STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265693	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF INDEPENDENCE	1800 S SWOPE DRIVE INDEPENDENCE, MO 64057

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 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on interviews and record reviews, the facility failed to follow their policy to provide the resident council members the opportunity to meet for council meetings without facility staff present. This affected 15 residents of 15 present at the group interview held during the survey process. The facility census was 107 . 1. Review of the facility undated Resident and Family Council Policy, with a revision date of 2/19, showed: - Appointment of the Family Council: the facility designates, with the approval of the council, an administrative representative who will provide assistance and facilitate communication between council and facility management. - The council MAY invite facility staff to attend Council meetings. -Council members may appoint a resident member to record the minutes. 2. During a group interview on [DATE] at 10:00 AM, all residents in attendance said: - The assistant Social Services Director (SSD) attends each of the meetings and takes notes. -They were told they are not allowed to hold resident council meetings without the SSD present because he was responsible for taking the minutes of the meeting. -They did not feel their concerns were properly addressed because the SSD served as the grievance officer as well, so he was controlling the responses to their grievances. During an interview on 3/12/20 at 3:20 P.M. the Administrator said: -The Resident Council is held monthly. The residents can have their own private meeting. The assistant SSD, sets up the meeting and takes the minutes of the meeting.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one additional resident's (Resident #3) Advanced Directive (a document stating the resident's wishes if his/her heart stopped beating and/or he/she stopped breathing) were consistently stated in his/her medical records. The facility census was 107. 1. Review of the undated facility policy on Advanced Directives (AD) showed: - The purpose of the policy was to allow residents to make decisions regarding their health care. - The facility must honor a resident's AD. - The resident's Advanced Directive must be in the resident's medical record. 2. Review of Resident #3's AD, dated [DATE] showed the resident requested do not resuscitate (DNR) status, if the resident's heart stopped beating and/or the resident stopped breathing staff would not perform cardio-pulmonary resuscitation (CPR), staff trying to restart a resident's heart beat and/or breathing for the resident. Review of the resident's care plan, dated [DATE], showed the resident requested DNR status. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: - Cognitively intact; - Independent for cares; - Used a wheelchair or walker; - [DIAGNOSES REDACTED]. Review of the resident's physical order sheet (POS) showed an order, dated [DATE], for DNR. Review of the resident's Medication Administration Record [REDACTED]. During an interview on [DATE] at 3:00 P.M. the Director of Nursing (DON) said: - The resident's code status on his/her MAR indicated [REDACTED]. - In event that a resident needed CPR staff would quickly check either the MAR, POS, or AD to determine the resident's code status. - He/she was uncertain who was responsible for checking a resident's code status.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to maintain a safe, clean and comfortable homelike environment for one sampled resident (Resident #58) when staff failed to remove food from the resident's room that had mold growing in the food and the food was above the acceptable temperature to be safe for consumption. The facility census was 107. The facility did not provide a policy for cleaning, monitoring and the removal of food from resident's room. 1. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 1/27/20 showed: -Alert and oriented and able to make decisions; -No behavior problems; -Independent with Activities of Daily Living (ADL's); -[DIAGNOSES REDACTED]. During an observation on 3/11/20 at 10:50 A.M. and multiple times through out the day showed the resident had multiple containers of food and two glasses of milk sat on the over the bed table. During an observation on 3/11/20 at 5:00 P.M. showed: -A Styrofoam container with fruit cocktail with (dark brown green substance resembling mold) on top. The temperature of the fruit cocktail was 71 degrees (this is a potential dangerous temperature that could cause food born illness, with the normal temperature of 45 degrees or lower); -A Styrofoam container with coleslaw. The cabbage was brown with a temperature of 71.1 degrees (this is a potential dangerous temperature that could cause food born illness, with the normal temperature of 45 degrees or lower, -Two milk glasses. One glass of milk had a temperature of 67.7 degrees and the other had a temperature of 69.1 degrees. (This is a potential dangerous temperature that could cause food born illness, with the normal temperature of 45 degrees or lower); - A plastic glass with pieces of fish that was hard and dry with a temperature of 68 degrees,(this is a potential dangerous temperature that could cause food born illness, with the normal temperature of 45 degrees or lower); -A Styrofoam container of what appeared to be apple cobbler that had a temperature of 73.4 degrees and a berry cobbler that had a temperature of 69.9 degrees (this is a potential dangerous temperature that could cause food born illness, with the normal temperature of 45 degrees or lower); -The resident said that the food was fine and he/she was saving the food for later. That he/she could not eat all of the food with his/her meal; -He/she could not recall how long the food had sat out on the over the bed table. During an interview on 3/11/20 at 10:54 A.M. Housekeeper A said: -He/she will take out food in resident rooms if the food is causing pests. -Nursing is in charge of picking up of the food left in the resident rooms. -He/she is aware that the resident will keep food in his/her room. The resident tells him/her that the food is fine and that he/she will eat it later. -He/she has worked on the hall that the resident resides on since last Thursday and multiple bowels of food have been on the resident's over the bed table. -He/she mentioned the food to nursing, but the no one removed the food. During an interview on 3/11/20 at 11:06 A.M. Certified Nurse Aide (CNA) G said: -The resident will keep food off the meal tray. Usually his/her desserts. - Hospitality aides will pass the trays and pick up the trays; -The resident eats all meal in his/her room; -The resident will get upset if aides try to take the food off his/her over bed table. During an interview on 3/11/20 at 11:24 A.M.

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Registered Nurse (RN) D said: -The resident will keep food off his/her meal trays; -It is nursing's job to ensure that the food is not left at the bedside unless in a refrigerator and that the residents are being monitored; -Housekeeping should be monitoring also. During an interview on 3/11/20 at 4:00 P.M. the Director of Nursing said: -The resident should be monitored for hoarding food in his/her room; -The person who picks up the tray, and the aide that provides care and the nurse passing medications are all responsible for monitoring to ensure the uneaten food is removed from the residents room.
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 interview and record review, the facility failed to ensure that they reported to the Department of Health and Senior Services (DHSS) and local law enforcement immediately, but not later than two hours, after one resident (Resident #12) reported to staff an allegation of physical abuse by a staff member. The facility census was 107. Review of the facility policy for abuse, dated 12/17 showed: - Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and /or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. - The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, and staff from other agencies servicing residents, family members, legal guardians, surrogates, sponsors, friends and visitors. -The Administrator may delegate coordination and implementation of components of the abuse prevention program to other staff within the Facility. - Staff, residents and families will be able to report concerns, incidents and grievances without fear of retribution or retaliation. -Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring. -The Facility conducts an ongoing review and analysis of abuse incidents and implements corrective actions to prevent future occurrences of abuse. - The facility provides Facility Staff with training to enable the identification of the following signs and symptoms of potential resident abuse and neglect: Welts or bruises; Abrasions or lacerations; Fractures, dislocations or sprains of questionable origin; Black eyes; Broken teeth; Improper use of restraints; Sexual exploitation; Rape; Excessive exposure to heat or cold; Involuntary seclusion; [MEDICAL CONDITION] bites. -The Facility utilizes preventable audits to identify occurrences and patterns of potential mistreatment/abuse and crime. -The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown sources, or criminal acts. -The Facility ensure protection of residents during abuse investigations. -Facility Staff who have been accused of resident abuse may be reassigned to duties that do not involve resident care or suspended from duty until the Administrator has reviewed the investigation results. -Facility staff are mandatory reporters and are obligated by the Elder Justice Act and any State specific regulations to report known or suspected instances of abuse to elder or dependent adults. If the reportable event does not result in serious bodily injury, the Administrator, and his/her designed, will make a telephone report to the local law enforcement agency within 24 hours of the observation, knowledge, or suspicion of the physical abuse. 1. Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 12/10/19, showed: -Cognitively intact, made own decisions; -Extensive assist of one staff for bed mobility, personal hygiene, dressing, and toileting; -Occasionally incontinent of bladder and bowel -[DIAGNOSES REDACTED]., revised on 12/19/2019, showed: -Resident requires extensive assistance by Staff to turn and reposition in bed. -Resident requires extensive assistance by staff to dress; -Resident requires extensive assistance staff with personal hygiene and oral care; -Resident requires extensive assistance by Staff for toileting; -Resident requires skin inspection daily with cares and on bath days. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse; -Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Observation on [DATE] at 10:30 A.M. showed; -Resident has two dark purple, quarter sized, irregular shaped bruises to the front of his/her right forearm. There were no open areas to Resident's skin. During an interview on [DATE] at 10:30 A.M. the Resident said; -Staff is often in a hurry and is rough while performing care. -One particular Staff member is often rude and does not allow the Resident to assist in turning over for care but instead the staff member shoves him/her over to his/her right side to clean his/her skin and change his/her brief after being incontinent of urine overnight. He/she is unsure of staff member's name but reports that the staff member worked last night. -He/she believes that the bruising to his/her right forearm is a result of his/her arm being caught underneath him/her or between the wall and the mattress when being turned by this staff member. -On [DATE], Certified Nursing Aide (CNA) E and CNA F assisted the him/her in getting dressed. The CNA's were complaining about their jobs while performing his/her cares. The CNA's began dressing him/her while he/she was in bed. The CNA's placed a new incontinent brief and a pair of clean pants on his/her feet before throwing his/her legs off the side of the bed and abruptly repositioning him/her to a seated position. He/she was then stood on his/her own feet and allowed to hold onto the bedside table while the CNA's pulled his/her clean brief and clean pants up over the wet brief he/she had been wearing overnight causing urine to run onto his/her clean clothing and onto the floor. The CNA's did remove the wet overnight brief but did not change his/her clothing or the new brief causing him/her to have to wear clothing that were wet with urine. -He/she was upset by the bruising to his/her arm, condition of his/her clothing and the rough treatment overnight and notified a nursing staff member that was at the nurses' station. He/she was not able to remember the staff member's name at the time of the interview. Observation on 3/11/20 at 5:08 P.M. showed; -The resident had two additional dark purple, half-dollar sized, irregular shaped bruises the side of his/her right forearm. The two original bruises to the front of the resident's forearm were beginning to fade and were light reddish/pink in color. There were no open areas to resident's skin. During an interview on 3/11/20 at 5:08 P.M. the Resident said; - The bruising to his/her arms usually fade fast. -There are some CNA's that scold him/her for having incontinent episodes. The CNA fusses at me for peeing. He/she is unable to control their bladder due to taking diuretics (a medication that increases the flow of urine) in the evening to relieve swelling in his/her arms and legs and that is when the CNA scold him/her for wetting him/herself. It makes him/her feel bad. -He/she is not aware of the Elder Abuse and Neglect Hotline service available to Seniors. Review of the resident's Nurse's notes for [DATE], [DATE], and 3/11/20 showed; -No documentation identifying the bruises to the resident's right forearm or when and how the injury occurred. Review of the Nurse's notes on 3/12/20 at 11:38 A.M., written by the Assistant Director of Nurses (ADON) showed; -She spoke with Resident regarding his/her report of night shift staff being rough with him/her on Sunday night. -The Resident does have some bruising to right arm. No other abnormal findings to skin upon full skin assessment. -The Resident stated that he/she has had no issues with staff being rough with him/her since Sunday night. -The Resident stated he/she does not remember the names of the staff but that they have not taken care of him/her again since the incident. -The Resident is satisfied with his/her nursing care since the incident on Sunday night. During an interview on 3/12/20 at 8:18 A.M. CNA E said; -He/She was assigned to the 300 hall and worked with the resident on the morning of [DATE]. -The Resident did not report to her/him that anyone had been rough with the Resident while turning him/her overnight. -He/she was interviewed by the ADON on Monday morning regarding the he/she and CNA F performed for the Resident earlier that morning. He/She said that the Resident was angry and that the Resident spoke unkindly to the CNAs as they assisted in dressing the Resident. -The Resident's clothing became wet with urine while changing the Residents brief. The clothing became wet after the resident had a subsequent incontinent episode while standing at bedside. He/She said that both staff members offered to change the Resident's clothing but that the Resident became angry and refused to allow them to change his/her clothing. -Shortly afterward, the resident allowed him/her to assist the resident in changing his/her clothing without the assistance of CNA F. -The resident's brief, clothing and shoes were wet with urine. He/she believes that this was caused by the Resident having a subsequent incontinent episode while transferring from the wheelchair to the toilet. During an interview on 3/12/20 at 10:06 A.M. the ADON said; -On the morning of [DATE], the resident did report to him/her that the resident received rough treatment overnight by the staff and that the morning staff were in a hurry and double briefed the resident. The ADON did interview CNA E and CNA F on the morning of [DATE] regarding the resident's report that the CNA's had double briefed the resident and caused his/her clothing to become wet with urine. CNA E and CNA F reported that the resident was upset and was mean to the staff while they attempted to assist him/her with dressing that morning. -He/she had intended to look at staffing sheets to see who had worked the night before but became busy and did not get that done. -He/she is unsure if the staff member who provided the Resident's cares has worked or been in contact with the Resident since the alleged rough treatment on Sunday night. -The staff member should

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) have been suspended until an investigation could be conducted into the alleged incident. -Failure to suspend a staff member could result in additional abuse/rough treatment to the resident. -The proper procedure would be to report alleged abuse to the Abuse Coordinator/Administrator immediately. -He/she did not notify the Abuse Coordinator/Administrator or the DON of the residents allegations. -He/she did not notify the Department of Health and Senior Services (DHSS) of the abuse or rough treatment of [REDACTED]. During an interview on 3/12/20 at 10:27 A.M. the Director of Nursing (DON) said; -She unaware of any allegations of abuse from any residents prior to the ADON notifying her this morning. -He/she was unaware of the allegations reported by the resident; -She did not notify DHSS of the allegations; -She expects that staff will immediately notify the Abuse Coordinator/Administrator of any reported or suspected abuse of any resident. -Upon notification, the Abuse Coordinator would provide guidance and delegate the task of the abuse investigation to the DON. The Abuse Coordinator/Administrator would also notify the Department of Health and Senior Services of the abuse allegations. During an interview on 3/12/20 at 10:42 A.M. the Abuse Coordinator/Administrator said; -He was unaware of any allegations of abuse from any residents prior to the ADON notifying him this morning. -No investigation was conducted into the allegation as the he was unaware of the allegations until just minutes prior to this interview. -He did not notify DHSS of the allegation of abuse as he was unaware of the allegations. -He expects that staff will immediately notify the Abuse Coordinator/Administrator of any reported or suspected abuse of any resident. -Following notification, the Abuse Coordinator would complete a formal abuse investigation and would immediately suspend any employees who may have been involved in the alleged abuse. The Abuse Coordinator/Administrator would notify DHSS of the suspected or reported abuse and would have the residents immediately assessed by the DON and the Director of Social Services.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to follow their policy when they failed to conduct an investigation for an allegation of abuse by a staff member involving one resident (Resident #12). The facility census was 107. Review of the facility policy for abuse, dated 12/1/17 showed: - Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and /or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. - The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, and staff from other agencies servicing residents, family members, legal guardians, surrogates, sponsors, friends and visitors. -The Administrator may delegate coordination and implementation of components of the abuse prevention program to other staff within the Facility. - Staff, residents and families will be able to report concerns, incidents and grievances without fear of retribution or retaliation. -Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring. -The Facility conducts an ongoing review and analysis of abuse incidents and implements corrective actions to prevent future occurrences of abuse. - The facility provides Facility Staff with training to enable the identification of the following signs and symptoms of potential resident abuse and neglect: Welts or bruises; Abrasions or lacerations; Fractures, dislocations or sprains of questionable origin; Black eyes; Broken teeth; Improper use of restraints; Sexual exploitation; Rape; Excessive exposure to heat or cold; Involuntary seclusion; [MEDICAL CONDITION] bites. -The Facility utilizes preventable audits to identify occurrences and patterns of potential mistreatment/abuse and crime. -The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown sources, or criminal acts. -The Facility ensure protection of residents during abuse investigations. -Facility Staff who have been accused of resident abuse may be reassigned to duties that do not involve resident care or suspended from duty until the Administrator has reviewed the investigation results. -Facility staff are mandatory reporters and are obligated by the Elder Justice Act and any State specific regulations to report known or suspected instances of abuse to elder or dependent adults. If the reportable event does not result in serious bodily injury, the Administrator, and his/her designed, will make a telephone report to the local law enforcement agency within 24 hours of the observation, knowledge, or suspicion of the physical abuse. Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 12/10/19, showed: -Cognitively intact, made own decisions; -Extensive assist of one staff for bed mobility, personal hygiene, dressing, and toileting; -Occasionally incontinent of bladder and bowel -[DIAGNOSES REDACTED]., revised on 12/19/19, showed: -Resident requires extensive assistance by Staff to turn and reposition in bed. -Resident requires extensive assistance by staff to dress -Resident requires extensive assistance staff with personal hygiene and oral care -Resident requires extensive assistance by Staff for toileting -Resident requires skin inspection daily with cares and on bath days. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. -Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Observation on [DATE] at 10:30 A.M. showed; -Resident has two dark purple, quarter sized, irregular shaped bruises to the front of his/her right forearm. There were no open areas to Resident's skin. During an interview on [DATE] at 10:30 A.M. the Resident said; -Staff is often in a hurry and is rough while performing care. -One particular Staff member is often rude and does not allow he/she to assist in turning over for care but instead the staff member shoves him/her over to his/her right side to clean his/her skin and change his/her brief after being incontinent of urine overnight. He/She is unsure of staff member's name but that the staff member worked last night. -He/She believes that the bruising to his/her right forearm is a result of his/her arm being caught underneath him/her or between the wall and the mattress when being turned by this Staff member. -On [DATE], Certified Nursing Aide (CNA) E and CNA F assisted him/her in getting dressed. The CNA's were complaining about their jobs while performing his/her cares. The CNA's began dressing him/her while he/she was in bed. The CNA's placed a new incontinent brief and a pair of clean pants on his/her feet before throwing his/her legs off the side of the bed and abruptly repositioning him/her to a seated position. He/she was then stood on his/her own feet and held onto the bedside table while the CNA's pulled his/her clean brief and clean pants up over the wet brief he/she had been wearing overnight causing urine to run onto his/her clean clothing and onto the floor. The CNA's did remove the wet overnight brief but did not change his/her clothing or the new brief causing him/her to have to wear clothing that were wet with urine. -He/she was upset by the bruising to his/her arm, condition of his/her clothing and the rough treatment overnight and notified a nursing staff member that was at the nurses' station. He/she did not remember the nursing staff members name. Review of the nurses notes for 2/11/20, showed; -A 4 centimeter (cm) x 3 cm dark purple bruise noted to Resident's right arm. -The resident said that the bruise likely occurred while being repositioned during the night for incontinence care. -Resident takes [MED] (a blood thinner used to prevent and/or treat blood clots) and [MEDICATION NAME] (a man-made steroid medication used for suppressing the immune system and reducing inflammation) which causes him/her to bruise easily. -Physician and the Director of Nursing (DON) were notified of this incident. Observation on 3/11/20, at 5:08 P.M. showed; - The Resident has two additional dark purple, half-dollar sized, irregular shaped bruises the side of his/her right forearm. The two original bruises to the front of the his/her forearm were beginning to fade and were light reddish/pink in color. There were no open areas to Resident's skin. During an interview on 3/11/20 at 5:08 P.M. the Resident said; -The bruising to his/her arms usually fade fast. -There are some CNA's that scold him/her for having incontinent episodes. The CNA fusses at me for peeing. -He/she is unable to control his/her bladder due to taking diuretics (a medication that increases the flow of urine) in the evening to relieve swelling in his/her arms and legs. When the CNA scolds him/her for wetting him/herself it only makes him/her feel bad. -He/she is not aware of the Elder Abuse and Neglect Hotline service available to Seniors. Review of the resident's Nurse's notes for [DATE], [DATE], and 3/11/20 showed; -No documentation identifying bruising to the Resident's right forearm or when and how the injury occurred. Review of the resident's Nurse's notes on 3/12/20 at 11:38 A.M., written by the Assistant Director of Nurses (ADON) showed; -She spoke with the Resident regarding his/her report of night shift staff being rough with him/her on Sunday night. -The Resident does have some bruising to his/her right arm. No other abnormal findings to skin upon full skin assessment. -The Resident states that he/she has had no issues with staff being rough with him/her since Sunday night. -The Resident states he/she does not remember the names of the staff but that they have not taken care of him/her again since the incident. -The Resident is satisfied with his/her nursing care since the incident on Sunday night. During an interview on 3/12/20 at 8:18 A.M. CNA E said; -He/She was assigned to the 300 hall and worked with the Resident on the morning of [DATE]. -The Resident did not report to him/her that anyone had been rough with the Resident while turning her in bed overnight. -He/she was interviewed by the ADON on Monday morning regarding the cares he/she and CNA F performed for the Resident earlier that morning. He/she said that the Resident was angry and that she spoke unkindly to the CNAs as they assisted in dressing the Resident. -The Resident's

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) clothing became wet with urine while changing the Residents brief. The clothing became wet after the Resident had a subsequent incontinent episode while standing at bedside. He/she said that both staff members offered to change the Resident's clothing but that the Resident became angry and refused to allow them to change his/her clothing. -Shortly afterward, the Resident allowed him/her to assist the Resident in changing his/her clothing without the assistance of CNA F. -The resident's brief, clothing and shoes were wet with urine. He/she believes that this was caused by the Resident having a subsequent incontinent episode while transferring from the wheelchair to the toilet. During an interview on 3/12/20 at 10:06 A.M. the ADON said; -On the morning of [DATE], the Resident did report to him/her that the Resident received rough treatment overnight by staff and that the morning staff were in a hurry and double briefed the Resident. The ADON did interview CNA E and CNA F on the morning of [DATE] regarding the Resident's report that the CNA's had double briefed the Resident and caused his/her clothing to become wet with urine. CNA E and CNA F reported that the Resident was upset and was mean to the staff while they attempted to assist him/her with dressing that morning. -He/she had intended to look at staffing sheets to see who had worked the night before but became busy and did not get that done. -He/she is unsure if the staff member who provided the Resident's cares has worked or been in contact with the Resident since the alleged rough treatment on Sunday night. -That staff member should have been suspended until an investigation could be conducted into the alleged incident. -Failure to suspend the staff member could have resulted in additional abuse/rough treatment to the Resident. -The proper procedure would be to report alleged abuse to the Abuse Coordinator/Administrator immediately. -He/she did not notify the Abuse Coordinator/Administrator or the Director of Nurses (DON) of the resident's allegations. -He/she did not notify the Abuse Coordinator/Administrator or the Department of Health and Senior Services (DHSS) of the abuse or rough treatment of [REDACTED]. During an interview on 3/12/20 at 10:27 A.M. the DON said; -He/She was unaware of any allegations of abuse from any residents prior to the ADON notifying him/her this morning. -He/she did not notify DHSS of the allegations. -He/she expects that staff will immediately notify the Abuse Coordinator/Administrator of any reported or suspected abuse of any resident. -Upon notification, the Abuse Coordinator would provide guidance and delegate the task of the abuse investigation to the DON. The Abuse Coordinator/Administrator would also notify the DHSS of the abuse allegations. During an interview on 3/12/20 at 10:42 A.M. the Abuse Coordinator/Administrator said; -He was unaware of any allegations of abuse from any residents prior to the ADON notifying him this morning. -No investigation was conducted by the Administrator into the allegation until just minutes prior to this interview. -He did not notify the DHSS of the allegation of abuse as he was unaware of the allegations. -He expects that staff will immediately notify the Abuse Coordinator/Administrator of any reported or suspected abuse of any resident. -Upon notification, the Abuse Coordinator would complete a formal abuse investigation and would immediately suspend any employees who may have been involved in the alleged abuse. The Abuse Coordinator would notify the DHSS of the suspected or reported abuse and would have the residents immediately assessed by the DON and the Director of Social Services.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff provided written notice of transfer or discharge to residents and their responsible party and the reasons for the transfer in writing in a language they understood for one resident (Resident #111). The facility census was 107. The facility did not provide a policy for discharge or transfer from the facility. 1. Review of Resident #111's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 10/1/19 showed: -The resident was admitted to the facility on [DATE]; -An active discharge plan was in place to return to the community. Review of the discharge MDS dated [DATE] showed the resident was discharged from the facility on [DATE] with no return anticipated. Review of the medical record on 3/12/20 at 2:11 P.M. showed no documentation of the resident being discharged . During an interview on 3/12/20 at 4:44 P.M. Registered Nurse (RN) C said: -He/she cannot remember where the resident was discharged to or when the resident was discharged . He/she cannot find any documentation in the medical record to show that the resident was discharged . He/she thinks the resident was discharged to home with home health. He/she cannot find any discharge letter in the medical record. During an interview on 3/12/20 at 4:50 P.M. the Social Services Director said: -The resident was discharged to the hospital for surgery. This was a planned hospitalization . The family decided that the resident would go home after the surgery. -He/she did not issue a letter of discharge, he/she did not know that a letter of discharge had to be written and given to the resident or the resident representative upon discharge to the hospital or to home. During an interview on 3/12/20 at 5:00 P.M. the Administrator said: -He was not aware that a discharge letter had to be given to a resident when that resident discharged to the hospital.
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to arrange for a safe discharge for one sampled resident (Resident #111). The facility census was 107. The facility did not provide a policy for safe discharge. 1. Review of Resident #111's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 10/1/19 showed: -The resident was admitted to the facility on [DATE]; -An active discharge plan was in place to return to the community. Review of the discharge MDS dated [DATE] showed the resident was discharged from the facility on [DATE] with no return anticipated. Review of the medical record on 3/12/20 at 2:11 P.M. showed no documentation of the resident being discharged . Review of the medical record on 3/12/20 at 2:11 P.M. showed no care plan for discharge or a discharge plan. During an interview on 3/12/20 at 4:44 P.M. Registered Nurse (RN) C said: -He/she cannot remember where the resident was discharged to or when the resident was discharged . He/she cannot find any documentation in the medical record to show that the resident was discharged . He/she thinks the resident was discharged to home with home health. He/she cannot find any discharge letter in the medical record. During an interview on 3/12/20 at 5:00 P.M. the Social Services Director said: -He/she was aware of the resident wanting to be discharged after a planned surgery; -He/she did not develop a discharge plan; -He/she did not make any contacts with any home health agencies or providers for the resident.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to inform resident and family or legal representative of their bed hold policy at the time of transfer to the hospital for one resident (Resident #111). The facility census was 107. The facility did not provide a policy for bed hold. 1. Review of Resident #111's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 10/1/19 showed: -The resident was admitted to the facility on [DATE]; -An active discharge plan was in place to return to the community. Review of the discharge MDS dated [DATE] showed the resident was discharged from the facility on [DATE] with no return anticipated. Review of the medical record on 3/12/20 at 2:11 P.M. showed no documentation of the resident being discharged or a care plan for a discharge. During an interview on 3/12/20 at 4:44 P.M. Registered Nurse (RN) C said: -He/she cannot remember where the resident was discharged to or when the resident was discharged . He/she cannot find any documentation in the medical record to show that the resident was discharged . He/she thinks the resident was discharged to home with home health. He/she cannot find any discharge letter in the medical record. He/she could not find any documentation to show the resident was given a bed hold letter. During an interview on 3/12/20 at 5:00 P.M. the Social Services Director said: -He/she did not give the resident a bed hold letter prior to discharge; -He/she was aware the resident was going to be discharged after a surgical procedure, but he/she did not know when the procedure was to occur; -He/she did not know what day the resident left the facility.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to provide discharge planning for one sampled residents (Resident #42). The facility census was 107. The facility did not provide a policy for discharge planning. Review of Resident #42's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated

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	265693	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF INDEPENDENCE	1800 S SWOPE DRIVE INDEPENDENCE, MO 64057

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F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) 1/2/20 showed: -Alert and oriented and able to answer questions; -Supervision with Activities of Daily Living (ADL's); -[DIAGNOSES REDACTED]. During an interview on [DATE] at 9:22 A.M. the resident said: -About a month ago, he/she attended a care plan meeting and expressed the desire to be able to go home. Staff told him/her that they would develop a plan with goals to work towards being discharged to home. The Social Services Director told him/her that they would begin working with mental health to help secure with a place to go and a job. He/she was told that he/she and the staff would set up a meeting for discharge but he/she has not heard from social services about a month. Review of the resident's care plans [DATE] showed that the resident does not have discharge goals or any documentation for contacting any referrals for discharge to the community. The care plan indicates that he is a long term care placement. During an interview on 3/11/20 at 4:44 P.M. the Social Services Director said: -The resident is his/her own person and can make decisions for his/her discharge; -The resident attended a care plan meeting about a month ago and expressed a desire to return to the community. He/she has contacted an outside referral source for the resident for a referral, but has not followed up with them and he/she does not know the status of the referral. -He/she did not document the referral; -He/she has not developed a discharge care plan. During an interview on 3/19/20 at 4:30 P.M. the Administrator said: -He would expect the Social Services Director to develop a discharge care plan for any resident who expressed a desire to be discharged to the community; -He would expect the Social Services Director to make community referrals for the resident.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents were offered at least two showers per week for two of 22 sampled residents (Residents #80 and #87); and the facility failed to ensure one resident (Resident #45) received assistance with meals. The facility census was 107. 1. Review of the facility policy, dated February 2019, on showers showed:- A shower was given to provide cleanliness, comfort, and to prevent body odor. - The facility offered each resident a minimum of one shower per week and at resident request. 2. Review of Resident #80's care plan, dated 11/1/2018, showed: - The resident required staff assistance due to swollen legs and obesity. - The resident required extensive assistance with showers twice a week and as needed per resident preference. - [DIAGNOSES REDACTED]. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE]20, showed: - Cognitively intact; - Required extensive staff assistance for toileting; - Required physical help for bathing; - Frequently incontinent of bladder; - [DIAGNOSES REDACTED]. Review of the resident's shower sheets for 2/15/2020 through [DATE] showed the resident received a shower on 2/16, 2/26, and [DATE]. Observation on [DATE]20 at 2:00 P.M. showed the resident appeared unkempt with greasy hair. During an interview on [DATE]20 at 2:00 P.M. the resident said: - Staff gave him/her infrequent showers, less than one a week. - He/she would like showers more often. 3. Review of Resident #87's care plan, dated 11/7/2019, showed: - The resident required staff assistance with bathing due to dementia and dizziness. - Staff to assist the resident with showers twice a week and as needed. Review of the resident's physician's order sheet dated 1[DATE]19 showed the resident should receive a warm shower every Monday, Wednesday, and Friday. Review of the resident's quarterly MDS, dated [DATE], showed: - Cognitively impaired; - Required physical assistance with bathing; - Frequently incontinent of urine; - [DIAGNOSES REDACTED]. Review of the resident's shower sheets from 2/15/2020 through [DATE] showed the resident received a shower on 3/3, 3/2, and [DATE]20. During an interview on [DATE]20 at 4:00 P.M. the resident's family member said: - The family transferred the resident to another facility today. - Staff did not help the resident with grooming and the resident appeared unkempt. - Staff did not give the resident a shower very often and the resident had body odor. - The family talked to the Director of Nursing (DON) but nothing changed. 4. During an interview on [DATE] at 10:00 A.M. the DON said: - The Assistant Director of Nursing (ADON) should track showers. - The ADON had been quite busy. - Residents should be offered two showers a week. - If a resident has an order for [REDACTED]. - Staff were responsible for providing showers. - Recently the facility hired a shower aide. During an interview on [DATE] at 12:00 P.M. the shower aide (SA) said: - He/she was hired several weeks ago to provide showers. - Due to call-ins, frequently he/she was pulled to the floor and showers did not get given. Review of Resident #45's comprehensive MDS dated [DATE] showed: -Cognitive impairment, unable to make decisions; -Extensive assistance with bathing, dressing, transfers and toilet use. Supervision with eating; -Frequently incontinent of bowel and bladder; -[DIAGNOSES REDACTED]. Review of the medical record showed the following weights: - 10/3/19 153.8 pounds; 11/1[DATE]9 145.0 pounds; 1/8/20 148.6 pounds; 2/7/20 142.3 pounds; and 3/4/20 139.8 pounds. Review of the physician orders dated March 2020 showed the resident is on a regular diet, with no supplement ordered. Review of the care plan for ADL's dated 1/24/20 showed: -The resident requires supervision and occasionally limited assistance by the staff to eat. Observation on [DATE] at 8:20 A.M. and 10:45 A.M. showed the resident in bed with eyes closed. The breakfast tray sat on the over the bed table approximately two feet away from the resident. The food had not been eaten. Observation on [DATE] at 11:30 A.M. showed the staff remove the untouched breakfast tray and place the noon meal tray on the over the bed table. The resident was in the bed with eyes closed. The staff placed the over the bed table approximately three feet away from the resident. Observation on [DATE] at 1:23 P.M. showed the resident in bed with eyes closed. The noon tray sat on the over the bed table and consisted of beef and noodles, carrots, bread, dessert and a glass of juice approximately three feet away from the resident. No food had been eaten off the plate. Observation on [DATE] at 3:36 P.M. showed the resident laid in bed with his/her eyes closed. The lunch tray sits on the over the bed table with a few bites of beef and noodles, a few bites of carrots and a few bites of the cobbler eaten and two thirds of the glass of juice drank. The resident did not open his/her eyes when spoken to. Observation on 3/11/20 at 8:50 A.M. showed the resident in bed with his/her eyes closed. The breakfast tray of cereal, scrambled eggs and biscuit with glass of juice sat on the over the bed table. Plastic wrap still on bowel of cereal, eggs and biscuit was untouched. There was no milk for the cereal. The resident's roommate said that the resident has not awakened in two days to eat and no staff member has come in to help or assist the resident to eat. Observation on 3/11/20 at 9:50 A.M. showed: CNA G assisted the resident into the bathroom. The resident said that he/she was hungry and wanted something to eat. He/she said that he/she doesn't feel like him/herself and was more sleepy. CNA G took the resident's breakfast tray to the kitchen and reheated the food and served the resident. During an interview and observation on 3/11/20 at 10:58 A.M. the resident said: -He/she has not felt good, feels blah, does not have any pain, he/she just feels tired. He/she feels depressed, but does not feel like talking about depression to anyone. He/she would prefer to go to the dining room but no one asks him/her if he/she would like to go to the dining room. The resident's breakfast was tray sitting on over bed table with one half of the eggs eaten, one half of the biscuit and the bowel of cereal eaten. During an interview on 3/11/20 at 11:06 A.M. CNA G said: -The resident was more independent a couple of months ago, now he/she needs more help. The resident was a morning person, but he/she is sleeping more now. The resident needs assistance to get out of bed and use the bathroom. The resident needs supervision with meals and encouragement to get out of bed to eat. During an interview on 3/11/20 at 11:24 A.M. Registered Nurse (RN) said - -The resident has some dementia, there are days when she is tearful, has some anxiety, and some days he/she is depressed and will not come out of the room. He/she has has some weight loss. He/she needs more care when. The staff need to monitor him/her more closely and should have checked on him/her to ensure that he/she is eating. During an interview on 3/12/20 at 4:30 P.M. the Director of Nursing said: -She would expect the to staff monitor that resident has eaten and if not eating, inform the charge nurse; -She would expect the staff to assist the resident as needed; -She would expect the charge to notify the physician if the resident is not eating and ask for supplement. The facility does have several supplements that they can give health shakes, or fortified ice cream.
F 0686 **Level of harm** - 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** Based on observations, interviews, and record reviews, the facility failed to provide effective interventions to prevent the development of pressure ulcers (PU) (localized areas of tissue damage or necrosis (death) that develop because of pressure over a bony prominence), for a newly admitted resident when Resident #69 developed an unstageable (Injuries that include full thickness tissue loss in which the base of the ulcer is covered by slough (dead tissue that is yellow, tan, gray, green or brown) and/or eschar (dead tissue tan, brown or black in the wound bed), PU to his/her left ankle and a Stage II (an area of partial thickness, loss of tissue presenting as a shallow open ulcer with a red pink wound bed,

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF INDEPENDENCE	1800 S SWOPE DRIVE INDEPENDENCE, MO 64057

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) without slough), PU to his/her right buttock when facility staff failed to ensure treatment was provided for the Stage II PU's resulting in the resident being admitted to the hospital with [REDACTED]. Additionally, staff failed to communicate, document, asses, and obtain treatment orders for both newly identified PU's when the new PU's were first identified. The facility census was 107. 1. Review of the facility's policy titled PU/Prevention revised February 2019, showed: -Purpose: To identify residents at risk for skin breakdown, implement measures to prevent and/or manage PU and minimize complications; -The facility will identify residents at risk for PU and provide care and services to promote the prevention of PU development; -The Licensed Nurse will complete a Braden (a tool to identify risk of developing PU) Assessment upon admission and quarterly to identify residents at risk for skin breakdown; -If a resident is identified as having a wound upon admission, findings will be documented on the admission assessment and a Wound Monitoring Record (tool used by the facility) will be implemented; -If a resident is identified as having a wound at any time other than admission, the Wound Monitoring Record will be implemented; -A Wound Monitoring Record will be implemented for each identified wound; -The Licensed Nurse will develop a care plan specific to the resident's risk factors; -Certified Nurse Aides (CNA) will inspect the resident's skin during activities of daily living (ADL)'s care and report unusual findings to the Licensed Nurse; -CNA's will complete body checks on resident's shower days and report unusual findings to the Licensed Nurse; -The Licensed Nurse will document effectiveness of PU prevention techniques in the resident's medical record on a weekly basis. Review of Resident #69's admission progress note dated 1/30/20, showed: -admitted for [DIAGNOSES REDACTED]. Review of resident's Resident Data Set (RDS) (an assessment tool used by the facility) dated 1/30/20, showed: -admitted [DATE]; -Reason for admission compression fracture; -Skin conditions/wounds: scab to back of right hand and upper extremity, left heel: scab to left ankle and lower extremity; -No PU; -At risk skin care plan left blank. Review of the resident's admission Braden skin assessment dated [DATE], showed: -Score of 14 which indicated the resident was a moderate risk of developing a PU. Review of resident's physician admission progress note dated 1/31/20, at 9:47 A.M., showed: -Face to face encounter; -Recent hospitalization for a fall with compression fracture; -Skin intact no sores [MEDICAL CONDITION] or rash noted. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 2/5/20, showed: - Severe cognitive impairment; - Extensive assist of two staff for bed mobility, transfers, dressing and hygiene needs; - Indwelling catheter (a tube going into the bladder to drain urine); - Frequently incontinent of bowel; - At risk for PU; -No unhealed PU - [DIAGNOSES REDACTED]. Review of the resident's Braden dated 2/20/20, showed: -Score of 13 which indicated the resident was a moderate risk of developing a PU. Review of the resident's shower sheets for February 2020, showed: -2/1/20, staff documented random bruising all over; -2/9/20, staff documented redness to groin; -2/15/20, staff documented no skin concerns identified; 2/23/20, staff documented no new skin issues and the charge nurse signed the shower sheet which indicated the resident had no new skin issues; -[DATE] staff documented very confused refused shower. Review of the resident's care plan, revised on [DATE], showed: - Extensive staff assistance with activities of daily living (ADL)s; - Skin inspection daily with cares and on bath days; -On [MEDICATION NAME] (antibiotic) related to wound infection; -The care plan did not include interventions for wound care or indicate the resident was at risk for PU development. Review of the resident's medical record from 1/30/20, thru 3/8/20, showed:-No documentation of a PU to the resident's left ankle or right buttock. Review of the resident's physicians' order sheet (POS) for March 2020, showed: -Start date [DATE], Cleanse wound to left outer ankle with normal saline or wound cleanser pat dry calcium alginate (a highly absorbent, biodegradable dressing derived from seaweed) to wound bed cover with dry dressing every day shift and as needed. -Start date [DATE], [MEDICATION NAME] tablet 650 milligrams (mg) give one tablet orally two times daily for wound infection; -Start date [DATE], Heel raiser (foam protector) to both lower extremities to promote wound healing; -Start date [DATE], Barrier cream to buttock every shift and as needed to promote skin integrity. Review of the resident's shower sheets for March 2020, showed: - Staff documented no showers provided. Review of the resident's skilled nurses' notes dated 3/8/20, at 1:27 A.M., showed: -The charge nurse documented no changes in skin integrity. Review of the resident's skilled nurses' notes dated 3/8/20, at 4:15 P.M., showed: -LPN B charted no changes in skin integrity. Review of the resident's skilled nurses' notes dated [DATE], at 12:09 A.M., showed: -The charge nurse documented no changes in skin integrity. Review of the resident's skilled nurses' notes dated [DATE], at 11:15 A.M., showed: -The charge nurse documented no changes in skin integrity. Review of the resident's nurses' notes dated 3/8/20 and [DATE], showed: -No documentation that facility staff notified the responsible party of the newly identified PU's. Review of the resident's skilled nurses' notes dated [DATE], at 4:12 P.M., showed: -Registered Nurse (RN) A documented no changes in skin integrity Review of the resident's skilled nurses' notes dated [DATE], at 11:39 P.M., showed: -The charge nurse documented no changes in skin integrity. Observation and interview on 3/11/20, at 10:44 A.M., CNA A and CNA C entered the resident's room to provide incontinent care and they did and said the following: -Removed the resident's brief, provided perineal care, then rolled the resident onto his/her side; -The resident's right buttock showed an open area with a dark brown and crusty material indicative of eschar that was approximately 0.4 centimeters (cm) by 0.4 cm; -Both staff said they first discovered the area on the resident's right buttock on 3/8/20; -They also identified a PU to the resident's left ankle on 3/8/20; -Both of these skin changes were identified when they assisted the resident with a shower; -On 3/8/20, they verbally reported these new findings to LPN B; -After providing a shower staff should complete a shower sheet which should include newly identified skin concerns; -A shower sheet was not completed on 3/8/20. Observation on 3/11/20, at 11:00 A.M., the resident lay in his/her bed and Licensed Practical Nurse (LPN) C did the following: -Entered the resident's room and informed the resident that he/she planned to change the dressing to his/her left ankle; -There was a foul odor in the room; -He/she attempted to remove a [MEDICATION NAME] (elasticized tubular bandage) from the resident's left ankle; -The resident yelled out in pain; -LPN C informed the resident that he/she would inform LPN B that he/she required pain medication and he/she would return after the medication had been administered. Observation on 3/11/20, at 11:08 A.M., LPN B entered the resident's room and administered an [MEDICATION NAME] (medicines that are used to relieve pain) medication as the resident lay in his/her bed. During an interview on 3/11/20, at 11:15 A.M., the Assistant Director of Nursing (ADON) said: -He/she was not aware that the resident had an unstageable PU to his/her left ankle; -He/she was not aware that the resident had an open area to his/her right buttock; -The last skin report he/she had for Resident # 69 was related to his/her left heel; -When staff identify a new skin issue the charge nurse should assess the area, measure, inform the physician to obtain treatment orders, inform him/her, start a wound monitoring record and document his/her interventions and findings; -He/she reviewed the resident's electronic medical record and LPN B did not complete the required documentation. Review of the resident's medical record on 3/11/20, at 11:25 A.M showed: -No assessment to include measurements or new treatment orders on 3/8/20, for the unstageable PU to the resident's left ankle; -No assessment to include measurements or new treatment orders on 3/8/20, for the open area to the resident's right buttock; -No measurements on [DATE] or [DATE], for the unstageable PU to the resident's left ankle; - No measurements on [DATE] or [DATE], for the open area to the resident's right buttock. -No documentation staff did a new Braden skin assessment on 3/8/20 when the new skin issues were identified. Observation and interview on 3/11/20, at 11:40 A.M., LPN C did and said the following as the resident lay in his/her bed: -Said he/she is the wound nurse; -He/she entered the resident's room and informed the resident that he/she planned to change the dressing to his/her left ankle; -There was a foul odor in the room; -The linen under the resident left ankle was soiled with a large amount of serosanguineous (term used to describe discharge that contains both blood and a clear yellow liquid known as blood serum) drainage; -LPN C removed the saturated [MEDICATION NAME] stocking and gauze dressing dated [DATE], from the resident's ankle and the foul odor significantly increased; -The unstageable PU to the resident's left ankle was approximately the size of a tangerine and 80 % of the wound bed was covered with slough with eschar present with redness noted around the wound; -LPN C cleaned the wound with wound cleanser and applied calcium alginate to the wound bed and secured a clean gauze dressing; -Said the unstageable PU to the ankle was identified on 3/8/20, and he/she provided wound care on [DATE]; -Said he/she notified the physician on [DATE], and obtained treatment orders and the resident was started on [MEDICATION NAME]; -On [DATE], he/she did not document measurements of the wound because he/she did not measure either PU on [DATE]; -He/she should have measured the unstageable PU on [DATE]; -Said he/she was not aware the resident had an open area on his/her right buttock; -Said he/she will asses the area now and LPN C and CNA A removed the resident's brief and rolled the resident onto his/her side; -Said the resident had an open area that contained eschar; -Said any wound with eschar is considered an unstageable wound. Review of the resident's Skin Check dated 3/11/20, at 12:39 A.M., showed: -LPN C documented new skin injury/wounds identified; -Wound type pressure; -PU noted to left ankle, PU to right buttock; -Scab noted to right buttock redness noted on left hip blanches no open area noted. Review of the resident's nurses' notes dated 3/11/20, at 12:43 P.M., showed: -Nurse Practitioner notified orders implemented to promote healing verbal consent obtained for the resident to followed by outside wound care team. Review of the resident's nurses' notes dated 3/11/20, at 4:40

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	265693	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF INDEPENDENCE	1800 S SWOPE DRIVE INDEPENDENCE, MO 64057

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 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 6) P.M., showed: -Resident has increased pain to wound on left ankle requested pain medication for the resident prior to the treatment being done. Dressing saturated from drainage foul odor present. Area on buttock small scab noted origin unknown unable to determine depth due to scab. Stage II PU noted to right buttock approximately 0.8 cm by 0.5 cm. Review of the resident's temperature recorded on [DATE], at 8:16 A.M., showed: -Temperature of 101.3 degrees Fahrenheit (F) (normal range 97.7 to 99.5 F). Review of the resident's Skin and Wound Evaluation dated 3/12/20, at 9:18 A.M., showed: -Facility acquired Stage II PU to right buttock; -Area less than 0.1 cm length 0.4 cm, width 0.3 cm, wound bed [MEDICATION NAME] (outer layer of tissue) 80% wound covered, slough 20 % wound filled, no evidence of infection, light exudate (fluid) . Review of the resident's Skin and Wound Evaluation dated 3/12/20, at 9:24 A.M., showed: -Facility acquired Unstageable PU to left ankle with slough/eschar area 36.7 cm, length 11.7 cm, width 6.2 cm, slough to 70 % of wound bed eschar 30% of wound filled; -Evidence of infection increased drainage, pain, redness and inflammation, moderate exudate [MEDICAL CONDITION] (drainage that is a combination of serous (clear)drainage and pus indicative of infection), strong odor; -Painful facial grimacing, tense, and troubled; During an interview on 3/12/20, at 10:20 A.M., the resident lay in his/her bed and said the following: -He/she feels very ill and feels like he/she may die; -The resident then began to curse. Observation and interview on 3/12/20, at 12:25 A.M., LPN C did and said the following as the resident lay in his/her bed: -Entered the resident's room and attempted to inform the resident that he/she planned to change the dressing to his/her left ankle; -The resident was slow to arouse and appeared to be lethargic (a state of tiredness, weariness, fatigue, or sluggish); -Additional staff were called to the room to arouse the resident and obtain vitals signs; -LPN C Removed the [MEDICATION NAME] stocking and gauze dressing from the resident's ankle and the foul odor significantly increased; -Redness was noted from the resident's toes half way up the resident's leg; -The unstageable PU to his/her left ankle was approximately the size of a tangerine and 90 % of the wound bed was covered with slough with a moderate amount of [MEDICAL CONDITION] drainage noted; -LPN C reapplied a clean dressing and said the resident's condition has deteriorated and they plan to send the resident to the hospital. During an interview on 3/12/20, at 12:37 P.M., LPN B said: -On 3/8/20, CNA A and CNA C informed him/her that the resident had a reddened area to his/her left ankle; -He/she does not recall CNA A and CNA C informing him/her that the resident also had an open area to his/her right buttock; -He/she did not provide a treatment to the resident's buttock on 3/8/20; -On 3/8/20, he/she obtained a verbal treatment order for the resident's left ankle but failed to write the verbal order in the resident's medical record; -When a new skin issue is identified staff are expected to complete the necessary documentation and report their findings to LPN C and the ADON; -He/she should have measured the PU to the resident's left ankle on 3/8/20, and documented the findings; -He/she should have completed a new Braden skin assessment on 3/8/20; -He/she left notes for the ADON and the wound nurse. During an interview on 3/12/20, at 4:30 P.M., LPN C said: -Initially he/she staged the PU on the resident's right buttock as an unstageable PU because of the eschar but the resident's nurse practitioner assessed the PU and staged it as a stage II PU. During an interview on 3/12/20, at 5:35P.M., LPN B said: -The resident was admitted with osteomylitis (an infection of the bone, a rare but serious condition). During an interview on 3/12/20 at 3:25 P.M. RN A said: -He/she was the charge nurse on [DATE]; -He/she was unaware that the resident had an unstageable PU to his/her left ankle; -He/she was unaware that the resident had PU to his/her right buttock. During an interview on 3/12/20, at 2:15 P.M., the Director of Nursing (DON) said: -The goal is to implement measures before a resident's skin breaks down or developes a PU; -When a resident has a change in skin condition or when there is a sign of skin breakdown there are several things that need to be done to provide treatment and promote healing; -Nursing should do a thorough skin assessment, obtain treatment orders, document the information, and she expects the charge nurse to report these changes to the ADON and wound nurse; -A foul odor from a wound can be indicative of infection; -A Braden skin assessment should be done on admission and when there is a change in the resident's skin; -When a nurse receives a treatment order she expects the nurse to enter the new order into the electronic system.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure restorative nursing services (RA) were maintained in accordance with therapy recommendations to maintain or improve and to prevent further decline in mobility and/or range of motion for six of 22 sampled residents (Resident #42, #45, #50, #56 and #104). The facility census was 107. Review of the undated facility policy for Restorative Nursing (RA) showed: -The Restorative Nursing Program provides nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. The program actively focuses on achieving and maintaining optimal physical, mental and psychosocial functioning; -A resident may be started on a RA upon admission to the facility with restorative needs, but is not a candidate for a formalized rehabilitation therapy; when RA needs arise during the course of a longer-term stay; in conjunction with formalized rehabilitation therapy; or when a resident is discharged from formalized physical therapy (PT), occupational therapy (OT), or speech rehabilitation therapy (ST). -The Director of Nursing (DON), or their designees, manages and directs the RA program. Licensed rehabilitation professionals, (PT, OT and ST) provide ongoing consultation and education for the RA program; -The RA documentation will be done in Point Click Care (PCC, a computerized medical record); -The Restorative Nursing aide (RNA)carries out the restorative program according to the care plan and documents daily. In addition the RNA completes a written weekly summary for residents on a Restorative nursing program; -The Restorative Nursing Program Coordinator (DON or designee) reviews the RNA weekly summary notes on a regular basis. 1. Review of Resident #35's Therapy Recommendation Form (a form completed by therapy for RA) dated [DATE] showed: -Problems: decreased strength; -Goal: The resident will maintain both upper extremity (BUE) strength; -Approaches: Active Range of Motion (AROM) (the patient performs the exercise to move the joint without any assistance to the muscles surrounding the joint.) two or three times with hand weight for 15 to 20 repetitions or 15 minute on omnicycle. Review of the quarterly Minimum Data Set (MDS,) a federally mandated assessment instrument completed by staff dated 3/7/20 showed: -Alert and oriented; -Extensive assistance with ADL's; -[DIAGNOSES REDACTED]. Review of the medical record showed no documentation of the RA program. 2. Review of Resident #42's comprehensive MDS dated [DATE] showed: -Alert and oriented and able to make decisions; -Requires minimal assistance of one staff for Activities of Daily Living (ADL's); -[DIAGNOSES REDACTED]. Review of the therapy recommendation form dated 2/20/20 showed: -Problem: decrease strength, stability and gait; -Goal: to maintain level of strength and stability for functional mobility; -Approaches: supine (lying horizontally with the face and torso facing up) and seated exercise; walk with two wheeled walker up to resident's tolerance, approximately 50 feet; standing an marching in place; and sit to stand 10 times. Review of the medical record showed no documentation of the RA program. During an interview on [DATE] at 11:00 A.M. Resident #42 said: -He/she was receiving physical therapy, but has been discharged ; -He/she was to receive RA, but has not received an RA; -He/she would like to return home. 3. Review of Resident #45's comprehensive MDS dated [DATE] showed: -Unable to make decisions; -Extensive assistance with ADL's; -[DIAGNOSES REDACTED]. Review of the therapy recommendation form dated 1/20/20 showed: -Problem: reduced both lower extremity (BLE) strength; decreased transfer safety awareness and decreased ambulation; -Goal: maintain current BLE strength; maintain transfer status and maintain ambulation with using a two wheeled walker with assistance for 20 to 30 feet; -Approaches: have the resident perform mini squats 10 repetitions, three times, side stepping with cuff weights; have resident perform stand, pivoting and transfer from various surfaces with two wheeled walker; have the resident perform ambulation using two wheeled walker three times. Review of the medical record showed no documentation of the RA program. 4. Review of Resident #50's comprehensive MDS dated [DATE] showed: -Alert and oriented and able to answer questions; -Requires limited assistance with ADL's; -[DIAGNOSES REDACTED]. Review of the therapy recommendation form dated [DATE] showed: -Problem: decreased strength and endurance; -Goal: maintain strength and endurance; -Approaches: Seated BLE exercise with two to three pounds resistance times 15 repetitions for all range of motion or omnicycle for 15 minutes; gait training with forward wheeled walker for distance of up to greater than 500 feet or as tolerated. Review of the medical record showed no documentation of the RA program. 5. Review of Resident #56's comprehensive MDS dated [DATE] showed: -Alert and able to answer questions; -Dependent upon staff for ADL's; -[DIAGNOSES REDACTED]. Review of the therapy recommendation form dated 1/28/20 showed: -Problems: decreased BUE strength and decreased gross motor coordination; -Goal: Maintain BUE strength and maintain bilateral gross motor and fine motor skills; -Approaches: BUE AROM with two pound wrist weights for 15 to 20 repetitions and all directions; The resident will pick up each bag and toss to appropriate side. Stabilize BUE with wrist weights. Review of the residents medical record showed no documentation for the RA program. 6. Review of #104's comprehensive MDS

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) dated [DATE] showed: -Alert and oriented and able to make decisions; -Extensive assistance of one staff member for ADL's; -[DIAGNOSES REDACTED]. Review of the therapy recommendation form dated 3/4/20 showed: -Problem: contratures (a permanent shortening (as of muscle, tendon, or scar tissue) producing deformity or distortion) of left hand and fingers; -Goal: maintain skin integrity of the left hand and fingers; maintain left hand orthotic (splint) schedule and maintain BUE range of motion (ROM); -Approaches: apply left resting hand splint in the morning and remove after two hours; right upper extremity exercises and left upper exercises; passive range of motion and active range of motion all joints and movements. Review of the medical record showed no documentation of the RA program. During an interview on 3/12/20 at 8:56 A.M. the therapy program director said: - Resident #45 was discharged from physical therapy on 2/20/20 and placed on the RA program for transfers, walking, standing endurance and a specialized walker, exercise program. -Certified Nurse Aide (CNA) H is the restorative aide that completes the RA program. Assistant Director of Nursing (ADON) oversees the RA program. She writes the orders and communicates the program with CNA H. During an interview on 3/12/20 at 10:25 A.M., CNA H said: -He/she has been the RA for the last several weeks, but have not done any restorative aide job functions or any RA programs because of being pulled to the floor to work as an aide and obtaining the residents weights. During an interview on 3/12/20 at 10:30 A.M. the ADON said: -There are not any CNA's that are cross trained to do RA in the absence of CNA H; -She assumed the roll of the RA coordinator in mid January; - Since she had taken over the RA program, there has been no RA done. During an interview on 3/12/20 at 1:43 P.M. the DON said: -There has not been an RA program for several months; -Staff should follow the recommendation of the therapy department; -She is working on the development of the RA program.; -The new RA aide started a few weeks ago and he/she will be training staff on the floor the RA program.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to follow their policy and asses a resident for his/her ability to smoke safely upon admission and failed to ensure smoking materials were stored in a secure area for one of 22 sampled residents (Resident #107) and failed to ensure staff used proper techniques to reduce the possibility of accidents or injuries when transferring two sampled residents (Resident #88, and # 7) with a mechanical lift (a lift that allows residents who can bear weight to transfer from a sitting position to a standing position). The facility census was 107. Review of the facility's policy titled Smoking by Residents revised February 2019, showed: -Purpose: To respect resident choice to smoke and to maintain a safe and healthy environment for both smokers and non-smokers; -The facility permits smoking only in the area(s) designated by the Facility's Safety Committee; -Residents who want to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke independently in these areas; -Residents who are not able to smoke independently and safely will be accompanied by facility staff while smoking; -Smokers will be identified at the time of admission and will be provided with a copy of this policy during the admission process; -A licensed Nurse will complete a Safe Smoking Assessment for residents who wish to smoke; -All smoking materials will be stored in a secure area to ensure they are kept safe; -Based on the individual resident smoking safety assessment facility staff shall determine the most appropriate method of secure storage. Review of the website, https://www.nfpa.org, National Fire Prevention Association (NFPA, an international nonprofit organization devoted to eliminating death, injury, property and economic loss due to fire, electrical and related hazards) showed: Never smoke and never allow anyone to smoke where medical [MED]gen is used. Medical [MED]gen can cause materials to ignite more easily and make fires burn at a faster rate than normal. It can make an existing fire burn faster and hotter. Review of the facility's policy titled Total Mechanical Lift revised February 2019, showed: -Purpose: A mechanical lift is used appropriately to facilitate transfers of residents; -The resident will have a physicians order for the mechanical lift; -Nursing staff will be trained to use the mechanical lift; -At least two people are present while a resident is being transferred with the mechanical lift; -Place the lift sling under the resident; -Set base legs to the widest position under the resident and lock the wheels; -Hook the loops from the lift sling to the sling bar attaching each corner of the sling to the correct hook on the sling bar; -Raise the boom bar on the lift while ensuring the resident is centered between the legs of the base and facing toward the person who is operating the mechanical lift; -Lower the resident and position the resident comfortably. Review of the Manufacturer guidelines and Owner's Manual for the Medline MDS400EL Patient Lift from the Medline Industries showed: -Resident should be lying flat in the center of the bed. -Centrally position the sling under the resident by rolling resident from side to side. -Once sling is centered, feed leg sections under the thighs and draw them between the thighs. -Raise the head of the bed if this function is available. -Open the base legs and move the lift slowly towards the resident and position the spreader bar over the resident's chest. Warning: Do not lift a patient with the caster brakes on. Always let the lift find the correct center of gravity. -Attach loop A of the sling to hook A on the spreader bar; Attach loop B to hook B; attach loop C to hook C; attach loop D to hook D. (Pass loops E and F through each other, crossing them through each other and attach them to hook E and F on the spreader bar) -Lift the resident above the bed by using the hand control while watching and reassuring them. -Pull the lift away from the bed. Close the base and move resident over the wheelchair (chair wheels should be locked) or commode opening the base for stability and fit. Then lower the resident onto the surface by pressing the down button. -Note: Reverse the above procedures when returning the use/patient to bed. 1. Review of Resident #107's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated [DATE], showed: -No cognitive impairment; -Current tobacco use; -Does not use [MED]gen therapy; -[DIAGNOSES REDACTED]. disease that causes obstructed airflow from the lungs); - Limited physical mobility related to [MED]gen dependence; -The care plan did not address the resident smoking. Review of the resident's March 2020, physicians' order sheet (POS) showed: -admitted [DATE]; -Oxygen at 2 liters (L) minute via nasal cannula as needed to keep [MED]gen saturation greater than 90 percent (%). Review of the resident's medical record on 3/11/20, at 5:24 P.M. showed; -admitted [DATE]; -Smoking safety screen was blank which indicated staff failed to complete the screening. During an observation and interview on [DATE], at 11:39 A.M., the resident did and said the following: -Said the facility has a designated smoking area and he/she self propels him/herself to the smoking area to smoke; -The resident had a pack of cigarettes and a lighter in his/her shirt pocket; -The resident's [MED]gen concentrator was turned on to 2L and the nasal cannula laid on the foot of the resident's bed; -Said frequently he/she does not need the [MED]gen during the day and he/she uses the [MED]gen at night while sleeping. Observation on 3/11/20, at 7:41 A.M., the resident sat in his/her wheelchair next to his/her bed with a pack of cigarettes and a lighter in his/her shirt pocket. 2. Review of Resident #88's care plan revised on 2/11/20, showed: -Total dependence of two staff for transfers with a mechanical lift. Review of Resident # 88's admission MDS dated [DATE], showed: -No cognitive impairment; -Extensive assistance of two staff for transfers; -[DIAGNOSES REDACTED]. Review of the resident's March 2020, POS showed: -No order for mechanical lift. Observation on [DATE], at 11:00 A.M., showed Certified Nurse Aide (CNA) B and -CNA D entered the resident's room to provide care as the resident lay in bed and did the following: -After assisting with care both staff placed the mechanical lift seat under the resident; -CNA D pushed the mechanical lift over the resident's bed and staff attached the lift seat straps to the lift bar of the mechanical lift; -The brakes on the mechanical lift remained unlocked and the legs of the base remained closed as CNA D used the control and raised the resident from his/her bed; -The brakes on the mechanical lift remained unlocked and the legs of the base remained closed as CNA D used the control and raised the resident from his/her bed; -CNA D moved the mechanical lift and opened the legs at the base as CNA B held the resident in the lift seat and positioned the resident's wheelchair between the legs of the mechanical lift; -CNA D used the controller and lowered the resident into his/her wheelchair. During an interview on [DATE], at 11:40 A.M., CNA D said: -The legs on the mechanical lift should be apart and the brakes should be locked when lifting a resident. 3. Review of Resident #7's care plan for Activities of Daily Living (ADL's) dated 3/11/20, showed: -Resident is dependent on two staff for transfers with a mechanical lift. Review of Resident #7's admission MDS dated [DATE], showed: -Severe cognitive impairment; -Total assistance of two staff for transfers; -[DIAGNOSES REDACTED]. Review of the resident #7's March 2020, POS showed: -No order for mechanical lift. Observation on 3/09/20, at 11:00 A.M., showed CNA E and CNA F entered the resident's room to provide care as the resident lay in bed and did the following: -After assisting with care and placing the mechanical lift seat under the resident, CNA E pushed the mechanical lift to the resident's bed with the base of the lift closed and slid the lift under the resident's bed; -CNA E applied the brake to the left caster wheel on the mechanical lift, while both staff attached the lift seat straps to the lift bar of the mechanical lift. -The left caster brake remained locked and the legs of the base remained closed as CNA E used the control and raised the resident from his/her

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) bed; - While CNA F assisted in guiding the resident in the sling, CNA E unlocked the left caster brake, leaving the legs of the base closed, and moved the mechanical lift over the resident's geri-chair. -CNA F held the resident in the lift sling and assisted in positioning the geri-chair between the legs of the mechanical lift; -CNA E used the controller and lowered the resident into his/her wheelchair. During an interview on 3/12/20, at 08:20 A.M., CNA E said: -The legs on the mechanical lift should be apart and the brakes should be locked when lifting a resident. During an interview on 3/12/20, at 2:15 P.M., the Director of Nursing (DON) said: -The admitting nurse or Social Services staff should complete the Safe Smoking Assessment when a resident is admitted ; -Resident #107's Safe Smoking Assessment was not completed upon admission; -She expects staff to follow the manufacture guidelines for the mechanical lift; -When lifting a resident the the legs at the base of the mechanical lift should be open and the brakes locked.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to perform catheter care in a manner that would prevent urinary tract infections (UTIs) when staff failed to remove their gloves and wash their hands after providing incontinent care before they continued with catheter care and failed to empty the urinary drainage bag in a way to prevent infections when staff used a disposable wipe to clean the drain spout for two of 22 sampled residents (Resident #109 and # 88). The facility census was 107. 1. Review of the facility's policy on Catheter Care revised on February 2019, showed: -Wash hands and apply clean gloves prior to handling the catheter, drainage system or bag; -Cleanse the perineum (the region of the body between the pubic symphysis (pubic arch) and the coccyx (tail bone) and urinary meatus (opening of the urethra), with soap and water, cleansing wipe, or a perineal rinse as part of the morning and night care and after each bowel movement or incontinence episode; -Cleanse the perineum from front to back and cleanse the outside of the catheter wiping away from the meatus; -Remove gloves and wash hands; -Urinary collection bags should be emptied when three fourths full using a separate clean graduate for each resident; -Empty the collection bag each shift or more often as indicated; -When emptying the collection bag, the drainage spout, and the non-sterile collection container/graduate should never come in contact; -The policy did not include instructions for the cleaning of the urinary drain spout. Review of the facility's policy on Hand Hygiene revised February 2019, showed: - The facility considers hand hygiene the primary means to prevent the spread of infections; -Wash hands in between glove changes; -Hand hygiene is always the final step after removing personal protective equipment (PPE) items includes gowns and gloves; -The use of gloves does not replace hand hygiene procedures. 2. Review of Resident #109's care plan revised on 2/28/20, showed: - Perform catheter care every shift and as needed; - At risk of developing a UTIs related to having an indwelling catheter; -Goal to be free of any infection from his/her catheter; - Staff to monitor for signs and symptoms of UTI. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: - Moderate cognitive impairment; - Extensive assistance of two staff for bed mobility, transfer, and toilet use; - Indwelling urinary catheter and always incontinent of bowel; - [DIAGNOSES REDACTED]. Review of the resident's March 2020, physicians' order sheet (POS) showed: - No order for a urinary catheter; - [DIAGNOSES REDACTED]. Observation on [DATE], at 4:53 P.M., Certified Nurse Aide (CNA) B and CNA D entered the resident's room to provide catheter care as the resident lay in his/her bed and did the following: - Both staff washed their hands and put on clean gloves; -CNA D pulled several disposable wipes from the package and cleaned the resident's frontal perineal skin folds removing a large amount of fecal material; -CNA D did not remove his/her gloves and wash his/her hands; -With dirty gloves CNA D held the catheter at the insertion site and he/she used four disposable wipes to remove fecal material from the resident's catheter tubing; -After completing incontinent care both staff then secured the clean brief on the resident, removed their gloves, washed their hands, and exited the resident's room. During an interview on [DATE], at 5:07 P.M., CNA D said: - He/she should not have touched the resident's catheter tubing with dirty gloves. Observation on 3/11/20, at 10:15 A.M., CNA A and Licensed Practical Nurse (LPN) C did the following as the resident lay in his/her bed: - Both staff used hand sanitizer and put on clean gloves; -CNA A used several disposable wipes to cleanse the resident's frontal perineal skin folds removing a moderate amount of fecal material; -CNA A did not remove his/her gloves or wash his/her hands; -CNA A held the catheter at the insertion site with dirty gloves and used two disposable wipes to remove fecal materiel from the tubing; - CNA A used an additional disposable wipe did not hold the catheter at the insertion site to prevent the catheter from pulling and wiped the catheter tubing downwards about six inches; -After staff completed incontinent care and applied moisture barrier they removed their gloves, and used hand sanitizer prior to exiting the resident's room. During an interview on 3/11/20, at 11:10 A.M., CNA A said: -After providing peri care staff should remove their gloves and wash their hands before providing catheter care; -Staff should ensure they hold the catheter at the insertion site to prevent the catheter from pulling. 3. Review of Resident #88's care plan revised on 2/11/20, showed: -Perform catheter care every shift and as needed; -At risk of developing a UTIs related to having an indwelling catheter; -Goal to be free of any infection from his/her catheter; -Staff to monitor for signs and symptoms of UTI. Review of the resident's admission MDS, dated [DATE], showed: -No cognitive impairment; -Extensive assistance of two staff for bed mobility, dressing, and toilet use; -Indwelling urinary catheter and always incontinent of bowel; -[DIAGNOSES REDACTED]. Review of the resident's March 2020, POS showed: -Catheter care every shift. Observation on [DATE], at 11:00 A.M., showed CNA B and CNA D entered the resident's room to provide catheter care as the resident lay in bed and did the following: -Both staff washed their hands and put on clean gloves; -CNA B pulled several disposable wipes from the package and cleaned the resident's frontal perineal skin folds removing a moderate amount of fecal material; -CNA B did not remove his/her gloves and wash his/her hands; -With dirty gloves CNA B held the resident's catheter at the insertion site and he/she used a disposable wipe to remove fecal material from the resident's catheter tubing; -After CNA B completed incontinent care he/she obtained the graduate (measuring container) from the resident's bathroom that was in a plastic bag; - He/she set the graduate on a paper towel that sat on the floor directly below the resident's catheter and drained the urine into the graduate; - He/she obtained a disposable wipe, cleansed the drain spout with the disposable wipe and placed it back into the protective sleeve; - CNA B did not clean the drain spout with an alcohol swab; - He/she emptied the catheter contents in the toilet; -CNA D removed his/her gloves and exited the resident's room; - CNA B went to the sink, filled the container with water to rinse it and dumped the water in the toilet then placed the container in a plastic bag in the resident's bathroom; -CNA D returned to the resident's room with an alcohol pad handed the alcohol pad to CNA B and applied clean gloves without washing his/her hands; -CNA B did not remove his/her gloves and wash his/her hands after emptying the resident's catheter; -With dirty gloves CNA B removed the drain spout from the protective sleeve and cleaned the drain spout with the alcohol pad, then he/she placed it back into the protective sleeve; -CNA B removed his/her gloves did not wash his/her hands before he/she applied clean gloves; - Both staff then used the mechanical lift to transfer the resident from his/her bed to his/her wheelchair. During an interview on [DATE], at 11:30 A.M., CNA B said: - It is acceptable to clean the drain spout with a disposable wipe until an alcohol pad is available; -After he/she emptied the resident's catheter he/she should have removed his/her gloves and washed his/her hands before cleaning the drain spout with the alcohol pad; - He/she should not have touched the resident's catheter tubing with dirty gloves; -Staff should not touch clean items with dirty hands. During an interview on 3/12/20, at 2:15 P.M., the Director of Nursing (DON) said: -Staff should ensure they use good infection control practices when providing perineal and catheter care for residents to prevent UTIs; - Hand washing should be performed after glove removal and when going from a dirty tasks to clean tasks; - Staff should not touch clean items with dirty hands; -Staff should use an alcohol swab to cleanse the drain port after emptying.
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** Based on observations, interviews, and record reviews, the facility failed to ensure staff administered medications with a less than 5% medication error rate. Staff made four medication errors out of 25 opportunities for error, resulting in a 16% medication error rate which affected one of 22 sampled residents (Resident #106) and one additional resident (Resident #79). The facility census was 107. 1. The facility did not provide a policy on medication administration. Review of the Medline website, dated 2020, on [MEDICATION NAME] (used to treat high blood sugar) showed the medication should be given with food. 2. Review of Resident #106's Medication Administration Record [REDACTED].M. Resident #106 did not have a tube feeding running. - He/she aspirated the resident's feeding tube and did not get any residual feeding. - At 8:00 A.M. he/she administered 500 milligrams (mg) crushed [MEDICATION NAME] into the resident's feeding tube. - LPN D did not give the

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) resident a snack. - The resident did not receive any food until 8:45 A.M. During an interview on 3/11/2020 at 9:00 A.M. LPN D said: - The resident's tube feeding was turned off around 7:00 A.M. - He/she did not notice when the resident received some food. - He/she did not realize [MEDICATION NAME] should be administered with food. 3. Review of Resident #79's MAR, dated March 2020, showed medication orders [REDACTED]. Observation on [DATE] at 8:00 A.M. of Certified Medication Technician (CMT) A administering medication to the resident showed: - The resident did not have any [MED]; - The resident received 81 mg of [MEDICATION NAME] coated (medication with a coating so the medication dissolves in the small intestine) aspirin; - The resident did not have any [MEDICATION NAME] nasal spray. During an interview on [DATE] at 8:15 A.M. CMT A said: - The resident had not received any [MED] for several days because pharmacy did not refill the medication. - The facility e-kit (provides missing medications) did not contain [MED]. - He/she should have administered the resident aspirin instead of [MEDICATION NAME] coated aspirin. - The resident did not have any [MEDICATION NAME] nasal spray. - The resident missed several doses of [MEDICATION NAME] nasal spray. - He/she always reordered a resident's medications when the resident had seven days of medication left. - The facility pharmacy frequently did not send the medications. - He/she would reorder a resident's medications several times before the medication was provided. 4. During an interview on [DATE] at 10:41 A.M. the Director of Nursing (DON) said : - Staff should notify the DON if medications do not come in as ordered. - Staff should call a resident's physician if a resident missed any doses of medication. - Staff should administer medications according to manufacture's instructions. - Staff should not administer [MEDICATION NAME] coated aspirin when plain aspirin is ordered.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to properly dispose of a resident's discontinued controlled substances (medications with a high probability for physician and/or psychological dependence) which affected one of 22 sampled residents (Resident #88). Staff also failed to discard controlled substances that were behind torn bubbles in a medication card which affected three additional residents (Residents #23, #29, and #31). Staff also failed to label when opened one sampled resident's liquid controlled substance (Resident #7). Staff failed to label when opened a vial of [MED] with the resident's name. Also staff failed to refrigerate stock [MEDICATION NAME], a supplement, after opening. The facility census was 107. 1. Review of the facility policy, dated December 2009, on medication storage showed:- Staff must safely, securely, and properly store medications. - Medications requiring refrigeration, must be stored in the refrigerator. - All outdated medications must be removed and destroyed. - Any multi-use medication must be dated when opened and destroyed when outdated according to manufacture's instructions. Review of the back of the package of stock [MEDICATION NAME] showed: - The medication should be stored in a cool, dry place until opened. - After the bottle was opened the medication should be stored in the refrigerator. 2. Observation on [DATE]20 at 1:51 P.M. of Registered Nurse (RN) A and RN B counting controlled substances in the recovery unit showed: - Resident #88's bubble pack of [MEDICATION NAME] (a controlled substance used to treat [MEDICAL CONDITION]) 200 milligrams (mg) containing two tablets, with a note on the bubble pack saying discontinued; - Resident #88's bubble pack of [MEDICATION NAME] containing seven tablets, with a note on the bubble pack saying discontinued. - Resident #78's bubble pack of [MEDICATION NAME] (a controlled substance used to treat pain) 5 mg/325 mg with bubble #30 torn with a pill inside the bubble. - Resident #23's bubble pack of [MEDICATION NAME] (a controlled substance used to treat pain) with bubbles #5 and #6 torn with pills inside the bubbles. During an interview on [DATE]20 at 2:00 P.M. RN A and RN B said: - Resident #88's [MEDICATION NAME] was discontinued several days ago. - They should have destroyed the medication when it was discontinued. - They should destroy medications behind torn bubbles. 3. Observation on [DATE]20 at 2:22 P.M. of the Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN) D checking medication storage in the skilled nursing portion of the facility showed: - Resident #29's bubble pack of [MEDICATION NAME] (a controlled substance used to treat anxiety) 0.5 mg with bubble #8 torn with a pill behind the bubble. - Resident #31's [MEDICATION NAME] 1 mg/milliliter (ml) with an expiration date of 1[DATE]19. - Resident #7's [MEDICATION NAME] liquid bottle opened without a date the bottle was opened. - An opened vial of [MED] [MED] (used to treat elevated blood sugar), with no name and an expiration dated of 12/2019. - Observation of the stock [MEDICATION NAME] (a supplement) opened on the medication cart. During an interview on [DATE]20 at 2:30 P.M. the ADON and LPN D said: - Pills behind torn bubbles should be discarded. - Expired medications should be discarded. - Liquid [MEDICATION NAME] should be dated when opened. 4. During an interview on [DATE] at 10:40 A.M. the Director of Nursing (DON) said: - Staff must discard discontinued and outdated medications. - Staff must label liquid [MEDICATION NAME] when opened. - Staff must destroy controlled substances behind torn bubbles. - Staff must store opened acidophilus bottles in the refrigerator. - Staff must label with the resident's name and when the medication was opened.
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** Based on observation, interview and record review, the facility failed to ensure each resident receives food prepared in a form designed to meet individual needs by failing to provide residents with all menu items pureed. This affected one resident (Resident #82) who was on a pureed diet. The census was 107. 1. Review of the facility's undated Resident Preference Interview policy, showed: -The purpose of the policy was to ensure that residents' nutritional needs are met through thorough and individualized nutritional care plans. -The dietary manager or designee will meet with resident to review the attending physician's dietary order. -Resident preferences will be reflected on the tray card and the dietary department will provide residents with meals consistent with their preferences as indicated on the tray card. Review of the lunch menu for 3/11/20 showed: -Asian marinated chicken, mixed vegetables, steamed rice, egg roll, and cake. Observation on 3/11/20 starting at 10:38 AM, showed: -Dietary staff pureed the chicken, vegetables, and rice and placed each food item in a hotel pan and placed them on the steam table for service. -At the time of meal service, when dietary staff prepared trays containing the pureed food items, the tray did not include pureed egg roll or cake. Observation and interview of 3/11/20 at approximately 12:30 PM, showed: -Resident #82 had three scoops of pureed food on his plate, which did not include an eggroll or pureed cake, he/she was eating a bowl of ice-cream. -The resident said he/she did not know what was prepared for dessert, someone just brought him/her some ice-cream and he/she was not sure what was on his/her plate or if he/she got everything listed on the menu. -He/she said it made him feel angry that he/she did not get everything listed on the menu and wanted someone to ask him/her what he/she wanted and explain what was on his/her plate. -The resident's tray card was laying on the table next to his/her tray and it had a column with the header preferences written on it and had pureed diet written below it. During an interview on 3/11/19 at 3:00 PM., the Dietary Manager said: -Resident dietary preferences and orders are listed on the back of their tray cards. She expected staff to prepare and serve all menu items to residents on therapeutic diets.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, record review and interview, the facility failed to prepare food in accordance with professional standards for food service safety when staff did not wash their hands between clean and dirty tasks while washing dishes and failed to sanitize food preparation equipment according to policy and procedure. The facility had a census of 107. 1. Review of the Facility's policy for Hand Hygiene, with a revision date of 2/19, showed: -The purpose of the policy is to unsure all individuals use appropriate hand hygiene while at the facility. -Facility staff wash hands with soap and water

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) before and after food preparation; and before and after assisting residents with dining if direct contact with food is anticipated or occurs. 2. Review of the facility's undated policy for Food Processor Use and Cleaning showed: -The food processor will be sanitized between uses. -Wash attachments to the food processor in the pot and pan sink. -Rinse and sanitize the attachments. -Allow the attachments to air dry. Observations on 3/11/20 starting at 10:25 AM, showed: -Dietary Staff (DS) C used the pre-rinse hose to remove food particles from soiled plates, utensils, and serving trays, placed the items on a rack and pushed the rack into dishwasher, then immediately moved to the clean end of the dishwasher to remove a rack of clean dishes from the rack and began putting up the clean dishes, then return to placing dirty dished on the dish racks. -At approximately 11:30 A.M. DS C washed and dried hands, opened the lid of a large gray trash can, with clean hand, threw the paper towels into the trash can, returned to the clean dishes, pick up a clean oven rack and started to carry it to the oven to replace it, the registered dietician stopped DS C, instructed him to rewash his hand and run the oven rack through the dishwasher again. Observations on 3/11/20 starting at 11:25 AM, showed: -DS A used the robot coupe (food processor) to puree chicken, removed the bowl from the base, took it to DS C asked him to wash it, once the bowl ran through the dishwasher, DS A retrieved the bowl from the dish rack and returned it to the base to process more food, the bowl and lid were dripping with water and there was water standing in the bowl when he/she placed it back on the base. During an interview on 3/11/20 at 3:00 PM., the Dietary Manager said: -DS C was new and had not completed his food handling course work so he/she was still learning when he/she should wash his/her hands and what not to touch. She expected dietary staff to wash, rinse, sanitize food processor attachments between each use and allow them to air dry before using again.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on observation, interview and record review, the facility failed to provide documentation that the Quality Assessment and Assurance (QAA) committee met on a quarterly basis and included the appropriate attendees and failed to identify, develop, implement, monitor, and evaluate system problems. This had the potential to affect all residents. The facility census was . The facility did not provide a policy for the QAA Committee. Review of the facility's QAA program showed meeting minutes from January 2019 until June 2019. There were no meeting minutes from July 2019 through December 2019. Duriring an interview on 3/12/20 at 3:50 P.M. the Administrator said: -He began working at the facility in December 2019, since then QA has been conducted monthly. He cannot find any meeting minutes or evidance that the QAA committe was done from July 2019 until December 2019.
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** Based on observation, interview and record review, the facility failed to assure staff practiced infection control measures including appropriate hand hygiene when staff failed to use personal protective equipment (PPE, equipment worn to minimize exposure to a variety of hazards examples include gloves) when administering a subcutaneous (under the skin) injection for one additionally sampled resident (Resident # 261); failed to remove their gloves and wash their hands after providing incontinent care before they continued with catheter care and failed to wash their hands between clean and dirty tasks during catheter care; and failed to wash their hand between clean and dirty tasks when providing incontinent care. This affected three of 22 sampled residents (Residents, #109, #88 and #45.). The census was 107. 1. Review of the website, https://www.cdc.govinfection control/guidelines showed healthcare staff should wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, or potentially contaminated intact skin. Review of the facility's policy on Hand Hygiene revised February 2019, showed: - The facility considers hand hygiene the primary means to prevent the spread of infections; -Wash hands in between glove changes; -Hand hygiene is always the final step after removing personal protective equipment (PPE) items includes gowns and gloves; -The use of gloves does not replace hand hygiene procedures. Review of the facility's policy on Catheter Care revised on February 2019, showed: -Wash hands and apply clean gloves prior to handling the catheter, drainage system or bag; -Cleanse the perineum (the region of the body between the pubic symphysis (pubic arch) and the coccyx (tail bone) and urinary meatus (opening of the urethra), with soap and water, cleansing wipe, or a perineal rinse as part of the morning and night care and after each bowel movement or incontinence episode; -Cleanse the perineum from front to back and cleanse the outside of the catheter wiping away from the meatus; -Remove gloves and wash hands; -Urinary collection bags should be emptied when three fourths full using a separate clean graduate for each resident; -Empty the collection bag each shift or more often as indicated; -When emptying the collection bag, the drainage spout, and the non-sterile collection container/graduate should never come in contact; -The policy did not include instructions for the cleaning of the urinary drain spout. 2. Review of Resident #261's care plan revised on 3/6/20, showed: Administer anticoagulant (blood thinner used to prevent blood clots) medications as ordered. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/11/20, showed: - No cognitive impairment; - Limited staff assistance of one staff for bed mobility, transfer, and dressing; -Received anticoagulant medications six out of seven days. Review of the resident's March 2020, physicians' order sheet (POS) showed: -[MEDICATION NAME] sodium solution (anticoagulant), Injection 40 milligrams(mg)/0.4 milliliters (ml) inject 40 mg subcutaneously in the morning to prevent blood clotting. Observation on 3/12/20, at 9:56 A.M., Licensed Practical Nurse (LPN) B did the following: -Entered the resident's room and informed the resident that he/she planned to administer his/her [MEDICATION NAME] injection; -Did not wash his/her hands and with ungloved hands he/she opened an alcohol pad and wiped a small area on the resident's abdomen with the alcohol pad then administered the [MEDICATION NAME] 40 mg injection subcutaneously in the resident's abdomen; -Pulled the needle out of the resident's abdomen and a small amount of clear fluid and blood leaked out onto the resident's abdomen; -Without gloves LPN B opened an alcohol pad and placed the alcohol pad on the area holding it in place for about five seconds with his/her ungloved hand; -He/she then washed his/her hands and exited the resident's room. During an interview on 3/12/20, at 10:10 A.M., LPN B said: -Staff should wash their hands upon entering a room; -He/she should have washed his/her hands and applied gloves prior to administering the injection; -He/she should not have used an ungloved hand to wipe the fluid and blood from the resident's abdomen. 3. Review of Resident #109's care plan revised on 2/28/20, showed: - Perform catheter care every shift and as needed; - At risk of developing a urinary tract infections (UTIs) related to having an indwelling catheter; -Goal to be free of any infection from his/her catheter; - Staff to monitor for signs and symptoms of UTI. Review of the resident's comprehensive MDS, dated [DATE], showed: - Moderate cognitive impairment; - Extensive assistance of two staff for bed mobility, transfer, and toilet use; - Indwelling urinary catheter and always incontinent of bowel; - [DIAGNOSES REDACTED]. Review of the resident's March 2020, physicians' order sheet (POS) showed: - No order for a urinary catheter; - [DIAGNOSES REDACTED]. Observation on [DATE], at 4:53 P.M., Certified Nurse Aide (CNA) B and CNA D entered the resident's room to provide catheter care as the resident lay in his/her bed and did the following: - Both staff washed their hands and put on clean gloves; -CNA D opened the resident's disposable brief folding it down between the resident's legs; -CNA D pulled several disposable wipes from the package and cleaned the resident's frontal perineal skin folds removing a large amount of fecal material; -CNA D did not remove his/her gloves and wash his/her hands; -With dirty gloves CNA D held the catheter at the insertion site and he/she used four disposable wipes to remove fecal material from the resident's catheter tubing; -CNA D removed his/her gloves washed his/her hands and put on clean gloves; -Both staff rolled the resident onto his/her side and CNA D pulled the dirty brief that contained a large amount of fecal material from underneath the resident and discarded the brief into the trash can; - CNA D used multiple disposable wipes and cleaned the resident's buttock and rectal area removing fecal material; -CNA D did not remove his/her gloves and with dirty gloves obtained the resident's clean brief that lay on his/her bedside table and laid the clean brief on the resident's bed; -CNA D removed his/her gloves washed his/her hands and applied clean gloves; -Both staff then secured the clean brief on the resident, removed their gloves, washed their hands, and exited the resident's room. During an interview on [DATE], at 5:07 P.M., CNA D said: - He/she should not have touched the resident's catheter tubing with dirty gloves; -Staff should wash their hands when going from a dirty task to clean task; -Staff should not touch clean items with dirty hands. Observation on 3/11/20, at 10:15 A.M., CNA A and LPN C did the following as the resident lay in his/her bed: - Both staff used hand sanitizer and put on clean gloves; - CNA A opened the resident's brief and folded it down between the

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) resident's legs; -CNA A used several disposable wipes to cleanse the resident's frontal perineal skin folds removing a moderate amount of fecal material; -CNA A did not remove his/her gloves and wash his/her hands; -CNA A held the catheter at the insertion site with dirty gloves and used two disposable wipes to remove fecal materiel from the tubing; - CNA A used an additional disposable wipe did not hold the catheter at the insertion site to prevent the catheter from pulling and wiped the catheter tubing downwards about six inches; -CNA A removed his/her gloves used hand sanitizer and applied clean gloves; -Both staff rolled the resident onto his/her side and LPN C used the brief to wipe fecal material from the resident's buttock then he/she removed the soiled brief and discarded it into the trash can; -LPN C removed his/her gloves used hand sanitizer and applied clean gloves; - CNA A used multiple disposable wipes and cleansed the resident's buttock and rectal area removing fecal material; -CNA A did not remove his/her gloves and with dirty gloves CNA A slid the resident's clean brief under him/her; -LPN C applied moisture barrier cream to the resident's buttock he/she did not remove his/her gloves and with dirty gloves both staff assisted the resident to roll onto his/her back; -Both staff removed their gloves, used hand sanitizer, applied clean gloves, and then secured the resident's clean brief; -Both repositioned the resident in his/her bed, provided him/her with the call light, removed their gloves, and used hand sanitizer prior to exiting the resident's room. During an interview on 3/11/20, at 11:10 A.M., CNA A said: -After providing peri care staff should remove their gloves and wash their hands before providing catheter care; -Staff should wash their hands when going from a dirty task to clean task; -Staff should ensure they hold the catheter at the insertion site to prevent the catheter from pulling. 4. Review of Resident #88's care plan revised on 2/11/20, showed: -Perform catheter care every shift and as needed; -At risk of developing a UTIs related to having an indwelling catheter; -Goal to be free of any infection from his/her catheter; -Staff to monitor for signs and symptoms of UTI. Review of the resident's admission MDS, dated [DATE], showed: -No cognitive impairment; -Extensive assistance of two staff for bed mobility, dressing, and toilet use; -Indwelling urinary catheter and always incontinent of bowel; -[DIAGNOSES REDACTED]. Review of the resident's March 2020, POS showed: -Catheter care every shift. Observation on [DATE], at 11:00 A.M., showed CNA B and CNA D entered the resident's room to provide catheter care as the resident lay in bed and did the following: -Both staff washed their hands and put on clean gloves; -CNA B opened the resident's brief folding it down between the resident's legs; -CNA B pulled several disposable wipes from the package and cleaned the resident's frontal perineal skin folds removing a moderate amount of fecal material; -CNA B did not remove his/her gloves and wash his/her hands; -With dirty gloves CNA B held the resident's catheter at the insertion site and he/she used a disposable wipe to remove fecal material from the resident's catheter tubing; -CNA B removed his/her gloves did not wash his/her hands or use hand sanitizer; -With dirty hands CNA B reached into the box of clean gloves obtained a pair of gloves then placed the gloves on the resident's bedside table; -CNA B washed his/her hands and applied the gloves that he/she laid on the resident's bedside table with dirty hands; -Both staff rolled the resident onto his/her side and CNA B used the brief to wipe fecal material from the resident's buttock as he/she attempted to remove the brief from under the resident his/her gloves contained fecal material; -CNA B removed his/her gloves as they contained fecal material he/she washed his/her hands and applied clean gloves; -Both staff secured a clean brief on the resident; -CNA B obtained the graduate (measuring container) from the resident's bathroom that was in a plastic bag he/she set the graduate on a paper towel that sat on the floor directly below the resident's catheter and drained the urine into the graduate; - He/she obtained a disposable wipe, cleansed the drain spout with the disposable wipe and placed it back into the protective sleeve; - CNA B did not clean the drain spout with an alcohol swab; - He/she emptied the catheter contents in the toilet; -CNA D removed his/her gloves and exited the resident's room; - CNA B went to the sink, filled the container with water to rinse it and dumped the water in the toilet then placed the container in a plastic bag in the resident's bathroom; -CNA D returned to the resident's room with an alcohol pad handed the alcohol pad to CNA B and applied clean gloves without washing his/her hands; -CNA B did not remove his/her gloves and wash his/her hands after emptying the resident's catheter; -With dirty gloves CNA B removed the drain spout from the protective sleeve and cleaned the drain spout with the alcohol pad, then he/she placed it back into the protective sleeve; -CNA B removed his/her gloves did not wash his/her hands before he/she applied clean gloves; - Both staff then used the mechanical lift to transfer the resident from his/her bed to his/her wheelchair. During an interview on [DATE], at 11:30 A.M., CNA B said: - It is acceptable to clean the drain spout with a disposable wipe until an alcohol pad is available; -After he/she emptied the resident's catheter he/she should have removed his/her gloves and washed his/her hands before cleaning the drain spout with the alcohol pad; - He/she should not have touched the resident's catheter tubing with dirty gloves; -Staff should wash their hands when going from a dirty task to clean task; -Staff should not touch clean items with dirty hands. During an interview on [DATE], at 11:40 A.M., CNA D said: -Staff should always wash their hands upon entering a room prior to applying clean gloves. During an interview on 3/12/20, at 1:00 P.M., LPN C said: -After applying moisture barrier staff should remove their gloves and wash their hands; -Staff should not touch clean items withy dirty hands. 5. Review of Resident #45's comprehensive MDS dated [DATE] showed: -Alert, but unable to answer questions; -Extensive assistance with ADL's; -Frequently incontinent of bowel and bladder. Observation on 3/11/20 at 9:30 A.M. showed: -CNA G transferred the resident from the wheelchair to the toilet; -The resident had been incontinent of urine; -CNA G washed his/her hands and applied gloves and threw the paper towels onto the floor, without removing his/her gloves picked up the paper towels and other trash off the floor and placed in the trash can; -CNA G then removed his/her gloves and without washing hands, put on a clean pair of gloves and with the resident in a standing position provided incontinent care; -Without removing the soiled gloves and washing his/her hands, put the residents blouse, underwear and pants on; -CNA G removed the soiled gloves and without washing hands, put the resident's sweater on and transferred the resident to the wheelchair; -CNA G removed his/her soiled gloves, wet several wash clothes and handed them to the resident to wash his/her face; -CNA G then put on a new pair of gloves without washing hands, gathered the soiled clothing and linen, placed in a trash bag, pushed the resident into the resident's room, then removed the gloves and washed his/her hands. During an interview on 3/11/20 at 10:00 A.M. CNA G said: -He/she should wash hands before give care and after, and sometime in between; -The resident's bathroom room is very tight and there was clothing on the side of the sink and he/she could not wash his/her hands. -He/she should have washed his/her hands when gloves are removed and before new gloves are applied. During an interview on 3/11/20 at 11:24 A.M. Registered Nurse (RN) D said: -Staff should wash their hand before and after care, before putting gloves on, when going in and out of room, and when becoming soiled. 6. During an interview on 3/12/20, at 2:15 P.M., the Director of Nursing (DON) said: -Staff should always use the appropriate PPE; -Staff should wear gloves when administering an injection as it is anticipated that there could be contact with blood or other potentially infectious materials; -Staff should ensure they use good infection control practices when providing perineal and catheter care for residents to prevent UTIs; - Hand washing should be performed after glove removal and when going from a dirty tasks to clean tasks; - Staff should not touch clean items with dirty hands; -Staff should use an alcohol swab to cleanse the drain spout after emptying.