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	165286	A. BUILDING ______ B. WING ______	05/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE HILL CARE CENTER	909 6TH STREET TRAER, IA 50675

(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 Correction date 6-7-19 The following deficiencies relate to the facility's annual health survey and investigation of incident #79504. (See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C). Complaint #82848 was not substantiated.	F 000	**F000** This Plan of Correction constitutes my written credible allegation of compliance. This Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusion set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law.	
F 576 SS=B	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing	F 576	**F576** The facility reasonably ensures that each resident has their mail delivered on Saturdays. Residents 20,40,41,42, & 54 have their mail delivered on Saturdays. All residents are potentially at risk for failure of mail to be delivered on Saturdays. On 6/7/2019 an audit of residents at random were interviewed regarding Saturday mail delivery. Mail Audits will be conducted by the Administrator or designee weekly for 8 weeks, bi-monthly times 1 month with findings reviewed by the facilities QA Team for further determination.	06/1/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mara Martin | TITLE: Administrator | (X6) DATE: 05/28/2019

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 576	Continued From page 1	F 576		

implements at the resident's own expense.

§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
(i) If the access is available to the facility
(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
(iii) Such use must comply with State and Federal law.
This REQUIREMENT is not met as evidenced by.
Based on observations and resident and staff interviews, the facility failed to deliver resident Saturday mail for 5 of 67 residents (Resident #20, #40, #41, #42 and #54). The facility census was 67.

Findings include:

During a Resident Council group interview on 5/09/19 at 1:32 p.m. Resident #40 stated mail sits on the Nurse's Station desk and not delivered to residents on Saturdays. Resident #40 further stated he asked at his Care Conference about Saturday mail delivery but he continues to not receive his mail on Saturday.

During Resident Council group interview on 5/09/19 at 1:32 p.m. Resident #20, #41, #42 and #54 stated mail is not delivered on Saturdays.

During interview on 5/11/19 at 11:15 a.m. the Acting Administrator (AA) stated business office staff sort mail Monday through Friday and activities staff deliver it to the residents. The AA stated no mail is delivered on weekends because

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F 576	Continued From page 2 no one is working to sort it. The DON stated no one has voiced concerns about mail not being delivered on week ends. During interview on 5/11/19 at 11:18 a.m. the MDS (Minimum Data Set) Nurse stated Resident #40 was the only resident who voiced concerns regarding mail not being delivered on Saturday particularly his newspaper. The MDS nurse stated she told Resident #40 he could ask staff to get his newspaper on the weekend from the mail.	F 576		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the 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	F 657	**F657** The facility reasonably ensures that each resident has a comprehensive care plan that is reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly or as needed based on the resident's condition. Resident #28 was reassessed and has no pressure ulcers and skin issues currently. All residents at risk for having pressure ulcers in the facility are at risk. On 5/10/2019 an audit of residents at risk of having a pressure ulcer care plans were reviewed and updated along with adding interventions to provide guidance to the staff for the care and treatment for the resident. Facility staff were in-serviced on 5/10/2019 and ongoing on the facility process/standards on Resident Care Plans. Care Plan Audits will be conducted by the DON or designee weekly for 8 weeks, bi-monthly times 1 month with findings reviewed by the facilities QA Team for further determination.	05/10/19

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F 657	Continued From page 3	F 657		

team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, resident interview, and staff interview, the facility failed to revise a care plan to include the presence of a pressure sore with measurable goals and interventions for 1 of 21 residents sampled and reviewed for care planning revisions (Resident # 28). The facility reported a census of 67 residents.

Findings include:

Review of Resident #28's Minimum Data Set (MDS) assessment dated 2/19/19 identified a Brief Interview for Mental Status Score (BIMS) of 15 without signs/symptoms of delirium. A score of 15 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 2 persons for bed mobility, transfers, and toilet use. The MDS documented diagnoses that included heart failure, diabetes mellitus, and chronic kidney disease. The MDS revealed the resident did not have pressure sores present at the time of the assessment.

The Care Plan dated 2/28/19 identified the resident had moisture related skin alterations with interventions which included: document on wound sheets weekly for skin alterations; provide treatment as ordered for skin alterations; observe for signs/symptoms of insomnia and report to nurse/doctor; and skin inspection to observe for redness, open areas, scratches, cuts, bruises with bathing/cares, and report changes to the nurse. The care plan lacked documentation

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F 657	Continued From page 4 pertaining to a pressure sore.	F 657		

On 5/9/19 at 11:30 a.m., Resident # 28 stated she had a pressure sore on her bottom and the staff treated it with salve. Resident # 28 commented the staff liked to lay her down once a day to get her off her bottom.

On 5/10/19 at 10:59 a.m., Staff L, Licensed Practical Nurse (LPN), stated she applied a cream for treatment to the resident's buttocks area that morning. Staff L stated the area very superficial, pink in color, and did not blanch.

On 5/10/19 at 4:40 p.m., the Assistant Director of Nursing (ADON), stated Resident # 28 had a cushion that staff transferred from the wheelchair to the recliner depending on where she sat.

The Weekly Pressure Wound Monitoring sheet for Resident # 28 identified a pressure sore on the left inner buttock with onset date of 4/5/19. The ongoing weekly measurements documented the wound remained present 5/9/19 with a measurement of 0.4 cm (centimeters) by 0.2 cm and the resident encouraged to lay down in bed as tolerates.

On 5/10/19 at 5:00 p.m., the MDS Coordinator confirmed the care plan lacked a revision to reflect the presence of the resident's pressure sore. The MDS Coordinator stated the care plan revision process included skin condition meetings held on Tuesdays, she would become aware of any new areas, and then she updated care plans to reflect new skin conditions. The MDS Coordinator acknowledged the care plan should have addressed the resident's pressure sore.

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F 689	Continued From page 5	F 689		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interviews the facility failed to ensure safety devices in place at all times and ensure safe transfer techniques used for 2 of 6 residents reviewed with a history of falls. (Resident #44 and #64) The facility reported a census of 67. Findings include: 1. The Minimum Data Set (MDS) assessment reference dated 10/16/18 revealed Resident #64 required extensive assistance with all transfers and mobility. The MDS identified the resident walked in room with extensive assistance of two staff. The assessment documented the resident had a history of falls and experienced two falls since admission. The MDS identified active diagnoses of difficulty walking, osteoarthritis, and diabetes mellitus. The Brief Interview for Mental Status (BIMS) revealed a score of 11 which indicated moderately cognitive impairment. The resident's care plan dated 10/25/18 identified the resident as a fall risk. The care plan informed the staff the resident had fluctuating cognitive ability, is impulsive and personal alarms in place	F 689	**F689** The facility reasonably ensures that each resident with a history of falls have safety devices in place at all times and ensure safe transfer techniques are used. Resident #44's safety device is in place at all times and safe transfer techniques are used. Resident #64 is deceased. All residents at risk for falls in the facility are potentially at risk. On 6/7/19 an audit of residents at risk of having a fall's care plans were reviewed and updated along with adding interventions to provide guidance to the staff for the care and treatment for the resident. Facility staff were in-serviced on 6/6/19 and ongoing on the facility process/standards on safety devices and safe transfer techniques. Audits will be conducted by the DON or designee weekly for 8 weeks, bi-monthly times 1 month with findings reviewed by the facilities QA Team for further determination.	06/07/1'

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F 689	Continued From page 6 for the resident's safety. The care plan directed the staff to ensure placement and functioning of alarms at all times, answer sounding alarms promptly and to encourage the resident to use his call light to make needs known. The care plan revealed Resident #64 attempted to self transfer from his recliner to wheelchair and staff implemented a pull tab alarm on 10/25/18. A document titled Fall Risk Evaluation dated 10/25/18 revealed the resident received a score of 20 which indicated he had a high risk for falls. Review of Progress notes dated 10/25/18 at 7:04 a.m. revealed a CNA called Staff O-RN into the resident's room, the CNA reported having difficulty assisting the resident to sit up at the side of the bed requiring assist of 2 to sit up, the CNA also reported to the nurse the resident kept sliding out of bed and required assistance back into wheelchair with the use of a Hoyer Lift (mechanical lift). Review of Progress notes dated 10/25/18 at 12:50 p.m. the staff reported the resident self transferred from his wheelchair to recliner, reporting to the staff how difficult the transfer was. Review of Progress notes dated 10/25/18 at 6:50 p.m. revealed the staff found Resident #64 on the floor on his right side, leaning against his wheelchair. The resident stated he went to the bathroom but didn't make it back. The resident complained of discomfort in his knees and staff noted in the progress notes this is a normal complaint for the resident. The staff transferred the resident back into his wheelchair via mechanical lift then into bed. Resident #64 continued to complain of knee discomfort but did	F 689		

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F 689	Continued From page 7	F 689		

not have signs or symptoms of an injury at the time.

A fall/incident report dated 10/18/18 at 6:45 a.m. revealed Resident #64 experienced a fall in his room, he leaned over to pick up something off the floor and fell out of bed. The staff provided fall interventions which consisted of education on use of the call light and to wait for help.

A fall/incident report dated 10/25/18 at 6:50 p.m. Resident #64 experienced a fall while in his bathroom. The resident self transferred to his bathroom and slid off the toilet. The staff provided fall interventions which consisted of education on use of the call light and to wait for assistance.

A Progress note dated 10/26/18 at 7:07 a.m. revealed the staff transferred the resident a local emergency room for evaluation for possible right fractured knee from fall on 10/25/18.

Review of a progress note dated 10/26/18 at 10:17 a.m. revealed Staff N-LPN/ADON placed a call to the local emergency room, the staff reported the resident had a fractured right femur.

Review of a progress note dated 10/28/18 at 11:30 a.m. revealed the facility received a call from the local hospital, they reported the resident experienced a serious medical issue during the surgical repair of the hip on 10/27/18. The surgeon could not complete the hip repair and placed the resident on a ventilator. The Primary Care Physician ordered the resident to return to the facility and placed on Hospice services. The resident transferred back to the facility on 10/29/18.

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F 689	Continued From page 8 Review of the Progress Notes dated 11/8/18 at 7:24 a.m. Resident #64 expired. A document titled Fall Risk Evaluation dated 10/25/18 revealed the resident received a score of 20 which indicated he had a high risk for falls. Review of the North/West nursing report dated 10/25/18 revealed the staff initiated a pull tab alarm for Resident #64 on that day. Review of a Personal Alarm Monitoring sheet dated 10/25/18 revealed the staff initiated a pressure pad in the resident's bed and a personal pull tab alarm while in chair recliner. Review of an x-ray report dated 10/26/18 revealed the resident fell on 10/25/18 and complained of right knee pain. The resident had a diagnosis of a displaced fracture of the distal right femur, just above the right total knee arthroplasty. Review of an internal facility investigation completed on 10/26/18 revealed Staff C and Staff D-Agency Certified Nurses Aides transferred Resident #64 into a dining room chair during the evening meal and failed to put the pull tab alarm on the resident. During an interview on 5/9/19 at 1:30 p.m. Staff D-Agency CNA verified she worked on the evening staff found Resident #64 on the floor, she reported being assigned to Resident #64 that evening. Staff D acknowledged knowing the resident utilized alarms but couldn't find the alarm in the resident's room prior to his fall. Staff D stated after the 10/25/18 fall she found the pull tab alarm behind the blinds in the resident's room. Staff D stated she should have double	F 689		

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F 689	Continued From page 9 checked the resident to make sure he had his alarm on. Staff D assisted the resident after the fall on 10/25/18 and stated the resident did not have an alarm on at the time of the fall. During an interview on 5/9/19 with Staff C-Agency CNA at 3:25 p.m. she verified she worked and took care of Resident #64 on the evening of 10/25/18. Staff C stated when she got Resident #64 up for supper he did not have an alarm on and had no idea he should have an alarm. Staff C verified at the time of the fall on 10/25/18 the resident did not have an alarm on. During an interview on 5/9/19 with Staff E-CNA at 2:52 p.m. she verified she worked first shift on 10/25/18. Staff E stated the tab alarm initiated around lunch time on 10/25/18 due to the self transfer the resident did earlier in the day. Staff E stated Staff G-LPN communicated they initiated an alarm for the resident. Staff E said she thought walking rounds were done between first and second shift that day but did not specifically tell second shift the resident now had pull away/tab alarm. During an interview on 5/9/19 at 4:40 p.m. with the Staff N-LPN/Assistant Director of Nursing she stated she placed the pull away alarm on this resident while he sat in his recliner. She stated she remembered putting the strap for the alarm around the window crank. During an interview on 5/9/19 with Staff G-LPN at 5:05 p.m. stated she had decided per her nursing judgment to start the pull away alarm on Resident #64. Staff G stated she told first shift she initiated the alarm and the expectation is for first shift to walk the halls with second shift and communicate	F 689		

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F 689	Continued From page 10 the changes During an interview dated 5/10/19 at 8:00 a.m. the Director of Nursing (DON), revealed the internal investigation concluded the staff failed to put the pull away alarm on the resident. She stated she could not identify a final result of who did not place the alarm. The DON stated that staff are expected to follow the care plans. 2. The MDS assessment dated 3/14/19 revealed Resident #44 had diagnoses non-Alzheimer's dementia, multiple sclerosis (MS), diabetes, and anxiety disorder. The MDS indicated the resident had moderately impaired cognition, and required extensive assistance of two staff for transfers. The Care Plan, revised on 4/23/19 recorded Resident # 44 had a diagnosis of MS and needed assistance for all cares. The staff directives included use an EZ stand or Hoyer lift per nursing discretion for safety. The physician's orders dated 4/18/19 revealed an order for physical therapy evaluation for transfers. A Physical Therapy (PT) evaluation 4/22/19 revealed Resident #44 had MS, dementia, muscle weakness, and left hand contracture. PT recommended staff use a Hoyer lift when the resident transferred for staff safety. Nursing progress notes revealed the following: a. On 4/18/2019 at 9:41 a.m., new order from the physician for PT/OT evaluation for transfers. b. On 4/23/2019 at 2:16 p.m., per PT at Medicare meeting, recommended a Hoyer lift used for	F 689		

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transfers.

The Rehab to Nursing communication form dated 4/23/19 revealed Resident # 44 required assistance with a Hoyer lift effective 4/23/19.

During observation on 5/9/19 at 1:22 p.m., Staff I, Agency CNA, and Staff H, Agency CNA, entered the resident's room and reported they planned to transfer Resident #44 into bed. Resident #44 sat in a high back wheelchair. Staff H questioned why someone removed the Hoyer sling from under the resident. Staff H placed a mesh sling behind the resident's back, then pulled the leg straps under the resident's legs. After they attached the sling straps to the lift, Staff H and Staff I attached the sling straps to the mechanical lift . Staff H took the remote and raised the resident up above the wheelchair using the mechanical lift. Resident #44 said "I'm falling". Staff H looked under the resident and said the sling wasn't under the resident properly, then lowered the resident back into the wheelchair, and stated they needed to use a different sling. Resident #44 slid down in the wheelchair with her bottom near the edge of the wheelchair seat. At 1:29 PM, Staff H stated she didn't like how the resident sat in the wheelchair and requested Staff I to help her pull the resident up. Staff H and Staff I reached under the resident and pulled the resident up in the wheelchair. At 1:33 PM, Staff H removed the mesh sling under the resident and placed a light blue sling behind the resident's back, then attempted to push the sling under the resident's legs. Staff H had the resident lean forward and tucked the sling down lower on her back. Staff I brought a Maxi Move mechanical lift into the resident's room. The DON knocked on the door to the resident's room and asked if staff

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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 689	Continued From page 12 needed anything. Staff H told the DON there wasn't a sling under the resident and questioned how staff had transferred the resident earlier. The DON stated she had to check the care plan as she thought they had upgraded her transfer but then returned to the room and told the CNA's the resident required a Hoyer for all transfers, then left the room. Staff H and Staff I attached the sling straps to the metal buttons on the Maxi Move mechanical lift. Staff H pulled the leg straps between the resident's legs and attached the lower straps to the Maxi Move buttons with much effort. Staff H took the remote and raised the resident up with the mechanical lift, transferred the resident to the bed, and then lowered the resident into bed. Staff H and Staff I started to remove the sling straps from the mechanical lift when the resident yelled "ouch". The bar on the mechanical lift struck the resident's right arm. Staff H apologized to the resident, then removed the sling under the resident. On 5/9/19 at 1:22 PM, Staff I, agency CNA, and Staff H, agency CNA, reported they were assigned to West Hall but came and helped staff in the 200 hall. Staff I reported she had only worked a few shifts at the facility and not familiar with the residents. During an interview 5/9/19 at 1:55 PM, Staff H reported she had a "cheat sheet" with information about the residents on her assigned hall (hall 300), but didn't have a cheat sheet for the 200 hall because she was assigned to work the 300 hall that day. Staff H stated if she was not familiar with the resident cares needed or how to use equipment, she just figured it out. Staff H reported she worked as agency staff and had	F 689		

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F 689	Continued From page 13 received one day of orientation when she worked her first shift at the facility. The orientation entailed review of emergency procedures, such as if had a fire, and the location of supplies. Staff H acknowledged nobody showed her how to use the resident care equipment such as the mechanical lifts. In an interview 5/11/19 at 9:14 AM, the MDS Coordinator reported a care meeting held with therapy on 4/23/19, and therapy recommended staff used a Hoyer lift when they transferred Resident #44. In an interview 5/11/19 at 10:16 AM, Staff M, Physical Therapist, reported a PT evaluation completed on Resident #44 on 4/22/19. Staff M reported they recommended staff used a Hoyer lift for all transfers on Resident #44 because she had a decline in status. Staff M reported she had provided staff education on transfers for all staff a year ago. Staff M stated the staff education pertaining to transfers included agency staff. In a skill set for "Hoyer Lift, EZ Lift and EZ stand" transfers revealed the following procedural steps: a. Bring Hoyer to bedside. b. Roll resident onto his/her side away from the attendant c. Place wider seat of sling under the resident's thighs, so the lower edge of the seat is in under the knees d. Place narrow part of sling just above the small of the back. e. Roll resident toward attendant and pull slings through, like positioning a draw sheet. f. Position seat sling, elevate head of bed to facilitate placing the back piece. g. Attach S hooks of the chains to the loops on	F 689		

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F 689	Continued From page 14 the seat hangers, attach ends of the chains to the swivel bar hooks, attach S hooks on the back in the links as required. Check to see S hooks are hooked all of the way into the chains and the seat is close to the knees for safety. h. Check chains and S hooks to ensure they are properly positioned. i. Position wheelchair and lock brakes. Once resident lifted and cleared from the bed, grasp steering handles and move resident over the chair, then lower the resident slowly and guide his/her descent. j. Detach the S hooks from the seat and back, and remove the chains and back.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690	**F690** The facility reasonably ensures that each incontinent resident will have a complete bladder and bowel assessment completed in order to maintain or reduce the frequency of incontinence. The facility reasonably ensures that proper incontinence care will be completed for all residents who require assistance with incontinence care. All incontinent residents in the facility are potentially at risk. On 6/5/19 an audit of incontinent resident's care plans and assessments were reviewed and updated.	06/05/1

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F 690	Continued From page 15 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 clinical record review, observation, resident and staff interviews, and policy review, the facility failed to complete bladder and bowel assessments for an incontinent resident in an effort to maintain or reduce the frequency of incontinence for one of two residents reviewed for bladder and bowel assessments (Resident #40), and failed to provide proper incontinence care to minimize the risk of cross-contamination and infection for one of six residents observed for incontinence care (Resident #44). The facility reported a census of 67 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/7/19 identified Resident # 40 had diagnoses of cerebrovascular accident (stroke), hemiplegia (flaccid on one side), heart failure, and benign prostate hypertrophy with lower urinary tract symptoms. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS recorded the resident	F 690	Facility staff were in-serviced on 6/6/19 and ongoing on the facility process/standards on proper incontinence care. Staff was in-serviced on 6/1/19 on Bowel and Bladder Assessments. Audits will be conducted by the DON or designee weekly for 8 weeks, bi-monthly times 1 month with findings reviewed by the facilities QA Team for further determination.	

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F 690	Continued From page 16 required the extensive assistance of two staff for toileting and transfers and experienced frequent episodes of bladder incontinence. The MDS revealed the resident had no trial or current toileting program such as a scheduled toileting or bladder training since incontinence had been noted to manage the resident's urinary incontinence. The MDS revealed the resident took a diuretic seven of seven days during the look-back period. The care plan revised 3/14/19 revealed the resident needed assistance with cares due to a stroke, right sided hemiplegia, and left side weakness. The resident had bladder incontinence at times and took a diuretic. Staff directives included providing assistance with toileting and peri-care. The physician's order dated 4/5/19 revealed bumex (a diuretic) by mouth twice a day for edema. The clinical record lacked documentation of bladder and bowel assessments. During observation on 5/10/19 at 12:20 PM, Staff D, Certified Nursing Assistant (CNA) stood Resident #40 by the toilet. The resident had visibly wet pants and a wet pull up brief. Staff D removed and changed the resident's pants and brief after he sat on the toilet. During an interview 5/9/19 at 10:10 AM, Resident #40 stated he had a stroke and required assistance for cares. The resident reported sometimes it took awhile before staff responded when he placed his call light on and provided assistance when he had to go to the bathroom.	F 690		

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The resident reported at times staff told him they would be back to provide assistance, turned his call light off, but then didn't come back. The resident stated he took a diuretic and couldn't always wait a long time for assistance to the BR.

During an interview 5/10/19 at 2:08 PM, the MDS nurse confirmed no bowel or bladder assessments done on the residents at the facility.

2. The MDS assessment dated 3/14/19 revealed Resident #44 had diagnoses of non-Alzheimer's dementia, multiple sclerosis (MS), and diabetes. The MDS indicated the resident had moderately impaired cognition and required extensive assistance of two staff for toileting and hygiene. The resident had a catheter and frequent bowel incontinence.

The Care Plan revised on 3/21/19 recorded Resident # 44 had a diagnoses of MS. The care plan revealed the resident had a suprapubic catheter and bowel incontinence, and had an allergy to incontinence products and frequently scratched herself causing skin conditions. The staff directives included provide assistance with pericare.

During observation on 5/9/19 at 1:22 PM, Staff H, CNA, and Staff I, CNA, transferred Resident #44 into bed then donned a pair of gloves. Staff H removed the resident's pants and a washcloth in her peri area. At the time, Staff H reported the resident had no brief due to skin breakdown that had occurred when incontinence product worn. At 1:29 PM, Staff H had the resident roll onto her left side, then took a wet washcloth and cleansed between the resident's buttocks. Staff H folded the washcloth and wiped the area again. Staff H

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Continued From page 18

had the resident roll onto her back, then took another washcloth and cleansed the peri area and groin area front to back. Staff H folded the washcloth several times between wiping the areas. Staff H rolled the resident onto her left side again, then used another washcloth and cleansed the buttocks area, folding the washcloth twice in-between wipes. Resident #44's had redness to her groin and buttock area, and complained of the area being sore when staff performed peri care.

An Incontinence Care Checklist tool revealed the following procedural steps:
a. Don gloves
b. Remove soiled pads, clothing, linen
c. If gloves are soiled, remove and complete hand hygiene, and reapply clean gloves
d. Place a towel under the perineum
e. For females, use a washcloth and wash the labia from front to back
f. Turn resident onto his/her side, wash buttocks, upper thighs, and anal area front to back.
g. Remove gloves and perform hand hygiene

During an interview 5/11/19 at 11:07 AM, the Assistant Director of Nursing (ADON) reported she performed staff audits for peri care every three months and whenever she noticed a trend in infections. The ADON reported she expected staff cleanse the front then the back side when performed peri care, and changed their gloves when contaminated.