STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey along with a complaint survey, for CI MS # 16071 related to an elopement, from 07/16/19 through 07/19/19. The SA did not substantiate the complaint CI MS #16071 for the facility's self-reported incident for an elopement. The SA did not cite any deficiencies related to the complaint. However, during the survey the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited regulatory deficiencies F623, F641, F645, F656, F690, F759, and F880. The census at the time of the survey entrance was 46, and the facility was licensed for 98 beds.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		8/23/19

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

Electronically Signed | 08/13/2019

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F 623	Continued From page 1 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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F 623	Continued From page 2 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to provide Resident #41 and/or the Resident's	F 623	This Plan of correction does not constitute an admission or agreement by the provider, Sunplex Subacute Center, of	

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F 623	Continued From page 3 Representative (RR), a written notification of a resident's transfer to an acute care facility for one (1) of three (3) resident hospitalizations reviewed. Findings include: Review of the facility's policy titled, "Notice of Transfer and/or Discharge," dated November 23, 2016, revealed it is the policy of this facility to provide residents , and/or the residents' representatives (sponsors), with a written notice of a transfer or discharge. The facility policy stated this policy applies to transfers or discharges initiated by the facility. The facility policy stated that by definition, transfer or discharge included movement of a resident to a bed outside of the certified facility, whether that bed is in the same physical plant or not. Review of an untitled document in Resident #41's medical record documentation, revealed a verbal order dated 4/15/2019. The verbal order was given to the facility by Resident #41's Nurse Practitioner (NP). The telephone order in Resident #41's medical record documentation stated the resident was to be transferred to the hospital related to (R/T) critical labs (platelets). Review of an untitled document in Resident #41's medical record documentation, revealed a telephone order dated 4/27/2019. The telephone order was given to the facility by Resident #41's primary physician. The telephone order in Resident #41's medical record documentation stated the resident was to be transferred to the hospital for rectal bleeding. Review of an untitled document in Resident #41's medical record documentation, revealed a	F 623	the truth of the facts alleged or conclusion set forth in this Statement of Deficiencies. This plan of correction has been respectfully developed solely because it is required by State and Federal Law. " Resident #41 was provided a corrected Notice of Transfer by the Nursing Home Administrator on 7/18/19. The Ombudsman was notified by the Nursing Home Administrator previously regarding resident #41 transfers to the hospital per the facility transfer/discharge log. The Nursing Home Administrator (NHA) in-serviced the Business Office Manager on the correct form to use upon a resident being transferred or discharged to the hospital on 7/18/19. " The facility recognizes that all residents that are transferred to the hospital could be affected by the same deficient practice. All residents that have been transferred/discharged out of the facility in the past 60 days, total of eighteen (18) were audited on 8/14/19 by the Nursing Home Administrator to ensure the proper transfer/discharge form was completed upon transfer. Eighteen (18) were found to not be properly completed and were completed on 8/20/19 by the Business Office Manager and provided to the resident and/or resident representative. " The Business Office Manager (BOM) has instituted using the correct form upon transfer/discharge to the hospital as of 7/18/19. The BOM will mail or hand delivered the Notice of Transfer to the Resident or the Responsible Party. The	

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F 623	Continued From page 4 telephone order dated 6/18/2019. The telephone order was given to the facility by Resident #41's primary physician. The telephone order in Resident #41's medical record documentation stated to transfer to the er (Emergency Room) for rectal bleeding. During an interview, on 7/18/2019 at 11:36 AM, the Administrator revealed the written notice of transfer to an acute care facility for Resident # 41's hospitalizations, were not completed as required. The Administrator stated the staff member responsible had been in-serviced and provided with the correct form and instructions. Review of the Face Sheet revealed Resident # 41 was admitted by the facility, on 8/14/2017 and re-admitted to the facility on 4/29/2019, with diagnoses to include Gastrointestinal Hemorrhage and Myelodysplastic Syndrome.	F 623	Business Office Manager will maintain a copy of the transfer form in a tracking notebook and a copy in the Resident s financial folder. The NHA will send the transfer/discharge tracking log (provided by the State of Mississippi)to the State Ombudsman on a monthly basis, indicating the use of the correct form and when the notice was provided. All discharges/transfers will be reviewed daily in standup meeting to ensure the BOM is aware of all discharges/transfers requiring a notice to be given. " The NHA will audit the completion of the Transfer Notice on a weekly basis for 12 weeks, starting 8/5/19, to ensure all residents transferred/discharged to the hospital have been provided the correct notice. The NHA will bring the results of the Notice of Transfer/Discharge Audit to the monthly Quality Assurance Performance Improvement Committee for review, revision, and/or resolution.	
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. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to have an accurate assessment for a resident with a diagnosis of a mental disorder for one (1) of sixteen (16) residents reviewed, Resident #38. Findings Include:	F 641	• The Minimum Data Set (MDS) for Resident #38 Admission Assessment Section A1500 was corrected to reflect the resident does have a serious mental illness/or intellectual disability or a related condition, and resubmitted on 8/7/19 by the Minimum Data Set (MDS)	8/23/19

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F 641	Continued From page 5 Review of the facility's policy titled , "Resident Assessment Using the MDS", revised on March 2019, revealed each discipline will use the computerized audit system for their assigned section of the Minimum Data Set (MDS) to ensure accuracy prior to submission. Record review of the Admission Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 3/14/19, revealed under section 15950 "Yes" was documented for Psychotic disorder and Anxiety under section 15700 for Psychiatric/Mood Disorder. Section A1500 was coded zero (0) which indicated Resident #38 did not have a serious mental illness/or intellectual disability or a related condition. Review of the Level I Pre-Admission Screening and Resident Review (PASSAR) completed, on 3/6/19, for Resident #38, noted a Level II was not indicated. On 07/17/19 at 3:15 PM, an interview with Licensed Practical Nurse (LPN #2)/MDS Coordinator revealed she was not real sure what the guidelines for the PASARR Level II are, but confirmed the resident has a diagnosis which included Delusional Disorder with Paranoia and Histrionic Personality Disorder, and was admitted with these diagnoses, and no Level II was done. LPN #2/MDS Coordinator confirmed the PASARR, dated of 3/6/19, noted a Level II was not indicated, thus was inaccurate. In an interview with the Social Service Director, on 7/17/19 at 3:30 PM, she confirmed Resident #38's PASARR, dated 3/6/19, indicated Resident #38 had a diagnosis of Delusional Disorder with	F 641	Coordinator. • The facility recognizes that all residents with a serious mental illness/or intellectual disability or a related condition have the potential to be affected by the same deficient practice. On 8/13/19 the Regional Nurse Consultant a Registered Nurse initiated an audit for 100%, fifty-two (52), of current resident's most recent comprehensive MDS Section A1500 ensuring all have been properly coded. Section A1500 was corrected/updated by the Regional Nurse Consultant to reflect the resident does have a serious mental illness/or intellectual disability or a related condition for 11 residents. • The Regional Nurse Consultant in-serviced both MDS Coordinators on 8/12/19 on proper coding the MDS Section A1500. • The Director of Nurses (DON) will audit all newly completed MDS, Section A1500 for 12 weeks to ensure proper coding of section A1500 starting 8/10/19. The Director of Nursing will bring the results of the Section A1500 audit to the monthly Quality Assurance Performance Improvement Committee for review, revision, and/or resolution.	

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F 641	Continued From page 6 Paranoia and Histrionic Personality Disorder. Review of the Face Sheet revealed facility admitted Resident #38, on 3/4/19, with diagnoses which included Delusional Disorder, Histrionic Personality Disorder, Anxiety, Stage III Chronic Kidney Disease, Hypertension (High Blood Pressure) and Amnesia. Review of the Admission MDS, with the ARD of 3/11/19, revealed Resident #38 scored an eight (8) on the Brief Interview for Mental Status (BIMS) that indicated moderate cognitive impairment.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645		8/23/19

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F 645	Continued From page 7 intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).	F 645		

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F 645	Continued From page 8 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to do a Level II screening for Resident #38 with a diagnosis of mental disorder, for one (1) of six (6) resident's PASSAR reviews. Findings include: Record review revealed the Admission Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 3/14/19, for Resident #38 revealed under section 15950 "Yes" was documented for Psychotic disorder and Anxiety under section 15700 for Psychiatric/Mood Disorder. Section A1500 documented zero (0) which indicated Resident #38 does not have a serious mental illness/or intellectual disability or a related condition. The Level I PASSAR completed, on 3/6/19, noted a Level II was not indicated. During an interview with the MDS Coordinator/ Licensed Practical Nurse #2, on 07/17/19 3:15 PM, she stated she was not real sure what the guidelines for the PASARR Level II are, but confirmed the resident has a diagnosis which included Delusional Disorder with Paranoia and Histrionic Personality Disorder and was admitted with these diagnoses. LPN #2 stated no Level II was done. LPN #2 confirmed the PASARR, with the date of 3/6/19, noted a Level II was not indicated. In an interview, on 7/17/19 at 3:30 PM, the Social	F 645	• The Social Services Director (SSD) updated and submitted Resident #38 Pre-Admission Screening and Resident Review (PASARR) to request a Level II Screening on 7/31/19. • The facility recognizes that all residents admitted with a mental disorder and/or an intellectual disability has the potential to be affected by the same deficient practice. On 8/12/19 the SSD audited all current residents with a mental disorder and/or intellectual disability residents, which were twelve (12) to ensure those needing a PASARR and Level II have been completed. All twelve (12) residents had a new PASARR performed requesting a Level II determination. • The Nursing Home Administrator (NHA) in-serviced the SSD on completing an accurate PASARR for residents admitted with a mental disorder and/or intellectual disability on 8/1/19. All new admissions will have a diagnosis review upon admission Monday-Friday by the Minimum Data Set Nurse and the SSD to ensure that all PASARRs are completed for residents requiring a level II. All new admissions from Saturday and Sunday will be reviewed on the following Monday by the MDS nurse and SSD. All PASARR forms will be completed by the SSD at the	

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F 645	Continued From page 9 Service Director (SSD), confirmed Resident # 38's PASARR, dated 3/6/19, noted that a Level II was not indicated, and the resident had a diagnosis of Delusional Disorder with Paranoia and Histrionic Personality Disorder. The SSD stated she was not sure if it was needed, and confirmed it was not done. Review of the Face Sheet revealed the facility admitted Resident #38, on 3/4/19, with the Diagnoses which included Stage III Chronic Kidney Disease, Delusional Disorder, Anxiety, Histrionic Personality Disorder, Hypertension (High Blood Pressure) and Amnesia. Review of the Admission MDS, with the ARD of 3/11/19, revealed Resident #38 scored an eight (8) on the Brief Interview for Mental Status (BIMS) that indicated moderate cognitive impairment.	F 645	time of diagnosis review. • The NHA will audit all new PASARR forms to ensure a Level II screening has been requested for those newly admitted residents requiring a Level II on a weekly basis for 12 weeks starting 8/10/19. The NHA will bring the results of the PASARR Level II request audit to the monthly Quality Assurance Performance Improvement Committee for review, revision, and/or resolution.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		8/23/19

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F 656	Continued From page 10 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to follow the Comprehensive Care Plan one (1) of twenty (20) care plans reviewed, for Resident #36. Findings include: Record review of the facility's policy titled, "Comprehensive Care Plan Policy", no date, revealed it is the policy of this facility to develop comprehensive care plan for each resident that includes measurable objectives and timetables to	F 656	• Resident #36 was assessed by the Wound Care Registered Nurse on 7/18/19 for any negative physical findings related to Certified Nursing Assistant (CNA) #1 not following the care plan during catheter care with no negative findings noted. Proper catheter care was performed for Resident #36 by the Wound Care Resident Nurse on 7/18/19. CNA #1 was in-serviced on 7/18/19 by the Director of Nursing related to following the care plan and policy for proper cleaning during	

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F 656	Continued From page 11 meet the resident's medical, nursing and psychological needs. Record review of the Comprehensive Care Plan, dated 7/5/2019, revealed Resident #36 had an indwelling Foley catheter related to Obstructive Uropathy and pressure ulcer to the coccyx. The goal stated Resident #36 will be/remain free from catheter-related trauma. Interventions included: Indwelling Foley catheter care each shift with water and peri wipes. During an observation, on 7/18/19 at 12:21 PM, Certified Nursing Assistant (CNA) #1 provided Resident #36's catheter care. Observations revealed CNA #1 failed to rotate the wipes while providing the catheter care, failed to change the area of the wipe while cleaning the penis, and to secure the tip of catheter to prevent trauma to the meatus as she wiped from the meatus towards the end of the catheter tubing. During an interview, on 07/19/19 at 9:44 AM, CNA #1 confirmed she failed to secure the tubing while cleaning the catheter tubing. CNA # 1 said she thought she rotated the wipes, but she was nervous. During an interview, on 07/19/19 at 9:53 AM, Licensed Practical Nurse (LPN) #3/Care Plan Nurse revealed she expected the CNAs to perform catheter care according to the professional standards. A review of the facility's Face Sheet revealed the facility admitted Resident #36, on 05/14/2019, with diagnoses which included Urinary Tract Infection , Acute Cystitis with Hematuria, Obstructive Uropathy and Pressure Ulcers .	F 656	catheter care and proper securing of the tip of the catheter while performing catheter care. • The facility recognizes that all residents with catheters, two (2), could have the potential to be affected by the same deficient practice. Two (2) residents with catheters had catheter care observed by the Wound Care Director of Nursing on 7/18/19 to ensure that proper catheter care was provided per care plan with no concerns noted. Care plans for the two (2) residents were reviewed for accuracy on 7/18/19 by the Minimum Data Set Licensed Practical Nurse with no updates or changes made. • The Director of Nursing (DON) in-serviced all nursing staff on providing proper catheter care and following the care plan on 8/9/19. All care plans will be updated with any new orders regarding catheters. Any catheter care for residents will be communicated to the staff by the task section in the computer system that reflects the current care plan to ensure that the care plan for catheter care is followed. • The Transitional Care Unit Registered Nurse will observe and document catheter care per care plan for one (1) resident twice a week for 4 weeks, then once a week for eight (8) weeks to ensure proper catheter care is being performed per care plan beginning 8/19/19. The Transitional Care Unit Registered Nurse will bring the results of the catheter care observations to the monthly Quality Assurance Performance Improvement Committee for review, revision, and/or resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. BUILDING _____ B. WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

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F 656	Continued From page 12 A review of Resident #36's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/25/2019, revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident is cognitively impaired.	F 656		
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 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	F 690		8/23/19

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F 690	Continued From page 13 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, record review and facility policy review, the facility failed to provide catheter care in a manner to prevent the possibility of trauma to the urethra and a Urinary Tract Infection for one of three (1 of 3) residents reviewed for catheters and catheter care observations, Resident #36 Findings include: Record review of the facility's policy titled, "Catheter Care, Urinary", dated August 25, 2014 revealed the steps in the procedure for male residents included to use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. Use clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. An observation, on 07/18/19 at 12:21 PM, revealed Certified Nursing Assistant (CNA) #1 provided Resident #36's catheter care. Observations during the catheter care revealed CNA #1 failed to rotate the wipes. CNA #1 failed to change the area of the wipe while cleaning the	F 690	• Resident #36 was assessed by the Wound Care Registered Nurse on 7/18/19 for any negative physical findings related to Certified Nursing Assistant (CNA) #1 not providing catheter care in a manner to prevent the possibility of trauma to the urethra and a Urinary Tract Infection with no negative findings noted. Proper catheter care was performed for Resident #36 by the Wound Care Resident Nurse on 7/18/19. CNA #1 was in-serviced on 7/18/19 by the Director of Nursing regarding the policy for proper cleaning during catheter care and proper securing of the tip of the catheter while performing catheter care. • The facility recognizes that all residents with catheters, two (2), could have the potential to be affected by the same deficient practice. Two (2) residents with catheters had catheter care observed by The Wound Care Registered Nurse on 7/18/19 to ensure that proper catheter care was provided with no concerns noted. • The Director of Nursing (DON) in-serviced all nursing staff on providing proper catheter care on 8/9/19. New catheter care check offs for all CNAs were initiated on 8/15/19 by the Director of Nursing, Transitional Care Manager	

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F 690	Continued From page 14 penis. CNA #1 also failed to secure the tip of the catheter to prevent trauma to the meatus. During an interview, on 07/19/19 at 9:44 AM, (CNA) #1 confirmed she failed to secure the tubing while cleaning the catheter tubing. CNA # 1 said she thought she rotated the wipes, but she was nervous. Record review of the facility's training titled, Post Test Catheter Care, revealed Certified Nursing Assistant (CNA) #1 was trained on catheter care on 6/29/18. Record review of Resident #36's Lab Report, dated 6/25/2019, revealed a Urine Culture and Sensitivity (C&S) report was positive for Vancomycin Resistant Enterococcus (VRE). Record review of the Physicians Orders revealed an order, dated 7/1/19, for Contact Precautions due to VRE in the Urine During an interview, on 07/19/19 at 9:48 AM the Director of Nursing (DON) confirmed CNA #1 should have rotated the wipes while performing Resident #36's catheter care. The DON also said CNA #1 should have secured the tip of the tubing while performing catheter care. The DON said the resident could develop infections when appropriate catheter care is not provided. A review of the Face Sheet revealed the facility admitted Resident #36, on 05/14/2019, with diagnoses which included Urinary Tract Infection, Acute Cystitis with Hematuria and Pressure Ulcers . A review of Resident #36's Quarterly Minimum	F 690	Registered Nurse, the Minimum Data Set Licensed Practical Nurse, and the Wound Care Registered Nurse. A catheter care education packet with a post-test was initiated for all CNAs on 8/9/19 by the Director of Nursing. All newly hired CNAs will complete a catheter care check-off, education packet and post-test prior to performing any catheter care in the facility. • The Transitional Care Unit Registered Nurse will observe one resident and document an audit for catheter care twice a week for four (4) weeks, then once a week for eight (8) weeks to ensure proper catheter care is being performed beginning 8/19/19. The Transitional Care Unit Registered Nurse will bring the results of the catheter care observations to the monthly Quality Assurance Performance Improvement Committee for review, revision, and/or resolution.	

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F 690	Continued From page 15 Data Set (MDS), with an Assessment Reference Date (ARD) of 6/25/2019, revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident is cognitively impaired.	F 690		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to maintain a medication error rate of less than five (5) percent as evidenced by two medication administration errors were identified out of 34 medication administration opportunities. The medication error rate was 5.88%. The Licensed Practical Nurse (LPN) failed to administer the correct dose of Sodium Bicarbonate to Resident #197, and Pred Forte eye drops to Resident #29. Findings include: Review of the facility's policy titled, "Medication Administration-General Guidelines", dated November 1, 2008, revealed for Administration: Medications are administrated in accordance with written orders of the attending physician. Resident #197 An observation during the medication pass, on 7/18/19 at 10:15 AM, revealed Licensed Practical	F 759	• Resident # 197 was administered the second Sodium Bicarbonate 650 milligrams by LPN #1 on 7/18/19. The physician for resident #29 was informed by the Director of Nursing (DON) of providing resident #29 two (2) drops of Pred Forte versus one drop as ordered by the physician with no new orders given on 7/18/19. Resident #197 was assessed by the Director of Nursing on 7/18/19 for any negative physical findings related to the medication error with no negative findings noted. Resident #29 was assessed on 7/18/19 by the Director of Nursing for any negative physical findings related to the medication error with no negative findings noted. LPN #1 was immediately in-serviced by the Director Of Nursing on 7/18/19 regarding administering medications as ordered by the physician. • The facility recognizes that all residents could be affected by the same deficient practice. On 8/19/19 the	8/23/19

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F 759	Continued From page 16 Nurse (LPN) #1 gave one (1) Sodium Bicarbonate 650 milligram (mg) by mouth to Resident #197. An interview with Licensed Practical Nurse (LPN) #1, on 7/18/19 at 10:15 AM, after the medication administration for Resident #197, revealed she had finished giving medications to this resident, and was asked what the MAR showed for the Sodium Bicarbonate. LPN #1 confirmed she only gave one (1) tablet and not two (2) per the MAR. LPN #1 stated, "I just didn't see that". Review of the Physician Orders for Resident #197 revealed an order, dated 7/17/19, for Sodium Bicarbonate 650 mg two (2) to be given twice a day by mouth. Review of the Medication Administration Record (MAR) for July 2019 revealed Resident #197 received Sodium Bicarbonate 650 mg 2 (two) given by mouth twice a day. Resident #29 During the medication pass observation, on 7/18/19 at 10:29 AM, LPN #1 was observed to administer two (2) drops of Pred Forte eye drops into Resident #29's right eye. An interview, with LPN #1 on 7/18/19 at 10:29 AM, confirmed she administered two (2) drops of Pred Forte to Resident #29's right eye, and stated when reviewing the MAR she didn't see that it was one (1) drop instead of two (2). Review of the July 2019 Physician Orders for Resident #29 revealed an order, dated 6/14/19, for Pred Forte one (1) drop to the right eye four	F 759	morning medication pass was observed by the Transitional Care Unit Registered Nurse and the Director Of Nursing for all residents (fifty (50) residents) to ensure that all medications were administered as ordered by the physician with no concerns noted. • The DON has in-serviced all nurses on following medication orders to ensure all medications are administered as ordered by the physician on 8/10/19. Medication pass check-offs for all nurses initiated on 8/19/19 by the Director of Nursing and the Transitional Care Unit Register Nurse to ensure all nurses in the facility are educated on correct medication pass. All newly hired nurses will complete all medication pass check-offs prior to providing any resident care without another nurse present. • The DON and Transitional Care Unit Registered Nurse will perform an eye drop medication pass weekly and one (1) additional random medication pass observation weekly. This audit is for one (1) resident that has eye drops and an addition resident for a medication administration pass weekly for 12 weeks to ensure proper delivery of eye drop medication and proper administration of medications to residents, beginning 8/19/19. The DON and the Transitional Care Unit Registered Nurse will bring the results of their audit to the monthly Quality Assurance Performance Committee for review, revision, and/or resolution.	

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F 759	Continued From page 17 (4) times a day. Review of the MAR for Resident #29 revealed Pred Forte for one (1) drop to be given to the right eye four (4) times a day.	F 759		
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;	F 880		8/23/19

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F 880	Continued From page 18 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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 observation, staff interview, record review and facility policy review, the facility failed to provide wound care in a manner to prevent the possible spread of infection for one (1) of four (4)	F 880	• Resident #36 was assessed for any negative physical findings related to not providing wound care in a manner to prevent the spread of infection by the	

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F 880	Continued From page 19 wound care observations, for Resident # 36. Findings Include: Record review of the facility's Infection Prevention and Control policy titled, "Hand Hygiene", dated 10/27/17, revealed hand Hygiene is performed to reduce the risk of transmission of infection by appropriate hand hygiene. 5 moments for hand hygiene: Before touching a patient, Before clean/aseptic procedures, After body fluid exposure risk, after touching a patient, and after touching patient surroundings. Observation, on 07/18/19 at 12:39 PM, of wound care provided by Registered Nurse (RN) #2 revealed she left the room to get a tongue blade. On her return to the room, RN #2 failed to wash her hands, and applied gloves RN #2 applied santyl inside the sacral wound with the tongue blade, covered the wound with an abdominal pad and dry dressing. During an interview, on 07/18/19 at 3:42 PM, (RN) #2 confirmed she did not wash her hands when she returned to the room. RN #2 also confirmed Resident #36 did have Methicillin-Resistant Staphylococcus Aureus (MRSA) in the wound. RN# 2 said she should have washed her hands to prevent further infection. Record review of the facility's training titled, Medication Administration/Wound Care, dated 2/9/2019, revealed Registered Nurse (RN) #2 was in-serviced on wound care. Record review of the facility's July 2019 Physician Orders revealed an order, dated 7/3/19, for the	F 880	Wound Care Registered Nurse on 7/18/19 with no negative findings noted. The Director of Nursing (DON) in-serviced Registered Nurse (RN) #2 on proper hand washing during wound care and frequency of handwashing for infection control purposes as of 7/18/19. Resident #36 wound care was performed in the proper manner by The Wound Care Registered Nurse on 7/19/19. • The facility recognizes that all residents eighteen receiving wound care could be affected by the same deficient practice. On 7/19/19 all wound care for residents with wound care orders were observed by Director of Nursing to ensure all wound care was provided in a manner to prevent the spread of infection with no concerns noted. • The DON has in-serviced all nursing staff on proper hand washing during wound care and hand washing frequency as of 8/10/19. Regional Nurse Consultant Registered Nurse provided one on one education to RN #2 regarding proper handwashing to prevent the spread of infection during wound care on 8/14/19. Annual check off/education by the DON for handwashing and wound care will be changed to twice yearly for the wound care nurse. • The DON will observe and audit one (1) wound care treatment weekly for 12 weeks to ensure proper hand washing during wound care to the resident beginning 8/19/19. The DON will bring the results of the audit to the monthly Quality Assurance Performance Committee for review, revision, and/or resolution.	

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F 880	Continued From page 20 resident to be on Contact Isolation due to a Methicillin /Resistant Staph Aureus (MRSA) infection in the sacral wound. Record Review of Resident #36 Lab Reports revealed a Wound Culture and Sensitivity (C&S), dated 6/28/2019, Methicillin /Resistant Staph Aureus (MRSA) in the sacral wound. Review of the July 2019 Physician's Orders revealed an order dated 7/16/19 for Vancomycin HCL solution use 1 gram intravenously one time a day for Methicillin Resistant Staphylococcus Aureus (MRSA) in the wound. Record review of the Care Plan revealed Resident #36 has a pressure ulcer and is at risk for pressure ulcer r/t dehydration. Intervention: Administer medications as ordered, administer treatment as ordered and monitor for effectiveness, assess/record/monitor wound healing. measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to Medical Doctor. Observe dressing to ensure it is intact and adhering, report lose dressing to treatment nurse. Observe nutritional status. Serve diet as ordered, observe intake and record. During an interview, on 07/18/2019 at 4:00 PM the Director of Nurses (DON) confirmed the wound nurse should have washed her hands when she came back into the room. The DON also said this could cause the wound to become infected.	F 880		

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	255244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/17/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 08/05/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments ********** Survey conducted on 07/17/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 08/05/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.