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	535025	A. BUILDING _____ B. WING _____	C 08/15/2019

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 8/12/19 through 8/15/19. Also reviewed in the course of the survey was complaint intake WY00002853. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing Services LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		9/7/19

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

Electronically Signed | 09/06/2019

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services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this

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F 645	Continued From page 2 section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the pre-admission screening and resident review (PASARR) process was accurately completed for 1 of 2 sample residents (#66). The findings were: Review of the medical record showed resident #66 had a diagnosis on 6/9/19 (date of admission) of "Unspecified Psychosis Not Due To a Substance or Known Physiological Condition (F29)." In addition, review of the August 2019 MAR showed this diagnosis continued to be used for the medication order of Zyprexa (an anti-psychotic). The following concerns were identified: a. Review of the PASARR level 1 dated 6/9/19 showed this diagnosis was not listed, nor was any other psychiatric diagnosis, and a level 2 was not indicated. b. Interview with the social worker on 8/14/19 at 12:14 PM revealed the diagnosis should have been included based on the information at that time, and a PASARR 2 would have been required. The social worker further revealed the physician wrote an order dated 8/14/19 to change the diagnosis code, having decided it had been in error.	F 645	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. The plan of correction serves as the facility□s allegation of compliance. F 645 PASRR Screening for MD & ID CORRECTIVE ACTION The primary physician updated the diagnosis for resident #66 on 8/14/19 from psychosis to the more appropriate of Dementia with psychosis which does not require a Level II PASRR. IDENTIFICATION OF OTHERS The social workers reviewed a list of diagnosis and medications to a list of residents who have PASRR Level II	

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F 645	Continued From page 3	F 645	screens on 8/28/19. No additional residents were identified as needed PASRR Level II screens. SYSTEMIC CHANGE In-service training was provided to the Social Service and admissions staff related to PASRRs and requirements and triggers for a Level II screen on 9/5/19 by the Social Service Consultant. The admissions coordinator reviews diagnosis of potential admissions with the nursing administration team or the social worker for triggering diagnosis prior to acceptance and processes the Level I PASRR with the appropriate diagnosis to identify a need for a Level II PASRR. During the morning meeting the social workers reviews the diagnosis and medications of newly admitted residents that may trigger the need for a Level II screen. Upon identification of the need, the social worker will make the appropriate referrals to initiate the Level II process. The social workers will track all referrals for Level IIs to ensure that the process is completed and the Level II is received by the facility. MONITORING The social workers will review the newly admitted residents and need for Level II PASRR Screens and report any identified patterns or trends of missing Level II Screens to the Quality Assurance	

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F 645	Continued From page 4	F 645	Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		9/7/19

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F 725	Continued From page 5 Based on resident interview, family interview, staff interview, review of daily nurse staff postings, and review of hours per patient per day requirements (HPPD), the facility failed to ensure sufficient nursing staff to meet resident needs for 2 of 2 units (South, North). The census was 89. The findings were: Review of daily nurse staff postings from 8/1/19 through 8/13/19 showed the facility posted actual hours worked and the number of staff for each nursing category which included CNAs, LPN-LVNs, and RNs. The postings also showed the daily census. Review of the facility-determined HPPD for each nursing staff category showed 1.713 HPPD were required for CNAs, 0.306 HPPD were required for LVNs/LPNs, and 0.4355 HPPD were required for RNs. The review showed the HPPD were not separated per unit and reflected the facility as a whole. The following concerns were identified: 1. Concerns from nurse staff postings from 8/1/19 through 8/13/19: a. The review showed the facility determined ratio of 1.713 HPPD for CNAs was not met for 6 of the 13 days (8/3/19, 8/4/19, 8/6/19, 8/8/19, 8/10/19, 8/11/19). Four of those 6 days were on the weekend. b. The review showed the facility determined ratio of 0.306 HPPD for LVN-LPNs was not met for any of the 13 days reviewed. c. The review showed the facility determined ratio of 0.4355 HPPD for RNs was not met for 6 of the 13 days (8/1/19, 8/2/19, 8/6/19, 8/7/19, 8/8/19, 8/9/19). 2. Concerns from resident interviews: a. Interview with resident #84 on 8/12/19 at	F 725	F 725 Sufficient Nursing Staff CORRECTIVE ACTION A facility representative met with residents #6, #16, #34, #37, #44, #45, #50, #56, #73, #82, and #85 before 9/6/19 to discuss staffing and care concerns. Any concerns identified were placed on a concern form and the NHA or Director of Nursing/designee followed up with the resident to resolve the concern. Residents #3 and #187 no longer reside in the facility. IDENTIFICATION OF OTHERS Facility Ambassadors or designees meets with the residents assigned to them 3 days per week to discuss and/or address care concerns. Additionally, the facility Ambassador contacts the Resident□s Representative for those residents unable to speak for themselves weekly to discuss concerns. The weekend manager addresses manager addresses concerns that arise during the weekend (Saturday and Sunday) and report the concerns to the facility leadership team the following business day. If additional concerns are identified, corrective action will be taken. SYSTEMIC CHANGE The of Nursing and nurse management team will utilize On Shift Staffing Software	

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F 725	Continued From page 6 11:06 AM revealed staff took from 30 to 40 minutes to answer call lights. b. Interview with resident #187 on 8/12/19 at 10:23 AM revealed call lights were not answered promptly. S/he stated it had taken up to an hour for staff to answer call lights. S/he further stated staff would sometimes "peek in the door" and say they would return. However, staff would not return for up to an hour. c. Interview with resident #44 on 8/12/19 at 3:45 PM revealed s/he felt the facility needed more help, so more than one resident at a time could be helped. d. Interview with resident #6 on 8/12/19 at 10:17 AM revealed the facility was short-staffed and baths and showers were sometimes delayed as a result. In addition, medications were sometimes administered late as a result of insufficient staffing. e. Interview with 8 residents on 8/13/19 at 9:05 AM showed 7 of 8 residents felt the facility was short-staffed. The residents voiced concern the call lights were not answered for extended periods of time. Resident #85 stated the noise of the call lights affected his/her ability to have quality sleep. In addition, resident #79 stated inadequate staffing on weekends resulted in delayed smoking times because they required staff supervision. f. Interview with resident #37 on 8/12/19 at 4:13 PM showed s/he felt the facility was understaffed, and s/he felt staff was overworked and "worked their butts off." g. Interview with resident #3 on 8/12/19 at 4:13 PM revealed one CNA was dedicated to baths and showers and s/he felt the facility was short-staffed. S/he felt when the shower aide was pulled to work the floor, baths and showers were delayed.	F 725	program to assist with consistent daily scheduling and staffing needs, to include any changes in daily staffing scheduling. The NHA and DON participate in daily staffing meetings (Monday-Friday) with weekend staffing discussed in the days prior to the upcoming weekend) and weekly recruitment calls with field support until staffing is stabilized. The NHA, Director of Nursing and Staff Development Coordinator will participate in hiring processes for facility staff. The HR represented will coordinate orientation and on boarding process for newly hired employees to assist with a smooth transition and adjustment to facility. The NHA/DON interviews 4 direct care staff members per week for 90 days to obtain feedback on how they are feeling about their job and their suggestions. Actions will be taken as needed based on feedback. The NHA, DON, Nurse Management team, facility department managers and the Area Human Resource Representative are available in the facility or by phone whenever staff have concerns or struggles or need to talk. The Management team provides or seeks appropriate assistance for staff as needed. The NHA with input from the Management Team will select a C.N.A. to participate in the Quality Assurance Performance	

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F 725	Continued From page 7 3. Concerns from family interviews: a. Interview on 8/12/19 at 7:58 PM with a family member of resident #187 showed on 8/12/19 during a visit on the day shift, s/he told staff the resident was incontinent of urine and required incontinence care. The family member stated the staff took at least 30 minutes to respond. According to the family member this was a result of insufficient staffing to meet the needs of the residents in a timely manner. 4. Concerns from staff interviews: a. Interview with CNA #1 on 8/14/19 between 3:21 PM and 4:20 PM revealed staffing levels were okay during the weekdays, but the facility had insufficient staffing on weekends which resulted in a delay of resident care in areas that included call light response, meal assistance, and getting residents to bed in a timely manner after meals. The CNA confirmed she sometimes would answer a call, not be able to provide care, turn the call light off and have to return at a later time to provide the assistance to the resident. She also had a concern regarding residents who required 1 to 1 staff assistance due to episodes concerning aggressive behavior issues, particularly if the episode happened on the weekend. She stated residents #6 and #37 had complained to her about insufficient staffing and delays in answering call lights. b. Interview with CNA #2 on 8/14/19 between 3:21 PM and 4:20 PM revealed the "weekends are rough" regarding staffing levels, but staff work together and they "get it done." She stated resident #37 complained about staff not answering call lights in a timely manner, and resident #6 complained about not being placed in bed in a timely manner. The CNA expressed	F 725	Improvement Committee. The C.N.A. will provide input on staffing to the Committee. MONITORING The NHA reviews the facility resident interviews completed by the Ambassadors to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue. The NHA/designee tracks and trends resident interviews, turnover rates, numbers of vacant positions and number of new hires, reasons for termination and reports identified concerns to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	

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concern about residents who required 1 to 1 staffing due to behaviors, as there was insufficient staff to provide the increased supervision on the weekends.

c. Interview with CNA #3 on 8/14/19 between 3:21 PM and 4:20 PM revealed the facility was very short of staff on Fridays and the weekends, which caused a delay in care for residents who required mechanical lifts for transfer. She stated the South Unit was of particular concern, as one nursing position and the accompanying medication cart was discontinued as a result of staffing issues, and those nurses had sometimes assisted the CNAs. This staffing downgrade sometimes resulted in a delay of making the required every 2 hour rounds on residents for incontinence and other cares and answering call lights. She stated the bath aide was also pulled to work the floor sometimes, which resulted in a delay for resident showers and baths. Residents she knew of who complained about insufficient staffing included residents #45 and #82. The CNA was concerned when residents had behaviors and required 1 to 1 staff assistance, there was not enough staff to accommodate the increased supervision.

d. Interview with CNA #4 on 8/14/19 between 3:21 PM and 4:20 PM revealed the bath aide was pulled to the floor quite often, with the North Unit bath aide getting pulled more. The CNA stated there were not enough staff to get required tasks done for residents in a timely manner, which affected all shifts. She stated the weekends were "absolutely terrible" and approximately 3 days during Monday to Friday the facility had insufficient staff to meet the needs of the residents in a timely manner. Residents that complained about insufficient staffing included residents #6, #37, #44, and #50. She stated

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some nurses assisted with answering call lights. However, call lights were not always answered in a timely manner. The CNA expressed concern there was not always enough staff to provide the required 1 to 1 care for residents when they had behaviors.

e. Interview with CNA #5 on 8/14/19 between 3:21 PM and 4:20 PM revealed there were some days the facility was completely staffed and some days there was only 1 CNA per unit, which was insufficient to meet the needs of the residents in a timely manner. She stated the time the facility was most short of staff was the day shift on weekends. The CNA stated the nurses would sometimes answer call lights, but there remained an issue with answering call lights in a timely manner. She stated rounds on the residents were required every 2 hours, but sometimes that was not realistic and when staff finished one round it was already time to start again. She stated resident rounds included urinary catheter emptying with catheter care, making beds, checking and changing the residents, and providing toileting assistance to residents who require that assistance. The CNA stated there were residents who sometimes required 1 to 1 staffing due to behaviors, and she was not sure if the issue with the facility not providing the 1 to 1 care as required was a result of insufficient staffing or staff being frightened of the residents and refusing.

f. Interview with CNA #6 on 8/14/19 between 3:21 PM and 4:20 PM revealed the facility was not fully staffed on the weekends. Due to the shortages there were delays in answering call lights and completing resident rounds. She stated the care provided on resident rounds included catheter emptying and catheter care, incontinent care and toileting needs, providing water, and

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providing safety checks. There were also delays in placing residents in bed at the times they wanted. The aide knew of 2 residents who complained about insufficient staffing, these were residents #37 and #56. She also stated there was a resident who required 1 to 1 staff supervision at times due to his/her aggressive behaviors, and on the weekends there were not enough staff to accommodate this.

g. Interview with CNA #7 on 8/14/19 between 3:21 PM and 4:20 PM revealed it was "hard most of the days when short-staffed" She stated that for awhile staff was short at night, then evening, and now staffing was more of an issue on mornings and weekends. Insufficient staffing during meal times made it hard to get meals out, and rounds on residents were sometimes late. She stated residents complained of insufficient staffing, these included residents #6, #16, #34, #37, #50, and #73. She stated bath aides were pulled to work the floor about twice a week, which caused a delay in baths and showers being done. She stated at times one of the residents required 1 to 1 staffing for behaviors, but there was insufficient staff sometimes to provide the increased supervision. She felt it was "too risky" for the facility to have residents with behaviors who required 1 to 1 staffing. She stated this issue was of particular concern on the night shift when there were only 2 CNAs to cover a unit, as one would be required to provide the 1 to 1 care, which left only 1 CNA for the entire unit.

5. Interview on 8/15/19 at 8:38 AM with the corporate director of regulatory compliance, administrator, and DON confirmed the facility utilized 2 agency staff nurses, had 2 additional agency staff nurses contracted to work at the facility, and had one more open nursing slot. They

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F 725	Continued From page 11 stated the facility was not utilizing agency CNAs because there were none available in the area. Each confirmed staffing was more of a challenge on the weekends. Each confirmed their expectation was for staff to meet the needs of residents in a timely manner, and the hope was that residents would not have to wait more than 15 minutes for staff assistance. The administrator stated her expectation was for staff to leave the resident's call light on until staff attended to the resident's needs.	F 725		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		9/7/19

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F 756	Continued From page 12 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a medication irregularity was reported to the DON, medical director, and attending physician for 1 of 3 sample residents (#37) reviewed for pain management. The findings were: 1. Review of the medical record for resident #37 showed s/he was admitted to the facility on 11/7/17 with allergies which included acetaminophen with the severity level listed as unknown. The following concerns were identified: a. Review of the most current physician orders showed Tylenol (acetaminophen) 325 mg; give 650 mg by mouth every 4 hours as needed for headache, was prescribed on 7/9/19. Further review showed the order for the Tylenol was communicated via phone. b. Review of the July 2019 medication administration record (MAR) showed acetaminophen was administered 6 times. c. Review of the August 2019 MAR from 8/1/19 through 8/12/19 showed acetaminophen was administered 1 time.	F 756	F 756 Drug Regimen Review CORRECTIVE ACTION On 8/15/19 the primary physician documented that resident # 37 has tolerated the Tylenol without problems and therefore she has no allergy. The medical record was updated to reflect that resident # 37 has a sensitivity to Tylenol rather than an allergy on 8/26/17. IDENTIFICATION OF OTHERS On 9/6/19 the pharmacy consultant conducted an audit of residents with documented allergies who receive medication that may cause a hypersensitivity when taking the medication. These interactions were reviewed with the primary physician for	

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F 756	Continued From page 13 d. Review of the drug regimen review dated 8/1/19 showed "This medical record has been reviewed with no recommendations or irregularities noted at this time." e. Interview with the DON on 8/15/19 at 8:57 AM revealed if the allergy was not a "true allergy" the physician would have addressed it in a progress note when he prescribed it. In addition, the nurses should have recognized the irregularity before administering the medication. f. Interview with the director of regulatory compliance on 8/15/19 at 10:13 AM revealed the pharmacist should have identified the irregularity. g. The facility's pharmacist was unresponsive to multiple attempts to contact him for an interview.	F 756	direction. SYSTEMIC CHANGES The pharmacist reviews all medications monthly, including over the counter medications, for allergies. The pharmacist notifies the DON of any identified concerns and the DON ensures the physician is aware to allow for proper intervention related to the allergy. The licensed nursing staff was provided in-service education by the SDC completed by 9/7/19 related to the appropriate action to be taken when the EMR notifies them of a potential allergic reaction to include notifying the physician of the medication allergy related to the new medication order and documenting the physician□s response. The DON/designee reviews the Order Alerts Listing Report 5 days per week to identify any ordered medications that may cause an allergic reaction and follows up to ensure the primary physician is aware of the allergy. MONITORING The DON/designee reports any patterns or concerns related to medication orders and allergies to the Quality Assessment Performance Improvement Committee monthly for their review and resolution. These reviews will continue for 3 months unless the Quality Assessment Performance Improvement Committee	

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F 756	Continued From page 14	F 756	deems it prudent to continue.	
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 reported; (iii) Standard and transmission-based precautions	F 880		9/7/19

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F 880	Continued From page 15 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, staff interview, and policy and procedure review, the facility failed to ensure effective infection control practices were followed during 2 random resident observations (#75, #82). The findings were: 1. Observation on 8/12/19 at 12:30 PM showed the DON performed a dressing change for	F 880	F 880 Infection Prevention and Control CORRECTIVE ACTION In-service education was provided to the nurse who provided treatment to resident	

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F 880	Continued From page 16 resident #75. The following concerns were identified: a. After the DON finished the removal of the old dressings, cleaned the wounds, and measured the wound she failed to remove her gloves, perform hand hygiene, and don clean gloves before applying the new dressing. b. Interview with the Infection Control nurse on 8/15/19 at 9:30 AM revealed the expectation was for the nurse to change gloves after removing the old dressing and putting on the new dressing. c. Review of policy and procedure titled "Alginate dressing application" last revised on 2/15/19 showed "...Clean the wound... Remove and discard your gloves. Perform hand hygiene. Put on a new pair of clean or sterile gloves... ...Assess wound severity..." 2. Review of the 5/20/19 quarterly MDS assessment showed resident #82 had diagnoses which included multiple sclerosis and neurogenic bladder, and had an indwelling catheter. Review of the 7/3/19 care plan showed the resident had a history of urinary tract infections. The following concerns were identified: a. Observation on 8/13/19 at 1:05 PM showed the resident was in his/her wheelchair in front of the building. The catheter bag was noted to be attached to the back of the wheelchair hanging at shoulder level with urine visible in the tubing. b. Interview with the infection control nurse on 8/15/19 at 10:07 AM confirmed the catheter bag should not be held above the level of the bladder.	F 880	# 75 as to hand washing and glove changing during treatments on 9/5/19 In-service education was provided by the SDC to the staff member who placed the catheter drainage bag on the back of the wheelchair for resident # 82 wheelchair as to the proper placement of the catheter drainage bag on 9/5/19. IDENTIFICATION OF OTHERS All residents who require treatments have the potential to be affected by hand washing and glove changing practices. An audit was conducted by the DON/designee on 8/26/19 to observe each resident with a catheter to ensure that all catheter drainage bags were place below the bladder. All were correctly placed. SYSTEMIC CHANGES In-service education was provided to the licensed nursing staff by the SDC related to hand washing and glove changing and when providing treatments and completed on 9/7/19 In-service education was provided to the facility staff by the SDC to the staff related to proper placement of a catheter drainage bag and completed on 9/7/19. Random rounds are conducted by the SDC with a minimum of 5 observations per week of infection control practices	

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F 880	Continued From page 17	F 880	with an emphasis on use of hand washing and glove changing during treatments and proper location of the catheter drainage bag. Findings are reported to the DON. MONITORING The DON/designee reports any patterns or concerns related to infection control observations to the Quality Assessment Performance Improvement Committee monthly for their review and resolution. These reviews will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	