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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/11/2020 through 02/13/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/11/2020 through 02/13/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint [VA00048187] was investigated during the survey. The census in this 92 certified bed facility was 80 at the time of the survey. The survey sample consisted of 42 resident reviews.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/09/2020

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residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to implement the facility policies to meet the requirements for advanced directives for six of 42 residents in the survey sample, Residents #6, #54, #44, #73, #31 and #63. The facility staff failed failed to evidence periodic review of resident (or the resident's representative) decisions for advance directives, with the opportunity to develop an advance directive, for Resident #6, #54, #44, #73, #31, and #63.

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The findings included:

1. Resident #6 was admitted to the facility on 11/06/2019. His diagnoses included muscle weakness, depression, and high cholesterol. Resident #6's most recent Minimum Data Set (MDS) Assessment was a Significant Change Assessment with an Assessment Reference Date (ARD) of 11/14/2019. The Brief Interview for Mental Status (BIMS) scored Resident #6 at a 10, indicating moderate impairment. Resident #6 was coded as requiring extensive assistance of 1 person for most Activities of Daily Living (ADLs).

A review of the facility policy on Advanced Directives revealed the following:
"Upon Admission and during Your Path Meetings, advanced directives will be discussed with resident and/or resident representative to determine if any advanced directives have been chosen." "Advanced directives will be reviewed at minimum annually according to MDS schedule."

A review of the resident record failed to reveal documented evidence that facility staff had conducted reviews of Resident #6's wishes regarding advanced directives.

On 02/11/2020, at approximately 5:00 p.m., the facility staff were asked to look for documentation of periodic reviews of the advanced directives and to provide this information.

On the morning of 02/12/2020, at approximately 8:30 a.m., the facility staff provided documentation of "My Path" meetings for Resident #6. On the "My Path" meeting sheet the following was documented: "DNR - Reviewed/Addressed". There was no

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documentation of Advanced Directives was made.

On 02/12/2020 at 3:20 p.m., an interview was conducted with Other Staff Member (OSM) #3, the Social Services Director. OSM #3 was asked about the importance of reviewing the Advanced Directive. OSM #3 stated "An advanced directive tells us if there is gonna be a DNR [do not resuscitate], whether there is gonna be CPR [cardiopulmonary resuscitation], it contains a few separate things." When asked if there was a difference between an Advanced Directive and a resident's Code Status, OSM #3 stated yes there is. When presented with the "My Path" meeting document for Resident #6, and asked if the line documented above was referring to an Advanced Directive or just Code Status. OSM #3 stated that it looked like a description of Code Status was written. OSM #3 was asked to locate any further documentation of a review of the Advanced Directives for Resident #6.

On 02/13/2020 at 9:59 a.m., OSM #3 stated that no further documentation related to Advanced Directives was available for Resident #6.

Administrative Staff Member (ASM) #1, the facility Administration, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 02/13/2020. No further information was provided.

2. Resident #28 was admitted to the facility on 08/10/2019. His diagnoses included muscle weakness and depression. Resident #28's most recent MDS Assessment was a Quarterly Assessment with an ARD of 12/10/2019. The

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BIMS scored Resident #28 at a 9, indicating moderate impairment. Resident #28 was coded as requiring extensive assistance of 1 person for most ADLs.

A review of the resident record failed to reveal documented evidence that facility staff had conducted reviews of Resident #28's wishes regarding advanced directives.

On 02/11/2020, at approximately 5:00 p.m., the facility staff were asked to look for documentation of periodic reviews of the advanced directives and to provide this information.

On the morning of 02/12/2020, at approximately 8:30 a.m., the facility staff provided documentation of "My Path" meetings for Resident #28. On the "My Path" meeting sheet the following was documented for Resident #28 on the line "Adv. Dir/Code Status": Full Code - Addressed/Reviewed. No documentation of Advanced Directives was made.

On 02/13/2020 at 9:59 a.m., OSM #3 stated that no further documentation related to Advanced Directives was available for Resident #28.

Administrative Staff Member (ASM) #1, the facility Administration, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 02/13/2020. No further information was provided.

3. Resident #59 was admitted to the facility on 12/19/2019. Her diagnoses included pneumonia and depression. Resident #59's most recent MDS Assessment was a Quarterly Assessment with an

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ARD of 01/13/2020. The BIMS scored Resident #59 at a 7, indicating severe impairment. Resident #59 was coded as requiring extensive assistance of 1 person for ADLs.

A review of the resident record failed to reveal documented evidence that facility staff had conducted reviews of Resident #59's wishes regarding advanced directives.

On 02/11/2020, at approximately 5:00 p.m., the facility staff were asked to look for documentation of periodic reviews of the advanced directives and to provide this information.

On the morning of 02/12/2020, at approximately 8:30 a.m., the facility staff provided documentation of "My Path" meetings for Resident #59. On the "My Path" meeting sheet the following was documented for Resident #59 on the line "Adv. Dir/Code Status": Full Code - Addressed/Reviewed. No documentation of Advanced Directives was made.

On 02/13/2020 at 9:59a.m. OSM #3 stated that no further documentation related to Advanced Directives was available for Resident #59.

Administrative Staff Member (ASM) #1, the facility Administration, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 02/13/2020. No further information was provided.

4. Resident # 73 was admitted to the facility with diagnoses that included but were not limited to high blood pressure and anxiety [1].

Resident # 73's most recent MDS (minimum data set), a quarterly assessment with an ARD

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(assessment reference date) of 01/30/2020, coded Resident # 73 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions.

Review of Resident # 73's clinical record failed to evidence an advance directive. Further review of the clinical record revealed a "Care Plan Conference Summary" dated 11/06/2019. The "Care Plan Conference Summary" documented in part, "Topics Discussed: Adv. Dir. [Advance Directive/Code Status: Discussed with Res. Rep [Resident Representative]. Comments DNR [Do Not Resuscitate]." Further review of the "Care Plan Conference Summary" failed to evidence a review was conducted to provide Resident # 73 and/or Resident # 73's representative with the opportunity to develop an advance directive.

The comprehensive care plan for Resident # 73 with a revision date of 01/20/2020 documented in part, "Focus: Code Status: Resident/Responsible party has chosen DNR." Under "Interventions" it documented, "Review code status annually, quarterly and/or PRN [as needed]. Revision on: 01/20/2020."

On 02/12/2020 at 3:20 p.m., an interview was conducted with OSM [other staff member] # 3, social services director. When asked about the facility process for advanced directives, OSM # 3 stated that on admission staff follow up with the family to see if the resident has an advanced directive and get a copy if they do. OSM # 3 stated that if the resident comes from the hospital they contact the hospital to obtain any advanced directive to have on file. OSM # 3 stated that the admissions director is the first point of contact for

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new admission and the social services department is the second. OSM # 3 stated that the welcome packed it given to new admissions by the admissions director which contains information on formulating advanced directives. OSM # 3 stated that an admission huddle is also performed prior to admission where advanced directives are discussed.

On 2/12/2020 at 3:51 p.m., an interview was conducted with OSM # 4, the admission director. When asked about the facility process for advanced directives, OSM # 4 stated that residents are asked if they have an advanced directive and if the resident has one, a copy is obtained and placed in the chart. OSM # 4 stated that if the resident comes from home or the hospital a welcome packet is given to the resident which contains information on advance directives. OSM # 4 stated that a path meeting is conducted with the resident or the responsible party and an advance directive is offered during the meeting. When asked if it is documented that advance directives are offered on admission, OSM # 4 stated that if the resident elects to develop an advance directive on admission the document would be on the chart and if they do not elect to develop an advance directive on admission there is no documentation of it. OSM # 4 stated that after admission social services picks up the advance directive process for review and revision.

On 02/13/2020 at 10:00a.m., a follow up interview was conducted with OSM #3. After OSM #3 reviewed Resident # 75's "Care Plan Conference Summary" they were asked if there was evidence that Resident # 73 and/or Resident # 73's representative was given the opportunity to

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develop an advance directive. OSM # 3 stated no.

On 02/13/2020 at 1:20 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and RN [registered nurse] # 1, assistant director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
[1]Fear. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.
5. The facility staff failed to periodically review Resident #31's (or the resident's representative) decisions regarding advance directives.

Resident #31 was admitted to the facility on 12/05/2016 with a readmission on 9/06/2016. Resident #31's diagnoses included but were not limited to major depressive disorder (1) and dementia (2).

Resident #31's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/10/2019, coded Resident #31 as scoring a 1 (one) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 1- being severely impaired for making daily decisions.

Review of Resident #31's clinical record revealed a document "Care Plan Conference Summary" dated 12/18/19 which documented in part "DNR (do not resuscitate) addressed-reviewed" but failed to evidence documentation of periodic

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review of advance directives with Resident #31's representative.

The comprehensive care plan for Resident #31 documented "Code Status: Resident/Responsible party has chosen Full Code. 10/2/19 Resident is DNR per order. 2/1020 [sic] Followed by [Name of Hospice] Date Initiated: 01/14/2018; Revision on 02/10/2020. Review code status annually, quarterly and/or PRN (as needed)." The care plan failed to evidence documentation for periodic review of advance directives with Resident #31's representative.

On 2/12/20 at approximately 10:00 a.m., a request was made via written list to ASM (administrative staff member) #1, the administrator for evidence of offering advance directives on admission to the facility and evidence of periodic review of advance directives for Resident #31.

On 2/12/20 at approximately 1:45 p.m., ASM #1 provided the document "Care Plan Conference Summary" dated "12-18-19" which documented "DNR addressed-reviewed" and a copy of "Durable Do Not Resuscitate Order" dated "9-30-19" for Resident #31.

On 2/12/20 at 3:20 p.m., an interview was conducted with OSM (other staff member) #3, the social services director. When asked about the facility process for offering advance directives OSM #3 stated that on admission staff discuss with residents and family to see if the resident has an advance directive. OSM #3 stated that if the resident already has an advance directive they request a copy to have in the chart. OSM #3 stated that the admissions director is the first

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point of contact for new admissions to the facility and the social services department is the second contact. OSM #3 stated that the welcome packet given to new residents by the admissions director contains information on how to formulate an advance directive. OSM #3 stated that an admission huddle is also performed prior to admission where advance directives are discussed. When asked if advance directives are periodically reviewed with residents and/or resident representative, OSM #3 stated that it is discussed during the care plan conferences. When asked if it is documented that the advance directives are reviewed or offered, OSM #3 stated it would be documented on the Care Plan Conference Summary.

On 2/12/20 at 3:20 p.m., a request was made to OSM #3, the social services director for evidence that periodic review for advance directives were conducted for Resident #31.

On 2/12/20 at 3:51 p.m., an interview was conducted with OSM #4, the director of admissions. When asked about the facility process for advance directives, OSM #4 stated that residents are asked if they have an advance directive on admission so a copy can be obtained for the chart. OSM #4 stated that if the resident comes from home or the hospital a welcome packet is given to the resident which contains information on advance directives. OSM #4 stated that a Path (plan of care) meeting is conducted with the resident or the responsible party on admission and an advance directive is offered during the meeting. When asked if it is documented that advance directives are offered on admission, OSM #4 stated that if the resident elects to develop an advance directive on

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admission the document would be on the chart and if they do not elect to develop an advance directive on admission there is no documentation of it. OSM #4 stated that after admission social services picks up the advance directive process for review and revision.

On 2/13/20 at 10:00 a.m., OSM #3, the director of social services stated that she did not have any additional information regarding the periodic review of advance directives for Resident #31. OSM #3 reviewed the "Care Plan Conference Summary" dated "12-18-19" for Resident #31 and stated that code status was being discussed during the care plan meetings. OSM #3 stated that the facility had in-service training planned for the following week on advance directives review. OSM #3 stated that if the periodic review was not documented on the care plan conference summary she could not say that it was being done.

The facility policy, "Advance Directives Protocol" documented in part, "Upon Admission and during Your Path Meetings, advance directives will be discussed with resident and/or resident representative to determine if any advance directives have be [sic] chosen."

On 2/13/20 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

References:

1. Major depressive disorder
Major depression is a mood disorder. It occurs

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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.

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.

6. Resident #63 was admitted to the facility on 11/23/2015 with a readmission on 01/07/2020. Resident #63's diagnoses included but were not limited to aphasia (1) and major depressive disorder (2). Resident #63's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/21/2020, coded Resident #63 as being severely impaired for making daily decisions.

Review of Resident #63's clinical record revealed a document "Care Plan Conference Summary" dated "11-13-19" which documented "DNR (do not resuscitate) reviewed- addressed" but failed to evidence documentation of review of advance directives.

The comprehensive care plan for Resident #63 documented "Code Status: Resident/Responsible party has chosen DNR. 1/20/20 NP (nurse practitioner) met with RP (responsible party) who declines hospice services at present. Date Initiated: 01/07/2020, Revision on: 01/21/2020. Review code status annually, quarterly and/or

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PRN (as needed)." The care plan failed to evidence documentation for periodic review of advance directives with Resident #63's representative.

On 2/12/20 at approximately 10:00 a.m., a request was made via written list to ASM (administrative staff member) #1, the administrator for evidence of offering advance directives on admission to the facility and evidence of periodic review of advance directives for Resident #63.

On 2/12/20 at approximately 1:45 p.m., ASM #1 provided the document "Care Plan Conference Summary" dated "11-13-19" which documented "DNR reviewed- addressed" and a copy of "Durable Do Not Resuscitate Order" dated "2/27/17" for Resident #63.

On 2/12/20 at 3:20 p.m., a request was made to OSM #3, the social services director for evidence that periodic review for advance directives were conducted for Resident #63.

On 2/13/20 at 10:00 a.m., OSM #3, the director of social services stated that she did not have any additional information regarding the periodic review of advance directives for Resident #63. OSM #3 reviewed the "Care Plan Conference Summary" dated "11-13-19" for Resident #63 and stated that code status was being discussed during the care plan meetings. OSM #3 stated that the facility had in-service training planned for the following week on advance directives review. OSM #3 stated that if the periodic review was not documented on the care plan conference summary she could not say that it was being done.

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F 578	Continued From page 14 On 2/13/20 at approximately 12:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. References: 1. Aphasia A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html 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. References: [1]Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review it was determined that the facility staff failed to accurately complete a MDS (minimum data set) resident assessment for one of 42 residents in the survey sample, Resident #77. The facility staff failed to accurately complete the quarterly MDS (minimum data set) regarding the use of psychotropic medications for Resident #77 with the ARD (assessment reference date) of 01/31/2020.

The findings include:

Resident #77 was admitted to the facility on 02/26/2019 with a readmission on 01/11/2020 with diagnoses that included but were not limited to anxiety disorder (1), schizoaffective disorder (2) and major depressive disorder (3).

Resident #77's most recent MDS, a quarterly assessment with an ARD of 01/31/2020, coded Resident #77 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 12, 12 - being moderately impaired for making daily decisions.

Review of the clinical record revealed a list of Resident #77's MDS assessments. The list revealed that a quarterly MDS assessment was completed on 01/31/2020. Section N0410 "Medications Received" of the 1/31/2020 assessment documented Resident #77 as having received antipsychotic medication during the previous seven days of the assessment period. Further review of the MDS assessment in section N0450 "Antipsychotic Medication Review" documented no antipsychotics were received

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since admission, reentry or the prior assessment.

The physician order summary dated 2/13/20 documented "Seroquel (4) tablet 100 mg (milligram), give 1 (one) tablet by mouth at bedtime related to schizoaffective disorder, unspecified; Order Date: 01/11/2020; Start Date: 01/12/2020."

Review of the January MAR (medication administration record) revealed the above physician order and documented the medication was administered as ordered.

The comprehensive care plan "Antipsychotic med use: Schizoaffective Disorder, The resident uses antipsychotic medications r/t (related to) Schizoaffective Disorder, Date Initiated: 02/26/2019, Revision on: 07/22/2019" for Resident #77 documented in part, "Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 02/26/2019."

On 2/13/20 at 9:45 a.m., an interview was conducted with LPN (licensed practical nurse) #5, MDS coordinator. When asked how the MDS is completed, LPN #5 stated that the RAI (resident assessment instrument) manual is used as their guide in completing the assessment. When asked about section N of the 1/31/2020 quarterly MDS assessment for Resident #77, LPN #5 stated that both questions regarding antipsychotics should have documented Resident #77 receiving antipsychotics. LPN #5 stated that Resident #77 had been on antipsychotics since her initial admission to the facility and the question that documented no antipsychotics received since admission or reentry was incorrect

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and would be corrected.

According to the RAI Manual, Version 1.16, dated October 2018, guidance for completion of Section N documented the following:
Steps for Assessment
1. Review the resident's medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent.
2. If the resident received an antipsychotic medication, review the medical record to determine if a gradual dose reduction has been attempted.
3. If a gradual dose reduction was not attempted, review the medical record to determine if there is physician documentation that the GDR is clinically contraindicated.
Coding Instructions for N0450A
- Code 0, no: if antipsychotics were not received: Skip N0450B, N0450C, N0450D and N0450E.
- Code 1, yes: if antipsychotics were received on a routine basis only: Continue to N0450B, Has a GDR been attempted?
- Code 2, yes: if antipsychotics were received on a PRN basis only: Continue to N0450B, Has a GDR been attempted?
- Code 3, yes: if antipsychotics were received on a routine and PRN basis: Continue to N0450B, Has a GDR been attempted?

On 2/13/20 at approximately 10:20 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy on the completion of the MDS.

On 2/13/20 at approximately 11:15 a.m., ASM #1, the administrator stated that the facility did not

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have a policy for the completion of the MDS and that they use the RAI manual.

On 2/13/20 at approximately 12:30 p.m., ASM #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

References:

1. Anxiety - is fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

2. Schizoaffective disorder is a mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.

3. Major depressive disorder 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.

4. Seroquel (quetiapine) is an antipsychotic medicine. It works by changing the actions of chemicals in the brain. Seroquel is used to treat schizophrenia in adults and children who are at least 13 years old. Seroquel is used to treat bipolar disorder (manic depression) in adults and children who are at least 10 years old. Seroquel

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F 641	Continued From page 19 is also used together with antidepressant medications to treat major depressive disorder in adults. Seroquel may also be used for purposes not listed in this medication guide. This information was obtained from the website: https://www.drugs.com/seroquel.html	F 641		
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 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:	F 657		

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Based on resident interview, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to review and revise the comprehensive care plan for one of 42 residents in the survey sample, Residents # 23. The facility staff failed to revise Resident #23's comprehensive care plan to include the use of a spirometer.

The findings include:

Resident # 23 was admitted to the facility with diagnoses that included but were not limited to: pulmonary edema [2], chronic obstructive pulmonary disease [3]. Resident # 23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/06/19, coded Resident # 23 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 23 was coded as requiring supervision of one staff member for activities of daily living.

On 02/11/20 at 11:40 a.m., 02/11/20 at 1:00 p.m., and 02/12/20 at 8:10 a.m., observations of Resident #23 room revealed an incentive spirometer on the over-the-bed table uncovered.

The "Physician's Order Sheet" for Resident # 23 dated "02/122020" failed to evidence an order for the use of an incentive spirometer.

The comprehensive care plan for Resident # 23 with a revision date of 07/19/2019 failed to evidence any documentation addressing the use of an incentive spirometer.

On 02/12/20 at 9:36 a.m., an interview with

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Resident # 23. When asked about the incentive spirometer Resident # 23 stated, "I use it almost every day I have COPD [chronic obstructive pulmonary disease]."

On 02/12/20 at 2:23 p.m., an interview was conducted with LPN [Licensed practical nurse] # 4 and LPN # 5, MDS coordinators. When asked to describe the procedure for updating a resident's care plan, LPN # 4 stated that they go through the physician's orders every day for new orders and update the care plan with the new orders and that it is also done quarterly. LPN # 4 further stated that any changes with a resident would require an update or revision of the care plan and anything communicated from nursing about a change for a resident would also trigger them to update the care plan. After reviewing the comprehensive care plan for Resident # 23 with a revision date of 07/19/2019, LPNs # 4 and # 5 were asked if the care plan was updated to reflect Resident # 23's use of an incentive spirometer. LPNs # 4 and 5 stated no, the incentive spirometer should be on the care plan.

On 02/13/20 at 10:27 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked what standard of practice followed by the facility, ASM # 2 stated, "We follow Lippincott and our policies and procedures."

The facility's policy "Comprehensive Care Planning" documented in part, "F. The Comprehensive Care Plan is reviewed and updated at least every 90 days by the interdisciplinary team."

According to Fundamentals of Nursing Lippincott

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Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)
(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

On 02/12/2020 at 6:00 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of clinical services and RN [registered nurse] # 1, assistant director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.

(2) An abnormal buildup of fluid in the lungs. This buildup of fluid leads to shortness of breath. This

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F 657	Continued From page 23 information was obtained from the website: https://medlineplus.gov/ency/article/000140.htm. (3) 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.	F 657		
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, staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards for two of 42 residents in the survey sample, Resident # 79, and Resident #50. The facility staff obtain a physician's order for the use of an "Iceman machine" post Resident #79's total knee replacement, and failed to administer the prescribed dosage of the scheduled Calcium/Vitamin D during the medication administration observation for Resident #50 on 02/12/2020 at 8:00 a.m. The findings include: 1. Resident # 79 was admitted with diagnoses that included but were not limited to: aftercare following joint replacement [knee] surgery, and muscle weakness. Resident # 79's admission MDS (minimum data set), could not be completed	F 658		

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before they were discharged to another facility. The facility's nursing admission assessment for Resident # 79 documented in part, "Admission: 01/10/2020. 16:55 [4:55 p.m.]. Cognitive Status/Orientation: AO [alert and orientated]. ADL [activity of daily living]/Mobility: WC [wheelchair and bedside commode]."

Review of Resident # 79's EHR [electronic health record] revealed a "Discharge Summary" from [Name of Hospital] for Resident # 79 dated "01/10/20." Under "Discharge Summary" it documented in part, "2. Status post total knee replacement. A&P [assessment and plan]. Weight bearing as tolerated. Skilled nursing facility placement for nursing/PT [physical therapy]/OT [occupational therapy]. ICEMAN machine [1] was used postoperatively to prevent swelling, and given to the patient for use after discharge."

The POS [physician's order sheet] for resident # 79 dated 01/10/2020 through 01/14/2020 failed to evidence an order for the use of an "Iceman" machine.

The comprehensive care plan for Resident # 79 dated 01/10/2020 failed to evidence the use of an "Iceman" machine.

The facility's nursing "Progress Notes" for Resident # 79 dated 01/11/2020 at 13:24 [1:24 p.m.] documented in part, "She has iceman machine on morning part of shift and off at this time. Author [Name of LPN (licensed practical nurse) # 10] - e-SIGNED [electronically signed]."

The facility's nursing "Progress Notes" for Resident # 79 dated 01/11/2020 at 16:55 [4:55

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p.m.] documented in part, "Using iceman for cold therapy to L [left] knee & [and] also receiving reg [regular] sced [scheduled] pain med [medication]."

On 02/13/2020 at approximately 12:33 p.m., a telephone interview was conducted with CNA (certified nursing assistant) # 10. When asked if they recalled Resident # 79, CNA #10 stated yes. When asked if Resident # 79 had an "Iceman" machine" CNA #10 stated yes. When asked if they set up the machine, CNA # 10 stated that she filled the machine with ice and water but did not put it on Resident # 79.

On 02/13/2020 at approximately 12:53 p.m., a telephone interview was conducted with RN (registered nurse) # 4. When asked if they recalled Resident # 79, RN #4 stated yes. When asked if Resident # 79 was using the "Iceman" machine during their shift on 01/11/2020, RN # 4 stated yes. When asked about the "Iceman" machine for Resident # 79, RN # 4 stated, "She would have already had it on at the beginning of my shift. I kept it filled with ice." When asked if there was a physician's order for the use of the machine, RN # 4 stated that they were not aware that there was not an order. When asked to describe the procedure for the use of a treatment device, RN # 4 stated, "To get the order to use the machine."

On 02/13/2020 at approximately 1:09 p.m., a telephone interview was conducted with LPN [licensed practical nurse] # 10. When asked if they recalled Resident # 79, LPN #10 stated yes. When asked about the "Iceman" machine for Resident # 79, LPN # 10 stated, "She would have already had it on at the time of my shift." When

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asked if there was a physician's order for the use of the machine, LPN # 10 stated that they thought there was an order. LPN # 10 further stated that Resident # 79 put the machine on and turned it on herself. When asked to describe the procedure for the use of a treatment device, LPN # 10 stated, "There should be an order for any medication or treatment."

On 02/13/20 at 12:11 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked about a physician's order for Resident # 79's use of the "Iceman" machine, ASM # 2 stated that there was no order for the "Iceman" machine. After reviewing Resident # 79's nurse's progress notes dated 01/11/2020, ASM # 2 agreed that staff used the "Iceman" machine for Resident #79 on 1/11/2020. ASM # 2 further stated that they should not have used the machine without the order. When asked to describe the procedure the staff should have followed, ASM # 2 stated, "The nurse should have checked the hospital discharge instructions and called the physician to obtain an order."

RN # 5 was unable to be interviewed due to the fact that they were no longer employed with the facility at the time of the survey.

On 02/13/20 at 10:27 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked what standard of practice the facility follows, ASM # 2 stated, "We follow Lippincott and our policies and procedures."

On 02/13/2020 at 1:20 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2,

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director of nursing, and RN [registered nurse] # 1, assistant director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Iceman® Cold Therapy System helps reduce pain and swelling while facilitating rehabilitation by providing up to seven hours of continuous cold therapy before needing to be refilled with ice. Wrap-on pad (sold separately) securely connects to unit. Semi-closed loop system helps maintain consistent and accurate temperature. Features two-position locking top, water tight seal and thermostat for easy temperature adjustments. This information obtain from the website: https://www.alimed.com/iceman-cold-therapy-system.html.
2. Resident #50 was admitted to the facility on 09/30/2019. Resident #50's diagnoses included but were not limited to atrial fibrillation (2), dementia (3) and chronic obstructive pulmonary disease (4). Resident #50's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/07/20, coded Resident #50 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions.

On 2/12/20 at 8:00 a.m., an observation was made of medication administration to Resident #50 by RN (registered nurse) #2. RN #2 prepared the following medications for Resident #50:
-Acetaminophen 500 mg (milligram) one tablet (used to treat pain or fever)
-Potassium Chloride ER (extended release)

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10 meq (milliequivalents) one tablet (mineral supplement)

-Calcium/Vitamin D 600mg/400 IU (international units) one tablet (mineral/vitamin supplement)

-Eliquis 2.5 mg one tablet (used to prevent blood clots)

-Donepezil 23 mg one tablet (used to treat dementia)

-Amlodipine 2.5 mg one tablet (used to treat high blood pressure)

-Amiodarone HCL (hydrochloride) 200 mg one tablet (used to treat abnormal heartbeats).

RN #2 then proceeded to administer the medications as prepared to Resident #50.

Review of Resident #50's clinical record revealed a physician's order which documented, "Calcium-Vitamin D Tablet 600-125 mg-unit (Calcium Carbonate-Vitamin D) Give 1 (one) tablet by mouth three times a day for hypocalcemia (5); Order Date: 11/08/2019, Start Date: 11/08/2019."

Review of Resident #50's clinical record revealed an eMAR (electronic medication administration record) dated 2/1/2020 through 02/29/2020. The eMAR documented, "Calcium-Vitamin D Tablet 600-125 mg-unit (Calcium Carbonate-Vitamin D) Give 1 (one) tablet by mouth three times a day for hypocalcemia; Start Date: 11/08/2019 1200 (12:00 p.m.)" to be administered at 0800, 1200, and 1600 (8:00 a.m., 12:00 p.m. and 4:00 p.m.). The eMAR documented the Calcium-Vitamin D tablet 600-125 mg-unit medication administered on 2/12/20 at 8:00 a.m. by RN #2.

On 2/13/20 at 7:45 a.m., an interview was conducted with RN #2 regarding the medication

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administration observation on 2/12/20 at 8:00 a.m. When asked what is checked prior to medication administration, RN #2 stated that the rights are checked, right patient, right drug and right route. RN #2 stated the medications are checked with the eMAR. When asked about the Calcium-Vitamin D tablet administered to Resident #50 on 2/12/20 at 8:00 a.m., RN #2 stated that after administering the medication she noticed that the house stock medication contained the incorrect dosage of Vitamin D. RN #2 stated that she had already clarified the physician order with the prescribing physician and updated the order and notified Resident #50. RN #2 stated that she normally works the night shift and is not familiar with the daytime medications for Resident #50. RN #2 stated that the physician order for the Calcium-Vitamin D had been updated to reflect the current dosage to be administered.

On 2/13/20 at 10:27 a.m., an interview was conducted with ASM [administrative staff member] #2, the director of nursing. When asked what standard of practice the nursing staff follow ASM #2 stated, "We follow Lippincott and our policies and procedures."

The facility policy "General Dose Preparation and Medication Administration, Effective Date 12/01/07, Revision 05/01/10, 01/01/13" documented in part, "Procedure ...3.7 Facility staff should verify that the medication name and dose are correct and should inspect the medication for contamination, particulate matter, discoloration or defects ..."

According to Lippincott, Williams & Wilkins. 5th edition, Philadelphia, PA. Page 568 documented,

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"Procedure 29-1; Administering Oral Medications
Procedure:
1. Wash hands
2. Arrange MAR next to medication supply....
3. Prepare medications for only one client at a time
4. Remove ordered medications from supply....
5. Calculate correct drug dosage....
6. Prepare selected medications....
7. Take medication directly to client's room. Do not leave medication unattended."

On 2/13/20 at approximately 12:30 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the findings.

No further information was provided prior to exit.

References:

1. Calcium/Vitamin D: Uses of Calcium and Vitamin D Capsules and Tablets: It is used to help growth and good health. It is used to prevent or treat soft, brittle bones (osteoporosis). It is used to treat or prevent low calcium levels. It may be given to you for other reasons. Talk with the doctor. This information was obtained from the website:
https://www.drugs.com/cdi/calcium-and-vitamin-d-capsules-and-tablets.html

2. Atrial fibrillation is a problem with the speed or rhythm of the heartbeat. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

3. Dementia is a loss of brain function that occurs with certain diseases. It affects memory,

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F 658	Continued From page 31 thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 4. Chronic obstructive pulmonary disease is a 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. 5. Hypocalcemia is a deficiency of calcium in the bloodstream. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/007229.htm.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		

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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 possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, it was determined that facility staff failed to provide care and services for an indwelling catheter for one of 42 residents in the survey sample, Residents # 75.

The findings include:

Resident # 75 was admitted to the facility with diagnoses that included but were not limited to: sacral [tail bone] pressure ulcer and obstructive uropathy [2]. Resident # 75's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/31/2020, coded Resident # 75 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 75 was coded as requiring extensive assistance of one staff member for activities of daily living. Section H "Bladder and Bowel" coded Resident # 75 as having an indwelling catheter.

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On 02/11/20 at 11:46 a.m., an observation of Resident # 75 revealed the resident was in bed. Observation of the bed revealed a catheter collection bag hanging on the right side of the bed and resting dirctly on the floor. Further observation revealed a CNA [certified nursing assistant] # 1 entered Resident # 75's room during this observation per the request of Resident # 75. CNA # 1 came into the room and readjusted Resident # 75's sheet and blanket on both sides of the bed and did not reposition the catheter collection bag.

On 02/11/20 at 12:59 p.m., an observation Of Resident # 75 revealed the resident in bed. Observation of the bed revealed a catheter collection bag hanging on the right side of the bed resting on the floor.

On 02/12/20 at 8:10 a.m., an observation Of Resident # 75 revealed the resident in bed. Observation of the bed revealed a catheter collection bag hanging on the right side of the bed resting directly on the floor.

The POS [physician's order sheet] for Resident # 75 dated 02/12/2020 documented in part, "Foley catheter size 16 F [French] with a 30ml [milliliter] Balloon. Related to pressure ulcer. Order date: 08/09/2019."

The comprehensive care plan for Resident # 75 dated 05/10/2019 documented in part, "Focus: Foley catheter: Obstructive uropathy. The resident has Indwelling Catheter (16F w[with]/30cc [cubic centimeter] balloon): R/T [related to] obstructive uropathy; hip and sacral pressure ulcers." Under "Interventions" it documented in part, "Position catheter bag and

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tubing below the level of the bladder. Revision on: 05/10/2019."

On 02/12/20 at 12:44 p.m., an interview and observation of Resident # 75's catheter collection bag was conducted with CNA [certified nursing assistant] # 1. When asked to describe the position a catheter collection bag should be placed in, CNA # 1 stated that it should be positioned on side of bed, at the lower end of the bed, below the bladder, off the floor and covered. After observing the position of Resident # 75's catheter collection bag CNA # 1 agreed that it was touching the floor and immediately raised the bed to keep the bag off the floor.

On 02/13/20 at 10:27 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked what standard of practice the facility follows, ASM # 2 stated, "We follow Lippincott and our policies and procedures."

According to Fundamentals of Nursing Lippincott Williams and Wilkins Eighth Edition 2006, Lippincott Company, page 757, titled Renal and Urinary Disorders, under the heading "Management of a Patient with an Indwelling Catheter and Closed Drainage System" the subheading: "Maintaining a closed drainage system: 2. Maintain an unobstructed urine flow. b. Urine should not be allowed to collect in tubing because free flow of urine must be maintained to prevent urinary tract infection. Improper drainage occurs when the tubing is kinked or twisted, allowing pools of urine to collect in the tubing. c. Keep the bag off the floor to prevent bacterial contamination."

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F 690	Continued From page 35 On 02/12/2020 at 6:00 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of clinical services and RN [registered nurse] # 1, assistant director of nursing were made aware of the above findings. No further information was provided prior to exit. References: [1] A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm. [2] A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, it was determined that facility staff failed	F 695		

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to ensure respiratory care and services consistent with professional standards of practice for one of 42 residents in the survey sample, Residents # 23. The facility staff failed obtain a physician's order for Resident #23's use of an incentive spirometer and failed to store the resident's incentive spirometer in a sanitary manner.

The findings include:

Resident # 23 was admitted to the facility with diagnoses that included but were not limited to: pulmonary edema [2], chronic obstructive pulmonary disease [3]. Resident # 23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/06/19, coded Resident # 23 as scoring a 15 on the staff assessment for mental status, of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 23 was coded as requiring supervision of one staff member for activities of daily living.

On 02/11/20 at 11:40 a.m., and at 1:00 p.m., and on 02/12/20 at 8:10 a.m., observations of Resident #23's room revealed an incentive spirometer on the over-the-bed table uncovered.

The "Physician's Order Sheet" for Resident # 23 dated "02/122020" failed to evidence the use of an incentive spirometer.

The comprehensive care plan for Resident # 23 with a revision date of 07/19/2019 failed to evidence documentation addressing the use of an incentive spirometer.

On 02/12/20 at 9:36 a.m., an interview with Resident # 23. When asked about the incentive

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spirometer, Resident # 23 stated, "I use it almost every day I have COPD [chronic obstructive pulmonary disease]."

On 02/12/2020 at 12:55 p.m., an interview and observation was conducted with LPN [licensed practical nurse] # 3. When asked if a spirometer is a piece of respiratory equipment, LPN # 3 stated yes. When asked how it should be stored when not in use, LPN # 3 stated it should be in a bag and dated. At this time, LPN # 3 was accompanied to Resident # 23's room. After observing the incentive spirometer on Resident # 23's over-the-bed table, LPN # 3 stated that the incentive spirometer should have been placed in a bag."

On 02/13/2020 at 11:20 a.m., an interview and observation was conducted with LPN # 2. When asked about lack of a physician's order for Resident # 23's incentive spirometer, LPN # 2 stated they typically have a physician's order for the incentive spirometer. LPN # 2 further stated, "Speech therapy will teach residents how to use them and recommend the use, we get the order for the use. If they come from the hospital with an incentive spirometer [sic] will call the physician to get the order. Usually do not use them long term, usually after surgery or for COPD. When asked about the physician's order for Resident # 23's incentive spirometer, LPN # 2 stated that Resident # 23 has an order for the incentive spirometer on 02/12/2020 after the surveyor observed it.

02/13/20 at 10:27 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked what standard of practice the facility follows, ASM

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2 stated, "We follow Lippincott and our policies and procedures."

The facility's policy "Incentive Spirometer Policy" documented in part, "Procedure: 1. Verify order via [by] order sheet, MAR [medication administration record] or TAR [treatment administration record]."

"Wash the mouthpiece in warm water and dry it. Avoid immersing the spirometer itself in water because water enhances bacterial growth and impairs the internal filter's effectiveness in preventing inhalation of extraneous material. Place the mouthpiece in a plastic storage bag between exercises, and label it and the spirometer, if applicable, with the patient's name to avoid inadvertent use by another patient. Keep the incentive spirometer within the patient's reach." Lippincott's Nursing Procedures (6th Edition) 2013.

On 02/12/2020 at 6:00 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of clinical services and RN [registered nurse] # 1, assistant director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This

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information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.

(2) An abnormal buildup of fluid in the lungs. This buildup of fluid leads to shortness of breath. This information was obtained from the website: https://medlineplus.gov/ency/article/000140.htm.

(3) 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.
On 02/13/20 at 10:27 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked what standard of practice the facility follows, ASM # 2 stated, "We follow Lippincott and our policies and procedures."

According to Fundamentals of Nursing Lippincott Williams and Wilkins Eighth Edition 2006, Lippincott Company, page 757, titled Renal and Urinary Disorders, under the heading "Management of a Patient with an Indwelling Catheter and Closed Drainage System" the subheading: "Maintaining a closed drainage system: 2. Maintain an unobstructed urine flow. b. Urine should not be allowed to collect in tubing because free flow of urine must be maintained to prevent urinary tract infection. Improper drainage occurs when the tubing is kinked or twisted, allowing pools of urine to collect in the tubing. c. Keep the bag off the floor to prevent bacterial contamination."

On 02/12/2020 at 6:00 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of

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F 695	Continued From page 40 clinical services and RN [registered nurse] # 1, assistant director of nursing were made aware of the above findings. No further information was provided prior to exit. References: [1] A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm. [2] A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be	F 757		

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F 757	Continued From page 41 reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a drug regimen free from unnecessary medication for one of 42 residents in the survey sample, Resident # 73. The facility staff failed to implement non-pharmacological interventions prior to the administration of the prn [as needed] pain medications Hydrocodone-Acetaminophen and Tylenol to Resident #73. The findings include: Resident # 73 was admitted to the facility with diagnoses that included but were not limited to high blood pressure and chronic pain. Resident # 73's most recent MDS (minimum data set), an quarterly assessment with an ARD (assessment reference date) of 01/30/2020, coded Resident # 73 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Section J "Health Conditions" coded Resident # 73 as having frequent pain with a pain level of seven on a scale of zero to ten with ten being the worse pain. The comprehensive care plan for Resident # 73 dated 12/29/2019 documented in part, "Focus: PAIN RISK: The resident has chronic pain r/t [related to] Diabetic neuropathy, low back pain as well as generalized pain. Date Initiated:	F 757		

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12/29/2019." Under "Interventions" it documented in part, "Administer analgesia/medication per orders. Date Initiated: 12/29/2019

The POS [physician's order sheet] dated 11/2019 for Resident # 73 documented, "Hydrocodone-Acetaminophen Tablet 5-325MG [milligrams]. Give 1 [one] tablet by mouth every 8 [eight] hours as needed for pain related to OTHER CHRONIC PAIN. Order Date: 11/12/2019."

Resident # 73's eMAR [electronic medication administration record] dated November 2019 documented the physician's order as above. The eMAR failed to evidence documentation of attempted non-pharmacological interventions. Further review of the eMAR revealed the administration of Hydrocodone-Acetaminophen on 11/28/2019 at 8:57 p.m. with a pain level of six.

The POS [physician's order sheet] dated 01/2020 for Resident # 73 documented, "Tylenol Tablet (Acetaminophen). Give 1000 mg [milligram] by mouth every 12 hours as needed for pain. Order Date: 12/29/2019."

Resident # 73's eMAR [electronic medication administration record] dated January 2020 documented the above physician's order. The eMAR failed to evidence documentation of non-pharmacological interventions attempted. Further review of the eMAR revealed the administration of Tylenol on: 01/13/2020 at 5:31 a.m. with a pain level of five, and on 01/22/2020 at 5:47 a.m. with a pain level of two.

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Resident # 73's eMAR [electronic medication administration record] dated February 2020 documented the above physician's order for Tylenol. The eMAR failed to evidence documentation of attempted non-pharmacological interventions. Further review of the eMAR revealed the administration of Tylenol on: 02/08/2020 at 3:56 a.m. with a pain level of three.

Review of the eMAR notes and nurse's notes dated 11/13/2019 through 02/12/2020 failed to evidence documentation of attempted non-pharmacological interventions prior to the administration of Resident # 73's prn pain medications on the dates cited above.

On 02/12/20 at 9:57 a.m., an interview was conducted with Resident # 73. When asked if the staff attempt to alleviate the pain before administering pain medication, Resident # 73 stated sometimes.

On 02/13/20 at 8:40 a.m., an interview was conducted with LPN [licensed practical nurse] # 2. LPN #2 was asked to describe the procedure staff follows when administering as needed pain medication to a resident. LPN # 2 stated ask the resident their pain level on a scale one to ten with one being minor pain and ten being unbearable, ask where the pain is and offer an intervention before giving the pain medication and if it doesn't work give the pain medication and follow up in about an hour. When asked where they document the interventions attempted prior to administering the pain medication, LPN # 2 stated that they document them on the eMAR notes. After reviewing the eMAR notes and nurse's notes for Resident # 73 for the above dates, LPN # 2 stated there was no documentation of

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non-pharmacological interventions being attempted. When asked about the lack of documentation of attempted non-pharmacological interventions, LPN # 2 stated, "It's not documented can't say it's being done." When asked why it was important to attempt non-pharmacological interventions, LPN # 2 stated that it is possible that they are getting a pain medication they might not need.

On 02/13/20 at 10:27 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked what standard of practice the facility follows, ASM # 2 stated, "We follow Lippincott and our policies and procedures."

The facility's policy "Pain Management and Pain Protocol" documented in part, "3. Non-pharmacological intervention will be attempted prior to the administration of PRN pain medications."

On 02/13/2020 at 3:30 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and RN [registered nurse] # 1, assistant director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. This information was obtained from the website:

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F 757	Continued From page 45 https://medlineplus.gov/druginfo/meds/a601006.html. [2] Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		

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abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review it was determined that facility staff failed to ensure an expired three milliliter multi-dose vile of Humalog [1] was not available for use for one of 42 residents in the survey sample, Resident # 47.

The findings include:

Resident # 47 was admitted to the facility with diagnoses that included but were not limited to: diabetes mellitus without complications [2].

Resident # 47's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/04/2020, coded Resident # 47 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section N "Medications" coded Resident # 47 as "0 [zero]" under "N0300 Injections. Record the number of days that injections of any type were received during the last 7 [seven] days or since admission/entry or reentry if less than 7 days. If 0 ---skip to N0410 Medications Received." Under "N0350 Insulin" sections "A. Insulin Injections. Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days; B. Orders for insulin. Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders

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during the last 7 days or since admission/entry or reentry if less than 7 days."

On 02/18/19 at 10:55 a.m., an observation of the facility's medication cart for the 200 Hall was conducted with LPN [licensed nurse] # 2. Observation inside of the top left drawer revealed a multi-dose vile of Humalog insulin inside a plastic, orange pharmacy bottle. Further observation of the vile of insulin revealed it was opened. Observation of the outside of the pharmacy bottle revealed a label documenting Resident # 47's name. Further observation reveal another label that documented, "Discard 28 days after opening. Date Open - 7/28/19." After observing the vile of insulin and the plastic pharmacy bottle the insulin was in LPN # 2 was asked to give an approximation of the amount of insulin that remained in the vile. LPN # 2 stated it was about half full. When asked when the insulin should be discarded, LPN #2 read the label on the outside of the pharmacy bottle and stated, "28 days after opening." LPN #2 was asked when the vile of Humalog insulin was opened. LPN # 2 read another label on the outside of the pharmacy bottle and stated, "7/28/19." LPN # 2 further stated that Resident # 47 was not currently taking insulin. When asked how staff ensure the medication cart does not contain expired medications, LPN # 2 stated, "As soon as the medication is discontinued I remove it from the cart. I check the cart daily to make sure there is nothing old in it." When asked about the expired Humalog for Resident # 47 being available in the medication cart, LPN # 2 stated that they didn't know how it got into the medication cart.

The comprehensive care plan for Resident # 47 with a revision date of 10/01/2019 documented in

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part, "Diabetic Needs: Resident is at risk for hypo/hyperglycemia [high and low blood sugar] episodes R/T [related to]: NIDDM [non-insulin-dependent diabetes mellitus]. Revision on: 10/01/2019." Under "Interventions" it documented in part, Diet as directed. Date Initiated: 10/01/2019."

Review of the EHR [electronic health record] for Resident # 47 revealed a "Discontinue Order." The order documented, "Humalog. Discontinue Date: 9/30/2019."

On 02/13/20 at 10:27 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked what standard the facility follows, ASM # 2 stated, "We follow Lippincott and our policies and procedures."

The "Name of Manufacturer's] Information Sheet" for Humalog documented in part, "16.2 Storage and Handling. 3mL [three milliliter]. In-Use (Opened) Room Temperature (Below 86 F [degrees Fahrenheit] 28 days, refrigerated/room temperature."

The facility's policy "Discontinued Medications" documented in part, "Policy: When a medication is discontinued, the medication will be sent back to pharmacy or destroyed. Procedure: Nurse discontinuing the medication will remove the medication from the cart."

On 02/12/2020 at 6:00 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of clinical services and RN [registered nurse] # 1, assistant director of nursing were made aware of

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F 761	Continued From page 49 the above findings. No further information was provided prior to exit. References: (1) A rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f . [2] A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		

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(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review it was determined facility staff failed to store food in a sanitary manner and discard food past its expiration date in two of two facility nourishment rooms observed.

The findings include:

On 2/11/20 at 3:15 p.m., an observation was made of the South unit nourishment room was conducted with ASM (administrative staff member) #2, the director of nursing. Observation of the refrigerator revealed a white paper bag inside of the bottom drawer. There was no name or date observed to be on the bag. Upon inspection by ASM #2 it was determined that the bag contained a white Styrofoam bowl with "potato" written on the lid. The bowl was observed to not contain a date or name on it. Further observation of the drawer revealed a second white paper bag without a date or a name. Upon inspection by ASM #2 it was determined that the bag contained a white Styrofoam bowl with "vegetable beef" written on the lid. The bowl was observed to not contain a date or name on it. Three plastic deli bags without a date or name on the packaging were located in the drawer of the refrigerator underneath the white plastic bags. The plastic deli bags were observed to contain German bologna with a use by date of 1/26/20 on the

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package label, marble cheese with a use by date of 1/25/20 on the package label and liverwurst with a use by date of 1/26/20 on the package label.

When asked about the paper bags containing the Styrofoam bowls ASM #2 stated that it could not be determined who the food belonged to or when it was placed in the refrigerator because it did not have a date or a name on it. ASM #2 stated that the food should be discarded because it could not be determined how long it had been in the refrigerator. When asked about the plastic deli bags which contained the German bologna, marble cheese and liverwurst ASM #2 stated that it could not be determined who the food belonged to or when it was placed in the refrigerator because it did not have a date or name on it. ASM #2 stated that the deli bag contents were past their dates and should be discarded. When asked which staff is responsible for the nourishment room, ASM #2 stated that dietary staff stock the snacks and drinks in the refrigerators for all resident use and that the nursing staff handle any resident food that is brought into the facility. ASM #2 stated that the nursing staff are to label all outside food brought in with the resident name and the date that it is brought in. ASM #2 stated that the food is kept for three days. ASM #2 stated that the refrigerator is supposed to be checked by the nurses every night on the night shift and anything that is not dated or past its expiration date is disposed of. ASM #2 discarded the soups, bologna, liverwurst and marble cheese.

On 2/11/20 at 3:30 p.m., an observation of the North unit nourishment unit was conducted with ASM #2. Observation of the refrigerator revealed

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one 5.3 ounce container of orange cream yogurt with the date Dec 16 2019 (December 16, 2019) on the container, one 5.3 ounce container of strawberry yogurt with the date Dec 29 2019 (December 29, 2019) on the container, two 5.3 ounce containers of blueberry yogurt with the date Jan 05 2020 (January 5, 2020) and two 5.3 ounce containers of cherry yogurt with the date Dec 27 2019 (December 27, 2019) on the container. The containers were observed to contain a name of a resident of the facility.

When asked about the yogurt containers and the date on the containers ASM #2 stated that the date was the expiration date and that they all should have been discarded and the resident that they belonged to should have been notified that they were being discarded. ASM #2 discarded the yogurt containers. ASM #2 stated that the refrigerators should be checked by the nurses every night on the night shift and anything that is not dated or past its expiration date be disposed of.

The facility policy "Food Brought in From Outside the Facility, Effective Date: November, 2016, Date Revised: February 25, 2019" documented in part, "The container will be labeled with name of food item and Resident name, dated, and placed in an appropriate non-dietary refrigerator (floor/unit fridge, neighborhood fridge, activities fridge ....Food dated by facility staff will be discarded within seven days from the date mark, with the exception of condiments, see dietary department for clarification."

On 2/12/20 at approximately 5:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and

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F 812	Continued From page 53 ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 812		
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: §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	F 880		

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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.

§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 resident interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed to implement infection control practices to prevent the development and spread of infection for two

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of 42 residents in the survey sample, Resident #23 and Resident #42. Resident #73's incentive spirometer was observed stored in an unsanitary manner. The spirometer was observed uncovered on the residents over the bed table during separate observations. Resident #42's catheter bag was observed resting directly on the floor during separate observations.

The findings include:

1. Resident # 23 was admitted to the facility with diagnoses that included but were not limited to: pulmonary edema [2], chronic obstructive pulmonary disease [3].

Resident # 23's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/06/19, coded Resident # 23 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 23 was coded as requiring supervision of one staff member for activities of daily living.

On 02/11/20 at 11:40 a.m., and at 1:00 p.m., and on 02/12/20 at 8:10 a.m., observations of Resident #23's room revealed an incentive spirometer on the over-the-bed table uncovered.

The "Physician's Order Sheet" for Resident # 23 dated "02/122020" failed to evidence the use of an incentive spirometer.

The comprehensive care plan for Resident # 23 with a revision date of 07/19/2019 failed to evidence documentation addressing the use of an incentive spirometer.

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On 02/12/20 at 9:36 a.m., an interview with Resident # 23. When asked about the incentive spirometer Resident # 23 stated, "I use it almost every day I have COPD [chronic obstructive pulmonary disease]."

On 02/12/2020 at 12:55 p.m., an interview and observation was conducted with LPN [licensed practical nurse] # 3. When asked if a spirometer is a piece of respiratory equipment, LPN # 3 stated yes. When asked how it should be stored when not in use, LPN # 3 stated it should be in a bag and dated. At this time LPN # 3 was accompanied to Resident # 23's room. After observing the uncovered incentive spirometer on Resident # 23's over-the-bed table LPN # 3 stated that the incentive spirometer should have been placed in a bag." When asked why it was important to store the incentive spirometer in a bag, LPN # 3 stated that it could cause a respiratory infection if it was not stored in a bag.

On 02/13/20 at 10:27 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked what standard of practice the facility follows, ASM # 2 stated, "We follow Lippincott and our policies and procedures."

"Wash the mouthpiece in warm water and dry it. Avoid immersing the spirometer itself in water because water enhances bacterial growth and impairs the internal filter's effectiveness in preventing inhalation of extraneous material. Place the mouthpiece in a plastic storage bag between exercises, and label it and the spirometer, if applicable, with the patient's name to avoid inadvertent use by another patient. Keep

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the incentive spirometer within the patient's reach." Lippincott's Nursing Procedures (6th Edition) 2013.

On 02/12/2020 at 6:00 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of clinical services and RN [registered nurse] # 1, assistant director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.

(2) An abnormal buildup of fluid in the lungs. This buildup of fluid leads to shortness of breath. This information was obtained from the website: https://medlineplus.gov/ency/article/000140.htm.

(3) 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.

2. Resident # 75 was admitted to the facility with diagnoses that included but were not limited to: sacral [tail bone] pressure ulcer and obstructive uropathy [2].

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Resident # 75's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/31/2020, coded Resident # 75 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 75 was coded as requiring extensive assistance of one staff member for activities of daily living. Section H "Bladder and Bowel" coded Resident # 75 as having an indwelling catheter.

On 02/11/20 at 11:46 a.m., an observation of Resident # 75 revealed the resident in bed. Observation of the bed revealed a catheter collection bag hanging on the right side of the bed resting on the floor. Observation of the catheter collection bag revealed that it had a privacy flap covering the front of the collection bag. Further observation revealed a CNA [certified nursing assistant] # 1 entered Resident # 75's room during this observation per the request of Resident # 75. CNA # 1 came into the room and readjusted Resident # 75's sheet and blanket on both sides of the bed and did not reposition the catheter collection bag.

On 02/11/20 at 12:59 p.m., an observation of Resident # 75 revealed the resident lying in bed. Observation of the bed revealed a catheter collection bag hanging on the right side of the bed resting on the floor. Observation of the catheter collection bag revealed that it had a privacy flap covering the front of the collection

On 02/12/20 at 8:10 a.m., an observation Of Resident # 75 revealed the resident lying in bed. Observation of the bed revealed a catheter

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collection bag hanging on the right side of the bed resting on the floor.

The POS [physician's order sheet] for Resident # 75 dated 02/12/2020 documented in part, "Foley catheter size 16 F [French] with a 30ml [milliliter] Balloon. Related to pressure ulcer. Order date: 08/09/2019."

The comprehensive care plan for Resident # 75 dated 05/10/2019 documented in part, "Focus: Foley catheter: Obstructive uropathy. The resident has Indwelling Catheter (16F w [with]/30cc [cubic centimeter] balloon): R/T [related to] obstructive uropathy; hip and sacral pressure ulcers." Under "Interventions" it documented in part, "Position catheter bag and tubing below the level of the bladder. Revision on: 05/10/2019."

On 02/12/20 at 12:44 p.m., an interview and observation of Resident # 75's catheter collection bag was conducted with CNA [certified nursing assistant] # 1. When asked to describe the position a catheter collection bag should be placed in, CNA # 1 stated that it should be positioned on side of bed, at the lower end of the bed, below the bladder, off the floor and covered. When asked why it was important to keep the catheter collection bag off the floor, CNA # 1 stated, "Its unsanitary could cause an infection." After observing the position of Resident # 75's catheter collection bag, CNA # 1 stated that it was touching the floor and immediately raised the bed to keep the bag off the floor.

02/13/20 at 10:27 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked

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what standard of practice the facility follows, ASM # 2 stated, "We follow Lippincott and our policies and procedures."

According to Fundamentals of Nursing Lippincott Williams and Wilkins Eighth Edition 2006, Lippincott Company, page 757, titled Renal and Urinary Disorders, under the heading "Management of a Patient with an Indwelling Catheter and Closed Drainage System" the subheading: "Maintaining a closed drainage system: 2. Maintain an unobstructed urine flow. b. Urine should not be allowed to collect in tubing because free flow of urine must be maintained to prevent urinary tract infection. Improper drainage occurs when the tubing is kinked or twisted, allowing pools of urine to collect in the tubing. c. Keep the bag off the floor to prevent bacterial contamination."

On 02/12/2020 at 6:00 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional director of clinical services and RN [registered nurse] # 1, assistant director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm.

[2] A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was

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