STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195447	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE MANOR WEST	7060 COTTONWOOD BLVD SHREVEPORT, LA 71129

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based upon record review, interviews and facility policy review, the facility failed to ensure the facility's Grievance policy was followed for 1 (# 109) out of 42 sampled residents. The facility failed to complete a grievance report in response to a complaint from Resident #109's RP (Responsible Party). Findings: During an interview on 3/5/2020 at 8:45am Resident #109's RP showed surveyor a letter and indicated he had given the letter to the administrator in January 2020 regarding Resident #109's care. Review of 2020 Grievance Binder failed to reveal a grievance was done for Resident #109 in January. During an interview on 3/5/2020 at 11:45am S1 Administrator indicated he had written down notes regarding the incident on a tablet but did not file the complaint as a grievance and should have. Review of Grievances-Residents Policy revealed: Upon receipt of a grievance/complaint the staff receiving the complaint will initiate the Grievance/Complaint Form NS-795. . NS-795 will be completed electronically in the Quality Assurance module.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure incidents involving injury of unknown origin were reported to the State Survey and Certification Agency for 1 (#33) of 4 (#33, #98, #211, #83) residents reviewed for accidents. Findings: Review of Resident #33's [DIAGNOSES REDACTED]. Review of Resident #33's MDS (Minimum Data Set) dated 12/27/19 revealed BIMS (Brief Interview Mental Status) coded as 12 which indicated moderately impaired cognition. Review of Resident #33's records from 9/1/19 thru 3/2/2020 revealed the following incidents with injury of unknown origin noted for Resident #33: 1. 11/8/19-incident=other with localized tissue [MEDICAL CONDITION] bruise 2. 11/24/19-incident=fall with head injury-laceration-deep bruise Review of records regarding Resident #33's incidents of unknown origin from 9/1/19 thru 3/2/2020 revealed: 1. 11/8/19 incident: -Review of Resident #33's incident report dated 11/8/19 revealed Resident #33 was noticed with a swollen left black eye and bruising noted around the eye and near the hair line on the left side of her head. Documentation revealed the cause was unknown and Resident #33 reported she did not know she had a black eye and denied any fall or incident to her eye. -Review of Resident #33's nurse's note dated 11/8/19 revealed Resident #33 was noticed with a swollen left black eye and bruising noted around the eye and near the hair line on the left side of her head. Documentation revealed Resident #33 reported she did not know she had a black eye and denied any fall or incident to her eye. 2. 11/24/19 incident: -Review of Resident #33's incident report dated 11/24/19 revealed Resident #33 was found in the bathroom sitting on the toilet saturated in blood. Resident #33 reported she just came to the bathroom and sat on the toilet and blood started leaking down. Resident #33 was noted to have a bump with swelling to left anterior side of forehead and was actively bleeding. Emergency Medical Services were called and Resident #33 was transported to the emergency room . -Review of Resident #33's nurse's note dated 11/25/19 revealed documentation of late entry for 11/24/19 revealed Resident #33 was found in the bathroom sitting on the toilet saturated in blood. Resident #33 reported she did not know what happened and denied hitting her head on anything. Emergency Medical Services transported Resident #33 to the emergency room where she received 2-3 sutures. Review of the facility Statewide Incident Management System (SIMS) reports reports for 2019 revealed no reports regarding Resident #33. During an interview on 3/5/2020 at 12:30PM S6 DON (Director of Nursing) reviewed Resident #33's incidents from 9/1/19 thru 3/2/2020 and reported to her knowledge there were no SIMS reports submitted for Resident #33. During an interview on 3/5/2020 at 1:10 PM S1 Administrator reported there were no SIMS reports submitted to the State Survey and Certification Agency for Resident #33 from 9/1/19 thru 3/2/2020.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assure that each resident's assessment is updated at least once every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a discharge assessment was completed for 1 (#2) of 5 (#1, #2, #111, #112, #113) residents reviewed for discharge assessments. Findings: Review of Resident # 2's medical record revealed resident was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident # 2's MDS's (minimum data sets) failed to reveal a discharge MDS was completed. During an interview on 3/5/2020 at 10:15am S4 RN Case Manager acknowledged Resident # 2 did not have a discharge MDS completed and one should have been completed.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure assessments were transmitted within the required timeframe for 1 (#1) of 1 (#1) residents reviewed for timely transmission of assessments. Findings: Review of Resident #1's medical record revealed resident was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident # 1's Discharge MDS (minimum data set) dated 10/31/19 revealed the status of Transmitted. Further review of the Assessment Administration section revealed Section X and Z were completed 3/3/2020. During an interview on 3/5/2020 at 10:15am S4 RN (registered nurse) Case Manager acknowledged Resident # 1's Discharge MDS was transmitted on 3/3/2020 and not transmitted within 14 days after assessment as it should have been.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure assessments were accurate for 4 (#1, #83, #112, #113) of 28 residents reviewed for assessments. The facility failed to ensure date of discharge was correct (#1, #113), discharge status was correct (#112) and presence of wander guard (#83) was assessed. Findings: Resident # 1: Review of Resident #1's medical record face sheet revealed resident was admitted to the facility on [DATE]. Review of Resident # 1's nurses' notes revealed a note dated [DATE] at 6:09pm stating Nurse entered resident room to find him non responsive. Nurse was not able to obtain any vitals. Skin is cold and clammy. Resident not responding to tactile stimuli or verbal. Nurse notified hospice answering service at 613pm. Notified DON (director of nursing) at 615pm. Nurse spoke with hospice nurse at 625pm. Review of Resident # 1's hospice care fax cover document indicated date of death as [DATE]. Review of Resident # 1's Discharge MDS (minimum data set) dated [DATE] revealed a discharge date of [DATE] and discharge status of 08-deceased . During an interview on [DATE] at 10:15am S4 RN (registered nurse) Case Manager, after review of Resident # 1's nurses notes, medical

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) record and MDS dated [DATE], confirmed Resident # 1 expired in the facility on [DATE] and the entry on the MDS of discharge date of [DATE] was incorrect. Resident # 83: Review of Resident #83's medical record revealed resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 10:00am revealed Resident # 83 self-propelling herself in her wheelchair on the 300 hallway towards her room with wander guard to right ankle in place. Observation on [DATE] at 2:19pm revealed Resident # 83 sitting in her wheelchair at the nurse's station drinking juice with wander guard to right ankle in place. Observation on [DATE] at 9:58am revealed Resident # 83 sitting in her wheelchair at the nurse's station with wander guard to right ankle in place. Observation on [DATE] at 3:24pm revealed Resident # 83 self-propelling herself in her wheelchair on the 300 hallway towards her room with wander guard to right ankle in place. Review of Resident # 83's yearly MDS dated [DATE] revealed wander/elopement alarm was coded as not used. During an interview on [DATE] at 9:15am S4 RN Case Manager, after review of Resident # 83's MDS dated [DATE], confirmed wander/elopement alarm was coded as 0 - not used in error and should have been coded as 2 - used daily. Resident # 112: Review of Resident # 112's medical record revealed resident was admitted to facility on [DATE] and was discharged on [DATE]. Review of Resident # 112's [DATE] physician's orders [REDACTED]. Review of Resident # 112's nurses' notes revealed a note dated [DATE] at 3:15pm stating Resident has been discharged from facility in stable condition via wheelchair accompanied by daughter. No distress or pain expressed. Respirations even and unlabored. Provided medications and education to responsible party on directions of medication administration and discharge instructions. Review of Resident # 112's Discharge Summary revealed anticipated date of discharge [DATE] with discharged to home with caregiver, discharge planning needs include durable medical equipment (trapeze bar, walker, hospital bed, wheelchair) and home health, home equipment has been ordered, approved and will be delivered to resident home prior to resident arriving home. Review of Resident # 112's discharge MDS dated [DATE] revealed a discharge date of [DATE] and discharge status of 03 - acute hospital. During an interview on [DATE] at 2:00pm S4 RN Case Manager, after review of Resident # 112's medical record and MDS dated [DATE], confirmed Resident # 112 was discharged to home on [DATE] and the entry on the MDS of discharge status to acute hospital was incorrect. Resident # 113: Review of Resident #113's medical record face sheet revealed resident was admitted to the facility on [DATE]. Review of Resident # 113's nurses' notes revealed a note dated [DATE] at 10:22am stating Resident nonresponsive to verbal or touch stimuli. Unable to obtain vital signs at this time. No respirations or heartbeat noted. Pale skin color noted. Resident has expired. Hospice in facility at time and stated that she would notify the family and the coroner's office. Review of Resident # 113's Nursing Home/Home Hospice Notification form revealed date of death [DATE]. Review of Resident # 113 discharge MDS dated [DATE] revealed discharge date of [DATE] and a discharge status of 08-deceased . During an interview on [DATE] at 3:05pm S4 RN Case Manager, after review of Resident # 113's MDS dated [DATE] and medical record, confirmed Resident # 113 expired in the facility on [DATE] and the entry on the MDS of discharge date of [DATE] was incorrect.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure: 1. The plan of care had been followed for 1 (#9) of 25 residents reviewed for plan of care. The facility failed to ensure physician's orders were followed. 2. An individualized, person-centered plan of care to meet the needs of a resident was developed for diuretic therapy for 1 (#41) of 5 (#13, #41, #66, #72, #98) residents reviewed for unnecessary medications. Findings: Resident # 9: Review of Resident # 9's medical record revealed resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview on 3/03/20 at 9:24 am Resident # 9 reported her blood sugars have been running high. Review of Resident # 9's March 2020 physician's orders revealed the following orders: - 1/20/2020 [MEDICATION NAME] 100 unit/ml (milliliter), give 10 units every morning subcutaneous. - 5/21/19 BGFS (blood glucose finger stick) twice daily before breakfast and supper per [MEDICATION NAME] 100 unit/ml [MEDICATION NAME] subcutaneous per sliding scale as follows: 0-60: Notify MD; 61-199: 0 units; 200-250: 4 units; 251-300: 6 units; 301-350: 8 units; 351-400: 10 units. Greater than 400: 12 units and notify MD. - 12/12/19 [MEDICATION NAME] 2.5 mg (milligrams), one by mouth every day. Review of Resident # 9's comprehensive care plan revealed a problem of diabetes mellitus with approaches including observe for signs and symptoms of [DIAGNOSES REDACTED]/[MEDICAL CONDITION], administer medications as ordered and notify physician of any complications. Review of Resident # 9's quarterly MDS (minimum data set) dated 11/26/19 revealed BIMS (brief interview for mental status) of 14 out of 15 indicating intact cognitive response. Review of Resident # 9's February and March 2020 MAR (medication administration record) revealed on 2/10/2020 at 4:30pm blood sugar was 426 with 12 units administered, on 2/14/2020 at 4:30pm blood sugar was 518 with 12 units administered, on 2/18/2020 at 7:30pm blood sugar was 404 with 12 units administered, and on 3/3/2020 at 4:30pm blood sugar was 519 with 12 units administered. Further review of Resident # 9's MAR failed to reveal the physician and/or nurse practitioner were notified of blood sugars greater than 400 as indicated in the physician's orders. Review of Resident # 9's February and March 2020 nurses' notes failed to reveal the physician and/or nurse practitioner were notified of blood sugars greater than 400 as indicated in the physician's orders. During an interview on 3/4/2020 at 12:20pm S10 NP-C (nurse practitioner - certified) reported she was not aware of or had not been notified of Resident # 9's blood sugar levels of 519 on 3/3/2020 and should have been according to the physician's order. S10 NP-C further reported she was not aware of Resident # 9's blood sugar levels of greater than 400 that occurred in February 2020 and confirmed she should have been notified. During an interview on 3/4/2020 at 12:31pm S6 DON (director of nursing) confirmed the physician and/or nurse practitioner should have been notified of Resident # 9's blood sugar levels greater than 400. Resident # 41: Review of Resident # 41's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 41's March 2020 physician's orders revealed an order dated 9/4/19 for [MEDICATION NAME] 20 mg one by mouth per day. Review of Resident # 41's comprehensive care plan failed to reveal a problem or approaches related to diuretic therapy. Review of Resident # 41's yearly MDS dated [DATE] revealed diuretic medication administered to resident for 7 out of the past 7 days. During an interview on 3/5/2020 at 12:00pm S4 RN (registered nurse) Case Manager, after review of Resident # 41's comprehensive care plan, acknowledged Resident # 41 was not care planned for diuretic therapy and should have been.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to ensure resident's plan of care was reviewed and revised for 3 (#11, #93, #211) of 25 residents reviewed for plan of care. The facility failed to ensure the care plan was revised to include: 1. Refusal of care for Resident #11 2. Refusal of medication for Resident #93 3. Update for 2/19/2020 and 2/22/2020 falls for Resident #211 Findings: Resident #11 Review of Resident #11's [DIAGNOSES REDACTED]. Review of Resident #11's Quarterly MDS (Minimum Data Set) dated 12/3/2019 revealed: -BIMS (Brief Interview of Mental Status) of 99 (Resident was unable to complete interview). -Review of Section E. Behavior revealed Resident #11 had no rejection of care. -Review of Section G. Functional Status revealed Resident #11 required total dependence with one person physical assist for personal hygiene. Review of Resident #11's March 2020 Physician order [REDACTED]. Apply to lips two times a day -6/5/2018: RN (Registered Nurse) to trim/file toenails every other week/ PRN (as needed) -6/5/2018: CNA (Certified Nurse Assistant) to apply left palm protector in the AM (morning) and remove in PM (night). Review of Resident #11's Care Plan revealed the following Problems and Approaches: -Problem: Requires limited to extensive assistance with ADL's (Activities of Daily Living) related to impaired mobility, lack of coordination and unsteady gait with approaches for extensive assistance x 1 with bathing, dressing and grooming, total assist x 1 with oral care daily and after meals -Problem: Resident has oral [MEDICAL CONDITION] approaches to apply white petroleum to lips as ordered and provide stringent oral care twice a day Further review of Resident #11's care plan failed to reveal refusal of care. Observation on 3/2/20 at 1:41 PM revealed Resident #11's lips were dry and peeling, and tongue was covered with thick white patches. Observation on 3/4/2020 at 11:40 AM with S8 CNA revealed Resident # 11's hair was not groomed, lips were dry and peeling, and tongue was covered with thick white patches. Further observation revealed Resident #11 had a rolled hand towel in the right hand and fingernails were long in length on both hands. During an interview on 3/4/2020 at 11:40 AM S8 CNA stated

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Resident # 11 refused to allow staff to comb hair and provide oral care. S8 CNA stated Resident # 11 will holler and snatch away when staff attempted daily care. During an interview on 3/4/2020 at 11:45 AM Resident #11 replied No, I don't want my hair combed; when surveyor asked to observe Resident # 11 fingernails she hollered and snatched her hands away from the S8 CNA. During an interview on 3/4/2020 at 12:05 PM S9 LPN (Licensed Practical Nurse) stated Resident # 11 will refuse care but S9 LPN stated if you check back with Resident # 11 and use a calm approach sometimes Resident #11 will allow staff to comb hair and do oral care. During an interview on 3/4/2020 at 12:30 PM S4 RN Case Manager confirmed Resident # 11 was not care planned for refusal of care. Resident #211 Review of Facility's Incident log revealed Resident # 211 had falls on the following dates: -2/19/2020 at 5:30 PM: (unobserved fall) Narrative: CNA found Resident lying on her floor with pillow and covers half asleep. Immediate action taken: Assessment from head to toe, assisted back to bed. Family at bedside, NP (nurse practitioner) notified. -2/22/2020 at 2:35 PM: (unobserved fall) Narrative: called to resident room upon entry observed resident on the floor, assess head for injuries and bruises or any abnormal findings. Alert and oriented to self for baseline mental status for this resident. Unable to verify if resident actually hit head. Started neuro checks. Immediate action taken: Started neuro checks, notify RP (responsible party) and primary physician, encourage to use call light Review of Resident #211's [DIAGNOSES REDACTED]. Review of Resident #211's Admission MDS (Minimum Data Set) dated 2/17/2020 revealed a BIMS of 00 (unable to conduct an interview). Review of Functional Status revealed Resident #211 required extensive assistance with two person physical assist with bed mobility, transfers, walking in room and walking in corridor and required extensive assistance with one person physical assist with locomotion on/ off the unit. Further review of Functional Status revealed Resident #211 required balance during transitions and walking, and was not steady, only able to stabilize with staff assistance. Review of Resident #211's Care Plan revealed the following Problems and Approaches: Problem: Resident is at risk for falls related to poor balance and [DIAGNOSES REDACTED]. Review of Care Plan failed to reveal Resident # 211's care plan was updated/ revised when Resident #211 had an actual fall on 2/19/2020 & 2/22/2020. During an interview on 3/5/2020 at 10:00 AM S4 RN Case Manager confirmed Resident #211's care plan was not updated/revised when Resident #211 had an actual fall. Resident #93 Review of Resident #93's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #93's current Physician order [REDACTED]. Administer one unit every six hours per day per HHN (hand-held nebulizer) and once med is put in machine resident may turn the machine on and off. Review of Resident #93's February 2020 and March 2020 MAR (Medication Administration Record) revealed the order for [MEDICATION NAME] 0.5 mg-3mg/3ml soln. Administer one unit every six hours per day per HHN and once med is put in machine resident may turn the machine on and off had not been administered at 12:00am on 2/1/2020 to 2/4/2020, 2/7/2020 to 2/11/2020, 2/13/2020 to 2/16/2020, 2/19/2020 to 2/21/2020, and 2/25/2020 to 2/28/2020 and 3/2/2020 to 3/4/2020. Review of Resident #93's Care Plan failed to reveal Resident #93 was care planned for refusing the [MEDICATION NAME] breathing treatment. During an interview on 3/4/2020 at 2:30pm Resident #93 indicated she did not want the midnight breathing treatment and would rather get a good night's sleep. During an interview on 3/4/2020 at 2:35pm S4 RN Case Manager reviewed Resident #93's care plan and agreed Resident #93 was not care planned for refusing [MEDICATION NAME] treatments. During an interview on 3/4/2020 at 3:20pm S5 ADON (Assistant Director of Nursing) reviewed the February 2020 MAR and agreed Resident #93 did not receive her [MEDICATION NAME] breathing treatment at 12:00am most of the nights in February 2020 and indicated Resident #93 probably declined the treatment. S5 ADON further indicated Resident #93 should have been care planned for refusing the [MEDICATION NAME] treatments when Resident #93 had refused treatments.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and policy review, the facility failed to ensure that narcotic records were maintained and reconciled for 2 out of 4 medication carts observed. The census was 112 according to the Resident Census and Conditions of Residents Form dated 3/2/2020. Findings: Observation on 3/5/2020 at 1:25 PM of Medication Cart #4 with S7 LPN (Licensed Practical Nurse) revealed the following: -Resident #38's narcotic medication card revealed 58 remaining [MEDICATION NAME] 5mg (milligram)-[MEDICATION NAME] 325mg tablets. Review of Medication Cart #4 narcotic log book revealed Resident #38 had 59 remaining [MEDICATION NAME] 5-[MEDICATION NAME] 325 tablets. -Resident #212's narcotic medication card revealed 57 remaining [MEDICATION NAME] 5-[MEDICATION NAME] 325mg tablets. Review of Medication Cart #4 narcotic log book revealed Resident #212 had 58 remaining [MEDICATION NAME] 5- [MEDICATION NAME] 325mg tablets. Review of Resident #38's EMAR (Electronic Medication Administration Record) revealed S7 LPN administered [MEDICATION NAME] 5-[MEDICATION NAME] 325mg tablet on 3/5/2020 at 11:00 AM. Review of Resident #212's EMAR revealed S7 LPN administered [MEDICATION NAME] 5-[MEDICATION NAME] 325mg tablet on 3/5/2020 at 11:00 AM. During an interview on 3/5/2020 at 1:30 PM S7 LPN stated she did not sign out [MEDICATION NAME] 5mg-[MEDICATION NAME] 325mg when administered to Resident #38 and Resident #212. During an interview on 3/5/2020 at 3:15 AM S6 DON (Director of Nursing) confirmed along with the policy that narcotic medications should be recorded at the time administered. Review of Facility's Policy on Drug- Controlled Substances revealed: -Controlled medications are to be signed out on Form NS-618- Individual Resident Narcotics Record at the time they are administered. -RNs (Registered Nurse) and LPNs only will sign out for and/or administer controlled medications, recording the date, time, resident's name, and signature of the administering nurse on the narcotic count sheet. The administering nurse will also check for accuracy of the remaining count.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interviews and facility policy review, the facility failed to ensure proper infection control measures were practiced to provide a safe, sanitary environment and prevent the development and transmission of communicable diseases and infections by failing to ensure proper infection control techniques were practiced for 1 (#109) of 1 (#109) resident observed during perineal care. Findings: Observation of perineal care on 3/5/2020 at 10:05am revealed S2 CNA (Certified Nursing Assistant), with the assistance of S3 CNA Coordinator, performed perineal care for Resident #109. During the observation of perineal care, S2 CNA was observed cleaning the front of Resident #109's perineal area wiping from front to back multiple times with the same area of washcloth. During interview on 3/5/2020 at 10:40am S2 CNA and S3 CNA Coordinator agreed the same part of the washcloth was used multiple times, wiping front to back, when cleaning the front perineal area and should not have been. Review of Perineal Care Policy revealed the following: Female-Without Catheter .4. Wash genital area, moving from front to back, while using a clean portion of the washcloth or pre-moistened wash wipe for each stroke. . 6. When soap is used, rinse genital area moving front to back using a clean portion of the washcloth or pre-moistened wash wipe for each stroke.