STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175263	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - OLATHE	20705 W 151ST STREET OLATHE, KS 66061

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 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** The facility identified a census of 136 residents. The sample included 29 residents. Based on observations, record reviews, and interviews, the facility failed to clearly identify the expressed choices to initiate or withhold resuscitative measures (restoration to life or consciousness of one apparently dead, or whose respirations had ceased) by maintaining a Do Not Resuscitate (DNR) (an order to withhold resuscitative measures) advance directive for Resident (R) 79, signed by R79 or her representative. Findings included: - R79's electronic medical record (EMR) from the [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] documented a staff assessment revealed moderate impairment in decision making. The MDS documented R79 required extensive assistance of one staff member for Activities of Daily Living (ADL). The Quarterly MDS dated [DATE] documented a staff interview revealed R79 had moderately impaired decision making. The MDS documented R79 required extensive assistance of two staff members for ADL's. The ADL Care Area Assessment (CAA) dated 11/08/19 documented R79 required assistance with her ADL's. The care plan lacked interventions to direct staff regarding R79's code status. The EMR documented a physician order [REDACTED]. Review of the EMR for R79 lacked a signed DNR form by her or her representative. Observation on 03/03/20 at 08:59 AM R79 propelled herself in the wheelchair in the hallway toward the dining room for breakfast. Her right lower extremity was on her foot pedal. During an interview on 03/05/20 at 10:45 AM Licensed Social Worker X stated when a resident was transferred to the hospital the original DNR form was sent with the resident to the hospital. Upon return from the hospital a new DNR form was signed by the resident or designated power of attorney (a resident's legal representative). During an interview on 03/05/20 at 01:50 PM with Licensed Nurse (LN) I stated staff know a resident's code status by looking in the code status books kept in the nurse's charting office and from the resident's EMR. LN I did not find R79's signed DNR form in the code status book in the Meadows nurses' office. LN I stated R79 would be a Full Code if found unresponsive. During an interview on 03/05/20 at 02:57 PM Administrative Nurse D stated every unit had a code status book where the DNR forms could be located. Administrative Nurse D stated code status was reviewed every care plan conference. The Advance Care Planning and Advanced Directives policy with revision date of 04/16 lacked documentation related to the DNR form in the medical record and availability to nursing staff. The facility failed to maintain a copy of the DNR advanced directive, signed by R79, her legal representative, or the physician., which had the potential to deny her expressed wishes to initiate with resuscitative measures.
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** The facility identified a census of 136 residents. The sample included 29 residents, with three residents sampled for hospitalization . Based on observations, record reviews, and interviews the facility failed to issue a written notification of discharge which indicated the reason for hospitalization for Resident (R) 96 and R7. Findings included: - The [DIAGNOSES REDACTED]. The Admission Minimum (MDS) data set [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. She required limited staff assistance of one person with her Activities of Daily Living (ADL). The Care Area Assessment for Communication dated 02/03/20 documented R96 spoke clearly and made her needs known. She heard others if background noise was decreased. The ADL care plan revised 02/05/20 documented R96 had a self-care performance deficit related to [MEDICAL CONDITION] and needed assistance with ADL's. A Progress Note dated 02/10/20 in R96's EMR documented she was transferred to the hospital for evaluation of a critical potassium lab level. R96's EMR lacked documentation of a written notification of discharge which indicated the reason for transfer and location where R96 was being transferred. On 03/03/20 at 01:57 PM R96 was observed in her room. A staff member knocked on her door and entered her room. The staff member pushed R96 in her wheelchair to the nurses' cart in the hallway. On 03/05/20 at 10:09 AM Licensed Nurse (LN) H stated no written notice was sent to the family when a resident is transferred to the hospital. The family was called. On 03/05/20 at 10:41 AM Social Services X stated written notice was sent to the family when a resident was transferred to the hospital. The notice was scanned into the EMR. On 03/05/20 at 12:09 PM Social Services X stated she did not find the written notice of hospitalization mailed to the family of R96 for the hospital transfer dated 02/10/20 so she had not done it. On 03/05/20 at 01:40 PM LN G stated no written notice was sent to a resident's family when a resident was transferred to the hospital. On 03/05/20 at 02:56 PM Administrative Nurse D stated written notification was sent to a resident's family when they were transferred to the hospital and a copy was scanned into the resident's EMR. The facility policy Discharge and Transfer revised September 2017 documented the facility notified the resident, and/or representative of the transfer and the reason for the transfer in writing and in a language and manner they understood. The facility failed to provide written notification of the reason and location for the transfer to the hospital for R96 or her representative. - R7's electronic medical record (EMR) from the [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] documented a staff interview revealed R7 had severely impaired decision making. The MDS documented R7 required extensive assistance of two staff members for Activities of Daily Living (ADLs). The Quarterly MDS dated [DATE] documented a staff interview revealed R7 had severely impaired decision making. The MDS documented R7 required total assistance of two staff members for ADL's. The Cognitive Loss Care Area Assessment (CAA) dated 04/02/19 documented R7 was non-verbal most of the time. The Care Plan dated 01/26/18 directed staff R7 understood consistent, simple, and direct sentences. Under the Progress Note tab dated 11/20/19 at 02:47 PM documented R7 was transported to the hospital related to difficulty breathing and was admitted . The EMR lacked documentation in the nurses note of written notification to resident or representative. Observation on 03/03/20 at 09:44 AM R7 laid on her back with her blanket pulled up to her chest, eyes closed, no distress noted, and call light pinned to blanket. On 03/05/20 at 10:09 AM Licensed Nurse (LN) H stated no written notice was sent to the family when a resident is transferred to the hospital. The family was called. On 03/05/20 at 10:41 AM Social Services X stated written notice was sent to the family when a resident was transferred to the hospital. The notice was scanned into the EMR. On 03/05/20 at 12:09 PM Social Services X stated she did not find the written notice of hospitalization mailed to the family of R96 for the hospital transfer dated 02/10/20 so she had not done it. On 03/05/20 at 01:40 PM LN G stated no written notice was sent to a resident's family when a resident was transferred to the hospital. On 03/05/20 at 02:56 PM

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 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Administrative Nurse D stated written notification was sent to a resident's family when they were transferred to the hospital and a copy was scanned into the resident's EMR. The facility policy Discharge and Transfer revised September 2017 documented the facility notified the resident, and/or representative of the transfer and the reason for the transfer in writing and in a language and manner they understood. The facility failed to provide written notification of the reason and location for the transfer to the hospital for R7 or her representative.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 136 residents. The sample included 29 residents. Based on interviews and record reviews, the facility failed to complete an accurate Minimum Data Set (MDS) assessment for anticoagulant (medications used to decrease the coagulation time of the blood) use for Resident (R) 41. Findings included: - The [DIAGNOSES REDACTED]. The Quarterly MDS dated [DATE] revealed R41 received an anticoagulant seven days during the assessment period. The care plan dated 07/15/19, resolved 10/10/19 revealed R41 was on anticoagulant therapy related to history of [MEDICAL CONDITION] and directed facility staff to monitor R41's condition based on clinical practice guidelines or clinic standards of practice related to the use of [MED] (apixaban-an anticoagulant) The Orders tab of the EMR documented R41 had an order for [REDACTED]. Observation on 03/03/20 at 02:06 PM revealed R41 attended resident council meeting with surveyors. R41 sat in her wheelchair and was active answering questions. On 03/09/20 at 10:45 AM, Administrative Nurse E stated she looked at the Medication Administration Record [REDACTED]. The facility policy Assessment (MDS) last revised December 2019 directed a registered nurse to coordinate and conduct the assessment with appropriate participation of other team members. The results of the assessments were used to develop, review, and revise the residents' comprehensive care plans. The facility failed to accurately document that R41 was not on an anticoagulant during the assessment period. This had the potential of ineffective identification of her care plan needs.
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** The facility identified a census of 136 residents. The facility 300 hall had 59 residents. Based on observation, and interview the facility failed to ensure a safe environment free of accidents for 14 of the 59 residents who were cognitively impaired and independently mobile that resided on the 300 hall. Findings included: - An observation on 03/03/20 at 07:30 AM revealed a clear plastic container that contained new and unused lancets (a device the used a sharp needle to prick the skin to obtain a blood sample) and a glucometer (an instrument used to calculate blood glucose). The container was sitting on a bedside table unattended in the hallway near room [ROOM NUMBER]. An observation on 03/03/20 at 10:05 AM revealed the clear plastic container with new lancets and the glucometer was still sitting on a bedside table unattended in the hallway near room [ROOM NUMBER]. An observation on 03/04/20 at 08:36 AM revealed a clear plastic container that contained new and unused lancets and a glucometer sitting on top of a bedside table out in the main hallway of the 300 hall. Interview of Certified Medication Aide (CMA) R on 03/05/20 at 01:54 PM stated she kept the lancets and glucometer in a plastic container in the bottom drawer of the medication cart. She would not leave it on a table in the hallway unattended. Interview of Licensed Nurse (LN) L on 03/03/20 at 10:05 AM stated that the container of lancets on the bedside table in the hallway was there so the items would be available to use when needed. Interview of LN G on 03/0520 at stated that the lancets and glucometer should be kept in the bottom drawer of the medication cart when not being used. Interview of Administrative Nurse D on 03/05/20 at 02:56 PM stated that supplies used for obtaining blood sugars such as lancets and the glucometer should be stored in the medication cart when not being used. The facility failed to provide a policy for storage of lancets. The facility failed to ensure a safe environment that was free of possible accidents for 14 residents who resided on 300 hall, when the facility failed to store lancets appropriately. This deficient practice had the potential to cause harm to 14 cognitively impaired and independently mobile residents.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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** The facility reported a census of 136 residents with a sample size of 29 which included four residents reviewed for urinary catheter use. Based on observations, interviews and record reviews the facility failed to care for the urinary catheter (tube inserted into the bladder to drain urine into a collection bag) in a manner to prevent urinary tract infections for Resident (R)122 and R27. Findings included: - The [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS), dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four which indicated severe cognitive impairment. The resident required extensive assistance of two staff for bed mobility, transfers, and toileting. The resident had an indwelling catheter. Review of the Quarterly MDS dated [DATE] revealed a BIMS score of eight which indicated moderately impaired cognition. R122 required extensive assistance of two staff for transfers and toileting. The ADL (Activities of Daily Living)/Functional Rehabilitation Care Area Assessment (CAA), dated 02/12/2020, revealed R122 required staff assistance with ADL's. The Urinary Incontinence and Indwelling Catheter CAA, dated 02/12/2020, revealed R122 required a catheter to empty his bladder. The indwelling catheter worked better since he was less mobile. Review of the Catheter Care Plan, revised on 02/20/2020, revealed staff was directed to perform catheter care every shift. The Order Tab of the EMR documented an order to insert indwelling catheter 16 French (FR)/5 cubic centimeters (cc) dated 02/10/20. The order lacked documentation for catheter care. Review of Catheter Care under Documentation Survey Report in the EMR from 02/20/20 through 03/04/20 revealed lack of documentation catheter care was done for R122 every shift. The record revealed the placement of the catheter occurred on 02/10/20. The EMR also lacked documentation of catheter care eight shifts in February 2020 after 02/20/20 and three shifts from 03/01/20 through 03/04/20. On 03/04/20 at 07:15 AM R122 sat in the dining room in his wheelchair. R122's catheter was in a dignity bag under the seat of his wheelchair. On 03/05/20 at 10:09 AM Certified Nurse Aide (CNA) M stated catheter care was done by aides or nurses. It was done each time a resident toileted, first thing in the morning or whenever care was done. She said catheter care was documented by the aides in the EMR. On 03/05/20 at 10:15 AM Licensed Nurse (LN) H stated catheter care was done at least once a shift by aides or nurses. It was documented in the EMR. On 03/05/20 at 12:10 PM LN J stated catheter care should be done every shift and documented under tasks in the EMR. Blank spaces in the documentation meant the catheter care was not done. On 03/05/20 at 02:56 PM Administrative Nurse D stated catheter care was done at least once a shift. The catheter care was documented in the kiosk. The task was assigned to the aides, but anyone could perform catheter care. If there were blank spaces in the documentation someone did not document, so it was not done. The facility policy Catheter revised December 2019 lacked documentation for care of the urinary catheter. The facility failed to ensure facility staff documented R122's catheter care to ensure the resident received the appropriate care and services to prevent catheter related urinary tract infections. - R27's electronic medical record (EMR) from the [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R27 required extensive assistance of two staff members for Activities of Daily Living (ADL). The MDS documented R27 had an indwelling catheter during the look back period. The Quarterly MDS dated [DATE] documented R27 was independent with decision making. The MDS documented R27 was totally dependent of two staff members for ADL's. The MDS documented R27 had an indwelling catheter during the look back period. The Urinary, Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 04/11/19 documented R27 had an indwelling catheter due to his [MEDICAL CONDITION] bladder. The Care Plan dated 12/22/19 directed staff to provide catheter care every shift for R27. The Physician order [REDACTED]. The POS lacked an order for [REDACTED]. On 03/05/20 at 10:09 AM Certified Nurse Aide (CNA) M stated catheter care was done by aides or nurses. It was done each time a resident toileted, first thing in the morning or whenever care was done. She said catheter care was documented by the aides in the EMR. On 03/05/20 at 10:15 AM Licensed Nurse (LN) H stated catheter care was done at least once a shift by aides or nurses. It was documented in the EMR. On 03/05/20 at 12:10 PM LN J stated catheter care was done every shift and documented under tasks in the EMR. Blank spaces in the documentation meant the catheter care was not done. On 03/05/20 at 02:56 PM Administrative Nurse D stated catheter care was done at least once a shift. The catheter care

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) was documented in the kiosk. The task was assigned to the aides, but anyone could perform catheter care. If there were blank spaces in the documentation someone did not document, so it was not done. The facility policy Catheter revised December 2019 lacked documentation for care of the urinary catheter. The facility failed to ensure facility staff documented R27's catheter care to ensure R27 received the appropriate care and services to prevent catheter related urinary tract infections.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 136 residents. The sample included 29 residents. Six residents were reviewed for nutrition. Based on observations, record reviews, and interviews, the facility failed to address a significant weight loss for Resident (R) 56 Findings included: - The [DIAGNOSES REDACTED]. The Significant Change MDS dated [DATE] documented R56 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. She required extensive assistance of one to two staff members for most of her Activities of Daily Living (ADLs), and set-up and supervision assistance with eating. The MDS recorded R56 had weight loss. The Care Area Assessment (CAA) for Nutrition dated 01/24/20 documented R56 had a high body mass index (BMI) (measure of body fat based on height and weight) and recent weight loss. R56's appetite was fair, and she didn't always let staff know if didn't like what was served. The Nutrition care plan revised on 02/19/20 documented R56 had a recent unplanned weight loss. She was to be referred to the Registered Dietician and the Nutrition Risk Committee. She was to be provided nutritional supplement as ordered, weighed weekly, and labs monitored. The Care Plan lacked interventions related to resident's food likes or dislikes. The EMR, under the Weight tab, revealed a weight dated on 01/08/20 of 253 pounds (lbs.) and a weight of 230 lbs. dated 02/05/20, which indicated a 23 lbs. and 9.09% weight loss in one month. The EMR lacked any documentation the physician was notified of the 23 lb./9.09% weight loss. Observation on 03/04/20 at 08:00 AM R56 sat in her wheelchair in the main dining room. She consumed 100% of breakfast after staff set it up. During an interview on 03/05/20 at 01:44 PM Certified Medication Aide (CMA) S stated the staff was informed of weight loss or other changes concerning the residents in shift report. During an interview on 03/05/20 at 01:50 PM Licensed Nurse (LN) I stated if she noted a weight loss for a resident, she notified the MDS coordinator. During an interview on 03/05/20 at 02:57 PM Administrative Nurse D stated weights were obtained monthly and weekly for residents that are at a nutritional risk. The MDS coordinators reviewed the monthly and weekly weights. The registered dietician came weekly and reviewed the at-risk residents monthly. During an interview on 03/05/20 at 03:40 PM Administrative Nurse E stated she reviewed the monthly weights for R56. Administrative Nurse E stated R56 had not fallen into the significant weight loss parameter set by the policy. The Weight and Height policy with a revision date of 10/17 documented residents that are at nutritional risk were weighed weekly. If a resident's weight varied more than three percent, the resident was reweighed, and the weight was documented. A significant weight change was defined as five percent in 30 days, 7.5 percent in 90 days and 10 percent in 180 days. The facility failed to identify and place intervention for R56's significant weight loss, which had the potential for physical complications related to nutritional deficits.
F 0730 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Observe each nurse aide's job performance and give regular training.** The facility identified a census of 136 residents. The sample included 29 residents. Based on record reviews, observations and interviews the facility failed to complete annual performance reviews for the Certified Nurse's Aides (CNAs). Findings included: - Review of the CNA Training Hours Report by Employee records from April 2019 through February 2020 lacked documentation for annual performance reviews for the CNAs. On 03/05/20 at 01:34 PM CNA N stated she had worked in facility about two years. She received competency skills demonstration testing when she was hired, but none since hire. She was told a while back she had to do a perineal care (washing the genitals and anal area) demonstration but, this was not completed. On 03/05/20 at 02:58 PM Administrative Nurse D stated competency skills demonstration testing was done on all new employees. The skills testing was only done when the facility noticed a problem during spot checks or when trends were noted and not on an annual basis. The facility's Competency Validation Process-Clinical Skills policy dated December 2019 documented competency validation of clinical skills was required and completed annually, at a minimum, and more often when training needs were identified. The facility failed to complete annual CNA performance reviews. This had the potential to ensure the residents were provided with competent care for the prevention of accidents and possible complications in their health.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** The facility identified a census of 136 residents. The facility had one kitchen. Based on observations, interview, and record review, the facility failed to ensure safe and sanitary storage of food for residents related to opened and undated food items in the facility freezer. Findings included: - During initial tour of the facility's kitchen on 03/02/20 at 07:30 AM an observation of the main kitchen freezer revealed one opened and undated bag of tater tots, one bag of opened and undated pork patties, one bag of opened and undated french fries, and one opened and undated bag of peas and carrots. The pork patties and peas and carrots were open to the air. During an interview on 03/05//20 at 7:07 AM Dietary Staff (DS) BB stated staff performed spontaneous checks of the contents in the freezer at least two times per week. He stated packages were dated when opened by the staff member who received the delivery. He stated opened, unsealed, and undated packages of food were discarded. The facility's Food/Supply Storage Policy revised August 2019 included guidelines to ensure refrigerated and frozen food were properly stored, but it did not directly address the labeling and storage of opened foods. The facility failed to follow safe and sanitary storage of food, which had the potential of unpalatable and unsafe food for residents.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 136 residents. The sample contained 29 residents. Based on observations, interviews, and record reviews, the facility failed to ensure the use of standard infection control precautions (infection prevention practices which include but are not limited to hand hygiene and use of gloves) while performing wound care for Resident (R)24's right buttock pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Findings included: - The [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] revealed R24 was at risk for pressure ulcers, had moisture associated damage to skin, and had pressure relieving devices for bed and wheelchair. Observation on 03/03/20 at 10:44 AM revealed Licensed Nurse (LN) J walked into R24's room with LN K for a dressing change to R24's right buttock. LN J and LN K performed hand hygiene, then put on gloves and provided privacy. LN K rolled R24 onto her left side so LN J could assess the wound. R24 laid on an incontinence pad with no underwear or incontinence brief on, incontinence pad had scant (barely sufficient or adequate) drainage (the removal of fluids and/or gases from a body part) on it where the wound laid open against it. LN J stated resident had loose stools recently and they cannot keep a dressing on long. LN J cleaned R24's perineal area (the area of soft tissue covering the muscles and ligaments of the pelvic floor between the vagina and the anus in women and between the scrotum and the anus in men) with hygiene wipes, removed gloves, performed hand hygiene, then donned new gloves. LN J cleansed wound with normal saline and gauze three times. LN K laid R24 onto her back onto the soiled incontinence pad with wound exposed. LN J removed gloves, performed hand hygiene, and donned clean gloves then put [MEDICATION NAME] (medical honey that aides in wound healing) onto a folded piece of gauze. LN K rolled R24 over onto her left side again, so her buttocks were exposed to LN J. LN J applied [MEDICATION NAME] gauze to the wound and secured with medical tape. Soiled incontinence pad removed then LN K placed linens in a plastic bag and covered R24 with blanket. Both LN J and LN K performed hand hygiene before exiting room. Interview with LN J on 03/05/30 at 12:28 PM revealed LN J stated R24 is incontinent of urine. LN J stated R24's incontinence was the reason for her skin issues. Her skin looked good when she had an indwelling catheter. Interview with LN J on 03/05/30 at 12:28 PM revealed LN J stated R24 is incontinent of urine. LN J stated R24's incontinence was the reason for her skin issues. Her skin looked good when she had an indwelling catheter. The facility policy Infection Preventionist, last revised December 2019, directed the facility to continually monitor employee infection control practices, ensuring aseptic technique is used when appropriate, and work to prevent infections common to the rehabilitation/skilled care location. The facility failed to ensure use of standard infection

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) control practices when performing wound care for R24. This deficient practice had the potential for transmission and/or development of infections among the residents and staff.