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	255272	A. BUILDING _____ B. WING _____	07/19/2019

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MYRTLES NURSING CENTER, LLC	1018 ALBERTA AVENUE COLUMBIA, MS 39429

(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 from 7/16/19 through 7/19/19. 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 583, F 641, F 645, F 656, F 657, F 690, and F 880. At the time of the survey, the census was 83 and the facility held a license for 98 beds.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		8/13/19

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

Electronically Signed | 08/03/2019

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 583	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide privacy during the administration of enteral medication for Resident #64 and for continuous enteral feedings for Resident #72; for two (2) of six (6) residents observed for privacy during medication pass and for residents with enteral feedings. Findings include: A review of the facility policy titled "Administering Medications through Nasogastric or Gastrostomy Tube", revised 3/2018, revealed to provide privacy to the resident. A review of the facility policy titled, "Resident Rights", dated 11/17, revealed the residents residing at this facility would be provided personal privacy, which included any medical treatment. A review of the facility policy titled, "Gastrostomy/Nasogastric Tube", dated 12/18, revealed that during the administration of tube feedings, to provide privacy and explain procedure to resident.	F 583	* On 07/18/2019 Director of Nursing was made aware of facility failure to provide privacy during the administration of enteral medication for Resident #64 and provision of privacy for continuous enteral feedings for Resident #72, when out of room. Director of Nursing assessed Resident #64 and Resident #72 on 7/18/2019 with no adverse findings noted. * All residents receiving enteral medications or enteral feedings have the potential to be affected by this deficient practice. * Director of Nursing conducted one on one in-service with LPN #3 on 7/19/2019, addressing proper procedures to ensure privacy during administration of enteral medications. In-service training was initiated on 7/18/2019 for Licensed Practical Nurses, Registered Nurses, Certified Nurse Aides and therapy personnel, regarding provision of privacy during enteral medication administration and during enteral feeding. * Director of Nursing and or Charge Nurse will monitor privacy during provision of enteral medications or enteral feedings three (3) times weekly for four (4) weeks	

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F 583	Continued From page 2 Resident #64 An observation on 07/17/19 at 1:54 PM, revealed Licensed Practical Nurse (LPN) #3, while administering enteral medications, left Resident #64's door open and only pulled the middle curtain between the other resident in the room. LPN #3 pulled Resident #64's gown up to under her breast, which was covered, and the sheet was pulled down to the top of the thigh. LPN #3 also went to the door and asked for a cup, but did not close the door. LPN #3 provided the medication per enteral tube, per the Medication Administration Record (MAR) on 7/17/19 at 2:00 PM. An interview on 7/17/19 at 2:15 PM, with LPN #3, revealed it was policy for the door to be closed during care and he usually did close the door, but he was nervous. LPN #3 said that he would expect a reasonable person to want the door closed when administering an enteral medication. In an interview on 7/17/19 at 3:00 PM, the Director of Nursing stated it was not the facility policy to leave the door open during any care, and she would expect the door to be closed while administering the enteral medications for the resident's privacy. A review of Resident #64's Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 6/14/19, revealed severely impaired cognition. Resident #64 was unable to verbalize when asked about the door being open. A review of Resident #64's face sheet revealed diagnoses of unspecified sequelae of unspecified Cerebrovascular Disease and Aphasia.	F 583	and monthly for two (2) months. The Quality Assurance Committee will evaluate during monthly meeting findings from monitoring and make any needed recommendations. Quality Assurance and Performance Improvement (QAPI) will be initiated if warranted.	

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F 583	Continued From page 3 Resident #72 An observation on 07/16/19 at 12:22 PM, revealed the Certified Occupational Therapy Assistant (COTA) brought Resident #72 to the main dining room, with a percutaneous endoscopic gastrostomy (PEG) tube feeding infusing via a feeding pump; the pump/tube/bag was exposed and not covered. An observation on 07/17/19 at 01:32 PM, revealed Resident #72 to be in the Therapy Department with the PEG tube feeding exposed and not covered. In an interview on 07/17/19 at 02:00 PM, LPN #2 stated, concerning Resident #72, "We've never covered the PEG Tube, no one ever told us to do that." In an interview on 07/17/19 at 02:05 PM, Certified Nursing Assistant (CNA) #1 stated, "We've never covered the PEG tubes." In an interview on 07/18/19 at 12:02 PM, the Director of Nursing (DON) stated, "They have never covered the PEG tube feeding bags up." The DON also stated, "I do not have a policy for PEG tubes being covered." In an interview on 07/18/19 at 2:17 PM, Resident #72 stated, "I don't understand about the PEG Tube."	F 583		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		8/13/19

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F 641	Continued From page 4 resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) related to discharge for one (1) of 24 resident MDS assessments reviewed, Resident #86. Findings include: A review of the Resident Assessment Instrument (RAI) Manual dated October 2017, chapter 2.1, revealed the RAI process is the basis for the accurate assessment of each resident. A review of the most recent MDS with an Assessment Reference Date (ARD) of 6/24/19, revealed a Discharge End of Prospective Payment System (PPS) Assessment Return not Anticipated was coded with the discharge status being acute hospital. Review of a nurse progress note, dated 6/24/19, revealed Resident #86 was discharged from the facility on 6/24/19, to home. Review of physician's orders, dated 6/24/19, documented to discharge Resident #86 home with all medications, with Home Health Services. On 07/18/19 at 9:21 AM, an interview with the Medical Records Nurse, Licensed Practical Nurse (LPN) #7, revealed Resident #86 was discharged to home. On 07/18/19 at 10:36 AM, an interview with LPN #1 revealed the resident was admitted for short-term rehabilitation, received therapy, and	F 641	* Director of Nursing was notified on 7/16/2019 that facility had failed to accurately code the Minimum Data Set (MDS) related to discharge for one(1) of twenty four (24) resident MDS assessments reviewed, Resident #86 discharge assessment was coded inaccurately. MDS on Resident #86 was re-opened on July 29, 2019, discharge status was corrected and assessment was resubmitted. * All residents discharged from the facility have the potential to be affected by this deficient practice. * Director of Nursing provided in-service training to Assessment Nurses on accurate coding of the Minimum Data Set (MDS) on 7/19/2019. Minimum Data Set (MDS)discharge assessments on residents discharged from the facility for the past twelve (12) months were reviewed for accuracy of discharge status, completed on 08/02/2019. Assessments with an incorrect discharge status will be corrected and resubmitted by 8/6/2019 * Director of Nursing and or Nursing Home Administrator and or Medicare Nurse Case Manager will review the accuracy of the discharge status coding on assessments during weekly transmission meeting for six (6) weeks. Issues noted during this review will be brought to the Quality Assurance and Improvement Committee to be addressed for a period of three (3) months. Quality Assurance and Performance	

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F 641	Continued From page 5 was discharged home. She also confirmed the most recent discharge End of Therapy Assessment indicated the resident was discharged to an acute hospital. She stated that is not an accurate MDS assessment of the resident because she went home. LPN #1 stated she will have to make a correction. On 7/16/19 at 3:05 PM, an interview with the Director of Nurses (DON) revealed she would expect the MDS to be coded accurately.	F 641	Improvement (QAPI) will be initiated if warranted.	
F 645 SS=C	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental	F 645		8/13/19

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F 645	Continued From page 6 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)	F 645		

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F 645	Continued From page 7 or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and staff interview, the facility failed to complete an accurate Preadmission Screening (PAS) upon admission for three (3) of three (3) resident PASs reviewed, Resident #78, Resident #15, and Resident #23. Findings include; A review of the facility policy titled "Pre-Admission Screening PAS/PASRR (Pre-Admission Screening Resident Review)", with an original date of 11/06, and revised date of 10/18, revealed the PAS with Level I must be submitted to Division of Medicaid (DOM) and approved prior to admission to a nursing facility, regardless of payment source. The policy also revealed the Level II evaluation must occur prior to admission and whenever the resident has a significant change in status. A change in status referral for Level II Resident Review Evaluation is required for individuals previously identified by PASRR to have Mental Illness, Intellectual Disability/Development Disability, or a related condition in the following circumstances: A resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASRR Level II evaluation and determination. (Note that a referral for a possible new Level II PASRR evaluation is required whenever such a disparity is discovered is discovered, whether or not associated with a SCSA). The Nurse Case Manager or other facility designee will be responsible for completing the	F 645	* Director of Nursing was notified 7/18/2019 of the deficient practice of failing to complete an accurate Preadmission Screening (PAS) upon admission for three (3) of three (3) residents reviewed, Resident #78, Resident #15, and Resident #23. PAS level II Change in Status Request completed on Resident #78, Resident #15, and Resident #23 completed and submitted to ASCEND on 7/31/2019. * All residents admitted to facility with a diagnosis of mental illness or taking Psychotropic medications have the potential to be affected by this deficient practice. * The PAS of all residents currently in the facility taking psychotropic medications will be reviewed for accurate documentation of diagnosis and or medication for the treatment of mental illness. The audit will be completed by 8/09/2019. Any inaccuracies will be addressed by completion of a PAS Level II Change in Status Request. The Director of Nurses provided in-service training to the Assessment Nurses and Social Services Director addressing proper completion of the PAS to include current medications and diagnosis prior to the submission of the PAS on 7/29/2019. Upon hire to the assessment office the new employee will receive training on the proper completion and submission of the PAS.	

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F 645	Continued From page 8 PAS. Resident #15 A review of Resident #15's Diagnosis/History revealed Resident #15 was re-admitted on 11/10/2016, with a diagnosis of Bipolar Disorder, unspecified. A review of Resident #15's PAS, dated 11/11/2016, revealed the response to the question, "Person takes, or has a history of taking, psychotropic medication" was documented "no". The PAS also revealed the level II evaluation was not indicated at this time. A review of Resident #15's "Physician Order List" revealed an order for Abilify 15 milligram (mg) tablet one (1) by mouth every morning related to Bipolar Disorder, dated 1/2/18. In an interview on 7/18/19 at 12:26 PM, the Director of Nursing (DON) stated about Resident #15's PAS, "We did not complete a PASARR II with correct diagnosis on the resident." The DON stated that Resident #15's PAS was not completed with the correct diagnosis. The DON stated the Social Worker Assistant with a Registered Nurse (RN) usually completed the screening. Resident #23 A review of the PAS dated 12/24/14, revealed Resident #23 did not have a diagnosis of a major mental illness or a history of a mental illness. The PAS also indicated the resident did not take or have a history of taking a psychotropic medication. The PASRR Level I re-review Identification Screen, reviewed by Ascend, showed nursing home placement was appropriate	F 645	* The Director of Nursing and or Medicare Nurse Case Manager will monitor PAS screening forms prior to submission on all admissions or returns from Geriatric Behavior Unit along with others who may have status changes related to medications or diagnosis for proper documentation of current psychotropic medications or diagnosis for the next six (6) admissions to facility and periodically thereafter. Issues noted during the review will be brought to the Quality Assurance and Improvement committee to be addressed. Quality Assurance and Performance Improvement (QAPI) will be initiated if warranted.	

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F 645	Continued From page 9	F 645		

for Resident #23.

Review of the Admission Medicare 5 Day (AM5) Minimum Data Set (MDS) with an ARD of 12/26/14, was coded to include antipsychotic, antianxiety, and antidepressant medications.

A review of the facility's Face Sheet revealed the facility admitted Resident #23 on 12/19/14, with diagnoses of Unspecified Psychosis and Major Depressive Disorder.

On 7/18/19 at 1:55 PM, an interview with the Director of Nurses (DON) revealed the case managers as well as herself completed the PAS. She also confirmed the PAS dated 12/24/14, for Resident #23, indicated she did not have a diagnosis of a major mental illness or a history of a mental illness. The DON stated the PAS indicated the resident did not take or have a history of taking psychotropic medications. She confirmed the Diagnosis/History list indicated the resident was admitted with the diagnoses of Psychosis and Major Depressive Disorder on 12/19/14.

Resident #78
A review of the PAS Application, dated 11/20/15, documented in the Part B- Level II Referral Criteria section that Resident #78 had no history of, or presented any evidence of, cognitive or behavior functions that indicate the need for a Mental Retardation (MR) evaluation, no diagnosis of a major mental illness, and was not taking or had no history of taking, psychotropic medications.

A review of a PAS Application for Long Term Care, dated 12/7/15, for Resident #78, identified

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diagnoses of Major depressive Disorder and Schizophrenia. The PAS does not indicate that Resident #78 meets Part B Level II Criteria based on Mental Health issues.

A review of Department of Mental Health Letter, dated 12/16/15, revealed Resident #78 meets nursing level of care and may be admitted to a nursing facility.

A review of face sheet revealed Resident #78 was admitted to facility on 11/20/15, with a diagnosis of Major Depressive Disorder and Schizophrenia. A review of facility document titled "Diagnosis/History", revealed Resident #78 with diagnoses of Major Depressive Disorder and Schizophrenia on 11/20/15.

A review of facility document titled "Physician Orders List" revealed Resident #78 received Seroquel for Schizophrenia, dated 11/14/16.

An interview on 07/18/19 at 08:15 AM, with LPN #5 Assessment Nurse /Care Plan Nurse, revealed Resident #78 came from another facility. LPN #5 stated that they should have picked up on the Schizophrenia diagnosis and done a new Level II request or a change in status. LPN #5 stated that the Minimum Data Set (MDS)/Care plan nurse is supposed to do the change in status, based on orders. LPN #5 stated, "It just fell thru the crack.

An interview on 07/18/19 at 08:20 AM, with the Social Services Director (SSD) stated that the facility where the resident is coming from does the PAS Level I screening and then the information is "sent to me and I put it in the computer just like they have it. I don't check

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F 645	Continued From page 11 diagnoses at that time". The Social Service Director stated that "the diagnosis of Schizophrenia should have been captured before the resident entered the facility. The Social Service Director stated, "However, it is our responsibility to identify the diagnosis if there is a change in status. The capturing of the Schizophrenia diagnosis just fell through the crack." An interview on 07/18/19 at 08:32 AM, with Director of Nursing (DON), revealed the facility should have picked up on Resident #78's diagnosis of Schizophrenia when she came into the facility. The DON stated that it is the facility's responsibility to correct a Level I diagnosis. The DON stated, "According to our policy, the Nurse Case Manager or their designee is responsible for completion and accuracy of the PAS. I have been known to fill out a PAS". An interview 07/18/19 at 01:59 PM, with LPN #1/Care Plan Nurse, revealed, "If the level I assessment is not filled out correctly that makes the Level II inaccurate". An interview on 07/18/19 at 03:03 PM, with the DON revealed, "I expect the PAS to be filled out correctly".	F 645		
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	F 656		8/13/19

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F 656	Continued From page 12 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 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 facility policy review, staff interview, and record review, the facility failed to develop a care plan related to the diagnosis of Depression	F 656	* Director of Nursing was notified on 7/18/2019 of the deficient practice of failure to develop a care plan related to	

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F 656	Continued From page 13 for one (1) of 24 resident care plans reviewed, Resident #70. Findings include: A review of facility policy titled "Care Plan Process", revised 08/17, revealed: Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and need in relation to a number of specified areas. The results of the assessment, which must accurately reflect the residents status and needs, are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care. The Resident Assessment Instrument (RAI) will be used to determine guidelines for revisions and completion dates for the Comprehensive Care Plan. A review of Resident #70's Comprehensive Care Plan, dated 5/24/19, revealed no care plan for Anxiety, or Depression. A review of Physician's Orders, dated 5/24/19, revealed Resident #70 was prescribed Cymbalta and Seroquel with a Diagnosis of Depression. A review of a Physician's Order, dated 6/28/19, revealed to ADD the diagnosis of Anxiety/chronic pain for Cymbalta. The order also showed to decrease Seroquel and taper to discontinue medication. A review of the July 2019 Physician's Orders, revealed Resident #70 was prescribed Cymbalta with a diagnosis of Anxiety and Seroquel for a diagnosis of Depression on 6/28/19.	F 656	diagnosis of depression for Resident #70. A care plan for Depression/Anxiety was developed on 7/18/2019 and implemented for resident #70. * All residents with diagnosis of depression in the facility have potential to be affected by this deficient practice. * Director of Nursing provided in-service to Assessment Nursing staff on the care plan process on 7/19/2019. Upon hire to the assessment office new employees will receive training on the proper development of care plans for each residents specific needs. An audit of residents with diagnosis of depression was conducted on 08/02/2019 by Director of Nursing with areas of concern addressed. The Director of Nursing will review care plans of residents with diagnosis of Depression weekly for four (4) weeks and then monthly for two (2) months. The Quality Assurance Committee will evaluate the Director of Nursing assessments monthly for three (3) months and make any needed recommendations to ensure ongoing compliance. Quality Assurance and Performance Improvement (QAPI)will be initiated if warranted.	

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F 656	Continued From page 14 An interview on 07/18/19 at 08:05 AM, with Licensed Practical Nurse (LPN) #5/Assessment Nurse/Care Plan Nurse, revealed, "If a care plan is created, then I expect all staff should follow the care plan. If a care plan needs updating, it should be updated. After reviewing Resident #70's care plan, I see it was not developed to reveal diagnoses of Depression and Anxiety". LPN #5 stated that Comprehensive Care plans are developed to provide care for the resident. LPN #5 confirmed that there was no care plan developed for Depression or Anxiety for Resident #70. An interview on 07/18/19 at 08:50 AM, with the Director of Nursing (DON), revealed a care plan should have been created for Resident #70 to show diagnoses of anxiety and depression and the medication Resident #70 was taking at the time.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		8/13/19

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F 657	Continued From page 15 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on facility policy review, staff interview, and record review, the facility failed to revise the comprehensive care plan related to an antipsychotic medication for one (1) of five (5) residents reviewed for unnecessary medication review, Resident #34; and, failed to revise the comprehensive care plan related to catheter care for one (1) of four (4) residents care plans reviewed for catheter care, Resident #3. Findings include: A review of facility policy titled, "Care Plan Process", revised 08/17, revealed: The results of the comprehensive assessment, which must accurately reflect the residents status and needs, area to be used to develop, review, and revise each resident's comprehensive person centered plan of care. The Resident Assessment Instrument (RAI) will be used to determine guidelines for revisions and completion dates for the Comprehensive Care Plan. Resident #34. A review of the Comprehensive Care Plan,	F 657	* Director of Nursing was notified on 7/18/2019 of the deficient practice of care plan not being updated to reveal current antipsychotic medication on Resident #34 and care plan for catheter care was not updated to reveal a leg bag with positioning while in bed for proper tube drainage on Resident #3. Assessment Nurse revised care plan to update antipsychotic medication for Resident #34 and revised catheter care plan of care to include leg bag and positioning while in bed for proper tube drainage on Resident #3. These revisions were completed on 7/18/2019. * All residents prescribed antipsychotic medications or having indwelling catheter have the potential to be affected by this deficient practice. * Director of Nursing provided in-service training to Assessment Nursing staff on care plan process 7/19/2019. Upon hire to the assessment office new employees will receive training on the proper development and revision of care plans	

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F 657	Continued From page 16 initiated 8/15/18, revealed Resident #34's care plan for Antipsychotic Medications was not updated to reveal current Psychotropic Medication usage of Seroquel, Buspirone, and Zoloft. The care plan included the use of Risperdal. A review of the July 2019 Physician Orders, revealed Resident #34 was prescribed Buspirone 10 milligram (mg) twice daily for Anxiety on 4/23/19; Zoloft 75 mg daily related to Depression on 2/15/19; and Seroquel 12.5 mg at bedtime related to Psychosis on 4/23/19. There was no order for Risperdal. An interview on 07/18/19 at 8:05 AM, with Licensed Practical Nurse (LPN) #5/Assessment Nurse/Care Plan Nurse, after reviewing Resident #34's Comprehensive Care Plan on the computer, confirmed a care plan was not updated for current Psychotropic medication; she stated that the care plan should have been revised. An interview on 07/18/19 at 08:50 AM, with the Director of Nursing (DON), revealed if a care plan is written it should be updated and followed by staff. The DON stated that Resident #34's care plan should have been updated to reveal current antipsychotic medications. A review of face sheet revealed Resident #34 was admitted to the facility on 8/5/18, with diagnoses of Major Depressive Disorder and Unspecified Psychosis. Resident #3 A review of the Comprehensive Care Plan for Resident #3, with a problem onset of 5/9/17, revealed that the Care Plan for an Indwelling	F 657	for each resident specific needs. In-service to include " Comprehensive Care Plan" policy. An audit of care plans for residents on antipsychotic medications and residents with an indwelling catheter was conducted to ensure current and appropriate interventions were in place by Director of Nursing, completed on 8/3/2019, corrections made as warranted. * The Director of Nursing and or Medicare Nurse Case Manager will review care plans of residents with indwelling catheters weekly for four (4) weeks and then monthly for two (2) months. The Director of Nursing and or Medicare Nurse Case Manager will review care plans of residents with new orders for antipsychotic medications for four (4) weeks and then monthly for two (2) months. The Quality Assurance Committee will evaluate the Director of Nursing and or Medicare Case Manager assessments monthly for three (3) months and make recommendations as needed to ensure ongoing compliance. Quality Assurance Performance Improvement (QAPI) will be initiated if warranted.	

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F 657	Continued From page 17 Catheter had not been updated for the use of a leg bag drainage system or positioning while in bed with use of the leg bag. Observation of Resident #3 and interview with LPN #6, on 07/16/19 at 10:00 AM, revealed Resident #3 was lying flat in bed with both legs up on the bed. A Catheter bag was felt on the right leg through the resident's pants to be located below the knee at the lower leg level. Resident #3's pants leg was pulled up slightly to view the bag, which contained urine. LPN #6 confirmed the resident had a leg bag drainage system for the catheter. An interview on 07/18/19 at 08:30 AM, with Licensed Practical Nurse (LPN) #5, Assessment Nurse/Care Plan Nurse, confirmed the Catheter care plan should have been updated to reflect a leg bag catheter, positioning of the resident, and catheter care for Resident #3. An interview on 07/18/19 at 08:50 AM, with the Director of Nursing (DON), revealed catheter care for Resident #3 should have been updated on the care plan to reveal a leg bag and positioning while in bed for proper tube drainage. An interview on 07/18/19 at 08:50 AM, with Registered Nurse (RN) #1/Infection Control Nurse, revealed the Indwelling Catheter Care Plan should reflect positioning of Resident #3 while lying in bed and placing the drainage bag below the level of the bladder. A review of face sheet for Resident #3 revealed the facility admitted the resident on 5/12/16, with a diagnosis of Urethral stricture.	F 657		

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F 690	Continued From page 18	F 690		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal 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:	F 690		8/13/19

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F 690	Continued From page 19 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide catheter care in a manner to prevent cross contamination and trauma to the bladder for one (1) of two (2) catheter care observations for Resident #3. Findings include: A review of facility policy titled: Perineal Care-Resident with Catheter", revised 10/18, revealed: The purpose of the policy is to prevent irritation or infection. When preparing for care, perform hand hygiene and apply gloves. While performing perineal care, secure the catheter tubing to one leg without causing traction of the urethra. Once perineal care has been provided, unfasten the tubing from the leg. Using one hand hold the catheter close to the urethral opening to prevent tension as you wash the tubing. Do not let the tubing cause traction on the urethra opening at any time. Use a clean washcloth or wash wipe, start as the meatus and wash the tubing in a circular motion away from the body about 4-5 inches. Rinse in the same method. Observe the tubing for any cracks, breaks or occlusions. Observe the urine in the tubing for any sediment, blood or discoloration. Re-secure the tubing to the resident's leg once it has been cleaned. Ensure tubing is not kinked or coiled and is not positioned above the level of the bladder. Remove gloves. Perform hand hygiene. An observation on 07/17/19 at 1:50 PM, revealed Certified Nurse Aide (CNA) CNA #3 performed catheter care on Resident #3 and CNA #2 assisted. CNA #3 gloved and assisted CNA #2 to pull Resident #3 up in bed. CNA #3 used the same gloves to unbutton Resident #3's pants and	F 690	* On 7/17/2019 Director of Nursing and Infection Control Nurse RN#1 were notified of the deficient practice of Certified Nurse Aide (CNA) #3 not washing her hands appropriately through out the catheter care process, tossing cloth in her hand after wiping an area and then wiping another area, holding catheter tubing at the base of the drainage bag and wiping the catheter tubing upward towards the head of the penis during care of Resident #3. Director of Nursing assessed Resident #3 on 7/17/2019 with no adverse findings noted. * All residents with indwelling urinary catheters have the potential to be affected by this deficient practice. * On 7/20/2019, RN #1 conducted one on one in-service with CNA #3 related to proper care of indwelling catheter, including proper hand washing technique. In-servicing for Certified Nurse Aides initiated regarding Perineal Care of residents with catheters, including hand washing technique, in-service training to be concluded by 8/7/2019. * The Director of Nursing and or Staff Development Nurse and or Charge Nurse will observe Perineal care of four (4) residents with indwelling urinary catheters per week for four (4) weeks and then monthly for two (2) months. The Quality Assurance Committee will evaluate these audits monthly for three (3) months to make any needed recommendations to ensure ongoing compliance. Quality Assurance and Performance Improvement (QAPI) will be initiated if warranted.	

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F 690	Continued From page 20	F 690		

to pull his pants down. Resident #3 was lying flat on his bed with both legs up on bed. Resident #3's head of bed (HOB) was flat. The Indwelling urinary Catheter was located at Resident #3's right ankle with the strap loosened but intact on his leg. CNA #3 then un-taped Resident #3's brief and when she went to pull the brief from between his legs Resident #3 yelled out, "it hurts". The Indwelling catheter bag tubing was noted to be pulled very tight. CNA #3 then removed the brief from between Resident #3's legs and left the brief lying under Resident #3 buttocks. CNA #3 did not change her gloves or wash her hands after pulling Resident # 3 up in bed, pulling Resident #3's pants down or after pulling brief from between Resident #3's legs. The Indwelling Catheter tubing was pulled tight from Resident #3's penis to the bag located at ankle. CNA #3, with assistance from CNA #2, reached and pulled the catheter drainage bag up on Resident #3's leg and reattached the strap to hold the bag above Resident #3's knee. The catheter bag/tubing was never detached from the leg during perineal care. Resident #3's right leg was bent in a position that the bag was pointing down towards the tubing, allowing the urine to possibly flow back into the tubing/bag. Approximately 250 cubic centimeters (cc) of urine was noted in the catheter drainage bag at this time. CNA #3 took an unfolded wash cloth and applied soap and water, wiped Resident #3's right groin with one (1) sweep downward, then tossed the cloth around in her hand and wiped the left groin area downward, and then tossed and flipped cloth again to wipe the left groin a final time. The wash cloth was then discarded in a bag. There was no way to determine the area used on cloth was not a repeat area. CNA #3 then took another wash cloth with soap and water and wiped the right

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groin area downward then tossed cloth around in hand, wiped the left groin area downward, and then tossed the cloth in her hand again and wiped the left groin a final time. CNA #3 dried the area with a towel. CNA #3 took another washcloth with soap and water, pulled back the foreskin on the head of the penis, and wiped it with the soapy cloth. CNA #3 then tossed the cloth in her hand and took her fingers and held the catheter tubing at the point it joins the catheter bag and wiped the tubing upwards toward Resident #3's penis. CNA #3 was then told by CNA #2 to hold the tubing at the base of the penis. CNA #3 then tossed the cloth in one hand and moved her other hand to hold the catheter at the base entering the penis and wiped down the tubing towards the catheter drainage bag. CNA #3 then rinsed and dried the tubing. CNA #3 then removed the old brief from under Resident #3's buttocks, applied a new brief and pulled Resident #3's pants back up. CNA #3 still had the same gloves on as used during the entire process.

An interview on 07/17/19 at 2:12 PM, with Licensed Practical Nurse (LPN) #4, revealed that Resident #3 does have a catheter with a leg drainage bag and it is supposed to be anchored to his thigh so it won't move. LPN #4 stated, "We are supposed to keep the bag below the bladder for drainage". LPN #4 stated that the head of the bed should be elevated when Resident #3 is lying in bed. LPN #4 stated that she could see how with Resident #3 lying flat in bed with the catheter drainage bag strapped to his leg and the drainage bag not being below the bladder, could possibly allow the urine to backflow into the tubing and possibly back into the bladder. LPN #4 stated "It could very well cause an issue. If the bag is not secured where it will not move, it could cause a

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F 690	Continued From page 22	F 690		

problem to the urethra". LPN #4 stated that she didn't think the bag could possibly be below the bladder with Resident #3 lying flat in bed. LPN #4 stated that Resident #3 should always have the head of the bed elevated so that the bag would be below the bladder. LPN #4 confirmed that Resident #3 had numerous appointments with a Urologist. LPN #4 reviewed Resident #3's chart and revealed that Resident #3 had appointments with the Urologist on 4/3/19, 5/14/19, 5/6/19, 6/13/19 and 7/2/19 (appointment rescheduled for 7-10-19 per daughter). Resident had a diagnosis of Urinary Retention.

An interview on 07/17/19 at 02:27 PM, with CNA #3, revealed that she had changed Resident #3's linens before doing catheter care and she had left Resident #3 lying flat on the bed. CNA #3 stated that she did not know how long the catheter strap had been loosened or how long the catheter bag had been located at Resident #3's ankle, since she had not assisted him to the restroom today. CNA #3 stated that she remembered holding the catheter at the top of the bag and wiping upward on the catheter tubing towards the head of the penis during catheter care and then she caught herself and moved her hand to hold the tubing at the penis and then she wiped down. CNA #3 stated she did toss the cloth in her hand during catheter care and wiped with the same cloth three (3) times when washing and rinsing Resident #3's catheter tubing and washing his groin area. She stated the cloth was not folded but, "I could tell where I was on the cloth, I can assure you". CNA #3 could not demonstrate with a clean cloth how she could determine what area on the cloth was used. CNA #3 stated that she "just knew what area had been used ". CNA #3 verified the wash cloth was not folded but rather moved around in

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	255272	A. BUILDING _____ B. WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRTLES NURSING CENTER, LLC	1018 ALBERTA AVENUE COLUMBIA, MS 39429

(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 690	Continued From page 23	F 690		

her hand to different areas. CNA #3 stated she did not wash hands or change gloves after removing the dirty brief from between Resident #3's legs and before doing catheter care.

An interview on 07/17/19 at 02:27 PM, with CNA #2, confirmed CNA #3 did wipe upward on the catheter tubing towards the penis while doing catheter care. CNA #2 stated that CNA #3 was nervous and she was trying to talk her through it. She stated that CNA #3 grabbed the tubing at the bag and not at the head of penis and wiped upward on the tubing. CNA #2 stated that CNA #3 did toss the cloth in her hand and she could see where it might be hard to tell where she was on the cloth and to know if she was using a clean area on the cloth.

An interview on 07/18/19 at 08:30 AM, with RN #1/Infection Control Nurse, revealed that It was an infection control issue with CNA #3 not washing her hands appropriately through-out the catheter care process. It was an infection control issue with CNA #3 tossing the cloth in her hand after wiping an area and then wiping another area. It could have been cross contamination. RN #1 confirmed CNA #3 holding the catheter tubing at the base of the drainage bag and wiping the catheter tubing upward towards the head of the penis could have caused trauma to the Urethra with the tubing pulled so tight. It could cause a urinary tract infection with him lying flat in bed and the bag being at the ankle.

An interview on 07/18/19 at 8:30 AM, with the Director of Nursing (DON), revealed, "I agree with the statements made by Registered Nurse (RN) #1. We do work hard at training our CNA's on infection control and catheter care".

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F 690	Continued From page 24 Record Review revealed Resident #3 had the following diagnoses: Urinary tract infection, Retention of Urine, Benign prostatic hyperplasia with lower urinary tract, Unspecified complication of genitourinary prosthetic device/graft, Chronic kidney disease, and Unspecified urethral stricture. Record Review of Physician Orders dated July 2019, revealed Resident #3 ordered Pyridium 100 milligram (mg) tablet three (3) times a days needed for bladder pain, since 7/7/17. Record Review of Physician Orders dated 5/15/19, revealed Resident #3 received an order for the Antibiotic Ciprofloxacin for Urinary Retention.	F 690		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		8/13/19

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F 880	Continued From page 25 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 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.	F 880		

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F 880	Continued From page 26 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to prevent possible spread of infection during catheter care by not providing a barrier, washing hands or changing gloves for one (1) of two (2) catheter care observations, for Resident #3. Findings include: A review of facility policy titled, "Infection Prevention and Control Program" dated 06/14, revealed, "The facility has developed and maintains an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection. A review of facility policy titled "Infection Control Nursing Department Responsibilities" dated 6/14, revealed the urinary drainage bags must always be kept below the level of the bladder to prevent the urine from flowing back into the bladder. A review of facility policy titled "Infection Control" dated 5/11, revealed handwashing is the most simple and effective means of preventing infection. A review of facility policy titled "Perineal	F 880	* Director of Nursing and Infection Control Nurse RN #1 were notified of the deficient practice which occurred on 7/17/2019 in which Certified Nurse Aide #3 failed to prevent possible spread of infection during catheter care by not providing a barrier, washing hands or changing gloves for one (1) of two (2) catheter care observations. Director of Nursing assessed Resident #3 on 7/17/2019 with no adverse findings noted. * All residents that receive catheter care have the potential to be affected by this deficient practice. * On 7/20/2019 RN #1 conducted one on one in-service training with CNA #3 related to proper catheter care, and proper hand washing technique. In-servicing for Certified Nurse Aides initiated regarding Perineal Care of residents with indwelling catheter, completed in-service on 8/7/2019. * The Director of Nursing and or Infection Control Nurse and or Charge Nurse will observe Perineal Care of four (4) residents with indwelling urinary catheters per week for four (4) weeks and then monthly for two (2) months. The Quality Assurance Committee will evaluate the	

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F 880	Continued From page 27 Care-Resident with Catheter", revised 10/18, revealed: The purpose of the policy is to prevent irritation or infection. When preparing for care, perform hand hygiene and apply gloves. Using one hand hold the catheter close to the urethral opening to prevent tension as you wash the tubing. Do not let the tubing cause traction on the urethra opening at any time. Use a clean washcloth or wash wipe, start as the meatus and wash the tubing in a circular motion away from the body about 4-5 inches. Rinse in the same method. Remove gloves. Perform hand hygiene. An observation on 07/17/19 at 1:50 PM, revealed Certified Nursing Assistant (CNA) #3 performed catheter care with the assistance of CNA #2. CNA #3 placed two (2) clear bags at foot of bed stating that they were for dirty linen and trash. CNA #3 enter the restroom in Resident #3's room and washed her hands, dried them with paper towels, and then turned the faucet off with her bare hands. CNA #3 obtained a wash basin and ran water into basin then took the wash basin over to the Resident #3's bed and placed it on the bed without a barrier under it, then placed it on a towel on the over-bed table. CNA #3 then donned gloves. CNA #3 assisted CNA #2 to pull Resident #3 up in bed. CNA #3 used the same gloves to unbutton Resident #3's pants and to pull his pants down. CNA #3 then un-taped Resident #3's brief and pulled the brief between his legs. CNA #3 removed the brief from between Resident #3's legs and left the brief lying under Resident #3 buttocks. CNA #3 did not change her gloves or wash her hands after pulling Resident # 3 up in bed, pulling Resident #3's pants down or after pulling the brief from between Resident #3's legs. The Indwelling Catheter tubing was pulled tight from Resident #3's penis to the bag located at	F 880	assessments monthly for three (3) months and make any needed recommendations to ensure ongoing compliance. Quality Assurance and Performance Improvement will be initiated if warranted.	

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ankle. CNA #3 pulled the catheter drainage bag up on Resident #3's leg and reattached the strap to hold the bag above Resident #3's knee. CNA #3 performed catheter care tossing the unfolded washcloth around after each wipe of the tubing and groin area, so that it wasn't possible to determine if a different area of the cloth was used. Resident #3's right leg was bent in a position that the bag was pointing down towards the tubing allowing the urine to possibly flow back into the catheter bag. CNA #3 pulled back the foreskin on the head of the penis and wiped it with a soapy cloth. CNA #3 then tossed the cloth in her hand and then CNA #3 took her fingers and held the catheter tubing at the point it joins the catheter bag and then wiped the tubing upwards toward Resident #3's penis. CNA #3 removed the old brief from under Resident #3's buttocks and rolled Resident #3 over and applied a clean brief and pulled the resident's pants back up. CNA #3 picked up the wash basin and dumped the water in toilet, took a paper towel and dried the inside of the basin out. CNA #3 still had the same gloves on as used during the entire process. CNA #3 returned to Resident #3's bedside and removed the towel from the over-bed table and placed it in the dirty linen bag that was on the foot of Resident #3's bed. CNA #3 picked up the bag with the dirty brief in it, tied it, and then placed the dirty bag on top of the over-bed table without a barrier on the table. CNA #2 told CNA #3 to remove the bag containing the dirty brief from the over-bed table and place it back on the bed until she was finished. CNA #3 removed the bag and placed it back on the foot of Resident #3's bed. CNA #3 removed her gloves and went to bathroom where she washed her hands. CNA #3 dried her hands with a paper towel and then turned the faucet off with her bare hands.

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F 880	Continued From page 29 An interview on 07/17/19 at 02:12 PM, with LPN #4, revealed, "We are supposed to keep the bag below the bladder for drainage". LPN #4 stated that if Resident #3 is lying flat in bed, she could see how urine might could possibly drain back up into the catheter tubing. LPN #4 stated "It could very well cause an issue. LPN #4 reviewed Resident #3's chart and confirmed that Resident #3 had appointments with the Urologist on 4-3-19, 5-14-19, 5-6-19, 6-13-19 and 7-12-19. She confirmed that Resident #3 had a diagnosis of Urinary Retention. An interview on 07/17/19 at 02:27 PM, with CNA #3, revealed that she recalled holding the catheter at the top of the bag and wiping upward on the catheter tubing towards the head of the penis during catheter care. CNA #3 stated she did toss the cloth in her hand during catheter care and wiped with the same cloth three (3) times when washing and rinsing Resident #3's catheter tubing and washing his groin area. CNA #3 verified the wash cloth was not folded but rather moved around in her hand to different areas. CNA #3 stated she did wash her hands and then turn the faucet off with her clean hands. CNA #3 confirmed she did not wash hands or change gloves after removing dirty brief from between Resident #3 legs and before doing catheter care. An interview on 07/17/19 at 02:27 PM, with CNA #2, confirmed CNA #3 did wipe up on the catheter tubing towards the penis while doing catheter care and did put the dirty bag on the over-bed table after the towel used as a barrier was removed. CNA #2 stated that CNA #3 did toss the cloth in her hand and she could see where it might be hard for CNA #3 to tell where she was	F 880		

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on the cloth and to know if she was using a clean area on the cloth.

An interview on 07/18/19 at 08:30 AM, with RN #1/Infection Control Nurse, revealed that It was an infection control issue with CNA #3 not washing her hands appropriately through-out the catheter care process and with her touching the faucet to turn it off after washing her hands. RN #1 confirmed it was an infection control issue with CNA #3 tossing the cloth in her hand after wiping an area and then wiping another area; it could have been cross contamination.

An interview on 07/18/19 at 08:30 AM, with the Director of Nursing (DON), revealed, "I agree with the statements made by Registered Nurse (RN) #1."

Record Review of the Physician Orders List dated 5/15/19, revealed Resident #3 received an order for the Antibiotic Ciprofloxacin for Urinary Retention.

Record Review of the July 2019 Physician Orders, revealed Resident #3 was ordered Pyridium 100 milligram (mg) tablets three (3) times a days needed for bladder pain.

Record Review for Resident #3 revealed diagnoses of the following: Urinary tract infection, Retention of Urine, Benign prostatic hyperplasia with lower urinary tract, Unspecified complication of genitourinary prosthetic device/graft, Chronic kidney disease, and Unspecified urethral stricture.

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	255272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/18/2019**

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

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

Electronically Signed | 08/05/2019

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

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E 000	Initial Comments ********** Survey conducted on 07/18/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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