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F 000	INITIAL COMMENTS Correction Date: 7/10/22 The following deficiencies relate to the recertification survey conducted 5/16/22 through 5/23/22.	F 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.	
F 554 SS=D	(See Code of Federal Regulations (42CFR) Part 483, Subpart B-C) Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and clinical record review, the facility failed to assess a resident for self-administration of medications before leaving medications with a resident for one of eight residents reviewed (Resident #19) during medication administration. The facility reported a census of 34 residents. Findings include: Resident #19's Minimum Data Set (MDS) assessment dated 3/16/22 documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Resident #19's Care Plan Focus revised 3/2/21 indicated the diagnoses of impaired swallowing, high risk for aspiration r/t (related to) ST (Speech Therapy) swallowing assessment results, and moderate dysphagia (difficulty swallowing).	F 554		

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

06/23/2022

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F 554	Continued From page 1 The Care Plan for Resident #19 lacked documentation related to Resident #19's ability to self-administer medications. On 5/17/22 at 6:50 AM, Staff A, Registered Nurse (RN), prepared nine medications in the dining room to administer to Resident #19. On 5/17/22 at approximately 6:54 AM, the nurse left medications with Resident #19 while at the dining table. On 5/17/22 at 7:01 AM and 7:09 AM, the medications remained on the table. On 5/17/22 at 7:14 AM, observation revealed Resident #19 sat at the table in the dining room and eating. The pills remained in the cup next to the resident. An observation revealed Staff A present in the dining room. Staff A asked another resident if they were ready for their medications. On 5/17/22 at 7:18 AM, Resident #19's pills remained at the table. Resident #19 picked up the pill cup, placed the plastic medication cup on their dishes, and began taking the pills with water. On 5/18/22 at 11:40 AM, when queried as to the process if medications were not taken when they had been offered to residents, the Director of Nursing (DON) acknowledged staff would stay with the resident until the medications were taken, and if refused they could come back to them. When queried if they should have been left with the resident, the DON explained not unless the nurse was supervising that. When queried if any of the residents had been assessed as fine to self-administer medications, the DON	F 554	F554: Resident Self -Administration of Medications-Clinically Appropriate 481-58.21(135C) Drugs, storage, and handling. Staff Nurse A was re-educated on 05/19/2022 regarding the medication administration policy and to ensure residents take their medication before the nurse leaves the resident unless otherwise specified in resident care plan. Nursing staff re-education of the medication administration policy was completed during an in-service for all licensed nursing staff on 05/25/2022. Audits will be completed by the DON/or Designee periodically to ensure compliance. Ongoing Audit findings will be brought to the quarterly QAPI meetings. Ongoing	

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F 554	Continued From page 2 acknowledged they had not been. The undated Facility Policy titled Medication Administration Policy documented the following: 11. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. 15. The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR (Medication Administration Record), and action is taken as appropriate.	F 554		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries,	F 640		

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F 640	Continued From page 3 and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, facility policy reviews, and staff interviews, the facility failed to submit a Minimum Data Set (MDS) assessment in a timely manner for two of two residents reviewed for MDS (Resident #19 and Resident #21). The facility reported a census of 34 residents. Findings include: 1. Review of Resident #19's Quarterly MDS	F 640	F640: Encoding/transmitting resident assessments 483.20(f)(3) Transmittal requirements. Resident #19's MDS was completed on 03/25/2022; however, was not submitted until 04/15/2022. Resident #21's MDS was completed on 03/25/2022; however, not submitted until 04/15/2022. MDS coordinator acknowledged the assessments under CMS guidelines should have been submitted no later than 04/07/2022 for both resident #19 and resident #21. MDS Nurse was provided a 1:1 verbal education on 05/19/2022 by DO Education was provided to the MDS coordinator regarding MDS completion on all residents quarterly, annually, and as needed on 5/19/2022. Administrator completed an internal audit on all other residents who had MDS submissions due on 04/07/2022. The DON/Designee will be completing audits periodically to ensure MDS's are completed with accuracy. Ongoing Audit findings will be reported in quarterly QAPI meetings. Ongoing.	

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F 640		F 640		

Continued From page 4 assessment, Assessment Reference Date (ARD) 3/16/22, documented as completed on 3/25/22. The assessment got submitted on 4/15/22, 21 days after the completion date.

2. Review of Resident #21's Annual MDS assessment, ARD 3/16/22, documented as completed on 3/25/22. The assessment got submitted on 4/15/22, 21 days after the completion date.

On 5/19/22 at 3:01 PM, the MDS Coordinator acknowledged the assessments should have been submitted on 4/7, and acknowledged the assessments had been late.

On 5/19/22 at 3:20 PM, when queried if they had been aware of any concerns with the MDS, the Director of Nursing (DON) acknowledged they had not been.

The Facility Policy titled MDS Completion and Submission Timeframes dated 2001 documented, the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.

The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) verison 3.0 Manual dated October 2019 on page 5-3 documented that transmitting data: submission files are transmitted to the Quality Improvement and Evaluation System (QIES) Assessment Submission and. Processing (ASAP) system using the CMS wide area network. Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or

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F 640	Continued From page 5 correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted. - Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days)	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		

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F 656	Continued From page 6 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and clinical record reviews the facility failed to include wandering, risk for elopement, and the use of antidepressant medications in the comprehensive plan of care for one of fourteen residents reviewed for care planning (Resident #21). The facility reported a census of 34 residents. Findings include: Resident #21's Minimum Data Set (MDS) assessment dated 3/16/22 documented a score of 5 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating severe cognitive impairment. Per the assessment, Resident #21 wandered four to six days in the lookback period, but less than daily. The assessment documented that Resident #21 received antidepressant medication for seven out of seven days in the lookback period. Resident #21's Quarterly Wandering Risk Scale	F 656	F656: Develop/Implement Comprehensive Care Plan 481-58.18 (135C) Resident # 21's care plan was updated with anti-depressant use and wandering risk on 05/19/2022. Care plans are reviewed and revised quarterly and as needed to reflect changes in the plan of care. MDS/Care Plan Nurse and staff who oversee updating care plans were educated regarding the importance and efficiency of updating resident care plans on 05/19/2022. Internal audit was completed on 06/30/2022 of all current residents' care plans. Audits will be completed by the DON/Designee periodically to ensure compliance. Ongoing. Audit findings will be brought to the quarterly QAPI meetings.	

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F 656		F 656		

Continued From page 7 dated 12/28/21
identified the resident as a high risk to wander.

The Behavior Note dated 3/2/22 at 1:16 AM documented, that staff reported that Resident #21 got up and needed to go home because the kids were home. The nurse talked with her, got her into her room, and got her feet up with the television (TV) on. Resident #21 observed to be awake but more calm.

Resident #21's Care Plan lacked documentation related to wandering or risk for elopement.

Resident #21's Physician Orders Sheet (POS) signed 1/24/22 included an order for citalopram hydrobromide tablet 10 MG (milligrams) Give one tablet by mouth one time a day for depression.

Resident #21's Medication Administration Record (MAR) for the months of 3/22, 4/22 and 5/22 revealed she received antidepressant medication.

Resident #21's Care Plan lacked documentation related to the use of antidepressant medication.

On 5/18/22 at 8:21 AM, observation revealed Resident #21 in their room in their recliner chair, with the foot portion of the chair elevated.

On 5/19/22 at 1:29 PM, when queried about the review of care plans, the MDS Coordinator explained that Care Plans got reviewed with a new MDS assessment, with falls, and a change in condition. When queried about a wandering care plan for Resident #21, the MDS Coordinator explained that due to her being in the locked unit, that she could easily be redirected, and if she got upset, staff could call her son who could redirect

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F 656	Continued From page 8 the resident. The MDS Coordinator acknowledged that if someone got assessed as an elopement risk or required a wanderguard that would be Care Planned. When queried about whether antidepressants would be care planned, the MDS Coordinator acknowledged it should go on the Care Plan. On 5/19/22 at 3:20 PM, when queried if antidepressants would be included on the care plan, the DON responded antidepressants would normally be on the care plan or included under high risk medications. When queried if identification of wandering behaviors on the MDS if it should be care planned, the DON responded that a Care Plan should get updated for a resident at risk for elopement and a wander risk assessment would be done as well. The Facility Policy titled Care Plans, Comprehensive Person-Centered, dated 2001 documented the following: 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The Care Plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		

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F 657	Continued From page 9 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-(A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and clinical record reviews the facility failed to update the Care Plan to include a diagnosis of diabetes, the use of a catheter, and revise a resident's plan of care to remove use of antidepressant medication for three of fourteen residents reviewed for care planning (Resident #8, Resident #13, and Resident #15). The facility reported a census of 34 residents. Findings include: 1. Resident #8's Minimum Data Set (MDS) dated 2/23/22 documented a score of 6 out of 15 on the Brief Interview for Mental Status (BIMS) exam,	F 657	F657: Care Plan Timing and Revision 481-58.20(135C) Duties of health service supervisor. Resident # 8's care plan was updated diagnosis of diabetes mellitus with signs and symptoms to monitor on 05/19/2022. Resident # 13's care plan was updated with antidepressant use on 05/19/2022. Resident # 15's care plan was updated to reflect urinary catheter on 05/19/2022. All other similarly situated resident care plans were reviewed for accuracy on 05/19/2022. Care plans are reviewed and revised quarterly and as needed to reflect changes in the plan of care. Staff who oversee updating care plans were educated regarding resident care plans on 05/19/2022. Internal Audit of all Resident Care Plans to review for accuracy was completed on 06/30/2022. Audits will be completed by the DON/or Designee periodically to ensure compliance. Ongoing. Audit findings will be brought to the quarterly QAPI meetings. Ongoing	

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Continued From page 10 indicating severe cognitive impairment. The MDS included that Resident #8 showed physical behavioral symptoms directed toward others for one to three days in the lookback period. Resident #8's MDS included diagnoses of diabetes mellitus, non-Alzheimer's dementia, and unspecified dementia with behavioral disturbance. Resident #8 used an antipsychotic medication for seven out of seven days in the lookback period.

Diagnoses for Resident #8 included dementia with behavioral disturbance (added 6/7/21), and type 2 diabetes mellitus (added 8/11/21).

The Nurse's Note dated 8/10/21 at 5:56 PM documented that the facility received a fax back from the MD (Medical Doctor) with new orders to start metformin (oral diabetic medication) 500 mg (milligrams) BID (twice a day), add DM (diabetes mellitus) type two to Resident #8's diagnosis list, check her glucose daily, and draw Hgb A1C (a laboratory blood draw to determine an average blood sugar over the previous three months). Resident #8's Niece verbalized understanding when informed that Resident #8 had new orders.

The Physician Order Sheet signed 3/28/22 documented an order for metformin hydrochloride (hcl) tablet 500 MG (milligrams) to give 500 mg by mouth one time a day for diabetes mellitus type two.

On 5/16/22 at 11:36 AM, observed Resident #8 walked around the area of the facility where the resident resided.

Resident #8's Care Plan lacked documentation related to her diagnosis of diabetes mellitus and

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F 657		F 657		

Continued From page 11 what signs or symptoms should be monitored.

2. Resident #13's MDS dated 3/9/22 documented a score of 4 out of 15 on the BIMS assessment, indicating severe cognitive impairment. Per the assessment, Resident #13 received antidepressant medication for zero of the last seven days.

The Care Plan dated 1/4/21 revised 2/18/21 documented, that Resident #13 used an antidepressant medication r/t (related to) dementia in other diseases classified elsewhere with behavioral disturbance.

Resident #13's Physician Order Sheets signed 1/24/22 and 3/28/22 did not include an antidepressant medication.

The Medication Administration Record (MAR) for the month of May 2022 did not include an antidepressant medication.

On 5/19/22 at 1:29 PM, when queried about the review of Care Plans, the MDS Coordinator explained that Care Plans got reviewed with a new MDS assessment, with falls, and a change in condition. The MDS Coordinator acknowledged that a couple were missed with changes of condition, and that was something that was being worked on. When queried how they would be updated with changes, the MDS Coordinator explained they would review miscellaneous records, would scan in orders changed, etc., and the staff were pretty good about letting them know. When queried if diabetes would be Care Planned, the MDS Coordinator acknowledged it would be something that she liked to Care Plan. When queried as to the process for Care

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F 657		F 657		

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Planning for the discontinuation of medications, the MDS Coordinator explained she believed she would go in and try to resolve it.

On 5/19/22 at 3:20 PM, the Director of Nursing (DON) acknowledged diabetes would normally be on the Care Plan. When queried as to how long it would take for antidepressants to be removed from the Care Plan if the resident no longer received the medication, the DON responded she hoped right away, and if there had been a change she thought it should be updated.

The Facility Policy titled Care Plans, Comprehensive Person-Centered, dated 2001 included that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

3. Resident #15's MDS assessment dated 1/3/22 identified a BIMS score of 9, indicating moderately impaired cognition. The MDS included diagnoses of atrial fibrillation (an abnormal heart rhythm), obstructive uropathy (a condition in which the flow of urine is blocked) and non-Alzheimer's dementia. The MDS identified that Resident #15 required extensive assistance of one person with all activities of daily living. The assessment indicated that Resident #15 had an indwelling catheter.

The Physician Orders dated 4/11/22 documented an order for a urinary catheter, size 16 French silver coated with 10 cc (cubic centimeters) balloon, to be change every 30 days.

The Care Plan with the target date of 7/18/22 lacked documentation related to the use of an indwelling catheter or interventions on the proper

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F 657	Continued From page 13 care. Observations during the survey from 5/16/22 through 5/23/22 revealed Resident #15 had an indwelling catheter. On 5/18/22 at 10:48 AM, Staff B, Registered Nurse (RN), reported that if a resident had an indwelling catheter, it would be the responsibility of the MDS coordinator to ensure it had been addressed on the Care Plan. On 5/18/22 at 11:27 AM, the DON (Director of Nursing) reported she would expect the foley catheter to be addressed on the resident's Care Plan. On 5/19/22 at 1:38 PM, the MDS Coordinator reported that she expected the resident's care plan to address the indwelling catheter and that she forgot to add it to his Care Plan when he returned with it.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and staff interviews, the facility failed to document an	F 684		

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F 684	Continued From page 14 assessment of a resident prior to and upon return from the hospital for one of two residents reviewed with hospitalizations (Resident #23). The facility reported a census of 34 residents. Findings included: Resident #23's MDS dated 3/23/22 identified a BIMS (Brief Interview for Mental Status) score of 11, indicating moderately impaired cognition. The MDS included diagnoses of cancer, obstructive uropathy, and renal insufficiency (kidney failure). It also identified Resident #23 required extensive assistance of one person with bed mobility, transfers, locomotion on the unit, locomotion off the unit, dressing, and personal hygiene. Resident #23 required an extensive assistane of two persons with toilet use. The assessment documented that Resident #23 used an indwelling catheter. The MDS documented Resident #15 as always incontinent of urine and frequently incontinent of bowels. The Care Plan Focus revised 9/3/21 identified Resident #23 required an indwelling catheter due to an obstruction and stent placement on 8/9/21. The Care Plan interventions directed staff to monitor, record, and report to the physician signs and symptoms of a urinary tract infection (UTI) such as: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and a change in eating patterns. Nurse's Notes review a. 2/2/22 at 4:01 PM Resident #23 returned from surgery by a van accompanied by staff. Resident	F 684	F684: Assessment and Intervention 481-58.19(135C) Required nursing services for residents. The resident assessment policy was reviewed on 05/19/2022. Staff Nurse B was re-educated regarding completing full assessments on residents on 05/20/2022. Education was provided to all other staff nurses regarding completing of full resident assessments on 05/25/2022. Audits will be completed by DON/Designee periodically. Ongoing. Audit findings will be brought to the quarterly QAPI meetings. Ongoing.	

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#23's color appeared pink, warm, and dry with a temperature of 97.9.

* The note lacked documentation of an assessment of Resident #23's indwelling catheter, appearance of urine, presence of pain, and etc.

b. 2/3/22 at 3:57 AM Resident #23 had emesis (vomited) of bile. Notified Doctor of Resident #23's condition.

* The note lacked an assessment of palpation of the abdomen, presence of bowel sounds, the amount, color of emesis, or vital signs (VS).

c. 2/3/22 at 4:48 AM the doctor returned a phone call with new orders to send Resident #23 to the emergency room (ER). The nurse called an ambulance for transport. Resident #23 left the facility awake, alert with some confusion, and in no apparent distress. The facility called a report to the hospital staff, appropriate paperwork sent with the ambulance.

* The note lacked documentation of the time and how Resident #23 got transported, a complete assessment of Resident #23 upon time of transfer.

d. 2/7/22 at 12:43 PM Resident #23 returned to the facility by the facility van following his hospital stay for sepsis secondary to a UTI (urinary tract infection) following a recent renal stent placement. VS: temperature of 96.9, heart rate of 81, respiration rate of 24, blood pressure of 136/62 and Sp02 (serum pressure and oxygen - the amount of oxygen in the body) 96% on RA (room air). Resident #23 denied pain. The nurse observed a catheter intact draining yellow urine. Staff assisted Resident #23 to transfer into bed, mild weakness observed during the transfer.

The hospital physician's History and Physical dated 2/3/22 documented the following: patient

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presented with a history of ureteral fibrosis with double-J stenting (insertion of a plastic tube to help drain urine from the kidney). The patient had a stent exchange the day before. The patient noted to have a temperature of 101 with increased confusion that day. In the emergency room, he had a bolus of 500 mls (milliliters) and blood cultures sent. The patient received ceftriaxone (an antibiotic used to treat infections) for treatment and got admitted to the hospital.

On 5/18/22 at 10:48 AM, Staff B, Reigsterd Nurse (RN) reported that when a resident got transferred to the hospital, the nurse should document some kind of assessment, document the communication with the physician and family, if the paramedics were called, and other way the resident got transported to the hospital.

On 5/23/22 at 8:13 AM, the DON reported that she would have the following expectations:
a. When a resident transferred to the hospital, the nurse should document the resident's assessment, that they notified the family and physician, the time and mode of how they were transported to the hospital.
b. When a resident had symptoms of emesis and got transferred to the hospital, the nurse should document the amount, color, bowel sounds, and any other concerns
c. When a resident returned from the hospital with an indwelling catheter, the nurse should document placement, functioning properly, and color of the urine.

The Resident Examination and Assessment policy revised February 2014 documented the following:
DOCUMENTATION

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F 684	Continued From page 17 The following should be documented in the resident's medical record a. the date and time the procedure was performed b. the name of the individual who performed the procedure c. all assessment data obtained during the procedure d. how the resident tolerated the procedure e. if the resident refused the procedure, why and interventions taken f. signature and title of the person recording the data REPORTING Notify the physician of any abnormalities such as but not limited to: a. abnormal vital signs; b. distended, hard abdomen or absence of bowel sounds c. worsening pain as reported by the resident	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690	F690: Bowel/Bladder incontinence, catheter, UTI 481-58.19(135C) Required nursing services for residents. Staff C, Certified Nurse Aide was re-educated regarding catheter emptying, catheter tubing touching the floor, catheter bag placement, dignity bag use, and touching catheter tubing without gloves on 05/19/2022. (F690 continued next page)	

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F 690	Continued From page 18 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 observations, clinical record reviews, and staff interviews, the facility failed to ensure the catheter tubing had been kept up off the floor for 3 out of 3 residents reviewed (Residents #1, #15 and #23). The facility also failed to ensure indwelling catheter bags got placed in a dignity bag for 2 out of 3 residents reviewed with catheters (Residents #15 and #23). The facility reported a census of 34 residents. Findings included: 1. Resident #1's Minimum Data Set (MDS) assessment dated 2/1/22 documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Resident #1's MDS included diagnoses of obstructive uropathy, cerebrovascular accident	F 690	Staff F, Certified Nurse Aide was re-educated regarding catheter emptying, catheter tubing touching the floor, catheter bag placement, dignity bag use, and touching catheter tubing without gloves on 05/19/2022. Staff A, RN was re-educated regarding catheter emptying, catheter tubing the floor, catheter bag placement, dignity bag use, and touching catheter tubing without gloves on 05/19/2022. Staff E, Certified Nurse Aide was re-educated regarding catheter emptying, catheter tubing on the floor, catheter bag placement, dignity bag use, and touching catheter tubing without gloves on 05/19/2022. Staff D, Certified Nurse Aide was re-educated regarding catheter emptying, catheter tubing on the floor, catheter bag placement, dignity bag use, and touching catheter tubing without gloves on 05/19/2022.	

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F 690	Continued From page 19 (stroke) and hemiplegia (paralysis of one side of the body). The MDS coded that Resident #1 required extensive assistance of two person with bed mobility, transfers, dressing, personal hygiene, and toilet use. The Care Plan Focus revised 2/12/21 identified Resident #1 used an indwelling catheter for urinary retention on. The Care Plan lacked direction regarding the care of the catheter while in the wheelchair or in bed. It did not have interventions that directed staff to keep the catheter tubing off the floor. The following observations of the resident revealed the catheter tubing on the floor at: a. 5/17/22 at 9:12 AM Staff C, Certified Nurse Aide (CNA), pushed Resident #1 in her wheelchair out to the activity area as the catheter tubing dragged across the floor. Staff C did not reposition the tubing from off the floor before leaving Resident #1. b. 5/17/22 at 9:19 AM Staff C, assisted another resident to sit at a table next to Resident #1 while the catheter tubing remained on the floor. Staff F, CNA, and Staff C did not adjust Resident #1's catheter tubing before leaving the area. c. 5/19/22 at 9:32 AM observed catheter tubing remained on the floor. Staff F, did not reposition the tubing before leaving the area. d. 5/17/22 at 9:58 AM observed the tubing off the floor, as Resident #1 remained in the activity area playing Bingo. e. 5/17/22 at 11:40 AM witnessed Resident #1 sitting in her wheelchair in the main dining room with her catheter tubing noted on the floor. Staff A, Registered Nurse (RN) sat beside the resident's tablemate and did not reposition Resident #1's catheter tubing.	F 690	Staff B, Certified Nurse Aide was re-educated regarding catheter emptying, catheter tubing on the floor, catheter bag placement, dignity bag use, and touching catheter tubing without gloves on 05/19/2022. Licensed Nursing Staff was re-educated during in-service on 05/25/2022 regarding catheter emptying, catheter tubing on the floor, catheter bag placement, dignity bag use, and touching catheter tubing without gloves on 05/19/2022. Certified Nursing Staff was re-educated during in-service on 06/23/2022 regarding catheter emptying, catheter tubing on the floor, catheter bag placement, dignity bag use, and touching catheter tubing. CNA/CMA Inservice Video Recorded and Made Available to all CNA/CMA Staff via Relias. Audits will be completed by the DON/or Designee periodically to ensure compliance. Ongoing Audit findings will be brough to the quarterly QAPI	

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F 690	Continued From page 20 f. 5/17/22 at 11:44 AM catheter tubing remained on the floor. Staff A walked up to Resident #1 and asked if she could give her medications. Staff A returned to the medication cart and did not pick up tubing off floor before she went. g. 5/17/22 at 11:50 AM Staff A sat beside Resident #1 at the main dining room table and began to spoon feed her medications as the catheter tubing remained on the floor. Staff A did not reposition the catheter tubing before she left the table. h. 5/17/22 at 12:00 PM Staff C assisted the resident's tablemate away from the table as Resident #1's catheter tubing remained on the floor. Staff C did not reposition the tubing off floor before leaving the dining room. i. 5/17/22 at 12:03 PM catheter tubing remains on floor, Staff A walked up to resident's table and mixed medications in the resident's cup of juice and did not reposition tubing before she returned to the medication cart. j. 5/17/22 at 12:15 PM catheter tubing remains on floor, Staff A remained in the dining room did not reposition the tubing. k. 5/17/22 at 12:22 PM Staff C pushed Resident #1 in her wheelchair while the catheter tubing remained on the floor. After Staff C left Resident #1, they didn't reposition the tubing off floor. 2. Resident #15's MDS assessment dated 1/3/22 identified a BIMS score of 9, indicating moderately impaired cognition. Resident #15 MDS included diagnoses of atrial fibrillation (an abnormal heart rhythm), obstructive uropathy, and Non-Alzheimer's Dementia. It identified that Resident #15 required extensive assistance of one person with most activities of daily living (ADLs). Resident #15's MDS documented he used an indwelling catheter.	F 690		

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F 690	Continued From page 21 The Care Plan with the target date of 7/18/22 lacked documentation related to an indwelling catheter or interventions on the proper care. The following observations of the resident revealed the catheter tubing and or tubing on the floor at: 5/17/22 at 9:09 AM while the resident slept in the recliner in his room with the catheter bag out of the dignity bag lying on the floor in front of him and the catheter tubing also noted on the floor. 5/17/22 at 9:16 AM assessment unchanged, tubing and bag remained on the floor. 5/17/22 at 9:34 AM assessment unchanged, catheter bag and tubing remained on the floor 5/17/22 at 10:03 AM door to room closed 5/17/22 at 12:04 PM resident able to self-propel out of the main dining room with the catheter tubing dragging along the floor. Staff F CNA pushed another resident behind this resident and did not reposition tubing off the floor. 5/17/22 12:20 PM asked Resident #15 to sit in the recliner in his room as he held the catheter bag in his lap with the catheter tubing on the floor. 3. Resident #23's MDS dated 3/23/22 identified a BIMS score of 11, indicating moderately impaired cognition. The MDS included diagnoses of cancer, obstructive uropathy, and renal insufficiency (kidney failure). The MDS coded Resident #23 required extensive assistance of one person with bed mobility, transfers, locomotion on the unit, locomotion off the unit, dressing, and personal hygiene. Resident #23 required extensive assistance of two persons with toilet use. The Care Plan Focus revised 9/3/21 identified	F 690		

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F 690	Continued From page 22 Resident #23 with an indwelling catheter due to an obstruction and stent placement on 8/9/21. The Care Plan lacked interventions that directed staff to keep the catheter bag and tubing off the floor. The following observations of Resident #23 revealed the catheter tubing on the floor: a. 5/17/22 at 6:53 AM seen him self-propelled around the dining room table to move his tablemate's chair closer to the table as she requested. As he moved around in the wheelchair, his catheter tubing dragged across the floor. Staff A began to assist his tablemate to move closer to the table. Staff A did not check his catheter tubing to reposition it off the floor. b. 5/17/22 at 6:57 AM catheter tubing remained on the floor c. 5/17/22 at 7:05 AM Staff A administered medications to the resident's tablemate. Staff A did not reposition Resident #23's tubing off the floor before she left the table. d. 5/17/22 at 7:16 AM Resident #23's catheter tubing remained on the floor. Staff E, CNA assisted another resident to sit behind Resident #23, Staff E did not reposition his cathteter tubing off the floor. e. 5/17/22 at 7:20 AM Staff E sat beside Resident #23 and talked to him. She did not reposition his catheter tubing which remained on the floor. f. 5/17/22 at 7:31 AM catheter tubing remained on the floor, Staff F stood beside the resident briefly, but did not reposition the tubing off the floor. Staff F and Staff E sat at table beside Resident #23, neither one repositioned the catheter tubing off the floor. g. 5/17/22 at 11:36 AM he sat in the dining room in his wheelchair with his catheter tubing on the floor.	F 690		

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F 690	Continued From page 23 h. 5/17/22 at 11:43 AM he remained in the dining room in his wheelchair with his catheter tubing still on the floor. i. 5/17/22 at 11:53 AM his catheter tubing remained on the floor as Staff A stood beside Resident #23 as he asked her a question. Staff A did not reposition the tubing before she left the table. j. 5/17/22 at 12:02 PM his catheter tubing remained on the floor. Staff A remained in dining room by medication cart and did not reposition the tubing off floor. k. 5/17/22 at 12:12 PM Staff C stood beside Resident #23 and asked him a question. Staff C then walked toward another table without repositioning the catheter tubing that remained on the floor. l. 5/17/22 at 12:13 PM his catheter tubing remained on the floor. Staff A stood beside Resident #23 and did not reposition the tubing before she left the table. m. 5/17/22 at 12:15 PM his catheter tubing remained on the floor. Staff A remained in the dining room and did not reposition the tubing. n. 5/17/22 at 12:24 PM Staff D, CNA, pushed Resident #23 in his wheelchair, while his catheter tubing dragged across the floor, to his room. o. 5/18/22 7:17 AM he sat in his wheelchair in main dining room. Staff B stood in front of him and asked if he needed help. Resident #23's catheter tubing remained on the floor as he self-propelled around the table. On 5/18/22 at 10:08 AM, Staff D reported that she would need to check to make sure correct placement of the strap on their leg, make sure the bag is not touching the floor, in a privacy bag, make sure the drainage tube got clamped, make sure the urine drains correctly, and not kinked	F 690		

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F 690		F 690		

Continued From page 24 anywhere. Staff D explained that she would never handle a catheter with her bare hands.

On 5/18/22 at 10:14 AM, Staff E reported that she would need to check residents with an indwelling catheter to see if it had output, make sure correct placement of the leg strap and not pulling, clean tubing, no leaking from the bag, ask the resident if they had any pain and if so, they need to let the nurse know. Staff E explained that she would make sure the foreskin got pulled down, a privacy bag covered the catheter bag, watch for any blood or sediment starting to form as it could be a possible UTI starting, make sure keep to them hydrated and let the nurse know. She also reported she would never handle the catheter with her bare hands.

On 5/18/22 at 10:22 AM, Staff F reported that she would need to check residents with catheters their output, the position of the bag to make sure the bag is not touching the floor and check that the resident does not have any pain. She also reported she would never handle the catheter with her bare hands.

On 5/18/22 at 10:30 AM, Staff G, CNA, explained that she would need to check that the leg strap did not pull on the resident, make sure the bag hanged below their hips, that it flowed right, and make sure the clamps were closed so nothing leaked out. She also reported she would never handle the catheter with her bare hands.

On 5/18/22 at 10:48 AM, Staff B reported that she would expect the CNAs to check on residents with an indwelling catheter to ensure the catheter is intact, the strap is on the leg, the catheter is secure, that the line is patent and not kinked, the

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F 690	Continued From page 25 bag isn't leaking, the spout is clipped and not dragging on the floor. Ensure the catheter bag is in a dignity bag, check the color of the urine, and to let the nurse know if there is anything abnormal. On 5/18/22 at 11:27 AM, the DON (Director of Nursing) reported she would expect the CNAs to check on residents with indwelling catheters to ensure correct placement of the catheter, that a dignity bag covered the urinary bag, secured clamps, and secured leg bags. If staff saw the tubing on the floor, she would expect them to pick up the tubing off the floor. During a follow-up interview on 5/19/22 at 7:45 AM, the DON reported they didn't complete audits, but she did re-educate the staff on perineal care and catheter care. A review of the outline for the staff meeting held 10/21/21 contained a copy of a competency assessment for emptying a urinary drainage bag. The competency assessement directed the staff to keep the drainage bag and tubing off the floor at all times to prevent contamination and damage. The Urinary Catheter Care policy revised September 2014 documented under the section infection control to be sure the catheter tubing and drainage bag were kept off the floor	F 690		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		

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F 880	Continued From page 26 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: (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	F 880	F880: Infection Prevention and Control 481-58.10 (135C) General Policies Staff C, Certified Nurse Aide was re-educated regarding catheter emptying, catheter tubing touching the floor, catheter bag placement, privacy bag use, and touching catheter tubing without gloves on 05/19/2022. Staff A RN was re-educated wound care procedures as well as changing gloves between cleansing each wound as to not cause cross contamination on 5/19/2022. All nursing staff was re-educated regarding infection control practices, along with specific items outlined above on 05/25/2022. Audits will be completed by the DON/designee periodically to ensure compliance. Ongoing Audit findings will be brought to the quarterly QAPI meetings. Ongoing.	

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F 880		F 880		

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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 observations, clinical record reviews, and staff interviews the facility failed to 1. Don (put on) gloves prior to handling a indwelling catheter for one of three residents reviewed with catheters (Resident #15)
2. Failed to change gloves after cleaning wounds and before applying new treatments for one of two residents reviewed with wounds (Resident #16).
The facility reported a census of 34 residents.

Findings included:

1. Resident #15's MDS assessment dated 1/3/22 identified a BIMS score of 9, indicating

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Continued From page 28 moderately impaired cognition. The MDS included diagnoses of atrial fibrillation (an abnormal heart rhythm), obstructive uropathy (a condition in which the flow of urine is blocked) and non-Alzheimer's dementia. The MDS identified that Resident #15 required extensive assistance of one person with all activities of daily living. The assessment indicated that Resident #15 had an indwelling catheter.

The Care Plan with the target date of 7/18/22 lacked documentation related to the use of an indwelling catheter or interventions on the proper care.

Observations of catheter care revealed the following:
a. 5/17/22 at 12:37 PM Staff C, Certified Nurse Aide (CNA), and Staff D, CNA, entered Resident #15's room as his urinary catheter tubing laid on the floor.
b. At 12:43 PM Staff C washed her hands and filled a wash basin with water. Staff C then placed the wash basin on top of a tray table without a barrier.
c. At 12:44 PM after both aides pulled Resident #15's pants down Staff C did not have gloves on when she touched the urinary catheter just below the insertion site with her bare hands. After touching the urinary catheter tubing, Staff C then used alcohol hand sanitizer.

On 5/18/22 at 10:08 AM, Staff D reported that she would need to check to make sure correct placement of the strap on their leg, make sure the bag is not touching the floor, in a privacy bag, make sure the drainage tube got clamped, make sure the urine drains correctly, and not kinked anywhere. Staff D explained that she would never

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F 880		F 880		

Continued From page 29 handle a catheter with her bare hands.

On 5/18/22 at 10:14 AM, Staff E, CNA, reported that she would need to check residents with an indwelling catheter to see if it had output, make sure correct placement of the leg strap and not pulling, clean tubing, no leaking from the bag, ask the resident if they had any pain and if so, they need to let the nurse know. Staff E explained that she would make sure the foreskin got pulled down, a privacy bag covered the catheter bag, watch for any blood or sediment starting to form as it could be a possible UTI starting, make sure keep to them hydrated and let the nurse know. She also reported she would never handle the catheter with her bare hands.

On 5/18/22 at 10:22 AM, Staff F, CNA, reported that she would need to check residents with catheters their output, the position of the bag to make sure the bag is not touching the floor and check that the resident does not have any pain. She also reported she would never handle the catheter with her bare hands.

On 5/18/22 at 10:30 AM, Staff G, CNA, explained that she would need to check that the leg strap did not pull on the resident, make sure the bag hanged below their hips, that it flowed right, and make sure the clamps were closed so nothing leaked out. She also reported she would never handle the catheter with her bare hands.

On 5/18/22 at 10:48 AM, Staff B, Registered Nurse (RN), reported that she would expect the CNAs to check on residents with an indwelling catheter to ensure the catheter is intact, the strap is on the leg, the catheter is secure, that the line is patent and not kinked, the bag isn't leaking, the

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F 880		F 880		

Continued From page 30 spout is clipped and not dragging on the floor. Ensure the catheter bag is in a dignity bag, check the color of the urine, and to let the nurse know if there is anything abnormal.

On 5/18/22 at 11:27 AM, the DON, Director of Nursing, reported that she would expect the CNAs to check on residents with indwelling catheters to ensure correct placement of the catheter, that a dignity bag covered the urinary bag, secured clamps, and secured leg bags. If staff saw the tubing on the floor, she would expect them to pick up the tubing off the floor.

During a follow-up interview on 5/19/22 at 7:45 AM, the DON reported they didn't complete audits, but she did re-educate the staff on perineal care and catheter care.

The Urinary Catheter Care policy revised September 2014 directed staff to wash their hands, fill a wash basin with water, and don gloves. The policy lacked direction to place a barrier underneath the wash basin.

2. Resident #16's MDS dated 4/6/22 identified a BIMS score of 13, indicating intact cognition. The MDS included diagnoses of heart failure, coronary artery disease, and chronic obstructive pulmonary disease. The assessment documented Resident #16 required extensive assistance of two persons with bed mobility, transfers, toilet use, and personal hygiene. The MDS indicated Resident #16 had a risk to develop pressure ulcers. Resident #16 had open lesions on his feet that required applications of dressings. Resident #16 took antibiotics for seven out of seven days in the lookback period.

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The Care Plan Focus revised 10/21/21, identified Resident #16 had an open area to his buttock, he had multiple areas to his BLE (both lower extremities/legs), and had the potential for pressure ulcer development. The Care Plan lacked direction to change their gloves during wound care, after handling soiled dressings, or when going from a soiled area to a clean area.

An observation of wound care on 5/17/22 at 10:09 AM revealed the following:
Staff A, RN and the DON entered Resident #16's room, they both washed their hands and donned gloves.
At 10:13 AM Staff A removed Resident #16's dressings to his right foot.
At 10:15 AM Staff A cleaned Resident #16's wounds with a wound spray and dabbed the wound with gauze dressings.
At 10:18 AM without changing her gloves, Staff A used wound cleanser to clean the open areas of Resident #16's toes.
At 10:19 AM Staff A removed her gloves, washed her hands, and donned new gloves.
At 10:29 AM Staff A squirted normal saline on collagen dressings , then without changing her gloves before she picked up the large mepilex dressing and she applied it to the top of the collagen dressings
At 10:31 AM without changing her gloves, Staff A opened up packets of skin prep, then she applied it to Resident #16's open areas on his toes on both feet. Without changing her gloves, Staff A used a cotton tipped applicator to apply Santyl ointment with collagen to Resident #16's open areas on his toes.

On 5/18/22 at 10:48 AM, Staff B, RN, reported that when a nurse completed wound care or

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F 880	Continued From page 32 dressing changes, they should change their gloves any time their gloves got soiled, for example, after cleaning a wound and before you applying clean treatments or dressings. Staff B explained they should change their gloves in between different wounds so you are not transferring bacteria from one wound to another wound. On 5/18/22 at 11:27 AM, the DON reported that when a nurse completed wound care or dressing changes, she would expect the nurse to change their gloves any time they enter the room, whenever they go from dirty to clean, after removing a dressing, and before placing a new dressing. The Wound Care policy revised October 2010 lacked direction for staff to change their gloves after removing a dressing, after cleansing a wound, before placing a new dressing, or treatment on the wound.	F 880	Administrator re-educated all staff on survey results and policies in all staff meeting on 06/02/2022.	