI committee. In addition, the pharmacist will check to be sure the narcotics log and destruction box match when they pick up medications for destruction on an ongoing basis.	

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national 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	F 880		10/22/18

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F 880	Continued From page 13 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. 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, record review, review of facility policy, and staff interview, the facility failed to follow infection control practices for 4 of 9 sampled residents (Resident #30, #32, #33, and #35) and 3 supplemental residents (Resident #20, #28, and #40). Failure to offer hand hygiene to a resident after cares (Resident #40), follow	F 880	1. Actions taken for the residents found to have been affected: A note written by the Nursing Services Coordinator was placed in the communication record on 9/19/18 and reviewed at shift-to-shift report for the following 7 days. The note included information about expectations	

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F 880	Continued From page 14 infection control practices related to hand hygiene and glove use during resident personal/perineal cares (Resident #28, #30, #32, #33), with wound cares (Resident #20), and with medication administration, has the potential for transmission of infections and communicable diseases to residents and staff. Findings include: Review of the facility policy and procedure titled, "INFECTION PREVENTION AND CONTROL PROGRAM" occurred on 09/18/18. This policy, dated November 2017, stated ". . . require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice . . . Institutional factors may also facilitate transmission of infections among residents . . . Improper hand hygiene. Improper glove use . . . Infection control precautions used by the facility include . . . Standard Precautions . . . Standard precautions include . . . hand hygiene . . . Hand Hygiene continues to be the primary means of preventing the transmission of infection . . . Residents will be encouraged and assisted as needed to perform hand hygiene after any personal cares . . . Glove Hygiene . . . Remove and discard gloves in appropriate receptacles after every procedure that involves potential exposure to blood and body fluids . . ." - Observation on 09/17/18 at 9:36 a.m. showed a certified nursing assistant (CNA) (#1) donned gloves, completed a partial bath and assisted the resident with dressing her upper body, applied the socks and shoes and removed her gloves. Without performing hand hygiene, the CNA (#1)	F 880	and procedures for proper hand hygiene and infection control. 2. Identification of other residents having the potential to be affected: All residents have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce risk of future occurrence: A review and re-education session for nurses, medication aides, C.N.A's, and restorative care aides on proper infection control procedures, including hand hygiene, will be included in the skills fair to be held October 10th coordinated by the Nursing Services Coordinator. Examples directly from the 2567 will be used in the training and it will include a post-test. 4. How the corrective actions will be monitored to ensure the practice will not recur: Quality Assurance regarding infection control practices when providing direct resident care and medication administration will be done by selecting 5 ransom residents who require assist with person cares or wound cares. The QA will be completed by the Nursing Services Coordinator or her designee once/week for four weeks, monthly for two months, and quarterly thereafter until deemed not necessary by the QAPI committee. The results of these QA's will be reviewed by the QAPI committee.	

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donned gloves, completed perineal cares and removed her gloves. Without performing hand hygiene, the CNA (#1) pulled Resident #28's pants up and adjusted her shirt, assisted with a pivot transfer from the toilet to the wheelchair, removed the gait belt, hung the gait belt on the bathroom door, applied the foot pedals to the wheelchair, emptied the wash basin, and picked up the laundry and garbage bags. The CNA (#1) failed to perform hand hygiene before and after removing gloves while completing Resident #28's perineal and personal cares.

- Observation on 09/17/18 at 12:07 p.m. showed a CNA (#1) with gloved hands assisted Resident #33 off the toilet, completed perineal care and removed her gloves. Without performing hand hygiene, the CNA (#1) assisted Resident #33 with her incontinence product, pulled up the resident's pants, assisted the resident with a pivot transfer from the toilet to the wheelchair, handed Resident #33 a disposable wipe to cleanse her hands, removed the gait belt, hung it on the bathroom door, applied Resident #33's oxygen nasal cannula, applied the foot pedals to the wheelchair and placed a box of tissues on Resident #33's lap. The CNA (#1) failed to perform hand hygiene before and after removing gloves while completing Resident #33's perineal and personal cares.

- Observation on 9/17/18 at 1:50 p.m. showed two CNAs (#1 and #7) performed hand hygiene, donned gloves, and provided Resident #30's bowel and bladder incontinence cares while the resident was in bed. The CNAs (#1 and #7) repositioned the resident onto his side. One CNA (#1) supported the resident while the other CNA

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(#7) provided the incontinence cares. After incontinence cares and without performing hand hygiene, the CNA (#7) applied a clean incontinence product, repositioned the resident in his bed, and pulled his blankets up. The CNA (#7) then removed her gloves, and without performing hand hygiene, lowered the bed utilizing its control and moved the bed against the wall. After Resident #30's cares were provided and his tasks were completed, the CNA (#7) washed her hands. The CNA (#7) failed to remove her gloves and perform hand hygiene after providing incontinence cares.

- Observation on 09/17/18 at 2:04 p.m., showed a CNA (#2) performed personal and perineal cares for Resident #32 while wearing gloves. After removing her gloves, the CNA poured the resident a glass of water and brushed her hair. The CNA failed to perform hand hygiene after removing her gloves and before performing further resident cares.

- Observation on 09/18/18 at 10:34 a.m., showed two CNA's (#4 and #9) performed a check/change for Resident #35. The CNA (#4) removed her gloves, retrieved a jar of moisturizer out of the resident's drawer, handed it to the other CNA (#9) and moved the bedside table. The CNA (#9) removed her gloves, applied moisturizer to the resident's legs, pulled up Resident #35's pants and repositioned her onto her side. The CNA's (#4 and #9) failed to perform hand hygiene after removing their gloves and before performing further resident cares.

During an interview on 09/18/18 at 11:09 a.m., an administrative nurse (#3) stated her expectations

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are for all staff to perform hand hygiene before resident cares and between glove changes.

- Observation on 09/17/18 at 12:01 p.m. showed a CNA (#4) assisted Resident #40 with toileting. While in the bathroom, the resident put his hand into his brief and touched his perineal area. The CNA helped the resident back to bed and left the room. The CNA failed to offer hand hygiene to Resident #40.

During an interview on 09/18/18 at 11:11 a.m. an administrative nurse (#3) stated the expectation is that staff should offer resident's hand hygiene after toileting.

DRESSING CHANGES:

- Observation on 09/17/18 at 1:51 p.m., showed a staff nurse (#8) entered Resident #20's room and palpated a wound on the back of her right calf. The staff nurse (#8) applied gloves, cleansed the wound and with the same gloves applied a Vaseline gauze. The nurse removed her gloves and secured the dressing with kerlix and tape. The staff nurse failed to perform hand hygiene prior to and after palpating the wound, and failed to change gloves after cleansing the wound and before applying the dressing.

During an interview on 09/18/18 at 11:09 a.m., an administrative nurse (#3) stated her expectations are for all staff to perform hand hygiene before resident cares, between glove changes and when going from dirty to clean during a dressing change.

MEDICATION ADMINISTRATION:

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F 880	Continued From page 18 - Observation on 09/17/18 at 9:16 a.m., showed a staff nurse (#8) preparing morning medication. One tablet fell from the container to the counter. The nurse used her fingers to pick up the tablet and placed it in the medication cup. The nurse failed to use a sanitary method to pick the tablet off the counter and failed to perform hand hygiene after touching the tablet.	F 880		