STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 11/12/19 and concluded 11/14/19.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident	F 565		12/19/19

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

Electronically Signed | 11/27/2019

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F 565	Continued From page 1 representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, the resident council group interview, and staff interview, the facility failed to actively seek a resolution to resident grievances related to failing lift batteries for 3 of 7 sampled residents (Resident #30, #63, and #91) observed during a full-body mechanical lift transfer. Failure to act upon the resident grievances regarding issues with lift batteries resulted in continued dissatisfaction with delayed care. Findings include: During the resident council group interview on the morning of 11/13/19, two residents (A and B) reported lift batteries continued to fail during lift transfers after Resident Council previously addressed the issue. - Observation on 11/13/19 at 7:38 a.m., showed two certified nursing assistants (CNAs) (#2 and #7) attached the full-body mechanical lift and started to transfer Resident #63 from the bed to the wheelchair. During the transfer the CNA (#2) noticed the battery losing power. The CNAs (#2 and #7) lowered the resident back onto the bed, the CNA (#2) left the room, returned with a different battery, and completed the resident transfer. - Observation on 11/13/19 at 9:10 a.m. showed CNAs (#8 and #9) transferred Resident #91 from the bed to the wheelchair using a full-body	F 565	1. For residents #30, #63, and #91, see #3 below. 2. All residents who require a mechanical lift for transfers have the potential to be affected. 3. All mechanical lift batteries are being replaced with new batteries facility wide. These batteries arrived at the facility on 11-25-19 and were immediately put into service. A charging schedule for lift batteries has been developed and implemented, so that batteries will have adequate charging time per manufacture□s guidelines. All facility staff will be educated on the procedure at mandatory all-staff meetings on 12-10-19 and 12-12-19. C.N.A. staff will also be educated on the new procedures at the mandatory CNA meetings on 11-27-19, 12-5-19, 12-12-19, or 12-19-19 4. The QAPI director or designee will conduct a random audit of eight (8) residents who utilize mechanical lifts for transfers, weekly for ten (10) weeks, then monthly thereafter, to assure that the new charging procedure is being adhered to and that residents are not inconvenienced during cares due to weak or dead batteries, beginning on 12-4-19. The results will be discussed at the monthly	

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F 565	Continued From page 2 mechanical lift. The CNA (#8) initiated the transfer, and the battery failed. The CNA (#8) lowered Resident #91 to the bed and left the room to retrieve a new battery. The CNA (#8) returned with a new battery and transferred Resident #91 to the wheelchair. - Observation on 11/13/19 at 9:33 a.m. showed two CNAs (#1 and #2) transferred Resident #30 from the bed to the wheelchair. During the transfer, the CNA (#2) stated the battery was dying and lowered the resident down to the bed. The CNA (#2) replaced the battery, transferred Resident #30 to the wheelchair, and stated the battery was dying again as he/she completed the transfer. During an interview on 11/13/19 at 11:43 a.m., a CNA (#9) reported night staff charged batteries over night to ensure a full charge during the day and stated staff often forgot to do this. The facility failed to ensure failing batteries did not delay care provided to residents. During an interview on the morning of 11/14/19, two administrative nurses (#4 and #10) confirmed night staff should charge batteries and acknowledged failing batteries as an ongoing issue.	F 565	QAPI meeting with the appropriate action and follow up if indicated.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		12/19/19

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F 578	Continued From page 3 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the	F 578	1. Resident #91□s code status was reviewed by nurse manager, and the	

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F 578	Continued From page 4 medical records for 1 of 2 sampled residents (Resident #91) with code level 3 accurately reflected the residents' wishes consistently throughout the medical record. Failure to ensure Resident #91's medical record accurately reflects his/her wishes limits emergency personnel from knowing the residents' wants in the event of a medical emergency. Findings include: Review of the facility titled "Code Status" occurred 11/14/19. This policy, dated February 2018, stated, "Obtaining Code Status . . . On admission, Uniform Code Level Directives for Cardiopulmonary Resuscitation will be discussed with resident or designee . . . When original received, placed in resident's chart. . . . Place code level in the EMR [electronic medical record] under physician's orders. . . . Nurse to place on routine care sheet. . . ." Record review for Resident #91 occurred all days of survey. A document titled "Uniform Code Level Directives for Cardiopulmonary Resuscitation," dated 08/10/18, stated, ". . . CODE LEVEL 2: No intervention will be made in the event of a cardiac or respiratory arrest including defibrillation, chest compression, artificial respiration or chemical resuscitation. Other conditions will be treated medically appropriate . . . CODE LEVEL 3: Resident wishes to be kept comfortable, no CPR [cardiopulmonary resuscitation] or defibrillation, and no transfer to a higher level of care. . . ." The document designated Resident #91 wishes as code level 3. A document titled "Routine Care Sheets," revised 09/12/19, hung on Resident #91's door and stated, ". . . Code Status DNR [do	F 578	routine care sheet and EMR were made to agree on 11/15/19. See #3 below. 2. All residents in the facility have the potential to be affected. 3. The outdated resident code status document/form that was posted in the nurses station was removed and destroyed immediately on 11-14-19. The current policy/procedure regarding resident code status has been updated to state that the resident□s code status will be placed on the routine care sheet and the EMR under physician□s orders. Nurses will be updated of this change in policy at the mandatory staff meeting on 12-10-19 and 12-12-19, and also at the mandatory nurses meetings on 11-27-19 and 12-19-19. 4. The QAPI director or designee will conduct a random audit of eight (8) residents, weekly for ten (10) weeks, then monthly thereafter, beginning on 12-4-19. The purpose of the audit will be to assure that code status on all residents is being documented appropriately and that the routine care sheet and the EMR agree and are both accurate. The results will be discussed at the monthly QAPI meeting, with appropriate action and follow up as necessary.	

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F 578	Continued From page 5 not resuscitate] . . ." Another document, dated 11/04/19, posted in the nurses' station, listed facility residents by name and room number with their code level status and stated, ". . . DNR 2 . . . Resident #91 . . ." A physician's order in pointclickcare, dated 04/26/18, stated, ". . . Code Status: DNR . . ." During an interview on the afternoon of 11/12/19, a registered nurse (#3) reported staff referenced the list in the nurses' station, the order in the EMR, the Uniform Code Level Directives for Cardiopulmonary Resuscitation form, and the residents' name plate outside their room to confirm a resident's code status. During an interview on the morning of 11/14/19, two administrative nurses (#4 and #10) reported the order in the EMR, the Uniform Code Level Directives for Cardiopulmonary Resuscitation form, and the name plate should all match. They also reported the list of residents at the nurses' station should not be used. The facility failed to ensure Resident #91's code status reflected his/her wishes consistently throughout his/her medical record and in documents used by nursing.	F 578		
F 657 SS=E	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--	F 657		12/19/19

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F 657	Continued From page 6 (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, review of facility policy, and staff interview, the facility failed to ensure staff reviewed and revised the comprehensive care plan to reflect the residents' current status for 4 of 23 sampled residents (Resident #24, #66, #82, and #91). Failure to review and revise the care plans to reflect each resident's current status limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Planning" occurred on 11/14/19. This policy, dated November 2018, stated, ". . . Each discipline is	F 657	1. For resident #24, the requirement to use proper personal protective equipment (PPE) when assisting with toileting and peri-cares was added to her care plan on 11-14-19. Resident #66 has a customized wheelchair with a seatbelt for positioning, and the use of the seatbelt was added to his care plan on 11-25-19. For resident #82, the code alert was added to her care plan on 11-14-19. For resident #91, her care plan was updated to reflect that the resident is in fact NPO and receives her nutrition via G-tube. Oral cares were added to her care plan to reflect that she requires total assistance in this area, and as was the need to perform swabbing of	

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F 657	Continued From page 7 responsible to initiate, change, or discontinue problems on the Care Plan as they arise and prior to the Care Conference. . . ." - Observation on the morning of 11/12/19 showed a small cabinet outside of Resident #24's room. During an interview at this time, a licensed nurse (#3) stated staff use Personal Protective Equipment (PPE) of gloves and a gown when working with Resident #24's urine. Resident #24's care plan failed to identify staff needed to use PPE when working with Resident #24's urine. During an interview on 11/14/19 at 8:25 a.m., an administrative nurse (#4) confirmed staff failed to include the use of PPE on Resident #24's care plan or routine care card. - Review of Resident #66's medical record occurred on all days of survey and identified the resident wore a lapbelt while in a wheelchair. The care plan failed to reflect the current use of a lap belt. During an interview on 11/14/19 at 10:41 a.m., an administrative staff member (#5) agreed the care plan lacked the resident's current use of seatbelt/lap belt. - Observation of Resident #82 throughout the survey showed the resident ambulated with a walker, which had a wanderguard (device that alarms if passed through an unapproved area) attached to the walker frame. Review of Resident #82's medical record occurred on all days of survey. A physician's	F 657	mouth every 2 hours and as needed. This was done on 11-15-19. 2. All residents have the potential to be affected. 3. All nurses will be educated on the importance of updating care plans with any change in resident status or condition, along with any need for new interventions at mandatory nurses meetings on 11-27-19 and 12-19-19. CNAs will also be educated at mandatory CNA meetings on 11-27-19, 12-5-19, 12-12-19, and 12-19-19. All staff will be educated at mandatory all-staff meeting on 12-10-19 and 12-12-19. 4. The QAPI director or designee will conduct a random audit of ten (10) residents, weekly for ten (10) weeks, then monthly thereafter beginning on 12-4-19 to assure that each care plan reflects that resident□s current status. The results will be discussed at the monthly QAPI meeting, with appropriate action and follow up as necessary.	

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F 657	Continued From page 8	F 657		

order, dated 08/09/18, stated, "Check Wanderguard on walker q [every] shift." The quarterly Minimum Data Set (MDS), dated 10/27/19, identified a wander/elopement alarm used daily and wandering behavior occurred on four to six days of the seven-day look-back period.

Resident #82's care plan, dated 05/14/18, stated, ". . . She shows impairment in her memory, decision making skills, thought processes, judgement and safety awareness and has been showing periods of paranoia and agitation which contribute to behaviors. . . . She has been noted to wander into other rooms - however easily redirected most times. . . . Staff will help orientate her to her room when she is wandering into other rooms with helpful reminders and explain to her where her room is. . . ." The care plan failed to include the use of a wanderguard.

During an interview on 11/14/19 at 9:06 a.m., a nurse manager (#11) agreed Resident #82's care plan should include the wanderguard.

- Observation throughout survey showed Resident #91 ate nothing by mouth (NPO), and staff failed to provide oral cares.

Review of Resident #91's record occurred all days of survey. A document titled "Dysphasia Evaluation Results," dated 01/11/19, stated, ". . . pt [patient] to remain NPO [nothing by mouth] . . ." A progress note, dated 11/4/19, stated, "requires tube feedings and is NPO. . . ."

Review of Resident #91's current care plan occurred all days of survey and stated, ". . .

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F 657	Continued From page 9 Resident has potential for nutritional risks r/t [related to] weight gain of 5% or more in the last month and receiving Mechanically altered diet, Tube feeding, CVA [cerebrovascular accident] . . . Offer menu alternatives, provide when possible. . . . OT [occupational therapy] to screen and provide adaptive equipment for feeding as needed. . . ." Resident #91's care plan failed to identify his/her current status of NPO and additional interventions required for a resident with an NPO status such as oral cares. During an interview on the morning of 11/14/19, two administrative nurses (#4 and #10) confirmed Resident #91's NPO status and agreed his/her current care plan did not reflect his/her current status and need for oral cares.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide assistance with activities of daily living (ADL) to 1 of 8 sampled, dependent residents (Resident #91) observed during cares. Failure to provide appropriate assistance to residents who cannot independently carry out ADLs may result in poor grooming/hygiene and decreased self-esteem. Findings include:	F 677	1. For resident #91, staff on Dakota Lane were educated on 11-26-19 and 11-27-2019 regarding proper perineal care procedures as well as to provide oral cares twice daily and as needed. 2. All residents who require assistance with perineal care and oral cares have the potential of being affected. 3. CNAs were educated on proper perineal cares and oral care at huddle	12/19/19

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F 677	Continued From page 10 Review of the facility policy titled "Perineal Care With or Without a Catheter" occurred 11/14/19. This policy, dated October 2019, stated, ". . . Procedure for a female perineal care: . . . D. Separate labia, washing front to back, wash down each side of labia then down the center over urethra and vaginal openings using a different part of cloth for each stroke. Pat dry. . . . F. Usng a new washcloth, wash upper and outer buttocks and down back of thighs. Pat dry. . . . G. Wash Rectal area wiping from the base of labia towards anus. Change area of washcloth with each stroke. Pat dry. . . ." Review of the facility policy titled "Oral Care Routine" occurred on 11/14/19. This policy, dated January 2018, stated, " POLICY: Oral hygiene is provided to residents by the Resident Assistants twice daily and whenever necessary. . . ." Review of Resident #91's record occurred all days of survey. Her current care plan stated, ". . . Self Care deficit r/t [related to] CVA [cerebrovascular accident] . . . Personal Hygiene: Total assist of 1 . . . TOILETING: Total assist of 1 . . ." A document titled "Routine Care Sheets," revised 09/12/19, hung on Resident #91's door and stated, ". . . Oral cares: Total assist . . . Grooming/Hygiene: Total assist of 1 . . . Toileting: Total assist of 1 . . . Incontinence Product: Yes . . ." A document titled "Standards of Care," updated August 2017, hung on Resident #91's door and stated, "DAILY MORNING CARE . . . Wash hands . . . Peri [perineal] care . . . Dress . . . style hair . . . Oral care . . . place hearing aides . . ." Observation on 11/13/19 at 9:10 a.m. showed a certified nursing assistant (CNA) (#8) provided "Daily Morning Care" for Resident #91. The CNA	F 677	meetings on all four lanes on 11-26-19 and 11-27-19. All staff will be on 12-10-19 and 12-12-19 at a mandatory all-staff meeting, and CNAs will be educated at mandatory CNA meetings on 11-27-19, 12-5-19 and 12-12-19 and 12-19-19. (This topic was also covered with CNAs at monthly CNA meeting on 11-14-2019 which was the last day of the survey.) 4. The QAPI director or assigned designee will conduct a random audit of ten (10) residents, weekly for ten (10) weeks, then monthly thereafter, beginning on 12-4-19 to assure that each resident is receiving proper perineal care and regular oral care when necessary. The results will be discussed at the monthly QAPI meeting with appropriate action and follow up as necessary	

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F 677	Continued From page 11 (#8) removed Resident #91's incontinence brief, wiped excess stool, and cleaned her rectal area but failed to complete step "D" of the "Procedure for a female perineal care." The CNA (#8) then dressed Resident #91, placed her hearing aides, and brushed her hair but failed to provide oral cares. During an interview on the morning of 11/14/19, two administrative nurses (#4 and #10) agreed staff had not performed perineal or oral cares per the facility's policy.	F 677		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution	F 761		12/19/19

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	355082	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 12 systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to establish a system to secure/store controlled medications for 1 of 1 MedSafe collection system. Failure to assure all controlled medications collected for destruction are appropriately secured/stored at all times has the potential for medication loss or diversion of medications. Findings include: Observation of the MedSafe collection system occurred on the morning of 11/14/19 with an administrative nurse (#6). Observation showed a locked collection receptacle in the Cottonwood nurses' station. The administrative nurse (#6) stated, "When the inside container/box is full, two nurses close and seal the box, it is then stored in the Director of Nursing (DON) office." The administrative nurse (#6) reported it takes a few days until the MedSafe company arrives to collect and remove the box from the facility. The facility failed to properly secure/store controlled medications after removed from the MedSafe collection system and prior to the medications removed from the facility.	F 761	1. None of the residents were affected by the deficient practice. 2. None of the residents have the potential of being affected by the deficient practice. 3. The policy/procedure has been updated to read as follows: “The MedSafe system involves a local pharmacy staff member and the facility Director of Nursing or designee, who is charged with the removal, sealing, and packaging of the liner immediately upon removal from the MedSafe, without emptying or touching the contents. Both individuals shall sign the step log form. The box containing the medications will then immediately be removed from the facility and the pharmacy staff member will take to UPS for shipping.” 4. The procedure noted in #3 has been added to our policy and procedure manual and implemented. The DON and nurse management team were educated on the procedure on 11-22-19. The QAPI director or designee will conduct an audit of each removal of liner, which is done as needed when the MedSafe box is full to assure that the correct disposal procedures are followed. This will be done for six months and the results will be discussed at the monthly QAPI meeting	

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F 761	Continued From page 13	F 761	with appropriate action and follow up as necessary.	
F 880 SS=D	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	F 880		12/19/19

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F 880	Continued From page 14 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. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 8 sampled residents (Residents #24, #72, and #91)	F 880	1. For residents #24, #72, #91, the staff on Dakota Lane were re-educated on proper hand hygiene and use of personal protective equipment as required on	

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F 880	Continued From page 15 observed during personal cares. Failure to follow infection control practices for hand hygiene (Resident #72 and #91) and use of required PPE (Personal Protective Equipment) (Resident #24) has the potential to spread infection to other residents, personnel, and visitors. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 11/14/19. This policy, dated October 2019, stated, ". . . Hand Hygiene Should Be Practiced . . . Before and after caring for each resident. . . . Before and after changing dressings. . . . Before applying and after removing gloves. . . ." Review of the facility policy titled "Perineal Care With or Without a Catheter" occurred 11/14/19. This policy, dated October 2019, stated, ". . . apply hand sanitizer, per facility protocol, after removing soiled gloves and before applying clean gloves. . . . Remove gloves and put in bag. Apply hand sanitizer. Apply clean brief. Wash hands . . ." - Observation on the morning of 11/12/19 showed a small cabinet outside of Resident #24's room. During an interview at this time, a licensed nurse (#3) stated staff use Personal Protective Equipment (PPE) of gloves and a gown when working with Resident #24's urine. Observation on 11/12/19 at 3:53 p.m. showed two certified nursing assistants (CNAs) (#12 and #13) checked and changed Resident #24's brief. The CNAs donned gloves and failed to don gowns for the personal cares.	F 880	11-26-19. 2. All residents who require assistance with personal care have the potential to be affected. 3. CNAs were educated on proper hand hygiene and PPE at huddle meetings on all four lanes on 11-26-19 and 11-27-19. All staff will be educated on 12-10-19 and 12-12-19 at a mandatory all-staff meeting. CNAs will be educated at the mandatory CNA meetings on 11-27-19, 12-5-19, 12-12-19 and 12-19-19. 4. The QAPI or designee will conduct a random audit of ten (10) residents, weekly for ten (10) weeks, then monthly thereafter, beginning on 12-4-19 to assure that staff are using appropriate hand sanitizing techniques and procedures, and to assure that the residents are receiving proper perineal care. The results will be discussed at the monthly quality assurance meeting and the appropriate action and follow up will be taken as necessary.	

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F 880	Continued From page 16	F 880		

During an interview on 11/14/19 at 8:25 a.m., an administrative staff member (#5) stated she would expect staff to use gloves and a gown when doing a check and change or toileting Resident #24.

- Observation on 11/12/19 at 4:14 p.m. showed two CNAs (#12 and #13) transferred Resident #91 from the bed to a wheelchair using a full-body mechanical lift. When leaving the room, both CNAs (#12 and #13) failed to complete hand hygiene.

- Observation on 11/12/19 at 4:46 p.m. showed a CNA (#12) provided perineal cares for Resident #72 with an incontinent bowel movement (BM). The CNA (#12) applied a barrier cream to the resident's buttocks, removed gloves, assisted with the residents clothing and without performing hand hygiene exited the room to retrieve a mechanical lift.

- Observation on 11/13/19 at 9:10 a.m. showed a CNA (#8) provided perineal cares for Resident #91 after an incontinent bowel movement. After completing perineal cares and transferring Resident #91 to his/her wheelchair, the CNA (#8) wheeled him/her to mass without performing hand hygiene.

During an interview on the morning of 11/14/19, two administrative nurses (#4 and #10) agreed staff had not performed proper hand hygiene.