STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165435	A. BUILDING _____ B. WING _____	C 06/17/2021

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ACCURA HEALTHCARE OF SIOUX CITY, LLC	3800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 000	INITIAL COMMENTS - Correction Date:_____ The Iowa Department of Inspections and Appeals (DIA) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 483, Subpart B-C, conducted this Medicare Recertification Survey and Investigation of a complaint. The facility was found to be NOT IN COMPLIANCE. Total residents: 27 Onsite dates: 6/14/2021 - 6/17/2021 Complaint # reviewed: #93580- C not substantiated	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		

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 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 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: - Based on interviews and record reviews the facility failed to notify the physician of abnormal blood pressure readings for a peritoneal dialysis	F 580		

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resident for 1 of 3(#22) residents reviewed. The facility reported a census of 27 Residents.

Findings Include:

1. The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 5/17/21 for Resident #22 showed a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. The MDS showed the Resident to have diagnoses of chronic kidney disease, dependence on renal dialysis, malignant neoplasm of the breast, and hypertension. The MDS showed the Resident needed limited assistance with bed mobility, transfers, and locomotion.

Review of the blood pressure summary showed a blood pressure reading of 94/57 on 5/27/21 at 6:27 AM.

Review of the blood pressure summary showed a blood pressure reading of 90/60 on 6/13/21 at 3:11 PM.

Review of the Electronic Record (EHR) showed the Resident had an order dated 4/14/21 to monitor blood pressure and notify the physician if blood pressure was less than 100 systolic or if signs and symptoms noted.

Review of the progress notes from 5/20/21 to 6/14/21 lacked documentation of notification to the physician of the blood pressure being lower than 100 systolic on 5/27/21 and 6/13/21.

Review of the Care Plan showed the Resident had a focus of chronic kidney disease and required peritoneal dialysis with an intervention to

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F 580	Continued From page 3 monitor vital signs and notify the physician with concerns with an initiation date of 3/5/21. Care Plan showed a focus of congestive heart failure with an intervention to monitor vital signs and report any abnormal findings to the physician with an initiation date of 2/18/21 Interview on 6/15/21 at 12:23 PM, Interim Director of Nursing (DON) stated that she was unable to find any documentation that the physician notified about the blood pressure results of 94/57 on 5/27/21 and 90/60 on 6/13/21. The DON stated that she expected the staff to notify the physician of abnormal blood pressure readings. Interview on 6/17/21 at 8:39 AM, DON stated they currently do not have a policy regarding physician notification and that they use standard of practice guidelines. -	F 580		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636		

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(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,

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F 636	Continued From page 5 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: - Based on Interviews and record reviews the facility failed to complete pre and post peritoneal dialysis assessments for 1 out of 2 (#22) Residents reviewed. The facility reported a census of 27 Residents. Findings Include: The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 5/17/21 for Resident #22 showed a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. The MDS showed the Resident to have diagnoses of chronic kidney disease, dependence on renal dialysis, malignant neoplasm of the breast, and hypertension. The MDS showed the Resident needed limited assistance with bed mobility, transfers, and locomotion. Review of the census tab in the electronic health record (EHR) showed the Resident to have an admit date of 2/17/21 to the facility. Review of the medical diagnosis tab in the EHR showed the Resident had a diagnosis of dependence on renal dialysis with a start date of 2/17/21. Review of the Care Plan showed the resident to have a focus of chronic kidney disease and required peritoneal dialysis dated 3/4/21.	F 636		

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Intervention to complete peritoneal dialysis daily flow sheet located in the resident's room dated 3/10/21. Intervention to complete pre and post assessments with vital signs and site access dated 3/5/21.

Review of the Daily flowsheets showed no blood pressure readings for 6/2/21 post dialysis, no post dialysis assessment on 6/7/21, no pre or post assessment on 6/10/21, no post dialysis assessment on 6/12/21 and 6/13/21.

Review of the Daily flowsheet showed no post dialysis assessment completed on 5/2/21, 5/3/21 and 5/5/21. No pre or post assessment completed on 5/6/21, 5/7/21, and 5/10/21. No post dialysis assessment completed on 5/8/21, 5/12/21, 5/14/21, 5/15/21, 5/16/21, 5/17/21, 56/22/21, 5/24/21, 5/25/21, and 5/28/21.

Review of the Patient Home Record Keeping procedure with an effective date of 3/7/12 stated the purpose of this procedure is to provide direction for documentation of dialysis treatments for home dialysis patients. Step 1 stated to train patients and/or patient caregiver to complete assessments and to fill out the home treatment log sheets.

Interview on 6/15/21 at 11:54 AM, Interim Director of Nursing (DON) stated she was aware of the missing information and assessments on the daily flowsheet. The DON stated she called the dialysis company to get the information on what the staff should document for the pre/post-peritoneal dialysis assessment. The DON stated that staff should at least document the daily weight and blood pressure prior to starting the dialysis and at least a blood pressure

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F 636	Continued From page 7 after the peritoneal dialysis procedure. The DON stated she is currently working on staff education to correct the issue.	F 636		
F 656 SS=D	- Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		

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F 656	Continued From page 8 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: - Based on interviews and record reviews the facility failed to develop a Comprehensive Person Centered Care Plan by including information on high-risk medications use for 1 resident (#22). The facility reported a census of 27 Residents. Findings include: The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 5/17/21 for Resident #22 showed a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. The MDS showed the Resident to have diagnoses of chronic kidney disease, dependence on renal dialysis, malignant neoplasm of the breast, and hypertension. The MDS showed the Resident needed limited assistance with bed mobility, transfers, and locomotion. Review of the orders tab in the electronic health record (EHR) showed an order for Eliquis with an order date of 3/16/21. Review of the medication administration record for the month of June 2021 showed the resident	F 656		

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F 656	Continued From page 9 received Eliquis twice a day from 6/1/21 to 6/15/21. Review of the Care Plan lacked any documentation of the high-risk medication use of Eliquis or the possible adverse side effects of bleeding and bruising to monitor for. Interview with the interim Director of Nursing (DON) on 6/16/21 at 12:20 PM states high risk medications should be on the Care Plan. Interview on 6/17/21 at 8:33 AM, DON stated the facility does not have a current policy regarding adding high-risk medication use and side effect monitoring to the Care Plan.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: - Based on interviews and record reviews the facility failed to meet professional standards by not obtaining a physician's order to preform peritoneal dialysis at the facility for 2 out of 2 (#22 and #3) residents reviewed and failed to follow through with physician's orders for 1 of 12 residents reviewed (#3). The facility reports a census of 27 Residents. Findings include:	F 658		

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1. According to the Minimum Data Set (MDS) dated 3/19/21, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognitive ability. The MDS showed that the resident was independent with transfers and walking and required set up only for dressing and toileting.

A Care Plan for Resident #3 last updated on 6/7/21 included diagnoses of hypertension, vascular dementia, bipolar disorder, and chronic obstructive pulmonary disease. The Care Plan directed staff to weigh the resident according to the doctors' order with a goal for her to maintain weight and nutritional balance. Staff directed to monitor vital signs as ordered per protocol and record and to notify the doctor of significant abnormalities.

According to an order dated 4/3/21 at 2:00 PM, the doctor directed staff to monitor for fluid overload three times a day and watch for symptoms such as edema, increased shortness of breath and weight gain of more than 3-5 pounds in 5 days.

According to the vitals tab in the electronic record, Resident #3 weighed on 3/25/21 at 9:36 AM at 278.4 pounds and not weighed again until 5/14/21 at 286.1 at 1:28 PM with a 7.7-pound weight gain. According to the nursing notes dated 6/2/21 at 11:59 AM, the resident taken to the hospital with shortness of breath, diminished lung sounds, and confusion. She returned to the facility on 6/4/21 at 12:45 PM.

On 6/16/21 at 7:25 AM, Licensed Practical Nurse (LPN), Staff D stated that if a physician asked to

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monitor a resident for fluid overload she would watch for shortness of breath, edema, oxygen saturation, fluid intake, and daily weights.

On 06/16/21 at 7:30 AM Certified Medication Aide (CMA) Staff F stated that when directed to watch for fluid overload, she would watch for fluid intake, urination patterns and vital signs. When asked what she expected for weight monitoring she stated that the facility provide daily weights. She then looked at the electronic chart for Resident #3 and documentation of the weights. Staff F had some difficulty finding were the weight history was and surprised to see that the resident's weights not taken as frequently as she would expect.

Registered Nurse (RN) Staff G then looked at the computer and the order to contact the physician with a 3-5 pound weight gain in a five-day period. She agreed that if the weight taken only monthly that would not be following the orders. She stated that she would contact the doctor for clarifying orders regarding frequency of weights.

On 6/17/21 at 8:39 AM, the interim Director of Nursing stated they do not have a policy for monitoring for fluid overload or following physician's orders.

2. The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 5/17/21 for Resident #22 showed a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. The MDS showed the Resident to have a diagnosis chronic kidney disease, dependence on renal dialysis, malignant neoplasm of the breast, and hypertension. The MDS showed the Resident needed limited assistance with bed

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mobility, transfers, and locomotion.

Review of the census tab in the electronic health record (EHR) showed the Resident to have an admit date of 2/17/21 to the facility.

Review of the medical diagnosis tab in the EHR showed the Resident had a diagnosis of dependence on renal dialysis with a start date of 2/17/21.

Review of the Care Plan showed the resident to have a focus of chronic kidney disease and required peritoneal dialysis dated 3/4/21. Intervention to complete peritoneal dialysis daily flow sheet located in the resident's room dated 3/10/21. Intervention to complete pre and post assessments with vital signs and site access dated 3/5/21, and to provide daily dressing change to peritoneal dialysis site as ordered, and monitor for signs and symptoms of infection, redness, warmth, drainage from peritoneal dialysis site, fever, and cloudy dialysate and to report to physician.

Review of the order tab in the EHR lacked documentation of an order to complete the peritoneal dialysis at the facility.

Interview on 06/15/21 at 8:17 AM, Interim Director of Nursing (DON) stated that she reviewed the EHR and she was unable to locate any order for the peritoneal dialysis to be given at the facility. The DON stated she did send a request to the physician requesting an order and would put it in the EHR once received. The DON stated the only order information the facility had was located on an after visit summary page 7 to facility from Unity Point dated 2/17/21 stating to continue

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F 658	Continued From page 13 peritoneal dialysis as ordered by Nephrology. The DON stated that she felt this was a concern due to having agency nursing at the facility, as they would not have known when to complete the dialysis treatment. The DON stated that they require agency nursing to go through the peritoneal training in order to provide the dialysis care. Review of the order tab in the EHR showed a new order for peritoneal dialysis via cycler machine daily. Cycle initiated 2PM-10PM shift for hook up, completed 6AM-2PM to unhook. See flow sheets for assessments with an order date of 6/15/21.	F 658		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not	F 725		

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F 725	Continued From page 14 limited to nurse aides. §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. This REQUIREMENT is not met as evidenced by: - Based on observation, interview and chart review the facility failed to provide adequate staffing for 1 of 12 residents (#26) reviewed. The facility reported a census of 27 residents. Findings include: A Minimum Data Set (MDS) assessment dated 5/26/21 showed that Resident #26 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognitive ability. The MDS showed that the resident required extensive assistance with the help of two for bed mobility, transferring, walking, dressing, and toileting needs. According to the residents care plan last updated on 4/26/21, he was suffering with pain in his legs related post-polio syndrome and had peripheral edema. The care plan showed that Resident #26 required two people to assist with incontinent cares and staff directed to monitor him daily to keep skin clean and dry. The care plan indicated that the resident was at risk for falls related to gait/balance problems and staff should keep the call light within reach. Observation and interview on 6/15/21 at 7:55 AM, Resident #26 laid in bed, stated that he had been waiting for someone to help him up and get him	F 725		

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F 725	Continued From page 15 ready for breakfast. Certified Nursing Assistant (CNA) Staff A, came into the room and told the resident that she was waiting for assistance to get him up and she would be right back with help. Observation and interview on 6/15/21 at 8:45 AM, upon entry to resident's room observed Staff A and Staff B, CNA helping the resident to his feet from the bedside, and a heavy odor of urine in the room. A nurse consultant was in the room observing as well as Physical Therapist, Staff E. Resident #26 was very upset and stated that he had been waiting for help for over an hour to get to breakfast. When asked if this happened often that he had to wait that long to get up for breakfast, he stated it did not happen often. On 6/16/21 at 07:35 AM, Staff E stated she had been in the room of Resident #26 the day before, because one of the CNA's had asked her to help get the resident out of bed. Staff E stated she that she agreed to help and wanted to see how the resident had been doing with transfers. She stated it does not happen very often that a CNA would come and ask her to help with transfers. On 6/17/21 at 8:41 AM, the interim Director of Nursing stated that they do not have a policy specific to call light response time.	F 725		
F 842 SS=D	- Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 17 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: - Based on observation chart review and interviews the facility failed to maintain medical records in accordance with professional standards for 1 out of 12 residents reviewed (#3). The facility reported a census of 27 residents. Findings include: According to the Minimum Data Set (MDS) dated 3/19/21, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognitive ability. The MDS showed that the resident was independent with transfers and walking and required set up only for	F 842		

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dressing and toileting.

A Care Plan for Resident #3 last updated on 6/7/21 included diagnoses of hypertension, vascular dementia, bipolar disorder, and chronic obstructive pulmonary disease. The Care Plan directed staff to weigh the resident according to the doctors' order with a goal for her to maintain weight and nutritional balance. Staff directed to monitor vital signs as ordered pursuant to protocol and record and to notify the doctor of significant abnormalities.

1. Observation on 6/14/21 at 9:57 AM, Resident #3 sitting on the side of her bed with supplemental oxygen per nasal cannula. A piece of tape wrapped around the oxygen tubing with date marked on it of 6/7/21.
A review of the Medication Administration Record (MAR) showed an entry on 6/13/21 that indicated that the tubing had been changed on that date.

Interview on 6/15/21 at 1:56 PM Interim Director of Nursing (DON) looked at the marked tape on the tubing and verified its date of 6/7/21, which indicated that the tubing changed on that date. She agreed that documentation on 6/13/21 on the MAR would be incorrect documentation.

Review of a Nursing Note dated 6/2/21 at 11:59 AM indicated that Resident #3 was complaining of double vision, dizziness, fatigue and was confusion. The note stated that her eyes were red, lung sounds diminished bilaterally, and she had some coughing at mealtime. The note indicated that the residents face flushed and taken to the emergency room for further evaluation.

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F 842	Continued From page 19 Review of a Quarterly Nursing Assessment dated 6/2/21 at 1:59 PM indicated that the resident was alert and oriented, no abnormal skin tone noted and her lung sounds were clear bilaterally. Interview on 06/16/21 at 9:48 AM, Registered Nurse (RN) Staff G stated that she had actually entered the quarterly assessment after the resident had gone to the hospital and that she also did the nursing note just before the resident left for the hospital. She looked at the conflicting information in the electronic record and could not explain why the quarterly assessment documented the systems within normal limits when the assessment just before going to the hospital stated that lung sounds diminished and the resident was confused. Interview on 6/17/21 at 8:41 AM, DON stated facility does not have a policy specific to nursing documentation. -	F 842		
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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F 880	Continued From page 20 §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	Continued From page 21 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: - Based on record review, observations and staff interviews, the facility failed to ensure appropriate infection control practices were taken when providing peritoneal dialysis for 1 of 2 (#22) residents reviewed The Facility reports a census of 27 Residents. Findings Include: The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 5/17/21 for Resident #22 showed a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. The MDS showed the Resident to have diagnoses of chronic kidney disease, dependence on renal dialysis, malignant neoplasm of the breast, and hypertension. The MDS showed the Resident needed limited assistance with bed mobility, transfers, and locomotion. Review of the medical diagnosis tab in the EHR showed the Resident had a diagnosis of dependence on renal dialysis with a start date of	F 880		

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F 880	Continued From page 22 2/17/21. Review of the Care Plan showed the resident to have a focus of chronic kidney disease and required peritoneal dialysis dated 3/4/21. Intervention to complete peritoneal dialysis daily flow sheet located in the resident's room dated 3/10/21. Intervention to complete pre and post assessments with vital signs and site access dated 3/5/21, and to provide daily dressing change to peritoneal dialysis site as ordered, and monitor for signs and symptoms of infection, redness, warmth, drainage from peritoneal dialysis site, fever, and cloudy dialysate and to report to physician. Observation on 6/15/21 at 7:56 AM, Staff D Licensed Practical Nurse (LPN) entered the resident's room and washed her hands. Staff D disconnected the dialysis machine from the resident's port located on the left side of the lower abdomen and removed the old dressing with a date of 6/14/21 with no gloves or hand sanitization. Staff D then proceeded to clean the catheter site with saline soaked gauze without gloves or hand sanitization. Staff D proceeded to apply a new gauze dressing over the catheter insertion point and dated the dressing with 6/15/21 without gloves or hand sanitization. Staff D secured the catheter to the resident's abdomen with tape and pulled down the resident shirt over the area, disconnected the effluent bags from the dialysis machine, placed the bags onto a black garbage bag on top of a bedside table without gloves or hand sanitization. Staff D then took the bags to the dirty utility room and drained effluent into the hopper and placed used bags in biohazard bag for disposal.	F 880		

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F 880	Continued From page 23 Interview on 6/15/21 at 8:50 AM Staff H Assistant Director of Nursing (ADON) stated that all the nurses were trained to not wear gloves when providing the peritoneal dialysis due to it giving a false sense of cleanliness to the procedure. ADON stated that the dialysis center came to the facility, provided the training, and instructed the staff that they only needed to wash their hands upon entering the room and use hand sanitizer when needed, but they did not have to wear gloves when handling effluent, conducting the procedure, or when giving exit site care. Review of the Saline Soaks for Peritoneal Dialysis Exit Site Care dated 6/19/13 directed a. Step 3: wash hands and put on PPE.	F 880		