COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

M. Norman Oliver, MD, MA
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
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March 29, 2019

Mr. Javier Cavero, Administrator
Manorcare Health Services-Arlington
550 South Carlin Springs Road
Arlington, VA 22204-1022

RE: Manorcare Health Services-Arlington
Provider Number 495102

Dear Mr. Cavero:

Based on deficiencies cited during the survey ending February 7, 2019, your facility was found not to be in compliance with Federal participation requirements for the long term care Medicare and/or Medicaid programs. On March 26 - 27, 2019, surveyors from the Virginia Department of Health's Office of Licensure and Certification conducted an unannounced revisit to verify that your facility had achieved and maintained compliance for deficiencies cited during the previous survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The survey findings are reflected on the enclosed Statement of Isolated Deficiencies ("A" Form) and/or the Statement of Deficiencies and Plan of Correction (CMS-2567) and/or the Post-Certification Revisit Report (CMS-2567). All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g) of the Federal requirements, the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

We had presumed, based on your allegation of compliance, that your facility was in substantial compliance. The March 27, 2019 revisit established the facility continues noncompliance with program requirements, including an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of D), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Nicole Keeney, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Officer's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.state.va.us/OLC/longtermcare/ To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification,

9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings. **An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.**

In regards to previously listed potential remedies, by copy of this letter we are notifying the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (DMAS) that this revisit found your facility was not in in substantial compliance with the participation requirements.

Recommended Remedies

The results of the February 7, 2019 survey were forwarded to you under the February 19, 2019 initial letter. At that time, we indicated several remedies could be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (Virginia Department of Medical Assistance Services) if compliance was not achieved. We are, by copy of this letter, notifying the CMS Regional Office and Virginia DMAS that the facility had not achieved compliance with program requirements at the time of the March 27, 2019 revisit. Those agencies will notify you about any remedy they intend to impose.

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The LTC Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at:
"http://www.vdh.virginia.gov/content/uploads/sites/96/2019/02/LTC-facility-survey-response-form.pdf"
We will appreciate your participation.

If you have any questions concerning the content of this letter, please contact me at 804/367-2100.

Sincerely,

Nicole Keeney

Nicole Keeney, LTC Supervisor
Division of Long Term Care Services

Enclosures

cc: Roxanne Rocco, Centers For Medicare & Medicaid Services
Joani Latimer, State Ombudsman (Sent Electronically)
Bertha Ventura, Dmas (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	R-C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 2/5/19 through 2/7/19, was conducted on 3/26/19 through 3/27/19. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. Uncorrected deficiencies, as well as a deficiency not previously cited, are identified within this report. The census in this 161 certified bed facility was 129 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents # 101 through 116).	{F 000}	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
{F 584} SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	{F 584}	**F584 Safe/Clean/Comfortable/ Homelike Environment** It is the practice of the facility to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely	

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

James Cuevas | NHA | 4/4/19

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 584}	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility failed to ensure a safe, clean homelike environment for one of 16 in the survey sample. In room 231-B, the chair rail located on the wall behind the bed was cracked and had sharp jagged bottom edges, the footboard on the bed was loose and not completely attached to the bed frame, and the bed remote had frayed wires. The findings include: On 03/26/18 at 1:50 p.m., during a resident interview, the chair rail located on the wall behind the bed was observed cracked and having sharp	{F 584}	**I** **Corrective Action** The chair rail behind the wall in room 231B was fixed. The footboard of the bed in room 321B was fixed. The bed controller in room 321B was replaced. **II** **Identification** All resident rooms have the potential to be affected by this practice. Entire audit of patient rooms was conducted to identify maintenance concerns. **III** **Systemic Changes** The Administrator /designee will develop a plan to systematically correct all areas identified from the complete audit of facility.	

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(F 584)	Continued From page 2 jagged bottom edges, the footboard on the bed was not completely screwed to the bed frame, and the bed remote had frayed wires. The resident who resided in 231-B bed stated the chair rail had been in disrepair since she transferred to the room a couple of weeks ago. The resident stated she needed another bed remote and held up the one attached to her bed, which showed frayed wires coming from the top of the cord which was attached to the remote. The resident stated that last night she noticed the footboard on her bed was loose and not attached to the bed frame. The footboard on the bed was observed attached with only two of the four screws into the bed frame. On 03/26/19 at 2:00 p.m., the certified nursing assistant (CNA #2) who routinely provides care for the resident in 231-B was accompanied to the room and interviewed regarding the above items. The CNA stated he was not aware of the work order needs and stated all work orders were entered in the electronic system for the maintenance department to review and complete. On 03/26/19 at 2:10 p.m., the interim maintenance director (OS #2) was interviewed regarding the work orders for the above items in room 231-B. Accompanied by the OS #2 to the room, OS #2 stated he did observe the cracked chair rail during his room inspections on Saturday, 03/23/19. He stated he was not aware of the issues with the footboard and the bed remote. OS #2 stated typically nursing entered the work order requests in the electronic system for the maintenance department; however, he had not received any orders for these items. He stated he had stack of work order requests for the entire facility and was contracting with other	(F 584)	**IV** **Monitoring** The Administrator/designee will educate all staff to on completing room rounds to identify areas needing repair along with the reporting system for maintenance to complete necessary repairs. The Administrator/designee will complete random environmental audits weekly for 4 weeks and randomly thereafter for 2 months. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate. The Quality Assurance and Performance Improvement Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **4/16/19**	

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{F 584}	Continued From page 3 maintenance staff and vendors to get the work orders completed as soon as possible. These findings were reviewed with the administrator, director of nursing, assistant director of nursing and corporate staff during a meeting on 03/26/19 at 4:00 p.m.	{F 584}		
{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)-	{F 656}	**F656 Development of Comprehensive Care Plans** It is the practice of the facility to develop a comprehensive person centered care plan for each resident. **I** **Corrective Action** Resident 116 now has a care plan to reflect the use of a Foley catheter. **II** **Identification** All resident with Foley catheters have the potential to be affected. The facility will conduct an audit of all current residents to identify residents who have a Foley to ensure that they have appropriate care plans in place.	

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{F 656}	Continued From page 4 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, observation, and clinical record review, the facility staff failed to develop a care plan for the use of a Foley catheter for one of 16 residents, Resident #116. Findings were: Resident #116 was originally admitted to the facility on 02/07/2018 and most recently readmitted on 03/09/2019. His diagnoses included but were not limited to: dysphagia, chronic kidney disease, congestive heart failure, hypertension, diabetes mellitus, obstructive and reflux uropathy, and vascular dementia. A significant change MDS (minimum data set) with an ARD (assessment reference date) of 01/22/2019, assessed Resident #116 as severely impaired with a cognitive summary score of "06". On 03/26/2019 at approximately 08:05 a.m., during initial tour of the facility, Resident #116 was heard yelling out, "Come here, come here." Resident #116 stated, "Help me...there is something in my penis...it hurts." LPN (licensed	{F 656}	**III** **Systemic Changes** The Director of Nursing/ designee will provide education to licensed nurses on development of care plans. **IV** **Monitoring** The Director of Nursing/ designee will randomly audit residents with Foleys weekly for 4 weeks and monthly for 2 months. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate. The Quality Assurance and Performance Improvement Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **4/16/19**	

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{F 656}	Continued From page 5 practical nurse) #1 was at the nurses station and was asked to come to the room. Resident #116 repeated to LPN #1 my penis hurts. LPN #1 pulled the covers back on Resident #116 and stated, "He has a Foley." The Foley catheter was observed exiting the side of Resident #116's brief. The clinical record was reviewed at approximately 10:00 a.m. There were no orders on the POS (Physician order sheet) for the Foley catheter, nor were there any entries on the care plan for the catheter. At approximately 2:10 p.m., the unit manager, RN (registered nurse) #1 was asked if the catheter should be on Resident #116's care plan. She stated, "Yes." She was informed that no interventions had been observed on the care plan. During an end of the day meeting on 03/26/2019 at approximately 3:55 p.m., the above information was discussed with the DON (director of nursing), the administrator, the regional clinical consultant, the ADON (assistant director of nursing) and the nurse consultant. No further information was obtained prior to the exit conference on 03/27/2019.	{F 656}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	{F 657}		

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{F 657}	Continued From page 6 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of 16 residents, Resident #113. Resident #113's care plan was not revised to reflect Geri sleeves to be placed on the resident. The Findings Include: Resident #113 was admitted to the facility on 02/23/17. The most current MDS (minimum data set) was an annual assessment with an assessment reference date (ARD) of 3/4/19. Diagnoses included: diabetes, and left arm paralysis. Resident #113 was assessed with a	{F 657}	**F657 Care Plan Timing and Revision** It is the practice of the facility to review and revise the comprehensive care plan. **I** **Corrective Action** Resident #113 care plan was reviewed and revised to reflect Geri sleeves **II** **Identification** All residents with Geri-sleeves have the potential to be affected by this practice. The Director of nursing/designee will conduct an audit of all current residents to identify residents who have Geri-sleeves to ensure that they have appropriate care plans and the Kardex is reflective.	

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(F 657)	Continued From page 7 cognitive score of 15, indicating cognitively intact. On 3/26/19 the clinical record was reviewed. Resident #113's current physician's order set documented a physician order initiated on 10/29/18 that read "Geri Sleeve to both arms every day [give patient 2 pairs for alternative hygiene] in the morning for skin integrity." Review of Resident #113's treatment administration record (TAR) indicated that the Geri sleeves were to be placed on Resident #113 at 6:00 AM daily. Resident #113's care plan and Kardex were reviewed and did not indicate Geri sleeves as an intervention for skin integrity or any other part of the comprehensive care plan. On 03/26/19 at 11:30 AM, Resident #113 was observed in her room sitting in a wheel chair. Resident #113 was not wearing Geri sleeves and when asked, Resident #113 verbalized that they were washed the other day and had not been put back on. Resident #113 was asked if there was another pair that the staff could put on while the other pair of Geri sleeves were in the laundry. Resident #113 verbalized that she was only aware of the one pair. On 3/26/19 at 2:15 PM, Resident #113 was again observed, this time laying in bed. Resident #113 was asked if staff had placed the Geri sleeve on. Resident #113 verbalized that the staff had not placed the Geri sleeves on all day. On 3/26/19 at 2:25 PM, the certified nursing assistant (CNA #1) assigned to Resident #113 was interviewed concerning the Geri sleeves.	(F 657)	**III** **Systemic Changes** The Director of Nursing/designee will provide education to licensed nurses on revision of care plans to reflect person centered care. **IV** **Monitoring** The Director of Nursing/ designee will complete random audits of residents with Geri-sleeves weekly for 4 weeks and monthly for 2 months. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate. The Quality Assurance and Performance Improvement Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **4/16/19**	

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{F 657}	Continued From page 8 CNA #1 verbalized that she was not aware that Resident #113 needed Geri sleeves. When asked how do CNAs get information regarding care for a Resident, CNA #1 verbalized that the nurses give the CNAs a report on what a resident is supposed to have in place. On 3/26/19 at 2:30 PM, registered nurse (RN) #2 who was assigned to Resident #113 was interviewed. RN #2 reviewed Resident #113's physician orders and TAR and verbalized that she wasn't aware of the order because the TAR only has night shift signing off that the task is carried out and therefore she (RN #2) would not be prompted to make sure the Geri sleeves were intact. RN #2 was asked why are the geri sleeve not part of the care plan. RN #2 verbalized that she did not know. On 3/26/19 at 4:00 PM, the above finding was presented to the administrator, director of nursing (DON) and regional vice president. The regional director of operations verbalized that he understood the concern and it would be corrected. No other evidence was presented prior to exit conference on 3/27/19.	{F 657}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	{F 684}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 9 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to follow physician's orders for treatment and care of skin integrity for one of 16 residents, Resident #113. Resident #113 did not have physician ordered Geri sleeves (arm protectors) on. The Findings Include: Resident #113 was admitted to the facility on 02/23/17. The most current MDS (minimum data set) was an annual assessment with an assessment reference date (ARD) of 3/4/19. Diagnoses included: diabetes, and left arm paralysis. Resident #113 was assessed with a cognitive score of 15, indicating cognitively intact. On 3/26/19 the clinical record was reviewed. Resident #113's current physician's order set documented a physician order initiated on 10/29/18 that read "Geri Sleeve to both arms every day [give patient 2 pairs for alternative hygiene] in the morning for skin integrity." Review of Resident #113's treatment administration record (TAR) indicated that the Geri sleeves were to be placed on Resident #113 at 6:00 AM daily. On 03/26/19 at 11:30 AM, Resident #113 was observed in her room sitting in a wheel chair. Resident #113 was not wearing Geri sleeves and when asked, Resident #113 verbalized that they were washed the other day and had not been put	{F 684}	**F684 Quality of Care** **I** **Corrective Action** A physician order was obtained for the Geri-sleeves for Resident #113. **II** **Identification** All residents who receive physician orders for Geri sleeves have the potential to be affected by this practice. The facility will conduct an audit to identify residents who have Geri-sleeves to ensure that physician orders are followed and person centered care is reflected.	

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	495102	A. BUILDING _____ B. WING _____	R-C 03/28/2019

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(F 684)	Continued From page 10 back on. Resident #113 was asked if there was another pair that the staff could put on while the other pair of Geri sleeves were in the laundry. Resident #113 verbalized that she was only aware of the one pair. On 3/26/19 at 2:15 PM, Resident #113 was again observed, this time laying in bed. Resident #113 was asked if staff had placed the Geri sleeve on. Resident #113 verbalized that the staff had not placed the Geri sleeves on all day. On 3/26/19 at 2:25 PM, the certified nursing assistant (CNA #1) assigned to Resident #113 was interviewed concerning the Geri sleeves. CNA #1 verbalized that she was not aware that Resident #113 needed Geri sleeves. When asked how do CNAs get information regarding care for a Resident, CNA #1 verbalized that the nurses give the CNAs a report on what a resident is supposed to have in place. On 3/26/19 at 2:30 PM, registered nurse (RN) #2 who was assigned to Resident #113 was interviewed. RN #2 reviewed Resident #113's physician orders and TAR and verbalized that she wasn't aware of the order because the TAR only has night shift signing off that the task is carried out and therefore she (RN #2) would not be prompted to make sure the Geri sleeves were intact. RN #2 was asked why are the geri sleeve not part of the care plan. RN #2 verbalized that she did not know. On 3/26/19 at 4:00 PM, the above finding was presented to the administrator, director of nursing (DON) and regional vice president. The DON verbalized that she understood the concern.	(F 684)	**III** **Systemic Changes** The Director of Nursing/ designee will provide education to licensed nurses on performing 24 hour chart check to identify physician orders. **IV** **Monitoring** The Director of Nursing/ designee will randomly audit residents with Geri-sleeves weekly for 4 weeks and monthly for 2 months. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate. The Quality Assurance and Performance Improvement Committee will determine the need for further audits and/or action plans. **V** **Date of Compliance** **4/16/19**	

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(F 684)	Continued From page 11 No other evidence was presented prior to exit conference on 3/27/19.	(F 684)	**F690 Bowel/Bladder Incontinence, Catheter, UTI**	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(e): 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 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690	**I** **Corrective Action** An order was obtained for resident #116 for a Foley catheter and his plan of care was revised to reflect person centered care. Resident #116 catheter was anchored correctly per manufacturer's recommendation. **II** **Identification** All residents with Foley catheters have the potential to be affected by this practice. The Director of Nursing/ designee will conduct an audit of all current residents to identify residents who have Foley catheters to ensure that physician orders are being followed , person centered care is reflective in plan of care along with correct	

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F 690	Continued From page 12 possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to provide care and services related to a Foley catheter for one of 16 residents, Resident #116. Resident #116 did not have orders for an indwelling catheter, the catheter was not care planned, the catheter was not anchored, and when the facility staff anchored the catheter it was not done per manufacturer's recommendations. Findings were: Resident #116 was originally admitted to the facility on 02/07/2018 and most recently readmitted on 03/09/2019. His diagnoses included but were not limited to: dysphagia, chronic kidney disease, congestive heart failure, hypertension, diabetes mellitus, obstructive and reflux uropathy, and vascular dementia. A significant change MDS (minimum data set) with an ARD (assessment reference date) of 01/22/2019, assessed Resident #116 as severely impaired with a cognitive summary score of "06". On 03/26/2019 at approximately 08:05 a.m., during initial tour of the facility, Resident #116 was heard yelling out, "Come here, come here." Resident #116 stated, "Help me...there is something in my penis...it hurts." LPN (licensed practical nurse) #1 was at the nurses station and was asked to come to the room. Resident #116 repeated to LPN #1 my penis hurts. LPN #1 pulled the covers back on Resident #116 and	F 690	procedure is followed for anchoring the catheter per manufacture guidelines. **III** **Systemic Changes** The Director of Nursing/ designee will provide education to licensed nurses on following physician orders as well as the manufacture guidelines for anchoring of Foley catheters. **IV** **Monitoring** The Director of Nursing/ designee will randomly audit residents with Foley catheters weekly for 4 weeks and monthly for 2 months. Data collected will be forwarded to Quality Assurance and Performance Improvement Committee for review and action, as appropriate. The Quality Assurance and Performance Improvement Committee will determine the need for further audits and/or action plans.	

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F 690	Continued From page 13 stated, "He has a Foley." The Foley catheter was observed exiting the side of Resident #116's brief. LPN #1 was asked if the catheter was anchored. She stated, "Yes", and pointed to the tubing exiting the brief. She undid the brief and pulled it back. There was no anchor observed on Resident #116's leg. She stated, "His penis is swollen." She then offered Resident #116 pain medication. The clinical record was reviewed at approximately 10:00 a.m. There were no orders on the POS (Physician order sheet) for the Foley catheter, nor were there any entries on the care plan for the catheter. At approximately 2:05 p.m. Resident #116 was observed sitting at his bedside. LPN #1 was asked if his catheter had been anchored that morning. She did not answer the question, but got up from the nurse's station and walked to a supply cart on the unit. She obtained and item and started towards Resident #116's room. She was asked if she had an anchor for the catheter. She stated, "Yes." The unit manager, RN (registered nurse) #1 came down the hall to the nurse's station. She was asked if catheters should be anchored. She stated, "Yes." She went to Resident #116's room. A CNA came into the room with a hoyer lift to get Resident #116 back into his bed. The unit manager and this surveyor left the room. The unit manager was asked if the catheter required physician orders. She stated, "Yes." She was asked if the catheter should be on the care plan. She stated, "Yes." She was informed that no physician orders had been observed on the clinical record, nor had any interventions been observed on the care plan.	F 690	V Date of Compliance 4/16/19	

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F 690	Continued From page 14 At approximately 2:15 p.m., Resident #116's was observed lying on his bed. His pants were pulled down. An anchor was observed on the outside of his thigh, the catheter was not attached to the anchor. The unit manager stated to LPN #1, "No, it goes on the inside of his thigh." The unit manager removed the anchor and attempted to place it on the inside of Resident #116's thigh. She stated, "It needs skin prep under it so it will stick." LPN #1 left the room. The unit manager looked around the room and then left stating to LPN #1 who was down the hall at a supply cart, "I have one here." Both LPN #1 and the unit manager returned to the room with another anchor. The unit manager placed the anchor on Resident #116's inner thigh. She then secured the catheter by pulling the anchor ties across both the catheter tubing and the port used to inflate the Foley catheter balloon with water. The unit manager was asked if the catheter was suppose to be secured with the anchor ties over both the water port and the foley tubing. She stated, "Yes." A copy of the facility policy regarding catheter care was requested and presented by the DON (director of nursing). Per the facility policy, "CATHETER CARE: INDWELLING CATHETER", Equipment:...Securement device or Velcro leg strap device as ordered or clinically indicated...Procedure: Verify physician's order...secure catheter tubing to patient's leg using a securement device or Velcro leg strap as ordered and clinically indicated-prevents traction on the urethral [sic]." The DON was asked how the catheter tubing should be anchored. She stated, "...I haven't	F 690		

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F 690	Continued From page 15 been at the bedside in a long time, I need to ask." A copy of the manufacturer's instructions on the wrapper of the anchor was requested. The manufacturer's instructions on the Anchor wrapper included a diagram of the proper way to secure the catheter. Per the diagram, the anchor should only be placed across the tubing of the port used to inflate the balloon. The ADON (assistant director of nursing) was observed coming out of Resident #116's room at approximately 3:15 p.m. She was asked if she had checked the anchor. She stated, "Yes." She was shown a diagram and asked where the anchor was. She stated, "It is across the balloon port at the 'Y'." During an end of the day meeting on 03/26/2019 at approximately 3:55 p.m., the above information was discussed with the DON, the administrator, the regional director of operations, the ADON and the nurse consultant. No further information was obtained prior to the exit conference on 03/27/2019.	F 690		