STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165626	A. BUILDING _____ B. WING _____	07/15/2021

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OAKVIEW NURSING & REHABLITATION - MARION	720 OAKBROOK DRIVE MARION, IA 52302

(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 OKV TNO Correction Date: 8/3/2021 The following deficiencies relate to the Recertification Survey and investigation of a Facility Self Reported Incident #97783 completed 7/12-15/2021. Incident #97783 not substantiated. (See Code Federal Regulations (42CFR) Part 483 Subpart B-C).	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the facility failed to follow professional standards during the medication pass. The nurse failed to follow professional standards by having 2 resident's medication in medication cups on top of the medication cart. Findings Include: During an observation on 7/14/21 at 10:10 AM, Staff C, Licensed Practical Nurse (LPN) had 2 stacks of 2 medication cups (4 medication cups total) on top of the medication cart. She took the medication cart to the doorway of room C-103 and entered the resident's room. She had a conversation with the resident and returned to the medication cart. She placed that resident's medication drawer in the cart. She stated the resident was unable to take her medication at that	F 658		

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

Administrator | 07/26/2021

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 658	Continued From page 1 time. Staff C then took the other medication cups that were on the cart and poured them into a crush pouch, crushed the medication and poured the crushed medications into a medication cup. She added applesauce to the cup. She then pushed the medication cart to the doorway of room C-102. She took the medication cup into the resident's room and administered the medication. During an interview on 7/14/21 at 10:38 AM, Staff C, admitted she had medications in cups for 2 different residents on the medication cart. She stated it is not normal practice to prepare more than one resident's medication at a time. During an interview on 7/14/21 at 11:56 AM, the Director of Nursing (DON) stated she would expect medications not to be put in the medication cups prior to administration time. She stated she expect them to be placed in the medication cup at the time they were to be given. She stated she would expect the nurse not to have medications for more than one resident on the top of the medication cart at the same time. Review of the facility policy titled Medication Administration dated 10/10/19 stated medication labels will be checked against the current Medication Administration Record (MAR) for the individual resident's medication pass. The policy stated to verify the resident, drug, strength, dose, route and hours of administration with the MAR. The policy further stated to identify the resident and administer the medication.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		

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F 690	Continued From page 2 §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 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, clinical record review, staff interview the facility failed to provide proper	F 690		

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F 690	Continued From page 3 care of a catheter for 2 of 2 residents observed with catheters (Residents #20 and # 37). The facility reported a census of 40. Findings Include: 1. Review of Resident #20's Face Sheet documented an admission date of 8/5/20. The Resident's Minimum Data Set (MDS) dated 6/1/21 documented the resident needed extensive assistance The MDS documented the resident had an indwelling urinary catheter and is always incontinent of bowel. Review of the Resident's Diagnosis Report documented diagnosis including benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy and other retention of urine. The Diagnosis Report also documented a urinary tract infection on 3/5/21. Resident # 20's Care Plan includes a focus of resident requires indwelling urinary catheter related to obstructive uropathy. Observation on 7/12/21 at 12:20 PM in the dining room, showed the resident's catheter bag hanging on the side of his wheelchair, above the level of his bladder. Observation on 7/14/21 at 11:34 AM, showed the resident sitting in his room beside his bed. His catheter bag was hanging on the side his wheelchair above the level of his bladder. Observation on 7/14/21 at 12:21 PM, showed the resident sitting in the dining room with his catheter bag hanging on the side of his wheelchair above the level of his bladder.	F 690		

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F 690	Continued From page 4 2. Review of Resident #37's Face Sheet documented an admission date of 5/25/21. Review of the resident's MDS dated 6/28/21 documented the resident needed extensive assistance with personal hygiene and was totally dependent on staff for toilet use. The MDS documented the resident had an indwelling catheter and is always incontinent of bowel. Review of the resident's Diagnosis Report documented diagnosis including obstructive and reflux uropathy. The Diagnosis Report also documented acute cystitis without hematuria with an onset date of 8/12/20 and a resolution date of 1/1/21. The resident's care plan includes a focus of requiring an indwelling catheter related to obstructive uropathy. Observation on 7/13/21 at 12:21 PM, showed the resident at the dining table with his catheter hanging on the side of his wheelchair above the level of his bladder. Observation on 7/13/21 at 1:04 PM, showed the resident in the common area by the TV on the B wing in his wheelchair with his catheter bag hanging on the side of his wheelchair above the level of his bladder. Observation on 7/14/21 at 12:12 PM, showed the resident at the dining table with his catheter hanging on the side of his wheelchair above the level of his bladder. During an interview on 7/15/21 at 8:16 AM, the Director of Nursing (DON) stated she would expect catheter bags to be below the level of the bladder.	F 690		
F 732 SS=B	Posted Nurse Staffing Information	F 732		

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F 732	Continued From page 5 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732		

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F 732	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to post the correct Daily Staff Posting for 3 out of 4 days observed. The facility reported a census of 40 residents. Findings Include: Observations of the Daily Staff Posting revealed the following: a. On 7/12/21 at 10:52 AM, the Daily Staff Posting in the hall between B and C wings reflected a dated of 7/7/21. b. On 07/12/21 at 3:39 PM, the Daily Staff Posting reflected a dated of 7/7/21. c. On 07/14/21 at 8:47 AM, the Daily Staff Posting reflected a date of 07/13/21. d. On 07/14/21 at 4:43 PM, the Daily Staff Posting reflected a date of 07/13/21. e. On 07/15/21 at 10:215 AM, the Daily Staff Posting reflected a date of 07/13/21. Review of the Daily Staff Posting sheets in the clear white box that held the Staff Postings, revealed 4 Staff Posting Sheets dated 6/1/21, 7/5/21,7/7/21 and 7/13/21. Interview on 7/15/21 at 10:12 AM, the Director of Nursing (DON), stated the Staff Postings are completed by the Night Shift Nurse and she expected the Staff Posting completed daily and updated with changes. Interview on 7/15/21 at 12:40 PM, the Administrator revealed the facility lacked a policy directing staff to complete the Staff Posting.	F 732		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		

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F 803	Continued From page 7 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on facility menu review, observation, document review, and staff interviews, facility staff failed to ensure all residents on pureed and general texture diets received the proper portion size based on the planned menu for 3 out of 3 residents (Resident #13, # 20, and #37) on a pureed diet and 7 of 32 residents on a Regular diet in 2 out of 2 dining rooms observed. The facility identified a census of 40 residents.	F 803		

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F 803	Continued From page 8 Findings Include: 1. The facility's Week 4 Menu, signed by the Consultant Dietitian, identified 1 cup of scalloped potatoes with ham for residents receiving general diet and 1 serving of pureed scalloped potatoes with ham for the pureed diets on 7/1/421. Review of the facility Diet Report revealed 3 residents on a pureed diet and 32 residents on a regular diet. C Wing had 2 residents with pureed diet and B Wing had 1 resident with a pureed diet. During an observation on 7/14/21 at 11:00 AM Staff F, Cook pureed one chicken breast and put it in the steam table pan for the C Wing kitchenette. She stated they only have one pureed diet on C Wing. During an observation on 7/14/21 at 12:41 PM, the Executive Chef directed staff to reheat the pureed plates of food which had been plated and allowed to sit on ledge in kitchenette on B wing. Staff E, Dietary Aide questioned him how to do it and he directed Staff F, Cook to make all new plates of pureed due to allowed to sit out and get cold. During an observation on 7/14/21 at 12:50 PM, Staff F, Cook used a green scoop to portion three servings of scalloped potatoes and ham. The Pureed diet portion sizes/scoops chart indicated a 2 and 2/3 ounces portion. The Cook failed to use the proper serving size for the scalloped potatoes and ham for the initial pureed process. The end volume after she pureed the food was 1 and 1/4 cups of food. The chart indicated this should be a	F 803		

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F 803	Continued From page 9 #12 scoop. Staff F, Cook wrote #8 scoop on the tin foil covering the steam table pan. Staff F then pureed three servings of cornbread. The end volume for the cornbread when measured was 3/4 cup. Per the pureed diet portion sizes chart indicated staff should use a #16 scoop for serving. Staff F, Cook wrote on the container a #16 scoop to be utilized for serving. During an observation on 7/14/21 01:38 PM Staff E, Dietary Aide served one plate of pureed food with the size scoops per what was sent up from the kitchen in the steam table pan. The second plate only received 1/2 scoop of the cornbread and 1/3 of the scoop of scalloped potatoes and ham due to the cook failed to measure and calculate properly. 2. On 7/14/21 at 12:32 PM, Staff D, Dietary Aide, scooped 1 blue scoop (2 ounces) of pureed chicken and set it aside on the counter. On 7/14/21 at 12:38 PM, after nursing staff requested a pureed meal, Staff D provided 1 full 2 oz blue scoop of pureed chicken. Staff served the plate. Interview on 7/14/21 at 1:07 PM, Staff D, confirmed she dumped the pureed chicken that she sat aside into the trash. Interview on 7/14/21 at 1:12 PM Staff D, reported the Puree scoop size is decided by the kitchen. Staff D stated and looked at the spread sheet for scoop sizes and confirmed, the spread sheet lacked puree portion sizes. Staff D reported, she is pretty sure the kitchen put scoop color on the tin foil over the pureed dish.	F 803		

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F 803	Continued From page 10 3. On 7/14/21 at 12:35 PM, Staff D, used a blue 8 oz scoop for the general diet of ham and potatoes and failed to fully fill the scoop with the portion for 7 residents served in the C Wing dining room. Interview on 7/15/21 at 9:14 AM, Staff F, Cook, reported the servers are expected to serve the food per the menu and fill the scoop. During an interview on 7/15/21 at 8:59 AM with Staff E, Dietary Aide states he serves the meals from the scoop size wrote on the tin foil covering the steam table pans and if not on there he can check the menu in the binder in the kitchenette. If can not tell from either of these he will call the kitchen with any questions. During an interview on 7/15/21 at 9:08 AM with Staff F, Cook states she looks at the chart on the wall in the kitchen for portion sizes, and 1 serving is one cup per the menu for the scalloped potatoes and ham from 7/14/21. I think the green scoop is the one cup. Staff F explained after you puree food you have to measure it and then take to the chart and then find it on the chart with the amount of food to amount of serving and then that is what tells you what scoop size to use. We communicate it to the kitchenette staff by covering the food with foil and write it on there. The Dietary Staff should have the correct scoops in the kitchenette area. During an interview on 7/15/21 at 9:16 AM, the Culinary Manager (CM) states his expectation would be for staff to find in the menu the correct serving size of menu items before pureeing the food. The CM would expect the Dietary Staff to	F 803		

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F 803	Continued From page 11 serve the correct amount. The Dietary Staff need to follow the Pureed diet portion sizes/scoops chart to determine the correct serving size. The facility provided a policy titled Dietary Policies and Procedures dated 4/17 Guidelines for Pureed Diet which directed staff to portion food as directed in recipe by cutting serving pan as specified, using the dipper corresponding to portion size, or following recipe for portion size.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. 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, staff interview and facility policy review the facility failed to ensure dietary staff properly restrained their hair under hairnets during preparation and serving of food. The	F 812		

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F 812	Continued From page 12 facility failed to properly air dry dishes prior to utilizing for serving food with potential for cross contamination. The facility reported a census of 40 residents. Findings Include: 1. During an observation on 7/12/21 at 12:22 PM, Staff D, Dietary Aide in the kitchenette on B Wing, noted with her hairnet in place, but with bangs uncovered serving the noon meal. During an observation on 7/13/21 at 12:20 PM, Staff D serving lunch in the kitchenette on C Wing with bangs outside of the hairnet. On 7/14/21 at 8:42 AM, observed Staff D in the kitchenette on C Wing wearing a hair net over only the back part of her head with 2 inches of bangs on outside of hair net serving breakfast. On 7/14/21 11:04 AM, Staff D observed scooping ice from ice machine in the kitchen with her hair net in the same position with her bangs sticking out. During an interview on 7/15/21 at 9:08 AM, Staff F, Cook states hair nets should cover all the hair at all times when working with food. During an interview on 7/15/21 9:16 AM, the Culinary Manager (CM) stated he would expect hair nets should cover all hair when serving food. The facility provided a policy titled Personal Hygiene dated 4/17 which directed Food Service Employees must wear a hair restraint such as a hairnet, chef hat, etcetera to effectively keep hair from coming in contact with exposed food or	F 812		

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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
F 812	Continued From page 13 clean equipment and utensils. Individuals with facial hair must keep tightly trimmed or provide for total enclosure of facial hair. 2. During an on observation on 7/14/21 at 12:50 PM, the Culinary Manager utilized paper towels to dry three steam table pans for the Cook to use for Pureed items. During an observation on 7/14/21 at 12 :50 PM, Staff F, Cook used a paper towel to dry a scoop from the dishwasher used to serve pureed foods. During an interview on 7/15/21 at 9:08 AM, Staff F states dishes coming out of the dishwasher should not be dried. They should be allowed to air dry. During an interview on 7/15/21 at 9:16 AM, the Culinary Manager states the dishes should be air dried to prevent contamination. The facility provided a policy titled Dishwashing Procedure, directed the staff all dishes should be dry before being stored or stacked and they should be covered when not in use. Toweling can re-contaminate the dishes. 3. During observations of the noon meal on 7/14/21 from 11:59 AM through 1:12 PM, noted Staff D, Dietary Aide wore a hair net that covered the sides and back of her hair. The hair net failed to contain over 2 inches of her bangs while she served the meal.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165626	A. BUILDING _____ B. WING _____	07/15/2021

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F 880	Continued From page 14 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual 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:	F 880		

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F 880	Continued From page 15 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and policy review, the facility failed to maintain infection control standards in regards to keeping catheter drainage bags off the floor for 3 of 4 residents reviewed (Resident #13, #20 and #37) and failed to provide proper catheter care for 1 out of 1 residents reviewed (Resident #20). Facility staff also failed to wear the proper face mask when working near residents. The facility reported a census of 40.	F 880		

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F 880	Continued From page 16 Findings Include: 1. Review of Resident #20's Face Sheet documented an admission date of 8/5/20. The Resident's Minimum Data Set (MDS) dated 6/1/21 documented the resident needed extensive assistance The MDS documented the resident had an indwelling urinary catheter and is always incontinent of bowel. Review of the Resident's Diagnosis Report documented diagnosis including benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy and other retention of urine. The Diagnosis Report also documented a urinary tract infection on 3/5/21. Resident # 20's Care Plan includes a focus of resident requires indwelling urinary catheter related to obstructive uropathy. An observation on 7/12/21 at 10:24 AM, showed the resident's catheter bag hanging on the outside of the dignity bag and touching the floor. During an observation on 7/12/21 at 2:30 PM, staff A, Certified Nurse Aide (CNA) and Staff B (CNA) performed catheter care for the resident. Staff B cleansed the catheter tubing wiping away from and back towards the meatus. Staff B used a clean wash cloth to rinse the catheter tubing away from and back towards the meatus. During an interview with the Director of Nursing on 7/15/21 at 11:24 AM, she stated she would expect catheter cleaning to be in one direction, away from the meatus. 2. Review of Resident #37's Face Sheet	F 880		

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F 880	Continued From page 17 documented an admission date of 5/25/21. Review of the resident's MDS dated 6/28/21 documented the resident needed extensive assistance with personal hygiene and was totally dependent on staff for toilet use. The MDS documented the resident had an indwelling catheter and is always incontinent of bowel. Review of the resident's Diagnosis Report documented diagnosis including obstructive and reflux uropathy. The Diagnosis Report also documented acute cystitis without hematuria with an onset date of 8/12/20 and a resolution date of 1/1/21. The resident's Care Plan includes a focus of requiring an indwelling catheter related to obstructive uropathy. An observation on 7/12/21 at 10:22 AM, the resident was in bed resting. His catheter bag was hanging off the side of the bed, not in a dignity bag, touching the floor. 2. The MDS assessment for Resident # 13 dated 5/17/21, listed a diagnoses of neurogenic bladder. The MDS read the resident required extensive assist of 1 staff for personal hygiene and toileting. The Care Plan for Resident # 13 dated 12/03/2020, identified Resident # 13 required a suprapubic catheter related to a neurogenic bladder. The Care Plan read, the Resident will have catheter care managed appropriately as evidenced by: not exhibiting signs of infection or urethral trauma. Review of the Hospital Discharge Medications dated 5/6/21, directed Entrancing (antibiotic) bladder instillation (480 milligrams (mg)	F 880		

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F 880	Continued From page 18 Gentamycin in 1 liter Normal Saline (NS)), instill 30 milliliters (ml) via suprapubic catheter two times a day for 7 days, then daily thereafter. Cap suprapubic (above the pubis) catheter and let remain in the bladder for 30 minutes, then drain. One time a day for recurrent UTI The Treatment Administration Record (TAR) dated July 2021, directed Gentamycin bladder instillation 480 milligrams (mg) Gentamycin 1 liter (NS), instill 30 (ml) via suprapubic catheter two times a day for 7 days, then daily thereafter. Cap suprapubic catheter and let remain in the bladder 30 minutes, then drain. One time a day for recurrent UTI. Observation on 7/13/21 at 8:27 AM, Resident # 13's catheter bag laid on the floor under his bed. On 7/13/21 at 8:32 AM, the Administrator entered the the resident's room and reported the Director of Nursing (DON) is on her way. On 7/13/21 at 8:37 AM, the DON entered the resident's room applied gloves and picked the catheter bag up from floor and hung the catheter bag on the side of the bed. Interview on 7/15/21 at 8:16 AM, the DON reported the expectation is a catheter bag is stored off the floor, in a privacy bag and below the bladder. The policy titled Catheter Care dated 10/1/18, directed the tubing and catheter bag should not touch the floor. 3. On 7/14/21 at 1:16 PM, Staff G, Housekeeper	F 880		

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F 880	Continued From page 19 entered the C Wing Dining Room and wore a black cloth face mask. On 7/15/21 at 7:28 AM, Staff G in the B Wing with a housekeeping cart wore a cloth facemask while talking to the Administrator. 4. During an observation on 7/14/21 at 8:39 AM, noted Staff G, Housekeeper clearing tables of breakfast dishes in the C Wing dining area with residents sitting at the tables. Staff G noted a black cloth mask on his face. During an observation on 7/14/21 at 11:00 AM, Staff G cleaned the main hall wearing a black cloth mask. During an interview on 7/15/21 at 8:55 AM, Staff G states they have not provided any education regarding the types of face masks he could wear. During the interview Staff G currently clearing dishes from residents table in the B Wing dining room with a black cloth face mask in place. During an interview on 7/15/21 at 9:37 AM, the Director of Nursing (DON) stated staff should not be wearing a cloth mask. They are supposed to wearing disposable face mask per our policy. The staff are screened when they enter the building. The facility provided a policy titled Personal Protective Equipment (PPE) use for COVID-19 Prevention revised 5/5/21 which directed staff current guidance from the Center for Disease Control (CDC), Public Health and Center for Medicare Services (CMS) regarding the use of PPE will be followed. All personnel must wear a face mask while they are in the facility. Disposable face masks should be utilized. Follow	F 880		

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F 880	Continued From page 20 CDC guidance for conserving PPE when a shortage is occurring. Review of the Center for Disease Control (CDC) website Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes last updated 3/29/21 had a definition of Cloth mask: Textile (cloth) covers that are intended primarily for source control. They are not Personal Protective Equipment (PPE) appropriate for use by healthcare personnel as the degree to which cloth masks protect the wearer is unclear.	F 880		

Plan of Correction

Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

Accept this as the facilities credible allegation of compliance

F658	Samantha Gaspar, RN Director of Nursing 07/20/21-7/28/21	Director of Nursing performed medication administration audits with the employee in question, as well as with all other licensed nurses.	Medication administration audits will be conducted by Director of Nursing with all licensed nurses upon hire; Medication administration audits will be conducted with each licensed nurse annually and when concerns arise.	Routine audits as previously discussed

Accept this as the facilities credible allegation of compliance

F690	Samantha Gaspar, RN, Director of Nursing	All-Staff Inservice conducted on 7/20/21, at which time DON provided education regarding placement of catheter bags in relation to resident bladder. DON also provided Indwelling Foley Catheter skills audits with all Certified Nursing Assistants between dates of 7/20/21 and 7/30/21. Changed type of privacy bag used to hold urinary drainage bag. Bags can now attach safely to seating to ensure bags are below the level of the bladder. Bags purchased through Medline on 7/28/21. Bags specifically provided to resident number 20 and 37.	Placement of bag will be checked during weekday rounds by management nurses. Charge nurses will be responsible for monitoring placement of urinary drainage bags throughout their shifts. Education on bag placement will be provided during routine skills audits with direct care staff. Director of Nursing will be responsible for ordering of drainage bag covers.	QA will monitor healthcare aquired catheter-associated infection rates at least quarterly. Infection preventionist will track infection rates monthly and report concerns quarterly and as needed.

Accept this as the facilities credible allegation of compliance.

F732	Samantha Gaspar, RN, Director of Nursing	All-Staff Inservice conducted on 7/20/21, at which time DON provided education specifically to overnight nurses who are responsible for initiating daily staff postings. Director of Nursing and Assistant Director of Nursing are responsible for checking posting in place and updated on weekdays. Day shift charge nurse assigned to B wing responsible for checking posting on weekends.	Director of Nursing will provide training on daily staff posting to all licensed nurses upon hire and at routine nursing inservices.	Director of Nursing will collect daily staff postings and organize them chronologically by date. QA to check at least quarterly.

Accept this as the facilities credible allegation of compliance

F803	Josh Bargman, Culinary Manager	On 7/21/21, all dietary staff attended an inservice on proper way to puree foods and serve them. All staff members demonstrated proper technique after education provided.	Culinary Manager will provide education on how to prepare and serve pureed food upon hire and perform audits annually and with concerns.	QA will discuss at least quarterly or when concerns arise.

Accept this as the facilities credible allegation of compliance

F812	Josh Bargman, Culinary Manager	On 7/21/21, all dietary staff attended an inservice on food safet requirements, including the usage of hairnets and how to store, prepare, distribute and serve food in accordance with professional standards for food safety.	Culinary Manager will provide education on food safety requirements upon hire and during regular inservices.	QA will discuss food safety at least quarterly or when concerns arise.

Accept this as the facilities credible allegation of compliance

F880	Samantha Gaspar, RN, Director of Nursing; Morgan Brunscheen, Administrator	All staff provided education through videos on 7/28/21. All staff completed video training by 8/3/21. All-Staff Inservice conducted on 7/20/21, at which time DON provided education regarding placement of catheter bags to be up off the floor. DON also provided Indwelling Foley Catheter skills audits with all Certified Nursing Assistants between dates of 7/20/21 and 7/30/21. Changed type of privacy bag used to hold urinary drainage bag. Bags can now attach safely to seating to ensure bags are off the floor. Bags purchased through Medline on 7/28/21. Bags specifically provided to resident number 13, 20, and 37, and all residents currently using bed bags. Staff audits performed for proper cleaning of tubing specifically for staff to clean away from the meatus.	Staff education regarding PPE use for COVID-19 Prevention will be provided upon hire and at regulary inservices. Indwelling foley catheter education will be provided upon hire and audits will be performed annually and with concerns.	QA will discuss quarterly and when concerns arise.

Root Cause Analysis

Team Facilitator: Samantha Gaspar, RN Director of Nursing
Date RCA started: 7/20/2021
Date Ended: 7/30/2021

Team Members:
Kelly Kimble, Restorative RN
Morgan Brunscheen, LPN, Administrator
Alyssa Brighi, RN, MDS Coordinator

Narrative Description of Event:
Tag F880: Catheter drainage bag was observed resting on the floor

Root Cause:	Staff need more education on infection control for indwelling urinary catheters
Corrective Action	Education provided to staff through inservice on 7/20/21 and skills audits with CNA's from 7/20-7/30/21;
Responsible person/group	Samantha Gaspar, RN Director of Nursing
Completion Deadline	7/30/2021

Corrective Action:	Education provided to staff through inservice on 7/20/21 and skills audits with CNA's from 7/20-7/30/21
Measure of Success:	No catheter bags observed on floor during routine daily rounds by DON or other nurse management staff.
Reporting and Responsibility:	QA to monitor quarterly and when concerns arise;

Signature of RCA team leader:_____

Team Facilitator: Samantha Gaspar, RN Director of Nursing
Date RCA started: 7/20/2021
Date Ended: 7/30/2021

Team Members:
Kelly Kimble, Restorative RN
Morgan Brunscheen, LPN, Administrator
Alyssa Brighi, RN, MDS Coordinator

Narrative Description of Event:
Tag F880: Improper catheter care cleaning performed by staff

Root Cause:	Staff need more education on proper catheter cleaning for indwelling foley catheters
Corrective Action	Education provided to staff through inservice on 7/20/21 and skills audits with CNA's from 7/20-7/30/21;
Responsible person/group	Samantha Gaspar, RN Director of Nursing
Completion Deadline	7/30/2021

Corrective Action:	Education provided to staff through inservice on 7/20/21 and skills audits with CNA's from 7/20-7/30/21
Measure of Success:	Reduction of urinary infection rates;
Reporting and Responsibility:	Infection control log monitored monthly by infection preventionist and through quarterly QAPI

Signature of RCA team leader:_____

Root Cause Analysis

Team Facilitator: Samantha Gaspar, RN Director of Nursing
Date RCA started: 7/20/21
Date Ended: 8/3/21

Team Members:
Kelly Kimble, Restorative RN
Morgan Brunscheen, LPN, Administrator
Alyssa Brighi, RN, MDS Coordinator
Angela Sarsfield, Administrative Assistant/Human Resources

Narrative Description of Event:
Tag F880: Employee was wearing a cloth mask on two separate days.

Root Cause:	Employee was not provided proper PPE use instruction
Corrective Action	All staff will be provided proper PPE use education upon hire by Human Resources
Corrective Action	Proper PPE use education will be provided to all staff through computer-based education.
Responsible person/group	Administrator, Director of Nursing, Human Resources
Completion Deadline	8/3/21

Corrective Action:	Proper PPE use education will be provided to all staff through computer-based education.
Measure of Success	All staff complete video training by 8/3/21; New hires complete education before training begins
Reporting Schedule and Respo	Admin will review completion on 8/3/21 to ensure staff have completed assigned videos Human Resources to check through QA process quarterly and as needed

Signature of RCA team leader:_____