STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057836	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PALOS HEIGHTS	7850 WEST COLLEGE DRIVE , PALOS HEIGHTS, Illinois, 60463

(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
S0000	Initial Comments Complaint Investigations 2595828/IL195380, 2595878/IL195401	S0000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to implement intervention related to use of bed alarm; and failed to follow manufacturer's recommendation for safety use of reclining chair in preventing fall for one (R1) of three residents reviewed for accidents. This deficiency resulted in R1 who is cognitively impaired fell out of bed and sustained a large bruise on the left side of neck and jaw. Findings include: R1 is a 90-year-old, male, originally admitted in the facility on 06/21/23 with diagnoses of Unspecified Dementia, Unspecified Severity, with Psychotic Disturbance; Psychotic Disorder with Delusions due to known Physiological Condition; and Delusional Disorders. R1's MDS (Minimum Data Set) dated 04/23/25 and 06/17/25 documented the following: Sec C - memory problem for short-term and long-term; cognitive skills for daily decision making is severely impaired. Sec GG - dependent on toileting, personal hygiene and mobility	S9999		

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S9999	Continued from page 2 Sec J - no falls since admission/entry/reentry or prior assessment R1's fall risk evaluations documented the following: 03/25/25 - 17, high risk 05/12/25 - 17, high risk 06/22/25 - 15, high risk R1's care plans on high risk for falls related to decline in functional status, difficulty maintaining standing position, fatigue, weakness, gait problem, such as unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, takes rapid steps, or lurching gait, impulsivity, poor safety awareness, muscle weakness, other dementia, history of falls, potential medication side effects documented the following interventions: Bed/chair alarm to alert staff when resident (R1) attempts to get out of bed unassisted, so staff can assist resident (R1) and prevent falls. Check resident (R1) frequently while in bed "I would like to staff to provide me a safe environment: even floors, free from spills and/ or clutter; adequate, glare-free light; a working and reachable call light; the bed in low position at night; side rails as ordered; handrails on walls." (3/25/25) According to incident report dated 05/12/25 at approximately 10 AM, R1 was observed sitting on the floor in front of his reclining chair. R1 was being transferred to the outside patio by the CNA (Certified Nurse Aide). Staff noticed him sitting upright on the floor on his bottom as alarm was sounding. R1 was being transferred by CNA in his reclining chair and fell out of the chair when reclining chair went over the bump of the door threshold. On 06/30/25 at 3:25 PM, V5 (CNA) was asked what happened to R1 on 05/12/25. V5 stated, "Around 11:00 AM after breakfast. We were putting residents out to the patio at the time. I was bringing him (R1) outside first. I grabbed the chair's push handle. I positioned myself behind the reclining chair and started to wheel it backwards. I am not tall enough to see what was	S9999		

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S9999	Continued from page 3 going on with him while I try to pull the reclining out when the door alarm went off so loud and when I saw him, he was already sitting on the floor. Since the door alarm was so loud, I didn't hear the chair alarm." On 07/01/25 at 1:59 PM, V19 (Licensed Practical Nurse, LPN) was asked regarding R1's fall on 05/12/25. V19 stated, "I do know it's towards the end of my shift. Lunch was completed, like 1 or 2 PM. We were going to take residents out of the patio. The CNA (V5) started to take him out. I didn't see him fall. When I turned around, he was on the floor already. I talked to (V2, Director of Nursing) and they reviewed the cameras. I was told that when he was taken out, when she (V5) was pulling him out, he must have grabbed the door and fell. I was there with other staff, but we were attending to other residents, and it was only her (V5) who started taking R1 outside." According to progress notes dated 06/22/25, time stamped 11:04 PM, V18 (Licensed Practical Nurse, LPN) was made aware by V4 (CNA) that R1 had a fall. R1 was observed on the floor mat lying on the right side in a fetal position. He (R1) was unable to give verbal statement. Physical assessment completed. Bowel movement at the time of fall noted. He (R1) is alert with confusion. Neuro assessment completed and log initiated. ROM (range of motion) with all extremities within normal limits. No new skin alteration. Apparent injury is not present. On 06/30/25 at 11:41 AM, R1 was observed in the dining room, attending activities. R1 was sitting in a high reclining chair. A working chair alarm was hanging at the back of his (R1) chair. R1 responded to name calling, alert with confusion. R1 speaks Spanish, was asked on how is he doing and stated he is doing very well. R1 was asked if he had fallen recently but he was unable to answer. A purplish skin discoloration was noticed on the left side of his neck and jaw, which appeared to be a bruise. R1 was asked how he got the bruise, stated "I don't know." V15 (Certified Nurse Aide, CNA) was asked regarding R1's bruise. V15 stated she does not know. R1 was also observed trying to get out of his chair. R1 appeared agitated, leaning forward and backwards, attempting to stand up. Around 1:15 PM, he (R1) appeared restless, kept leaning forward with several attempts made to stand up. V15 verbalized that he (R1) gets fidgety when he is wet and needs to get changed.	S9999		

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S9999	Continued from page 4 On 06/30/25 at 3:00 PM, incontinence care was provided to R1 by V4 and V15. Prior to putting R1 to bed, the alarm was left in the reclining chair. There was no alarm placed under R1 while in bed. On 06/30/25 at 3:15 PM, V4 was asked regarding R1's fall on 06/22/25. V4 replied, "It was around 8:00 PM that I put him to bed. I changed him, he had a bowel movement. Then, I left. Then, around 8:55 PM, I came back to check on him (R1), he was sitting on the mat, his right leg was under the back wheel of his reclining chair. When I saw him, I called the nurse, V18. The nurse assessed him and then use the mechanical lift to put him back to bed. We found out he had bowel movement again. When he is wet or has bowel movement, he gets agitated. Residents are monitored every two hours. He (R1) does not know how to use call light. I was in room (next door), just next door, and providing care." V4 was asked if she heard R1's bed alarm go off. V4 verbalized, "I didn't hear any alarm. It's because the batteries were not working. Any staff is responsible to check the alarm to make sure it is properly working." At this time, V4 took the alarm from R1's reclining chair and placed it under his (R1) lower back. The alarm was placed after surveyor asked about alarm. On 07/01/25 at 10:42AM, V18 was interviewed regarding R1's fall incident on 06/22/25. V18 stated, "It was towards the end of my afternoon shift. I actually had just came from his room like 40 minutes ago when I checked him (R1), and he was okay. I went back to my desk, 40 minutes after, the CNA (V4) told me that he had a fall. I went in, I assessed him. He was okay. I checked his brief, and he had a bowel movement. His bed alarm didn't go off but when I checked it. It seems like it was working so I asked her (V4) to change the batteries. No bruising, vital signs were checked. I called the eye doctor, the family and supervisor. I did not hear any alarm prior to fall." R1's eye health note dated 06/22/25, time stamped 11:52 PM documented: fall without injury. Patient (R1) is at risk for falls due to the following; recurrent falls, unwitnessed fall. Rolled down to the floor from the bed/recliner. The bed is at the lowest level. Did not hit the head. No skin tears or acute pain. Not on anticoagulation. On exam, no head injury, and no overt physical signs of trauma. No reports of syncope, chest pain, nausea or vomiting. Neuro checks are being performed. Orders: assess pain per protocol; monitor	S9999		

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S9999	Continued from page 5 with neuro-checks per facility protocol; fall precautions per facility protocol; notify a clinician of a change in condition; R1's NP (Nurse Practitioner) progress notes dated 06/23/25, time stamped 3:13 PM recorded that he (R1) was seen due to recent fall. Review of systems showed negative bruising, abrasions, skin tears, lacerations and pressure ulcers. Progress notes dated 06/25/25, time stamped 6:57 PM documented a bruise on R1's left side of neck was observed. Skin and Wound note dated 06/26/25, time stamped 1:50 PM recorded: Patient (R1) seen today at request of staff for skin alteration to left face/neck. Exam revealing for ecchymoses in late stages of healing without edema and with overlying skin intact. On 06/30/25 at 3:40 PM, V7 (Family Member) was asked about R1's bruise on the left side of his neck and jaw. V7 verbalized, "He had a big bruise on the left side of his neck because of the fall last Sunday, 06/22/25. I was told that he was trying to get up and hit his neck on the chair." On 07/01/25 at 10:55 AM, V8 (Wound Care Nurse) was interviewed regarding R1's bruise on the left side of neck and jaw. V8 verbalized, "I was first notified last Thursday, 06/26/25 about his bruise on neck, face and jaw, on his left side. They just wanted us to come and take a look. Bruise is not much about wound care to do something about it in terms of treatment but (V20 Wound Nurse Practitioner, NP) seen R1. We could have not given any details. I know they said that he (R1) had a fall, could be related to that." On 07/01/25 at 11:33AM, V2 (Director of Nursing/Fall Coordinator) was interviewed regarding R1 and falls. V2 stated, "He is alert, oriented to self, confuse all the time, He has very advanced Dementia. He is Spanish speaking. He is combative during care and during assistance. The fall incident on 05/12/25 could possibly be prevented by making sure he did not make sudden movements and having another person to supervise during the transport. There were staff present during that time watching other residents. Because of the	S9999		

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S9999	Continued from page 6 sudden movements by R1, staff could not get to him right away. The 06/22/25 fall incident happened around 10 PM. They observed him (R1) on the floor mat next to his bed. He (R1) was seen 15 minutes prior to fall. The bed was low, and he was positioned correctly in the center of the bed. He was not sleeping, moves around. He probably woke up, maybe he had a bowel movement and tried to go to the bathroom. There were no injuries at the time as assessed by nurse. The bruise on the neck and jaw could be related to the fall." On 07/01/25 at 12:23 PM, V9 (Nurse Practitioner) was interviewed regarding R1. V9 replied, "I have been seeing him more than 3 years now. He uses a reclining chair because he always climbs up from the wheelchair. I was notified with his fall incident on 05/12/25 and saw him on 05/14/25. There was no injury. He had a fall while he was transported to the patio. This fall could be prevented by assisting the patient or making sure resident is secure in the reclining chair. He has a behavior that he appears calm then suddenly become agitated, so staff needs to hold him to prevent him from falling or injuring himself or hurting other staff. I know his behavior, staff knows his behavior also, so staff should anticipate and make sure he won't fall. With the fall incident on 06/22/25, bed alarm is part of the intervention and staff make sure it is functioning. The bruise on the left side of his neck/jaw might be from the fall." On 07/03/25 at 9:54 AM, V20 was interviewed regarding R1's bruise. V20 stated, "I saw him on 06/26/25 for the bruise on left face/neck/jawline. There was ecchymosis and discoloration of yellow, purple and green indicating late stages of healing for a bruise. Looks like it's been there for a couple of days. He had a fall Sunday, 06/22/25, the bruise could be related to the fall, possibly related to fall because of the appearance of the bruise when I did the assessment. There was no edema, generally caused by hitting onto something which could be related to fall. Facility just have to follow their fall protocol." Facility's policy titled "Fall Occurrence" dated 7/26/24 stated in part but not limited to the following: Policy Statement: It is the policy of the facility to ensure that residents are assessed for risk for falls, that	S9999		

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S9999	Continued from page 7 interventions are put in place, and interventions are reevaluated and revised as necessary. R1's (Name of reclining chair) Operating Manual, documented in part but not limited to the following: 2 Safety Requirements 2.5 Hazards 2.5.6 Unintended Movement - "Danger of Falling or Collision" We recommend (name of reclining chair) chairs for indoor use within a long-term care institution and where there is not enough slope to cause the chairs to move unaided. Chairs used where the surface is uneven or sloped are at risk of unintended movement and could become a serious danger to the resident, caregiver (s) or a third party. We recommend that (name of reclining chair) chairs are located away from stairwells, elevators, and exterior doorways within a long-term care institution. Outdoor use is appropriate only under the strict supervision and full attention of a caregiver who is physically capable of preventing any unintended movement over any surfaces that are to be traveled on. We recommend that a second caregiver assist when the chair is moved over surfaces that could cause significant unintended movement. NO VIOLATION 2 of 2: 300.610a) 300.1210b) 300.1210c) 300.1210d)4)A)5)	S9999		

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S9999	Continued from page 8 physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.	S9999		

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S9999	Continued from page 9 These requirements were not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to follow their policy related to incontinence and perineal care for one (R1) of three residents reviewed for incontinence care. This failure resulted in R1 developing incontinence associated dermatitis (IAD) on the scrotal area. Findings include: R1 is a 90-year-old male, admitted in the facility on 09/26/24, with diagnoses of: Unspecified Dementia, Anemia, Acute Kidney Failure, Benign Prostatic Hyperplasia, and History of Cerebral Infarction. According to R1's MDS (Minimum Data Set) dated 06/17/25, R1's BIMS was not conducted due to R1's severe cognitive impairment. According to Section GG, R1 is dependent on staff for eating, toileting and hygiene, toilet transfer, mobility. Section H indicated that R1 is always incontinent of urine, and frequently incontinent of bowel. On 06/30/25 at 11:41am, R1 was sitting in the reclining chair in front of the dining table. Alert, not interviewable. Activity on-going, however R1 doesn't appear to participate. Chair alarm and star symbol were attached to the reclining chair. R1 was observed leaning forward and touching the table. On 06/30/25 at 12:48pm, surveyor observed R1 in the same location and position at the dining table. Surveyor observed R1 mumbling Spanish words. On 06/30/25 at 1:10pm, R1 remains sitting at the same area in the dining room. At 1:15pm, before R1 had his lunch, V5 (Certified Nurse Aide, CNA) and V15 (CNA) brought R1 to the washroom which is located at the corner of the dining room area. Surveyor observed the changing process in the washroom. V5 put anti-skid socks on R1, then using the standing lift, both V5 and V15 were instructing R1 to stand up, to which R1 was not able to follow. R1 was having difficulty standing up. Attempt to transfer to toilet, and brief changing was not done. V15 brought R1 back to the dining table to have lunch, without his brief checked and changed. When V5 and V15 were asked by this surveyor as to when	S9999		

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S9999	Continued from page 10 R1 was changed last, they said when R1 got up this morning around 8:00am. On 06/30/25 at 2:59pm, V5 and V15 brought R1 to his room to check and change R1's brief in bed. V5 and V15 pivot transferred R1 from reclining chair to the bed with scooped mattress. Brief was completely soaked with urine and feces. Scrotal lesion observed. V5 and V15 cleansed R1's perineal area with cloth towel with soap and water. On 06/30/25 at 4:00pm, V7 (Family Member) came to visit. V7 said that she visits every night and that R1 is soaking wet with double briefs almost every time she visits. V7 stated she has informed the staff about the wound on scrotal area. V7 noticed the scrotal wound when she was giving care to R1 on 6/26/25, she stated she's unsure how long the wound has been there. On 07/01/25 at 12:41pm, wound care observation with V8 (Registered nurse, RN/Wound Care Nurse) and V17 (CNA) was performed. R1's eyes were closed, non-verbal. V8 explained the process to R1. Hand Hygiene observed. V8 described the scrotal area as 100% granulation, no staging, about 0.3 x 0.2 mm (millimeters) in size full thickness. There was no bleeding or drainage. BPOC (Balsam Peru and Castor Oil)/Venelex ointment was applied after cleansing the wound area with normal saline. Sacral area observed with scar tissue. Perineal care was rendered, and brief was changed. TAR (Treatment Administration Record) showed administration of treatment per V8. On 07/01/25 at 10:55 am, interviewed V8 who has been working at this facility for 7 years, with 3 years working as the wound care nurse. When surveyor asked V8 regarding R1's skin condition, V8 said that currently he's following R1 for MASD (Moisture-Associate Skin Damage) of scrotum, this was reported to him on Friday, 6/27/25. V8 stated, "I went and did my assessment, it was MASD, all measurements and pictures are through Healing Partners. We don't have access to it. There's one small area on the left side of scrotum. Venelex Treatment ointment daily was ordered by V12)." When asked about other interventions and prevention of skin breakdown, V8 said "Stay clean and dry, since it is moisture related, according to WNP it is MASD rather than IAD (Incontinence Associated Dermatitis). R1 has co-morbidities and fragility, also keep patient clean and dry, making sure staff are doing their check and	S9999		

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(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
S9999	Continued from page 11 change at least every two hours." On 7/01/25 at 12:12 PM, V2 (Director of Nursing) regarding policy on incontinent and perineal care, stated, "They should check patients every 2 hours, do the rounds then check and change. We use cloth towels with soap and water for perineal care". On 7/1/25 at 12:25 PM, interviewed V9 (Nurse Practitioner, NP). "I was notified about the scrotal skin tear on same day he got the skin tear, on 6/27/25. I asked the staff to apply protective cream and follow up with the resident." When surveyor asked about the cause, V9 said, "Sometimes from wet briefs. (R1) has very fragile skin, moisture and incontinence, there should be protective skin care, and change brief ideally every two hours or per facility policy. For this resident (R1), should have at least two staff when changing, should be changed in bed ideally." On 7/01/25 at 3:03PM, phone interview with V12 (Wound Nurse Practitioner). When asked about wound status, she said it was the first time she saw it on 6/30/25. V12 stated, "The wound nurse said the family told them about the scrotal area. I categorized it as (IAD) Incontinence Associated Dermatitis, moisture skin damage. The patient is incontinent. This is due to the repeated exposure to body fluids". When V12 was asked what her expectations are from the staff when it comes to incontinence care, V12 said she would refer to the facility policy, for the facility to follow the incontinence care protocol. Progress Notes dated 6/30/2025 per V12 reads in part: "Information necessary for today's visit was obtained from nursing staff, per patient's medical record. Reason for visit: new skin and wound consult on current resident (R1). Patient unable to participate in full Review of Systems (ROS) related to altered mental status. Gastrointestinal: fecal incontinence, Genitourinary: urinary Incontinence. Musculoskeletal: Generalized weakness, multiple contractures. SKIN: warm and dry, thin, fragile, wound/skin condition noted. WOUND ASSESSMENT: Location: Scrotum Primary Etiology: Incontinence Associated Dermatitis (IAD).	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057836	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2025

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S9999	Continued from page 12 Stage/Severity: Partial Thickness. Wound Status: New; Odor Post Cleansing: None Size: 0 cm x 0 cm x 0 cm. Calculated area is 0 sq cm. Wound Base: 100% epithelial Exposed Tissues: Dermis Wound Edges: Attached Periwound: Dermatitis Exudate: None amount of None ASSESSMENT: Irritant contact dermatitis due to fecal, urinary or dual incontinence. PLAN: Wound # 17 Scrotum Incontinence Associated Dermatitis (IAD) Treatment Recommendations: 1. Cleanse with soap and water, pat dry. 2. apply Venelex/BPCO to base of the wound. 3. Leave open to air. 4. Daily, and PRN (as needed). PREVENTATIVE MEASURES: The resident is incontinent of bowel and bladder. Use appropriate moisture barrier creams per formulary to provide thorough skin care with each incontinent episode. Use formulary briefs when indicated to manage moisture and assess often. R1's care plan on incontinence dated/initiated on 06/29/23, reads in part: Resident has an actual impairment to skin integrity IAD to scrotum and is at risk for further skin breakdown related to recent surgery, impaired mobility, weakness, cognitively impaired, falls, anemia, and malnutrition. Interventions read in part: Call light placed within easy reach. Commonly used items placed within easy reach. The staff will check resident for incontinence episode and provide peri care as needed every shift.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057836	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2025

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S9999	Continued from page 13 Kept clean and comfortable. Provide assistance with toileting needs as needed. Skin check and barrier cream applied as necessary. The facility's "Incontinent and Perineal Care" Policy dated 7/31/24, reads in part, "It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. Procedures include doing rounds at least every 2 hours to check for incontinence during shift. Provide privacy. Avoid unnecessary exposure of resident. If the resident refuses the procedure - inform the charge nurse. Perform hand hygiene before the procedure. Put on gloves and appropriate personal protective equipment if indicated. Maintain clean techniques. Wash the perineal area and gently dry after the procedure. Discard disposable items into designated plastic bag. Wash hands. Put on new set of clean gloves to put on clean briefs/incontinent pads, to make resident comfortable, groom and change clothing. Complete hand washing after the procedure and do after care of equipment per facility protocols." (B)	S9999		