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	18HC	A. BUILDING: _____ B. WING _____	07/12/2019

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M 000	Initial Comments The State Agency (SA) conducted a recertification survey from 7/9/2019 through 7/12/2019. During the survey the SA determined the facility was not in compliance with the Minimum Standards for the Aged & Infirmed. The SA cited the state statutes at M620 and M655... . At the time of the survey the census was 173, and the facility held a license for 184 beds.	M 000		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. Level II Based on observations, record review, staff interview, and facility policy review, the facility failed to provide catheter/perineal care in a manner to prevent the possible spread of infection for four of six (4 of 6) catheter care observations, for Resident #7, Resident #88, Resident #89 and Resident #139. Findings include: Review of the facility's policy titled, "Catheter Care, Urinary," dated September 2014, revealed it is the policy of this facility that the purpose of this procedure is to prevent catheter-associated Urinary Tract Infections (UTI). The policy also stated under the general guidelines, that when maintaining unobstructed urine flow, the urinary	M 620	1. On 7/12/19, an immediate in-service was started with the Licensed Practical Nurse (LPN) #1 by disciplinary action. Certified Nursing Assistant (CNA) #1, CNA #2, CNA #3, CNA #4, CNA #5, and CNA #6, including hospice and agency staff members, were in-serviced regarding providing care for Resident #89, Resident #7, Resident #88, and Resident #139. Each resident was assessed for any negative outcomes by Director of Nursing, on 7/12/19 and monitored daily for seven days, to which no negative outcome was found. 2. Eleven residents with Foley catheters have potential to be affected by this deficient practice. All eleven residents were assessed on 7/12/19 by Director of	9/18/19

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M 620	Continued From page 1 drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Further review of the policy revealed to prevent catheter-associated Urinary Tract Infections the Steps included in the procedure for a male resident: Use a washcloth with warm water and soap/or cleansing wipe to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth/wipe with each stroke. With a clean wash cloth, if used, rinse with warm water using the above technique. Return foreskin to normal position. Use clean washcloth with warm water and soap/or cleansing wipe to cleanse and rinse the catheter from insertion site to approximately four inches outward. Resident #89 During the initial tour of the facility, on 07/09/2019 at 10:30 AM, it was observed, from the hallway Resident #89's catheter tubing was laying over the top of her bed's side rail, thus it was above the level of her bladder. It was observed that Resident #89's side rail on her bed was in an upright position. During a follow-up observation, on 07/09/2019 at 12:15 PM, it was observed that Resident #89's catheter tubing was still laying across the top of the bed's side rail, which was still in an upright position. Review of Resident #89's medical records document titled "New Physician's Orders (Physician Visits and Telephone Orders," dated 06/13/2019, revealed an order for a Foley	M 620	Nursing for potential negative outcomes as well as monitored for 7 days, no negative outcomes were found. 3. On 7/12/19, an in-service was initiated by the Quality Assurance Nurse to Nursing and Certified Nursing Assistant staff members who were in-serviced by 7/25/19 regarding Bowel/Bladder Incontinence, Catheter, and urinary tract infection prevention. Education Nurse will complete return demonstration for compliance for Nursing staff, Certified Nurses Assistants, agency staff, and hospice staff by 9/18/19. On 8/22/19, Quality Assurance committee reviewed policy and procedure for catheter and incontinent care for comprehensive care plans to which no changes were recommended. 4. Education nurse will observe four catheter care procedures per month for two months for accuracy and proper procedure per facility policy. Quality Assurance Committee will review findings of Education Nurse monthly for two months. All findings will be submitted to Quality Assurance Committee for review and any further discrepancies will be immediately rectified by Quality Assurance Nurse.	

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M 620	Continued From page 2 Catheter for Resident #89. The telephone orders also revealed that catheter care is to be done every shift (Q-shift) and as needed (PRN) per facility policy and procedure. During an interview, on 07/09/2019 at 12:18 PM, Licensed Practical Nurse (LPN) #1, revealed the catheter tubing should not be hanging over the bed's side rail, because it was above the level of Resident #89's bladder. LPN #1 stated that if the catheter tubing was higher than the bladder, it would cause the urine to back up into the resident's bladder causing a Urinary Tract Infection (UTI). During an interview, on 07/09/2019 at 3:11 PM, Registered Nurse (RN) #1/ Infection Control Officer, confirmed the catheter tubing should not be over the bed's side rail, above the level of Resident #89's bladder. RN #1 stated the Certified Nursing Assistants (CNA) know better. RN #1 stated they must have forgotten to re-position the catheter after giving her a bath. RN#1 also stated it could have been the hospice CNA. Review of the Face Sheet revealed Resident #89 was admitted by the facility, on 08/15/2014, with diagnoses to include Cardiac Arrhythmia and Alzheimer's Disease (AD). Resident #7 Record review of the facility's training titled, CNA (Certified Nursing Assistant) Performance And Skills Evaluation revealed the Certified Nursing Assistants (CNAs) were in-serviced 12/06/2018, 02/14/2019 and 04/15/2019 on providing appropriate catheter care.	M 620		

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M 620	Continued From page 3 An observation, on 07/10/19 at 2:24 PM, revealed CAN #2 provided Resident #7's catheter care. CNA #2 washed her hands and applied gloves. CNA #2 applied soap to the wet wipe, and cleansed the right side of the catheter tubing, and then cleansed the left side of the catheter tubing with the same wipe. CNA #2 did not rotate the wipe. CNA #2 rinsed the catheter tubing with a wet wipe without rotating the wipes. During an interview, on 07/10/19 at 3:46 PM, Registered Nurse (RN) #3/Staff Development Nurse revealed the CNAs are trained upon hire and annually on the appropriate way to provide catheter care in a manner to prevent infection. During an interview, on 07/10/19 at 3:49 PM, the Director of Nursing (DON) revealed CNA #2 should have rotated the wipe during the catheter care. The DON said the staff was trained annually how to provide catheter care. An interview, on 07/11/19 at 9:42 AM, CNA #2 confirmed the she failed to rotate the wipes during the catheter care. CNA #2 said she was nervous and did not realize she didn't rotate or change the wipes. Review of the Face Sheet revealed the facility admitted Resident #7, on 01/29/2018, with diagnoses, which included Neurogenic Bladder, Urinary Retention and Stage 4 Pressure Ulcers. A review of Resident #7's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/2/2019, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident was cognitively impaired.	M 620		

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M 620	Continued From page 4 Resident #139 An observation, on 07/10/19 at 2:30 PM, revealed Resident #139's catheter/peri care was provided by CNA #1. CNA #1 washed her hands, applied gloves, and then began to clean the catheter tubing with wet wipes. No concerns were noted. CNA #1 left the room to get more wipes. CNA #1 returned to the room and placed the wipes on the table without a barrier. CNA #1 did not wash her hands, placed gloves on her hand and wiped the shaft of the resident's penis three times and dried the shaft of the penis. CNA #1 did not clean the head of the penis. During an interview, on 07/10/19 at 2:31 PM, RN #3 Staff Development Nurse said the staff was trained upon hire and annually to clean the head of the penis while performing catheter and peri care. RN #3 said CNA #1 should have cleaned the head of the penis by pulling the skin back, and wipe the right and left side in a circular motion with the wipe. During an interview, on 07/10/19 at 2:35 PM, with the DON revealed CNA #1 should have cleaned the head of the penis to prevent infection. During an interview, on 07/11/19 at 9:26 AM, CNA #1 confirmed she forgot to wash the head of Resident #139's penis because she was in a hurry. CNA #1 also said she forgot to put down her barrier. A review of the Face Sheet revealed the facility admitted Resident #139, on 06/03/2019, with diagnoses which included Neuromuscular Dysfunction of the Bladder, Diabetes Mellitus and	M 620		

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M 620	Continued From page 5 Major Depressive Disorder. A review of Resident #139 Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2019, revealed Resident #139 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #88 On 07/09/19 at 2:45 PM, an observation revealed Certified Nursing Assistants (CNAs) #3 and #4 provided Resident #88's catheter care. CNA #3 and #4 washed their hands. CNA #3 set a clean barrier and placed a package of wipes, clean brief, and a box of clean gloves on the barrier. CNA #1 retrieved a clean wipe from the the package and cleaned around the resident's penis head x four (4) using the same wipe, did not rotate the wipe. CNA #3 discarded that wipe, retrieved another wipe from the package of wipes and cleaned around the resident's penis head x four (4) using the same wipe without rotating the wipe again. CNA #3 discarded that wipe, and CNA #3 retrieved another wipe from the package of wipes and cleaned around the resident's penis head x four (4) times using the same wipe and without rotating the wipe. Both CNAs positioned the resident onto his left side to remove the soiled brief and pad. They then positioned the resident onto his right side to finish removing soiled brief and pad. The CNAs applied a clean brief and pad to the resident. The CNAs discarded all of the soiled items into the biohazard trash and placed the linens in a biohazard linen hamper in the resident's room. Neither CNA cleaned the catheter tubing. The CNAs repositioned the resident on his left side, placed the catheter	M 620		

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M 620	Continued From page 6 drainage bag on the left side of the bed, ensured the catheter securing device was in place, covered the resident up, and washed their hands. On 07/10/19 at 9:15 AM, an observation revealed CNA #5 and #6 provided Resident #88's catheter care. CNA #5 set up her supplies; water basin, placed two clear trash bags on the foot of the resident's bed, a box of gloves, and a package of wipes. Both CNAs applied clean gloves, and CNA #5 removed several clean wipes from the package of wipes, and CNA #5 placed the wipes on the resident's bed. CNA #5 wet the washcloth with soap and water and wiped the resident's right groin area in a back and forth motion without rotating the washcloth. She then wiped the resident's left groin area in a back and forth motion multiple times. CNA #5 retrieved a wipe and anchored the resident's catheter tubing nearest the meatus and wiped in an outward motion x four (4) in a back and forth motion and without rotating the wipe. She retrieved another wipe and wiped the resident's catheter tubing in a back and forth motion x four (4), and without rotating the wipe. While using a dry towel, CNA #5 dried the area also using a back and forth motion four (4), and dried the catheter tubing again by patting around the catheter tubing and penis area x six (6) without rotating the dry towel. On 07/11/19 at 10:05 AM, an interview with CNA #5, revealed she should have wiped in a downward motion and should have rotated her washcloth. She also stated wiping in a back and forth motion is cross contamination and could cause an infection. On 07/11/19 at 10:15 AM, an interview with CNA #6, revealed she placed the wipes on the resident's bed, and could have used a barrier	M 620		

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M 620	Continued From page 7 before sitting them on the resident's bed covers or placed them in the clean plastic bag. She also stated the wipes became contaminated by sitting them on the resident's bed covers. On 07/11/19 at 10:20 AM, an interview with Registered Nurse (RN) #4/Unit Manager, revealed the CNA should not have wiped in a back and forth motion. RN #4 stated the CNA should have wiped in a downward motion one time and discarded the wipe. Donna stated, if the CNA was using a towel, she should have rotated the towel. She also stated, it is not okay to wipe in a back and forth motion, because it introduces germs back up the catheter and into the bladder and could cause a Urinary Tract Infection. On 07/11/19 at 11:25 AM, an interview with CNA #3, revealed she should have rotated her wipe as she was cleaning the resident's penal area. She stated she should have made the wipe to fit around her hand like a glove so she could have rotated it. She also stated, she should have held the catheter tubing at the end near the penis and wiped away from the penis. On 07/11/19 at 11:35 AM, an interview with CNA #4, revealed when cleaning the catheter tubing the CNA should hold it at the end close to the penis and wipe away from the penis and throw the wipe away. On 07/11/19 at 2:05 PM, an interview with RN #1/Infection Control Nurse, revealed CNA #3 should have rotated or thrown that wipe away and obtained another one, and not use the same wipe. She also stated the CNA should have cleaned from the meatus area outward on the catheter tubing.	M 620		

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M 620	Continued From page 8 On 07/11/19 at 2:10 PM, an interview with RN #1/Infection Control Nurse, revealed when CNA #6 placed the wipes that was pulled from the package on the resident's covers with no barrier present, that contaminated the wipes. She stated CNA #6 should have used a barrier. She also stated CNA #5 should have wiped once or only used one wipe and rotated that wipe and never clean in a back and forth motion. She also stated she should have wiped the catheter tubing once in an outward motion from the meatus area and thrown the wipe away and never wipe in a back and forth motion. On 07/12/19 at 10:45 AM, an interview with the DON, revealed the CNAs should not have gone from dirty to clean because they can introduce bacteria which could cause an infection.	M 620		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, record review, facility policy review, resident interview, and staff interview, the facility failed to provide tracheostomy care in a manner to prevent cross contamination for two (2) of three (3) residents	M 655	1.On 7/12/19, an immediate assessment was done on Resident #22 and Resident #88 to verify no adverse effects. Both residents were assessed on 7/12/19 and monitored for seven days by Assistant Director of Nursing along with Nurse Practitioner and Physician Assistant, to which no adverse effects were found.	9/18/19

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M 655	Continued From page 9 observed for tracheostomy care, (Resident #22 and Resident #88) and failed to provide nebulizer treatment under staff supervision for one (1) of two (2) resident nebulizer treatment observations. (Resident #86) Findings include Review of the facility's policy titled, "Administering Medications Though a Small Volume (Handheld) Nebulizer," dated October 2010, revealed it is the policy of this facility that the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into resident's airway. The facility policy stated that one of the steps in the procedure was to remain with the resident for the treatment. Resident #86 During an observation, on 07/10/2019 at 9:30 AM, revealed Resident #86 was in her room, lying in bed, with a nebulizer treatment in progress. Further observation revealed there was no staff or nurse present in the room, or nearby in the hallway. Review of Resident #86's medical record documentation titled, "Physician's Orders" dated July 2019, revealed an order, dated 11/27/2018, for one (1) vial containing 0.25 milligrams (mg) of the medication budesonide (a steroid) to be suspended in a Two (2) milliliters (ml) of saline solution, given via a Nebulizer, two (2) times (x) a day (BID). Review of Resident #86's medical record documentation titled, "E-Mar" (Electronic Medication Administration Record), revealed that one (1) vial containing 0.25 milligrams (mg) of the	M 655	Nurses and Respiratory Therapist providing care for tracheostomy patients were in-serviced on 7/12/19 from Director of Nursing regarding tracheostomy care and tracheal suctioning. 2. Ten tracheostomy residents and twenty-six residents receiving nebulizer treatments have potential to be affected by this deficient practice. On 7/12/19, all tracheostomy residents and nebulizer residents were assessed by Director of Nursing for any issues regarding negative outcomes and were monitored for seven days by Quality Assurance nurse. No adverse affects were found. 3.. All Nurses and Supervisors who care for tracheostomy patients were in-serviced by outside Respiratory Therapist on 7/31/19 including competency return demonstrations. Nursing and certified nursing assistant staff members were in-serviced by Education Nurse regarding nebulizer treatments and correct policy and procedure regarding the plan of care. On 8/22/19, the Quality Assurance committee reviewed the tracheostomy care policy and procedure and no changes were recommended. 4. Education nurse will observe three tracheostomy care procedures and three respiratory treatments for compliance every month for two months for accuracy. Quality Assurance Committee will review findings of Education Nurse monthly for two months. All findings will be submitted to Quality Assurance Committee for review and any further discrepancies will be	

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M 655	Continued From page 10 medication budesonide (a steroid) to be suspended in a Two (2) milliliters (ml) of saline solution, given via a Nebulizer was administered on 7/10/2019 at 9:30 AM, by Licensed Practical Nurse (LPN) #1. During an interview, on 7/10/2019 at 9:30 AM, with Resident #86, she stated the nurse never stays in the room for the entire treatment time. Resident #86 stated, sometimes when it is finished, I just take the mask off myself. An interview, on 07/11/2019 at 3:44 PM, revealed License Practical Nurse (LPN) #2/ Transitional Care Nurse, stated he was supervising the morning of 07/10/2019. LPN #2 said he was aware Resident # 86 was receiving a nebulizer treatment, but he had left the room to go check on something and left the resident alone with a nebulizer treatment in progress. LPN #2 stated he was aware that a nurse should remain with the resident for the duration of the treatment to monitor response and effectiveness of the treatment. A telephone interview, on 07/11/2019 at 4:26 PM, with Licensed Practical Nurse (LPN) #1, revealed she was the nurse who started the nebulizer treatment for Resident #86 on 7/10/2019. LPN #1 stated she got very busy preparing the rest of Resident #86's medications and did not stay with the resident for the duration of her nebulizer treatment. LPN #1 said she knew it was the facility's policy for the nurse to stay with a resident during a nebulizer treatment until it was finished. An interview, on 07/12/2019 at 10:19 AM, with the Director of Nursing (DON), confirmed that the nurse should have stayed with the resident for the duration of the nebulizer treatment. The DON	M 655	immediately rectified by Quality Assurance Nurse.	

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M 655	Continued From page 11 stated that the correct way for administering nebulizer treatments is in the facility's policy for nebulizer treatments administration. The DON said the nurse should have stayed with the resident Review of the Face Sheet revealed Resident #86 was admitted by the facility on 06/3/2015 and re-admitted the resident on 12/15/2015, with diagnoses to include Pressure Ulcer of the Sacral Region and Chronic Obstructive Pulmonary Disease (COPD). Resident #22 On 07/10/19 11:42 AM, an observation revealed Licensed Practical Nurse (LPN) #4 provided Resident #22's tracheostomy care. LPN #4 washed her hands and applied the sterile gloves just like they were regular gloves. She removed the tracheostomy dressing and inner cannula. LPN #4 washed her hands and applied clean gloves. She then cleaned around the tracheostomy plate area and around the inner cannula with a sterile water moistened 4x4 using a back and forth motion x six (6). She moistened a Q-tip with the sterile water and cleaned the inner cannula area in a back and forth motion multiple times and discarded the Q-tip. LPN #4 retrieved another Q-tip, moistened it with sterile water and cleaned the inner cannula area in a back and forth motion and discarded it. She then moistened a 4x4 gauze with sterile water and cleaned the neck plate wiping it in a back and forth motion multiple times and discarded it. She washed her hands, applied clean gloves, and placed a new inner cannula. She discarded all the soiled supplies. On 07/12/19 10:15 AM, an interview with LPN #4,	M 655		

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	18HC	A. BUILDING: _____ B. WING _____	07/12/2019

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M 655	Continued From page 12 revealed she should have wiped in one direction and thrown the 4x4 gauze and Q-tip away while providing tracheotomy care to Resident #22. She also stated wiping in a back and forth motion would cause cross contamination. On 7/12/19 at 10:35 AM, during an interview with the Director of Nursing (DON), the DON revealed LPN #4 should not have gone from dirty to clean, because that is cross contamination and could cause an infection. She also stated the nurse should have maintained a sterile technique with handling the inner cannula Resident #88 On 7/9/19 at 10:50 AM, an observation revealed the Respiratory Therapist (RT) entered the resident's room to provide Resident #88's tracheostomy care. The RT set up his supplies. He attempted to put on the sterile gloves that were in the packet but changed his mind and wrote the current date on the sterile water bottle. He organized his supplies, poured the sterile water into a clear plastic basin that he removed the sterile gloves and other tracheostomy supplies from the Tracheostomy Care Tray kit and placed the items on the barrier. He applied the sterile gloves that he had bought into the room with him, moistened a 4x4 gauze with the sterile water, and cleaned around the tracheostomy neck plate x eight (8) in a back and forth motion using the same 4x4 gauze without rotating the gauze. He then retrieved another gauze, moistened it with the sterile water and cleaned around the tracheostomy neck plate again using a back and forth motion x 10, and did not rotate the 4x4 gauze. He removed the inner disposable cannula and changed his gloves. The RT cleaned around the tracheostomy inner	M 655		

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M 655	Continued From page 13 cannula area using a 4x4 moistened gauze with sterile water wiping in a back and forth motion x six (6) and again did not rotate the gauze. He then used a Q-tip moistened with sterile water and cleaned around the tracheostomy inner cannula area in a back and forth motion x 10. The RT retrieved another Q-tip, moistened it with sterile water, and cleaned again around the tracheostomy inner cannula area using a back and forth motion x eight (8). He obtained a 4x4 gauze, moistened it with sterile water and wiped around the tracheostomy inner cannula area in a back and forth motion x four (4). He retrieved another 4x4 gauze, moistened it with sterile water and wiped around the tracheostomy inner cannula area in a back and forth motion x eight (8) without rotating the gauze. He placed a new inner cannula in the tracheostomy and disposed of the soiled supplies in the biohazard trash can in the resident's room. On 7/11/19 at 1:45 PM an interview with the RT, revealed, he probably should have washed his hands during glove changes. He also stated he did not have his "bag" and likes to have his soiled utility bag. The RT stated, he has an injury to his left smallest finger, so he could not wear the sterile gloves that were in the Tracheostomy kit. He stated because he knew Resident #88, he felt like he could provide tracheostomy care to the resident on room air and did not need to pre-oxygenate the resident prior to providing tracheostomy care. He also stated he had checked the O2 sat but forgot to tell the surveyor. The RT stated he could contaminate the area by not rotating the gauze or throwing away the gauze after wiping one time. He stated he would have most definitely done things differently, such as letting the surveyor know that he had checked the 2 sat, he would pre-oxygenate before providing O	M 655		

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M 655	Continued From page 14 tracheostomy care, and he would wipe once and discard the 4x4s and/or Q-tips. On 7/11/19 at 2:05 PM an interview with Registered Nurse (RN) #1/Infection Control Nurse revealed, the RT should have wiped the area once and thrown the 4x4 gauze away and wiped with a circular motion with the Q-tip once, thrown it away, and gotten another one to wipe again. An interview, on 07/10/19 8:36 AM with the Doctor revealed, the resident coded as a result of respiratory failure and had to receive the tracheostomy. Review of the Physician's Orders, dated July 2019, revealed the following orders: Suction tracheostomy site per policy and procedure prn (as needed) and as ordered by a physician. Change tracheostomy tubing, oxygen delivery, mask, T-tube (tracheostomy tube) and oxygen humidifier bottles and tubing prn. Change tracheostomy tubing, oxygen delivery, mask, T-tube and oxygen humidifier bottles and tubing prn. Oxygen sign on front and back of door. Check O2 sats (oxygen saturations) prn notify MD if sats < (less than) 88% (percent). Check O2 sats Q (every) shift, notify MD (Medical Doctor) if O2 sat is < 88%. Humidified O2 @ (at) 2 liters per trach mask T-tube. Chest physiotherapy (CPT) or positive expiratory pressure (PEP) therapy prn airway clearance, prevent or treat atelectasis. Pulmonary lavage with sterile normal saline per tracheostomy per licensed nurse or Registered Respiratory Therapist. May use 2-4 ML (milliliters) 20% mucomyst nebulized or via instillation with pulmonary lavage Q 4 hrs prn. Tracheostomy	M 655		

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M 655	Continued From page 15 HME (heat and moisture exchanger) applied to tracheostomy as needed for humidification when out of bed (use only if resident's secretions are thick). EzPAP (positive airway pressure therapy) via (by) tracheostomy x15 minutes prn lung expansion, airway clearance per licensed nurse or respiratory therapist. May use 3 ML 7% NaCL/duoneb (sodium chloride/dual nebulizer) 2 ML mucomyst. Mouth care every shift. Suction secretions from oral cavity prn. Notify MD if tracheostomy is dislodged. Type and size of tracheostomy, #8 Shiley DCT (disposable cuff tube). Document characteristics and amount of sputum secretions. A review of the Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/28/19, revealed the MDS was coded to include tracheostomy care.	M 655		