STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535053	A. BUILDING _____ B. WING _____	C 01/17/2019

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 1/14/19 through 1/17/19. Also reviewed in the course of the survey were complaint intakes WY00002610 and WY00002618. The following common abbreviations are used throughout the document: ADON: Assistant Director of Nursing CNA: Certified Nurse Aide MDS: Minimum Data Set PASRR: Pre-admission Screening and Resident Review RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were accurately coded for 1 of 15 sample residents (#44) with a PASRR determination. The findings were: 1. Review of the PASRR level II determination completed on 10/14/15 showed resident #44 met the state definition of having serious mental illness. The following concerns were identified: a. Review of the significant change MDS assessment dated 1/3/19 showed section A1500	F 641	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.	3/1/19

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

Electronically Signed | 02/08/2019

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F 641	Continued From page 1 [Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?] was coded as 0 [No]. b. Review of the annual MDS assessment dated 4/18/18 showed section A1500 was coded 0. c. Interview with the MDS coordinator on 1/16/19 at 9:53 AM revealed a resident who had a PASRR level II completed should be coded "yes" on all subsequent comprehensive MDS assessments. d. Interview with the MDS coordinator and social service director on 1/16/19 at 11:02 AM revealed the PASRR was not coded accurately on the resident's MDS assessments because a PASRR Level I was completed in 2016 that did not trigger a level II assessment, because it did not have accurate diagnoses listed. It was confirmed the resident did have a diagnosis that would trigger the PASRR level II assessment.	F 641	F 641 accuracy of assessments PASRR 2 Resident #44's MDS significant change assessment dated 1/3/19 was corrected, resubmitted and accepted on 1/18/19 to reflect the PASRR level 2 status. SSD and MDS coordinator will review all current resident's medical records to ensure accurate diagnoses for each resident. Any resident identified as requiring a PASRR level 2 will have their most recent assessment reviewed to ensure coding accuracy and will be corrected and resubmitted as indicated. SSD and MDS coordinator were reeducated on 2/5/19 regarding diagnosis codes that require a PASRR level 2 and on Section A of the RAI manual regarding pre-admission screening and resident review. SSD and/or MDS coordinator will conduct weekly random audits on all new admissions for diagnosis triggering PASRR 2. The audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The SSD and/or MDS coordinator will report the results of the audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		3/1/19

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F 656	Continued From page 2	F 656		

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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F 656	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff provided care as directed by the care plan for 1 of 20 sample residents (#33). The findings were: 1. Review of the 12/18/18 quarterly MDS assessment showed resident #33 required limited assistance with eating, and had non-physician prescribed weight loss. Review of the 12/18/18 care plan showed nutrition goals included "...eat a weekly average of 75% of meals." Interventions for weight loss included weighing the resident bi-weekly, and monitoring intake. Interview on 1/16/19 at 5:01 PM with the ADON revealed the resident had problems with weight loss last year, recently had gallbladder surgery, returned to the facility on 1/8/19, and continued to have problems with weight loss. She stated the physician prescribed appetite stimulants, the dietitian was consulted; and nursing staff encouraged the resident to eat his/her preferred foods. The following concerns were identified: a. Review of the documented weights for this resident showed his/her weight decreased from 148.6 pounds in October 2018 to 129.2 pounds on 12/23/18. Further review showed no resident weight had been recorded since the resident returned from the hospital on 1/8/19. b. Review of food consumption records showed documentation for the amount of food consumed by the resident was blank for 1 to 2 meals each day from 1/9/19 to 1/15/19. 2. During interview on 1/16/19 at 5:01 PM, the ADON stated a baseline weight after surgery and completed records of food intake were important to monitor the resident's weight loss. She	F 656	F 656 Care plans – missing weights, missing intakes Resident # 33 was weighed on 1/17/19 and 2/2/19 per his/her plan of care and his/her meal intakes were reviewed from 1/17/19 to current to ensure proper documentation of intake. All other residents will reviewed to ensure weights have been completed per their plan of care and meal intakes have been documented appropriately per their plan of care by 3/1/19. The facility has implemented a computerized triggering system to ensure staff is notified when a weight is due to be completed alerting nurse management staff if not complete. A process change in meal documentation has been put in place to ensure more timely meal intake recording. All staff affected by the process change will be educated on the changes by 3/1/19. The dietary manager or designee will conduct weekly random audits of resident intakes to ensure compliance. The audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The DON or designee will conduct weekly random audits of resident weights to ensure compliance. The audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. DON/ Dietary manager or designee will report the results of the audits at the QA&A	

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F 656	Continued From page 4 confirmed staff had not weighed the resident since 12/23/18 (before surgery) and the food consumption records were incomplete. She confirmed the care plan interventions for weight loss had not been followed.	F 656	meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure residents were offered meaningful and ongoing activities designed to improve or maintain the physical, mental, and psycho-social well-being for 1 of 2 sample residents (#29) reviewed for activities. The findings were: 1. Review of the significant change MDS assessment dated 6/29/18 showed resident #29 had diagnoses which included Alzheimer's disease and non-Alzheimer's dementia. Further review showed it was "very important" or "somewhat important" to the resident to have items to read, listen to music, be around animals, keep up with the news, do things with groups of people, and do his/her favorite activities. Review	F 679	F679 The facility will ensure meaningful and ongoing activities to improve or maintain the physical, mental and psycho-social well-being of residents are offered and recorded. A paper tracking system was in place to allow staff to follow each resident's activity care plan, however the system was not being monitored to ensure plans were followed. Resident #29 will be re-interviewed to assess his/her current needs with regard to meaningful and ongoing activities. New goals will be established based on the resident's preferences and care plan interventions will be revised and	3/1/19

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F 679	Continued From page 5 of a "one to one" activity care plan dated 1/13/19 through 1/19/19 showed "...I will have one to one visits with activities 2xW [two times per week]...Goals:...12/11/18 I will have one to one visits with activity staff 3xW [three times per week] through my next assessment...How can you help me:...Please continue to let me know what activities are happening that day/week and give me reminders and encourage me to come to activities..." The following concerns were identified: a. Observation on 1/16/19 at 9:22 AM showed resident #29 was sitting in his/her wheelchair facing the wall away from the television. The television was turned on, with a children's program playing. The resident remained facing the wall until 12:06 PM. The resident was not offered 1 to 1 or group activities during the observation. b. Review of the activity calendar for January 2019 showed on 1/16/19 scheduled group activities included bible study at 9:30 AM and manicures at 10 AM. c. Review of the "Activities Roster" for November 2018 showed the resident participated in 2 activities on 11/1/18, 1 activity on 11/6/18, and 1 activity on 11/29/18. There was no evidence the resident refused activities for the month, and no evidence the resident participated in any activities for 21 days between 11/6/18 and 11/28/18. d. Review of the "Activities Roster" for December 2018 showed the resident participated in activities on 6 days out of 31: 1 activity on 12/7/18, 1 activity on 12/14/18, 1 activity on 12/20/18, 1 activity on 12/26/18, 1 activity on 12/27/18, and 1 activity on 12/31/18. e. Interview with the activities director on 1/17/19 at 11:48 AM revealed the expectation for	F 679	implemented by 3/1/19. Residents who have care plans with interventions of one-to-one visits will be reviewed to ensure activity needs are being met. A new electronic medical record system was implemented 1/7/19, which will improve staff's ability to record activities attended and activities that were refused after offering. Activities staff will be educated and procedures will be updated to ensure resident activity interactions are reflected accurately in the medical record. The Activities Director or designee will conduct weekly random audits of resident participation charting to ensure compliance. The audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The Activities Director or designee will report the results of the audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	

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F 679	Continued From page 6 staff was to perform resident one to one visits as determined on the resident's care plan, document if an activity was not performed, and document why the activity was not performed. Further, she expected staff to offer activities to residents even if they may not attend, in case there is something that the resident does want to do.	F 679		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure monitoring was consistently implemented for 1 of 3 residents (#33) who had weight loss. The findings were:	F 692	F 692 Nutrition / Hydration Status- Resident # 33 was weighed on 1/17/19 and 2/2/19 per his/her plan of care and his/her meal intakes were reviewed from 1/17/19 to current to ensure proper	3/1/19

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F 692	Continued From page 7 1. Review of the 12/18/18 quarterly MDS assessment showed resident #33 required limited assistance with eating, and had non-physician prescribed weight loss. Review of the 12/18/18 care plan showed nutrition goals included "...eat a weekly average of 75% of meals." Interventions for weight loss included weighing the resident bi-weekly, and monitoring intake. Interview on 1/16/19 at 5:01 PM with the ADON revealed the resident had problems with weight loss last year, recently had gallbladder surgery, returned to the facility on 1/8/19, and continued to have problems with weight loss. She stated the physician prescribed appetite stimulants, the dietitian was consulted; and nursing staff encouraged the resident to eat his/her preferred foods. The following concerns were identified: a. Review of documented weights for this resident showed his/her weight decreased from 148.6 pounds in October 2018 to 129.2 pounds on 12/23/18. Further review showed no resident weight recorded since the resident returned from the hospital on 1/8/19. b. Review of food consumption records showed documentation for the amount of food consumed by the resident was blank for 1 to 2 meals each day from 1/9/19 to 1/15/19. 2. During interview on 1/16/19 at 5:01 PM, the ADON stated a baseline weight after surgery and completed records of food intake were important to monitor the resident's weight loss. She confirmed staff had not weighed the resident since 12/23/18 (before surgery) and the food consumption records were incomplete.	F 692	documentation of intake. All other residents will reviewed to ensure weights have been completed per their plan of care and meal intakes have been documented appropriately per their plan of care by 3/1/19. The facility has implemented a computerized triggering system to ensure staff is notified when a weight is due to be completed alerting nurse management staff if not complete. A process change in meal documentation has been put in place to ensure more timely meal intake recording. All staff affected by the process change will be educated on the changes by 3/1/19. The dietary manager or designee will conduct weekly random audits of resident intakes to ensure compliance. The audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The DON or designee will conduct weekly random audits of resident weights to ensure compliance. The audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. DON/ Dietary manager or designee will report the results of the audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		3/1/19

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F 755	Continued From page 8 §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 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, staff interview, and policy and procedure review the facility failed to ensure proper labelling and monitoring of expired medications for 2 of 4 medication storage areas (south station medication cart, south medication storage room). The findings were:	F 755	F 755- Pharmacy services The facility will ensure proper labeling and monitoring of medications and biologicals. All multi-use eye drop bottles will be dated when opened. Eye drop bottles will be discarded based on the manufacturers	

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F 755	Continued From page 9 1. Observation on 1/15/19 at 3:44 PM of the south station medication cart showed an open bottle labeled travatan 0.004% eye drops and an open bottle labeled timolol 0.25% eye drops. Neither bottle was marked with an open date. Interview with RN # 1 revealed the medications in the medication cart were for resident use. 2. Observation on 1/17/19 at 10:29 AM of the south medication room showed one box containing 33 white petroleum skin protectant packets with an expiration date of 7/17. Interview with RN #1 revealed the medications in the medication storage room were for resident use. 3. Review of the Storage of Medications Policy showed "The facility shall not use discontinued, outdated or deteriorated drugs..." 4. Review of the Administering Medications Policy with a revision date of 3/26/18, showed "When opening a multi-dose container, the date opened shall be marked on the container." 5. Review of the American Association of Ophthalmic Registered Nurses instruction found at www.asorn.org/client_datafiles/2014/303_asornmultidosemedicationed.pdf (retrieved 1/22/18) showed "...Label the medication bottle or tube with the date and time opened...and the expiration date of the vial, not to exceed 28 days..."	F 755	recommendations or if contaminated. The medication storage room and carts will be inspected by 3/1/19 for medications and biologicals available for resident use that have reached the expiration date. All medication and biologicals that have been found to have reached the expiry date will be discarded. The facility policy regarding storage of medications will be reviewed and updated if needed. Nursing staff will be educated on the process changes by 3/1/19. DON /designee will conduct monthly audits of the medication rooms and carts to ensure compliance. Any problems identified will result in immediate education and corrective action. DON /designee will report the results of the audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink	F 804		3/1/19

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F 804	Continued From page 10 Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and family interviews, and review of policy and procedure, the facility failed to ensure foods were served at appetizing temperatures. The facility census was 47. The finding were: Interview on 1/14/19 at 4:12 PM, with a family member revealed during visits to the facility in the past two months, she had noticed most of the meals were cold by the time they were served to the residents. Group interview with 12 residents on 1/15/19 at 1:27 PM revealed the food was cold and did not have a lot of flavor. The following concerns were identified: 1. Observation on 01/16/19 at 5:48 PM PM after the last supper tray was served to the residents, showed the dietary manager and dietary staff #2 placed some of the chicken a la king and chicken soup from the steam table in bowls and checked the temperatures. The chicken a la king was 128 degrees F, and chicken soup was 120 degrees F. 2. Interview with the dietary manager on 1/16/19 at 12:25 PM revealed her expectation was for holding temperatures to be above 140 degrees F. She further stated dietary staff recorded the food temperatures at the time of service, but were not aware of problems with the holding temperature.	F 804	F804 The facility will ensure potentially hazardous hot foods are served at appetizing temperatures of no less than 135 degrees Fahrenheit (F). The temperature of food being served has the potential to affect all residents in the facility. The steam table was tested and noted to be in working order. Staff was found to have removed the food product from the steam table, and had not covered the container to maintain heat, causing the product to cool below the proper holding temperature. The policy and procedure for “Critical Limits for Holding Hot and Cold Potentially Hazardous Foods” will be reviewed with the Dietary Manager and education will be provided to all food service employees by 3/1/19. The Dietary Manager or designee will conduct weekly random audits of food temperatures to ensure compliance. The audits will be conducted for no less than 3 months to ensure compliance. Any	

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	535053	A. BUILDING _____ B. WING _____	C 01/17/2019

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F 804	Continued From page 11 3. Review of the policy and procedure for "Critical Limits for Holding Hot and Cold Potentially Hazardous Foods", not dated, showed "All hot potentially hazardous foods should be 135 degrees Fahrenheit [F] or above before placing the food out for display or service."	F 804	problems identified will result in immediate education and corrective action. The Dietary Manager or designee will report the results of the audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
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:	F 880		3/1/19

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F 880	Continued From page 12	F 880		

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

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

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F 880	Continued From page 13 Based on observation and staff and resident interviews, the facility failed to implement measures to reduce cross contamination for 1 of 2 residents (#7) who used a urinal. The findings were: Observation on 1/14/19 at 5:15 PM showed resident #7 in bed. A urinal that was partially filled with urine was positioned on the bedside stand among a closed bag of partially consumed potato chips and various other snacks. At that time the resident stated s/he preferred eating meals in bed. Observation on 1/15/19 beginning at 9 AM showed the resident was in bed eating breakfast. The breakfast tray was on the overbed table. The urinal on the bedside stand contained approximately 300 milliliters of urine. During the observation the resident periodically touched the urinal, food and fluids positioned beside the urinal, and ate breakfast. Observation on 1/17/19 at 10:30 AM showed CNA #1 placed the urinal on the bedside stand with the snacks and food items after she emptied it, removed her glove, performed hand hygiene, then departed. Interview on 1/17/19 at 1:45 PM with the infection prevention nurse revealed she would be concerned about cross contamination of food when a urinal is stored next to it. She stated the expectation would be for staff to remove and empty the urinal, remove potential cross contamination, and clean the surface. She further stated the resident needed a dedicated surface for the urinal and possibly a cover.	F 880	F 880- IC cross contamination Resident #7 has been educated regarding the cross contamination concerns. Resident #7's care plan has been updated to reflect his/her preferences regarding the placement of his/ her personal toiletry items. Interventions regarding prevention of cross contamination were added to care plans for all other residents who use personal toiletry items. The infection control policy regarding cross contamination will be reviewed and updated if needed. Nursing staff will be educated on the new care plan interventions regarding cross contamination by 3/1/19 The infection control nurse/or designee will conduct weekly random audits of toiletry items and placement area for cleanliness to ensure compliance. The audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The infection control nurse or designee will report the results of the audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	

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F 880	Continued From page 14 Interview on 1/17/19 at 10:50 AM with the ADON revealed the resident refused to use a holder or separate surface area for storing the urinal before and after use. She further stated incidents of cross-contamination could be reduced if staff used disinfecting wipes on surfaces and the urinal prior to returning the emptied urinal to the bedside stand; but this practice had not been implemented.	F 880		