STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	1530 BROAD AVE GULFPORT, MS 39501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey from 3/5/19 through 3/8/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F 640, F 656, F 658, F 686, F 690, F 761, and F 880. At the time of the survey, the census was 143 and the facility held a license for 180 beds.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		4/30/19

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

Electronically Signed | 04/10/2019

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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F 640	Continued From page 1 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, facility statement review, and staff interview, the facility failed to submit the Minimum Data Set (MDS) assessment within seven (7) days after completion of Resident #67's MDS assessment. This concern was identified for one (1) of 31 MDS assessments reviewed. Findings include: Review of a typed statement on the facility's letterhead, dated 03/08/19 and signed by the Administrator, revealed: "The Boyington Health and Rehabilitation utilizes the RAI (Resident	F 640	Corrective Action: Registered Nurse (RN) #4 locked and transmitted the assessment on 3/8/19. RN #4 was in-serviced by Director of Nursing (DON) on 3/8/19 on requirements of completion of Minimum Date Set Assessments (MDS) per Resident Assessment Instrument (RAI) manual. A Performance Improvement Plan was initiated by the DON on 1/18/19 to address the late assessment.	

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F 640	Continued From page 2 Assessment Instrument) manual for MDS (Minimum Data Set) assessments and guidelines for completion of MDS." Record review revealed Resident #67 was admitted by the facility on 10/13/18, and was discharged on 10/14/18. Resident #67 had a one (1) day stay at facility. Review of the Casper Report revealed the MDS, with the target date of 10/14/18, was not submitted and accepted until 1/31/19. An interview, on 03/08/19 at 9:12 AM, revealed RN #1 stated, "I saw that it was late when I returned from maternity leave. RN #4 did the assessment while I was out and she closed it, but did not lock it. I saw it and transmitted it 120 days late. I use the RAI manual for coding the MDS". An Interview, on 03/08/19 at 9:06 AM, with the Director of Nursing (DON) revealed the MDS assessment was submitted late. The DON stated it was identified, corrected, and we put it on our Quality Assessment and Assurance Concern (QAPI). The DON stated Registered Nurse (RN) #4 was filling in for RN #1 due to our regular MDS Nurse was on maternity leave. The DON stated RN #4 did the assessment, but failed to lock it in, and when RN #1 returned to work she found the error and corrected it by submitting the assessment. We knew it was late, but we submitted it anyway. An interview, on 03/08/19 with 9:15 AM, revealed RN #4 stated, "I was doing MDS while RN #1 was out on maternity leave and I didn't lock the assessment. I guess I just over looked it somehow".	F 640	Identification of others with potential to be affected: RN #4 reviewed assessments on 3/8/19 to determine if there were any residents affected by this issue. No residents were affected by cited deficiency. To ensure deficient practice does not recur: Three MDS associates were in-serviced on 3/8/19 by DON on completion of MDS assessments per RAI manual. MDS assessments beginning 3/8/19 will be audited weekly for four weeks and monthly thereafter, by RN #4 to ensure compliance according to RAI manual requirements. Quality Assurance: Effective 3/9/19, a Performance Improvement Plan was initiated by the DON and MDS Coordinator to monitor timeliness of transmissions. Any deficiencies will be corrected and the findings will be documented and submitted at the monthly Quality Assurance meeting by the DON for further review or corrective action.	

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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	F 656		4/30/19

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F 656	Continued From page 4 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 observations, record review, facility policy review, and staff interview, the facility failed to implement the comprehensive care plans related to Residents #2, #57, and #133's wound care, and for Resident #51's catheter care. This concern was identified for four (4) of 31 care plans reviewed. Findings include: Review of the facility's policy titled, "Care Plans-Comprehensive," dated 11/2017, revealed that it is the policy of this facility that a Comprehensive Care Plan that includes measurable objectives and timetables to meet medical, nursing, mental and psychological needs is developed for each resident. The facility policy stated that each resident's Comprehensive Care Plan is designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, and reflect treatment goals and objectives in measurable goals. The facility policy stated that the Comprehensive Care Plan has been designed to prevent declines in the resident's functional status/ functional levels. The Comprehensive Care Plan has been designed to reflect treatment goals and objectives in measurable outcomes. The policy further stated care plans are revised as changes in the resident's condition dictate and reviews are made at least quarterly. Resident #2	F 656	Corrective Action: On 3/8/19 Registered Nurse (RN)#3 was in-serviced by Risk Manager (RM) to ensure care plan is followed for proper hand washing techniques to prevent contamination during wound care treatments. On 3/11/19 the RM in-serviced Certified Nursing Assistant (CNA) #1 to ensure Care Plan is followed on proper hand washing techniques to prevent contamination during catheter care. On 3/8/11 the RM in-serviced RN #3 to ensure the Care Plan is followed to ensure equipment and supplies are clean during wound care treatments. Identification of others with potential of being affected: The Director of Nursing (DON) made rounds on 3/11/19 to identify any residents requiring wound/foley care to determine if any resident was affected by this issue. There were no residents with negative outcomes noted. To ensure deficient practice does not recur: Hand washing in-services and catheter	

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F 656	Continued From page 5 A review of the Comprehensive Care Plan for Resident #2, revealed a Focus problem, initiated on 01/15/15, for Stage 4 pressure wounds to the right and left ischiums, and a Stage 4 pressure wound to the sacrum initiated on 09/10/2018. The Care Plan revealed the measurable goals stated there will have been noted improvement in size and depth of the pressure wounds to the right and left ischiums by next review with no further signs of skin integrity alterations, and no pain with wound treatment. The Target Date was 06/03/19. The Care Plan included an intervention, dated 03/05/2019, for nursing department to cleanse the wound to the left ischium, right ischium, and sacrum with Normal Saline (NS), pat dry, apply skin prep to peri-wound, Fill wound with alginate extra rope wound dressing, cover with four by four (4x4) gauze, and cover with super absorbent dry dressing daily and as needed (PRN). An observation, on 03/06/2019 at 8:46 AM, revealed Resident #2's wound care was provided by Registered Nurse (RN) #3. RN #3 performed the wound care on three (3) separate pressure wounds: A Stage 4 pressure wound to the left (L) Ischium, a Stage 4 pressure wound to the right (R) Ischium, and a Stage 4 pressure wound to the sacral area. RN #3 performed the wound care to both the Stage 4 pressure wound to the (L) Ischium and the Stage 4 pressure wound to the (R) Ischium, without incident. During the wound care on the Stage 4 pressure wound to the sacral area, RN #3 removed the soiled dressing from the wound, and then continued with the wound care by applying two (2) out of three (3) dressing ropes without washing her hands. After applying the second dressing rope, it was then that RN #3 removed her gloves, washed her hands, put on	F 656	care in-services were initiated on 3/11/19 by the DON and Risk Manager (RM) to ensure proper infection control practices are used during wound care treatments and catheter care as indicated on care plan. One hundred percent of CNAs and Nursing staff will be provided ongoing in-services. New staff will be trained during orientation by the orientation leader. Hand washing will be observed by DON, RM, Unit Managers (UM), and Staff Development Coordinator (SDC) three times per week for four weeks and one time per week thereafter starting 3/11/19 until compliance is achieved to prevent contamination during wound care and catheter care as indicated on care plan. Wound care treatments will be observed by DON, RM, and UM, and SDC three times per week for four weeks then one time per week thereafter starting 3/11/19 until compliance is achieved to ensure supplies and equipment are sanitized during wound care treatments as indicated on care plan. QA: On 3/9/19, a Performance Improvement Plan was initiated by the DON and RM to monitor infection control practices in regards to wound care and catheter care. Any deficiencies will be corrected and the findings will be documented and submitted by the DON at the monthly Quality Assurance meeting for further	

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F 656	Continued From page 6 new gloves, and then continued to apply the third dressing rope into the wound. An interview with Registered Nurse (RN) #3, on 03/07/19 at 11:00 AM, revealed she did not wash her hands going from cleaning the sacral wound and discarding the soiled gauze, and applying the first two medicated rope dressings. An interview, on 03/07/2019 at 11:15 AM, with the Director of Nursing (DON), revealed Registered Nurse (RN) #3 should have washed her hands after she cleaned the sacral wound, and before she applied the medicated rope dressing. The DON also stated the staff was expected to follow the care plan. During an interview, on 03/07/2019 at 1:54 PM. with Licensed Practical Nurse (LPN) #1 / Care Plan Coordinator, it was revealed that it was the intent of developing the comprehensive care plan that the care plan was to be followed. LPN #1 stated that it was her expectation that the nurse would provide the wound care treatment, without risking the possible spread of infection. During an interview, on 03/07/2019 at 4:08 PM, with RN #1/ Care Plan Coordinator, it was revealed that it was her expectation that once the comprehensive care plan has been developed, that the care plan would be followed thereafter. RN #1 stated the discipline that the intervention task is assigned to, should perform the intervention. Review of Resident #2's Discharge Minimum Data Set (MDS), dated 02/14/19, revealed a Basic Interview for Mental Status (BIMS) score of	F 656	review or corrective action.	

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F 656	Continued From page 7 15, which indicated no cognitive impairment. Further review of the MDS revealed Resident #2 was coded for the presence of two (2) Stage 3 pressure wounds. Review of Resident #2's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/18, revealed a Basic Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Further review of the MDS revealed Resident #2 was coded for two (2) Stage 4 pressure wounds. Review of the Face Sheet revealed Resident #2 was admitted by the facility on 03/05/2013, and readmitted on 01/21/2015, with diagnoses to include Paraplegia and Pressure Ulcer to the left and right buttocks. Resident #51 On 3/7/19 at 2:05 PM, an observation revealed Certified Nursing Assistant (C NA) #1 performed Resident #51's catheter care. CNA #1 failed to wash her hands prior to beginning the catheter care. CNA #1 applied her gloves, pulled some clean wipes from the wipe container and began the catheter care. CNA #1 wiped around the catheter near the resident's penis three times using one wipe, and rotated the wipe as she wiped. She then used another wipe to wipe in a downward motion on the resident's groin areas, using a clean wipe for each side. CNA #1 held the catheter tubing near the meatus, and wiped away from the meatus three times. She then repositioned Resident #51 onto his left side, and cleaned his buttocks, wiping the buttock areas in a circular, and back and forth motion, using the same wipe to clean the resident's entire buttocks area.	F 656		

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F 656	Continued From page 8 On 03/07/19 at 4:26 PM, an interview with Registered Nurse (RN) #1 revealed, she would expect the staff to implement the comprehensive care plan. Review of the Physician Orders, with a start date of 12/21/18, revealed the order to change the Foley Catheter as needed for leakage or blockage, and check the leg anchor every shift and as needed. Foley Catheter care every shift. Foley Catheter size 16 French (FR) to bedside drainage, check for patency every shift and change as needed. Review of Resident #51's most recent comprehensive MDS, with an ARD of 12/19/18, revealed Resident #51 was coded for an indwelling urinary catheter/condom catheter, and not rated for urinary continence. Further review of the MDS revealed a BIMS score of 15, which indicated Resident #51 was cognitively intact. A review of the facility's Face Sheet revealed the facility admitted Resident #51 on 03/13/18 with a diagnosis of Paraplegia. Resident #57 Review of Resident #57's Comprehensive Care Plan revealed Focus for Impaired Skin Integrity, dated 12/03/18, for a Stage 2 Pressure Wound to the sacrum, and 01/23/18 for a current visual Stage 4. The Goal stated the Pressure Ulcer will show signs of healing and remain free from infection. The initial date was 01/23/19, and the Target date was 04/23/19. The Interventions included wound care as ordered dated 06/05/18.	F 656		

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F 656	Continued From page 9 Review of Resident #57's Treatment Administration Record (TAR), for January 2019, revealed the following: Clean Sacrum with NS (Normal Saline), Pat dry apply Santyl in a thin layer, pack with gauze and cover with silicone dressing daily and PRN (as needed). Order Date 01/08/19. An observation on, 03/07/19 at 10:15 AM, revealed Registered Nurse (RN) #3/Wound Care Nurse performed wound care to Resident #57's sacrum. RN #3 placed a red bag on Resident #57's bed to the right of the resident's right leg. RN #3 removed the old dressing, and discarded the dressing in the red bag. RN #3 washed her hands and began to clean the wound. RN #3 cleaned the wound and patted it dry. RN #3 applied the Santyl to the wound bed with a Q-tip, and covered the wound with a dressing. RN #3 used the same gloves that she had on while cleaning the wound to apply the Santyl and the clean dressing to the wound. RN #3 failed to remove her gloves, wash her hands and re-glove after cleaning the wound, and before applying the Santyl and the clean dressing to the wound. An interview, on 03/07/19 at 10:48 AM, revealed RN #3 confirmed, she knew what she did when she did it. RN #3 stated she didn't change gloves and wash her hands after cleaning the wound, and before she applied the Santyl and the clean dressing. An Interview, on 03/08/19 at 8:37 AM, revealed Licensed Practical Nurse (LPN) #1/Care Plan Nurse stated, "If Resident #57 had a care plan created for wound care then she would expect the care plan to be followed".	F 656		

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F 656	Continued From page 10 Review of Resident #57's Significant Change MDS, with an ARD of 01/11/19, revealed a BIMS score of 10, which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #57 was coded for an unstageable wound. Resident #133 Review of Resident #133's Care Plan revealed a Focus, dated 03/04/19, for impaired skin integrity due to a wound to the right foot related to amputation of the right great toe. The Goal stated the wound to the right great toe would show signs of healing by/through the review date. The Goal was initiated on 03/04/19, and the Target Date was 06/02/19. The Interventions included the Physician's Orders (1) Right Great Toe Amputation Site: Cleanse with NS (Normal Saline), pat dry, apply Dankins ½ strength wet to dry packing. Cover with 4x4s and wrap with Kerlix PRN (as needed) when wound vac is reapplied. Start Date 03/04/19. (2) Wound vac (negative pressure wound therapy) in place to wound to right great toe amputation site. Apply wound vac at amputation site at 125 mmHg (millimeters of Mercury) Change Q (every) Tuesday and Friday. Start Date 03/04/19. An observation, on 03/05/19, 4:40 PM, revealed Registered Nurse (RN) #3/Wound Care Nurse provided Resident #133's wound care to the right foot/great toe. RN #3 was assisted by Certified Nursing Assistant (CNA) #3. RN #3 set up the wound care supplies on the over bed table, and then she placed the red biohazard bag on Resident #3, which positioned the right toe wound between RN #3 and the red biohazard	F 656		

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F 656	Continued From page 11	F 656		

bag. After looking over the supplies RN #3 identified she forgot to get scissors from the wound care cart. RN #3 left the room, and returned with the scissors in her bare hands. RN #3 laid the scissors on the tray containing her clean dressings without cleaning the scissors. RN #3 removed the dirty dressing, and discarded it into the red biohazard bag. RN #3 washed her hands and gloved to begin cleaning the wound. RN #3 wiped the wound with normal saline soaked gauze, and discarded the gauze into the red bag. RN #3 got another piece of normal saline gauze, wiped the other side of the wound, and discarded the gauze into the red bag. RN #3 took another piece of the normal saline gauze, wiped the wound, and the normal saline dripped down the side of the foot. RN #3 took the same piece of gauze and reached down to catch the dripping saline and wiped back towards the cleaned wound going from an uncleaned area to a cleaned area, thus wiping dirty to clean. RN #3 did not reclean the wound before attempting to apply the wound vac to the wound. RN #3 washed her hands and gloved, and then picked up the foam that was to be packed into the wound and crossed the cleaned wound over to the red bag and held the foam above the red bag, with the dirty dressing and gauze in it, and began trimming the foam with the uncleaned scissors. RN #3 brought the foam from over the red bag back to the wound, and placed it on the wound. She then reached back over and got the second piece of foam and crossed the clean wound again going to the red bag. RN #3 began trimming the foam over the red bag, and then brought the foam back and placed it on wound. She picked up the end of the wound vac that was to be placed over the foam on the wound. RN #3 placed the wound vac tubing on Resident #133's

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gown. The end to the tubing was uncapped. RN #3 sealed the part of the wound vac with the dressings cut earlier. She then picked up the tubing from the gown and hooked it to the wound vac itself without cleaning the uncapped tube. Suction was obtained. RN #3 cleaned up her trash, washed her hands, and exited the room.

An interview, on 03/05/19 at 5:10 PM, with RN #3/Wound Care Nurse revealed, "I did wipe the wound from dirty to clean and I knew it when I did it." RN #3 stated, "I didn't think about crossing over the wound to the red bag with the foam then bringing it back over and putting it in the wound. I can see where that would be a contamination issue. I cleaned the scissors before bringing them in the room, but I didn't reclean them after bringing them into the room in my hand. I didn't think about that being an issue but I can see where they could be considered dirty being toted in my bare hand. I held the foam above the red bag to trim it, and I wasn't thinking about it being a contamination issue since I didn't touch it. But with the dirty dressing being in the red bag I can see it being a issue".

Record review of Resident #133's Physician Orders revealed the following orders: (1) Right Great Toe Amputation Site: Cleanse with NS (Normal Saline), pat dry, apply Dankins ½ strength wet to dry packing. Cover with 4x4s and wrap with Kerlix PRN (as needed) when wound vac is reapplied. Start Date 02/27/19. (2) Wound vac (negative pressure wound therapy) in place to wound to right great toe amputation site. Apply wound vac at amputation site at 125 mmHg (millimeters of Mercury) Change Q (every) Tuesday and Friday. Start Date 02/26/19.

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F 656	Continued From page 13 During an interview, on 03/08/19 at 8:37 AM, Licensed Practical Nurse (LPN) #1/Care Plan Nurse revealed she would expect a resident's care plan for wound care would be followed. Review of the Face Sheet revealed Resident #133 was admitted by the facility, on 02/12/19, with the included diagnoses Osteomyelitis, Diabetes Type 2, Generalized Muscle Weakness, and Hypertension. Review of Resident #133's Admission MDS, with an ARD of 02/19/19, revealed a BIMS score of 11, which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #133 was coded for a Stage 2 wound.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to administer Resident #61's multidose inhaler in a manner to prevent thrush for one (1) of three (3) residents observed for multidose inhaler administration. Findings include: Review of the Mississippi Nursing Practice Law, with an effective date of July 1, 2010, revealed on pages three and four (3 & 4) of 26: 73-15-5	F 658	Corrective Action: The Director of Nursing (DON) in-serviced Licensed Practical Nurse (LPN) #2 on 3/8/19 on proper administration of Symbicort in accordance with medication guidelines. Resident #61 was assessed by the DON on 3/8/19 no negative findings were noted in relation to the cited deficiency.	4/30/19

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F 658	Continued From page 14 Definitions. (2) The practice of nursing by a registered nurse means the performance for compensation of services which requires substantial knowledge of biological, physical, behavioral, psychological, and sociological sciences, and of nursing theory as the basis for assessment, diagnosis, planning intervention, and evaluation in the promotion, maintenance of health; management of individual's responses, to illness, injury or infirmity; the restoration of optimum function; or the achievement of a dignified death. Nursing practice includes, but is not limited to, administration, teaching, counseling, delegation, and supervision of nursing, and execution of the medical regimen, including the administration of medications, and treatments prescribed by any licensed or legally authorized physician, or dentist. (5) The practice of nursing by a licensed practical nurse means the performance for compensation of services requiring basic knowledge of the biological, physical, behavioral, psychological, and sociological sciences, and of nursing procedures which do not require the substantial skill, judgement, and knowledge required of a registered nurse. These services are performed under the direction of a registered nurse, or a licensed physician, or licensed dentist, and utilize standardized procedures in the observation, and care of the ill, injured, and infirm; in the maintenance of health; in action to safeguard life and health; and in the administration of medications, and treatments prescribed by any licensed physician, or licensed dentist authorized by state law to prescribe. Review of the Medication Guide (no date) for Symbicort revealed rinse mouth with water and spit the water out after each dose (2 puffs) of	F 658	Identification of others with the potential to be affected: Rounds were made by the DON on 3/11/19 to identify any residents affected as a result of the cited deficiency. There were no residents on inhalers with negative outcomes noted. To ensure deficient practice does not recur: On 3/11/19, the DON and Risk Manager (RM) initiated ongoing in-services to all Nursing Staff on administration of inhalers according to medication guidelines. New nursing associates will be trained during orientation by the Staff Development Coordinator (SDC) or Nurse providing the training. The Respiratory Therapist, DON, Unit Managers, RM, or SDC will observe administration of inhaler treatments three times per week for four weeks and one time per week thereafter until compliance is achieved. Observations were initiated on 3/11/19 by the DON, RM, and SDC. Quality Assurance: On 3/11/19, a Performance Improvement Plan was initiated by the DON and RM to monitor administration of inhalers. Any deficiencies will be corrected, and the findings will be documented and submitted by the DON at the monthly Quality Assurance Meeting for further review or corrective action.	

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F 658	Continued From page 15 Symbicort. Do not swallow the water. This will help to lessen the chance of getting a fungus infection (thrush) in mouth and throat. On 03/06/19 at 9:00 AM, an observation during the medication pass, revealed Licensed Practical Nurse (LPN) #2 administered Symbicort 80-4.5 mcg two (2) puffs to Resident #61. LPN #2 gave Resident #61 water, and told him to swish the water in his mouth. Resident #61 swallowed the water. LPN #2 said "great Job". LPN #2 did not educate the resident to spit the water out. Review of Resident #61's Physicians Orders, dated 02/04/19, revealed Symbicort Aerosol 80-4.5 mcg (micrograms)/ACT (Budesonide-Formoterol Fumerate) two (2) puffs inhaled orally every 12 hours related to Chronic Obstructive Pulmonary Disease, Unspecified. Rinse mouth with water after use do not swallow. Review of Resident #61's Medication Administration Record, for March 2019, revealed Symbicort Aerosol 80-4.5 mcg/ACT (Budesonide-Formoterol Fumerate) two (2) puffs inhaled orally every 12 hours related to Chronic Obstructive Pulmonary Disease, Unspecified. Rinse mouth with water after use do not swallow. During an interview, on 03/08/19 at 11:34 AM, LPN #2 confirmed she should have told the resident not to swallow the water. LPN #2 said the resident can get thrush by swallowing the water after inhaling steroids. During an interview, on 03/08/19 at 11:36 AM, the Director of Nursing (DON) confirmed the nurse should have asked the resident to spit the water out after inhaling steroids to prevent thrush.	F 658		

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F 658	Continued From page 16 A review of Resident #61's Face Sheet revealed the facility admitted Resident #61, on 01/03/2019, with diagnoses which included Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease and Hypertension. A review of Resident #61 Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/14/2019, revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review, and facility policy review, the facility failed to provide wound care in a manner to promote healing for three (3) of six (6) resident wound care observations: Resident #2, Resident #57, and Resident #133.	F 686	Corrective Action: Risk Manager (RM) in-serviced Registered Nurse (RN) #3 on 3/8/19 on providing wound care in a manner to promote healing and prevent infection.	4/30/19

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F 686	Continued From page 17 Findings Include: A review of the facility's policy titled, "Pressure Ulcer Treatment," dated September 2018, revealed that it is the purpose of this facility's procedure to provide guidelines for the treatment of pressure ulcers to facilitate healing and to prevent further deterioration. The Pressure Ulcer Treatment procedure outlined certain steps in the procedure as follows: Put on exam gloves, loosen tape and remove dressing, remove gloves, then wash hands, and now put on clean gloves. Observe the pressure ulcer, dress the pressure ulcer with the prescribed dressing, discard all disposable items into designated container, and remove gloves and discard into designated container. Wash hands. Resident #2 An observation, on 03/06/2019 at 8:46 AM, revealed Resident #2's wound care was provided by Registered Nurse (RN) #3. RN #3 performed the wound care on three (3) separate pressure wounds: A Stage 4 pressure wound to the left (L) Ischium, a Stage 4 pressure wound to the right (R) Ischium, and a Stage 4 pressure wound to the sacral area. RN # 3 performed the wound care to both of the Stage 4 pressure wounds to the (L) Ischium and (R) Ischium, without incident. During the wound care on the Stage 4 pressure wound to the sacral area, RN #3 discarded the soiled 4X4 gauze used for cleaning the wound, and then continued with the wound care by applying two (2) out of three (3) dressing ropes into the wound bed without changing her gloves and washing her hands. After applying the second dressing rope, it was then that RN #3 removed	F 686	These in-services included hand washing and cleaning of equipment during wound care treatments. Residents #2, #57, and #133 were assessed by the Director of Nursing (DON) on 3/11/19 for negative outcomes due to the cited deficiency and no negative outcomes were noted. Identification of others with potential to be affected: Rounds were made by the DON on 3/11/19 to identify any residents affected as a result of the cited deficiency. There were no residents identified with negative outcomes noted. To ensure deficient practice does not recur: Hand washing during wound care will be observed by the DON, Risk Manager (RM), Unit Managers, or Staff Development Coordinator (SDC) three times per week for four weeks and one time per week thereafter until compliance is achieved. These observations were initiated on 3/11/19 by DON and RM. Wound care treatments will be observed by DON, RM, Unit Managers, or SDC three times per week for four weeks and one time per week thereafter until compliance is achieved to ensure supplies/equipment are sanitized during wound care treatments. Observations were initiated on 3/11/19 by the DON and	

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F 686	Continued From page 18 her gloves, washed her hands, put on new gloves, and then continued to apply the third dressing into the wound. During an interview, on 03/07/2019 at 11:00 AM, Registered Nurse (RN) #3 confirmed she did not wash her hands after she discarded the soiled gauze from cleaning the sacral wound, and before she applied the first two (2) medicated rope dressings. RN #3 stated she remembered washing her hands before she applied the third medicated rope dressing. RN #3 stated, "I didn't realize I didn't wash my hands, because I usually wash my hands before and after each time I apply the rope dressing into the wound." RN #3 stated not washing your hands is an infection control concern. A review of Resident #2's Order Summary Report for Active Orders as of 03/08/2019, revealed an order, dated 03/05/19 and start date of 03/06/19, to cleanse wound to sacrum with normal saline, pat dry, apply skin prep to peri-wound. Fill wound with alginate extra rope wound dressing, cover with 4x4 gauze, and cover with super absorbent dry dressing daily and as needed (PRN) every day shift. Review of Resident # 2's Electronic Treatment Administration Record (ETAR), dated March 03/01/2019-03/31/2019) 2019, revealed the following treatment been provided for the sacral wound: Cleanse wound to sacrum with Normal Saline (NS) and pat dry, apply skin prep to peri-wound, Fill wound with alginate extra rope wound dressing, cover with four by four (4x4) gauze, and cover with super absorbent dry dressing daily and as needed (PRN) every day shift.	F 686	RM. In-services were initiated by Risk Manager on 3/11/19 to 100% of Nursing Staff on proper hand washing and sanitation of supplies/equipment procedures during wound care. These in-services are ongoing. New hires will be in-serviced on hand washing during wound care in orientation by the SDC or orientation leader. Quality Assurance: Effective 3/11/19, a Performance Improvement Plan was initiated by the DON and RM to monitor outcomes of the cited deficiency. Any deficiencies will be documented and submitted by the DON at the monthly Quality Assurance meeting for further review or corrective action.	

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F 686	Continued From page 19 During an interview, on 03/07/2019 at 11:15 AM, the Director of Nursing (DON) revealed RN #3 should have washed her hands after she cleaned the sacral wound, and before she applied the medicated rope dressing. The DON stated, "If your hands are not washed, that it is an infection control concern." An interview, on 03/07/2019 at 1:54 PM, with Licensed Practical Nurse (LPN) #1/Care Plan Coordinator, revealed it was her expectation that the nurse would provide the wound care treatment, without risking the possible spread of infection. An interview, on 03/07/2019 at 3:32 PM, with Registered Nurse (RN) #2/Infection Control Nurse, said during the wound care provided on Resident #2, RN #3 should have washed her hands after cleaning the wound, and prior to the packing of the wound with the rope dressing. Review of Resident #2's Discharge Minimum Data Set (MDS), dated 02/14/19, revealed a Basic Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Further review of the MDS revealed Resident #2 was coded for the presence of two (2) Stage 3 pressure wounds. Review of Resident #2's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/18, revealed a Basic Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Further review of the MDS revealed Resident #2 was coded for two (2) Stage 4 pressure wounds. Review of the Face Sheet revealed Resident #2	F 686		

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F 686	Continued From page 20 was admitted by the facility on 03/05/2013, and readmitted on 01/21/2015, with diagnoses to include Paraplegia and Pressure Ulcer to the left and right buttocks. Resident #57 An Observation, on 03/07/19 at 10:15 AM, revealed Registered Nurse (RN) #3/Wound Care Nurse, performed wound care to resident #57 sacrum with the assistance of Certified Nursing Assistant (CNA) #3. RN #3 placed a red bag on resident's bed to the right side of the resident's right leg. RN #3 removed the old dressing and discarded the dressing in the red bag. RN #3 washed her hands, gloved, and began to clean the wound. RN #3 cleaned the wound, and patted it dry. RN #3 applied Santyl to the wound bed with a Q-tip applicator, and covered the wound with a silicone dressing. RN #3 wore the same gloves that she had on while cleaning the wound to apply the Santyl and clean dressing to the wound. RN #3 failed to remove her gloves, wash her hands, and re-glove after cleaning the wound and before applying the Santyl and the clean dressing to the wound. During an interview, on 03/07/19 at 10:48 AM, RN #3/Wound Care Nurse, stated, "I knew what I did when I did it. I didn't change gloves and wash my hands after cleaning the wound and before I applied the Santyl and the clean dressing. It could be an infection control issue". Review of Resident #57's Electronic Treatment Administration Record (ETAR), dated March 2019, revealed the daily wound care treatment to the sacrum was provided daily as follows:. Clean sacrum with Normal Saline (N/S), Pat dry, and	F 686		

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F 686	Continued From page 21 apply Santyl in a thin layer. Pack with gauze and cover with silicone dressing daily and PRN. An interview, on 03/07/19 at 3:22 PM, with RN #2/ Infection control nurse, revealed, "RN #3 should have removed her gloves, washed hands and re-gloved before placing the Santyl and bandage on the clean wound". "I see that as an infection control Issue". An interview, on 03/07/19 at 3:44 PM, with the Director of Nursing (DON) revealed, "the nurse not changing her gloves and washing her hands after cleaning the wound and before applying Santyl and the dressing is an infection control issue". Review of Resident #57's Significant Change MDS, with an ARD of 01/11/19, revealed a BIMS score of 10, which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #57 was coded for an unstageable wound. Resident #133 An observation, on 03/05/19, 4:40 PM, revealed Registered Nurse (RN) #3/Wound Care Nurse provided Resident #133's wound care to the right foot/great toe. RN #3 was assisted by Certified Nursing Assistant (CNA) #3. RN #3 set up the wound care supplies on the over bed table, and then she placed the red biohazard bag on Resident #3, which positioned the right toe wound between RN #3 and the red biohazard bag. After looking over the supplies RN #3 identified she forgot to get scissors from the wound care cart. RN #3 left the room, and returned with the scissors in her bare hands. RN	F 686		

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F 686	Continued From page 22 #3 laid the scissors on the tray containing her clean dressings without cleaning the scissors. RN #3 removed the dirty dressing, and discarded it into the red biohazard bag. RN #3 washed her hands and gloved to begin cleaning the wound. RN #3 wiped the wound with normal saline soaked gauze, and discarded the gauze into the red bag. RN #3 got another piece of normal saline gauze, wiped the other side of the wound, and discarded the gauze into the red bag. RN #3 took another piece of the normal saline gauze, wiped the wound, and the normal saline dripped down the side of the foot. RN #3 took the same piece of gauze and reached down to catch the dripping saline and wiped back towards the cleaned wound going from an uncleaned area to a cleaned area, thus wiping dirty to clean. RN #3 did not reclean the wound before attempting to apply the wound vac to the wound. RN #3 washed her hands and gloved, and then picked up the foam that was to be packed into the wound and crossed the cleaned wound over to the red bag and held the foam above the red bag, with the dirty dressing and gauze in it, and began trimming the foam with the uncleaned scissors. RN #3 brought the foam from over the red bag back to the wound, and placed it on the wound. She then reached back over and got the second piece of foam and crossed the clean wound again going to the red bag. RN #3 began trimming the foam over the red bag, and then brought the foam back and placed it on wound. She picked up the end of the wound vac that was to be placed over the foam on the wound. RN #3 placed the wound vac tubing on Resident #133's gown. The end to the tubing was uncapped. RN #3 sealed the part of the wound vac with the dressings cut earlier. She then picked up the tubing from the gown and hooked it to the wound	F 686		

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F 686	Continued From page 23 vac itself without cleaning the uncapped tube. Suction was obtained. RN #3 cleaned up her trash, washed her hands, and exited the room. An interview, on 03/05/19 at 5:10 PM, with RN #3/Wound Care Nurse revealed, "I did wipe the wound from dirty to clean and I knew it when I did it." RN #3 stated, "I didn't think about crossing over the wound to the red bag with the foam then bringing it back over and putting it in the wound. I can see where that would be a contamination issue. I cleaned the scissors before bringing them in the room, but I didn't reclean them after bringing them into the room in my hand. I didn't think about that being an issue but I can see where they could be considered dirty being toted in my bare hand. I held the foam above the red bag to trim it, and I wasn't thinking about it being a contamination issue since I didn't touch it. But with the dirty dressing being in the red bag I can see it being a issue". Record review of Resident #133's Physician Orders revealed the following orders: (1) Right Great Toe Amputation Site: Cleanse with NS (Normal Saline), pat dry, apply Dankins ½ strength wet to dry packing. Cover with 4x4s and wrap with Kerlix PRN (as needed) when wound vac is reapplied. Start Date 02/27/19. (2) Wound vac (negative pressure wound therapy) in place to wound to right great toe amputation site. Apply wound vac at amputation site at 125 mmHg (millimeters of Mercury) Change Q (every) Tuesday and Friday. Start Date 02/26/19. During an interview, on 03/07/19 3:08 PM, RN #2/Infection Control Nurse, revealed wiping the resident's wound from dirty to clean and not recleaning the wound before dressing it would be	F 686		

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F 686	Continued From page 24 a infection control issue. RN #2 said RN #3 should not have crossed the leg with the foam to the red bag. RN #2 stated RN #3 shouldn't go across the wound with the wound vac foam because your crossing the clean wound with supplies coming from the over bed table. RN #2 said RN #3 was going back to the clean wound with something dirty after she held it over the red bag. RN #2 also stated the tubing should not have been laid on Resident #133's gown. It should have been on a clean surface or RN #3 should have cleaned it before connecting it to the other capped end of the tube. RN #2 also stated the scissors should have been recleaned before using them since she had transported them in her bare hand. An interview, on 03/07/19 at 3:49 PM, with the Director of Nursing (DON) revealed RN #3's failure not to reclean the scissors before cutting the clean dressing was an infection control issue. The DON stated RN #3 crossing the clean wound with the foam was an infection control issue also. The DON stated RN #3 holding the foam over the red bag to trim it, and then bringing it back to the wound and packing the wound with the foam was an infection control issue. The DON stated RN #3 laying the uncapped tube of the wound vac suction part placed on top of the wound on the resident's gown and not cleaning it before connecting it to the capped end of the actual wound vac was an infection control issue. The DON stated RN #3 should have cleaned her scissors after having them in her hand and before cutting a clean dressing. Review of the Face Sheet revealed Resident #133 was admitted by the facility, on 02/12/19,	F 686		

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F 686	Continued From page 25 with the included diagnoses Osteomyelitis, Diabetes Type 2, Generalized Muscle Weakness, and Hypertension. Review of Resident #133's Admission MDS, with an ARD of 02/19/19, revealed a BIMS score of 11, which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #133 was coded for a Stage 2 wound.	F 686		
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.	F 690		4/30/19

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F 690	Continued From page 26 §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, record review, and facility policy review, the facility failed to provide Resident #51 and Resident #109's catheter care in a manner to prevent the possibility of a Urinary Tract Infection (UTI), for two (2) of five (5) resident catheter care observations. Findings include: A review of the facility's policy titled "Catheter Care, Urinary" dated July 2015 revealed: Equipment and Supplies included pre-moistened wipes. Steps in the Procedure: 1. Wash hands. 17. Clean from the least contaminated to most contaminated area. Review of the facility's policy titled, "Perineal Care", dated December 2017, revealed: Equipment and Supplies included pre-moistened wipes. 18. For Male Resident- Steps in the Procedure - b. Wash perineal area starting with urethra and working outward. (2) Wash and rinse urethral area using a circular motion. f. Instruct, or assist resident to turn on his side. g. Using new washcloth, apply soap or skin cleansing agent or use pre-moistened wipe and wash. h. Using new washcloth, rinse the rectal area thoroughly to include the area under the scrotum, the anus, and	F 690	Corrective Action: Risk Manager (RM) in-serviced Certified Nursing Assistant (CNA)#1 on 3/11/19 on proper perineal care procedures, including hand washing, to prevent infection during catheter care. RM in-serviced CNA #2 on 3/11/19 on keeping the catheter bag/tubing below the bladder level to prevent backflow of urine and possible Urinary Tract Infection. Director of Nursing (DON) assessed Resident #51 and Resident #109 on 3/11/19 for negative outcomes due to cited deficiency and no negative outcomes were noted. Identification of others with the potential to be affected: Rounds were made by the DON on 3/11/19 to identify any residents with catheters affected as a result of the cited deficiency. There were no residents with negative outcomes noted. To ensure deficient practice does not	

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F 690	Continued From page 27 the buttocks. If pre-moistened wipes are used, rinsing is not necessary. On 03/07/19 at 2:05 PM, an observation revealed Certified Nursing Assistant (CAN) #1 provided Resident #51's catheter care. CNA #1 entered Resident #51's room, applied her gloves, pulled some clean wipes from the wipe container, and begin the catheter care. CNA #1 did not wash her hands prior to donning the gloves and beginning the catheter care. CNA #1 wiped around the catheter near the resident's penis three times using one wipe, and rotated the wipe as she wiped. She then used another wipe to wipe in a downward motion of the resident's groin areas, using a clean wipe for each side. CNA #1 held the catheter tubing near the meatus, and wiped away from the meatus three times. She then repositioned Resident #51 onto his left side and cleaned his buttocks, wiping the buttocks areas in a circular and back and forth motion, using the same wipe to clean the resident's entire buttocks area. CNA #1 failed to wipe Resident #51's buttocks from front to back, or from least contaminated area to most contaminated area. An interview on 03/07/19 at 3:44 PM, with CNA #1 revealed she should have washed her hands before beginning the procedure. She also stated she should have wiped from front to back in an upward motion. An interview on 03/07/19 at 9:29 AM, with Registered Nurse (RN) #7 revealed Resident #51 was very independent, and does not like for the staff to assist him with anything although he needs it. RN #7 stated he does not think Resident #51 has had any Urinary Tract Infections (UTIs), but he does have spasms. He	F 690	recur: RM initiated in-service to 100% of CNAs on 3/11/19 on proper catheter care and perineal care to prevent risk of infection. On 3/11/19, perineal and catheter care observations were initiated by RM, DON, Staff Development Coordinator, and Unit Managers three times per week for four weeks and one time per week thereafter until compliance is achieved. New hires will be trained on perineal and catheter care during orientation by SDC or orientation leader. Quality Assurance: Effective 3/11/19, a Performance Improvement Plan was initiated by the DON and RM to monitor perineal care and placement of catheter bags and tubing during catheter care. Any deficiencies will be corrected, and the findings will be documented and submitted by the DON at the monthly Quality Assurance meeting for further review or corrective action.	

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F 690	Continued From page 28	F 690		

stated the resident has the catheter because he has some Dystonia from his quadriplegia.

An interview, on 03/07/19 at 3:49 PM, with the Director of Nursing (DON) revealed CNA #1 should have washed her hands so she does not carry anything in to the resident. The DON stated CNA #1 should have wiped in an upward position for infection control purposes.

An interview, on 03/07/19 at 3:26 PM, with RN #2 revealed CNA #1 should have washed her hands, gathered her supplies, and placed her supplies on a barrier, and then proceed to perform the catheter care. RN #2 also stated CNA #1 should have used one wipe to wipe each time in an upward position.

Review of the Physician Orders, with a start date of 12/21/18, revealed; change Foley Catheter as needed for leakage or blockage. Foley Catheter, check leg anchor every shift and as needed. Foley Catheter care every shift. Foley Catheter size 16 French (FR) to bedside drainage, check for patency every shift and change as needed.

Review of Resident #51's most recent comprehensive MDS, with an ARD of 12/19/18, revealed Resident #51 was coded for an indwelling urinary catheter/condom catheter, and not rated for urinary continence. Further review of the MDS revealed a BIMS score of 15, which indicated Resident #51 was cognitively intact.

A review of the facility's Face Sheet revealed the facility admitted Resident #51 on 03/13/18 with a diagnosis of Paraplegia.

Resident #109

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F 690	Continued From page 29 An observation, on 03/07/19 at 8:45 AM, revealed Resident #109 was lying in bed with the head of bed elevated. Further observation revealed Resident #109's catheter bag was lying in the bed with the resident, and the urine was backing up into the tube into the bladder. An observation, on 03/07/19 at 9:00 AM, revealed Resident #109 was lying in the bed with the catheter bag lying in the bed with the resident, and the urine was backing up into the tube into the bladder. An observation, on 03/07/19 at 9:38 AM, with the Director of Nursing (DON) present, and another surveyor revealed Resident #109 was lying in the bed. The catheter bag was lying in the bed with Resident #109, and the urine was backing up in the tubing into the bladder. An interview, on 03/07/19 at 9:40 AM, with the Director of Nursing (DON) confirmed the catheter was lying in the bed with Resident #109. The DON also confirmed the urine was backing up in the tube into the bladder. The DON confirmed this resident has chronic Urinary Tract Infections. Review of Resident #109's Care Plan revealed a Focus for high risk for infection related to having an indwelling catheter due to Obstructive and Reflux Uropathy and Neuromuscular Dysfunction of the Bladder, and History of Urinary Tract Infections (UTIs). Review of the Interventions revealed no intervention for placement of the catheter bag/tubing below the bladder level to prevent backflow of urine and possible UTI. During an interview, on 03/07/19 10:40 AM,	F 690		

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F 690	Continued From page 30 Certified Nursing Assistant (CNA) #2 revealed she was looking for a wheelchair because the resident was going out to a doctor's appointment. CNA #2 stated she forgot to move the catheter bag off the bed. CNA #2 said the resident could develop an infection by allowing the urine to back up in the catheter. A review of the Face Sheet revealed the facility admitted Resident #109, on 05/06/2016, with diagnoses which included Obstructive and Reflux Uropathy, History of Urinary Tract Infection and Neuromuscular Dysfunction of the Bladder. A review of Resident #109's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/15/2019, revealed Resident #109 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Further review of the MDS revealed Resident #109 was checked for the use of an indwelling catheter, external catheter, or ostomy. Resident #109's Urinary Continence was checked not rated due to a catheter, urinary ostomy, or no urine output during the seven (7) day observation period.	F 690		
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	F 761		4/30/19

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F 761	Continued From page 31 §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 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, record review, and facility policy review, the facility failed to ensure the disposal of expired medications, for two (2) of three (3) medication storage room observations. Findings Include: Record Review of the facility's policy titled, "Storage of Medications" revealed drugs and biologicals should be stored in a safe, secure and orderly manner. No discontinued, outdated, or deteriorated drugs or biologicals are available for use in this center. All such drugs are destroyed. An observation, on 03/06/19 at 11:49 AM, revealed expired medication in the 100 Hall medication storage room. One (1) bottle of Geri-Mox (antacid), expired on 01/2019, and two (2) bottles Banophen (antihistamine) expired on	F 761	Corrective Action: Expired medications on 100 Hall were removed by Registered Nurse (RN) #5 on 3/6/19. Expired medications on 300 Hall were removed by Registered Nurse (RN) #7 on 3/7/19. Registered Nurse #5 and #7 were in-serviced by Risk Manager (RM) and Director of Nursing (DON) on 3/11/19 on proper labeling and storage of medications in accordance with cited deficiency. Identification of others with the potential to be affected: DON and RM made rounds on 3/11/19	

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F 761	Continued From page 32 01/2019. During an interview, on 03/06/19 at 11:52 AM, Registered Nurse (RN)# 5 confirmed the medications in the medication storage room on the 100 Hall were expired. RN #5 said she had just checked all of the meds to make sure there were no expired medications. An observation, on 03/07/19 at 11:54 AM, revealed the medication room on the 300 Hall had three (3) aspirin bottles with an expiration date of 01/2019, and two (2) Biscodyl bottles expired on 02/2019. During an interview, on 03/07/19 at 11:59 AM, RN #7 confirmed the medications in the medication storage room on the 300 Hall were expired. During an interview, on 03/08/19 at 12:03 PM, the Director of Nursing (DON) confirmed the meds were expired. The DON said the meds should be checked daily to make sure they are not expired.	F 761	residents identified as being affected by the cited deficiency. No residents were affected by cited deficiency. To ensure deficient practice does not recur: DON, RM, or Unit Managers will check medication rooms three times per week for four weeks and one time per week thereafter until compliance is achieved. Observations were initiated 3/11/19 by RM and DON. RM initiated in-services for 100% of Nurses and the Central Supply Clerk on 3/11/19 on storage and labeling of medications per deficiency cited. Effective 4/1/19, the Central Supply Clerk will monitor medication rooms monthly to ensure medications are stored and labeled per deficiency cited. QA: Effective 3/11/19, a Performance Improvement Plan was initiated by the DON and RM to monitor storage and labeling of medications. Any deficiencies will be corrected, and the findings will be documented and submitted at the monthly Quality Assurance meeting by the DON for further review or corrective action.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		4/30/19

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F 880	Continued From page 33 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 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	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 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 observations, staff interview, record review, and facility policy review, the facility failed to ensure measures to prevent the possibility of a Urinary Tract Infection (UTI) and/or cross contamination during catheter care for Residents #51, for one (1) of six (1 of 6) catheter care observations. The facility also failed to prevent the possible spread of infection and cross contamination during wound care by failure to wash hands during Residents #2, #57, and #133's wound care, for three of six (3 of 6) wound care observations.	F 880	Corrective Action: Risk Manager (RM) in-serviced Registered Nurse (RN) #3 on 3/8/19 on providing wound care in a manner to promote healing and prevent infection. These in-services included hand washing and cleaning of equipment during wound care treatments. RM in-serviced Certified Nursing Assistant (CNA) #1 on 3/11/19 on proper perineal care procedures, including hand washing,	

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F 880	Continued From page 35 Findings Include: Review of facility's policy titled, "Infection Control Monitoring", dated November 2017, revealed it is the policy of the center to investigate the cause of infections (nosocomial, community and hospital acquired) and the manner of spread. The records will be maintained and infectious trends or any identified problems or potential problems will be reported to the Administrator, Director of Nurses and the Quality Assurance Committee. Follow up action will be taken as necessary. The objectives of the facilities Infection Control Policies and Practices are to: prevent, identify, report, and control infections and other communicable diseases. Designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Establish guidelines to follow in the implementation of isolation precautions. Maintain records of incidents and corrective actions related to infections. Establish guidelines to follow in implementing standard precautions/universal precautions of the handling of blood/ bodyguards and Antibiotic Stewardship Program. A review of the facility's policy titled, "Hand Hygiene" dated November 2017, revealed that it is the policy of this facility handwashing/ hand hygiene shall be regarded by this center as a means of preventing the spread of infections. The policy stated that all personnel shall follow our established handwashing procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. The policy stated that associates must perform appropriate handwashing procedures under the following conditions: before handling clean or soiled	F 880	to prevent infection during catheter care. Director of Nursing (DON) assessed Residents affected by cited deficiency on 3/11/19 for negative outcomes due to cited deficiency. There was no residents identified with negative outcomes noted. Identification of others with the potential of being affected: DON and RM made rounds on 3/11/19 to identify any residents with catheter and wound care affected as a result of the cited deficiency. There were no residents with negative outcomes noted. To ensure deficient practice does not recur: Hand washing during wound and catheter care will be observed by DON, RM, Unit Managers, or Staff Development Coordinator three times per week for four weeks and one time per week thereafter until compliance is achieved. Observations were initiated on 3/11/19 by DON and RM. RM initiated in-services on hand washing on 3/11/19 to 100% of Nurse and CNAs to prevent infection during catheter care and wound care. These in-services also included sanitation of supplies/equipment. New associates will be trained in Orientation by Staff Development Coordinator or Nurse trainer. Quality Assurance:	

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F 880	Continued From page 36 dressings, gauze pads, etc., after handling used dressings, after handling items potentially contaminated items with blood, body fluids, excretions, or secretions, and after removing gloves. Review of the facility's policy titled, "Catheter Care, Urinary", dated July 2015, revealed the bag should be held below the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Resident #2 An observation, on 03/06/2019 at 8:46 AM, revealed Resident #2's wound care was provided by Registered Nurse (RN) #3. RN #3 performed the wound care on three (3) separate pressure wounds: a Stage 4 pressure wound to the left (L) Ischium, a Stage 4 pressure wound to the right (R) Ischium, and a Stage 4 pressure wound to the sacral area. RN #3 performed the wound care to both the Stage 4 pressure wounds to the (L) Ischium and the (R) Ischium without incident. During the wound care on the Stage 4 pressure wound to the sacral area, RN #3 discarded the soiled 4X4 gauze used for cleaning the wound, and then continued with the wound care by applying two (2) out of three (3) dressing ropes into the wound bed without washing her hands. After applying the second dressing rope, it was then that RN #3 removed her gloves, washed her hands, put on new gloves, and then continued to apply the third dressing into the wound. During an interview, on 03/07/2019 at 11:00 AM, Registered Nurse (RN) #3 confirmed she did not wash her hands after she discarded the soiled gauze from cleaning the sacral wound, and	F 880	Effective 3/11/19, a Performance Improvement Plan was initiated by the DON and RM to monitor hand washing during wound and catheter care and proper perineal care to prevent infection. Sanitation of supplies/equipment is also included in the Performance Improvement Plan. Any deficiencies will be corrected, and the findings will be documented and submitted at the monthly Quality Assurance meeting by the DON for further review or corrective action.	

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F 880	Continued From page 37 before she applied the first two (2) medicated rope dressings. RN #3 stated she remembered washing her hands before she applied the third medicated rope dressing. RN #3 stated, "I didn't realize I didn't wash my hands, because I usually wash my hands before and after each time I apply the rope dressing into the wound." RN #3 stated that not washing your hands is an infection control concern. During an interview, on 03/07/2019 at 11:15 AM, with the Director of Nursing (DON), the DON revealed RN #3 should have washed her hands after she cleaned the sacral wound, and before she applied the medicated rope dressing. The DON stated, "If your hands are not washed, that is an infection control concern." During an interview, on 03/07/2019 at 1:54 PM, with Licensed Practical Nurse (LPN) #1/Care Plan Coordinator, LPN #1 stated that it was her expectation that the nurse would provide the wound care treatment, without risking the possible spread of infection. An interview, on 03/07/2019 at 3:32 PM, with Registered Nurse (RN) #2/Infection Control Nurse, confirmed that during the wound care provided on Resident #2, that RN #3 should have washed her hands after cleaning the wound, and prior to the packing of the wound with rope dressing. Review of the Face Sheet revealed that Resident #2 was admitted by the facility on 03/05/2013, and readmitted on 01/21/2015, with diagnoses to include Paraplegia and Pressure Ulcer to the left and right buttocks.	F 880		

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F 880	Continued From page 38 Review of Resident #2's Discharge Minimum Data Set (MDS), dated 02/14/19, revealed a Basic Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Further review of the MDS revealed Resident #2 was coded for the presence of two (2) Stage 3 pressure wounds. Review of Resident #2's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/18, revealed a Basic Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Further review of the MDS revealed Resident #2 was coded for two (2) Stage 4 pressure wounds. Resident #57 An observation, on 03/07/19 at 10:15 AM, revealed Registered Nurse (RN) #3/Wound Care Nurse performed wound care to Resident #57's sacrum. Certified Nursing Assistant (CNA) #3 assisted RN #3 with the wound care. RN #3 placed a red bag on Resident #57's bed to the right side of Resident #57's right leg. RN #3 removed the old dressing, and discarded the dressing into the red bag. RN #3 washed her hands, gloved, and began to clean the wound. RN #3 cleaned and patted the wound dry. RN #3 applied Santyl to wound bed with a Q-tip applicator, and covered the wound with a silicone dressing. RN #3 wore the same gloves she had on while cleaning the wound to apply the Santyl and clean dressing to the wound. RN #3 failed to remove her gloves, wash her hands and re-glove after cleaning the wound, and before applying Santyl and the clean dressing to the wound. An interview, on 03/07/19 at 10:48 AM, revealed RN #3/ Wound Care Nurse stated, "I knew what I	F 880		

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F 880	Continued From page 39 did when I did it. I didn't change gloves and wash my hands after cleaning the wound and before I applied the Santyl and the clean dressing. It could be an infection control issue". An interview, on 03/07/19 at 3:22 PM, revealed RN #2/ Infection Control Nurse stated, "RN #3 should have removed her gloves, washed hands and re-gloved before placing the Santyl and bandage on the clean wound". "I see that as an infection control issue". An interview, on 03/07/19 at 3:44 PM, with the Director of Nursing (DON) revealed, "the nurse not changing her gloves and washing her hands after cleaning the wound and before applying Santyl and the dressing is an infection control issue". Review of Resident #57's Significant Change MDS, with an ARD of 01/11/19, revealed a BIMS score of 10, which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #57 was coded for an unstageable wound. Resident #133 An observation, on 03/05/19, 4:40 PM, revealed Registered Nurse (RN) #3/Wound Care Nurse provided Resident #133's wound care to the right foot/great toe. RN #3 was assisted by Certified Nursing Assistant (CNA) #3. RN #3 set up the wound care supplies on the over bed table, and then she placed the red biohazard bag on Resident #3, which positioned the right toe wound between RN #3 and the red biohazard bag. After looking over the supplies RN #3 identified she forgot to get scissors from the	F 880		

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F 880	Continued From page 40	F 880		

wound care cart. RN #3 left the room, and returned with the scissors in her bare hands. RN #3 laid the scissors on the tray containing her clean dressings without cleaning the scissors. RN #3 removed the dirty dressing, and discarded it into the red biohazard bag. RN #3 washed her hands and gloved to begin cleaning the wound. RN #3 wiped the wound with normal saline soaked gauze, and discarded the gauze into the red bag. RN #3 got another piece of normal saline gauze, wiped the other side of the wound, and discarded the gauze into the red bag. RN #3 took another piece of the normal saline gauze, wiped the wound, and the normal saline dripped down the side of the foot. RN #3 took the same piece of gauze and reached down to catch the dripping saline and wiped back towards the cleaned wound going from an uncleaned area to a cleaned area, thus wiping dirty to clean. RN #3 did not reclean the wound before attempting to apply the wound vac to the wound. RN #3 washed her hands and gloved, and then picked up the foam that was to be packed into the wound and crossed the cleaned wound over to the red bag and held the foam above the red bag, with the dirty dressing and gauze in it, and began trimming the foam with the uncleaned scissors. RN #3 brought the foam from over the red bag back to the wound, and placed it on the wound. She then reached back over and got the second piece of foam and crossed the clean wound again going to the red bag. RN #3 began trimming the foam over the red bag, and then brought the foam back and placed it on wound. She picked up the end of the wound vac that was to be placed over the foam on the wound. RN #3 placed the wound vac tubing on Resident #133's gown. The end to the tubing was uncapped. RN #3 sealed the part of the wound vac with the

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F 880	Continued From page 41 dressings cut earlier. She then picked up the tubing from the gown and hooked it to the wound vac itself without cleaning the uncapped tube. Suction was obtained. RN #3 cleaned up her trash, washed her hands, and exited the room. An interview, on 03/05/19 at 5:10 PM, with RN #3/Wound Care Nurse revealed, "I did wipe the wound from dirty to clean and I knew it when I did it." RN #3 stated, "I didn't think about crossing over the wound to the red bag with the foam then bringing it back over and putting it in the wound. I can see where that would be a contamination issue. I cleaned the scissors before bringing them in the room, but I didn't reclean them after bringing them into the room in my hand. I didn't think about that being an issue but I can see where they could be considered dirty being toted in my bare hand. I held the foam above the red bag to trim it, and I wasn't thinking about it being a contamination issue since I didn't touch it. But with the dirty dressing being in the red bag I can see it being a issue". During an interview, on 03/07/19 3:08 PM, RN #2/Infection Control Nurse, revealed wiping the resident's wound from dirty to clean and not recleaning the wound before dressing it would be a infection control issue. RN #2 said RN #3 should not have crossed the leg with the foam to the red bag. RN #2 stated RN #3 shouldn't go across the wound with the wound vac foam because your crossing the clean wound with supplies coming from the over bed table. RN #2 said RN #3 was going back to the clean wound with something dirty after she held it over the red bag. RN #2 also stated the tubing should not have been laid on Resident #133's gown. It should have been on a clean surface or RN #3	F 880		

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F 880	Continued From page 42 should have cleaned it before connecting it to the other capped end of the tube. RN #2 also stated the scissors should have been recleaned before using them since she had transported them in her bare hand. An interview, on 03/07/19 at 3:49 PM, with the Director of Nursing (DON) revealed RN #3's failure not to reclean the scissors before cutting the clean dressing was an infection control issue. The DON stated RN #3 crossing the clean wound with the foam was an infection control issue also. The DON stated RN #3 holding the foam over the red bag to trim it, and then bringing it back to the wound and packing the wound with the foam was an infection control issue. The DON stated RN #3 laying the uncapped tube of the wound vac suction part placed on top of the wound on the resident's gown and not cleaning it before connecting it to the capped end of the actual wound vac was an infection control issue. The DON stated RN #3 should have cleaned her scissors after having them in her hand and before cutting a clean dressing. Review of the Face Sheet revealed Resident #133 was admitted by the facility, on 02/12/19, with the included diagnoses Osteomyelitis, Diabetes Type 2, Generalized Muscle Weakness, and Hypertension. Review of Resident #133's Admission MDS, with an ARD of 02/19/19, revealed a BIMS score of 11, which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #133 was coded for a Stage 2 wound. Resident #51	F 880		

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F 880	Continued From page 43 On 3/7/19 at 2:05 PM, an observation revealed Certified Nursing Assistant (CNA) #1 performed Resident #51's catheter care. CNA #1 entered Resident #51's room, applied her gloves, pulled some clean wipes from the container, and began the catheter care. CNA #1 did not wash her hands. CNA #1 wiped around the catheter near the resident's penis three times using one wipe and rotated the wipe as she wiped. She then used another wipe to wipe in a downward motion of the resident's groin areas, using a clean wipe for each side. CNA #1 held the catheter tubing near the meatus, and wiped away from the meatus three times. She then repositioned Resident #51 onto his left side, and cleaned his buttocks, wiping the buttocks areas in a circular and back and forth motion using the same wipe to clean the resident's entire buttocks area. On 03/07/19 at 3:44 PM, an interview with CNA #1 revealed she should have washed her hands before beginning the procedure, and she should have wiped from front to back in an upward motion to prevent the possibility of an infection. An interview, on 03/07/19 at 9:29 AM, revealed Registered Nurse (RN) #7 stated Resident #51 was very independent and did not like for the staff to assist him with anything although he needed it. RN #7 stated he does not think Resident #51 has had any Urinary Tract Infections (UTIs), but he does have spasms. He stated the resident has the catheter because he has some Dystonia from his quadriplegia. On 03/07/19 at 3:49 PM, an interview with the Director of Nursing (DON) revealed CNA #1 should have washed her hands so she does not carry anything in to the resident. . The DON	F 880		

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F 880	Continued From page 44 stated CNA #1 should have wiped in an upward position for infection control purposes. On 03/07/19 at 3:26 PM, an interview with RN #2 revealed, CNA #1 should have washed her hands, gathered her supplies and placed her supplies on a barrier then proceeded to perform her catheter care. RN #2 also stated CNA #1 should have used one wipe to wipe each time in an upward position. Review of Resident #51's most recent comprehensive MDS, with an ARD of 12/19/18, revealed Resident #51 was coded for an indwelling urinary catheter/condom catheter, and not rated for urinary continence. Further review of the MDS revealed a BIMS score of 15, which indicated Resident #51 was cognitively intact. A review of the facility's Face Sheet revealed the facility admitted Resident #51 on 03/13/18 with a diagnosis of Paraplegia.	F 880		

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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 | 04/01/2019

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 *EMERGENCY PREPAREDNESS* Survey conducted on 3/7/9 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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