STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355040	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	750 MAIN ST E MAYVILLE, ND 58257

(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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 08/08/16 and completed on 08/11/16, the sampled included four (4) residents for complete review, 11 residents for focused review, and three (3) closed resident records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 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 care for 3 of 15 sampled residents (Resident #1, #9, and #11) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors and wait for a reply before entering a resident's room to ensure privacy during toileting (Resident #1 and #11) and failure to provide care in a manner and environment that enhances dignity during a disrobing behavior (Resident #9), did not promote the residents' dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Perineal Cares"	F 241	F241 1. Corrective action will be accomplished by providing a mandatory inservice for all staff for residents #1, 9 and 11 August 31, 2016 and all licensed staff August 23, 2016. Also for #9 door will be closed if she is having the disrobing behavior. 2. All residents have the potential to be affected by this. 3. The deficiency will be corrected by: All staff will be educated by LSW discussing #241 (Dignity & Respect) on August 31, 2016. This was discussed at mandatory licensed nurse and CMA meeting by DON August 23, 2016. Will discuss dignity and respect at monthly resident council meeting and respond as	9/16/16

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

Electronically Signed | 09/09/2016

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F 241	Continued From page 1 occurred on 08/10/16. This policy, revised January 2011, stated, ". . . Procedure: . . . Knock before entering room . . . Provide privacy, shut doors, curtains . . ." - Review of Resident #9's medical record occurred on all days of survey. Observation showed the following on 08/09/16: * 10:40 a.m - 10:56 a.m., Resident #9 sat in the recliner in her room and struggled to remove her shoes, pants, and underpants, as she held onto a pillow. The door to her room remained wide open. * 11:05 a.m., Resident #9 successfully removed her pants and underpants, which laid on the floor next to the recliner. The door to her room remained wide open. Observation showed three unidentified staff members walked past Resident #9's room to attend to other residents. * 12:27 a.m. - 1:56 p.m., Resident #9 sat in the recliner in her room, holding onto a pillow, with her incontinence pad visible between her legs. The door to her room remained half way open. * 2:00 p.m., The activity staff member (#12) squatted directly in front of Resident #9 (who remained in the chair with her incontinence pad visible between her legs) when providing one to one activities. The activity staff member (#12) exited leaving the door to her room wide open. * 2:30 p.m., Resident #9 sat in the recliner in her room, holding onto a pillow, with her incontinence pad visible between her legs. Two CNAs (#1 and #4) entered Resident #9's room to assist her with toileting needs. Observation showed the chair protector and incontinence pad soaked with urine and stool. During the observation, one of the CNAs (#4) stated, at 1:45 p.m., she had	F 241	needed. 4. The LSW or designated personnel will audit dignity/ privacy daily x1 week, weekly for 1 month and monthly x2 months. The QA coordinator or designated personnel will audit CNAs on their yearly audit. 5. Corrective action will be accomplished by 9/16/16.	

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F 241	Continued From page 2 attempted to assist Resident #9, but she refused to put her clothes back on. Facility staff failed to maintain Resident #9's dignity by assisting her to dress and/or closing the door to her room. - Observation showed the following on 08/09/16: * 3:05 p.m., showed a CNA (#5) provided Resident #11's toileting cares. The CNA (#5) failed to close the door to the bathroom and failed to pull the privacy curtain between the bathroom and her roommate's side of the room. The CNA (#5) assisted Resident #11 to stand, lowered her pants, and removed her soiled incontinence product. Resident #11 then sat down on the toilet with her pants pulled down to mid shin. Resident #11's roommate watched TV on her side of the room. * 12:30 p.m., a CNA (#9) assisted Resident #11 with toileting cares. Observation showed Resident #11 and the CNA (#9) in the bathroom when a second CNA (#4) knocked and entered the room without announcing herself and/or requesting permission prior to entering the room. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included history of Alzheimer's disease. The quarterly MDS, dated 07/31/16, identified extensive assistance of one person required for transfer and toilet cares. Observation on 08/09/16 at 1:21 p.m. showed a CNA (#13) assisted Resident #1 with toileting cares. Observation showed while Resident #1 and the CNA (#13) were in the bathroom, and an unidentified CNA knocked and entered the room	F 241		

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F 241	Continued From page 3 without announcing herself and/or requesting permission prior to entering the room. Failure to knock and wait for permission to enter Resident #1 and #9's rooms does not enhance their dignity and respect.	F 241		
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 observation, review of facility policy/procedure, and staff interview, the facility failed to follow professional standards of practice for medication administration during 1 of 6 observations (08/09/16 at 5:10 p.m.) of medication pass. Preparing medications prior to administration, leaving the prepared medications unattended on top of the medication cart, and handling medications with bare hands fails to meet the current standards of practice for medication administration. Findings include: Review of the facility policy/procedure, titled, "Oral Medication Administration" occurred on 08/11/2016. This policy/procedure, revised 01/2011, stated, ". . . 2. Set up medications one at a time, using the principles of medical asepsis (clean to dirty). . . ." An observation of medication pass occurred on 08/09/16 beginning at 5:10 p.m. Observation	F 281	F281 1. Corrective action will be accomplished by meeting with CMA responsible for this and reviewing F281 and counseling her. Also licensed staff and CMA inservices were presented by DON on August 23, 2016. 2. All residents in the nursing home have the potential to be affected by this. 3. The deficiency will be corrected by the DON counseling the CMA and having licensed nurse and CMA inservices on August 23, 2016 presented by the DON, discussing F281. 4. The QA nurse or designated personnel will randomly monitor medication pass 2x/week x2 weeks. The CMA responsible for the deficiency will be monitored by the QA nurse or designated personnel weekly x1 month. 5. Corrective action will be accomplished by 9/16/16.	9/16/16

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F 281	Continued From page 4 showed the certified medication aide (CMA) (#10) stirring eight cups of a water one at a time. When asked, the CMA (#10) identified the water contained dissolved MiraLax (a laxative). The CMA (#10) took one cup of MiraLax and another medication to a resident across the dining room from the medication cart, leaving seven cups of MiraLax unattended on top of the medication cart. The CMA (#10) passed medication to another resident, leaving the MiraLax unattended on top of the medication cart. The CMA (#10) dispensed a third resident's medication, taking medication out of a stock bottle (medication used by multiple residents). The CMA (#10) poured two tablets into the lid. Only needing one for the resident, the CMA (#10) place a finger (ungloved hands) on one pill, poured the pill she was not holding back into the bottle and then tipped the pill she held onto off the lid and into the medication cup. The CMA (#10) then took the medications to this third resident, leaving the MiraLax unattended on top of the medication cart. Observations made 08/09/16 from 5:19 p.m. to 6:00 p.m. showed residents passing the medication cart as they moved to and from the dining room tables, some independently, others with staff assistance. The CMA (#10) left the MiraLax unattended on top of the cart as she continued to pass medications in the dining room, eventually leaving only one cup of MiraLax on top of the medication cart. The CMA (#10) then pushed the medication cart out to a resident care area, leaving the cup of MiraLax unattended on top of the cart as she entered a resident room and shut the door. While the medication cart sat	F 281		

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F 281	Continued From page 5 unattended in the hallway, at least three residents and three staff members walked or wheeled past the medication cart. During an interview on 08/11/16 at 10:40 a.m., an administrative nurse (#11) agreed the CMA (#10) should not have made up eight MiraLax drinks one at a time, left the drinks unattended on top of the medication cart, and handled medications with her bare hands.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 and record review, the facility failed to provide the assistance necessary to meet the needs of 1 of 3 residents (Resident #9) observed being fed. Failure to provide the necessary assistance for Resident #9 during meals placed her at risk for increased behavior, reduced intake, and subsequent weight loss. Findings include: Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia, anxiety, and delusional disorder. The quarterly Minimum Data Set (MDS), dated 07/10/16, identified short and long term memory problems, moderately impaired problem solving	F 312	F312 1. Corrective action will be accomplished by providing inservice education to all staff by DON on August 31, 2016 and licensed nurses and CMA□s on August 23rd, 2016. It will also be accomplished by placing an eye in each room where a resident has blindness or significant visual loss in an eye. This includes resident #9. 2. All residents with blindness or significant visual loss in an eye have the potential to be affected by this. 3. The deficiency will be corrected by placing a small eye in each resident room on the over bed light who has an eye	9/16/16

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F 312	Continued From page 6 skills, impaired vision, swallowing problems, and extensive assist of one person for eating. The dietary progress note, dated 07/08/16, identified, "Significant change review: Wt [weight] 117# [pounds] . . . down 10#, 7.9% in 180 days. . . ." Resident #9's current care plan stated," . . . Problem: ADL [activities of daily living] SELF CARE DEFICIT . . . Approach . . . Approach her directly or from the left side due to vision loss on R [right]. Resident can become abruptly paranoid or aggressive . . . Problem: SENSORY PERCEPTION . . . Approach . . . She states has no vision in R eye . . ." Observation showed the following: * 08/09/16 at 8:15 a.m., a certified nursing assistant (CNA) (#6), sat to the right side of Resident #9 as she assisted her with breakfast. Resident #9 hesitated to open her mouth when approached with a spoonful of food. She stated "No, no, no," and attempted to push the CNA's arm away. * 08/09/16 at 5:20 p.m., a CNA (#16), sat to the right side of Resident #9 as she assisted her with supper. Resident #9 pushed the CNA's arm away when approached with a spoonful of food. * 08/10/16 at 8:30 a.m., a CNA (#8), sat to the right side of Resident #9 as she assisted her with breakfast. Resident #9 stated "No," and attempted to push the CNA's arm away. Resident #9 took three bites of food and three sips of liquid. * 08/10/16 at 5:35 p.m., a CNA (#17) followed the care plan and sat to the left side of Resident #9 as she assisted her with supper, Resident #9	F 312	deficit. If significant visual loss to right or left eye, place eye in room was added to resident admission checklist. Also updated hospital return check list to place an eye in room if significant visual change. Inservice education was provided by DON to all staff August 23, 2016 and August 31, 2016. 4. The QA Coordinator or designated personnel will monitor laminated eyes in each room weekly x1 month. Feeding audits will be done 2x/week x1 month then weekly x2 months. 5. Corrective action will be accomplished by 9/16/16.	

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F 312	Continued From page 7 demonstrated significantly less behaviors and her intake increased. Resident #9 reached for her tray, reached for the spoon, leaned forward towards the spoonful of food, opened her mouth, and handed her cup back to the CNA (#17). Resident #9 ate 100% of her peas, 25% of her hotdish, and drank 50% of her juice. Failure to provide assistance during meals from Resident #9's left side (as care planned) placed her at risk for increased behavior, reduced intake, and subsequent weight loss.	F 312		
F 323 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of the EZ Way Smart Stand - Operator's Instructions Manual, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 4 of 8 sampled residents (Resident #1, #7, #9, and #11) observed during transfers. Failure to ensure proper use of the mechanical stand lift resulted in Resident #1 and #7 experiencing pain. Failure to utilize gait belts appropriately (Resident #9 and #11) may result in pain, falls, or injury.	F 323	F323 1. Corrective action will be accomplished by having DON educate nurses and CMA□s at August 23, 2016 meetings and the QA nurse educate all nursing staff August 31, 2016 on keeping residents safe and free of hazards by proper use of the standing lifts and gait belts. Resident #1 is now a hoyer lift. Resident #7 remains a standing lift and staff educated on proper use. #9 uses a gait belt and staff educated. #11 no	9/16/16

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F 323	Continued From page 8 Findings include: SIT TO STAND LIFTS Review of the "EZ Way Smart Stand - Operator's Instructions," occurred on 08/11/16. The Operator's Instructions, revised 12/21/10, stated, ". . . Raise the patient . . . Position patient's arms on the outside of the harness and have them place their hands on the padded handles. . . . Press the UP button. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. Stop lifting when the patient is in a standing position. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, rheumatoid arthritis, polyosteoarthritis, osteoarthritis, osteoporosis, hip and knee replacements, deformities of the left and right foot, and history of tibia fracture. The quarterly Minimum Data Set (MDS), dated 07/31/16, identified severely impaired cognitive skills and extensive assistance of one or more persons with bed mobility, transfers. The current care plan stated, ". . . Problem . . . IMPAIRED MOBILITY/AMBULATION . . . Arthritic pain. Limited ROM [Range of Motion] in shoulders, knees. . . . Approach . . . Standing lift with assist of 1 . . ." Observation showed the following: *08/09/16 at 10:13 a.m.: A Certified Nursing Assistant (CNA) (#9) transferred Resident #1 from her wheelchair to the bathroom utilizing a sit-to-stand lift. The CNA (#9) placed Resident #1's hands on the handles of the lift. Resident #1	F 323	longer needs a gait belt. Care plans updated. 2. All residents receiving standing lift transfers or gait belt transfers have the potential to be affected by this. 3. The deficiency will be corrected by educating licensed nurses and CMA□s as stated in #1 and all nursing staff as also stated in #1. 4. The QA Coordinator or designated nursing staff will monitor gait belt and standing lift transfers 3x/week for 1 month, then weekly x2 months. QA monitoring will be done by designated nursing staff annually on all CNA□s. 5. Corrective action will be accomplished by 9/16/16.	

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F 323	Continued From page 9	F 323		

stated, "Ow!" as the CNA (#9) raised the lift. Resident #1's hands slid down the handles and the harness straps pulled upward into her armpits, raising her shoulders to ear level.
*08/09/16 at 1:21 p.m.: A CNA (#13) transferred Resident #1 from the bathroom to her bed utilizing a sit-to-stand lift. The CNA (#13) placed Resident #1's hands on the handles of the lift. Resident #1 stated, "Ouch!" as the CNA (#13) raised the lift. Resident #1's hands slid down the handles and the harness straps pulled upward into her armpits, raising her shoulders to ear level and extending her elbows out horizontally.
*08/10/16 at 9:50 a.m.: A CNA (#14) and a nurse (#15) transferred Resident #1 from the bathroom to her bed utilizing a sit-to-stand lift. The CNA (#14) and nurse (#15) placed Resident #1's hands on the handles of the lift. As the CNA (#14) raised the lift Resident #1's left hand slid down the handle and the harness straps pulled upward into her armpits, raising her shoulders to ear level. Her right hand dropped to her side. The CNA (#14) commented, "She doesn't hang on very good." Resident #1 replied, "I have arthritis, and it HURTS." The nurse observed the transfer and asked, "Is she able to hold onto the other side?" The CNA (#14) replied, "No."

Facility staff failed to ensure Resident #1 was able to bear weight and hold onto the handles of the lift during a transfer, and failed to report her inability to bear weight and hold onto the handles of the lift to nursing.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and osteoarthritis. The annual MDS, dated 06/29/16, identified

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extensive assistance from two staff members for transfers. The current care plan stated, ". . . Transfers: . . . ext [extensive] assist and s/l [stand lift (mechanical sit to stand lift)] with 2 . . ."

Observation on 08/09/16 at 9:05 a.m. showed two CNAs (#18 and #19) utilized a stand lift to transfer Resident #7 from a wheelchair to the commode. As the CNAs assisted her to an upright position with the lift, the waist harness/belt loosened, slipped up to the resident's armpits, and caused her shoulders to shrug upward. At 9:27 a.m., the CNAs (#18 and #19) utilized the lift to assist Resident #7 off the commode. Again, the harness loosened and slipped up to the resident's armpits and caused her shoulders to shrug upward. Resident #7 stated, "I can't help it! Oh God! It hurts!" The CNAs then lowered the resident to a wheelchair.

Observation on 08/10/16 at 9:22 a.m. showed two CNAs (#20 and #21) utilized the stand lift to transfer Resident #7 to the commode. When the CNAs assisted her to an upright position, the harness loosened and slipped up to resident's armpits and her shoulders shrugged upward.

In both examples, the CNAs failed to tighten the harness when it loosened and slipped up to Resident #7's armpits.

GAIT BELTS

Review of the facility policy titled "Gait Belt Use," occurred on 08/11/16. This policy, revised August 2014, stated, ". . . Procedure: . . . Apply gait belt to resident that requires assist with transfer . . . The belt will tend to slide up with transfer so

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F 323	Continued From page 11 make sure that you are tightening it as needed and make sure that it has a snug fit. . . . There should be approximately 2 finger widths between belt and the body . . ." - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia, delusional disorders, osteoarthritis, and unspecified abnormalities of gait and mobility. The significant change MDS, dated 07/19/16, identified short and long term memory problems and extensive assistance of two people required for transfers, walking in room, toileting, and personal hygiene. The current care plan stated, ". . . Problem . . . ADL SELF CARE DEFICIT. . . Approach . . . toilet res [resident] . . . Extensive assist of 2 . . . Problem . . . IMPAIRED MOBILITY/AMBULATION . . . due to recent falls and unsteadiness . . . Approach . . . Extensive assist of 2 . . . Evaluation Notes: 06/29/2016, . . . Continues to require extensive assist with . . . transfer and ambulation . . . Problem . . . BEHAVIOR PLAN . . . Resistive to cares, transferring self, Angry/Agitated/Yelling/Screaming with cares . . . Behaviors . . . revolve around cares . . ." Observation on 08/09/16 at 2:30 p.m. showed two CNAs (#1 and #4) assisted Resident #9 into the bathroom and onto the toilet without a gait belt. Resident #9 grabbed the handlebar and stood up from the toilet. The CNA (#1) then placed a gait belt around the resident's waist. Neither CNA (#1 and #4) held onto Resident #9's gait belt as they performed pericares and/or adjusted Resident #11's clothing.	F 323		

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	355040	A. BUILDING _____ B. WING _____	08/11/2016

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F 323	Continued From page 12 - Review of Resident #11's medical record occurred on all days of survey. Diagnoses included weakness. The quarterly MDS, dated 07/09/16, identified extensive assistance of one person for transfers, walking in room, and toileting. The current care plan stated, " . . . Problem . . . ADL SELF CARE DEFICIT . . . Approach . . . Extensive assist of 1 to 2 toileting . . . Problem . . . IMPAIRED MOBILITY/AMBULATION . . . Approach . . . Extensive assist of 1 gait belt--yes . . . Problem . . . AT RISK OF INJURY/FALLS . . . Approach . . . Remind resident to call for assist with transfers . . . Evaluation Notes . . . One fall this review . . . " Observation on 08/09/16 at 12:20 p.m., showed Resident #11 sitting on the toilet without a gait belt. A CNA (#9) opened the door to Resident #11's bathroom and assisted her with toileting cares. The CNA (#9) placed a gait belt around Resident #11's waist. Resident #11 held onto the armrests of her electric wheelchair and pulled herself into a standing position. The CNA (#9) failed to use the gait belt as they provided pericares and/or adjusted Resident #11's clothing. The CNAs failed to utilize a gait belt and/or utilize it correctly when assisting Resident #9 and #11with transfers.	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		9/16/16

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F 441	Continued From page 13 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility	F 441	F441	

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F 441	Continued From page 14 policy review, and staff interview, the facility failed to follow infection control practices for 4 of 10 sampled residents (Resident #6, #7, #9, and #11) observed during personal cares. Failure to follow infection control practices related to perineal cares and hand hygiene has the potential to spread infection within the facility. Findings include: Review of facility policy titled "Perineal Cares" occurred on 08/11/16. This policy, revised February 2011, stated, " . . . Purpose: To prevent urinary tract infections . . . Procedure: . . . Hand hygiene . . . Wash hands. Apply disposable gloves . . . For Females . . . wash with soap and water or disposable wipe and wiping downward from front to back and avoiding rectal area . . . Wash the rectal area, wiping from the base of the labia and extending over the buttocks using washcloth and soap and water or a disposable wipe . . . Dispose of gloves into garbage receptacle . . . Hand hygiene . . ." - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included incontinence. The resident's significant change Minimum Data Set (MDS), dated 07/19/16, identified long and short term memory problems, moderately impaired problem solving skills, and extensive assistance of one to two persons for dressing and toileting cares. Observation on 08/09/16 at 2:30 p.m., showed two certified nursing assistants (CNAs) (#1 and #4) assisting Resident #9 with toileting cares. Observation showed the resident incontinent of urine and stool. Both CNA's (#1 and #4) washed	F 441	1. Corrective action will be accomplished by providing all nursing staff education by Infection Control Nurse on August 31, 2016. This included education on proper infection control including pericares and hand hygien and DON educating licensed nurses and CMA□s on August 23, 2016 reviewing the same information. All nursing staff were informed of improper techniques used with #6, 7, 9 and 11 and the proper techniques to be used. 2. All residents have the potential to be affected by this. 3. This deficiency will be corrected by educating all nursing staff on proper pericares and hand hygiene. A clean hands save lives poster placed in 8 different places in the facility. 4. Monitoring will be done annually on CNA□s doing actual pericares and hand hygiene by QA coordinator or designated nursing staff. Also the QA coordinator or designated personnel will audit hand hygiene and pericares randomly 3x/week x1 month, then weekly x2 months. 5. The deficiency will be corrected by 9/16/16.	

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F 441	Continued From page 15	F 441		

their hands, donned gloves, and removed Resident #9's saturated incontinence pad. The CNA (#4) performed perineal care by wiping from back to front with a disposable cleansing wipe. With visible stool on the wipe, CNA (#4) continued to wipe an additional two times from the rectal area to the labia with out folding the wipe.

- Review of Resident #11's medical record occurred on all days of survey. Diagnoses included incontinence and history of urinary tract infections (UTIs). The quarterly MDS, dated 07/09/16, identified intact cognition and extensive assistance of one person required for toilet use and personal hygiene.

Observation on 08/09/16 at 12:30 p.m. showed a CNA (#9) assisting Resident #11 with toileting cares. Observation showed the resident incontinent of urine and stool. The CNA (#9) washed her hands, donned gloves, assisted the resident to stand, and provided pericares using disposable cleansing wipes. After cleansing Resident #11's rectal area and buttocks, the CNA (#9) wiped the resident's perineum from the labia to the rectum three times without turning the wipe to a clean area. The CNA (#9) failed to use a different area of the disposable wipe or to obtain a fresh wipe when cleansing the resident's perineum.

- Review of Resident #7's medical record occurred on all days of survey. The annual MDS, dated 06/29/16, identified extensive assistance for personal hygiene.

Observation on 08/09/16 at 9:27 a.m. showed

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F 441	Continued From page 16 Resident #7 seated on a commode. Two CNAs (#18 and #19) donned gloves, utilized the stand lift, and assisted Resident #7 to an upright position. Observation showed stool in the commode. The CNA (#18) provided perineal cares and removed her gloves. Both CNAs (#18 and #19) pulled Resident #7's brief and pants up but noticed stool on her pants. The CNA (#19) lowered the resident back onto the commode and the other CNA (#18) removed the lift harness and the resident's soiled pants with her bare hands. The CNA (#18) failed to perform hand hygiene after performing perineal cares and removing her gloves, failed to donn gloves before touching Resident #7's soiled clothing, and failed to perform hand hygiene after touching the soiled clothing and before reapplying the lift harness and operating the stand lift. Observation on 08/10/16 at 9:22 a.m. showed two CNA's (#20 and #21) donned gloves and utilized a stand lift to assist Resident #7 to the commode. Before lowering her onto the commode, the CNA (#20) removed her soiled (stool) brief, cleaned the resident's perineal area, and removed her gloves. The CNAs (#20 and #21) then lowered Resident #7 onto the commode and left the room. The CNA (#20) failed to perform hand hygiene before exiting the room. - Review of Resident #6's medical record occurred on all days of survey. The quarterly MDS, dated 05/19/16, identified extensive assistance for personal hygiene. Observation on 08/09/16 at 10:43 a.m. showed two CNAs (#22 and #23) donned gloves and	F 441		

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F 441	Continued From page 17 entered Resident #6's room. The CNA (#23) removed the bedpan they had placed earlier and the other CNA (#22) provided perineal cares. Observation showed stool in the bedpan. Without changing gloves, the CNA (#22) applied a barrier cream to Resident #6's buttocks and then to her front peri-area. The CNA (#22) failed to remove her gloves and perform hand hygiene after perineal cares, and failed to donn a clean pair of gloves before applying the barrier cream. During an interview on 08/11/16 at 10:00 a.m., an administrative nurse (#24) stated she expected the CNAs to follow proper perineal cares and hand hygiene as instructed.	F 441		