| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 165181 | A. BUILDING _____ B. WING _____ | 11/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ROCK RAPIDS HEALTH CENTRE | 703 SOUTH UNION ROCK RAPIDS, IA 51246 |

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| F 000 | INITIAL COMMENTS<br><br>Correction date 12-14-19<br><br>The following deficiencies relate to the facility's annual health survey and investigation of complaint #86527-C completed 11/12/19 to 11/14/19. Compaint #86527-C was substantiated. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C ) | F 000 | | |
| F 582 SS=D | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the | F 582 | F582 Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>Resident #0 is not identified in the resident identifier.<br><br>On 12/6/19 the Administrator notified the responsible party for Residents #12 of missing the notification letters when discharged from skilled care. These forms were provided to Resident #12 by the Social Service Director on or before 12/6/19.<br><br>On 12/6/19, the Administrator completed an audit to identify other residents who received skilled care in past 3 months and verified that the requirements for a notice of Medicare non coverage letter prior to the discontinuation of Medicare part A services was met. Concerns identified will be addressed at the time of identification. | |

12-4-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Harberts — TITLE: Administrator — (X6) DATE: 12-6-2019

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 582 | Continued From page 1<br>Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to provide the required forms for Medicare Liability Notices and Beneficiary Appeals when skilled services had been exhausted or services no longer covered for 2 of 3 residents (#0 and #12). The facility reported a census of 35.<br><br>Findings include:<br><br>1. Record review for Resident #0 indicated she had received skilled services from 7/12/19 to 9/18/19. The facility failed to complete and | F 582 | On 11/26/2019 the Administrator provided Inservice training to the management team, including, Director of Nursing, Social Services, Dietary Manager, Business Office Manager, and Medical Records related to the requirements for a notice of Medicare non coverage letter prior to the discontinuation of Medicare part A services.<br><br>The Administrator will add to the morning team meeting, 5 days weekly, discussion of any resident who will be discontinued from the Medicare part A services and verify that the notice of Medicare non coverage has been provided to the resident within regular required time frame. This will continue on an ongoing basis to ensure that #12 along with other like residents of the facility receive the required notification of Medicare non-coverage when being discontinued from Medicare Part A services. The Administrator and/or designee will report findings of the above monitoring system monthly times three months to the QAPI committee for further review and/or resolution. | |

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| F 582 | Continued From page 2<br>provide the resident with the Notice of Medicare Provider Non Coverage, CMS form #10123 or Skilled Nursing Facility Advanced Beneficiary Notice of Non Coverage (SNFABN), CMS form #10055.<br><br>2. Record review for Resident #12 indicated she had received skilled services from 3/26/19 to 5/10/19. The facility failed to complete and provide the resident with the Notice of Medicare Provider Non Coverage, CMS form #10123 or Skilled Nursing Facility Advanced Beneficiary Notice of Non Coverage (SNFABN), CMS form #10055.<br><br>During an interview at 6:25 PM on 11/13/19, the Administrator acknowledged the lack of forms #10123 and #10055 provided to the above residents when their skilled services exhausted. The Administrator stated she would expect these forms to be completed when residents have exhausted their skilled services | F 582 | | |
| F 607 SS=E | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced | F 607 | F607 Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>The Business Office Manager (BOM) ran a Background check immediately on Staff B, Staff C, and Staff F. They are current.<br><br>The BOM completed an audit on 11/14/19 to verify that the current staff of the facility are within requirements and expectations of having current background checks completed.<br><br>The Administrator will Inservice BOM related to new hire Background Check requirements and expectations. | |

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| F 607 | Continued From page 3 | F 607 | | |

by:
Based on personnel file reviews and staff interview, the facility failed to obtain criminal background checks within 30 days prior to hire for 3 of 3 currently employed staff (Staff B, C & F). The facility reported a census of 35 residents.

Findings include:

The personnel file for Staff B, Certified Nurse Aide, documented a hire date of 2/2/19. The file contained a criminal background check dated 2/11/19

The personnel file for Staff C, Maintenance, documented a hire date of 1/28/19. The file contained a criminal background check dated 10/9/18.

The personnel file for Staff F, Licensed Practical Nurse, documented a hire date of 1/20/19. The file contained a criminal background check dated 9/17/19.

Review of document titled Abuse Prevention Program and Reporting Policy, revised date 4/2014, noted all potential employees would be screened for history of abuse, neglect, or mistreating resident/patient during the hiring process. States screening will consist of, but not limited to:
* Inquiries into states licensing authorities
* Inquiries into state nurse aide registry.
* Reference checks.
* Criminal background checks.

Interview with Staff E, Business Office Manager (BOM), at 2:30 PM on 11/13/19, verified the criminal background checks were not done within

The BOM and/or designee will review 10 files per week until all employee files have been reviewed to ensure compliance for any hires going forward. Ongoing audits will take place monthly by the BOM or designee and findings will be reported to the QAPI committee for further review and/or resolution monthly.

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| F 607 | Continued From page 4<br>30 days prior to hire.<br><br>During an interview at 6:30 PM on 11/13/19, the Administrator stated her expectation would be the criminal background checks would be completed within 30 days prior to hire. | F 607 | | |
| F 625 SS=D | Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483 15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br>This REQUIREMENT is not met as evidenced | F 625 | F625 Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)<br><br>The nurse that discharged resident #180 will be educated by DON related to the requirements of providing the bed hold by 12/14/19. The bedhold policy was provided to Resident #180 on or before 12/6/19 by the Director of Nursing/designee.<br><br>DON or designee will audit hospital transfers by 12/14/19 on current residents in the past 30 days to ensure bed hold forms were completed with transfer as required.<br><br>Education provided by DON to Licensed Nursing Staff on or before 12/14/19 regarding requirements and expectations related to providing bed hold forms when resident is transferred to hospital, including completing documentations.<br><br>DON or Designee will audit hospital transfer during morning meeting, times 8 weeks to ensure bed hold forms continue to be provided with transfer to the hospital. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed. | |

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| F 625 | Continued From page 5 | F 625 | | |

by:
Based on record review and staff interview, the facility failed to notify a resident and/or the resident's representative of the facility policy for bed hold notice prior to transfer to the hospital for 1 of 3 residents reviewed (Resident #180). The facility reported a census of 35 residents

Findings include:

The admission Minimum Data Set (MDS) assessment tool, dated 11/1/19, documented Resident #180 admitted to the facility on 10/28/19 and the resident had short term memory impairment.

A nursing Health Status Note, dated 11/1/19 at 9:12 a.m., documented the resident had a change in condition, the resident assessed and the primary care provider notified. A Health Status Note written 11/2/19 at 1:17 p.m., documented the resident had been transferred to the hospital emergency department at a local hospital on 11/2/19 and then transferred on to another hospital.

An entry MDS, dated 11/7/19, documented the resident returned to the facility

The resident's clinical record lacked documentation the resident and/or resident representative had been notified of the facility bed hold policy.

During an interview on 11/13/19 at 12:39 p.m., the Corporate Nurse verified a bed hold notice had not been given to the resident and/or resident representative.

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F 655 Continued From page 6

F 655 Baseline Care Plan
SS=D CFR(s): 483.21(a)(1)-(3)

§483 21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483 21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders
(C) Dietary orders.
(D) Therapy services
(E) Social services
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident,

F 655
F 655 F655 Baseline Care Plan CFR(s): 483.21(a)(1)-(3)

The DON completed a baseline care plan for resident #180 on 12/4/19.

Audit was completed by DON/designee for current residents admitted In the past 30 days to verify that baseline care plan was completed, any that are found to be out of compliance will be completed by 12/14/19.

Education provided by DON to Licensed Nursing Staff and the Interdisciplinary Team by 12/14/19 regarding base line care plan completion requirements and expectations

DON or Designee will audit upon admission to ensure that baseline care plan is completed within 48 hours after admission for 3 months. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.

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| F 655 | Continued From page 7<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to complete a baseline care plan within 48 hours of admission for 1 of 1 new resident reviewed (Resident #180). The facility reported a census of 35 residents.<br><br>Findings include:<br><br>An admission MDS Minimum Data Set assessment tool, dated 11/1/19 documented Resident #180 admitted to the facility on 10/28/19.<br><br>Record review lacked documentation a baseline care plan had been completed.<br><br>During an interview on 11/13/19 at 6:25 p.m., the Director of Nursing verified staff had not completed a baseline care plan. | F 655 | | |
| F 675 SS=D | Quality of Life<br>CFR(s): 483.24<br><br>§ 483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and | F 675 | F675 Quality of Life CFR(s): 483.24<br><br>On 11/12/19 resident #29 was repositioned immediately when nursed observed her positioning and staff providing assist with feed was educated related to resident positioning needs when eating. A therapy referral for Resident #29 will be completed for wheelchair positioning by 12/14/19. | |

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| F 675 | Continued From page 8<br>psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, clinical review and interview the facility failed to provide necessary care to attain the highest practicable physical well-being consistent with the residents' comprehensive plan of care for 1 of 1 resident reviewed, ( Resident #29). The facility reported a census of 35.<br><br>According to the Minimum Data Set (MDS) dated 10/10/2019, Resident #29 had diagnoses including dementia and muscle weakness. The resident scored 0 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required extensive assistance for mobility and transfers with two person support and one person assistance with meals<br><br>According to the Care Plan revised on 7/21/19, Resident #29 had impaired cognitive functioning, impaired thought process and needed extensive assistance in the dining room at meals, needing assistance with eating.<br><br>On 11/12/19 at 12:05 PM Resident #29 was sitting up to the table in the dining room as lunch was being served. The resident was slowly sliding down in her wheelchair. At 12:08 PM she slid down to where her head was lower than the handles of the wheelchair. At 12:10 PM Staff A,Certified Nursing Assistant (CNA) began feeding her the lunch meal including the cut-up meat and sliced carrots. At 12:13 PM Staff F, Licensed Practicing Nurse (LPN) entered the | F 675 | The DON will complete an observational audit by 12/14/19 to identify other residents of the facility who require assist with eating and positioning.<br><br>The DON will provide education to nursing staff related to positioning of residents when assisting them to eat by 12/14/19.<br><br>The DON or designee will observe positioning of residents who are assisted with meals, 5 meals weekly times 6 weeks, then 1 meal 5 days per week times 4 weeks. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed. | |

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| F 675 | Continued From page 9<br>dining room, briefly observed Staff A feeding the resident and then left the dining area. At 12:29 PM Staff A and Staff H, CNA escorted the resident out of the dining area When they returned with her the resident had been repositioned up in her wheelchair and pushed back up to the table to finish her meal. At that point, 50% of her meal had been consumed.<br><br>An interview with Director of Nursing (DON) revealed she would expect staff to assist a resident to sit up to the best of their ability while eating She acknowledged the slouching position described is a choking and aspiration concern for a resident with dementia. | F 675 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483 25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, observations and staff interview the facility failed to prevent a pressure ulcer from developing for 1 of 1 resident reviewed (Resident #20) The facility reported a | F 686 | F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>Resident no longer resides at the facility.<br>For resident #20, a wound assessment was completed on 11/4/19, the wound care Nurse assessed wound on 11/13/19.<br><br>The DON or designee will complete an audit to determine residents who have pressure ulcers and who are at moderate to high risk for developing pressure ulcers and verify that preventative measures are in place for treatment and prevention by 12/14/19.<br><br>The DON and or designee will provide in-service by 12/14/19 to License Nurses and CNA's related to the requirements and expectations of providing care and treatment for pressure ulcers to promote healing and prevention. | |

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census of 35 residents.

Findings include;

According to the Minimum Data Set (MDS) dated 9/30/19, Resident #35's diagnoses included chronic kidney disease, osteoporosis and diabetes mellitus. The MDS indicated the resident had no pressure injuries at the time of admission. The resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated significant cognitive deficit. The resident required limited assistance for transfers, bed mobility and walking and extensive assistance with toileting The MDS documented Resident #20 was admitted to the facility on 8/27/19

The Care Plan dated 9/8/19, indicated the resident had a potential for nutritional problem, was recently hospitalized for a urinary tract infection and suffered with occasional incontinence and cognitive declines. The Care Plan had been updated on 11/1/19 to include a blister of the right heel and staff were instructed to inspect feet daily, report changes to the nurse, monitor and document progress in wound healing and notify physician as indicated.

In an observation on 11/12/19 at 1:50 PM Resident #20 was reclined in a chair in her room with her feet up She was wearing slip resistant stockings and no shoes On the other side of the room, a padded protective boot was laying on the couch. When asked about the boot, the resident stated she wears it "sometimes."

In an observation on 11/13/19 at 6:40 AM the resident was in bed and the boot was in a chair next to the bed. At 8:20 AM the resident was at

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The DON or designee will review resident's skin assessments daily for weekly completion for 8 weeks to ensure continuous compliance for residents of the facility who have pressure ulcers. Electronic skin assessment UDA (user defined assessment) for pressure ulcers will be completed weekly. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.

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the breakfast table with gripper socks on feet with the boot on a chair in her room. At 4:53 PM the resident was at the supper table without the boot on.

A review of Resident #20's clinical chart revealed a Doctors Order for a 5 centimeter by 5 centimeter blister like area noted to the right heel for betadine with non-adherent dressing and wrap with Kerlix one time a day ordered on 11/4/19

A review of the residents record revealed the following wound assessment records:
a. Weekly Skin Assessment dated 11/1/19 documented blister to right heel with clear drainage measured 5 centimeters (cm)
b. Non Pressure Weekly Skin Record dated 11/4/19 indicated right heel blister measurement of 5cm length 5cm width .1cm depth
c Non Prerssure Weekly Skin Record dated 11/11/19 indicated right heel wound measurement of 0 5cm x 0 5cm .1cm depth

A Doctor's Orders and Progress Notes dated 11/13/19 at 10:15 AM noted wound care evaluation completed at this time for pressure injury on right heel. Pressure injury is unstageable. 100% slough present on wound bed. Open area measured 2.5 cm (L) x 2 cm (W). There is deep tissue injury extending past wound that measured 6 (L) x 6.5 (W). Recommend referral to podiatry for further evaluation. Orders to paint right heal with betadine twice a day. Allow betadine to dry. Apply optifoam as needed drainage. Secure with Kerlix. Wear Rooke boots bilateral feet at all times.

In an interview on 11/14/19 at 2:50 PM the Nurse Consultant indicated she believed that

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interventions were in place to prevent the worsening of the pressure ulcer and while a boot would have been helpful, there was no doctors order for that intervention.

A review of the facilities policy for Skin Care & Wound Management dated 6/2015 instructed staff that in order to prevent development of pressure ulcers they should determine increased risk, including friction and shear to evaluate for consistent implementation of interventions and to modify interventions as indicated.

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; and
(iii) A resident who is incontinent of bladder

F 686

F 690 F690 Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)

On 11/13/19, the DON educated the specific staff who were observed providing care by the surveyor, related to the requirements and expectations of providing incontinence care including catheter care. Resident #180 was assessed by the Licensed Nurse on or before 12/5/19 for signs or symptoms of infection with no change of condition identified.

Audit completed by DON to determine other residents requiring incontinent care, including urinary catheters by 12/14/19. The DON/designee completed an observational audit of clinical staff providing incontinence care and care of an indwelling urinary catheter on or before 12/5/19 to validate required technique. Concerns were addressed at the time of identification.

Education provided by DON to Nursing Staff on 12/5/19 related to the requirements and expectations for incontinence and urinary catheter care.

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| F 690 | Continued From page 13<br>receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, staff interview and policy/procedure review the facility failed to provide perineal/catheter care in a manner to prevent infection for 1 of 2 residents observed (Resident #180). The facility reported a census of 35 residents.<br><br>Findings include:<br><br>An admission MDS (Minimum Data Set) assessment, dated 11/1/19, documented Resident #180 was admitted to the facility on 11/1/19. The MDS revealed the resident had short term memory impairment, required extensive staff assistance with bed mobility, transfers, dressing, and personal hygiene. The MDS documented the resident had been transferred to a hospital on 11/1/19<br><br>A reentry MDS, dated 11/7/19, documented the resident returned to the facility that day.<br><br>A hospital Discharge Instructions/Orders sheet, dated 11/7/19, revealed the resident returned to the facility with a urinary catheter for a diagnosis of neurogenic bladder. | F 690 | DON or Designee will observe incontinence and catheter care 5x/week for 4 weeks and 3x/week for 6 weeks to ensure incontinence care completed properly. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed. | |

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| F 690 | Continued From page 14<br><br>During an observation on 11/13/19 at 7:50 a.m., Staff G, CNA (Certified Nursing Assistant) provided catheter care and perineal care to the resident Staff G directed the resident to turn to her left side. Staff G used an open wash cloth and cleaned the white ointment off the resident's rectal area and used the same area of the cloth to clean the resident's groins from front to back several times to remove the white ointment. Staff G obtained a clean wash cloth, used soap and water to clean the resident's rectal area and groins again without turning the cloth any time, and made one swipe from front to back over the top of catheter from front to back. Staff G turned the cloth and used the same area of the wash cloth to wipe both groins and between the labia around the catheter insertion site and down the tubing.<br><br>During an interview on 11/14/19 at 1:05 p.m., the Corporate Nurse stated she expected staff to use a clean area of the cloth for each wipe during perineal/catheter care. | F 690 | | |
| F 725 SS=D | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required | F 725 | F725 Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)<br><br>On 11/12/19 the DON visited with resident #26 and initiated a grievance and reviewed the call light log.<br><br>On 11/21/19 the DON completed an audit with use of call light log for the current residents for a baseline. | |

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| F 725 | Continued From page 15<br>at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident record review, resident and staff interviews and review of call light response records, the facility failed to respond to call lights within 15 minutes for 1 resident (Resident # 26).The facility reported a census of 35 residents<br><br>Findings include:<br><br>A significant change MDS (Minimum Data Set) assessment tool, dated 10/10/19, documented Resident #26 with intact cognition, required limited assistance with personal hygiene, and extended assistance with room ambulation, bed mobility, transfers, dressing, and toilet use The MDS revealed the resident's diagnoses included abscess of the right lower limb, osteomylitis of the right tibula and fibula, diabetes, muscle weakness, and difficulty walking<br><br>During a resident interview, 11/12/19 at 4:11 p.m., Resident #26 stated he waited 20 to 30 minutes | F 725 | By 12/14/19, the DON will provide education to current facility staff related to the requirements and expectations of answering resident call lights within the required 15-minute time frame and included that any staff can answer the call light initially.<br><br>The DON or designee will monitor call light response times 3 days per week times 6 weeks, then weekly times 4 weeks. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed. | |

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for staff to respond to the call light when in the bathroom and this happens fairly often. The resident stated he had wet himself 2 to 3 times while waiting for staff to help him go to the bathroom, this makes him angry and he doesn't like it. The resident stated he used a urinal, wanted to use the toilet for bowel movements and urinated at the same time. The resident stated sometimes he guessed at the call light response time and other times he checked the clock when turned the call light on and when staff came to assist him. The resident stated he had asked for tissues 3 to 4 times since the day prior and the staff brought the tissues this afternoon.

During an interview on 11/13/19 at 3:55 p.m., the resident stated he had waited 40 minutes for staff to help him to and from the bathroom today at approximately 12:30 p.m.

During an interview on 11/13/19 at 3:37 p.m., Staff G, CNA (Certified Nursing Assistant) stated the facility had been short of staff, staff unable to answer call lights within 15 minutes, and the longest she had observed the call light computer screen, located at the nurse's station, lit up with a light on was 45 minutes.

During an interview on 11/13/19 at 6:45 p.m., the resident stated he had returned from lunch this afternoon, turned the call light on at approximately 12:30 p.m., staff had not come, and he transferred himself to the bathroom. The resident stated he transferred himself back to the chair alone because no staff came to assist him

Review of the facility call light response record with Resident #26 on 11/13/19 at 6:45 p.m., revealed the resident had turned on the call light

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| F 725 | Continued From page 17<br>at 12:32 p m., the call light shut off after 17 minutes and 21 seconds. The resident turned the call light on again at 12:50 p m. and the call light turned off after 14 minutes and 59 seconds. The resident stated he had taken himself to and from the bathroom because staff had not come in a timely manner. The resident stated he had difficulty gathering the wound vacuum machine, the vacuum tubing, and transfer to the wheel chair to go to the bathroom.<br><br>The facility call light response time records, dated 10/25/19 at 4:49 p m to 11/13/19 at 2:51 p m , revealed staff had responded to the resident's call light 22 times from 15 minutes and 4 seconds to 42 minutes and 48 seconds.<br><br>During an interview 11/14/19 at 1:05 p.m., the Corporate Nurse stated she expected staff to respond to resident call lights within 15 minutes | F 725 | | |
| F 726 SS=E | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies | F 726 | F726 Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)<br><br>On 11/12/19, the DON notified the nurses who had outdated CPR Certification and required they bring it up to date immediately. They are now current.<br><br>On 11/12/19, the DON completed an audit of current nurses to verify that others have current CPR Certification. | |

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| F 726 | Continued From page 18<br>and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure staff certified in Cardiopulmonary Resuscitation (CPR) were scheduled 24 hours per day. The facility reported a census of 35 residents<br><br>Findings include:<br><br>Review of document titled Nursing schedule, for October, updated 10/25/19, no staff certified in CPR scheduled for:<br>*10/5/19 - 6:00 AM - 6:00 PM<br>*10/6/19 - 6:00 AM - 6:00 PM<br>*10/19/19 - 6:00 AM - 6:00 PM<br>*10/20/19 - 6:00 AM - 6:00 PM<br><br>Review of document titled Nursing schedule, for November, updated 11/8/19, no staff certified in CPR scheduled for:<br>*11/2/19 - 6:00 PM - 6:00 AM<br>*11/5/19 - 6:00 PM - 6:00 AM<br>*11/9/19 - 6:00 AM - 2:00 PM and 10:00 PM - | F 726 | By 12/14/19, the DON will provide education/reminders to the licensed nurses regarding the requirements and expectations of having current CPR Certifications. On 11/14/19 the Regional Nurse Consultant discussed with the DON, the need and expectation of verifying that there is always a staff on duty that has current CPR Certification.<br><br>The DON or designee will review monthly, times 3 months, that staffs CPR Certifications are current. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed. | |

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| F 726 | Continued From page 19<br>6:00 AM<br>*11/10/19 - 6:00 AM - 2:00 PM and 10:00 PM - 6:00 AM<br><br>Review of document titled Standard & Procedure for Code Status orders and response, dated 10/2017, does not provide documentation that CPR certified staff will be on duty 24 hours a day, 7 days a week.<br><br>During an interview at 11:33 AM on 11/13/19, the Director of Nursing (DON) stated she would expect nursing staff to be CPR certified upon hire The DON stated she would expect the schedule to have 24 hour per day coverage of CPR certified staff. | F 726 | | |
| F 729 SS=E | Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6)<br><br>§483.35(d)(4) Registry verification<br>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless-<br>(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or<br>(ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.<br><br>§483.35(d)(5) Multi-State registry verification.<br>Before allowing an individual to serve as a nurse aide, a facility must seek information from every | F 729 | F729 Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6)<br><br>On 11/13/19 CNA registry checks not showing up on SING were conducted by the BOM for Staff A and Staff B via the corrected DIA website obtained from surveyors and placed in their file prior to survey exit.<br><br>The BOM and/or designee will audit current employee files on or before 12/14/19 to validate the nurse aide registry has been checked as required. Concerns will be addressed at the time of identification. | |

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| F 729 | Continued From page 20<br>State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.<br><br>§483 35(d)(6) Required retraining.<br>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.<br>This REQUIREMENT is not met as evidenced by:<br>Based on personnel file reviews and staff interview, the facility failed to obtain registry verification of a certified nurse assistant (CNA) prior to hire for 2 of 2 currently employed CNA's (Staff A & B). The facility reported a census of 35 residents.<br><br>Findings include<br><br>The personnel file for Staff A, CNA, documented a hire date of 9/20/19 The file contained a copy of Staff A, CNA's, direct care worker (DCW) card. The DCW card stated that possession of the card does not mean the individual is eligible for employment.<br><br>The personnel file for Staff B, CNA, documented a hire date of 2/2/19. The file contained a copy of Staff B, CNA's, 75 Hour CNA course completion certificate.<br><br>Review of document titled Abuse Prevention Program and Reporting Policy, revised date | F 729 | The Administrator will Inservice BOM related to requirements and expectations of having registry verification of a certified nurse assistant (CNA) prior to hire by 12/14/19.<br><br>The BOM and/or designee will review 10 files per week until all employee files have been reviewed to ensure compliance for any hires going forward. Ongoing audits will take place monthly and all findings will be reported to the QAPI committee for further review and/or resolution. | |

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| F 729 | Continued From page 21<br>4/2014, noted all potential employees would be screened for history of abuse, neglect, or mistreating resident/patient during the hiring process. States screening will consist of, but not limited to:<br>*Inquiries into states licensing authorities<br>*Inquiries into state nurse aide registry<br>*Reference checks<br>*Criminal background checks<br><br>During interview with Staff E, Business Office Manager (BOM), at 2:30 PM on 11/13/19, she verified she did not check the DCW Registry prior to the hire of Staff A and B, CNA's.<br><br>During interview at 6:30 PM on 11/13/19, the Administrator stated her expectation would be the DCW Registry would be checked to verify employment eligibility prior to hire of CNA's. | F 729 | | |
| F 803 SS=E | Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy<br>Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; | F 803 | F803 Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)<br><br>Staff D was educated by the Certified Dietary Manager (CDM), 1:1 on 11/14/2019 to discuss adding bread and/or crackers to their pureed soups and/or protein when it's indicated on the menu for residents #183 & #21 and other like residents of the facility.<br><br>The CDM completed an audit to identify other residents of the facility who receive puree diets on 12/5/19. The menus were reviewed by the CDM and RD to eliminate pureed lettuce on the extensions on 11/20/2019. | |

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| F 803 | Continued From page 22<br><br>§483 60(c)(5) Be updated periodically;<br><br>§483 60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview the facility failed to follow the therapeutic menu for 2 of 2 residents (Resident #183 & #21) on Pureed diet for one meal observed. The facility reported a census of 35 residents.<br><br>Findings include:<br><br>Review of document titled Diet List, undated, listed Resident #183 as required pureed meat and Resident # 21 as required pureed diet.<br><br>Review of document titled Diet Spreadsheet for Week 1 Tuesday, dated 10/15/19, noted Puree diet to be chili, crackers, tossed greens with dressing, fresh baked bread, sherbert, and milk. Menu approved by dietician on 10/9/19.<br><br>Review of document titled Menu Planning dated 6/2015: modify menus based on specific facility preferences, prepare menus for use by obtaining the facility registered dietician signature and date prior to starting menus and indicate menu substitutions on all posted menus and on main copy<br><br>Review of document titled Menu | F 803 | The CDM provided education to dietary cooks on 11/22/2019 regarding the pureed diet along with the policy and procedure.<br><br>CDM and/or designee will audit weekly for 4 weeks, monthly for three months to verify that puree diets are prepared and served according to requirements and expectations. The CDM and RD will continue to evaluate each menu with each new cycle on a bi-yearly basis and report findings to the QAPI committee for further review and/or resolution monthly times 3 months. | |

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F 803 Continued From page 23

Substitutions/Alternates dated 6/2015: provide permanent changes to the Registered/Licensed Dietician for approval.

During observation at 3:07 PM on 11/12/19, Staff D, cook, prepared pureed chili. Staff D did not puree crackers, tossed greens with dressing, or fresh baked bread.

During observation at 5:15 PM on 11/12/19, Staff D, cook, served Resident #183 pureed chili and regular crackers. Resident #21 was served pureed chili and pureed peas

During an interview at 3:07 PM on 11/21/19, Staff D, cook, stated she was not going to puree crackers or bread and she would only add them to chili if needed to thicken. Staff D stated she does not puree lettuce due to consistency, and this is not new for the facility.

During an interview at 11:46 AM on 11/13/19, Staff E, Dietary Manager, stated she would expect the cook to puree crackers and bread per menu. Staff E stated they do not pureed lettuce due to consistency. Stated she would expect the menu to have been changed and reviewed by Registered Dietician.

F 812 SS=F Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities
(i) This may include food items obtained directly

F 803

F812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)

The can opener was discarded prior to survey exit by the CDM and a new one has been purchased. The toaster was cleaned prior to exit by the dietary cook. Items with only an arrival date versus an opened date were discarded on 11/14/2019. Items on the steam table post meal that were below required temperatures were discarded.

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from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interview the facility failed to provide residents with a nourishing and palatable diet by not maintaining the hot foods at 135 degrees or higher on the steam table, in order to prevent food borne illness. The facility failed to maintain sanitation in the kitchen and label food when opened. The facility reported a census of 35 residents.

Findings include:

1. Observation at 12:23 PM on 11/12/19, Staff D, Cook, checked temperatures of hot food that remained in the steam table after lunch service:
*Pork - 135 degrees
*Sweet Potatoes - 120 degrees Fahrenheit (F)
*Peas & Carrots - 120 degrees F
*Brussel sprouts - 100 degrees F
*Cream peas - 100 degrees F

Observation at 4:54 PM on 11/12/19, Staff D, cook, checked temperatures of hot food that remained in the steam table after supper service:
*Brats -130 degrees F
*Chili - 115 degrees F

F 812 A kitchen sanitation audit will be completed by the Administrator/designee to include condition of equipment, labeling and dating of foods and serving temperatures of hot foods. Concerns identified will be addressed at the time of identification.

The dietary cooks were educated on 11/22/2019 about the food danger zone, menu prep and service, sanitation including cleaning of equipment and the importance of labeling and dating as per policy by the CDM. Steam table food temps are being checked before and after meal service to verify that foods are kept at or above 135 degrees.

Audits are being conducted by the CDM and/or designee daily for two weeks, 3 times weekly for 6 weeks, then monthly for three months to verify that hot foods are at 135 degrees or higher on the steam table and opened foods are labeled and dated and the equipment is on cleaning schedule and being cleaned routinely. The can opener will be inspected monthly going forward and any findings of rust reported to the CDM and/or designee. The CDM or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed.

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| F 812 | Continued From page 25 | F 812 | | |

Review of document titled Heating, Holding, and Cooling Foods Correctly Staff In-Services dated 6/2015: noted
danger zone is between 41 degrees F and 135 degrees F, check the internal temperature during holding, making sure hot foods are at least 135 degrees F during holding process.

During interview at 3:00 PM on 11/12/19, Staff D, Cook reported hold temperatures in the steam table for hot foods should be 135 degrees after meal service

During interview with Staff E, Dietary Manager, at 11:46 AM on 11/13/19, reported she would expect the holding temperature in the steam table for the hot food to be 135 degrees after meal service.

2. Initial tour of the kitchen on 11/12/19 at 10:15 a.m. revealed the following:

a. A can opener attached to the counter top had a large amount of an orange discoloration all around the shaft Staff D, cook, present and stated the material looked like rust and the material had not come off in the dishwasher and had not attempted to scrub the material off.

b. A toaster had carbon scattered on the entire inside and on the top along the entire area where bread inserted to toast.

During an interview, on 11/14/19 at 9:31 a.m., Staff H, cook, verified the carbon remained on the toaster.

c. A 3 door freezer had the following unlabeled

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and undated foods: 8 muffins in a freezer bag, a partial bag of sausage links, half of a baked bundt cake, a partial bag of baked biscuits, a plastic bag that contained 4 rib patties, and a partial bag of unbaked cookies. Staff D verified the foods had no label identifying the products and no open date.

A Nutrition Services Manual for Sanitation for Freezer Storage, dated 6/2015, directed staff to label frozen food with the date food delivered and to discard the food after 6 months.

F 880 SS=E 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 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;

F 812

F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)

F 880

On 11/14/19 the catheter bag was covered; tubing and bag was lifted from the floor by the nurse. Resident #180 was assessed by the licensed nurse on or before 12/5/19 for signs or symptoms of infection with no change in condition identified. The infection control program was reviewed by the Infection Control Committee on 11/26/19.

By 12/14/19 the DON will complete an observational audit of other residents of the facility to identify others with urinary catheter and validate infection control practices are in place as required. Concerns identified will be addressed at the time of identification.

By 12/5/19 the DON provided education to nursing staff related to Infection Control, including the requirements and expectation of keeping urinary catheter bags and tubing off the floor. The Administrator will re-educate the Infection Control Committee regarding the requirements of annual review and revision as required.

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| F 880 | Continued From page 27<br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review. | F 880 | The DON or designee will monitor via walking rounds 5 days per week times 6 weeks to verify that urinary catheter bags and tubing are not touching the floor. The DON or designee will report findings of the above monitoring systems monthly times 3 months through the facility Quality Assurance & Performance Improvement program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be reeducated as needed. | |

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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 record review, observation, facility procedure and staff interview the facility failed to provide cares in a manner to prevent infection for 1 resident of 1 resident reviewed with a urinary catheter (Resident #180) and failed to review the facility infection control procedures at least annually. The facility reported a census of 35 residents.

Findings included:

1. An admission MDS (Minimum Data Set) assessment, dated 11/1/19, documented Resident #180 was admitted to the facility on 11/1/19. The MDS revealed the resident had short term memory impairment, required extensive staff assistance with bed mobility, transfers, dressing, and personal hygiene

Record review revealed the resident was hospitalized from 11/1/19 to 11/7/19.

A hospital Discharge Instructions/Orders sheet, dated 11/7/19, revealed the resident returned to the facility with a urinary catheter for a diagnosis of neurogenic bladder.

An observation on 11/12/19 at 1:34 p.m. revealed the resident sitting in a recliner chair in room and a urinary collection bag without any type of privacy/protective bag touched the floor.

An observation on 11/13/19 at 6:50 a.m , revealed the resident in bed, her urinary collection bag hanging on the side of the bed, and the catheter

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tubing lay on the floor An observation at 7:50 a.m. revealed the catheter tubing remained on the floor.

During an observation on 11/13/19 at 8:28 a.m., Staff G and Staff A, CNA's (Certified Nursing Assistants) transferred the resident from the bed to a recliner chair. Following the transfer and completion of cares, the staff left the room and the bottom of the resident's urinary collection bag, without a privacy/protective bag, and part of the tubing touched the floor

During an observation on 11/14/19 at 7:45 a.m., the resident was in bed and the entire urinary collection bag and tubing lay on the floor beside the resident's bed. The Corporate Nurse Consultant and DON (Director of Nursing) verified the observation and stated the tubing and urine collection bag needed to be off the floor and in a privacy bag.

The facility Nursing Prodecure Manual for Catheter Care, dated 01/2013, documented staff needed to place the catheter drainage bag on the bed frame.

2. During review of the Infection Control policies and procedures manual on 11/13/19, the Annual Review signature sheet last review date was

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| F 880 | Continued From page 30<br>5/19/17.<br><br>During an interview with the Director of Nursing (DON) at 5:51 PM on 11/13/19, she stated the Infection Control policies and procedures manual was not reviewed annually The DON stated she would expect this to be done annually. | F 880 | | |