STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285215	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELWOOD CARE CENTER	P O BOX 315, 607 SMITH AVENUE ELWOOD, NE 68937

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep residents' personal and medical records private and confidential.** LICENSURE REFERENCE NUMBER 175 NAC 12-006.05 (21) Based on observation, interview, and record review; the facility staff failed to provide privacy during blood sugar checks and insulin administration for 3 residents (Resident 25, 17, and 24). This affected 3 of 4 residents observed during blood sugar checks and 3 of 3 residents observed during insulin administration. The facility identified a census of 32 at the time of survey. Findings are: A. Observation of Resident 25 on 9/9/20 at 11:32 AM revealed LPN-E (Licensed Practical Nurse) entered Resident 25's room with the glucometer (a machine used to check blood sugar levels). Resident 25 was sitting in a wheelchair in their room in view of the doorway. LPN-E left the door open and proceeded to lance Resident 25's finger and apply a drop of blood to the test strip on the glucometer. LPN-E announced Resident 25's blood sugar then walked out to the treatment cart. LPN-E then drew up insulin into a syringe and re-entered Resident 25's room. LPN-E pulled up Resident 25's shirt, exposed their abdomen and injected the insulin into Resident 25's abdomen. Resident 25 was still sitting in the wheelchair in view of the door which was open. As LPN-E was injecting the insulin into Resident 25's abdomen, MA-A (Medication Aide) observed that Resident 25 was exposed and closed the door. Resident 25 was visible to passers-by in the hall. B. Observation of Resident 17 on 9/9/2020 at 11:43 AM revealed LPN-E entered Resident 17's room with the glucometer. Resident 17 was sitting in their recliner in view of the door and the window. LPN-E lanced Resident 17's finger and applied a drop of blood onto the test strip that was in the glucometer. LPN-E announced Resident 17's blood sugar. LPN-E took the glucometer out to the treatment cart and retrieved an insulin pen. LPN-E took the insulin pen into Resident 17's room and proceeded to inject the insulin into Resident 17's abdomen after pulling up Resident 17's shirt and exposing their abdomen. The door was open and the window was not covered. Resident 17 was visible to passers-by in the hall and outside of the building. C. Observation of Resident 24 on 9/9/2020 at 11:52 AM revealed LPN-E wheeled Resident 24 to their room from the dining room. LPN-E then took the glucometer into Resident 24's room, lanced Resident 24's finger, and placed a drop of blood on the test strip in the glucometer. LPN-E then announced Resident 24's blood sugar. LPN-E then took the glucometer out to the treatment cart. LPN-E drew up insulin into a syringe for Resident 24 and took it into Resident 24's room. LPN-E then injected the insulin into Resident 24's arm. Resident 24 was sitting in their wheelchair in view of the doorway. LPN-E did not close the door when LPN-E checked Resident 24's blood sugar or injected Resident 24 with insulin. Resident 24 was visible to passers-by in the hall. Interview with the DON (Director of Nursing) on 9/10/20 at 7:45 AM revealed it was their expectation the nurse would close the door and provide the resident privacy if the nurse were giving insulin injections or doing blood sugar checks. Interview with the DON on 9/10/20 at 1:57 PM revealed the facility did not have a privacy policy. The DON revealed the facility staff were expected to follow the residents' rights to privacy which the staff were trained.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09C1a Based on interviews and record reviews, the facility failed to ensure the Resident or Personal Representative (PR) received a written summary of the baseline care plan (a written plan required to be developed within 48 hours of admission detailing the instructions needed to provide initial effective and person-centered quality care for a resident) prior to completion of the initial assessment for 7 of 11 sampled residents (Residents 20, 25, 15, 19, 23, 26, and 132). The facility census was 32. Findings are: A. Review of Resident 20's Admission MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 7/15/2020 revealed an admission date of [DATE]. Resident 20 had a BIMS (Brief Interview for Mental Status) score of 3 which indicated severe cognitive impairment. The MDS completion date was 7/20/2020. The CAA completion date was 7/21/2020. Review of Resident 20's Baseline Care Plan dated 7/8/2020 revealed no documentation a written summary was given to Resident 20's Personal Representative Review of Resident 20's Baseline Care Plan Summary revealed it was documented as verbally consented by POA 7/28/2020, 21 days after Resident 20 was admitted to the facility, and 6 days after the completion of the admission MDS. B. Review of Resident 25's quarterly MDS dated [DATE] revealed an admission date of [DATE]. Resident 25 had a BIMS score of 8 which indicated moderately impaired cognition. Review of Resident 25's admission MDS revealed an ARD of 5/19/2020 and a completion date of 5/26/2020. Review of Resident 25's Baseline Care Plan Summary revealed verbal consent by POA (Power of Attorney) was documented on 5/29/2020, which was day 17 of admission and after the admission MDS completion date. Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1 October 2019 revealed the following: Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the actual date of admission, regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., is considered day 1 of admission. o The ARD (Assessment Reference Date) (item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14). o Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT (Interdisciplinary Team) may choose to start and complete the Admission comprehensive assessment at any time prior to the end of day 14. Nursing homes may find early completion of the MDS and CAA(s) (Care Area Assessment) beneficial to providing appropriate care, particularly for individuals with short lengths of stay when the assessment and care planning process is often accelerated. o The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than. o The CAA(s) completion date (item V0200B2) must be no later than day 14. o The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days). Review of the undated facility policy Care Plan Guidance - Implementation and Review revealed the following: A written baseline care plan will be established within the first 48 hours of new admission. The baseline care plan will provide the minimum information that is necessary to care for the resident properly and safely. A written care plan summary will be completed within 7 days of MDS closure. This summary is presented to both resident and representative at time of first care plan meeting (or close to said date). Resident is able to sign summary themselves, unless resident has cognitive impairment, in which case resident representative will give consent (verbally or written signature). A care plan will be implemented into the EHR (Electronic Health Record) within 7 days of MDS completion, as to incorporate appropriate CAA's. Care plans will be reviewed at least quarterly, and more often if needed as situations arise such as significant changes. Care plans are reviewed by MDS Coordinator, Social Service Director, Activities Director, Dietary Manager, and by nursing floor staff (charge nurses and CNA/MA). Interview with the

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) MDSC (Minimum Data Set Coordinator) on 9/10/20 at 8:37 AM revealed they misunderstood the time frame the baseline care plan written summary needed to be provided to the PR. MDSC revealed they had been completing the baseline care plan at the time of admission then writing another care plan summary which they reviewed with the PR at the initial care plan meeting. MDSC revealed they were not giving the PR the written summary of the baseline care plan at the time of admission and prior to completion of the initial MDS assessment. MDSC revealed they were reviewing the care plan with the PR after the initial MDS was completed at the time of the initial care plan meeting to have the PR approve the information that was going to be included on the comprehensive care plan. C. Record review of the undated facility policy titled Care Plan Guidance - Implementation and Review revealed that: A written baseline care plan will be established within the first 48 hours of new admission. The baseline care plan will provide the minimum information that is necessary to care for the resident properly and safely. Record review of the facility Baseline Care Plan Summary form revealed the instructions on the bottom of the form that directed the facility to make a copy of the form. The original goes to the resident/representative. File copy in the medical record. Record review of the Resident Face Sheet (a document that gives a resident's information at a quick glance that can include contact details, a brief medical history and the patient's level of functioning) for Resident 15 revealed that Resident 15 admitted to the facility on [DATE]. Record review of the Baseline Care Plan Summary for Resident 15 revealed that the form was reviewed and signed by Resident 15 at the care plan meeting on 1/21/20 which was 11 days after the resident admitted to the facility. Interview with the facility MDS Coordinator (MDSC) on 9/10/20 at 8:37 AM confirmed that the facility developed baseline care plans in the first 48 hours after admission and did not share the care plan with the resident and family until the intial care plan meeting. D. Record review of the undated facility policy titled Care Plan Guidance - Implementation and Review revealed that: A written baseline care plan will be established within the first 48 hours of new admission. The baseline care plan will provide the minimum information that is necessary to care for the resident properly and safely. Record review of the facility Baseline Care Plan Summary form revealed the instructions on the bottom of the form that directed the facility to make a copy of the form. The original goes to the resident/representative. File copy in the medical record. Record review of the Resident Face Sheet for Resident 19 revealed that Resident 19 admitted to the facility on [DATE]. Record review of the Baseline Care Plan Summary for Resident 19 revealed that the form was reviewed with the resident representative at the care plan meeting on 7/28/20 which was 20 days after the resident admitted to the facility. E. Record review of the undated facility policy titled Care Plan Guidance - Implementation and Review revealed that: A written baseline care plan will be established within the first 48 hours of new admission. The baseline care plan will provide the minimum information that is necessary to care for the resident properly and safely. Record review of the facility Baseline Care Plan Summary form revealed the instructions on the bottom of the form that directed the facility to make a copy of the form. The original goes to the resident/representative. File copy in the medical record. Record review of the Resident Face Sheet for Resident 23 revealed that Resident 23 admitted to the facility on [DATE]. Record review of the Baseline Care Plan Summary for Resident 23 revealed that the form was reviewed with the resident representative at the care plan meeting on 3/25/20 which was 14 days after the resident admitted to the facility. F. Record review of the undated facility policy titled Care Plan Guidance - Implementation and Review revealed that: A written baseline care plan will be established within the first 48 hours of new admission. The baseline care plan will provide the minimum information that is necessary to care for the resident properly and safely. Record review of the facility Baseline Care Plan Summary form revealed the instructions on the bottom of the form that directed the facility to make a copy of the form. The original goes to the resident/representative. File copy in the medical record. Record review of the Resident Face Sheet for Resident 26 revealed that Resident 26 admitted to the facility on [DATE]. Record review of the Baseline Care Plan Summary for Resident 26 revealed that the form was reviewed with the resident representative and signed by the resident's Power of Attorney at the care plan meeting on 7/3/19 which was 36 days after the resident admitted to the facility. G. Record review of the undated facility policy titled Care Plan Guidance - Implementation and Review revealed that: A written baseline care plan will be established within the first 48 hours of new admission. The baseline care plan will provide the minimum information that is necessary to care for the resident properly and safely. Record review of the facility Baseline Care Plan Summary form revealed the instructions on the bottom of the form that directed the facility to make a copy of the form. The original goes to the resident/representative. File copy in the medical record. Record review of the Resident Face Sheet for Resident 132 revealed that Resident 132 admitted to the facility on [DATE]. Record review revealed that a Baseline Care Plan Summary had not been completed for Resident 132 as of 9/10/20 which was 8 days after the resident was admitted to the facility. Interview on 9/09/20 at 5:28 PM with the facility Social Services Director (SSD) confirmed that the signed baseline care plan summary for Resident 132 had not been completed yet.
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** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09C1c Based on interview and record review, the facility failed to review and revise the care plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) after falls and implement additional fall prevention measures to prevent falls for 4 of 16 sampled residents (Residents 20, 29, 23 and 26). The facility census was 32. Findings are: A. Review of Resident 20's Admission MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 7/15/2020 revealed an admission date of [DATE]. Resident 20 had a BIMS (Brief Interview for Mental Status) score of 3 which indicated severe cognitive impairment. Resident 20 had 2 or more falls with no injury and 1 fall with injury since admission. Review of Resident 20's Events revealed the following: On 7/11/2020 at 11:09 PM it was documented that Resident 20 fell in their room at 6:00 PM. On 7/09/2020 at 6:27 PM it was documented that Resident 20 fell in the hallway at 6:00 PM. Review of Resident 20's comprehensive Care Plan revealed a Problem Start Date: 07/28/2020 for Category: Falls. Review of Resident 20's Baseline Care Plan dated 7/8/2020 revealed Resident 20 had a high fall risk with need for walker and assistance with transfers, toileting, ambulating, and dressing. There was no documentation the baseline care plan was reviewed and revised with a new intervention after Resident 20 fell on [DATE] and 7/11/2020. Interview with the DON (Director of Nursing) on 9/10/20 at 8:15 AM revealed when a resident fell , the charge nurse completed an event form and it was submitted to the DON. The DON reviewed the event form to determine what interventions needed to be implemented and then the event was submitted to the Administrator. The DON revealed the report then went to the MDS Coordinator who reviewed it and documented the interventions on the care plan as part of the MDS process. The DON revealed Resident 20's Comprehensive Care Plan wasn't done yet so the staff couldn't put any interventions on it. The DON confirmed there were no interventions documented on the baseline care plan to prevent falls after Resident 20 fell on [DATE] and 7/11/2020. The DON revealed putting interventions on the baseline care plan prior to the completion of the initial comprehensive care plan was something the facility needed to work on. B. Review of Resident 29's SCSA (Significant Change in Status) MDS dated [DATE] revealed an admission date of [DATE]. Resident 29 had a BIMS score of 5 which indicated sever cognitive impairment. Resident 29 had 2 or more falls without injury since last assessment. Review of Resident 29's Progress Notes dated 8/13/2020 at 7:45 PM revealed Resident 29 was found on the floor laying on their right side. Resident 29 was assisted back into bed after being assessed. Review of Resident 29's Care Plan dated 12/15/2016 revealed a problem for Falls. There was no documentation the care plan was reviewed and revised with a new intervention after Resident 29 fell on [DATE]. Interview with MA-F on 09/09/20 at 4:21 PM revealed they got the information they needed to care for the residents from the care plan. Interview with the DON on 9/10/20 at 8:32 AM confirmed the facility staff did not put new interventions on the care plan after Resident 29 fell on ,[DATE]. Review of the undated facility policy Care Plan Guidance - Implementation and Review revealed the following: A written baseline care plan will be established within the first 48 hours of new admission. The baseline care plan will provide the minimum information that is necessary to care for the resident properly and safely. A written care plan summary will be completed within 7 days of MDS closure. This summary is presented to both resident and representative at time of first care plan meeting (or close to said date). Resident is able to sign summary themselves, unless resident has cognitive impairment, in which case resident representative will give consent (verbally or written signature). A care plan will be implemented into the EHR (Electronic Health Record) within 7 days of MDS completion, as to incorporate appropriate CAA's. Care plans will be reviewed at least quarterly, and more often if needed as situations arise

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) such as significant changes. Care plans are reviewed by MDS Coordinator, Social Service Director, Activities Director, Dietary Manager, and by nursing floor staff (charge nurses and CNA/MA). C. Interview on 9/10/20 at 1:27 PM with the facility Director of Nursing (DON) revealed the expectations of staff after a resident fall. The charge nurse should implement interventions to address the causal factors. The DON reviews the incident report and the report then goes to the facility MDS Coordinator (MDSC) for review of the fall and review of the resident's care plan. Interventions are reviewed to determine if the interventions are effective. The facility is expected to identify a new intervention to prevent falls that addresses the causal factors. The DON updates the care plan with the fall intervention. The DON confirmed that all fall interventions are to be on the resident care plan including the use of fall mats. Record review of the Resident Face Sheet for Resident 23 revealed that Resident 23 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. to communicate. [MEDICAL CONDITION] affects a person's ability to express and understand written and spoken language). Record review of the care plan for Resident 23 revealed the fall prevention intervention implemented on 3/25/20 to remind Resident 23 to not transfer without assistance. Record review of the electronic health record for Resident 23 revealed that Resident 23 had a fall on 7/4/20 at 6:31 PM. Resident 23 was found on the floor beside the recliner. The resident had ambulated from the hall to the recliner in the room (without assist) and missed the recliner. The resident had a 10 centimeter round bump to the back of the head with a 5 centimeter scratch in the center. Record review of the care plan for Resident 23 revealed the post fall intervention implemented on 7/6/20 was that Resident 23 was encouraged to call for assistance with transfers. Record review of the electronic health record for Resident 23 revealed that Resident 23 had a fall on 8/18/20 at 8:00 PM. Resident 23 had a fall while self-transferring without assistance. The charge nurse noted that Resident 23 had a laceration to the back right side of the head with a moderate amount of bleeding. A pressure dressing was applied and the resident's physician was contacted. The physician ordered the resident to be transported to the emergency room for evaluation. Record review of the care plan for Resident 23 revealed the post fall intervention implemented on 8/19/20 was that Resident 23 was encouraged to call for help and discouraged to self-ambulate. Interview on 9/09/20 at 3:18 PM with Restorative Aide-B (RA-B) revealed that staff try to anticipate Resident 23's needs. RA-B revealed that Resident 23's cognition declines as the resident becomes more tired as the day goes on and that the resident becomes more forgetful and performs self-transfers. Interview on 9/10/20 at 10:03 AM with Nursing Assistant-C (NA-C) revealed that Resident 23 fall prevention interventions should include a chair alarm (a personal alarm with a sensor pad that emits an alert sound when a resident stands up) due to the resident self- transferring. NA-C confirmed that encouraging Resident 23 to call for assistance and wait for help was not effective to prevent falls. NA-C revealed that current fall interventions for Resident 23 included a fall mat at the resident's bedside at night. Record review of the care plan for Resident 23 identified that the use of the fall mat was not included in the care plan for Resident 23. Interview on 9/10/20 at 2:34 PM with the Facility Administrator (FA) confirmed that for each fall causal factors should be identified and a new intervention for falls initiated and placed on the resident's care plan. The FA confirmed that fall interventions that are ineffective due to change in condition should be reviewed for effectiveness and revised as appropriate. D. Interview on 9/10/20 at 1:27 PM with the facility Director of Nursing (DON) revealed the expectations of staff after a resident fall. The charge nurse should implement interventions to address the causal factors. The DON reviews the incident report and the report then goes to the facility MDS Coordinator (MDSC) for review of the fall and review of the resident's care plan. Interventions are reviewed to determine if the interventions are effective. The facility is expected to identify a new intervention to prevent falls that addresses the causal factors. The DON updates the care plan with the fall intervention. The DON confirmed that all fall interventions are to be on the resident care plan including the use of fall mats. Record review of the Resident Face Sheet for Resident 26 revealed that Resident 26 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of the care plan for Resident 26 revealed the fall prevention interventions implemented on 5/29/19 included: Provide proper well-maintained footwear; Provide Resident 26 with an environment free of clutter; Keep personal items and frequently used items within reach; Resident 26 is assisted by staff during ambulation and transfers and is utilizing a walker most of the time and a wheelchair when needed. Record review of the electronic health record for Resident 26 revealed that Resident 26 had a fall on 6/1/19 at 1:47 PM. Resident 26 tried to stand up in the dining room and tripped and fell . The charge nurse noted a laceration on the left side of the head oozing blood for about 2 minutes. Pressure was applied to stop the bleeding. Record review of the care plan for Resident 26 revealed the post fall intervention implemented on 6/1/19 was that staff attempt to supervise the resident while the resident is wandering. Record review of the electronic health record for Resident 26 revealed that Resident 26 had a fall on 6/8/19 at 4:45 PM. Resident 26 was laying on the floor by the patio door in the dining room. The resident was transported by ambulance to the emergency room for evaluation of the right hip and knee. Record review of the care plan for Resident 26 revealed the post fall intervention implemented on 6/8/19 was that a walker was provided due to the resident's constant walking and wandering to the point of fatigue causing instability. A walker was already an intervention that was initiated previously on 5/29/19. Record review of the electronic health record for Resident 26 revealed that Resident 26 had a fall on 9/5/19 at 3:24 PM. Resident 26 was found sitting on the floor next to the wheelchair. Resident 26 had a skin tear to the right elbow. Record review of the care plan for Resident 26 revealed the post fall intervention implemented on 9/6/19 was a bed alarm (a personal alarm with a sensor pad placed on the bed that emits an alert sound when a resident stands up from the bed) placed on the resident's bed. Record review of the electronic health record for Resident 26 revealed that Resident 26 had a fall on 10/4/19 at 3:22 PM. Resident 26 was found sitting on the floor in the resident's room by the recliner entangled in the walker. Record review of the care plan for Resident 26 revealed the post fall intervention implemented on 10/7/20 was that rounds will be completed on Resident 26 in the afternoon to assist the resident with toileting. Record review of the electronic health record for Resident 26 revealed that Resident 26 had a fall on 10/17/19 at 7:00 PM in the dining room. Resident 26 was in the dining room after supper watching TV and got up and fell to the floor. Kitchen staff heard a crash and found the resident on the floor. Record review of the care plan for Resident 26 revealed the post fall intervention implemented on 10/21/20 was for the walker to be kept within reach at all times. Record review of the electronic health record for Resident 26 revealed that Resident 26 had a fall on 11/1/19 at 7:30 PM. Resident 26 was found on the floor beside the roommate's recliner. Record review of the care plan for Resident 26 revealed that no post fall intervention was implemented and added to the care plan for the resident's fall on 11/1/19. Record review of the electronic health record for Resident 26 revealed that Resident 26 had a fall on 11/14/19 at 4:52 PM in the facility living room. Resident 26 was reclined on a couch with staff assistance. Resident 26 was unable to get up on own without difficulty and fell . Record review of the care plan for Resident 26 revealed the post fall intervention implemented on 11/15/20 was to educate staff not to put Resident 26 in a reclined position. Record review of the electronic health record for Resident 26 revealed that Resident 26 had a fall on 2/21/20 at 4:05 AM. Resident 26 was observed lying on the resident's back next to the chair in the resident room. The water pitcher from the bedside dresser was noted on the floor. The charge nurse noted a 5 centimeter bump on the back right side of the resident's head. Record review of the care plan for Resident 26 revealed the post fall intervention implemented on 2/21/20 was for staff to offer additional fluids throughout the day and evening as it appeared the resident was getting a drink. Record review of the electronic health record for Resident 26 revealed that Resident 26 had a fall on 2/21/20 at 8:21 AM. The nurse heard a crash and found Resident 26 laying on the floor on the resident's right side. The charge nurse noted a 5.75 centimeter laceration on the top right side of the resident's head, a 2 centimeter long skin tear to the right side of the chin, and a 1 centimeter skin tear to the top of the right eyebrow. Resident 26 was transferred to the emergency room . The charge nurse noted that Resident 26 has dementia with diminished safety awareness and unable to educate the resident. Record review of the care plan for Resident 26 revealed the post fall intervention implemented on 5/11/20 was that Resident 26 needed frequent cuing and reminders to use the walker. Interview on 9/9/20 at 3:12 PM with Medication Aide-A (MA-A) revealed that staff toilet are to toilet Resident 26 every 2 hours and keep the walker in reach of the resident. Interview on 9/9/20 at 3:18 PM with Restorative Aide-B (RA-B) revealed that Resident 26's fall risk is dependent on the resident's motivation and if the resident is motivated to try doing things without assistance. RA-B revealed that fall interventions included that staff are to always keep the walker next to the resident, a fall mat is to be placed at the bedside when Resident 26 is in bed, offer to assist the resident to the bathroom, and offer a drink to the resident. Interview on 9/10/20 at 10:03 AM with Nursing Assistant-C (NA-C) revealed that interventions to prevent falls for Resident 26 included a fall mat at night, and items to be kept close to the resident such as eyeglasses, water, TV remote, and maybe a magazine. NA-C confirmed that Resident 26 transfers are to be with a gait belt and walker. NA-C did not identify the care planned intervention of keeping the walker

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) next to the resident. Record review of the care plan for Resident 26 identified that the use of the fall mat was not included in the care plan for Resident 26. Interview on 9/10/20 at 2:34 PM with the Facility Administrator (FA) confirmed that for each fall causal factors should be identified and a new intervention for falls initiated and placed on the resident's care plan. The FA confirmed that fall interventions that are ineffective due to change in condition should be reviewed for effectiveness and revised as appropriate.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D2b Based on observation, interview, and record review; the facility failed to assess and identify the presence of a pressure ulcer for Resident 82. This affected 1 of 1 sampled residents. The facility identified a census of 32 at the time of survey. Findings are: Review of Resident 82's Care Plan revealed an admission date of [DATE]. Observation of Resident 82 on 9/9/20 at 1:55 PM revealed the presence of a pressure ulcer to the sacral/coccyx area (tailbone). Review of Resident 82's physician's orders [REDACTED]. Review of Resident 82's Admission Body Observation dated 9/4/2020 at 6:13 PM revealed pressure sores was marked no. The following was documented: open area left knee; left heel small white dry area. There was no documentation of the pressure ulcer to Resident 82's coccyx. Review of the Resident 82's Clinical Admission Documentation dated 9/3/2020 revealed no documentation of the presence of a pressure ulcer. Review of Resident 82's Progress Notes revealed Resident 82 was admitted to the facility on [DATE] at 6:45 PM. On 9/5/2020 at 10:33 AM it was documented the nurse found orders for the coccyx wound treatment in Resident 82's hospital discharge paperwork. On 9/05/2020 at 2:32 PM it was documented the wound to Resident 82's coccyx was assessed and measured: 0.3 x 0.4 x 0.8 cm. and located wound dressing orders in discharge paperwork. There was no documentation of the pressure ulcer to Resident 82's coccyx prior to 9/5/2020 at 10:33 AM. Interview with the DON (Director of Nursing) on 9/10/20 at 7:59 AM revealed they were aware of the pressure ulcer Resident 82 had at admission as they had been notified about it from the nurse at the hospital during an oral report the nurse had given them over the phone. The DON revealed they had taken the nurse to nurse report from the hospital and reported the pressure ulcer to the charge nurse on the day Resident 82 was admitted to the facility. The DON confirmed that Resident 82's pressure ulcer did not get documented on the Clinical Admission Documentation or the Admission Body Observation. The DON confirmed the pressure ulcer for Resident 82 was not assessed at admission and should have been.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.10D Based on observations, interviews, and record reviews, the facility failed to maintain a medication error rate below 5% with 3 errors out of 25 opportunities resulting in a medication error rate of 12%. This affected 2 of 13 residents observed during medication administration (Residents 25 and 17). The facility identified a census of 32 at the time of survey. Findings are: A. Observation of Resident 25 on 9/9/2020 at 11:38 AM revealed LPN-E (Licensed Practical Nurse) administered 1 unit of Insulin [MEDICATION NAME] to Resident 25. LPN-E did not offer Resident 25 food, milk, or juice. Observation of Resident 25 on 9/9/2020 at 11:50 AM revealed they were sitting at the dining room table. Resident 25 had a glass of water and a diet Coke (a sugar free cola with no nutritive value). Observation of Resident 25 on 9/9/2020 at 12:00 PM, 12:05 PM, 12:19 PM, and 12:22 PM revealed Resident 25 continued to be observed sitting in the dining room without food, milk, or juice. Resident 25 did not have food, milk or juice 44 minutes after receiving the Insulin [MEDICATION NAME]. Review of the MAR (Medication Administration Record) for September for Resident 25 revealed documentation the insulin was administered to Resident 25. Review of Resident 25's physician's orders [REDACTED]. If Blood Sugar is 150 to 199, give 1 Units. If Blood Sugar is 200 to 249, give 2 Units. If Blood Sugar is 250 to 299, give 3 Units. If Blood Sugar is 300 to 349, give 4 Units. If Blood Sugar is 350 to 399, give 5 Units. If Blood Sugar is 400 to 499, give 6 Units. If Blood Sugar is greater than 499, call MD. subcutaneous four times a day. B. Observation of Resident 17 on 9/9/2020 at 11:47 AM revealed LPN-E administered 6 units of [MEDICATION NAME]via insulin pen to Resident 17. LPN-E did not prime the insulin pen prior to administering the insulin to Resident 17 or offer Resident 17 food, milk, or juice. Observation of Resident 17 on 9/9/2020 at 12:03 PM, 12:05 PM, and 12:18 PM revealed Resident 17 was sitting in their recliner in their room. Resident 17 did not have any food, milk, or juice. Observation of Resident 17 on 9/9/2020 at 12:22 PM revealed a staff person walked with Resident 17 to the dining room. Resident 17 did not have food, milk, or juice 35 minutes after receiving the [MEDICATION NAME] insulin. Review of the MAR (Medication Administration Record) for September for Resident 17 revealed documentation the insulin was administered to Resident 17. Review of Resident 17's physician's orders [REDACTED]. If Blood Sugar is 100 to 150, give 4 Units. If Blood Sugar is 151 to 200, give 6 Units. If Blood Sugar is 201 to 251, give 8 Units. If Blood Sugar is 252 to 400, give 9 Units. If Blood Sugar is greater than 400, call MD. subcutaneous before Meals and At Bedtime Interview with the DON (Director of Nursing) on 9/10/20 at 7:45 AM revealed the nurses were expected to follow the manufacturer's directions for the insulin pens. The DON revealed it was their expectation the nurses would follow the manufacturer's instructions for giving insulin in regards to meals. The DON revealed if the resident does not have their meal and was not eating, they were to receive juice or a protein or some sort of snack and it needed to be in front of them. Review of the [MEDICATION NAME] manufacturer's directions for use for the [MEDICATION NAME] dated 9/9/2020 revealed the following: A Guide to Using Your [MEDICATION NAME]: Prepare your pen: Remove the cap. Attach a new needle. Prime your pen: turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears. Give your injection: select your dose. Give your injection. Review of the FDA (Food and Drug Administration) prescribing information for [MEDICATION NAME] revealed the following: Subcutaneous injections: [MEDICATION NAME] should generally be given immediately (within 5-10 minutes) prior to the start of a meal. [MEDICATION NAME] is an insulin analog with an earlier onset of action than regular human insulin. Because [MEDICATION NAME] has a more rapid onset and a shorter duration of activity than human regular insulin, it should be injected immediately (within 5-10 minutes) before a meal. Review of the Insulin [MEDICATION NAME] Prescribing Information from the manufacturer dated 9/9/2020 revealed the following: Subcutaneous injection (2.2): Administer Insulin [MEDICATION NAME] Injection by subcutaneous injection into the abdominal wall, thigh, upper arm, or buttocks within 15 minutes before a meal or immediately after a meal. Review of the undated facility Skills Checklist received from the facility Administrator revealed the following: Checks to be sure the right insulin is being given in the right dose to the right person at the right time. Review of the undated [MEDICATION NAME] directions received from the facility administrator revealed the following: Giving the airshot before each injection: Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to 2 units. Hold your [MEDICATION NAME] with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop in insulin after 6 times, do not use the [MEDICATION NAME] and contact Novo [MEDICATION NAME].

F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.10D Based on observation, interview, and record review, the facility failed to maintain a medication error rate below 5% with 3 errors out of 25 opportunities resulting in a medication error rate of 12%. This affected 2 of 13 residents observed during medication administration (Residents 25 and 17). The facility identified a census of 32 at the time of survey. Findings are: A. Observation of Resident 25 on 9/9/2020 at 11:38 AM revealed LPN-E (Licensed Practical Nurse) administered 1 unit of Insulin [MEDICATION NAME] to Resident 25. LPN-E did not offer Resident 25 food, milk, or juice. Observation of Resident 25 on 9/9/2020 at 11:50 AM revealed they were sitting at the dining room table. Resident 25 had a glass of water and a diet Coke (a sugar free cola with no nutritive value). Observation of Resident 25 on 9/9/2020 at 12:00 PM, 12:05 PM, 12:19 PM, and 12:22 PM revealed Resident 25 continued to be observed sitting in the dining room without food, milk, or juice. Resident 25 did not have food, milk or juice 44 minutes after receiving the Insulin [MEDICATION NAME]. Review of the MAR (Medication Administration Record) for September for Resident 25 revealed documentation the insulin was administered to Resident 25. Review of Resident 25's physician's orders [REDACTED]. If Blood Sugar is 150 to 199, give 1 Units. If Blood Sugar is 200 to 249, give 2 Units. If Blood Sugar is 250 to 299, give 3 Units. If Blood Sugar is 300 to 349, give 4 Units. If Blood Sugar is 350 to 399, give 5 Units. If Blood Sugar is 400 to 499, give 6 Units. If Blood Sugar is greater than 499, call MD. subcutaneous four times a day. B. Observation of Resident 17 on 9/9/2020 at 11:47 AM revealed LPN-E administered 6 units of [MEDICATION NAME]via insulin pen to Resident 17. LPN-E did not prime the insulin pen prior to administering the insulin to Resident 17 or offer Resident 17

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	285215	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELWOOD CARE CENTER	P O BOX 315, 607 SMITH AVENUE ELWOOD, NE 68937

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 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) food, milk, or juice. Observation of Resident 17 on 9/9/2020 at 12:03 PM, 12:05 PM, and 12:18 PM revealed Resident 17 was sitting in their recliner in their room. Resident 17 did not have any food, milk, or juice. Observation of Resident 17 on 9/9/2020 at 12:22 PM revealed a staff person walked with Resident 17 to the dining room. Resident 17 did not have food, milk, or juice 35 minutes after receiving the [MEDICATION NAME] insulin. Review of the MAR (Medication Administration Record) for September for Resident 17 revealed documentation the insulin was administered to Resident 17. Review of Resident 17's physician's orders [REDACTED]. If Blood Sugar is 100 to 150, give 4 Units. If Blood Sugar is 151 to 200, give 6 Units. If Blood Sugar is 201 to 251, give 8 Units. If Blood Sugar is 252 to 400, give 9 Units. If Blood Sugar is greater than 400, call MD. subcutaneous before Meals and At Bedtime Interview with the DON (Director of Nursing) on 9/10/20 at 7:45 AM revealed the nurses were expected to follow the manufacturer's directions for the insulin pens. The DON revealed it was their expectation the nurses would follow the manufacturer's instructions for giving insulin in regards to meals. The DON revealed if the resident does not have their meal and was not eating, they were to receive juice or a protein or some sort of snack and it needed to be in front of them. Review of the [MEDICATION NAME] manufacturer's directions for use for the [MEDICATION NAME] dated 9/9/2020 revealed the following: A Guide to Using Your [MEDICATION NAME]: Prepare your pen: Remove the cap. Attach a new needle. Prime your pen: turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears. Give your injection: select your dose. Give your injection. Review of the FDA (Food and Drug Administration) prescribing information for [MEDICATION NAME] revealed the following: Subcutaneous injections: [MEDICATION NAME] should generally be given immediately (within 5-10 minutes) prior to the start of a meal. [MEDICATION NAME] is an insulin analog with an earlier onset of action than regular human insulin. Because [MEDICATION NAME] has a more rapid onset and a shorter duration of activity than human regular insulin, it should be injected immediately (within 5-10 minutes) before a meal. Review of the Insulin [MEDICATION NAME] Prescribing Information from the manufacturer dated 9/9/2020 revealed the following: Subcutaneous injection (2.2): Administer Insulin [MEDICATION NAME] Injection by subcutaneous injection into the abdominal wall, thigh, upper arm, or buttocks within 15 minutes before a meal or immediately after a meal. Review of the undated facility Skills Checklist received from the facility Administrator revealed the following: Checks to be sure the right insulin is being given in the right dose to the right person at the right time. Review of the undated [MEDICATION NAME] directions received from the facility administrator revealed the following: Giving the airshot before each injection: Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to 2 units. Hold your [MEDICATION NAME] with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop in insulin after 6 times, do not use the [MEDICATION NAME] and contact Novo [MEDICATION NAME].
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.17B LICENSURE REFERENCE NUMBER 175 NAC 12-006.17D Based on observations, interviews, and record reviews; the facility staff failed to perform hand hygiene with glucometer (a machine used to check blood sugar levels) checks and insulin administration which affected 3 of 4 sampled residents (Residents 25, 24, and 17); failed to wear gloves with injections which affected 3 of 3 sampled residents (Resident 25, 24, and 17), failed to clean a glucometer after each resident use, which had the potential to affect 3 of 3 residents (Residents 25, 24, and 17); and failed to perform a dressing change to prevent potential cross contamination which affected 1 of 1 sampled residents (Resident 82). The facility identified a census of 82 at the time of survey. Findings are: A. Observation of LPN-E on 9/9/20 at 11:32 AM revealed they donned gloves and took a glucometer into Resident 25's room. LPN-E then lanced Resident 25's finger and placed a drop of blood on the test strip that was inserted into the glucometer. LPN-E touched the glucometer and Resident 25's hand and finger. LPN-E then removed 1 glove and answered the phone that was in LPN-E's pocket. LPN-E then took the other glove off and put the phone back into their pocket. LPN-E took the glucometer out to the treatment cart and placed it into a caddy with another glucometer and the testing supplies including the lancets, test strips, alcohol wipes and cotton balls. LPN-E then drew up Resident 25's insulin, took the insulin into Resident 25's room, and injected the insulin into Resident 25's abdomen. LPN-E did not reapply gloves and with bare un-gloved hands, injected the insulin into Resident 25's abdomen. LPN-E did not clean the glucometer. B. Observation of Resident 17 at 11:43 AM revealed LPN-E took a glucometer, test strip, alcohol wipe, and cotton ball out of the caddy on the treatment cart and took it into Resident 17's room. LPN-E lanced Resident 17's finger and placed a drop of blood onto the test strip that was inserted into the glucometer. LPN-E touched the glucometer and Resident 17's hand and finger. LPN-E then removed their gloves, placed the glucometer into the caddy with the other glucometer, test strips, lancets, alcohol wipes, and cotton balls, and took the caddy out to the cart. LPN-E did not do any hand hygiene. LPN-E then took a wipe out of the container and wrapped it around the glucometer they had used to check Resident 25's blood sugar. LPN-E did not clean Resident 17's glucometer. LPN-E then opened the drawer on the cart and got an insulin pen out. LPN-E took the insulin pen into Resident 17's room, put the needle on it, dialed the dose and injected the insulin into Resident 17's abdomen at 11:47 AM. LPN-E did not wear gloves when administering the insulin injection to Resident 17. LPN-E then took the phone out of their pocket and answered it without doing any hand hygiene. LPN-E then touched the computer and the drawer of the treatment cart and put the insulin pen away. LPN-E then took the phone to LPN-G. C. Observation of Resident 24 on 9/9/2020 at 11:52 AM revealed LPN-E wheeled Resident 24 to their room from the dining room by touching the handles on the wheelchair. LPN-E then came out Resident 24's room and retrieved a pair of gloves out of the box. LPN-E then donned the gloves and took the glucometer, test strip, lancet, alcohol wipe, and cotton ball into Resident 24's room. Resident 17's glucometer that had not been cleaned was in the caddy with all of the supplies including the other glucometer, the test strips, lancets, alcohol wipes, and the cotton balls. LPN-E had not cleaned Resident 17's glucometer machine. LPN-E then lanced Resident 24's finger and placed a drop of blood on the test strip that was inserted into the glucometer. LPN-E touched the glucometer and Resident 24's hand and finger. LPN-E then removed the gloves and did not do hand hygiene. LPN-E then touched the computer screen, unlocked the cart, and opened the drawer. LPN-E took a bottle of insulin out of the drawer and drew up 2 units of insulin into a syringe. LPN-E then took the insulin into Resident 24's room and injected the insulin into Resident 24's right arm. LPN-E did not wear gloves to give Resident 24 the insulin injection and did not perform hand hygiene before or after administering the insulin injection to Resident 24. LPN-E then put the syringe into the sharps container and handled Resident 24's wheelchair handles and wheeled Resident 24 out to the hall. LPN-E then went back to the computer sitting on top of the treatment cart and touched the screen. LPN-E then opened the drawer on the cart and put the box of insulin away after. LPN-E had not performed hand hygiene. NA-D (Nurse Aide) then wheeled Resident 24 into the dining room by handling the wheelchair. D. Observation of Resident 82 on 9/9/2020 at 1:55 PM revealed LPN-E placed a tube of ointment that was in a clear plastic sandwich bag and a dressing onto Resident 82's bedside stand. LPN-E did not put a barrier on the stand before placing the ointment or the dressing on the stand which contained resident personal items. Resident 82 was observed resting in bed on their right side. LPN-E then removed the tube of ointment from the sandwich bag it was in and placed it on the nightstand next to the unopened dressing. There were no wound cleaning supplies observed such as gauze sponges or wound cleanser. LPN-E donned gloves and removed the old dressing from Resident 82's sacrum/coccyx area (tailbone). There was an open area observed on Resident 82's sacrum/coccyx. Wearing the same gloves, LPN-E dabbed the area with a tissue or peri-wipe then removed the gloves. LPN-E then donned new gloves. LPN-E did not do hand hygiene after removing the gloves that were worn while LPN-E removed the soiled dressing prior to donning new gloves. LPN-E then squeezed some gel out of the tube onto their gloved finger and put the gel on the open area on Resident 82's sacrum/coccyx. Wearing the same gloves, LPN-E opened the dressing and applied a new dressing to Resident 82's sacrum/coccyx. LPN-E then removed the gloves and put the tube of treatment gel back into the bag. LPN-E did not do hand hygiene after removing the gloves and did not cleanse the wound after removing the old dressing prior to applying the new dressing. Review of Resident 82's Physician's Orders dated 9/5/2020 revealed the following order for treatment to Resident 82's open coccyx wound: cleanse area; hydrogel (ointment); [MEDICATION NAME] (dressing); change twice daily and PRN (as needed). Interview with the DON (Director of Nursing) on 9/10/20 at 7:45 AM revealed gloves were not to take the place of hand washing and hands were to be washed before donning and after removing gloves. The DON revealed it was the expectation that the glucometers be cleaned no matter what, even if it was the residents own machine, especially if the staff put it in the same caddy with the other glucometer machine which is shared with the residents. It is the expectation the nurses would wear gloves when giving injections. They could get contaminated with blood during injections. Interview with the DON on 9/10/20 at 7:59 revealed the facility staff

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	285215	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELWOOD CARE CENTER	**P O BOX 315, 607 SMITH AVENUE ELWOOD, NE 68937**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) were expected to always put a paper towel down for a barrier or some other sort of barrier to put the dressing change supplies on. The DON revealed Resident 82's pressure area was supposed to be cleaned with wound wash. The DON revealed gloves were to be changed after removing soiled dressings and hand hygiene between glove changes was expected Review of the undated facility Skills Checklist received from the facility Administrator revealed the following. Washes hands with soap and water and puts on gloves. Checks to be sure the right insulin is being given in the right dose to the right person at the right time. Removes gloves and washes hands. Review of the facility Policy for Glucometer cleansing between residents updated 3/19/2020 revealed the following: Purpose: to prevent the spread of infection through use of a single glucometer. Policy: The glucometer will be cleansed after each use with a disposable germicidal cloth per manufacturer's institutions and allowed to dry before the next use. Review of the facility policy Gloves dated 7/2/2005 revealed the following: Non-sterile gloves should be used for invasive procedures to prevent contamination of the employee's hands when providing treatment or services to the resident and when cleaning contaminated surfaces. Wash hands after removing gloves. When to use gloves: When touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin. Review of the facility policy Handwashing Policy revision date 10/2011 revealed the following: Purpose: To prevent or minimize the spread of infection. When to Wash Hands (at a minimum): Before and after each resident contact. After touching a resident or handling his or her belongings. Whenever hands are obviously soiled. After contact with any body fluids. After handling any contaminated items. When to use hand sanitizing foam: Only when visible soil is absent. After contact with resident's intact skin. After contact with inanimate objects. Before donning gloves. Before entering the residents' room. Before exiting the residents' room.