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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 12/16/19 through 12/17/19. Three complaints [VA00047282 - unsubstantiated, VA00047015 - unsubstantiated, VA00045710 - unsubstantiated] were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 114 at the time of the survey. The survey sample consisted of six current Residents reviews (Residents #1 through #5 and #9) and three closed record review (Residents #6, #7 and #8).	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 center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
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 observation, resident interview, staff interview, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards of practice for the administration of medication for one of nine residents in the survey sample, Resident #9. The facility staff failed to follow manufacturers' instructions for use in the administration of Advair Diskus inhaler (used to treat breathing problems) for Resident #9. The findings include:	F658	1. Resident #9 experienced no adverse effect and MD made aware. Identified license nurse has been reeducated regarding medication administration guidelines. 2. Current Residents have the potential to be affected. 3. DNS/Designee will complete medication administration observations and education for medication administration guidelines for nurses. 4. Medication administration will be completed for 3 licensed nurses per week for 8 weeks. DNS/Designee will review audits. Findings reported to QAPI committee monthly for further action if necessary. 5. Compliance date 12/24/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 12/30/19 POC revision.

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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Resident #9 was admitted to the facility on 08/13/2018, with a readmission on 11/23/2019 with diagnoses that included but were not limited to chronic obstructive pulmonary disease (1) and major depressive disorder (2).

Resident #9's most recent MDS (minimum data set), an admission assessment with an ARD (Assessment Reference Date) of 11/01/2019 coded Resident #9 as scoring an 11 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 11- being moderately impaired for making daily decisions.

On 12/17/19 at approximately 8:20 a.m., an observation of medication administration for Resident #9 was conducted with LPN (licensed practical nurse) #4. LPN #4 prepared medications to administer to Resident #9 including Advair diskus 250/50mcg (microgram) inhaler. Following administration of the prescribed Advair diskus inhaler, observation revealed that LPN #4 failed to have Resident #9 rinse her mouth as documented in the instructions for use from the manufacturer of the medication.

Review of the "Order Summary Report" dated "12/17/2019" documented in part, "Fluticasone-Salmeterol (generic name for Advair diskus) Aerosol Powder Breath Activated 250-50 mcg/Dose, 1 (one) inhalation, inhale orally two times a day for COPD (chronic obstructive pulmonary disease). Order Date: 10/24/2019, Start Date: 10/24/2019."

The comprehensive care plan "Alteration in

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Respiratory Status Due to Chronic Obstructive Pulmonary Disease, Date Initiated: 11/18/2019." for Resident #9, documented in part under "Interventions," "Administer medications as ordered ..."

On 12/17/19 at 9:40 a.m., an interview was conducted with LPN (licensed practical nurse) #1, regarding the instructions for use that are followed when administering Advair diskus inhalers. LPN #1 stated that residents should ensure that they rinse their mouth out after using the inhaler. LPN #1 stated that rinsing the mouth is done to prevent thrush (fungal infection of the mouth and throat).

On 12/17/19 at 11:05 a.m., an interview was conducted with LPN #4 regarding the instructions for use that are followed when administering Advair diskus inhalers. LPN #4 stated that she forgot to inform this surveyor during the medication observation on 12/17/19 at 8:20 a.m. that Resident #9 refuses to rinse her mouth after using her inhaler. LPN #4 stated that is why she did not have her (Resident #9) rinse her mouth out during the observation on 12/17/19 at 8:20 a.m. LPN #4 stated that Resident #9 has been educated on why she needs to rinse her mouth after using the inhaler. When asked if the education provided to Resident #9, is documented in the clinical record, LPN #4 stated that she was not sure. LPN #4 stated that Resident #9 always refuses to rinse her mouth after using the inhaler when she administers it to her and has stated to her in the past that drinking the water to take her pills will rinse her mouth out. When asked if the refusals to comply with the instructions for use of the inhaler is documented in the clinical record, LPN #4 stated that it was

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not documented. LPN #4 stated that Resident #9 has been using the Advair inhaler since her admission to the facility and has not had any infections related to not rinsing her mouth after administration.

On 12/17/19 at 11:20 a.m., an interview was conducted with Resident #9. When asked about the process she follows, after using her Advair inhaler, Resident #9 stated that she rinses her mouth out most of the time after she uses it. Resident #9 stated that some of the staff bring her a separate cup of water that she uses to rinse her mouth out after she uses the inhaler. Resident #9 stated, "I rinse and spit it out. It is all good. They do a good job." When asked if staff have told her why she needs to rinse her mouth out, Resident #9 stated, "Yes."

On 12/17/19 at 2:30 p.m., an interview was conducted with LPN #4. When informed of the interview that was conducted with Resident #9, LPN #4 stated that when she has administered the Advair diskus inhaler to Resident #9 she has refused to rinse her mouth afterwards. When asked if Resident #9 was advised to rinse her mouth after the Advair diskus inhaler dose observed during the medication observation on 12/17/19 at 8:20 a.m., LPN #4 stated she was not.

The manufacturers' instructions for use provided by the facility for the "Advair diskus" documented in part, "Step 5. Rinse your mouth. Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it ..."

On 12/17/19 at approximately 3:30 p.m., ASM (administrative staff member) #3, the regional

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director of clinical services stated that the facility uses their policies and Lippincott as their standard of practice.

The facility policy "Medication Administration General Guidelines" dated "09/18" documented in part, "Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so."

According to "Lippincott Nursing Procedures" 7th edition, 2015; p.502 read: " ...When inhaled corticosteroids (medications used to treat inflammation) (such as beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone, and triamcinolone) (names of medications) are administered, instruct the patient to rinse and gargle with water and then to expectorate using an emesis basin, if necessary, after each does to help prevent an infection in the mouth."

On 12/17/19 at 4:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was presented prior to exit.

References:

1. Chronic obstructive pulmonary disease (COPD)
Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

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2. Major depressive disorder
Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website:
https://medlineplus.gov/ency/article/000945.htm.

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.
(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;

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1. Resident #6 discharged from facility on 7/5/19. Resident #3 and #5 experienced no adverse effect and MD made aware.
2. Current Residents have the potential to be affected.
3. DNS/Designee will complete education for medication administration documentation guidelines for nurses and incontinence care documentation guidelines for licensed staff.
4. Electronic Medication administration records compared against the Controlled Medication Accountability log and Incontinence care documentation will be reviewed in clinical start up 5x a week for 8 weeks by DNS/Designee. Findings reported to QAPI committee monthly for further action if necessary.
5. Compliance date 12/24/19

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(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 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 staff interview, clinical record review,

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facility document review and in the course of a complaint investigation it was determined facility staff failed to maintain a complete and accurate medical record for three of nine residents in the survey sample, Resident #6, Resident #3 and Resident #5. The facility staff failed to maintain an accurate record documenting dosages of Morphine Sulfate (1) administered to Resident #6 on the "Controlled Medication Accountability" log however failing to document the administration of the medications in the clinical record on the MAR (medication administration record) or the progress notes. The facility failed to maintain an accurate clinical record for Resident #3 and #5 as evidenced by inaccurate documentation of incontinence care provided.

The findings include:

1. The facility staff failed to maintain an accurate record documenting dosages of Morphine Sulfate (1) administered to Resident #6 on the "Controlled Medication Accountability" log however failing to document the administration of the medications in the clinical record on the MAR (medication administration record) or the progress notes.

Resident #6 was admitted to the facility on 06/20/2019 with a readmission on 07/04/2019. Resident #6's diagnoses included but were not limited to dementia (2) and hypertension (3).

Resident #6's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/20/19, coded Resident #6 as moderately impaired for making daily decisions.

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The physicians order summary for Resident #6 dated "07/01/2019-07/31/2019" documented "Morphine Sulfate (Concentrate) Solution 100 MG (milligram)/5 (five) ML (milliliter), Give 0.5 (five-tenths) ml by mouth every 1 (one) hours as needed for pain, Call [Name of Hospice] if sx (symptoms) persist past 12hrs (hours). Call immediately if sx worsen. Order Date 07/04/2019, Start Date 07/04/2019." The summary further documented, "Morphine Sulfate (Concentrate) Solution 100 MG/5ML, Give 0.5 ml by mouth every 4 (four) hours for pain/discomfort. Order Date 07/05/2019, Start Date 07/05/2019."

The "Controlled Medication Accountability" log dated "7-4-19" for Resident #6 documented, "Medication: Morphine, Medication Strength: 0.5ml (100mg/5ml)." Review of the log revealed that it documented 0.5ml dosages administered on the following dates and times:
- "7/4 (7/4/19) 12:20 (12:20 p.m.) ...quantity remaining 29.5 (ml),
- 7/5 (7/5/19) 0100 (1:00 a.m.) ...quantity remaining 29.0 (ml),
- 7/5 0500 (5:00 a.m.) ...quantity remaining 28.5 (ml),
- 7/5 1145 (11:45 a.m.) ...quantity remaining 28.0 (ml),
- 7/5 1600 (4:00 p.m.) ...quantity remaining 27.5 (ml),
- 7/5 2100 (9:00 p.m.) ...quantity remaining 27.0 (ml)."

The log further documented "7-6 (7/6/2019) 0930 (9:30 a.m.) Releasing 30ml's (thirty milliliters) to Hospice [signature of facility LPN (licensed practical nurse] [signature of Hospice RN (registered nurse)]."

Review of Resident #6's clinical record revealed

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an MAR (medication administration record) dated 07/01/2019 through 07/31/2019. The MAR documented, "Morphine Sulfate (Concentrate) Solution 100 MG/5ML, Give 0.5 ml by mouth every 4 (four) hours for pain/discomfort. Order Date 07/05/2019 1635 (4:35 p.m.)." The MAR documented Resident #6 receiving one dose of Morphine Sulfate on 7/5/19 at 10:00 p.m. The MAR documented to see nurses notes in regards to the scheduled dose for 7/5/19 at 6:00 p.m.

Review of the nurses notes revealed a progress note dated "7/5/2019 19:05 (7:05 p.m.)" for Resident #6 which documented, "Morphine Sulfate (Concentrate) Solution 100 MG/5ML, Give 0.5 ml by mouth every 4 (four) hours for Pain/discomfort. Given @ (at) 1600pm (4:00 p.m.)."

The MAR for Resident #6 also documented, "Morphine Sulfate (Concentrate) Solution 100 MG/5 ML, Give 0.5 ml by mouth every 1 (one) hours as needed for pain, Call [Name of Hospice] if sx persist past 12hrs. Call immediately if sx worsen. Order Date 07/04/2019 1304 (1:04 p.m.)." The MAR documented Resident #6 received doses of Morphine Sulfate on 07/04/2019 at 1:25 p.m. and 07/04/2019 at 7:36 p.m.

The MAR for Resident #6 failed to evidence documentation of administration of Morphine Sulfate on 7/5/19 at 1:00 a.m., 7/5/19 at 5:00 a.m., and 7/5/19 at 11:45 a.m. as documented on the Controlled Medication Accountability log.

On 12/17/19 at 11:05 a.m., an interview was conducted with LPN (licensed practical nurse) #4 regarding the process staff follows for controlled

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Medication Accountability log. LPN #1 stated it looks like it was written in error that the amount should have been 27 ml as documented on the log as the quantity remaining. LPN #1 reviewed the MAR dated 7/1/2019-7/31/2019 for Resident #6 and the Controlled Medication Accountability log dated 7/4/2019. LPN #1 stated that the MAR did not document the administration of the Morphine on 7/5/19 at 1:00 a.m., 7/5/19 at 5:00 a.m., and 7/5/19 at 11:45 a.m. as documented on the Controlled Medication Accountability log. LPN #1 stated that it appeared that the nurse failed to document the medication was administered in the computer system and only signed it off on the log sheet. LPN #1 reviewed the signatures of the staff listed on the Controlled Medication Accountability Log and then stated that one of the nurses no longer worked at the facility and the other was an agency nurse who was no longer there. When asked if the logs and the MAR were accurate LPN #1 stated that it did not look like they were.

On 12/17/19 at 5:15 p.m., ASM (administrative staff member) #2, the director of nursing stated that the facility did not have a policy for documentation in the medical record and uses Lippincott as their standard of practice. ASM #2 provided pages 236 and 238 titled "Documentation" and stated that they were from the Lippincott Nursing Manual.

The facility provided document "Documentation" pages 236-238 documented in part, " ...Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed documentation shows the extent and quality of the care that

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nurses provide the outcomes of the care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors."

Lippincott, Williams and Wilkins, Fundamentals of Nursing, 2007, Ambler, PA, page 181 reads "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time, in the right dose and by the right routes ...this includes accurate documentation and explanation ..." Page 165 reads, "After administering a tablet or capsule, be sure to record: drug given, dose given, date and time of administration, signing out the drug on the patients medication record ..."

The facility policy, "Medication Administration General Guidelines, 09/18" documented in part, "The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications."

On 12/17/19 at 4:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was presented prior to exit.

Complaint Deficiency

References:

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1. Morphine Sulfate
Morphine is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a682133.html

2. Dementia
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website:
https://medlineplus.gov/ency/article/000739.htm.

3. Hypertension
High blood pressure. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

2. Resident #3 was admitted to the facility on 06/15/2018, with a readmission on 10/05/2019 with diagnoses that included but were not limited to dementia (1) and dystonia (2).

Resident #3's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/12/19, coded Resident #3 as scoring a 2 (two) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 2- being severely impaired for making daily decisions. Section G coded Resident #3 as requiring assistance of one person for toileting. Section H coded Resident #3 as frequently

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incontinent of bowel and bladder.

The comprehensive care plan "Alteration in elimination of bowel and bladder r/t (related to) dementia, Date Initiated: 11/05/2019" for Resident #3 documented the following. Under "Interventions" it documented, "Incontinent care after each incontinent episode. Date Initiated: 11/05/2019" and "Evauate [sic] frequency/timing of incontinence episodes. Date Initiated: 11/05/2019."

Review of the clinical record for Resident #3 revealed "ADL (activities of daily living) Toilet use" which failed to document toileting or incontinence care being provided for Resident #3 on the following dates:
- "12/8/19 Day 7:00 -3:00 (7:00 a.m.-3:00 p.m.)" documentation area was observed to be blank.
- "12/8/19 Night 11:00 -7:00 (11:00 p.m.-7:00 a.m.)" documentation area contained "NA, NA, [Initials of Staff member] 00:25 (12:25 a.m.)."
- "12/10/19 Eve (evening) 3:00 - 11:00 (3:00 p.m.-11:00 p.m.)" documentation area contained "NA, NA, [Initials of Staff member] 20:56 (8:56 p.m.)."
- "12/12/19 Day 7:00 -3:00" documentation area was observed to be blank.
- "12/14/19 Day 7:00 -3:00" documentation area contained "NA, NA, [Initials of Staff member] 14:59 (2:59 p.m.)."
- "12/15/19 Day 7:00 -3:00" documentation area contained "NA, NA, [Initials of Staff member] 14:59 (2:59 p.m.)."
- "12/15/19 Eve 3:00 - 11:00" documentation area contained "NA, NA, [Initials of Staff member] 20:20 (8:20 a.m.)."
- "12/16/19 Night 11:00 -7:00" documentation area was observed to be blank.

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On 12/17/19 at 11:45 a.m., an interview was conducted with CNA (certified nursing assistant) #5, regarding incontinence care and documentation. CNA #5 stated that care is provided every two hours and as needed. CNA #5 stated that incontinence care is provided more frequently if needed or if requested. CNA #5 stated that residents should be provided incontinence care as soon as it is needed. CNA #5 stated that incontinence care is documented on the computer monitors in the facility hallways. When asked how often toileting or incontinence care is documented, CNA #5 stated that it should be documented each time it is provided to the resident. When asked why the care is documented, CNA #5 stated, "If it is not documented, it is like you didn't do it." CNA #5 reviewed the document, "ADL (activities of daily living) Toilet use" for Resident #3. When asked about the blank documentation areas on 12/8/19, 12/12/19 and 12/16/19, CNA #5 stated that the empty boxes mean that the care was not charted. When asked what the documentation "NA, NA" means in the documentation areas on 12/8/19, 12/10/19, 12/14/19 and 12/15/19, CNA #5 stated that it means that that the category does not pertain to the resident. CNA #5 stated that the "NA, NA" means that the care did not happen. CNA #5 stated that it appears that the staff are charting the care wrong. CNA #5 stated that the director of nursing has been educating the staff recently on documenting the care provided in the system accurately but it appeared that some of the staff are still not documenting it correctly.

On 12/17/19 at 5:15 p.m., ASM (administrative staff member) #2, the director of nursing stated that the facility did not have a policy for

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incontinence care or documentation in the medical record and uses Lippincott as their standard of practice. ASM #2 provided pages 384-385 titled "Incontinence Management, Urinary," and pages 236 and 238 titled "Documentation" and stated that they were from the Lippincott Nursing Manual.

The facility provided document "Incontinence Management, Urinary" pages 384-385 documented in part: " ...Clean the skin gently, using care to avoid rigorous scrubbing or friction to minimize the risk of compromising the skin barrier function. Return the patient's bed to the lowest position to prevent falls and maintain patient safety. Remove and discard your gloves and perform hand hygiene. Document the procedure."

The facility provided document "Documentation" pages 236-238 documented in part, " ...Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed documentation shows the extent and quality of the care that nurses provide, the outcomes of the care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors."

On 12/17/19 at 4:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was presented prior to exit.

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References:

1. Dementia
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

2. Dystonia
Dystonia is a movement disorder that causes involuntary contractions of your muscles. These contractions result in twisting and repetitive movements. Sometimes they are painful. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dystonia&_ga=2.99516954.502445942.1576702402-1838772440.1562936034

3. Resident #5 was admitted to the facility on 01/05/2018 with diagnoses that included but were not limited to cerebral infarction (1) and hemiplegia and hemiparesis (2).

Resident #5's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/24/19, coded Resident #5 as scoring a 7 (seven) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 7- being severely impaired for making daily decisions. Section G coded Resident #5 as being totally dependent of two or more persons for toileting. Section H coded Resident #5 as always incontinent of bowel and bladder.

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The comprehensive care plan "Alteration in elimination of bowel and bladder Stress Incontinence (3) ...dx (diagnosed) with a right scrotal hernia (4), Date Initiated: 01/10/2018" for Resident #5 documented the following. Under "Interventions" it documented, "Use of briefs/pads for incontinence protection ....no briefs while in bed, Date Initiated: 01/10/2018, Revision on: 04/05/2018."

Review of the clinical record for Resident #3 revealed "ADL (activities of daily living) Toilet use" which failed to document toileting or incontinence care being provided for Resident #3 on the following dates:
- "12/5/19 Day 7:00-3:00 (7:00 a.m.-3:00 p.m.)," documentation area contained "NA, NA, [Initials of Staff member] 16:36 (4:36 p.m.)."
- "12/5/19 Eve (evening) 3:00-11:00 (3:00 p.m.-11:00 p.m.)," documentation area contained "NA, NA, [Initials of Staff Member] 1640 (4:40 p.m.)."
- "12/6/19 Eve 3:00-11:00," documentation area contained "NA, NA, [Initials of Staff Member] 16:15 (4:15 p.m.)."
- "12/6/19 Night 11:00-7:00 (11:00 p.m. - 7:00 a.m.)," documentation area contained "NA, NA, [Initials of Staff Member] 01:16 (1:16 a.m.)."
- "12/8/19 Day 7:00-3:00," documentation area contained "NA, NA, [Initials of Staff Member] 14:19 (2:19 p.m.)."
- "12/8/19 Eve 3:00-11:00," documentation area contained "NA, NA, [Initials of Staff Member] 16:37 (4:37 p.m.)."
- "12/9/19 Day 7:00-3:00," documentation area contained "NA, NA, [Initials of Staff Member] 11:54 (11:54 a.m.)."
- "12/11/19 Eve 3:00-11:00," documentation area contained "NA, NA, [Initials of Staff Member]

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22:32 (10:32 p.m.)."
- "12/14/19 Night 11:00-7:00," documentation area contained "NA, NA, [Initials of Staff Member] 01:46 (1:46 a.m.)."
- "12/16/19 Day 7:00 -3:00" documentation area was observed to be blank.
- "12/16/19 Eve 3:00-11:00," documentation area contained "NA, NA, [Initials of Staff Member] 19:53 (7:53 p.m.)."

On 12/17/19 at 11:45 a.m., an interview was conducted with CNA (certified nursing assistant) #5, regarding incontinence care and documentation. CNA #5 stated that care is provided every two hours and as needed. CNA #5 stated that incontinence care is provided more frequently if needed or if requested. CNA #5 stated that residents should be provided incontinence care as soon as it is needed. CNA #5 stated that incontinence care is documented on the computer monitors in the facility hallways. When asked how often toileting or incontinence care is documented, CNA #5 stated that it should be documented each time it is provided to the resident. When asked why the care is documented, CNA #5 stated, "If it is not documented, it is like you didn't do it." CNA #5 reviewed the document, "ADL (activities of daily living) Toilet use" for Resident #5. When asked about the blank documentation area on 12/16/19, CNA #5 stated that the empty box means that the care was not charted. When asked what the documentation "NA, NA" means in the documentation area on 12/5/19, 12/6/19, 12/8/19, 12/9/19, 12/11/19, and 12/14/19, 12/16/19, CNA #5 stated that it means that the category does not pertain to the resident. CNA #5 stated that the "NA, NA" means that the care did not happen. CNA #5 stated that it appears that the staff are

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F 842	Continued From page 20 charting the care wrong. CNA #5 stated that the director of nursing has been educating the staff on documenting the care provided in the system accurately but it appeared that some of the staff are still not documenting it correctly.	F 842		
	On 12/17/19 at 5:15 p.m., ASM (administrative staff member) #2, the director of nursing stated that the facility did not have a policy for incontinence care or documentation in the medical record and uses Lippincott as their standard of practice. ASM #2 provided pages 384-385 titled "Incontinence Management, Urinary," and pages 236 and 238 titled "Documentation" and stated that they were from the Lippincott Nursing Manual.			
	The facility provided document "Incontinence Management, Urinary" pages 384-385 documented in part, " ...Clean the skin gently, using care to avoid rigorous scrubbing or friction to minimize the risk of compromising the skin barrier function. Return the patient's bed to the lowest position to prevent falls and maintain patient safety. Remove and discard your gloves and perform hand hygiene. Document the procedure."			
	The facility provided document "Documentation" pages 236-238 documented in part, " ...Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed documentation shows the extent and quality of the care that nurses provide, the outcomes of the care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication			

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and errors."

On 12/17/19 at 4:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was presented prior to exit.

References:

1. Cerebral infarction
A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

2. Hemiplegia and hemiparesis
Also called: Hemiplegia, Palsy, Paraplegia, and Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

3. Stress incontinence
Urinary incontinence is the unintentional loss of urine. Stress incontinence happens when physical movement or activity - such as coughing, sneezing, running or heavy lifting - puts pressure

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F 842	Continued From page 22 (stress) on your bladder. Stress incontinence is not related to psychological stress. This information was obtained from the website: https://www.mayoclinic.org/diseases-conditions/stress-incontinence/symptoms-causes/syc-20355727?DSECTION=all&p=1 4. Scrotal hernia A hernia happens when part of an internal organ or tissue bulges through a weak area of muscle. Most hernias are in the abdomen. There are several types of hernias, including Inguinal, in the groin. This is the most common type. Umbilical, around the belly button; Incisional, through a scar; Hiatal, a small opening in the diaphragm that allows the upper part of the stomach to move up into the chest. Congenital diaphragmatic, a birth defect that needs surgery This information was obtained from the website: https://medlineplus.gov/hernia.html	F 842		