

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/26/2019
NAME OF PROVIDER OR SUPPLIER ANAMOSA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1209 EAST THIRD STREET ANAMOSA, IA 52206		
(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)	(X6) COMPLETION DATE	
F 000	INITIAL COMMENTS Correction Date: 12/12/2019 The following deficiencies relate to the recertification survey completed 11/24-26/19 and Investigation of Complaint #85964 that was unsubstantiated. (See Code Federal Regulations (42CFR) Part 483. Subpart B-C).	F 000			
F 656 SS=B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 30 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 656	<p>Continued From page 1</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, resident and staff interviews, the facility failed to identify the resident with a pressure ulcer and document interventions on the Baseline Care Plan for one of three residents reviewed with pressure ulcers (Resident #261). The facility reported a census of 58 residents.</p> <p>Findings Include:</p> <p>A review of the Admission Record revealed the resident admitted to the facility on 11/21/19.</p> <p>The facility did not have a completed Minimum Data Set (MDS) Assessment Tool on the medical record for reference.</p> <p>A review of the hospital discharge instructions dated 11/21/19 documented the following:</p> <p>a. Upcoming appointment with the wound clinic on 11/26/19.</p> <p>b. Dressing and wound orders to left foot two</p>	F 656			

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F 656	<p>Continued From page 2</p> <p>times daily.</p> <p>c. Remove packing.</p> <p>d. Flush with normal saline, may then irrigate with 3 milliliters (ml) 1% lidocaine.</p> <p>e. Pack loosely with ¼ inch nuga gauze moistened with 0.125% Dakins's solution.</p> <p>f. Cover with 4x4 gauze folded in half, secure with medipore tape.</p> <p>An observation of wound care on 11/25/19 revealed the resident had a left plantar wound which measured 1.3 centimeters (cm) long, 2.0 cm wide and 0.5 cm deep. No signs of infection noted to wound bed or surrounding skin.</p> <p>A review of the Nurse's Notes revealed the following entries: 11/21/19 at 1:21 p.m., resident admitted for wound cares to the left foot, abrasion to left foot packed.</p> <p>During an interview on 11/25/19 at 10:53 a.m., the Director of Nursing reported the resident did have an open area to the bottom of her left foot upon admission and that she would expect that issue to be addressed on the Baseline Care Plan which all staff had the responsibility to develop.</p> <p>In an interview on 11/25/19 at 2:41 p.m., Staff E, Registered Nurse/ MDS Coordinator reported the resident admitted to have wound care for the open area she had to the bottom of her left foot. The Care Plan should have addressed this, and could not explain why it did not.</p>	F 656			
F 686 SS=G	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer</p> <p>CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity</p>	F 686			

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F 686	<p>Continued From page 3</p> <p>§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(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</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview, the facility failed to provide an admission assessment and physician clarification for use of an ED boot (stabilizer boot) resulting in the development of a pressure ulcer for 1 of 4 residents (Resident #46). The facility identified a census of 58 residents.</p> <p>The Admission Record showed Resident #46 admitted to the facility on 10/16/19 with a diagnoses of pulmonary embolism, pneumonia, pressure ulcer of the left ankle, Stage 4, dementia without behavioral disturbance, peripheral vascular disease, atherosclerotic heart disease, venous insufficiency, cognitive communication deficit, type 2 diabetes with other diabetic neurological complications, obesity, and hyperlipidemia.</p> <p>The Minimum Data Set (MDS) Assessment dated 10/23/19 showed a Brief Interview for Mental Status Score (BIMS) of 3 indicating severe memory impairment. The resident required extensive assistance with toileting, personal</p>	F 686			

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F 686	<p>Continued From page 4</p> <p>hygiene, dressing and had a Foley catheter. The MDS identified the resident at risk of pressure ulcers with a Stage IV pressure ulcer present upon admission and a Stage III pressure ulcer that developed after admission.</p> <p>A review of the Physician Transfer Order Report from the hospital, dated 10/16/19, did not address a physician order for the ED boot to resident #46 right lower extremity. The Physician Transfer Order Report dated 10/16/19 and the Treatment Administration Record dated 10/17/19 showed the resident admitted to the facility with a physician order for Santyl Ointment 250 units per Gram, apply topically every evening shift to wounds to bilateral ankles and affected area on right foot. Apply moist gauze and Kerlix.</p> <p>The Certificate of Care for Nursing Home Admission signed by the physician 10/16/19 documented the resident did not have chronic wounds.</p> <p>The Braden Scale for Predicting Pressure Sore Risk, completed 10/16/19, identified a score of 15, indicating the resident at risk of developing a pressure ulcer.</p> <p>The Admission Nursing Assessment, dated 10/16/19, failed to reveal any skin assessment documentation regarding a pressure ulcer to the right lateral foot or the presence of a ED boot to the right lower extremity.</p> <p>The Admission Progress Note, dated 10/16/19, identified the resident admitted with a bruise to the right hand, left antecubital and a wound to the left malleolus (ankle bone). The Admission Progress Note did not address any</p>	F 686			

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F 686	<p>Continued From page 5</p> <p>documentation of a wound to the right lateral foot or the presence of a ED boot to the right lower extremity.</p> <p>The Baseline Care Plan, dated 10/17/19, identified the resident had a stage 4 pressure ulcer to the left Malleolus (ankle) with treatment and would be seen at the wound clinic. The Baseline Care Plan did not identify the resident wore an ED boot to the right lower extremity when admitted on 10/16/19 or any wounds to the right lower extremity.</p> <p>A Nursing Home Rounds dictation, dated 10/18/19, by Resident #46 attending physician, documented the resident complained of pain with the ED boot. The physician documented that the resident would have the boot removed from the right lower extremity and protect his/her feet with boots on when he/she lays down. The dictation documented the resident had a fall the day prior to 10/1/19, had a boot placed to the lower extremity and the ankle is chronically deformed due to poor healing of a previous fracture in 2017. The Nursing Home Round dictation lacked documentation of the presence of a stage 3 pressure ulcer to the right lateral foot.</p> <p>A Physician Order, dated 10/18/19, instructed to discontinue all treatments, except the left ankle wound treatment.</p> <p>Physical Therapy Daily Treatment Notes dated 10/21/19 and 10/22/19 documented the resident required assistance with completing exercises to the right lower extremity due to the increased weight to the extremity from the resident wearing the ED boot.</p>	F 686			

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F 686	<p>Continued From page 6</p> <p>Resident #46 saw the attending physician at the wound clinic on 10/23/19. The Wound Clinic Provider Note, dated 10/23/19, documented a diagnosis of a new stage 3 (pressure) injury to the right foot. The subjective narrative, as dictated by the attending physician, documented the right foot wounds were healed, but unfortunately he/she developed a pressure injury from the ED boot. The attending physician dictated to remove the ED boot at this time due to causing more harm than helping. The wound to the right lateral foot presented as a black, unstageable wound that required debridement on 10/23/19. Post debridement the wound to the right lateral foot showed a stage 3 pressure injury measuring 1 cubic centimeter (CM) in length, by 0.8 cm in width, by 0.1 cm in depth. The physician documented the wound to the right lateral foot reopened 10/23/19 due to a deep tissue injury (DTI) resulting from the ED boot.</p> <p>A Wound/Skin Healing Record, dated 10/23/19, provided by the facility, documented a stage 3 pressure ulcer to the right lateral foot with an onset date of 10/23/19 per the wound clinic assessment.</p> <p>The facility Progress Notes dated 10/16/19-10/22/19 lacked documentation the condition of right lateral foot had been assessed, until the wound clinic appointment 10/23/19 when the Stage 3 to the right lateral foot received debridement. The facility progress note dated 10/23/19 documents a new wound site on the right lateral foot, a stage 3 pressure ulcer.</p> <p>The Care Plan, with an initiation date of 10/24/19, identified the resident had a stage 3 pressure ulcer to the right lateral foot. The Care Plan</p>	F 686			

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F 686	<p>Continued From page 7</p> <p>directed the following care:</p> <ul style="list-style-type: none"> a. Prevalon boot on when in bed, initiated 11/7/19. b. Wound clinic appointment weekly as ordered, initiated 10/24/19. c. Assess the pressure ulcer for location, stage, size (length, width, depth), presence and absence of granulation tissue, epithelization and condition of surrounding skin weekly, initiated 10/24/19. d. Apply treatment as ordered, initiated 10/24/19. e. Assist with repositioning, initiated 10/24/19. f. Monitor skin during cares. Report any further skin breakdown (sore, tender, red or broken areas), initiated 10/24/19. g. Provide incontinence care after each incontinence episode, initiated 10/24/19. h. Use pressure reduction cushion to chair, initiated 10/24/19. i. Use pressure reduction mattress when resident in bed, initiated 11/14/19. <p>A Physician Order signed by the physician on 11/7/19 directed the staff to apply Prevalon boots on both feet when in bed.</p> <p>During an observation on 11/25/19 at 1:33 p.m., Staff A, Certified Nursing Assistant (CNA) and Staff F, CNA, transferred the resident to bed utilizing a mechanical standing lift. The resident wore gripper socks in bed. Staff A and Staff F did not apply the Prevalon boots to both feet per the 11/7/19 physician order or per the care plan.</p> <p>During an observation on 11/26/19 at 9:30 a.m., Staff K, Licensed Practical Nurse (LPN), set up a clean field and supplies. Staff K proceeded to complete Santyl treatment as ordered by the physician for Resident #46's Stage 3, right lateral foot pressure ulcer. The pressure ulcer measured 0.8 cm in length, 0.5 cm in width, and</p>	F 686			

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F 686	<p>Continued From page 8</p> <p>0.1 cm in depth. The wound bed had a small amount of brown, tan slough present, no odor or drainage. The peri-wound area remained pink. The resident reported he/she did not have pain to the wound area.</p> <p>During an interview on 11/25/19 at 11:06 a.m., Staff B, CNA, reported if a resident wears a special boot, the CNA's would not remove the boot to look at the skin. The nurse would remove and look at the skin.</p> <p>During an interview on 11/25/19 at 11:09 a.m., Staff D, Registered Nurse (RN), reported nurses would only remove a immobilization boot to look at the skin if ordered to do so by a physician.</p> <p>During an interview on 11/25/19 at 3:00 p.m., The Director of Nursing (DON) stated the resident got the boot on 10/1/19 in the emergency room after a fall with fracture. The Don stated the resident did have the boot on until 10/23/19 after the wound clinic visit.</p> <p>During an interview on 11/25/19 at 1:57 p.m., Staff A, CNA, reported she remembered the resident admitted with a boot on the right lower extremity.</p> <p>During an interview on 11/25/19 at 4:05 p.m., Staff H, Physical Therapist Assistant (PTA), reported the resident did admit with a boot to the right lower extremity. She remember the team discussing the boot at the Medicare meeting on 10/23/19 as the resident did not have a physician order for a boot to the right lower extremity. She reviewed the therapy treatment notes for October 2019 and stated the resident continued to wear the boot on 10/21/19 and 10/22/19.</p>	F 686			

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F 686	<p>Continued From page 9</p> <p>During an interview on 11/25/19 at 4:53 p.m. via phone, Staff I, Doctor of Physical Therapy (DPT), reported the resident admitted with a boot to the right lower extremity. The resident had a fall a few weeks before coming to the nursing home and needed the boot to stabilize the weight bearing of the right foot due to a fibula injury. She reported the resident wore the boot to the right lower extremity for about 1 and a half weeks and did report pain, but the pain came from the right knee and calf area, not the right foot. Staff I could not recall if the right extremity boot had been physician ordered.</p> <p>During an interview on 11/25/19 at 5:07 p.m., via phone, the Primary Care Physician and Wound Clinic Physician, stated the resident had a history of wounds to the right foot. The resident had been place in a special boot on 10/1/19 at the hospital emergency department. He confirmed he saw the resident on 10/18/19 and addressed the ED boot to the right lower foot should be removed. He reported he may not have dictated to wait in his note because he wanted to talk to the resident's son before removing the boot. He stated the use of a stabilizer boot is the standard of care for a fibular fracture. He reported he would expect the nurses to remove the ED boot and assess the skin with admission. But as he did not order the boot, the facility should have clarified further instruction with the hospital regarding the use of the boot, if the boot had not been physician ordered. He stated the right foot, stage III pressure ulcer had reopened. The wound resulted from a fall with injury to the right fibula and the boot did not help the situation but does not feel the area would have been unavoidable. He stated he saw the wound when</p>	F 686			

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F 686	<p>Continued From page 10</p> <p>he did rounds 10/18/19 and assessed again on 10/23/19 when he saw the resident in the wound clinic.</p> <p>During an interview on 11/26/19 at 7:05 a.m., Staff K, Licensed Practical Nurse (LPN), stated resident did admit with a boot to the right lower extremity. She reported the resident admitted between 5:00 p.m. – 5:30 p.m. and it is a busy time of day. Staff K reported she didn't know if the ED boot had a physician order as the Assistant Director of Nursing (ADON) takes care of the admission orders. Staff K reviewed her admission assessment documentation from 10/16/19. She reported the assessment did not have documentation the right lower extremity had been assessed. She stated she could not remember 100% if she did or did not remove the boot to assess the right lower extremity and foot.</p> <p>During an interview on 11/26/19 at 7:33 a.m., the Director of Nursing (DON), reported she doesn't know why the resident's boot to the right lower extremity did not get removed on 10/18/19. She stated the boot should have been removed if the physician dictated the boot to be removed on 10/18/19. The DON confirmed the facility did not have a physician order for a ED boot to the right lower extremity for Resident #46.</p> <p>During an interview on 11/26/19 at 7:36 a.m., the ADON, reported she does not see the resident or assess the resident when they are admitted to the facility. She gets the physician orders from the hospital and puts the orders in the computer. The ADON reported she did not know resident #46 had admitted with a ED boot to the right lower extremity. She reported if the ED boot did not have a physician order, it should have been</p>	F 686			

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F 686	Continued From page 11 clarified with the physician. During an interview on 11/26/19 at 10:36 a.m., Staff C, Licensed Practical Nurse (LPN), reported she assisted Staff K with the assessment of Resident #46 on 10/16/19. Staff C reported she could not recall if they did or did not remove the boot, but thought they may not have removed the boot and assessed the right foot. She reported she did not know if the ED boot had a physician order as the admission orders were done by the ADON. During an interview on 11/26/19 at 10:15, the DON reported she would have expected the nurses to document the presence of an ED boot and to assess the skin condition of the right lower extremity upon admission. The Nurse Consultant reported 11/26/19 at 10:18 a.m., the facility did not have a pressure ulcer or admission skin assessment policy.	F 686			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program 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:	F 880			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166375	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/26/2019
NAME OF PROVIDER OR SUPPLIER ANAMOSA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1209 EAST THIRD STREET ANAMOSA, IA 52206		
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F 880	Continued From page 12 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880			

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F 880	<p>Continued From page 13</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to secure a urinary drainage bag and tubing from contacting the floor to maintain acceptable infection control for 1 out of 3 residents (Resident # 46). The facility identified a census of 58 residents.</p> <p>Findings Include:</p> <p>The Minimum Data Set (MDS) Assessment for Resident #46 dated 10/23/19 showed a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive loss. The resident required extensive assistance with toileting, personal hygiene, dressing and utilized a urinary catheter. The MDS documented diagnoses of benign prostatic hyperplasia (BPH), renal insufficiency, renal failure, neurogenic bladder and Non-Alzheimer's dementia.</p> <p>A Physician Transfer Order Report, dated 10/16/19, ordered the resident to continue with a urinary catheter due to urinary retention. A physician order dated 10/18/19 clarified an order for the placement of a 14 French 10 cubic</p>	F 880			

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F 880	<p>Continued From page 14</p> <p>centimeter balloon urinary catheter for the resident due to urinary retention.</p> <p>During an observation on 11/25/19 at 10:30 a.m., the resident sat in the lounge chair in the front lounge. The resident's catheter bag lay in a privacy bag on the floor underneath the lounge chair with the tubing laying directly on the floor.</p> <p>During an observation on 11/25/19 at 11:55 a.m., the resident sat in a lounge chair in the front lounge. The resident's catheter bag lay in a privacy bag on the floor under the chair with the tubing touching the floor and the resident's slipper shoes stepping on the top of the urinary drainage bag tubing. Staff A, Certified Nursing Assistant (CNA), talked to the resident on transferring to the wheelchair to go to the dining room for lunch. The resident refused to move from the lounge chair. Staff A did not pick the urinary drainage bag and tubing up off the floor and suspend from the chair.</p> <p>During an observation on 11/25/19 at 12:25 p.m., the resident sat in the lounge chair watching television. The resident's urinary drainage bag lay on the floor under the chair in the privacy bag with the drainage bag tubing laying on the floor and the resident stepped on the tubing with his/her slippers.</p> <p>During an observation on 11/25/19 at 1:45 p.m., Staff A and Staff F, CNA assisted the resident to lay down in bed and emptied the resident's urinary drainage bag. Staff A and Staff F did not put a privacy cover on the resident's urinary drainage bag after emptying the urinary drainage bag. Staff F lowered the electric bed to the low position causing the uncovered, urinary drainage</p>	F 880			

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F 880	<p>Continued From page 15</p> <p>bag to come into direct contact with the floor.</p> <p>During an observation on 11/25/19 at 1:54 p.m. the urinary drainage bag remained uncovered, dangling off the resident's bed touching the floor. No basin in place to keep the urinary drainage bag and tubing from laying on the floor.</p> <p>During an observation on 11/25/19 at 4:08 p.m. the urinary drainage bag remained uncovered, dangling off the resident's bed touching the floor. No basin in place to keep the urinary drainage bag or tubing from laying on the floor.</p> <p>The Care Plan, initiated 10/22/19, identified the resident would sit his/her catheter bag on the floor and directed the staff to encourage the resident not to do this and suspend the urinary drainage bag up off the floor when found.</p> <p>During an interview on 11/25/19 at 3:23 p.m., Staff G, (CNA) reported she had been trained that a urinary drainage bag should always be covered for privacy and the drainage bag/tubing should never come into contact with the floor.</p> <p>During an interview on 11/25/19 at 4:00 p.m., Staff C, Licensed Practical Nurse (LPN) stated a urinary drainage bag should always be covered for dignity and the bag or tubing should never come into contact with the floor. She reported the facility puts a basin under the urinary drainage bag when the bags are hung from the bed to keep the bag and tubing from contacting the floor.</p> <p>During an interview on 11/25/19 at 4:20 p.m., the Director of Nursing (DON) stated she would expect urinary drainage bags to be covered to protect the resident's dignity. She reported the</p>	F 880			

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F 880	Continued From page 16 urinary drainage bag and tubing should not come into contact with the floor for infection control. The Nurse Consultant reported on 11/26/19 at 10:18 a.m. the facility did not have a urinary catheter policy.	F 880			

Department of Health and Human Services Division of Health Facilities Plan of Correction (CMS-2567)

F000-Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

F656 DEVELOPMENT/IMPLEMENT COMPREHENSIVE CARE PLAN

CFR(s): 483.25

Resident #261 comprehensive care plan was created on 12/3/19 and addressed wound care for the wound on resident's foot. Nursing staff were educated on 12/12/2019 on development of a baseline care plan, including documenting interventions for services provided to attain or maintain the resident's highest practicable level. The DON or designee will monitor the completion of baseline care plans for the next 90 days and bring report findings to the quarterly CQI team.

Completion Date: 12/12/2019

F686 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCER

CFR(s): 483.25

Nursing staff were educated on 12/12/2019 regarding completion of nursing admission skin assessment. Nurses were also re-educated regarding clarification of admission orders for discrepancies noted during the admission process. The DON or designee will monitor the completion of admission assessments and audit admission orders for the next 90 days and report findings to the quarterly CQI team.

Completion Date: 12/12/2019

F880 INFECTION PREVENTION AND CONTROL

CFR(s): 483.25

Nursing staff were educated on 12/12/2019 on proper catheter tubing and bag placement for infection control. The DON or designee will audit nursing staff weekly for the first 30 days and monthly for the next 90 days on catheter bag placement and report any findings to the quarterly CQI team.

Completion Date: 12/12/2019