STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165177	A. BUILDING _____ B. WING _____	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	231 NORTH EIGHTH AVENUE WEST HARTLEY, IA 51346

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
x DC	Correction date 9/4/22 A re-certification survey and investigation of self report #101435-I and complaint #106345-C completed 7/25/22 to 8/2/22 resulted in the following deficiencies. Self report #101435-I was substantiated. Complaint #106345-C was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578	F 578 Resident # 7 code status changed on 7/26/22 after confirming with responsible party that these are his current issues which he verbalized yes. On 7/26/22 physician notified and CPR request signed by physician. On 7/27/22 all residents residing at Community Memorial Health Center reviewed for advanced directive by Nurse Manager, RN. Nursing staff and Social Service Staff retrained on process on resident/representative's advanced directive elections. In addition, nursing and social service staff retrained on requirements including provisions to inform and provide written information to all adult residents concerning the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steve Gilbertson	Provisional Administrator	8-31-2022

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 578	Continued From page 1 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure the resident/representative's advanced directive elections were accurately reflected in the resident's record for 1 resident reviewed (Resident #7). The facility reported a census of 55 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 4/28/22 Resident #7 scored 00 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident's diagnoses included anoxic brain damage. The resident's profile page listed a family member responsible for the resident.	F 578	F 578 continue, right to accept or refuse medical/surgical treatment and to formulate an advanced direction in accordance with the facilities policies and applicable State law. The Social worker or designee will complete audits weekly for 8 weeks, then monthly for 4 months, and quarterly thereafter until next annual survey. The audit will include verification of advanced directive and follow up review to occur quarterly with every resident assessment. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: September 4, 2022	

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F 578	Continued From page 2 The Clinical Physician's Orders dated 7/26/22 at 10:03 a.m. indicated the resident's code status was do not resuscitate (DNR). The Care Plan dated 2/10/22 identified the resident had a DNR. The interventions included the families health care choices would be met: if found without vital signs the resident had a DNR. The Iowa Physician Orders for Scope and Treatment (IPOST) dated 2/28/22 showed if the resident had no pulse and not breathing to attempt CPR/resuscitation, signed by the family 2/17/22 and the physician 2/28/22. The form indicated the preferences were reviewed 5/4/22. On 7/26/22 at 10:31 Staff G Registered Nurse (RN) stated the resident had always been a DNR. Staff G did not know the family had signed an IPOST in February changing the cardiopulmonary resuscitation status. On 7/27/22 at 11 a.m. the Director of Nursing (DON) stated the resident's code status should have been updated to CPR in February when the IPOST was signed by the family member, and communicated to the staff. On 8/1/22 at 8:21 a.m. the Social Worker (SW) stated she missed the code status change on the IPOST.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for	F 582	F 582 Social worker responsible for residents # 6 and #35 retrained on required information when completing ABN's. This training was completed on 8/1/22.	

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F 582	Continued From page 3 Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.	F 582	F 582 continue Since Survey the facility has had 4 Medicare Residents and 3 have been discharged from skilled services. All residents since survey exit have been completed appropriately. All attendees at the Medicare weekly meeting will be retrained on completion of the components of the Advanced Beneficiary notice on or before September 9, 2022. The administrator or designee will complete audits weekly for 8 weeks, then monthly for 4 months, and quarterly thereafter until next annual survey. The audit will include all ABN's issued during the audit period. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: September 4, 2022.	

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F 582	Continued From page 4 (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow the options chosen for skilled services when the facility determined the resident would not meet Medicare coverage requirements for 2 of 3 residents reviewed (Resident #6 and #35). The facility reported a census of 55 residents. Findings include: 1) The SNF Beneficiary Protection Notification Review showed the facility identified Resident #6 received skilled services 1/24/22 and the last covered day 2/16/22. The form indicated the resident received the CMS-10055 form. The Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABNN) notified the resident/representative beginning 2/17/22 the resident/representative may have to pay out of pocket for the care if they had no other insurance that may cover the cost. The notice included the resident's options. According to the form, the resident chose option #1 indicating the resident wanted the care listed, and wanted Medicare billed for an official decision on payment, which would be sent to the resident an a Medicare Summary Notice (MSN). The resident understood if Medicare didn't pay, she would be responsible	F 582		

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F 582	Continued From page 5 for paying, but could appeal to Medicare by following the directions on the MSN. 2) 1) The SNF Beneficiary Protection Notification Review showed the facility identified Resident #35 received skilled services 5/11/22 and the last covered day 5/25/22. The form indicated the resident received the CMS-10055 form. The SNFABNN notified the resident beginning 5/26/22 the resident/representative may have to pay out of pocket for the care if they had no other insurance that may cover the cost. The notice included the resident's options. According to the form, the resident chose option #1 indicating the resident wanted the care listed, and wanted Medicare billed for an official decision on payment, which would be sent to the resident an MSN. The resident understood if Medicare didn't pay, she would be responsible for paying, but could appeal to Medicare by following the directions on the MSN. On 7/27/22 at 11:52 a.m. the Director of Nursing (DON) stated she was able to reach the Social Worker (SW) (on vacation) and she had them mark option 1 or told them to mark option 1 because she thought that was the 1 they didn't have to do anything for. The residents did not continue to receive skilled services, so Medicare was not billed. On 8/1/22 at 8:21 a.m. the SW stated she screwed up and had the resident or the representative mark option 1. She said they did not want the services, or to have them billed to Medicare.	F 582		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies	F 607		

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F 607	Continued From page 6 CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, staff interviews, and facility policy review, the facility failed to obtain an evaluation by the Department of Criminal Investigation ((DCI) prior to hire to determine if an employee with a potential criminal history could work in the facility for 1 of 5 current employees sampled (Staff A). The facility reported a census of 55 residents. Findings include: 1. The personnel file for Staff A, Registered Nurse (RN) documented a hire date of 11/15/2021. The Single Contact License and Background Check (SING) dated 11/4/21 indicated a possible criminal hit for Staff A which required the DCI to clarify if the prospective employee did or did not have a criminal history. The personnel record lacked the documentation that further research from DCI had been completed. Review of facility policy titled Abuse Prevention,	F 607	F 607 Background check on Staff A was sent to Department of Health Services on 7/28/22. Approval from DHS received on 8/5/22. During the time of 7/27/22 thru 8/5/22 Staff A did not work. Review of all employees for completion of background checks completed on7/27/22 by office manager. Management staff retrained on policies in relation to abuse and neglect involving background checks that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, in addition investigation into allegations. Background process reviewed with management team on 8/24/22 by Administrator.	

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F 607	Continued From page 7 Identification, Investigation and Reporting Policy dated July 2019 revealed the following information under employee screening, the facility shall screen all potential employees for a history of abuse, neglect, exploitation, misappropriation of property, or mistreatment of residents. This will be accomplished through the following (including maintaining documentation of such results): the facility will conduct an Iowa criminal record check and dependent adult abuse registry check on all prospective employees and other individual engaged to provide services to residents prior to hire in the manner prescribed under 481 Iowa administrative code 58.11(3). Interview on 7/27/22 at 1:21 p.m., with the Administrator revealed he expected to have clearance prior to staff working on the floor. Staff A will not be working until the clearance has been received.	F 607	F 607 Continue, The administrator or designee will complete audits weekly for 8 weeks, then monthly for 4 months, and quarterly thereafter until next annual survey. The audit will include new employees hired in the facility and employees charged for criminal activities during the audit period. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: August 24, 2022	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and	F 644	F 644 Resident number 37 PASARR Status Change completed on 9/2/2022 by Nurse Manager. Residents residing at Community Memorial Health Center reviewed and status changes completed based on later identified with newly evident or possible serious mental disorder, intellectual disability, or other related conditions.	

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F 644	Continued From page 8 all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to refer 1 resident with a negative Level I result for the PreAdmission Screening and Resident Review (PASRR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 2 residents reviewed for PASRR requirements, (Resident #37). The facility reported a census of 55 residents. Findings include: The Minimum Data Set (MDS) assessment dated 6/23/22 for Resident #37 documented diagnoses of major depressive disorder, post traumatic stress disorder and non-Alzheimer's dementia. The MDS showed a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. Review of the clinical record revealed a Notice of Negative Level I Screen Outcome dated 2/18/2014 revealed the PASRR Level 1 screen remains valid for your stay at the nursing facility and should be transferred with you if you relocate. No further Level 1 screening is required unless you are known to have or are suspected of having a major mental illness or an intellectual or developmental disability and exhibit a significant change in treatment needs. Further review	F 644	F 644 continue Nursing Administrative Staff retrained on or before 9/9/22 on coordinating assessment with preadmission screening and resident review. Including incorporating the recommendations from the PASARR evaluation report into resident's assessment, care planning and transitions of care. Also included in the training that all residents with Level II and those with new evident or possible serious mental disorder, intellectual disability or a related condition for Level II resident review upon a significant change in status assessment. The Director of Nurses or designee will complete audits weekly for 8 weeks, then monthly for 4 months, and quarterly thereafter until next annual survey. The audit will include all new admissions and any residents identified with significant change in status. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: September 4, 2022	

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F 644	Continued From page 9 revealed question #1- Does the individual have any of the following Major Mental Illnesses, which major depression. The box was marked no. Question #3- Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? The box was marked no. The Medication Review Report dated 6/29/22 signed by the physician 7/5/22 revealed active diagnosis of major depressive disorder and posttraumatic stress disorder. Review of Resident #37 ' s chart lacked a follow-up and resubmission of a PASRR with the diagnosis of major depressive disorder and posttraumatic stress disorder. Interview on 7/28/22 at 8:36 a.m., with the Director of Nursing revealed the facility does not have a policy on PASRR. Interview on 7/26/22 at 3:04 p.m., with the Director of Nursing revealed the PASRR should have been redone with the diagnosis of major depressive disorder and posttraumatic stress disorder included.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657	F 657 Resident # 45 Care Plan updated on 7/27 per Director of Nurses. Resident's residing at Community Memorial Health Center reviewed by Director of Nurses for opioids and oxygen and any additional needs by 9/9/22. Interdisciplinary Team retrained on Care Policy on 9/7/22 by Director of Nurses.	

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F 657	Continued From page 10 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and policy review, the facility failed to revise and update care plans to include and address opioid medication usage and side effects and oxygen usage in 1 out of 14 sampled residents reviewed for comprehensive care plans (Resident #45). The facility reported a census of 55 residents. Findings include: The Minimum Data Set (MDS) assessment dated 5/5/21 for Resident # 45 documented diagnoses of coronary artery disease, anxiety disorder and occlusion and stenosis of both carotid arteries. The MDS showed the Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was not capable of completing the interview. Review of the Medication Review Report dated	F 657	F 657 continue, The DON or designee will complete audits weekly for 8 weeks, then monthly for 4 months and quarterly thereafter until next annual survey. The audit will contain any residents that require change of or additional clinical needs. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: September 4, 2022	

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F 657	Continued From page 11 6/29/22 signed by the physician lacking a date revealed the following orders: a. Monitor oxygen saturation. May use oxygen if sats below 90% as needed with an order date and start date of 5/10/22. b. Oxygen per nasal cannula. Tirate up to 4 liters per minute to keep saturation above 90% with an order date and start date of 10/5/21. c. Oxygen 2 liters per minute per nasal cannula at bedtime with an order date and start date of 4/21/22. d. Hydrocodone-Acetaminophen tablet 5/325 milligrams(mg) give a half a tablet by mouth every 6 hours as needed for pain with an order date and start date of 4/21/22. e. Hydrocodone- Acetaminophen tablet 5/325 mg give half a tablet by mouth one time a day for pain with an order date of 12/2/21 with a start date of 12/3/21. The revised Care Plan dated 6/8/22, lacked information regarding Resident #23 ' s oxygen usage and usage of opioid medication and side effects to watch for. Review of facility provided policy titled Policy of Care Plan dated 11/89 revealed document and date identifying specific problems, goals, and approaches for each resident in a measurable and realistic manner. The resident ' s plan of care is reviewed quarterly by the health care committee and necessary changes and additions are documented with assistance of all members of the committee. Interview on 7/27/22 at 12:48 p.m., with the Director of Nursing revealed she would expect the oxygen and opioid medication usage and side effects to be on the care plan.	F 657		

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F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide adequate assessment and timely intervention for a change in condition for 2 of 2 resident's reviewed (Resident #104, and #3). Resident #104 fell and sustained a head injury and fracture of the C1 vertebrae (neck) on 12/31/21. On 1/5/22 the resident had pain documented on the Treatment Administration Record (TAR) with no documentation interventions were implemented to relieve the pain. The resident also had a change of condition with his oxygen (O2) saturation (sat) dropping to 52% (normal above 90%) and respirations 30 (normal 16-20) and labored around 9:30 a.m. The facility failed to assess the resident's lung sounds related to the change. On 1/6/22 at 1:45 a.m. (approximately 16 hours after the drop in O2 sats) the resident left by ambulance to the emergency room with pain documented at a 6, respirations of 44, and crackles throughout his lungs. The resident went into respiratory arrest and died in the ambulance. Resident #3 had edema (swelling) in the lower extremities and a care plan intervention to weigh weekly. The facility failed to follow through with the intervention. The facility reported a census of 55	F 684	F 684 Resident 104 expired on 1/6/22 @0215. Resident 3 on 7/25/22 a fax was sent to her primary physician. On 7/26/22 her Lasix was increased to 80 mg po daily. On 7/27/22 resident's primary physician saw resident in the facility and ordered nursing staff to apply ace wraps. Resident remains on daily weight and continues to receive Lasix 80 mg every day. Residents with ordered daily weights reviewed on 8/25/22 to ensure weights are completed daily and recorded. In addition, those residents with diagnosis of hypertension, peripheral vascular disease, peripheral insufficiency, edema, peripheral neuropathy and any other cardiac/vascular diagnosis reviewed and monitoring implemented on 8/25/22 by Director of Nursing. Professional nursing staff retrained on 8/17/22 and 8/25/22 on adequate assessment and timely interventions for a change in condition in accordance with professional standards of practice and comprehensive person-centered care plan with residents' choice. This training included implementation of hot charts and fax process.	

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F 684	Continued From page 13 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 11/18/21 Resident #104 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with bed mobility, transfers, walking in the room, dressing, toilet use and personal hygiene. The resident required limited assistance with walking in the hallway. The resident's diagnoses included non-traumatic brain dysfunction, dementia with lewy bodies, and a stroke. The Progress Notes dated 1/1/22 at 12:02 a.m. documented the resident had an unwitnessed fall at 10:55 p.m. in his room. The nurse aide heard a sound and found him on his right side next to his bed bleeding from his head. The nurse evaluated the resident, called the wife at 11 p.m. and asked for permission to send him to the emergency room (ER) to be evaluated and treated. The hospital called at 11:02 p.m. to get a telephone order to send the resident. At 11:08 p.m. 911 called and they had to try to find an ambulance since all those around were dispatched out with other calls. At 11:35 a.m. dispatch called back and said another ambulance would transfer the resident. At 11:55 p.m. the ambulance came and transported the resident onto the gurney, leaving the facility at 12 a.m. The resident was alert after the fall and only complained of his head hurting in the general area where his head bled from. They cleaned the resident up with sodium chloride (NaCl), and gauze placed on his head with pressure to help with the bleeding. His wife would be at the	F 684	F 684 continue, The Director of Nursing or designee will complete audits weekly for 8 weeks, then monthly for 4 months, and quarterly thereafter until next annual survey. This audit will include adequate assessment, implementation of interventions, identification of condition change and utilization of new facility process on hot charts and faxing. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: August 25, 2022	

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F 684	Continued From page 14 hospital waiting for his arrival. A hospital Emergency Department note dated 1/1/22 documented the resident had a laceration of the head and a C1 cervical fracture. The history of present illness (HPI) documented a resident with dementia in the memory care unit apparently sustained a fall earlier in the night and had a laceration on the right eyebrow. The resident had some neck pain, and also pain in the pelvis. He had a stellate (a tear in the skin caused by blunt trauma) laceration above the right eyebrow, and hematoma or swelling around that area, approximate 5 or 6 cm total length. Basically gouged into the center of the stellate laceration and it kind of stretched the tissue due to frailty and old age. It had continuous oozing without a pressure dressing. The laceration measured 5 cm to 2 cm. The resident had a very irregular wound. He had Computed Tamography (CT) of the cervical spine without contrast. The findings included fractures of both the anterior and posterior arches of C1. The anterior arch fracture was distracted (widened) by about 11 mm. The Progress Notes dated 1/1/22 at 9:48 a.m. documented the Resident returned via ambulance at 9:05 a.m. The ER Dr. consulted with a neuro-surgeon. The resident with C1 fracture and felt not a candidate for surgery. He received a soft collar to wear. Per the Dr. notes they were to do best they could to keep collar on but understood it may be difficult to do. The resident had multiple sutures on top of his forehead. They were to leave the pressure bandage on for 48 hours then apply an ointment. Sutures should be removed in 10-14 days at follow-up appointment. The resident also needed	F 684		

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F 684	Continued From page 15 a neck x-ray to assess the break. Both orbital areas were very bruised and swollen. Told if became too anxious they were to call the ER for orders of a calming type medication. Also, if presented to be in excessive pain they could call. The Care Plan identified an actual post incident 12/31/21 when the resident sustained a C1 fracture. The interventions included monitoring the resident for a sudden increase of pain to the neck area or any other sudden unexplained pain, or sudden loss of sensation. Contact the Physician promptly with any concerns. If medication needed for pain call the ER. The Progress Notes dated 1/5/22 at 9:30 a.m. documented the on duty nurse reported the resident's oxygen (O2) saturation (sat) had dropped and she put him on oxygen. The nurse stated she tried calling the Physician's office but she was not in. The nurse went into the resident's room to assess him. The resident noted to be laying in bed with eyes closed, oxygen on per nasal cannula. The resident's spouse present. The nurse asked the spouse if she could do anything for the resident or her. The nurse brought the spouse a cup of coffee. As leaving the unit, the spouse came out of resident's room and stated the resident wanted a drink of water and he had to poop. The nurse suggested staff use the potty chair on wheels and transfer the resident from the bed and let him use the bathroom. Staff agreed and the nurse left the unit. At 9:50 a.m. the nurse paged to the unit. Upon entering room, nurse (Staff N Registered Nurse) noted to be taking vitals on the resident laying in bed. Staff P Licensed Practical Nurse (LPN), stated the resident became unresponsive on the	F 684		

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F 684	Continued From page 16 toilet so they laid him back down in bed. The nurse asked if he had a bowel movement and the other nurse stated yes. This nurse stated that he may have had a vagal response. The nurse asked the resident's spouse if she would like the resident to be sent to the hospital and the wife stated no, she wanted him to be comfortable and to stay at the facility. The nurse told the on duty nurse the spouse's wishes and reminded the on duty nurse to contact the doctor regarding the episode and need for O2 and to document. The January 2022 Medication Administration Record (MAR) showed the resident had an order for Tylenol Tablet 325 mg 2 tablet by mouth every 4 hours as needed for mild pain. The resident last received Tylenol for pain on 1/4/22 at 7:17 a.m. with pain documented at 6 (0 no pain, 10 worst pain) and indicated it was effective. The Treatment Administration Record (TAR) documented the resident's pain on 1/5/22: a. 4 at 4 a.m. b. 4 at 8 a.m. c. 3 at 12 p.m. d. 0 at 6 p.m. e. not assigned a number at 8 p.m. f. and a 6 on 1/6/22 at 12 a.m. The clinical record lacked documentation the facility implemented interventions to help relieve the pain. The Progress Notes dated 1/5/22 at 2:09 p.m. documented the resident was unresponsive while using the bathroom for 1-2 minutes. The resident had been weak and sleepy during the a.m. shift. The resident's 02 was down to 52% (90-100 normal) started O2 at 2 liters. Fax sent to the doctor and family notified. Vitals temp 97.7, pulse 46 (normal 60-100), B/P 110/46, respirations 30	F 684		

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F 684	Continued From page 17 (normal 12-20) with labored breathing. He refused his meals and noon shakes. A fax dated 1/5/22 notified the Physician of the resident's condition. The resident fell 12/31/22 with sutures at the forehead and soft neck collar. The resident's O2 sat dropped down to 52 %, and the nurse started O2, and the resident had labored breathing. The resident complained of abdominal pain, and request to use the restroom. In the process he became unresponsive for 1-2 minutes while sitting on the bathroom. His oxygen started going up to 74 %. Would keep monitoring him. Asked if the Physician would recommend continuing the O2, and how long. The Advanced Registered Nurse Practitioner responded to continue O2 at 2-3 liters to maintain O2 sats greater than 90% until progress report on 1/6/22 to the Physician. On 1/5/22 at 9:17 p.m. the resident refused to cooperate and became more combative when obtaining vital signs and assessment. He refused to put the oxygen back on but agreed to be changed and repositioned in bed. The resident refused his medications and meals. The resident slept peacefully in his room at that time. The Progress Notes dated 1/5/22 at 9:50 p.m. documented the fax came back to continue O2 per nasal cannula 2-3 liters to maintain O2 sats greater than 90%. Continue O2 continuously until progress report on Thursday, 1-6-22 to the physician. The Progress Notes dated 1/6/22 at 1:15 a.m. documented a call placed to the ER to get in touch with the on-call regarding the resident. The resident's vital signs were (VS) 97.4-108-44 O2 at	F 684		

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F 684	Continued From page 18 2 L NC. The resident's lung sounds had crackles throughout, and audible gurgling. The resident unable to verbalize the presence of pain, restless, moving his legs out of bed. A call placed to update the spouse. The on-call updated on the resident. Received an order to send resident to the ER for further evaluation. The spouse would follow the ambulance to the ER. The Progress Notes dated 1/6/22 at 1:55 a.m. documented the ambulance arrived 1:40 a.m. departed with the resident at 1:45 a.m. The ambulance personnel called at 1:52 a.m. and stated the resident quit breathing and asked if he had a do not resuscitate (DNR) and he did. The spouse followed behind the ambulance. The Progress Notes dated 1/6/22 at 2:49 a.m. documented the ER called and stated the resident passed away 1/6/22 at 2:15 a.m. with the spouse at the bedside. A hospital Discharge Plan dated 1/6/22 documented the resident dead on arrival to the hospital. The clinical impression: death due to respiratory arrest, C1 cervical fracture, and dementia. The history of present illness (HPI) documented the resident with a recent fall at the nursing home sustaining a laceration to his head and a C1 fracture. The Emergency Medical Service (EMS) was called today due to increasing respiratory difficulty. Upon arrival they said he had a pulse and breathing, however, shortly after coming out into the cold air he respiratory arrested. They did assist the the resident with bag mask ventilation although they did not find it to be that effective. He lost his pulse enroute. Because he had a DNR they did not do further intervention.	F 684		

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F 684	Continued From page 19 On 7/26/22 at 1:20 p.m. the resident's spouse stated on 1/5/22 the resident was not doing well. She went and spent time with him and went home to eat. She came back and the SW told her he was resting and she didn't need to be there. She went home and that was her biggest regret. He died in the ambulance and she didn't get to be with him. On 7/27/22 at 11:15 a.m. the Physician's Assistant (PA) stated she would definitely expect the resident's lung sounds to be assessed with a low O2 sat, and closely monitored. On 7/27/22 at 12:30 p.m. Staff O Registered Nurse (RN) Director of Nursing (DON) at the time, stated she was called to the unit because the resident became unresponsive (the a.m. of 1/5/22). They had oxygen on him but she did not know the O2 sat dropped down to 52. She would expect an assessment of the resident's lung sounds. That may have changed their response. She did talk to the resident's spouse (that morning) but maybe didn't know the full extent of his condition. On 7/27/22 at 4:50 p.m. Staff P Licensed Practical Nurse (LPN) stated she could not remember details. When looking at documentation she said she did neuro checks on the resident and his O2 sat was 52. He had labored breathing. She started oxygen. Then he became unresponsive on the commode. She called the other nurse (Staff N RN) to see what she thought of him. The other nurse called the DON. She said she did not check his lungs because others were assessing him. She didn't know who assessed what.	F 684		

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F 684	Continued From page 20 On 7/28/22 at 11:44 a.m. Staff N RN remembered Staff P calling her back to the unit 1/5/22 to see what she thought. She was maybe in the unit 5 minutes and called the DON. She did not do any assessment of the resident. On 7/28/22 at 2:40 p.m. Staff M RN worked at the facility a few shifts for agency. She worked 1/5/22 overnight into 1/6/22. She worked south hall. She didn't know why she went back to the unit but the resident clearly needed pain medication. When she asked the resident about pain he squeezed her hand. He had crackles throughout his lungs with labored breathing. He wasn't taking pills and he needed something in liquid form. She thought he needed Morphine. She said something should have been done before this. She had the other nurse come to the unit, (Staff L RN). She helped with phone calls. She did not feel the resident just suddenly got this way. On 7/28/22 at 3:19 p.m. Staff L stated she worked the night the resident died. When she went to the unit he was in bad shape. She thought he should have had something done sooner. 2. The Minimum Data Set (MDS) dated 7/14/22 revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12 which indicated mildly impaired cognition. The same MDS revealed the resident had diagnoses of hypertension (high blood pressure), peripheral vascular disease (reduced blood flow to legs), peripheral venous insufficiency (circulation issue causing blood to pool in legs), edema, peripheral neuropathy (damaged nerves cause numbness in feet), and 1 venous and arterial ulcer (wound) was present. Observation on 7/25/22 at 1:59 PM revealed the	F 684		

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F 684	Continued From page 21 resident had swollen feet and legs, she was wearing edema wear during observation. The Progress Note dated 7/25/22 at 3:30 PM revealed the resident had increasing pitting edema to bilateral lower extremities, 2+ to right lower extremity, 3-4+ to left lower extremity. Resident has had 7 lbs. weight gain in past month. Lungs with diminished bases. No dyspnea noted. Oxygen saturation 94% on room air. The Individual Care Plan, undated, revealed interventions directing staff the resident was to be weighed weekly or as specified by physician and to monitor weight as ordered and report 3-4 pound weight gain in 1 week. The Weight Summary dated 7/26/22 revealed the resident's weights from 8/1/21 to 7/25/22. The resident's weight was documented 2 times in 5/22 and 7/22, the remaining weights were taken monthly. The Medication Review Report dated 6/29/22 signed by a physician lacked orders for frequency of weight measurements. In an interview on 7/28/22 at 9:21AM, the Director of Nursing (DON) reported she would expect a resident's weight be obtained as directed by their care plan.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688	F 688 Resident #3, #34, and resident # 7 restorative programs reviewed and remain appropriate by 9/9/22 by DON.	

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F 688	Continued From page 22 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview, the facility failed to provide restorative therapy for 3 of 14 residents reviewed (Resident #3, #7, and #34). The facility reported a census of 55 residents. Findings include: 1. The Minimum Data Set (MDS) dated 7/14/22 revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12 which indicated mildly impaired cognition. The MDS revealed the resident needed the extensive assistance of 2 persons with bed mobility, transfers, and toileting. The Medication Review Report dated 6/29/22 signed by a physician revealed the resident's diagnoses of osteoarthritis of left shoulder, lumbago with bilateral sciatica, spinal stenosis, muscle weakness, difficulty in walking, acquired deformity of musculoskeletal system, bilateral osteoarthritis of hip, knee pain, and low back pain.	F 688	F 688 continue, All residents currently with restorative programs are affected by this practice and those individual programs were reviewed and remain appropriate, this will be completed by 9/9/22 by DON Nursing staff including restorative aide will be retrained on restorative program by 9/9/22 by DON. The DON/designee will complete audits weekly for 8 weeks, then monthly for 4 months, then quarterly till next annual survey. The audit will include residents with current restorative programs during the audit period. The results of the audit will be reported to the monthly QAPI meeting.	

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F 688	Continued From page 23 In an interview on 7/25/22 at 1:58 PM, the resident reported her left hand was contracted and that she would like exercises at least 2 times per week but that she doesn't get exercises some weeks. The Physical Therapy/Occupational Therapy-Restorative Program Orders signed by an Occupational Therapist dated 4/1/20 reveal a restorative therapy program to be performed 3 days per week. The Exercise Documentation Record for the months of April 2022 to 7/25/22 revealed the resident received restorative therapy 9 times. The Progress Notes revealed the following: a. On 5/8/2022 at 8:53 AM, resident reporting new pain to left shoulder. Resident unable to perform ROM without assistance to left shoulder. Unknown cause/source of pain to left shoulder. POA requested resident be sent to emergency department for evaluation of area. b. On 5/8/22 at 3:09 PM, the resident returned to facility. c. On 6/27/2022 at 2:59 PM, communication received from therapy for resident transition to restorative for upper body stretching, left side without increase in pain. In an interview on 7/27/22 at 8:04 AM, Staff F, Certified Nurse Assistant (CNA), reported that every resident in restorative therapy should have sessions at a minimum of 2 times per week, but she is unable to provide restorative therapy to residents as recommended by physical or occupational therapy because she is needed to assist on the floor due to staffing problems. In	F 688		

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F 688	Continued From page 24 the same interview, she reported she talked to the previous administrator about how residents were not getting the restorative therapy they were supposed to and a CNA was assigned to assist her, but the CNA was assigned to work the floor after 3 shifts as a restorative aide. In an interview on 7/28/22 at 9:21 AM, the Director of Nursing (DON) reported she would expect restorative therapy to be provided to residents at the frequency recommended by physical or occupational therapy. 2. The MDS dated 6/16/22 for Resident #34 revealed a BIMS score of 15 indicating intact cognition. The MDS revealed the resident's diagnoses of paraplegia, muscle spasms in the back, pain, depression, and ankylosing spondylitis of the spine. The MDS revealed the resident required the extensive assistance of 2 with transfers, bed mobility, and toileting. In an interview on 7/26/22 at 10:34 AM, the resident reported he was supposed to have restorative therapy 3 times per week but the restorative aide is too busy to provide session because she works on the floor and has over 40 residents to provide restorative therapy for. In the same interview, the resident reported he would like to have the 3 sessions per week he was supposed to have. The Care Detail Report revealed the following: a. Intervention with a start date of 8/15/19 if physical therapy and/or occupational therapy initiate a therapy program, restorative aide to follow plan as they instruct, see restorative aide flowsheet. b. Intervention dated 9/11/19 to give positive	F 688		

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F 688	Continued From page 25 reinforcement and don't rush the resident, he may give multiple excuses why he can't do exercises, state let's give it a try. The Exercise Documentation Record for the months of April 2022 to 7/25/22 reveal the resident received restorative therapy 13 times and refused 2 sessions. 3) According to the MDS assessment dated 4/28/22 Resident #7 scored 00 on the BIMS indicating severe cognitive impairment. The resident depended on staff for activities of daily living, and had limitations of functional range of motion (ROM) in all extremities. The MDS indicated the resident had no ROM in the 7 day look back period. The resident's diagnoses included anoxic brain damage. During an observation on 7/26/22 at 2:40 p.m. the resident laid in bed sleeping, hands contractured, head laying toward the right side. During an observation on 7/27/22 at 8:50 a.m. the resident sat in the wheelchair (w/c) in the dining room, leaning to the right. The w/c had supports in place. The Exercise Documentation Record for April 2022 showed the resident to have passive range of motion (PROM) to her upper extremities slow stretch, and gentle neck stretch 3-5 days a week. The record showed the resident had the exercise only 3 times the entire month. The Exercise Documentation Record for May 2022 showed the resident to have PROM to her upper extremities slow stretch, and gentle neck stretch 3-5 days a week, low gentle stretch. The	F 688		

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F 688	Continued From page 26 record showed the resident had only the exercises 3 times the entire month. The Exercise Documentation Record for June 2022 showed the resident to have PROM to her upper extremities slow stretch, and gentle neck stretch 3-5 days a week, and added 5/23/22 lower extremely slow stretch. The record showed the resident had had the exercises only 3 times the entire month. The Exercise Documentation Record for July 2022 showed the resident to have PROM to her upper extremities slow stretch, and gentle neck stretch 3-5 days a week, and added 5/23/22 lower extremity slow stretch. The record showed the resident had the exercises only 1 times so far in the month. On 7/28/22 at 8:57 a.m. the RA stated the reason the resident did not get restorative at least 3 times a week and had only 1 time in July stemmed from her getting called to the floor, and she could not do restorative.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 689	F 689 Resident 104 expired on 1/6/22 at 0215. Those residents with alarms reviewed to ensure the alarms and care plans are correct and alarms are operational at all times, this reviewed occurred on 8/25/22 by Director of Nursing.	

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F 689	Continued From page 27 interview, the facility failed to assure a resident had the identified interventions in place to prevent a fall with a major injury for 1 of 6 residents reviewed (Resident #104). Resident #104 had an intervention for a bed alarm to alert staff to his getting up. On 12/31/21 the resident sustained a fall in his room with no alarm. The resident sustained a head injury requiring sutures and C1 (neck) fracture. The facility reported a census of 55 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 11/18/21 Resident #104 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance with bed mobility, transfers, walking in the room, dressing, toilet use and personal hygiene. The resident required limited assistance with walking in the hallway The resident's diagnoses included non-traumatic brain dysfunction, dementia with lewy bodies, and a stroke. The resident had 2 falls without injury, and 2 falls with non-major injury since the prior assessment. The Care Pan identified the resident a high risk for injury and potential falls due to impaired balance, weakness, and need for assistance with mobility. Interventions included: A bed alarm would be used to alert staff to his getting up, initiated 12/8/21. A Tracking Record for Improved Patient Safety (TRIPS) form documented the resident fell on 11/21/22 at 7 p.m. The resident self transferred and walked with his walker. The root cause identified the resident stated he lost his balance.	F 689	F 689 continue, Nursing staff retrained on ensuring residents environment remains as free of accident hazards as is possible, adequate supervision and assistance devices to prevent accidents. This training provided by Director of Nursing on 8/25/22. This training included implementation of point of care documentation by certified nursing assistants every 2 hours on placement and functioning of alarms. In addition, professional nursing staff trained on new fall policy and process in addition will document functioning and placement of alarms every shift. The Director of Nursing/designee will complete audits weekly for 8 weeks, then monthly for 4 months, and quarterly thereafter until next annual survey. The audit will include monitoring of to ensure environment remains as free of accident hazards as is possible and utilization of assistance devices to prevent accidents. This audit will also include placement and functioning of alarms during this audit period. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: August 25, 2022	

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F 689	Continued From page 28 The immediate intervention was close monitoring. A TRIPS form documented the resident fell on 12/7/21 at 9 p.m. The root cause of the fall identified as decreased mental, cognitive and neuromuscular systems. The immediate intervention was a bed alarm. A TRIPS form documented the resident fell on 12/28/21 at 2:34 p.m. The resident fell trying to sit back on a chair. The immediate interventions included reminding the resident to check before sitting, and monitoring the resident closely in and out of his room. A TRIPS form by Staff J Licensed Practical Nurse (LPN) documented the resident fell on 12/31/21 at 10:55 p.m. The resident was alone and unattended. The alarm was not attached to the bed. The root cause of the fall was the alarm was not plugged in, in order for the resident to get help. The Progress Notes dated 1/1/22 at 12:02 a.m. documented the resident had an unwitnessed fall at 10:55 p.m. in his room. The nurse aide heard a sound and found the resident on his right side next to his bed bleeding from his head. He evaluated the resident, and called the wife at 11 p.m. and asked for permission to send him to the emergency (ER) to be evaluated and treated. The hospital called at 11:02 p.m. to get a telephone order to send the resident. At 11:08 p.m. 911 called and they had to try to find an ambulance since all around us were dispatched out with other calls. At 11:35 a.m. dispatch called back and said another ambulance would transfer the resident. At 11:55 p.m. the ambulance came and transported him onto the gurney, leaving the	F 689		

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F 689	Continued From page 29 facility at 12 a.m.. The resident was alert after the fall and only complained of his head hurting in the general area where his head bled from. They cleaned the resident up with sodium chloride (NaCl), and gauze placed on his head with pressure to help with the bleeding. His wife would be at the hospital waiting for his arrival. A hospital Emergency Department note dated 1/1/22 documented the resident had a laceration of the head and a C1 cervical fracture. The history of present illness documented a resident with dementia in the memory care unit apparently sustained a fall earlier in the night and had a laceration on the right eyebrow. The resident had some neck pain, and also pain in the pelvis. He had a stellate (tear in the skin caused by blunt trauma) laceration above the right eyebrow, and hematoma or swelling around that area, approximate 5 or 6 cm total length. Basically a gouged into the center of the stellate laceration and it kind of stretched the tissue due to frailty and old age. It had continuous oozing without a pressure dressing. The laceration measured 5 cm to 2 cm. The resident had a very irregular wound. The resident had Computed Tamography (CT) of the cervical spine without contrast. The findings included fractures of both the anterior and posterior arches of C1. The anterior arch fracture was distracted (widened) by about 11 mm. The Progress Notes dated 1/1/22 9:48 a.m. documented the Resident returned via ambulance at 9:05 a.m. the ER Dr. consulted with a neuro-surgeon. The resident with C1 fracture and felt not a candidate for surgery. He received a soft collar to wear. Per the Dr. notes they were to do the best they could to keep the collar on but	F 689		

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F 689	Continued From page 30 understood it may be difficult to do. The resident had multiple sutures on top of his forehead. They were to leave the pressure bandage on for 48 hours then apply an ointment. Sutures should be removed in 10-14 days at follow-up appointment. The resident also needed a neck x-ray to assess the break. Both orbital areas were very bruised and swollen. The were told if he became too anxious they were to call the ER for orders of a calming type medication. Also, if presented to be in excessive pain they could call. On 7/26/22 at 1:20 p.m. the resident's spouse stated she kept a diary of events. She said the night he fell they called her and she went to the hospital, getting there before he did. She could not understand why they didn't answer the alarm before he fell, they never explained that to her. She said he had a broken neck and had stitches on top of his head. She could not understand how that happened. He went back to the facility at 9:30 a.m. the next morning. On 7/26/22 at 3:02 p.m. Staff K Certified Nursing Assistant (CNA) worked 2-10 p.m. the night he fell. She didn't remember putting him to bed. He was supposed to have a bed alarm on. She gave report at 10 p.m. and didn't remember checking the alarm. She assumed it was on. On 7/27/22 at 9:51 a.m. Staff R CNA worked the night the resident fell and went to the hospital. He didn't recall report that night. He said he was sitting when he heard a bang and then found the resident on the floor and bleeding from the head. On 7/27/22 at 12:30 p.m. Staff O Registered Nurse (RN) stated she was the former Director of Nursing (DON) and was in that position when the	F 689		

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F 689	Continued From page 31 resident fell and sustained the injuries 12/31/21. She said apparently the resident did not have the alarm on at the time. Action was taken immediately to correct the problem. During an observation on 7/28/22 at 11:35 a.m. the current DON and Office Manager (OM) demonstrated the bed alarm. The office manager sat up and stood. The alarm sounded as soon as she stood up off of it. The DON stated if the alarm were on the night he fell, it should have sounded alerting staff to check on him. On 7/28/22 at 3:19 p.m. Staff L RN stated she worked the night the resident fell and had a fracture. She said he did not have the alarm on.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690	F 690 Identified staff identified as Staff G and H taking care of resident #19 retrained on peri care prior to 9/9/22 by DON/Education Nurse. All residents can be impacted by this practice however there were no negative outcome associated with the review completed by Director of Nurses. All direct staff working at Community Memorial Health Center retrained on peri care prior to 9/9/22 by DON/Education Nurse.	

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F 690	Continued From page 32 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to provide incontinent care in a manner to prevent infection for 1 resident reviewed for urinary tract infection (UTI) (Resident #19). The facility reported a census of 55 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 5/19/22 Resident #19 scored 5 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident depended on staff for transfers, dressing, and toilet use. The resident demonstrated incontinence of bowel and bladder, and diagnoses included diabetes and dementia. The current Care Plan dated 3/4/22 identified the resident had incontinence of bowel and bladder due to immobility with a goal to remain free of UTI's. The interventions included assisting with	F 690	F 690 continue, The DON/designee will complete audits weekly for 8 weeks, the monthly for 4 months then quarterly thereafter until next annual survey. The audit will involve residents with bowel and bladder incontinence requiring staff assistance with peri care. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: September 4, 2022	

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F 690	Continued From page 33	F 690		

brief changes every 2-3 hours and as needed to keep him as clean and dry as possible, providing good pericares with brief changes and applying moisture barrier, and monitoring him for signs and symptoms of UTI: dysuria (discomfort with urination), hematuria (blood in the urine), odorous/concentrated urine, fever, increased frequency, change in cognition, and report if present.

The Progress Notes dated 5/30/22 at 2 p.m. documented the resident transferred to the emergency room for evaluation of a change in condition. At 6 p.m. the resident returned and found to have a UTI.

On 7/25/22 at 1:40 p.m. Staff G Registered Nurse (RN) and Staff H Certified Nursing Assistant (CNA), did hand hygiene and gowned. Staff prepared to transfer the resident with a total mechanical lift. Staff lifted the resident from the recliner and transferred him to the bed. Staff pulled the residents pants down to reveal that he had feces that covered the front of his genital area and lower abdomen and also down on his thighs. Staff started to clean him up, Staff G doing the wiping and Staff H assisting. While rolling to remove his pants Staff H's gloves got contaminated with feces and she changed them with no hand hygiene. Staff G removed a roll from the residents lower abdomen that was covered in feces. She started using disposable wipes to wipe off the feces. She would wipe and then place the feces covered wipe down in between the residents legs underneath the genital area, leaving a build up of wipes with feces on them in that area. She wiped multiple times with some of the wipes to remove the feces. Staff G did not clean the penis underneath and did not clean the

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F 690	Continued From page 34 urinary meatus. During the cleansing she often had BM on the (right) glove and continued to wipe with that, and at one point changed one glove covered with feces, and then put a new glove on with the other hand that removed the contaminated glove, and did no hand hygiene. Staff G tried removing the pile of wipes with feces on them from between the resident's legs and some of them were caught in between his legs. They rolled the resident over and pulled the rest of the wipes through the back which smeared feces over the thighs. Staff G wiped the back area of the thighs, buttocks and anal area with the disposable wipes. When she thought it was clean in the back she changed gloves with no hand hygiene, and they turned him back to the front and she again used wipes down the groins. Staff G wiped over the penis and over the scrotum, but did not clean underneath the penis or clean the urinary meatus. When she stopped wiping, she assisted in securing the new incontinent pad without changing gloves. She then removed her gloves and did hand hygiene. On 7/28/22 at 3:11 p.m. the Director of Nursing (DON) stated she expected staff to clean areas thoroughly and perform hand hygiene between glove changes. The facility policy Incontinent Care reviewed 12/13/12 included incontinent care for male residents included: a. Washing hands. b Gloving. c. Removing soiled pads, clothing, linen. d. Remove gloves if feces present, e. Sanitize hands and apply gloves. f. If uncircumcised, gently pull the foreskin back, use a clean disposable wipe for each	F 690		

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F 690	Continued From page 35 washing stroke. g. Wipe circular around meatus (opening of the urethra). h. Wipe circular around the shaft of the penis. i. Replace foreskin. j. Wipe around scrotum. k. Wipe any surface exposed. l. If indicated remove gloves, sanitize hands to apply protective barrier. m. Turn resident to clean rectal area front to back. n. Cleanse half buttock then other half, being sure to clean all surfaces exposed to urine/feces. o. Remove gloves and sanitize hands. p. Apply incontinent pad and clothing. The Center for Disease Control (CDC's) Hand Hygiene in Healthcare Settings included doing hand hygiene Immediately before touching a patient, after touching a patient or the patient's immediate environment, and immediately after glove removal. Change gloves and perform hand hygiene during patient care, if gloves become damaged, and if gloves become visibly soiled with blood or body fluids following a task.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695	F 695 Resident #45 oxygen tubing labeled on 7/29/22 and documented on TAR All residents currently actively using oxygen reviewed and appropriate labels placed on the tubing by 9/9/22 by Director of Nurses. All professional nursing staff retrained on appropriate labeling of oxygen prior to 9/9/22.	

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F 695	Continued From page 36 by: Based on observations, record review, staff interviews and policy reviews, the facility failed to change and label oxygen tubing for 1 of 1 residents reviewed (Resident # 45). The facility reported a census of 25. Findings include: The Minimum Data Set (MDS) assessment dated 5/5/21 for Resident # 45 documented diagnoses of coronary artery disease, anxiety disorder and occlusion and stenosis of both carotid arteries. The MDS showed the Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was not capable of completing the interview. Observation on 7/25/22 at 8:31 a.m., revealed Resident #45's oxygen concentrator tubing was not labeled. Observation on 7/26/22 at 9:32 a.m., revealed Resident #45's oxygen concentrator tubing was not labeled. Observation on 7/27/22 at 11:09 a.m., revealed Resident #45's oxygen concentrator tubing was not labeled. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) on 7/27/22 at 2:37 p.m., revealed no order for oxygen or orders for changing oxygen tubing. Review of the Medication Review Report dated 6/29/22 signed by the physician lacking a date revealed the following orders: a. Monitor oxygen saturation. May use oxygen if sats below 90% as needed with an order date	F 695	F 695 continue, The DON/designee will complete audits weekly for 8 weeks, the monthly for 4 months, and quarterly thereafter until next annual survey. The audit will include any residents currently using routine oxygen and those only requiring prn during the audit period. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: September 4, 2022	

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F 695	Continued From page 37 and start date of 5/10/22. b. Oxygen per nasal cannula. Tirate up to 4 liters per minute to keep saturation above 90% with an order date and start date of 10/5/21. b. Oxygen 2 liters per minute per nasal cannula at bedtime with an order date and start date of 4/21/22. The revised Care Plan dated 6/8/22, lacked information regarding Resident #23's oxygen usage. Review of the facility policy titled procedure on care of oxygen concentrator dated 10/14 revealed nasal cannula and tubing are to be replaced weekly and as needed. Interview on 7/27/22 at 12:48 p.m., with the Director of Nursing revealed she would expect the oxygen tubing to be changed and labeled when changed.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758	F 758 Resident # 37 gradual dose reduction addressed on 7/27/22 by physician with clarification received. Residents receiving pharmacy recommendations for August reviewed by Director of Nurses and revealed no discrepancy on recommendations. Professional nursing staff retrained on Medication Regimen review completed monthly by 9/9/22.	

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F 758	Continued From page 38 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure antipsychotic medication changes were implemented after dose reduction order were given for 1 of 5 residents reviewed (Resident #37). The facility reported a census of	F 758	F 758 continue, The DON/designee will complete audits weekly for 8 weeks, the monthly for 4 months, and quarterly thereafter until next annual survey. The audit will include any resident that would receive a physician recommendation following the monthly medication regimen review during the audit period. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: September 4, 2022	

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F 758	Continued From page 39 55 residents. Findings include: The Minimum Data Set (MDS) assessment dated 6/23/22 for Resident #37 documented diagnoses of major depressive disorder, post traumatic stress disorder and non-Alzheimer's dementia. The MDS showed a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. Review of Gradual Dose Reduction (GDR) orders dated 5/9/22 revealed a recommendation from the pharmacy to please consider a trial reduction in Risperdal (antipsychotic medication) that read Risperdal 0.5 milligrams (mg) twice a day for 6 days per week and 0.25 mg by mouth twice a day one day per week (Wednesday). The physician responded on 5/10/22 with a check mark in the agree box and okay with above. Review of the May 2022 Medication Administration Record (MAR), June 2022 MAR and July 2022 MAR lacked a decrease in Risperdal. Interview on 7/26/22 at 3:05 p.m., with the Director of Nursing (DON) revealed the order looks to do the trial reduction. The DON would look to see if the reduction had been completed. Interview on 7/26/22 at 4:17 p.m., with the DON revealed she talked to another nurse regarding the clarification of what the physician had meant by his reply. The DON revealed the physician was responding to the note the nurse had written on the paper. If he wanted to do the reduction he would have rewritten the orders below. The DON	F 758		

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F 758	Continued From page 40 revealed the physician was coming to the facility on 7/27/22 and the DON would have him clarify the order. Review of the facility policy titled Drug Regimen Review undated revealed findings, recommendations and irregularities are reported to the director of nursing, the attending physician, the medical director and if appropriate the administrator. Recommendations are acted upon and documented by the facility staff and or the prescriber. The physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. Review of the facility policy titled Physician Orders Policy dated 12/19 revealed under resident summary and physician orders and progress notes, the physician will write orders pertinent to that visit on the resident summary, physician order and progress form. Nurse shall note and transcribe orders from the same form. Interview on 7/27/22 at 11:22 a.m., with the DON revealed the physician clarified the order and the physician wanted to trial the reduction in Risperdal. The physician rewrote the trial reduction orders as follows Risperdal 0.5 milligrams (mg) twice a day for 6 days per week and 0.25 mg by mouth twice a day one day per week (Wednesday) on the GDR sheet dated 7/27/22. The DON revealed she would expect the nursing staff to have clarified this order with the physician after receiving it.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812	F 812 It is the practice of Community Memorial Health Center to label all	

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F 812	Continued From page 41 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, and staff interview, the facility failed to date food when opened and perform hand hygiene when assisting residents to eat meals. The facility reported a census of 55 residents. Findings include: 1. Observation on 7/25/22 at 10:49 AM revealed 2 open bags of candy, 1 bag of opened meat patties, 1 bag of opened onion rings, and 1 bag opened french fries in the walk in freezer undated. Observation on 7/27/22 at 9:23 AM of the undated opened bags of food in the walk in freezer to include: 2 bags candy, 1 bag meat patties, 1 bag onion rings, 1 bag french fries.	F 812	F 812 continue, open containers and packages of food. Dietary staff received education beginning on 8/4/2022 regarding the updated policy pertaining to Dry/Cold Storage which includes guidelines/requirements associated with dating and proper storage of food. Dietary staff was in serviced and retrained 8/2/2022. Nursing staff was retrained on hand hygiene and meal assistance on 9/7/2022. The dietary staff /designee will complete audits starting weekly on 8/8/2002 for 8 weeks, then monthly for 4 months, and quarterly thereafter until next annual survey. The results of the audit will be reported to the monthly QAPI meeting to ensure compliance. Completion Date: September 4, 2022	

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F 812	Continued From page 42 The Dry/Cold Storage policy with a revision date of 08/21 revealed that all items that are opened and put back into the coolers are to be marked with the date opened. In an interview on 7/27/22 at 1:13 PM, the Certified Dietary Manager (CDM) reported that staff are usually good about writing dates foods are opened on the package, that sometimes the date rubs off when bags are repeatedly handled. 2. Observation on 7/25/22 at 12:46 PM revealed Staff E, Certified Nurse Assistant (CNA), assist Resident #54 with eating her noon meal. Staff E then assisted Resident #8 to eat her noon meal without performing hand hygiene first. Observation on 7/27/22 at 12:19 PM revealed Staff D, CNA, assist Resident #8 to eat her noon meal. Staff D then assisted Resident #7 to eat her noon meal without performing hand hygiene first. In an interview on 7/28/22 at 9:21 AM, the Director of Nursing (DON) reported that she would expect staff to perform hand hygiene in between assisting residents to eat meals.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:	F 867	F 867 QAPI Policy was distributed and reviewed at Quality Assurance Meeting on August 16, 2022.	

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F 867	Continued From page 43 Based on review of quality assurance and performance improvement (QAPI) sign in sheets, and staff interview, the facility failed to have the required members present 2 of 4 quarterly meetings. The facility reported a census of 55 residents. Findings include: The facility policy Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership documented individuals serving on the committee included the medical director. The committee met at least quarterly (or more often as necessary). The sign in sheets for 1/6/22 and 4/12/22 lacked participation of the medical director. On 7/28/22 at 3:23 p.m. the Administrator stated they had no more information.	F 867		
F 880 SS=E	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:	F 880	F 880 Identified staff C, G and H taking care of resident # 19 and resident #3 retrained on infection control with regards to dressing changes and peri care prior to 9/9/22 by DON/Education Nurse. All resident can be impacted by this practice, however there were no negative outcome associated with the review completed by Director of Nurses.	

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F 880	Continued From page 44 §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 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	F 880	F880 continue, Both certified nursing assistants and nurse working at Community Memorial Health Center retrained on peri care and aseptic dressing change and infection control practices prior to 9/9/22 by DON/Education Nurse. The DON/designee will complete audits weekly for 8 weeks, then monthly for 4 months then quarterly thereafter until next annual survey. The audit will involve residents with bowel and bladder incontinence and residents requiring dressing changes during the audit period. The results of audit will be reported to the monthly QAPI meeting to ensure compliance. Compliance Date: September 4, 2022	

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F 880	Continued From page 45 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and 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, record review, and staff interview, the facility failed to provide care to prevent infection during perineal care and wound care to 2 of 2 residents reviewed (Residents #3 and #19). The facility reported a census of 55 residents. Findings include: 1. The Minimum Data Set (MDS) dated 7/14/22 revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12 which indicated mildly impaired cognition. The MDS revealed the resident had diagnoses of peripheral vascular disease (reduced blood flow to legs), peripheral venous insufficiency (circulation issue causing blood to pool in legs), edema, peripheral neuropathy (damaged nerves cause numbness in feet), and 1 venous and arterial ulcer (wound) was present. Observation on 7/27/22 at 9:53 AM revealed Staff C, Licensed Practical Nurse (LPN), removed soiled dressing. Without removing gloves and performing hand hygiene, Staff A then cleansed the wound and applied a new dressing.	F 880		

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F 880	Continued From page 46 The Medication Review Reports dated 6/29/22 signed by a physician revealed the resident had a blister to the top of her left foot that was draining with orders to apply a daily dressing change. The Dressing - Aseptic Technique policy with an updated date of 11/19 directed staff to remove soiled dressing with gloved hands and discard in appropriate plastic bag, perform hand hygiene, apply gloves, and cleanse area with physician prescribed cleanser. In an interview on 7/28/22 at 9:21 AM, the Director of Nursing (DON) reported that she would expect gloves to be changed and hand hygiene performed when moving from soiled steps of a procedure to a clean step. According to the MDS assessment dated 5/19/22, Resident #19 scored 5 on the BIMS indicating severe cognitive impairment. The resident depended on staff for transfers, dressing, and toilet use. The resident had incontinence of bowel and bladder, and diagnoses included diabetes and dementia. The current Care Plan dated 3/4/22 identified the resident had incontinence of bowel and bladder due to immobility with a goal to remain free of urinary tract infections (UTI's). The interventions included assisting with brief changes every 2-3 hours and as needed to keep him as clean and dry as possible, providing good pericares with brief changes and applying moisture barrier, and monitoring him for signs and symptoms of UTI: dysuria, hematuria, odorous/concentrated urine, fever, increased frequency, change in cognition, and report if present.	F 880		

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F 880	Continued From page 47 On 7/25/22 at 1:40 p.m. Staff G Registered Nurse (RN) and Staff H Certified Nursing Assistant (CNA), did hand hygiene and gowned. Staff pulled the residents pants down to reveal that he had feces that covered the front of his genital area and lower abdomen and also down on his thighs. Staff started to clean him up, Staff G doing the wiping and Staff H assisting. While rolling to remove his pants Staff H gloves got contaminated with feces and she changed them with no hand hygiene. Staff G removed a roll from the residents lower abdomen that was covered in feces. She started using disposable wipes to wipe off the feces. She would wipe and then place the feces covered wipe down in between the residents legs underneath the genital area, leaving a build up of wipes with feces on them in that area. She wiped multiple times with some of the wipes to remove the feces. she did not clean the penis underneath and did not clean the urinary meatus. During the cleansing she often had BM on the (right) glove and continued to wipe with that, and at one point changed one glove covered with feces, and then put a new glove on with the other hand that removed the contaminated glove, and did no hand hygiene. Staff G tried removing the pile of wipes with feces on them from between the resident's legs and some of them were caught in between his legs. They rolled the resident over and pulled the rest of the wipes through the back which smeared feces over the thighs. Staff G wiped the back area of the thighs, buttocks and anal area with the disposable wipes. When she thought it was clean in the back she changed gloves with no hand hygiene, and they turned him back to the front and she again used wipes down the groins. Staff G wiped over the penis and over the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165177	A. BUILDING _____ B. WING _____	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	231 NORTH EIGHTH AVENUE WEST HARTLEY, IA 51346

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 48 scrotum, but did not clean underneath the penis or clean the urinary meatus. When she stopped wiping, she assisted in securing the new incontinent pad without changing gloves. She then removed her gloves and did hand hygiene. On 7/28/22 at 3:11 p.m. the Director of Nursing (DON) stated she expected staff to clean areas thoroughly and perform hand hygiene between glove changes. The Center for Disease Control (CDC's) Hand Hygiene in Healthcare Settings included doing hand hygiene Immediately before touching a patient, after touching a patient or the patient's immediate environment, and immediately after glove removal. Change gloves and perform hand hygiene during patient care, if gloves become damaged, and if gloves became visibly soiled with blood or body fluids following a task.	F 880		