DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165307	A. BUILDING _____ B. WING _____	10/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VIEW	1410 WEST DUNKERTON ROAD WATERLOO, IA 50703

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F 000	INITIAL COMMENTS VKK 11/14/18 Correction date 11/6/18 The following deficiencies relate to the facility's annual health survey. (See code of federal regulations (42CFR) Part 483, Subpart B-C) Facility reported incident #77155 was not substantiated.	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by this provider #165307 of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared solely because of provisions of federal and state law requires it. Country View will continue to operate and provide services in compliance with all federal, state and local laws, regulations and codes, and with professional standards and principles to	
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625	provide services within this facility. This is Country View's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol Laurie RN, Provisional Administrator — TITLE — (X6) DATE: 11/14/2018

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 625	Continued From page 1 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide a bed hold policy at the time of transfer to the hospital for seven of eight residents that required a bed hold notification. (Resident #7, #11, #42, #53, #56, #64 & #74) The facility census was 83 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/4/18, documented Resident #73 had a discharge assessment return anticipated. Nurse notes dated 9/4/18, documented the resident was admitted to the local hospital. Nurse notes dated 9/6/18, documented the resident arrived at the facility via facility vehicle from the hospital. The clinical record review lacked documentation the resident or resident representative received a bed hold notice at the time of transfer on 9/4/18. 2. The MDS assessment dated 9/9/18, documented Resident #42 was discharged to the hospital with return anticipated. The MDS assessment dated 9/12/18, documented the resident returned to the facility. Nurse notes revealed no documentation that a bed hold policy was given to or discussed with the	F 625	**F 625** Residents identified were notified and/or the resident representative was notified with multiple attempts documented to notify of the Bed Hold Policy. The Bed Hold Policy notification procedure was updated to include notification to the resident and/or resident representative of the Bed Hold Policy upon transfer, or in case of emergency transfer, within 24 hours. Documentation is to occur of multiple attempts to notify the resident and/or resident representative of the Bed Hold Policy. Nursing staff and social work staff were provided education on the new Bed Hold notification procedure on 11/07/2018. The Administrator and/or designee will audit weekly times 4 and monthly times 6 with results forwarded to the QAPI committee for continued compliance.	

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F 625	Continued From page 2 resident or the emergency contact upon discharge to the hospital. 3. The MDS assessment dated 6/28/18, documented Resident #53 required no assistance for bed mobility or transfer. Clinical record review revealed a transfer sheet dated 2/20/18, that documented the resident was sent to the hospital for respiratory distress. Further record review revealed no documentation a bed hold policy was given to or discussed with the resident or the emergency contact upon discharge to the hospital. 4. The MDS assessment dated 9/4/18, documented Resident #74 required assistance with dressing, toileting and personal hygiene. Nurse notes dated 8/24/18 at 3:40 p.m.,documented the hospital stated the resident was admitted with respiratory distress and acute pulmonary edema. The resident returned to the facility on 8/28/18. Documentation of notification to the resident or their representative regarding the bed hold policy was absent from the resident's health record. 5. Clinical record review for Resident #64 revealed no documentation of notification to the resident or resident's family regarding the bed-hold policy when the resident was transferred to the hospital on 8/20/18. The MDS assessment dated 8/20/18, revealed in section A discharge with return anticipated.	F 625		

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F 625	Continued From page 3 During interview on 10/23/18 at 2:29 p.m., the Assistant Administrator she stated there was not a process in place for the bed hold notifications. 6. The MDS assessment dated 7/18/18, documented Resident #7 was independent with transfers, bed mobility and ambulation. Nurse notes dated 4/5/18, documented the resident was transferred to the emergency room and admitted. Nurse notes dated 4/7/18, indicated the resident had returned to the facility. Documentation of notification of resident or their representative regarding the bed hold policy was absent from the resident's health record. Nurse notes dated 4/8/18, documented the resident was transferred and admitted to the hospital. The resident was returned to the facility on 4/11/18. Documentation of notification of resident or their representative regarding the bed hold policy is absent from the resident's health record. Nurse notes dated 9/18/18, indicated the resident was transferred and admitted to the hospital and returned to the facility on 10/3/18. Documentation of notification of the resident or their representative regarding the bed hold policy was absent from the resident's health record. 7. Nurse notes dated 5/14/18, documented Resident #11 was transferred to the emergency room and admitted.	F 625		

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F 625	Continued From page 4 Nurse notes dated 5/30/18, indicated the resident had returned to the facility. Documentation of notification of the resident or their representative regarding the bed hold policy was absent from the resident's health record.	F 625		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to follow physician orders for one of 25 residents reviewed. (Resident #74) The facility census was 83 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/4/18, documented Resident #74 had diagnoses that included anemia, hypertension, renal insufficiency, renal failure and/or end stage renal disease and received dialysis. A Physician Order dated 9/5/18, instructed staff to do a daily weight at the same time and record. The Treatment sheet dated 10/1/18-10/31/18, documented weight daily at the same time and record. Daily crossed off and after dialysis and 3 times a week added. The Treatment record	F 658	**F 658** The order for daily weights was discontinued by Resident #74's Physician. The plan of care was then updated to reflect Physician's orders. An audit of all dialysis residents revealed no further concerns. RN Managers were provided re-education on the RN Manager Weekly Checklist to ensure Physician's orders are being followed and weekly weights are being documented. DON and/or designee will audit RN Manager Weekly Checklist monthly times 3 with results forwarded to the QAPI committee for continued compliance.	

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F 658	Continued From page 5 lacked documentation the weights were completed. The Treatment record dated 9/1/18-9/30/18, instructed staff to do weight daily at the same time and record. The record lacked any documentation the weights were completed During interview on 10/24/18 at 8:10 a.m., Staff E, Register Nurse stated dialysis did the residents weights on Monday, Wednesday and Friday and the facility was to do the weights on the other days.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to ensure staff provided complete pericare for one of three residents observed. (Resident #17) The facility census was 83 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/29/18, documented Resident #17 had diagnoses of cerebrovascular accident, dementia, and hypertension and required total assistance for personal hygiene, dressing and toilet use. The Interdisciplinary Care Plan with a date of 8/2/18, directed staff to assist the resident with	F 677	**F 677** After identified, resident #17 was provided complete pericare per our Incontinence Care Policy and Procedure. Staff C was re-educated immediately on the Incontinence Care Policy and Procedure. Certified Nursing Aides were provided re-education on the Incontinence Care policy and procedure on 11/8/2018. The DON and/or designee will conduct incontinence care audits for each Certified Nursing Aide three times a year with results forwarded to the QAPI committee for continued compliance.	

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F 677	Continued From page 6 bathing, dressing and incontinence care. Observation on 10/23/18 at 8:38 a.m., revealed Staff C, Certified Nurse Aide, CNA and Staff D, CNA provided the resident with incontinence care. Staff C verified the incontinence brief was soiled. Staff C washed under resident's abdomen folds and down the front of the peri area without changing the areas of the wash cloth. Staff C removed the incontinent brief and washed their hands. Staff C proceeded to wash the resident's buttocks, but failed to wash the soiled brief had touched the resident. During interview on 10/24/18 at 9:46 a.m., the Provisional Director of Health Services stated staff was to wash any area where the incontinence brief touched the resident and any soiled areas.	F 677		
F 700 SS=K	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		

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F 700	Continued From page 7 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assess bed side rails for the risk of entrapment to ensure gaps in side rails were not large enough for residents to be at risk of serious injury, impairment or death, placing the residents in immediate jeopardy for 26 of 83 resident beds observed. (Resident #84, #2, #82, #63, #20, #29, #11, #61, #7, #46, #13, #66, #80, #38, #37, #7, #24, #72, #47, #83, #28, #74, #58, #15, #36 & # 4) The facility census was 83. Findings include: Review of the Food and Drug Administration (FDA) Hospital Bed Safety Workgroup article, Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings dated April 2003, indicated, in pertinent part, "...Use of bed rails should be based on patients assessed medical needs and should be documented clearly and approved by the interdisciplinary team...Bed rail use for patients mobility and/or transferring, for example, turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and	F 700	**F 700** On 10/24/18, immediately after the entrapment risk was identified, the maintenance department was re-educated to include Zone 1 in their bed rail audits. Next, a facility wide audit of all beds was completed. Side rails on beds that did not meet FDA Potential Zones of Bed Entrapment recommendations were immediately disabled with a tie down device that is unable to be cut for release per usual measures to ensure there are no entrapment risks. The RN Unit Managers then reviewed the residents' plan of care and the actual bed device usage and made lists of all residents care planned to use devices attached to the beds. The Assistant Administrator, Provisional Director of Health Services, and Provisional Administrator reviewed the lists and identified beds, which were in compliance to be utilized with the positioning devices. Beds that were found to be within compliance standards were relocated to accommodate residents who were in need of an assistive device for spatial identity and/or positioning. Side rails that were in compliance but were not used for this purpose were also disabled from use, using the tie down mechanism. A final facility wide audit was completed to ensure residents' plan of care matched any changes made to resident beds.	

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F 700	Continued From page 8 appropriately match the equipment of patient needs, considering all relevant risk factors...If it is determined that bed rails are required...The mattress to bed rail interface should prevent an individual from falling between the mattress and bed. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items...should be ongoing.." According to the FDA's Guidance for Industry and FDA Staff article, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment", issued 3/10/06, "For 20 years, FDA has received reports in which vulnerable patients have become entrapped in hospital beds while undergoing care and treatment in health care facilities. The term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. FDA received approximately 691 entrapment reports over a period of 21 years from January 1, 1985 to January 1, 2006. In these reports, 413 people died, 120 were injured, and 158 were near-miss events with no serious injury as a result of intervention. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or footboards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. Entrapments have occurred in a variety of patient care settings..."	F 700	During this transition, staff ensured residents did not return to their bed until a safety check was completed of their beds. After initial abatement, maintenance completely removed rails that were disengaged with the previous tie-down method. Another facility wide audit was conducted to ensure beds matched resident assessments and plans of care. The Administrator and/or Social Workers will continue to provide education about entrapment risks and potential side rail alternatives to staff, residents, and resident representatives. An assessment of residents with positioning and/or grip devices will be completed quarterly or more frequently if condition warrants. Alternate devices for consideration may include wing mattresses for persons who benefit from a spatial identity device, and a grip device to be used for positioning. Only devices that are less than the measurements given in the U.S. Food and Drug Administration's Potential Zones of Bed Entrapment will be considered. The Maintenance Director and/or designee will audit all Potential Zones of Bed Entrapment monthly and upon any bed move. Results of assessments and audits will be forwarded to the QAPI Committee for continued compliance.	

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F 700	Continued From page 9 A facility Bed Rail Policy revised 3/6/17, included the following section titled Overview of the U.S. Food and Drug Administration's (FDA) Potential Zones of Bed Entrapment: -Zone 1:Within the Rail-any open space between the perimeters of the rail can present a risk of head entrapment. FDA recommended space:less than 4 3/4 inches. -Zone 2: Under the rail, between the rail supports or next to a single rail support-the gap under the rail between the mattress, may allow for dangerous head entrapment. FDA recommended space: less than 4 3/4 inches. -Zone 3: Between the rail and the mattress-this area is the space between the inside surface of the bed rail and the mattress, and if too big can cause risk of head entrapment. FDA recommended space: less than 4 3/4 inches. - Zone 4: Under the rail at the ends of the rail-a gap between the mattress and the lower most portion of the rail poses a risk of neck entrapment. FDA recommended space: less than 2 3/8 inches. On 10/24/18 at 9:35 a.m., observation revealed the side rails on the bed in Room 231-1 appeared to be larger than 4 and 3/4 inches. At that time the surveyor asked the facility Director of Nursing (DON) if the facility assessed side rails for the risk of injury or entrapment. The facility Director of Nursing stated the facility maintenance department measured all side rails. At that time Staff I, Maintenance Director accompanied the surveyor to room 231-1. Staff I then held out two	F 700		

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F 700	Continued From page 10 small wood blocks (2" and 4") and stated the facility had used them to measure the distance from the mattress to the side rail, and the distance from the top of the mattress to the top of the side rail. Staff I stated the facility did not complete any other measurements to assess for side rail safety because they had not been aware they needed to measure anything else. Staff I then used a four inch wood block and measured the distance of the gap within the upper side (head) rail and found it to be eight inches by eight inches. Staff I stated there had been no resident assigned to the bed but verified a resident could be admitted and assigned to it. Upon completion of the observation the surveyor notified the facility DON of the findings. At 9:55 a.m., the facility Maintenance Director measured the following gaps within side rails on surveyor request: -Room 339, Resident # 84-7 inches x 7 1/2 inches, plastic side rail -Room 345, Resident #2- 9 inches x 7 1/2 inches, center metal rail -Room 327, Resident #82-7 inches x 7 1/2 inches, plastic rail -Room 224-1, Resident #63, 7 inches x 7 1/2 inches -Room 224-2, Resident #20, 7 inches x 7 1/2 inches -Room 223-1, Resident #29, 7 inches x 7 1/2 inches, plastic rail -Room 216-1, Resident #11, 7 inches x 7 1/2 inches, plastic rail -Room 216-2, Resident #61, 7 inches x 7 1/2 inches, plastic rail At that time the facility Maintenance Director stated they had not been aware of the	F 700		

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F 700	Continued From page 11 requirements for the measurement within the side rail. The surveyor informed the Maintenance Director the gaps had been an entrapment risk and they stated they had been in the process of correcting the issue and measuring all side rails. The facility Maintenance Director then measured the side rail in Room 213, Resident #7 with gap in plastic rail of 7 inches x 7 1/2 inches. (total of 9 beds/rails this observation) At 10:26 a.m., surveyors measured a gap between bars of the upper (head) side rail in Room 327, Resident #82 and found it to be seven inches (top to bottom, inside of rail gap) by seven and one half inches (across, inside of rail gap). The surveyors head easily fit through the rail. At 10:39 a.m., observation revealed Resident # 2 in Room 345-2 to be lying in bed with an upper (head) side rail in the up position. One side of the bed had been against the wall and one side of the bed had the upper (head) rail up. (earlier measured at 9:55 a.m. observation with gap 9 inches x 7 1/2 inches) At 11:02 a.m., surveyor observations revealed the following beds assigned to residents with side rails having greater than a 4 and 3/4 gap within the rail bars: -Resident #46, Room 205-1 -Resident #13, Room 206-1 -Resident #66, Room 207-1 -Resident # 80, Room 209-1 -Resident # 38, Room 334-1 -Resident #37, Room 335-3 -Resident #7, Room 213 -Resident #24, Room 217	F 700		

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	165307	A. BUILDING _____ B. WING _____	10/29/2018

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F 700	Continued From page 12 -Resident # 72, Room 222-2 -Resident # 47, Room 223-2 -Resident #83, Room 222-1 -Resident # 28, Room 220-2 -Resident #74, Room 219-2 -Resident # 58, Room 219-1 -Resident #15, Room 331-2 -Resident # 36, Room 340 -Resident # 21, Room 348 (total of 26 rails) Staff E, Registered Nurse stated on 10/24/18 at 3:30 p.m., no side rail safety assessments had ever been completed by the nursing department in the facility for any resident with a side rail. The facility abated the Immediate Jeopardy on 10/24/18 at 3:30 p.m. by implementation of the following actions: -11:00 a.m., facility maintenance staff were re-trained and immediately began process of assessment of facility side rails to identify beds that did not meet regulatory standards. -Registered Nurse Unit Managers reviewed the resident's plan of care and the actual bed device usage and made lists of all residents who use devices attached to the beds on the 3 units. -Assistant Administrator, Provisional Director of Health Services and Provisional Administrator reviewed the lists and identified beds which were available to be utilized with the positioning devices. -12:30 p.m., side rails on beds that did not meet guidelines were disabled with a tie down device that is not able to be cut off for release per usual	F 700		

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F 700	Continued From page 13 measures to ensure no risk for entrapment starting on the Oaks unit, completed as soon as the list complied to remove the opportunity of any resident entrapment risk. -Beds found to be within compliance standards were relocated to accommodate residents who were in need of an assistive device for spatial identity or a grip device for positioning aide. Side rails that were not used for this purpose were also disabled from use, using the tie down mechanism. Residents were not allowed to return to their bed until a safety check had been completed and relocation of a new bed if necessary. -12:50 p.m., Assistant Administrator and Provisional Director of Health Services went to Oaks unit to supervise bed relocation process. -1:55 p.m., Oaks unit bed relocation process complete. -Maintenance moved to Willow-Wood unit to complete bed relocation process. -2:05 p.m., Assistant Administrator to Oaks unit to complete final review of bed relocation. -2:30 p.m., informed surveyor team of plan of corrective action taken to address practice. -2:45 p.m., one-half of Willow-Wood unit completed. -3:30 p.m., Willow-Wood unit completed with final bed audit completed by Assistant Administrator. A review of positioning bed device will be	F 700		

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F 700	Continued From page 14 completed on all residents that currently use a bed positioning device and will be completed quarterly or more frequently if condition warrants. Alternate devices for consideration may include wing mattresses for persons who benefit from a spatial identity device, and grip device to be used for positioning. Only devices that pass the measurement test will remain in service. On 10/25/18 at 8:07 a.m., Staff I verified the facility had also found a total of 26 occupied beds that were found to have greater than 4 3/4 inch gaps within side rails. Staff I verified remedies were made to all beds during the abatement process on the previous day.	F 700		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		

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F 880	Continued From page 15 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 16 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure staff followed proper infection control technique for two of 25 residents observed. (Resident #20 & #73) The facility census was 83 residents. Findings include: 1. The Minimum data set (MDS) assessment dated 9/6/18, documented Resident #73 had diagnoses of chronic kidney disease, diabetes mellitus, anxiety and depression and required supervision for bed mobility, transfer and extensive assistance for dressing, toilet use and personal hygiene. Observation on 10/22/18 at 10:45 a.m., revealed Staff A, Licensed Practical Nurse (LPN), entered the residents room with wound care supplies, washed their hands and donned gloves. With gloved hands Staff A was observed painting the residents right great toe with pre moistened Betadine square. Staff A removed gloves and donned new gloves from the residents shared bathroom, under constant observation Staff A failed to wash or sanitize their hands prior to applying new gloves. Staff A completed the treatment and removed their gloves and gathered dressing supplies and left the residents room. Under continued observation Staff A walked up	F 880	**F 880** 1. After identified, resident #73 was provided a clean dressing change. Dressing change supply container and door handle to the enclosed nurses' station were sanitized. Staff A was re-educated immediately on the Dressing Change Clean Policy and Procedure. Nursing staff were provided education on Dressing Change Clean Policy and Procedure on 11/01/2018. The DON and/or designee will conduct dressing change audits for each nurse three times a year with results forwarded to the QAPI committee for continued compliance.	

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F 880	Continued From page 17 the hallway, disposed of the soiled gloves, opened the door to the enclosed nurses station and washed their hands in the handwashing sink. According to a document titled Dressing Change Clean identified the purpose as: To prevent spread of infection. The procedure section directed staff to cleanse the wound with prescribed solution if ordered, remove gloves and wash hands. Assist resident, and wash hands. During interview on 10/23/18 at 3:30 p.m., Staff B, Registered Nurse, confirmed staff was to change gloves and wash hands after wound treatment with Betadine and prior to applying a clean dressing. 2. The Minimum Data Set (MDS) assessment dated 8/9/18, documented Resident #20, had diagnoses of diabetes mellitus, non-Alzheimer dementia and depression and required extensive assistance with activities of daily living and was incontinent of bladder. Observation on 10/24/18 at 8:40 a.m., revealed Staff F, certified nurse aide, CNA and Staff G, CNA pushed the resident into the shower room and assisted the resident to stand. Observation revealed the residents sweat pants were wet. Staff F and Staff G sat the resident on the toilet. Once toileting was complete Staff F and Staff G stood the resident, placed a clean yellow brief on the resident and assisted the resident down in the wheelchair on top of a black pressure cushion. Upon request, Staff F assisted the resident to a standing position and noticed the back of the sweat pants was wet. Staff F changed the residents pants but failed to cleanse the black pressure cushion were the resident sat.	F 880	2. After identified, resident #20 was provided a clean brief, pants, and pressure cushion. Staff F and G were re-educated immediately on the Incontinence Care Policy and Procedure, which addresses sanitizing pressure cushions. Certified Nursing Staff were provided re-education on the Incontinence Care Policy and Procedure on 11/8/2018. The DON and/or designee will conduct incontinence care audits for each Certified Nursing Aide three times a year with results forwarded to the QAPI committee for continued compliance.	

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F 880	Continued From page 18 During interview on 10/24/18 at 8:50 a.m., Staff E, Registered Nurse, confirmed staff failed to cleanse off the seat of pressure reduction cushion prior to sitting the resident back down. The facility policy and procedure dated 3/94, documented wheelchairs, reclining chairs and cares will be cleaned weekly on Tuesday nights and as needed. First and second shift will be responsible for wiping chairs after meals to remove spilled food, beverages, etc. 1. Take items into nearest shower room, (DO NOT PUT IN SHOWER). Remove pad and place in soiled laundry bin. 2. Clean items with cloth and disinfectant provided by the housekeeping department. 3. Wipe down and allow to dry. 4. Replace with clean padding. 5. Return to proper rooms after cleaning.	F 880		