

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER WESTWOOD HILLS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1016 FLETCHER ST WILKESBORO, NC 28697	
(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 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility failed to provide toileting as requested by a resident for 1 of 3 residents who requested assistance with toileting. (Resident #181).</p> <p>The findings included:</p> <p>Resident #181 was re-admitted to the facility on 01/18/13 with diagnoses which included kidney failure, a history of urinary tract infections (UTIs) and urinary retention.</p> <p>A review of a hospital discharge summary dated 01/18/13 indicated Resident #181 had a urinary tract infection (UTI) with sepsis (the presence of bacteria and infection that spreads throughout the body). The summary further indicated Resident #181 had recurrent UTIs and was sent to the hospital with fever, low blood pressure, decreased level of consciousness and had been sick for more than 2 months.</p> <p>The most recent re-admission/significant change Minimum Data Set (MDS) dated 01/25/13</p>	F 246	<p>Westwood Hills Nursing and Rehabilitation Center (WWHNRC) acknowledges receipt of the Statement of Deficiencies (SoD) and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>WWHNRC's response to this Statement of Deficiencies (SoD) does not denote agreement with the SoD nor does it constitute an admission that any deficiency is accurate. Further, WWHNRC reserves the right to refute any of the deficiencies on this SoD through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>Nursing Assistants provided toileting assistance to Resident #181 on 02/28/13 at approximately 9:50 AM. She is currently receiving incontinence care timely as requested.</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The Quarterly Executive QI Committee will review audits to determine the continued need for frequency of monitoring. Any recommended changes in the plan will be discussed and carried out as agreed upon at that time.</p>	3/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jamie B. Jones

Administrator

5-15-13

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.

Original signature date: 3-22-13



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F 246	<p>Continued From page 1</p> <p>indicated Resident #181 had no problems with short term and long term memory and the resident was cognitively intact. The MDS further indicated Resident #181 was totally dependent on staff for transfers and required extensive assistance with toileting and hygiene and was incontinent with bladder and bowel.</p> <p>During an observation on 02/28/13 at 8:45 AM Resident #181 was heard crying loudly from her room out into the hallway. Nurse #4 entered the resident's room and Resident #181 told Nurse #4 she needed to urinate now because it hurt and she was burning and in pain. Nurse #4 told the resident the Nurse Aides (NAs) were busy but they would be there shortly and Nurse #4 walked out of the room to a medication cart in the hallway.</p> <p>During an interview on 02/28/13 at 8:46 AM with Resident #181 she stated she was in pain and was waiting on staff to help her because she needed to urinate. She further stated she had a yeast infection and thought she might have a UTI and if she wet herself the urine burned her skin.</p> <p>During an interview on 02/28/13 at 8:48 AM Nurse #4 stated she was aware Resident #181 needed to urinate and the NAs were aware. She further stated NAs were busy assisting other residents and they would assist Resident #181 shortly.</p> <p>During continuous observations on 02/28/13 from 8:48 AM until 9:25 AM Resident #181 continued to call out "nurse, please help me with the bathroom."</p>	F 246		

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F 246	<p>Continued From page 2</p> <p>During an observation on 02/28/13 at 9:25 AM Resident #181's call light was flashing above her door in the hallway and Nurse Aide (NA) #3 entered the room. Resident #181 stated she needed to go to the bathroom and wanted to get dressed. NA #3 removed clean clothing from Resident #181's closet and stated it would be about 25 minutes until her coworker could help her because she was busy helping another resident and NA #3 walked out of the room.</p> <p>During an observation on 02/28/13 at 9:39 AM the call light was flashing over the top of Resident #181's door in the hallway. Resident #181 was also calling out "nurse" then "hello."</p> <p>During an observation on 02/28/13 at 9:41 AM Resident #181 was crying and calling out "nurse, please hurry, somebody come here."</p> <p>During an observation on 02/28/13 at 9:42 AM Nurse #4 entered the room and Resident #181 stated she needed to urinate. Nurse #4 stated she would let the NAs know and they would be there in a few minutes. Resident #181 stated "in a few minutes I'll wet on myself" and Nurse #4 walked out of the room.</p> <p>During an observation on 02/28/13 at 9:46 AM NA #3 and NA #4 entered Resident #181's room. Resident #181 stated she needed to urinate and wanted privacy. Both NAs pulled the curtain around Resident #181's bed and stepped outside the curtain. Resident #181 stated she was finished and NA #3 and NA #4 walked back inside the curtain and removed Resident #181's brief which was wet with urine and provided incontinence care for her.</p>	F 246			

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F 246	<p>Continued From page 3</p> <p>During an interview on 02/28/13 at 10:22 AM with NA #3 she stated it always took 2 staff members to turn and provide incontinence care to Resident #181. She explained she could not assist Resident #181 when she first went into her room because she was busy providing care to other residents and could not assist Resident #181 until she had a co-worker available to help her. She stated Resident #181 was not able to stand and walk to the bathroom. She further stated she did not think Resident #181 would use a bedpan and she wore a brief all of the time and when she wet her brief they cleaned and changed her.</p> <p>During an interview on 02/28/13 at 2:46 PM Resident #181 stated her urine was really strong and it burned her skin. She stated she was calling for assistance this morning because she did not want to wet herself but she couldn't wait any longer. She verified her brief was wet when the NAs changed her and her skin was burning. Resident #181 explained she could use a bedpan if she needed to urinate but she usually wet her brief and the NAs changed her. She stated she had told nursing staff that her urine burned her skin and she had a yeast infection. She further stated she understood the NAs had to help other residents but she wanted them to come as soon as they could when she called them because she wanted them to get the urine off her skin so it would stop burning.</p> <p>During an interview on 03/01/13 at 11:24 AM the Director of Nursing (DON) stated it was her expectation for the NAs to keep Resident #181 clean and dry and assist her promptly with toileting. She explained she had talked with the</p>	F 246			

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F 246	Continued From page 4 NAs in the past and told them they should not make the resident wait for care but they should stop what they were doing, help each other to clean and change the resident and then they could go back to their previous tasks after they finished her care.	F 246			
F 279 SS=B	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan for congestive heart failure for 1 of 3 residents (Resident #85) reviewed for hospitalizations and a care plan for vision for 1 of 3 residents (Resident #41)	F 279	Resident #85's MDS, CAA's, CAT's and Care Plan were reviewed by the MDS Coordinator. Resident #85's Care Plan was updated to include potential for ineffective breathing pattern related to history of bronchitis and CHF. Resident #41's MDS, CAA's, and CAT's for vision were reviewed by the MDS coordinator. The Care Plan was updated to include visual impairments. All Care Plans will be developed per the RAI Manual and as discussed in training sessions during their next quarterly assessment. The Interdisciplinary Care Team members including MDS coordinators were re-educated by the corporate Nurse Consultant on Care Area Assessments, Care Area Triggers and decisions to proceed to Care Planning. This was done on 3/25/2013. The corporate Nurse Consultant will review 5 comprehensive assessments and care plans for triggered Care Assessment Areas weekly x 4 weeks for continued accuracy. Retraining will occur as needed for corrections.	3/26/13	

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F 279	<p>Continued From page 5 reviewed with impaired vision.</p> <p>The findings included:</p> <p>1. Resident #85 was admitted to the facility on 01/08/13. Review of Resident #85's medical record revealed he was admitted to the facility with the diagnosis of bronchitis, atrial fibrillation, chronic pain, and congestive heart failure.</p> <p>Further review of resident #85's medical record revealed he was discharged to the hospital on 01/21/13. Review of Resident #85's hospital discharge summary dated 01/24/13 revealed he was admitted to the emergency department with increasing shortness of breath. Further review of Resident #85's discharge summary read in part, "MD residing over the nursing facility should be notified immediately should the patient experience any worsening shortness of breath, associated chest pain, fevers, etc. He should have daily weights done and should weight be greater than 2 pounds in a day or greater than 5 pounds in a week, this weight change to be called to the physician resident over the nursing facility. He should be on a 1500 ml fluid restriction and 2 grams sodium diet." Resident #85 was discharged from the hospital and readmitted to the facility 01/24/13.</p> <p>Review of Resident #85's Minimum Data Set (MDS) Discharge Assessment dated 02/22/13 revealed return to the facility was anticipated. The MDS also noted he was cognitively intact and included the diagnosis of congestive heart failure.</p> <p>Further review of Resident #85's medical record</p>	F 279	<p>The Weekly QI Committee will review the audit results and recommend any changes in the plans as needed.</p> <p>The Quarterly Executive QI Committee will review audits to determine the continued need for frequency of monitoring. Any recommended changes in the plan will be discussed and carried out as agreed upon at that time.</p>	
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F 279	<p>Continued From page 6</p> <p>revealed he was again discharged from the facility to the hospital on 02/22/13. Review of the hospital discharge summary dated 02/25/13 revealed Resident #85 was admitted with bilateral pneumonia and sepsis. The hospital discharge summary read in part, "Chest X-ray on admission showed tubes and lines as noted above with persistent left pleural effusion, cardiomegaly, and decreased pulmonary vasculature most consistent with a resolving versus compensated congestive heart failure."</p> <p>Review of Resident #85's care plan revealed there was no plan addressing congestive heart failure. Furthermore, there were no measurable goals or nursing interventions regarding congestive heart failure for Resident #85.</p> <p>An interview was conducted on 03/01/13 with Nurse #3 who was working with Resident #85 when he was discharged to the hospital on 02/22/13. She stated Resident #85 was discharged to the hospital due to shortness of breath and wheezing. She stated is oxygen saturation was in the 80's, and his pulse and respirations were increased.</p> <p>An interview was conducted on 03/01/13 at 4:25 PM with the Director of Nursing (DON). The DON stated the resident was discharged to the hospital on 01/21/13 and 02/22/13 for congestive heart failure. She further stated congestive heart failure should have been addressed on Resident #85's care plan.</p> <p>An interview was conducted on 03/01/13 at 4:44 PM with Nurse #2 who is in charge of MDS and care planning. Nurse #2 stated Resident #85 was</p>	F 279		
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F 279	<p>Continued From page 7</p> <p>discharged to the hospital twice for congestive heart failure. She stated congestive heart failure should have been addressed on the care plan when the resident was readmitted to the facility on 01/24/13.</p> <p>2. Resident # 41 was admitted to the facility on 06/21/12 with diagnoses which included total vision impairment in one eye.</p> <p>A review of a facility document titled "Resident Care Guide" with an admission date of 06/21/12 indicated Resident #41 was blind in his right eye.</p> <p>The most recent quarterly Minimum Data Set (MDS) dated 12/03/12 indicated Resident #41 had problems with short term and long term memory and was severely impaired with cognition for daily decision making. The MDS further revealed in Section B titled Vision that Resident #41 had moderately impaired vision (defined as not able to see newspaper headlines but able to identify objects) and had no corrective device.</p> <p>A review of a Care Area Assessment worksheet dated 08/18/12 indicated visual function triggered. A section titled functional limitations related to vision problems indicated Resident #41 had difficulty seeing television, reading material of interest, or participating in activities of interest because of vision problems. A section labeled Care Plan Considerations indicated will not proceed to care plans due to resident exhibited no acute problems at the present time.</p> <p>A review of care plans indicated there was no care plan related to vision.</p> <p>A review of Resident #41's medical record</p>	F 279			

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F 279	Continued From page 8 revealed he had not seen an eye doctor since his admission to the facility regarding his moderately impaired vision. During an interview on 03/01/13 at 4:09 PM with MDS Coordinator #1 she stated she routinely did not develop vision care plans for residents unless the resident was experiencing an acute eye condition, if the resident's eye condition was expected to improve or if the condition was affecting the resident's ability to perform Activities of Daily Living. She explained Resident #41 could not see letters at all but he could identify people's faces. She stated his vision had not declined since he had been in the facility but she did not think there was any expectation for his vision to improve. She also confirmed that a referral had not been made for an eye exam to determine if the resident's vision could be corrected for the eye he could see out of. During an interview on 03/01/13 at 5:10 PM the Director of Nursing (DON) was interviewed and stated she would expect a care plan to be developed to address a resident with moderately impaired vision. She further stated the care plan goal would be to maintain a resident's visual status.	F 279			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Resident #22 was reassessed by the facility physician and the wound physician on 3/5/13 to determine the need for further pain interventions. Resident # 20 received pain medication on	3/26/13	

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F 309	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, resident interviews, and physician assistant interview, the facility failed to plan and administer effective pain control medication for 2 of 4 residents reviewed for pressure sores and implement the facility's bowel regime for 1 of 10 residents reviewed for constipation. Resident #22's pain regimen was not clarified and planned to coordinate with therapy and pressure ulcer dressing changes. Resident #20 was not assessed for pain prior to a dressing change and staff failed to stop the procedure when pain occurred. Resident #94's constipation was not addressed per the facility's protocol.</p> <p>The findings included:</p> <p>1. Resident #22 was admitted to the facility on 05/25/12. His diagnoses included heart disease, a pressure ulcer on his right heel, muscle weakness, osteoarthritis, knee and hip replacements, diabetes, malignant neoplasm prostate, anemia, hypertension and reflux.</p> <p>Review of physician orders revealed the pain medication of Norco 5-325 mg was ordered 11/15/12 to be administered routinely every six hours for pain and scheduled at 6 AM, 12 noon, 6 PM and 12 midnight. In addition, Lyrica 50mg twice daily was ordered on 12/11/12 for neuropathic pain and scheduled at 8 AM and 4 PM.</p> <p>On 12/31/12 a telephone order was written for</p>	F 309	<p>2/28/13 at 1:00 PM. Resident #20 was reassessed by the facility physician and the wound physician on 3/5/13 to determine the need for further pain interventions.</p> <p>Residents receiving pressure ulcer dressing changes and/or pulse lavage debridement have the potential to be affected by the deficient practice. Residents receiving wound care and/or pulse lavage debridement received a pain scale assessment of any pain before and during treatments. Any pain issues were addressed by physician notification. These will be completed by 3/25/2013.</p> <p>The Corporate Wound Nurse educated nursing staff responsible for wound care and physical therapy staff responsible for pulse lavage debridement of wounds on proper wound care technique and pain assessment prior to and during the procedures. Resident's complaints of pain will be addressed immediately. Physical Therapy staff responsible for pulse lavage will complete a pain assessment and document on the weekly therapy progress notes. This training was completed on 3/25/2013. Weekly nursing wound progress notes will include assessments for pain.</p>		

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F 309	<p>Continued From page 10</p> <p>Lidocaine cream 3% to be applied to the right heel ulcer twice a day along with a wound consult with a wound care physician for the evaluation and treatment of the right heel ulcer. On 01/03/13 the Lidocaine gel was changed to once a day (to coincide with once a day dressing changes).</p> <p>The most recent Minimum Data Set, a significant change dated 02/01/13, coded Resident #22 with severely impaired cognition skills, requiring extensive assistance with most activities of daily living skills, receiving schedule pain medications, having no pain, and having an unstageable deep tissue injury measuring 1.8 cm x 1.7 cm x 0.7 cm. There was no trigger for a care area assessment for pain.</p> <p>A current care plan, initiated 06/06/12, addressed the potential for actual pain related to cancer of the left hand and heart disease. The goal was for no interruption in normal activities due to pain through next review (05/7/13). Interventions included: *acknowledge presence of pain and discomfort and listen to resident's concerns; *administer pain medication as per MD orders and note the effectiveness; *anticipate resident's need for pain relief and respond appropriately; *monitor for signs/symptoms of non-verbal pain such as changes in breathing, grunting, moans, yelling out, mood/behavior changes, sad expression, crying, clenched teeth, grimacing, tenseness, rigidity of body/limbs and report to nurse.</p> <p>Review of the medical record revealed Resident</p>	F 309	<p>The Director of Nursing or her designee will perform weekly random audits x 2 weeks on 3 residents receiving wound care to determine if their pain has been addressed before and during wound care. Random audits will then be performed every 2 weeks x 2 weeks on 3 residents receiving wound care x 2 weeks, then 3 residents on a monthly to ensure compliance on an ongoing basis. Any concerns will be addressed at the time of the audit which may include staff re-education. Weekly then monthly audits will be turned into the Administrator for review.</p> <p>The Weekly QI Committee will review the audit results and recommend any changes in the plans as needed.</p> <p>The Quarterly Executive QI Committee will review audits to determine the continued need for frequency of monitoring. Any recommended changes in the plan will be discussed and carried out as agreed upon at that time.</p> <p>Resident #94's bowel movement record was reviewed on 3/1/13 by the QI nurse and revealed the resident was currently having bowel movements.</p>	

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F 309	<p>Continued From page 11</p> <p>#22 had been being treated by a wound care physician with notes including: *On 02/08/13 the wound care physician's note stated the wound measured 2.0 cm x 2.0 cm with a depth of 0.7 cm. There was minimum granulation tissue and the wound extended down to the tendon and also on probing this to the bone. The area was anesthetized with 5% Lidocaine jelly, but the resident "still had a fair amount of pain." The treatment was changed from bactroban to santyl ointment to try to have some enzymatic debridement as the physician was "not really able to effectively debride this with the pain." The subsequent nursing note dated 02/08/13 stated the wound care physician applied Lidocaine for 30 minutes prior to the examination of the heel and trimmed the wound. The resident stated he could not stand that and that it hurt. A new order for santyl was given by the wound care physician. *On 02/12/13 the area was "very tender to any manipulation." The treatment of santyl was continued. Nursing notes dated 02/12/13 revealed the wound care physician removed some yellow slough from the heel wound and the resident verbalized pain when the wound was touched or cleaned. *On 02/19/13 Lidocaine jelly was applied and this left on for several minutes. Using forceps the wound was debrided and curetted. The resident "had a fair amount of discomfort" and "given the pain and discomfort, not able to entirely debride this." The area was noted to be improving slightly with the santyl and the pulse lavage provided by physical therapy.</p> <p>On 02/28/13 at 10:02 AM, Resident #22 was observed receiving pulse lavage therapy from the</p>	F 309	<p>All residents have the potential to be affected by the deficient practice. The QI nurse reviewed all resident's bowel movement patterns on 3/1/13 and residents triggered for no bowel movements in 3 days received follow-up by the staff nurse.</p> <p>The Staff Development Coordinator educated all nursing staff the importance of not clearing electronic alerts for residents who have not had a bowel movement in three days. Nursing staff was also educated it is the responsibility of the QI nurse to clear alerts and address bowel movement concerns. Review and initiation of the facility's bowel protocol was included. This was completed 3/6/2013 thru 3/15/2013.</p> <p>The QI nurse, RN Supervisors or designee will audit all residents on the no bowel movement alert list to ensure the bowel protocol has been implemented. Audits will be completed daily on-going as a part of the QAPI program.</p> <p>The QI nurse will also complete weekly audits on all residents on an ongoing basis to ensure staff is compliant with training regarding alerts and bowel protocol implementation. Any concerns will be address by the QI nurse with retraining as needed.</p> <p>The Weekly QI Committee will review the audit results and recommend any changes in the plans as needed.</p>	

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F 309	<p>Continued From page 12</p> <p>physical therapist aide (PTA). When the PTA removed his right sock, the resident groaned. The PTA proceed to provide the pulse lavage therapy which included using 15 liters per minute of oxygen from a tank and spraying the wound with normal saline and oxygen to help clean and debride the pressure ulcer on his right heel. During the procedure, Resident #22 flinched; stated this one was the sorest he had ever had; stated he had all he could stand; flinched some more; stated it was ok for hurting; and stated it hurt so bad he didn't want to move it. The PTA stated the wound was very sensitive and that most of the time he was able to tolerate the spray but that it was debrided recently and he had more trouble with sensitivity since the debridement. The wound was covered loosely in anticipation the wound nurse would dress it soon. This procedure took approximately 15 minutes.</p> <p>On 02/28/13 at 10:40 AM, the wound nurse #1 and Nurse #2 entered to provide the treatment and dressing to Resident #22's right heel ulcer. When the wound nurse washed the open wound with sterile water, Resident #22 called out "don't mash it" and "you don't know how bad that hurts, I feel like kicking the moon." Lidocaine gel was then applied to the wound via a Qtip and santyl was immediately applied to the wound with another Qtip. Skin prep was then applied around the wound and foam covered the wound and was affixed with tape. The resident grimaced and flinched during this procedure. He called out again when his sock was reapplied.</p> <p>On 03/01/13 at 8:42 AM an interview was conducted with the wound care nurse #1. Per the wound care nurse #1, Resident #22's heel wound</p>	F 309	<p>The Quarterly Executive QI Committee will review audits to determine the continued need for frequency of monitoring. Any recommended changes in the plan will be discussed and carried out as agreed upon at that time.</p>		

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F 309	<p>Continued From page 13</p> <p>had been very sensitive causing the physician to order arterial studies and X-rays to rule out osteomyelitis. She stated some days were worse than others related to the pain the resident felt during treatment. The depth of the wound made it more sensitive per the nurse. She reviewed the chart and stated he had some routine pain meds ordered.</p> <p>A follow up interview with the PTA on 03/01/13 at 11:04 AM revealed Resident #22's complaints of pain varied. She had been gone for the past 3 weeks and before she left the right heel was not quite as sensitive to the lavage treatment as he was on 02/28/13. PTA stated his sensitivity had increased since the debridement. She stated she discussed the pain with the wound care nurse "a while back" who ordered the Lidocaine gel. There was no discussion with the wound care nurse to administer the Lidocaine gel or other pain medications before the pulse lavage treatment.</p> <p>Interview with the Director of Nursing (DON) on 03/01/13 at 11:08 AM revealed she thought the Lidocaine should work immediately but that it should be administered prior to the pulse lavage treatment.</p> <p>On 03/01/13 at 11:15 AM the Nurse Practitioner (NP) who ordered the Lidocaine gel was interviewed. She stated that the pain regimen should be coordinated around the pulse lavage and dressing treatment. The NP further stated the Norco should be given 30 minutes before the pulse lavage treatment and the Lidocaine should be administered 15 - 30 minutes prior to the dressing change. She stated staff had informed</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>her that the pain was under control.</p> <p>A follow up interview with the wound care nurse #1 on 03/01/13 at 11:23 AM revealed she initiated the order for Lidocaine gel for Resident #22. She stated she never clarified the Lidocaine order to determine if there was any wait time for effectiveness. She further stated she had checked to make sure he had routine pain medications ordered but had not tried to coordinate the time of the routine pain meds with the therapy and dressing changes. She stated she tried to do the dressing change shortly after the pulse lavage treatment but there was no set time and no coordination of pain regimen. She further stated that additional studies had been completed due to the fact Resident #22 was having more pain with the wound care than staff thought he should.</p> <p>Observations on 03/01/13 revealed the pulse lavage was finished at 11:34 AM, the dressing change began at 11:38 AM and Resident #22 received his routine Norco at 11:59 AM.</p> <p>2. Resident #20 was readmitted to the facility on 11/17/11 with diagnoses that included pain and anxiety among others. The most recent Minimum Data Set (MDS) dated 12/04/12 specified the resident's cognition was not impaired. The MDS also specified the resident experienced frequent pain that made it hard for her to sleep at night and limited her day-to-day activities.</p> <p>The Care Area Assessment (CAA) dated 12/10/12 for pain specified Resident #20 acknowledged presence of pain and discomfort; specified to listen to resident's concerns and</p>	F 309		

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F 309	<p>Continued From page 15</p> <p>administer pain medication as ordered by the medical doctor. The CAA also specified to encourage resident to request pain medication before pain becomes severe and monitor resident for characteristics of pain and non-verbal signs of pain such as moans, yelling out, clenched teeth, grimacing and rigidity of body.</p> <p>Resident #20's care plan for pain dated 11/30/11 specified the resident would have pain relief and included interventions such as:</p> <ul style="list-style-type: none"> - Acknowledge pain and discomfort. Listen to resident's concerns - Administer pain medications as ordered by the physician - Encourage resident to request pain medication before pain becomes severe <p>Review of Resident #20's medical record revealed physician orders for pain medication that included:</p> <ul style="list-style-type: none"> - Ultram 100mg twice a day - Norco 5/325mg every 4 hours as needed for pain <p>Further review of Resident #20's Medication Administration Records (MAR) dated 01/13 and 02/13 revealed she requested her as needed pain medication daily because of complaints of pain.</p> <p>On 2/28/13 at 12:40 PM observations were made of the treatment nurse providing wound care to Resident #20. The observations revealed the resident was in bed for the wound care. The resident's right foot was noted to be wrapped with bandages and rested on a covered pillow. The</p>	F 309		

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F 309	<p>Continued From page 16</p> <p>treatment nurse removed the bandages from Resident #20's right foot. Resident #20 replied, "My foot's burning me to death." The treatment nurse proceeded to provide wound care to Resident #20's right heel. Resident #20 reported to the treatment nurse that the treatment hurt. At 12:45 PM Resident #20 grimaced in pain and flinched when her ankle was turned. During this time the treatment nurse was interviewed and stated that she usually checked with the nurse to determine if a resident had received pain medications prior to wound care. She added she had not checked with Resident #20's nurse prior to beginning the treatment. She reported she assumed the resident had already received pain medication. She added that it was the responsibility of the resident to ask for pain medication prior to receiving wound care. Resident #20 spoke and added that pain medication was effective in lessening the pain of the treatment. At 12:51 PM the treatment nurse offered to get Resident #20 pain medication. The treatment nurse continued providing the wound care and had completed the care as the nurse entered the room with Resident #20's as needed pain medication.</p> <p>On 03/01/13 at 10:30 AM the Director of Nursing (DON) was interviewed. The DON reported that she expected the treatment nurse to assess a resident's pain level prior to beginning treatment. She added that she would also expect the treatment nurse to coordinate with the medication nurse to offer a resident pain medication prior to performing a treatment to prevent the resident from experiencing pain during wound care.</p> <p>3. Resident #94 was admitted to the facility on</p>	F 309		
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F 309	<p>Continued From page 17</p> <p>07/25/12 with diagnoses that included dementia. The most recent Minimum Data Set (MDS) dated 01/15/13 specified the resident was cognitively impaired and required extensive assistance with Activities of Daily Living (ADL). The MDS also specified the resident was frequently incontinent of bowel and bladder.</p> <p>Resident #94's care plan dated 10/25/12 for bowel incontinence specified interventions that included:</p> <ul style="list-style-type: none"> - Record bowel movement, note size and consistency and report any abnormalities to nurse - Evaluate resident's bowel control and pattern <p>Review of Resident #94's medical record revealed a document titled "Standing Orders" signed by the physician on 07/25/12 that read in part:</p> <p>2) Milk of Magnesia (laxative) as needed for constipation. Notify attending physician if constipation persists.</p> <p>3) Fleets enema per rectum as needed for constipation not relieved by Milk of Magnesia. Notify attending physician if constipation persists.</p> <p>Resident #94's bowel elimination records were reviewed and revealed the following:</p> <ul style="list-style-type: none"> a. Starting 01/22/13 and continuing for 4 days no bowel movements were documented. b. Starting 02/14/13 and continuing for 5 days no bowel movements were documented. c. Starting 02/20/13 and continuing for 7 days no bowel movements were documented. 	F 309			

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F 309	<p>Continued From page 18</p> <p>A review of nursing notes for Resident #94 for the periods of 01/22/13 through 01/25/13; 02/14/13 through 02/18/13; and 02/20/13 through 02/27/13 revealed no documentation of assessment or treatment for constipation.</p> <p>Further review of Resident #94's medical record revealed he did not receive routine laxatives or medications for constipation and did not receive Milk of Magnesia or a Fleets enema per standing orders.</p> <p>On 03/01/13 at 9:00 AM the Quality Improvement nurse (QI) was interviewed and reported that the facility monitored residents to ensure they experience a bowel movement every 3 days. She added that daily a report was generated from the computer to identify residents who had not had a bowel movement in 3 days. She stated that the report was given to individual nurses to administer medications to relieve constipation. The QI nurse added that she would follow-up the next day to ensure the interventions were effective in relieving a resident's constipation. The QI nurse reviewed Resident #94's bowel elimination record and revealed that she discovered that the periods of constipation had not been reported to the nurse to address. She stated this was an oversight.</p> <p>On 03/01/13 at 10:30 AM the Director of Nursing (DON) was interviewed and stated all residents were expected to be monitored for constipation. She stated there was an oversight that resulted in the nurses not being notified of Resident #94's episodes of constipation.</p>	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	<p>Continued From page 19</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, facility policy, medical record review and staff interview, the facility failed to provide mouth care for 1 of 3 residents observed for activities of daily living. (Resident #123)</p> <p>The findings included:</p> <p>The facility's policy entitled Grooming, dated 08/2012, read, "Grooming will be performed daily and as needed. This includes shampooing, shaving, nail care, and mouth care."</p> <p>Resident #123 was admitted to the facility with Alzheimer's dementia and depression. Review of Resident #123's most recent Quarterly Minimum Data Set (MDS) dated 01/20/13 revealed she had severe cognitive impairment. The MDS assessment of behavior indicated rejection of care was not exhibited by Resident #123. Further review of the MDS revealed Resident #123 needed extensive assistance with all activities of daily living.</p> <p>Review of Resident #123's care plan dated 01/22/13 did not address activities of daily living.</p> <p>An observation was made on 02/27/13 at 10:07</p>	F 312	<p>Resident #123 was approached immediately and refused oral care from the Nursing Assistant and the nurse. Several attempts were made and Resident #123 refused oral care each time. Oral care will continue to be rendered daily and as needed, as the resident will allow.</p> <p>All residents who are dependent on staff for oral care have the potential to be affected by the deficient practice. Mouth care is being provided daily and as needed</p> <p>All Nursing Assistants were educated by the Staff Development Coordinator and Nursing Supervisors to provide daily oral care for residents who are dependent on staff for oral hygiene. Education included resident resistance to care and the proper way to handle and report refusals. This retraining was completed 3/6/2013 thru 3/15/2013.</p> <p>Staff members on vacation, leave and prn staff will receive education prior to returning to work.</p>	3/26/13	

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F 312	<p>Continued From page 20</p> <p>AM of Resident #123. She was noted to have a thick yellow coating on her top and bottom teeth. Her lower gums were red and appeared inflamed.</p> <p>An observation was made on 02/28/13 at 9:48 AM of Resident #123 sitting in the day room. Her teeth were noted to have a thick yellow coating.</p> <p>An interview was conducted on 02/28/13 at 9:57 AM with Nursing Assistant (NA) #1. NA #1 stated when providing morning care for Resident #123 she helped her wash her face, and go the restroom. She stated Resident #123 was usually dressed and had her shoes on when she started work in the morning. NA #1 did not mention mouth care as part of Resident #123's morning care.</p> <p>An observation was made on 03/01/13 at 8:40 AM of Resident #123 sitting in the dining room. Resident #123 continued to have a thick yellow coating on her teeth. Her gums were red and appeared inflamed.</p> <p>An interview was conducted on 03/01/13 at 8:40 AM with NA #1 regarding morning care for Resident #123. NA #1 stated Resident #123 could be resistive to care at times but she found if she went slow and talked to the resident she would cooperate.</p> <p>An interview was conducted on 03/01/13 at 8:43 AM with NA #2 who also provided care for Resident #123. NA #2 stated she and NA #1 both provided morning care for Resident #123. She stated she did not provide mouth care for Resident #123 that morning nor had she ever provided mouth care for her.</p>	F 312	<p>The QI nurse or designee will audit oral care for 5 residents per week x 2 weeks, then 5 residents every 2 weeks x 2 weeks then monthly to ensure compliance on an ongoing basis. Any concerns will be addressed at the time of the audit which may include staff re-education. Weekly then monthly audits will be turned into the Administrator for review.</p> <p>The Weekly QI Committee will review the audit results and recommend any changes in the plans as needed.</p> <p>The Quarterly Executive QI Committee will review audits to determine the continued need for frequency of monitoring. Any recommended changes in the plan will be discussed and carried out as agreed upon at that time.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	Continued From page 21 An interview was conducted on 03/01/13 at 8:53 AM with NA #1. She stated she had worked on the Sparks Unit (locked Alzheimer's unit) for approximately 2 months. She stated she had never provided mouth care for Resident #123. On 03/01/13 at 8:59 AM an observation was made of the closet in the bathroom of the Sparks Unit. During this observation both NA #1 and NA #2 were able to show where the residents' personal care items were kept. These items were kept in labeled plastic individual containers for all 28 residents on the Sparks Unit. NA #1 and NA #2 looked for Resident #123's toothbrush but were able to find one. NA#1 and NA #2 also looked for other residents' toothbrushes but no one had them in their personal care boxes. NA #1 and NA #2 were unable to say where the residents of the Sparks Unit's toothbrushes were kept or if they had one. An interview was conducted on 03/01/13 at 9:05 AM with Nurse #1. Nurse #1 stated mouth care should be provided for the residents in the morning and at bedtime. She stated all resident should have a toothbrush. An interview was conducted on 03/01/13 at 3:03 PM with the Director of Nursing (DON). The DON stated her expectation was for mouth care to be provided in the morning either before or after breakfast. The DON further stated she expected mouth care to be provided at least once per day. The DON stated if residents are resistive to care she would expect staff to go back and try again to provide the care needed.	F 312		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		

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F 314 SS=D	<p>Continued From page 22 PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to keep an open wound from being contaminated during wound care for 1 of 4 sampled residents with pressure ulcers (Resident #20).</p> <p>The findings include:</p> <p>Resident #20 was readmitted to the facility on 11/17/11 with diagnoses that included pain, hypertension, anxiety and atrial fibrillation among others. The most recent Minimum Data Set (MDS) dated 12/04/12 specified the resident's cognition was intact. The MDS also specified the resident was at risk for developing a pressure ulcer but did not currently have a pressure ulcer.</p> <p>The pressure ulcer Care Area Assessment (CAA) dated 12/10/12 specified the resident had risk factors for skin breakdown that included pain, infection, decreased mood and increased behavior. The CAA also specified a care plan would be developed to minimize the risk for</p>	F 314	<p>Subsequent dressing changes for Resident #20 are to be performed on a clean field.</p> <p>Residents with open wounds were identified by the facility to have the potential to be affected by the deficient practice. They will continue to be provided with a clean field during dressing changes.</p> <p>The Corporate Wound Nurse educated nursing staff responsible for wound care on proper wound care technique on 3/25/2013.</p> <p>The Director of Nursing or her designee will perform weekly random audits x 2 weeks on 3 residents receiving wound care to ensure correct aseptic technique is performed during wound care. Random audits will then be performed every 2 weeks x 2 weeks on 3 residents receiving wound care x 2 weeks, then 3 residents on a monthly to ensure compliance on an ongoing basis. Any concerns will be addressed at the time of the audit which may include staff re-education. Weekly then monthly audits will be turned into the Administrator for review.</p> <p>The Weekly QI Committee will review the audit results and recommend any changes in the plans as needed.</p> <p>The Quarterly Executive QI Committee will review audits to determine the continued need for frequency of monitoring. Any recommended changes in the plan will be discussed and carried out as agreed upon at that time.</p>	3/26/13	

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F 314	<p>Continued From page 23 complications.</p> <p>The care plan for pressure ulcer dated 11/30/11 specified the resident would have no further development of pressure ulcers. Interventions listed on the care plan included:</p> <ul style="list-style-type: none"> - follow facility protocol for treating breaks in skin integrity - treatment as ordered by physician <p>Review of Resident #20's medical record revealed a nurses' entry made by the Treatment nurse dated 01/04/13 that specified the resident was noted to have an area with broken skin on her right heel.</p> <p>Further review of the medical record revealed a pressure ulcer assessment dated 02/27/13 that specified Resident #20 had an unstageable pressure ulcer on her right heel that measured 3.1 centimeters (cm) by 2.8 cm and had a depth of 0.1 cm.</p> <p>On 2/28/13 at 12:40 PM observations were made of the treatment nurse providing wound care to Resident #20. The observations revealed the resident was in bed for the wound care. The resident's right foot was noted to be wrapped with bandages and rested on a covered pillow. Observations were made of the covered pillow that revealed the pillow case had red stains that appeared dried and splotchy throughout the pillow case. The treatment nurse removed the existing bandages and allowed Resident #20's bare foot to rest on top of pillow case. Resident #20's exposed pressure ulcer on her right heel was directly in contact with the stains. The treatment</p>	F 314			

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F 314	Continued From page 24 nurse was interviewed at this time and reported that the red stains were dried drainage from the resident's wounds. The treatment nurse completed the wound care and was interviewed. She stated that it was not possible to provide a sterile environment when providing wound care and confirmed the resident's open ulcer on her right heel had direct contact with the drainage on the pillow. She stated that she could have put down a barrier to prevent the open wound from coming into contact with a soiled cloth, such as towel, but failed to do so. She added it was not her usual practice to use a clean barrier to prevent wound contamination when providing wound care. On 03/01/13 at 10:30 AM the Director of Nursing (DON) was interviewed. The DON reported that she expected the treatment nurse to use a clean barrier between the resident's wound and that area of contact. She stated that this was to ensure the resident's wound didn't become infected.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	Resident #181 is currently being provided with incontinence care as needed with proper technique. All female residents who are dependent on staff for incontinence care have the potential to be affected by the deficient practice. They are be provided with incontinence care as needed with proper technique.	3/26/13	

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F 315	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews and staff interviews the facility failed to provide toileting as a resident requested and failed to separate the resident's legs and labia to clean the skin during incontinence care for 1 of 3 residents who requested assistance with toileting. (Resident #181).</p> <p>The findings included:</p> <p>Resident #181 was re-admitted to the facility on 01/18/13 with diagnoses which included kidney failure, a history of urinary tract infections (UTIs) and urinary retention.</p> <p>A review of a facility policy titled "Perineal Care" dated 02/2007 indicated in part to expose perineal area and wash perineal area.</p> <p>The most recent re-admission/significant change Minimum Data Set (MDS) dated 01/25/13 indicated Resident #181 had no problems with short term and long term memory and the resident was cognitively intact. The MDS further indicated Resident #181 required extensive assistance with toileting and hygiene and was incontinent with bladder and bowel.</p> <p>A review of a hospital discharge summary dated 01/18/13 indicated Resident #181 had a urinary tract infection (UTI) with sepsis (the presence of bacteria and infection that spreads throughout the body). The summary further indicated Resident #181 was sent to the hospital with fever, low blood pressure, and decreased level of consciousness and had been sick for more than 2</p>	F 315	<p>All Nursing Assistants were educated by the Staff Development Coordinator and Nursing Supervisors on the correct technique on providing incontinence care to the female resident. This was provided 3/6/2013 thru 3/15/2013.</p> <p>Nursing Assistants on vacation, leave and/or prn staff will receive education prior to returning to work.</p> <p>The QI nurse or designee will audit female incontinence care for 5 residents per week x 2 weeks, then 5 residents every 2 weeks x 2 weeks then monthly to ensure compliance on an ongoing basis. Any concerns will be addressed at the time of the audit which may include staff re-education. Weekly then monthly audits will be turned into the Administrator for review.</p> <p>The Weekly QI Committee will review the audit results and recommend any changes in the plans as needed.</p>	

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F 315	<p>Continued From page 26</p> <p>months. The summary also indicated Resident #181 had recurrent UTIs and was treated with an antibiotic and was also treated for a yeast infection.</p> <p>A review of a physician's order dated 01/18/13 indicated Nystatin Cream daily to groin for 2 weeks for yeast infection.</p> <p>A review of a physician's order dated 01/22/13 at 11:00 AM indicated a urinalysis and culture and sensitivity due to difficulty and pain with urination.</p> <p>A review of a physician's order dated 01/25/13 at 1:15 PM indicated and antibiotic (Augmentin 875/125 milligrams (mg.) by mouth twice a day for 7 days for a UTI.</p> <p>A review of a physician's order dated 02/08/13 at 10:00 AM indicated a urinalysis and culture and sensitivity.</p> <p>A review of a physician's order dated 02/12/13 at 2:00 PM indicated and antibiotic (Primaxin 500 mg.) intravenously every 6 hours for 7 days for a UTI.</p> <p>During an observation on 02/28/13 at 8:45 AM Resident #181 was heard crying loudly and Nurse #4 entered her room and Resident #181 told Nurse #4 she needed to urinate now because it hurt and she was burning and in pain. Nurse #4 told the resident the Nurse Aides (NAs) were busy but would be there shortly and Nurse #4 walked out of the room to a medication cart in the hallway.</p> <p>During an interview on 02/28/13 at 8:46 AM with</p>	F 315		

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F 315	<p>Continued From page 27</p> <p>Resident #181 she stated she was in pain and was waiting on staff to because she needed to urinate. She further stated she had a yeast infection and thought she might have a UTI and if she wet herself the urine would burn her skin.</p> <p>During an interview on 02/28/13 at 8:48 AM Nurse #4 stated she was aware Resident #181 needed to urinate and the NAs were aware. She further stated NAs were busy and would assist Resident #181 shortly.</p> <p>During continuous observations on 02/28/13 from 8:48 AM until 9:25 AM Resident #181 continued to call out "nurse, please help me with the bathroom."</p> <p>During an observation on 02/28/13 at 9:25 AM Resident #181's call light was flashing above her door in the hallway and NA #3 entered the room. Resident #181 stated she needed to urinate and wanted to get dressed. NA #3 removed clean clothing from Resident #181's closet and stated it would be about 25 minutes until her coworker could help her because she was busy helping another resident and NA #3 walked our of the room.</p> <p>During an observation on 02/28/13 at 9:39 AM the call light was flashing over the top of Resident #181's door in the hallway. Resident #181 was also calling out "nurse" then "hello."</p> <p>During an observation on 02/28/13 at 9:41 AM Resident #181 was crying and calling out "nurse, please hurry, somebody come here."</p> <p>During an observation on 02/28/13 at 9:42 Nurse</p>	F 315		

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F 315	<p>Continued From page 28</p> <p>#4 entered the room and Resident #181 stated she needed to urinate. Nurse #4 stated she would let the NAs know and they would be there in a few minutes. Resident #181 stated "in a few minutes I'll wet on myself" and Nurse #4 walked out of the room.</p> <p>During an observation on 02/28/13 at 9:46 AM NA #3 and NA #4 entered Resident #181's room, washed their hands and put on gloves. Resident #181 stated she needed to urinate and wanted privacy. Both NAs pulled the curtain around Resident #181's bed and stepped outside the curtain. Resident #181 stated she was finished and NA #3 and NA #4 walked back inside the curtain and removed Resident #181's brief which was wet with urine. Resident #181 was turned to her right side and NA #4 wiped back and forth inside the resident's buttocks with a pre-moistened wipe. Resident #181 was then turned to her left side and NA #3 wiped from back to front with a pre-moistened wipe and the resident was turned to her back. NA #3 wiped across the top of Resident #181's pubic area twice with a pre-moistened wipe and then pushed the wipe down inside each groin twice on each side. NA #3 did not separate the resident's legs to expose the labia and did not clean inside the labia. NA #3 and NA #4 placed a clean brief on the resident and changed her clothing.</p> <p>During an interview on 02/28/13 at 10:22 AM with NA #3 she stated it took 2 staff members to turn and provide incontinence care to Resident #181. She explained she was busy with providing care to other residents and could not assist Resident #181 until she had a co-worker available to help her. She stated Resident #181 was not able to</p>	F 315			

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F 315	<p>Continued From page 29</p> <p>stand and walk to the bathroom. She further stated she did not think Resident #181 would use a bedpan and she wore a brief all of the time and when she was wet they cleaned and changed her. NA #3 explained she received orientation for incontinence care when she was hired at the facility and the expectation was to wipe from front to back and get the resident clean. She verified she did not separate Resident #181's legs or clean inside the labia because Resident #181 had a certain way she wanted to be cleaned so they cleaned her "her way."</p> <p>During an interview on 02/28/13 at 2:46 PM Resident #181 stated her urine was really strong and it burned her skin. She stated she called for assistance this morning because she did not want to wet herself but she couldn't wait any longer. She verified her brief was wet when the NAs changed her and her skin was burning. Resident #181 explained she could use a bedpan if she needed to urinate but she usually wet her brief and the NAs changed her. She stated she had told nursing staff that her urine burned her skin and she had a yeast infection. She further stated she knew the NAs were busy helping other residents but she wanted them to come and clean her as soon as they could when she called them so the urine would stop burning her skin.</p> <p>During an interview on 03/01/13 at 11:24 AM the Director of Nursing (DON) stated it was her expectation for the NAs to keep Resident #181 clean and dry and they should have provided incontinence care according to facility procedures. She further stated Resident #181 had a history of UTIs and had just finished intravenous antibiotics last week for a UTI. She</p>	F 315		

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F 315	Continued From page 30 explained she had told the NAs they should not make the resident wait for care but they should stop what they were doing, help each other to clean and change the resident and then they could go back to their previous tasks after they finished her care. She stated the resident's incontinence care should not be compromised and she expected the NAs to separate the resident's legs and labia during incontinence care to ensure they got the resident clean.	F 315		