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F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification from 9/30/19 through 10/3/19. The SA also conducted a complaint survey for MS #16027, MS #16115, and MS #15907. Upon investigation, the SA could not substantiate any alleged abuse regarding MS #16027 and MS #15907, but did substantiate the facility failed to prevent a resident from falling, related to use of a mechanical lift and cited regulatory deficiencies at F656 and F689, related to MS #16115. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited other regulatory deficiencies F645, F646, F656, F689, F690, F727, and F 880. At the time of the survey, the census was 85 and the facility held a license for 88 beds.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		11/1/19

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

Electronically Signed | 10/24/2019

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 645	Continued From page 1 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 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	F 645		

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F 645	Continued From page 2 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) 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 staff interviews, record reviews, and facility policy review, the facility failed to accurately complete the Level I Preadmission Screening (PAS) for one (1) of four (4) resident preadmission screenings reviewed, Resident #78. Findings include: A review of the facility's email statement, dated 10/4/19, revealed the facility follows the state guidelines for completing the PAS. Review of the Pre-Admission policy, dated August 26, 2016, revealed the facility conducted a Mental Illness (MI)/Mental Retardation (MR) screening if the diagnosis required. Review of the Preadmission Screening (PAS) Summary and Physician Certification with a PAS date of 6/5/19, indicated Resident #78 did not have a diagnosis of a major mental illness or a history of a mental illness. A review of the facility's Face Sheet revealed the facility admitted Resident #78 on 6/7/19, with diagnoses of Major Depressive Disorder and	F 645	1. Immediate actions taken for the residents found to have been affected: A Level One Preadmission Screening was performed for Resident #78 by the facility Social Worker and corrected on 10/4/2019. 2. Identification of other Residents having the potential to be affected was accomplished by: All Residents have been determined to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk future occurrence: The Social Worker was in-serviced by the Administrator on 10/4/2019 informing her that all Residents must have a Level 1 Preadmission Screening. The Social Worker will perform a 100% audit on each Resident beginning on 10/04/2019 to ensure the Residents have a Level 1 Preadmission Screening by 11/01/2019. 4. How the corrective actions will be	

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F 645	Continued From page 3 Delusional Disorders. Review of the most recent quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 9/3/19, revealed Resident #78 was coded for Psychotic Disorder (other than Schizophrenia) and Depression. The most recent Admission/Discharge MDS assessment, for Resident #78, with an ARD of 6/9/19, was coded to include Manic Depression (Bipolar Disorder) and Psychotic Disorder (other than Schizophrenia). On 10/02/19 at 3:32 PM, an interview with Social Service Worker #1 revealed, upon review of the Diagnosis List from Resident #78's admission, she verified the admission diagnosis of Major Depression Disorder and Delusional Disorder. She confirmed the PAS was inaccurately documented and the resident should have been referred for a Level II. She stated she did not refer the resident for a Level II review after the completion of the MDS, with an ARD of 6/13/19.	F 645	monitored to ensure the practice will not reoccur: The Social Worker will implement a Preadmission Level 1 Tracking Tool on 11-01-2019 to use for monitoring Preadmission Screenings. This Tracking Tool will be brought to the Quality Assurance Performance Improvement Committee monthly for two months for recommendations and corrections that may be needed through the month of the December 2019.	
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to refer the	F 646	1. Immediate actions taken for the residents found to have been affected: A	11/1/19

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F 646	Continued From page 4 resident for a Level II review after a significant change in condition for one (1) of four (4) residents reviewed for preadmission screening, Resident #78. Findings include: A review of the facility's statement dated 10/4/19, revealed the facility follows the guidelines for a Level II referral. Review of Resident #78's medical record revealed no referral for a Level II. Review of the Preadmission Screening (PAS) Summary and Physician Certification with a PAS, dated 6/5/19, indicated the resident did not have a diagnosis of a major mental illness or a history of a mental illness, however, Resident #78 had admitting diagnoses on 6/7/19, of Major Depressive Disorder and Delusional Disorder. Review of a Significant Change (SC) Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/13/19, revealed Resident #78 had Diagnoses of Manic Depression (Bipolar Disorder) and Psychotic Disorder (other than Schizophrenia). Review of the most recent quarterly MDS, with an ARD of 9/3/19, was coded to include Psychotic Disorder (other than Schizophrenia) and Depression. On 10/02/19 at 3:18 PM, an interview with Registered Nurse (RN) #1 revealed she has not communicated to Social Service Worker #1 the need for a Level II review of this resident when completing the SC MDS.	F 646	Level Two Preadmission Screening was performed for Resident #Seventy-Eight on 10/4/2019 by the facility Social Worker. 2. Identification of other Residents having the potential to be affected was accomplished by: All Residents who have a significant change in their mental or physical condition or who has a mental illness or intellectual disability have been determined to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk future occurrence: The Social Worker was in-serviced by the Administrator on 10/04/2019 informing her that all Residents who have a mental illness or mental intellectual disability with a significant change, must have a Level 2 Preadmission Screening Performed. The Social Worker will perform a 100% Audit beginning 10/04/2019 on each resident with a mental illness or mental intellectual disability or significant change to insure these Residents have a Level 2 Preadmission Screening by 11/01/2019. 4. How the corrective actions will be monitored to ensure the practice will not reoccur: The Social Worker will implement a Preadmission Screening Level 2 Tracking Tool on 11/01/2019 to use for monitoring Preadmission Screenings. This Tracking Tool will be brought to the Quality Assurance Performance Improvement Committee monthly for two months for recommendations and corrections that may be needed through	

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F 646	Continued From page 5 On 10/02/19 at 3:26 PM, an interview with Licensed Practical Nurse (LPN) #5 revealed she have not talked to Social Services Worker #1, regarding a Level II review after Resident #78's MDS. She stated Social Services Worker #1 participated in the completion of the SC MDS. On 10/02/19 at 3:32 PM, an interview with Social Services Worker #1 revealed if the resident had changes in behaviors, and/or a new psychotropic medication introduced, she would refer the resident for a Level II review. She stated this is the only time that she knows of to refer the resident for a Level II review. She stated a Major Mental Illness is, for example, Depression and Anxiety. Upon review of the Diagnosis List from the resident's admission, Social Service Worker #1 verified the admission diagnosis of Major Depression Disorder and Delusional Disorder. She stated she did not refer the resident for a Level II review after the completion of the SC MDS, with an ARD of 6/13/19. A review of the facility's Face Sheet revealed, the facility admitted Resident #78 on 6/7/19, with diagnoses of Major Depressive Disorder and Delusional Disorders.	F 646	the month of the December 2019.	
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	F 656		11/1/19

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F 656	Continued From page 6 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: MS #16115 Based on observation, staff interview, record review, and facility policy review, the facility failed	F 656	1. Immediate Action taken for the Residents found to have been affected include: The Care Plan of the Residents affected were reviewed by the Minimum	

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F 656	Continued From page 7 to follow the care plan for two (2) of 23 resident care plans reviewed, Resident #9 for the use of a full body lift, and Resident #3 for catheter care. Findings include: Review of the facility's "Care Plans" policy, not dated, revealed: Each resident will have a plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provide care. The Certified Nursing Assistant (CNA) Daily Care Guide is part of the comprehensive care plan and used as the tool to make staff aware of the resident's daily care needs. Assigned disciplines will be identified to carry out the interventions. Review of Resident #9's comprehensive care plan, dated 3/19/19, revealed that a total lift with two (2) person assist and medium sling were required for transfers, related to her risk for falls and history of falling, Review of a "Resident Incident Report", dated 7/20/19 at 6:00 AM, revealed Resident #9 was found lying on her right side on the floor in her room. The incident report documented that CNA #2 stated she was using the sit-to-stand lift and Resident #9 didn't stand up, so she lowered her to the floor. The incident report was documented by Licensed Practical Nurse (LPN) #4. Review of the summary and conclusion to the investigation provided by the facility, dated 7/26/19, revealed the facility determined CNA #2 did transfer Resident #9 with the incorrect lift, resulting in a fall for Resident #9. Review of the "Departmental Notes", dated	F 656	Data Set Coordinator on 10/04/2019 and found to be accurate. The Certified Nursing Assistant involved in this incident was terminated on 07/20/2019. Resident #3 was assessed by the Director of Nursing Services with no adverse outcomes being identified on 10/04/2019. 2. Identification of other Residents having the potential to be affected was accomplished by: The facility has determined all Residents requiring a lift and requiring catheter care have the potential of being affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The MDS Coordinator began a 100% Audit on 10/21/2019 on all Care Plans to insure Residents requiring a lift and Residents requiring catheter care are properly assessed for the correct lift and proper catheter care. This information was corrected by 10/23/2019 and placed on the Resident's Care Plan. An In-service, beginning on 10/21/2019, will be performed by the CNA Coordinator with all CNAs concerning Following Activities of Daily Living Care according to the Care Plan by 11/01/2019. This information is provided to the CNAs daily through the Electronic Medical Record System by Kiosks placed throughout the facility. Also the Staff Development Nurse or Registered Nurse Supervisor will perform an ADL In-Service with all new hires during their orientation, instructing them to follow the Resident Care Plan.	

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F 656	Continued From page 8 7/20/19 at 7:17 AM, documented by LPN #4, revealed a CNA stated she was getting Resident #9 up with the sit to stand lift and the resident didn't stand up, so she assisted her to the floor, lying on her right side. Resident #9 then complained of pain in her right shoulder, according to the nurses notes. LPN #4 note documented she notified the physician with new orders for a stat X-ray of the right arm and Tylenol 650 milligram (mg) was given for pain. Review of the X-ray report, dated 7/20/19, revealed no fracture, however there was a dislocation of the right shoulder. Resident records revealed Resident #9 returned with orders for a sling, which she refused to wear. An attempt to call CNA #2 at 10/01/19 at 02:59 PM, resulted in no answer, with a message left to return the call. During an interview on 10/01/19 at 3:46 PM, LPN #4 stated CNA #2 called for help after Resident #9 had been placed on the floor. LPN #4 said the stand-up lift was used for Resident #9, and was still in the room. LPN #4 stated she helped assist Resident #9 back to the bed, by using the lift pad. She said Resident #9 complained of pain in her shoulder and she notified the physician, who ordered an x-ray of the arm. During an interview on 10/03/19 at 11:05 AM, Registered Nurse (RN) #1 stated Resident #9's care plan matched the Resident Assessment and the need for a total lift. RN #1 said the expectation was to follow the care plan according to the evaluation of the resident assessment, which for Resident #9 included using the full body lift and using two (2) people at all times	F 656	4. How the Corrective Actions will be monitored to ensure the practice will not reoccur: The MDS Coordinator will perform an audit on all Care Plans to ensure Residents requiring a lift and requiring catheter care are properly assessed for the correct lift for two months beginning on 10/21/2019 through December 2019. This Audit will be brought monthly to the Quality Assurance Performance Improvement Committee for two months for recommendations or corrections that may be needed through December 2019.	

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F 656	Continued From page 9	F 656		

during the lift.

Resident #3
A review of Resident #3's care plan, initiated 4/6/18, revealed the resident had an indwelling catheter, related to a diagnosis of Benign Prostatic Hyperplasia (BPH) and was at Risk for Infection. An intervention included catheter care every shift.

An observation on 10/01/19 at 05:11 PM, revealed CNA #3 performed catheter care on Resident #3. CNA #3 washed her hands, gloved and touched her uniform as if she was wiping her hands. CNA #3 obtained a cloth and wiped the head of the penis moving the cloth from place to place around the head of the penis. CNA #3 using the same cloth, and without turning the cloth, wiped up and down the shaft of the penis. CNA #3 removed her gloves, and re-gloved without washing her hands. CNA #3 dried the groin area and the penis with the same area of towel.

During an interview on 10/02/19 at 03:04 PM, CNA #3 revealed that she should have wiped the head of the penis once, discarded the cloth, and gotten a clean cloth to wipe the penis again. CNA #3 stated that she remembered wiping the head of the penis more than once with the same cloth. CNA # 3 stated she should have not wiped the shaft of the penis with the same cloth that she used to wipe the head of the penis, and she should have dried each area separately, instead of wiping the whole area with the same towel. CNA #3 stated that she should have washed her hands after removing her gloves and before gloving again.

During an interview on 10/01/19 at 1:50 PM, LPN

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F 656	Continued From page 10 #5 stated the she expected the care plan to be followed and updated by the staff when needed. During an interview on 10/03/19 at 12:55 PM, the Director of Nursing stated Resident #3's care plan was not followed for the correct procedure to provide catheter care.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #MS #16115 Based on staff interview, record review, and facility policy review, the facility failed to provide adequate supervision and assistance, related to the use of mechanical lifts, to prevent falls with minor injury for one (1) of four (4) residents reviewed for accidents, Resident #9. Findings include: Review of the facility's "Modified Lifting Policy", revised 5/29/15, revealed the staff would follow the documented lifting protocol deemed appropriate for each resident. The policy also revealed the information related to the lift would be documented in the smart charting and a	F 689	1. Immediate Actions taken for the residents found to have been affected include: The Certified Nursing Assistant involved in this deficient practice was terminated on 7/20/2019. The Licensed Practical Nurse Charge Nurse on duty performed an In-service on Proper Body Mechanics, Proper Use of a Mechanical Lift and the Dot Identifier System for using the correct lift on 7/20/2019 the morning of the incident. The Staff Development Nurse performed an In-Service on Facility Policy on 7/20/2019 requiring two people assisting when using any lift while transferring a Resident. This In-service also includes the use of the Dot Identifier System for identifying the correct mechanical lift and using the Kiosk	11/1/19

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F 689	Continued From page 11 sticker system, which was located on each lift. Review of a "Resident Incident Report", dated 7/20/19, and the facility investigative report, dated 7/26/19, revealed Resident #9 was found lying on her right side on the floor in her room. The incident report documented that Certified Nurse Aide (CNA) #2 used the wrong lift to transfer the resident; she used the sit-to-stand lift and the resident had been assessed for the total lift. The CNA reported Resident #9 didn't stand up, while using the lift, so she lowered her to the floor. Resident #9 was transferred to the hospital, where X-rays revealed a dislocation of the right shoulder. Treatment included a shoulder immobilizer. Review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/26/19, revealed the resident needed extensive assist of two (2) persons to transfer. The care plan, initiated 3/19/19, revealed Resident #9 required the use of the total lift with two (2) person assistance. Review of the "Departmental Notes", dated 7/20/19 at 7:17 AM, documented by LPN (Licensed Practical Nurse) #4, revealed a CNA reported she was transferring Resident #9 with the sit-to-stand lift and the resident was unable to stand up, so she assisted her to the floor, lying on her right side. Resident #9 complained of pain in her right shoulder, the physician was notified and a new order received for a stat X-ray to the right arm. Tylenol 650 milligram (mg) administered for pain. Interview on 10/01/19 at 09:46 AM, with the Administrator revealed the facility policy was to	F 689	System, placed throughout the facility, to find the lift requirements for residents. This In-Service was performed on 7/20/2019. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing Services will be In-Serviced by the Director of Nursing Services, Staff Development Nurse or Registered Nurse Supervisor on the policy for Accidents and Supervision beginning 10/21/2019 to be completed by 11/01/2019. All Resident Falls/Accidents will be reviewed daily by the Interdisciplinary Team during the Morning Stand Up Meeting to ensure appropriate implementation of safety interventions including updating the Plan of Care. 4. How the Corrective Actions will be monitored to ensure the practice will not reoccur: The Interdisciplinary Team and the Director of Nursing Services, Facility Administrator or RN Supervisor will review each incident report upon occurrence beginning 10/04/2019 to ensure appropriate interventions are implemented and an updated Plan of Care is complete. The Director of Nursing Services or RN Supervisor will complete weekly chart audits for two months through December	

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F 689	Continued From page 12 use two (2) people for all lifts, and to transfer residents according to the resident assessment. The Administrator stated CNA #2 was terminated after the investigation on 7/21/19, for failure to follow the facility policy. An attempt to call CNA #2 at 10/01/19 at 02:59 PM, was unsuccessful, with a message left to return the call. Review of CNA #2's personnel file revealed she was terminated on 7/21/19, for wrong or improper lift with a resident causing an injury. During an interview on 10/01/19 at 3:46 PM, LPN #4 said she first became aware of the incident after CNA #2 called for help and Resident #9 was already on the floor. LPN #4 said the stand-up-lift was still in the resident's room. LPN #4 stated Resident #9 complained of pain in her shoulder, so she notified the Physician, received orders for an X-ray, and gave the resident Tylenol. Review of the Departmental Notes dated 7/20/19 at 11:25 AM revealed Resident #9 was transferred to the hospital for evaluation. Review of the "Radiology Report", dated 7/20/19, revealed the humerus of Resident #9's right shoulder was anteriorly and inferiorly dislocated, with respect to the glenoid. There was no fracture. Conclusion: Anterior shoulder dislocation. Review of the Emergency Department form, dated 7/20/19, revealed the reason for visit was shoulder pain-swelling, shoulder dislocation/fall. The final Diagnosis: shoulder dislocation, unspecified subluxation of right shoulder joint.	F 689	2019 and will review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of falls/accidents and that Care Plans have been updated to reflect these interventions. Audited records will be reviewed by the High Risk Committee weekly beginning 11/01/2019 and the Quality Assurance Performance Improvement Committee will review monthly and will make recommendations and changes as needed until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Performance Improvement Committee.	

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F 689	Continued From page 13 Review of Nurse's Notes, dated 7/20/19 at 11:25 AM, revealed Resident #9 returned to the facility at 8:00 AM with a should immobilizer in place, however the care plan addressed the resident's refusal of the care. An observation on 10/02/19 at 10:55 AM, revealed Resident #9 was transferred with a full body lift and two (2) staff, without difficulty or distress. There was no noted injury to Resident #9. Interview on 10/02/19 at 03:18 PM, with the Director of Nursing (DON), revealed she was not working at this facility when the incident happened with Resident #9. The DON said the check off with the lifts, for CNA #2, could not be located. There was a documented "New Hire Orientation Video Checklist", dated 10/31/18, signed by CNA #2, for a 25 minute video completion for Vander and Vera lifts. Review of facility "Face Sheet" revealed Resident #9 was admitted on 4/14/15, with a diagnosis of Dementia, Unspecified.	F 689		
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	F 690		11/1/19

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F 690	Continued From page 14 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: Based on observation, staff interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection during catheter care for one (1) of two (2) resident catheter care observations, which affected Resident #3. Findings include: A review of facility's "UTI Prevention with Indwelling Catheter Use" policy, dated January 27, 2015, revealed "A resident with an indwelling	F 690	1. Immediate actions taken for the Residents found to be affected include: Resident #3 was assessed on 10/2/2019 by the Director of Nursing Services with no adverse outcomes being identified by this deficient practice. Certified Nursing Assistant #3 was in-serviced by the Staff Development Nurse on 10/2/2019 and CNA #3 observed incontinent care, performed by the Staff Development Nurse on 10/2/2019. 2. Identification of other residents having	

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F 690	Continued From page 15 catheter is susceptible to Urinary Tract Infections. Catheter care should be provided daily or anytime an incontinent episode occurs". An observation on 10/01/19 at 5:11 PM, revealed Certified Nursing Aide (CNA) #3 entered Resident #3's room to perform catheter care. CNA #3 washed her hands, gloved and touched her uniform as if she was wiping her hands. CNA #3 obtained a cloth and wiped the head of the penis, moving the cloth from place to place around the head of the penis. CNA #3, using the same cloth, and without turning the cloth, wiped up and down the shaft of the penis. CNA #3 removed her gloves, and re-gloved without washing her hands. CNA #3 dried the groin area and the penis with the same area of the towel. During an interview on 10/02/19 at 3:04 PM, CNA #3 revealed that during Resident #3's catheter care, she should have wiped the head of the penis one time, discarded the cloth and retrieved a clean cloth to wipe again. CNA #3 stated she remembered wiping the head of the penis more than once with the same cloth. CNA # 3 stated she should not have wiped the shaft of the penis with the same cloth that she used to wipe the head of the penis; she should have dried each area separately, instead of wiping the whole area with the same towel. CNA #3 stated she should have washed her hands after removing her gloves and before gloving again. During an interview on 10/03/19 at 12:45 PM, Registered Nurse (RN) #2, Infection Control Nurse, confirmed CNA #3, not performing catheter care correctly, could be considered an Infection control issue, sending germs straight to the bladder. She stated that not washing hands	F 690	the potential to be affected was accomplished by: Incontinent Residents in the Facility as identified by the Electronic Medical Record have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing Services Staff will be in-serviced by 11/01/2019 on the Guidelines of Incontinent Care and following Infection Control Procedures. These In-Services will be conducted by the Director of Nursing Services, Staff Development Nurse or RN Supervisor beginning 10/04/2019. The Staff Development Nurse or Registered Nurse Supervisor will observe CNA Staff providing incontinent Care on five Residents for nine weeks beginning 10/25/2019 through December 2019. 4. How the Corrective Actions will be monitored to ensure the practice will not reoccur: Findings of the weekly Observations will be brought to the Quality Assurance Performance Improvement Committee Monthly and reviewed by the Quality Assurance Performance Improvement Committee for recommendations or changes needed until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Performance Improvement Committee.	

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F 690	Continued From page 16 and gloving properly is also an infection control issue. During an interview on 10/03/19 at 12:55 PM, the Director of Nursing (DON) stated the lack of training was an issue as well as technique with Infection Control. The DON stated that CNA #3 wiping the head of the penis and the shaft of the penis, with the same cloth, could have caused germs to enter the head of the penis, resulting in an infection. She stated it was a big UTI risk. She stated, "By not doing hand hygiene/gloving properly, you can spread germs and infection. The DON stated the whole process was an infection control issue.	F 690		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review, facility statement, and staff interview, the facility failed to provide a Registered Nurse (RN) Supervisor, for a facility with a census greater than 60 residents, for eight	F 727	1. Immediate actions taken for the residents found to have been affected include: A Registered Nurse Supervisor was hired on 9/27/2019. An As Needed	11/1/19

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F 727	Continued From page 17 (8) of 17 days reviewed. Findings include: Review of a document on facility letterhead, undated and signed by the Administrator, revealed the facility does not have a policy for RN staffing. Review of the facility census, during survey, revealed a census of 85 residents. Review of a staffing grid and the working schedule, provided by the Director of Nursing (DON), revealed the DON served as RN Supervisor on 9/16/19, 9/17/19, 9/18/19, 9/19/19, 9/20/19, 9/23/19, 9/24/19, and 9/25/19. A written statement, provided by the DON, on 10/02/19 at 3:22 PM, revealed "I served as Supervisor for all units on the following dates: 9/16/19, 9/17/19, 9/18/19, 9/19/19, 9/20/19, 9/23/19, 9/24/19, and 9/25/19. During an interview on 10/02/19 at 3:22 PM, the DON revealed a lot of times, during the week, she served as the Registered Nurse (RN) Supervisor for both units. She stated on the weekends, she had a RN Supervisor. The DON stated, "To be honest, the lowest the my census has been is 80. I've done treatments, supervising, I've done it all for a while now". The DON stated she had only heard about not being able to be the DON and the Supervisor, once in the past, and had actually forgot about it. She stated she didn't have anyone else to cover the RN Supervisor position, so she did what she had to do and filled the RN Supervisor position herself.	F 727	(PRN)RN was employed to serve as RN Supervisor on 9/26/2019 & 9/27/2019. 2. Identification of other residents having the potential to be affected was accomplished by: All Residents within the facility have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service was given to the Director of Nursing Services concerning Adequate RN Coverage in a Nursing Facility according to Federal and State Guidelines on 10/3/2019 by the Facility Administrator. Beginning 10/1/2019 the Nursing Schedule will be audited by the Director of Nursing Services or Staff Development Nurse daily to determine adequate RN Coverage is established. 4. How the corrective actions will be monitored to ensure the practice will not reoccur: The Facility Administrator will audit the Nursing Schedule to determine that RN Coverage is in compliance with Federal and State Regulations for four weeks beginning 10/25/2019. These audits will be presented to the Quality Assurance Performance Improvement Committee for review for recommendations or changes as needed until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Performance Improvement Committee.	

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F 727	Continued From page 18 An interview on 10/03/19 at 9:50 AM, with the Administrator, revealed he knew the DON could not serve as Charge Nurse in a facility with more than 60 beds. The Administrator stated he just didn't catch the DON serving as the RN Supervisor. The Administrator stated there were other RN's at the facility some of those days, but they were in and out of the offices doing work. The Administrator stated the DON did serve as RN Supervisor on some days.	F 727		
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, 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,	F 880		11/1/19

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F 880	Continued From page 19 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. §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.	F 880		

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F 880	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to utilize proper infection control techniques while providing care for six (6) of 10 care observations. This included wound care for two (2) of four (4) observations, Resident #41 and #83; stoma care for three (3) of four (4) Percutaneous Endoscopic Gastrostomy (PEG) tube care observations, Residents #3, #11 and #20; and catheter care for one (1) of two (2) catheter care observations, Resident #3. Findings include: A review of the facility's "Infection Prevention and Control" policy, dated 2016, revealed all contaminated disposable items shall be discarded in a waste receptacle lined with a red plastic bag. Review of the facility's "Infection Prevention and Control Program", policy, implemented 4/17/18, revealed the Hand Hygiene Protocol: All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after Personal Protective Equipment (PPE) removal, before and after eating, before and after toileting, and before going off duty. Staff shall wash their hands before and after performing resident care procedures. Hands shall be washed in accordance with the facility's established hand washing procedure. A review of facility's "Hand washing", policy, not dated, revealed, "Staff will use proper hand washing technique to prevent the spread of	F 880	1. Immediate actions taken for the residents found to have been affected include: The Licensed Practical Nurse #3 was in-serviced on Proper Hand Hygiene Procedures on 10/4/2019 by the Director of Nursing Services. Residents #3, #11, # 20, #41 and #83 were assessed by the Nursing Supervisor on 10/4/2019. No adverse outcomes were identified by this deficient practice. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all Residents have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All Nursing Personnel will be in-serviced on the facility's policy for hand hygiene beginning on 10/04/2019 by the Director of Nursing Services, Staff Development Nurse and Registered Nurse Supervisor and completed by 11/01/2019. In-service training includes weekly observation of nursing personnel performing hand hygiene procedures according to facility policy. These observations will be performed by the Staff Development Nurse or Registered Nurse Supervisor beginning 10/23/2019. In-service training includes random observations of nursing personnel performing hand hygiene procedures according to facility policy. Theses	

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F 880	Continued From page 21 infection". A review of facility's "UTI (Urinary Tract Infection) Prevention with Indwelling Catheter Use" policy, dated January 27, 2015, revealed "A resident with an indwelling catheter is susceptible to Urinary Tract Infections. Catheter care should be provided daily or anytime an incontinent episode occurs". A review of a document provided by the facility, not dated and signed by the Administrator, revealed, "The facility does not have a policy for PEG tube care". A review of a document provided by the facility, not dated and signed by the Administrator, revealed, "The facility does not have a policy concerning gloving". Resident #83 During an observation of pressure ulcer care, on 9/30/19 at 3:50 PM, LPN #3 sat the red wound care biohazard bag on Resident #83's floor bedside the resident's bed. LPN #3 performed wound care, changing her gloves throughout the wound care procedure, but did not wash her hands at all during the wound care procedure. The red biohazard bag remained on Resident #83's floor beside her bed during the entire wound care procedure, as she placed soiled items in the bag. On 9/30/19 at 4:35 PM, an observation revealed LPN #3 performed as needed (PRN) wound care on Resident #83 after the resident's dressing had become soiled. LPN #3 sat the red biohazard bag on Resident #83's floor beside the resident's bed. She performed wound care on Resident	F 880	observations will be performed by the Staff Development Nurse or RN Supervisor. 4.Actions taken/systems put into place to reduce the risk of future re-occurrence include: The DON,Staff Development Nurse or RN Supervisor will complete weekly Validation Checklists of personnel and the technique of hand hygiene procedure beginning 10/23/2019. These checklists will be brought to the Quality Assurance Performance Improvement Committee monthly beginning 11/01/2019 for recommendations or changes needed until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Performance Committee. 1. Immediate actions taken for the residents found to have been affected include: The Licensed Practical Nurses and other Nurses performing Wound Care/Stoma Care were in-serviced on proper placement of Bio-Hazard Bags during treatments on 10/4/2019 by the Director of Nursing Services and the Staff Development Nurse. Residents #3, #11, #20, #41 and #83 were assessed on 10/4/2019 by the Director of Nursing Services. No adverse outcomes were identified by the deficient practice. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined on 10/4/2019 that all residents	

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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 22 #83, changing her gloves, but did not wash her hands. The red biohazard bag remained on the resident's floor beside her bed during the entire wound care procedure. On 10/03/19 at 10:44 AM, interview with LPN #3 revealed she should not have placed the red biohazard bag on the resident's floor but should have used a trash can to place her bag, and when finished with the wound care, she would remove the bag from the trash can. LPN #3 stated when she placed the red bag on the resident's floor, it caused contamination. She also stated she should have washed her hands when she removed her gloves and the resident's dressing. On 10/03/19 at 11:04 AM an interview with RN #1 revealed, she would expect the nurse to use clean technique when performing wound care. Resident #41 An observation on 10/01/19 at 2:13 PM, revealed LPN #3 had a red biohazard bag on the floor beside Resident #41's bed. LPN #3 cleansed and dried the wound and discarded the gauze in the red biohazard bag on the floor. Without washing her hands or changing gloves, LPN #3 applied ointment to a clean gauze dressing, and applied the dressing to the right buttock wound. LPN #3 moved to the other side of the bed to perform left heel care. LPN #3 went back to the side of the bed where the red biohazard bag lay on the floor and with her foot, she pulled the red biohazard bag across the floor to the other side of the bed. LPN #3 washed her hands, gloved and removed the soiled dressing from left heel and discarded the dressing in the red biohazard bag lying on the floor. LPN #3 removed her gloves and without	F 880	have the potential of being affected by this deficient practice. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: All Nurses will be in-serviced and observed during care by the Director of Nursing Services or RN Supervisor beginning 10/21/2019 to ensure Bio-Hazard Bags are not placed onto the floor or onto a Resident's bed. This will be performed for four weeks. 4. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Nursing Services or RN Supervisor will complete random Validation Checklists of nurses and CNAs handling soiled linens and Red Bio-Hazzard Bags beginning 10/21/2019. To comply with Regulatory Guidelines, random auditing will be performed by the Director of Nursing Services RN Supervisor for Four weeks beginning on 10/28/2019. Finding of these audits will be brought to the Quality Assurance Performance Improvement Committee monthly beginning 11/01/2019 for review and recommendations and changes as needed until such time consistent substantial compliance has been met determined by the Quality Assurance Performance Improvement Committee 1. Immediate actions taken for the residents found to have been affected include: Certified Nursing Assistant #3 was in-serviced on 10/4/2019 on the	

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	255300	A. BUILDING _____ B. WING _____	10/03/2019

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F 880	Continued From page 23 washing her hands, she reapplied gloves and wiped the left heel and discarded the gauze in the red biohazard bag on the floor. LPN cleansed the wound twice more, then discarded the gauze in the biohazard bag. Without washing her hands or changing gloves, LPN #3 took ointment, and while applying the ointment to a gauze, the resident touched the clean heel to the sheet. LPN #3 stated, "Don't touch it to the sheet, you gonna make me have to clean it again". LPN #3 continued the wound care, without cleaning the wound again. During an interview on 10/03/19 at 12:40 PM, LPN #3 stated the she remembered dragging the red bag with her foot and she should not have. LPN #3 stated she thought you only washed your hands and changed gloves after a sterile procedure. She confirmed not changing gloves/washing hands correctly could have caused infection. LPN #3 stated that she went home and read about wound care, hand washing, and gloving and saw where she should have done differently. She stated she even watched a you tube video of the correct technique during wound care. During an interview on 10/03/19 at 12:45 PM, RN #2 stated that not performing hand hygiene and gloving properly is an infection control issue. Resident #3-Stoma Care An observation on 10/01/19 at 3:00 PM, revealed LPN #3 entered Resident #3's room without gloving, and wiped the over bed table with a sani-wipe germicidal wipe. LPN #3 placed a red biohazard bag on the floor beside Resident #3's bed. LPN #3 washed her hands, gloved, removed	F 880	facility's Incontinent Policy & Procedure by the Director of Nursing Services. CNA #3 was shown the proper technique for Incontinent Care/Peri-Care on 10/4/2019 by the Staff Development Nurse. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined all Residents who are incontinent have the potential of being affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: In-Services and checkoffs will be performed by the DON, Staff Development Nurse or RN Supervisor beginning 10/04/2019 to be completed by 11/01/2019. 4. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Nursing Services or RN Supervisor will conduct random observations of staff providing Incontinent Care/Peri-Care monthly for three months beginning 10/21/2019 to ensure staff are promoting and maintaining the Infection Control Policy. These findings will be brought to the Quality Assurance Performance Committee monthly beginning 11/01/2019 for review and any recommendations or changes as needed until such time consistent substantial compliance has been met determined by the Quality Assurance Performance Improvement Committee.	

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F 880	Continued From page 24	F 880		

the dirty dressing from the PEG stoma, and discarded it into the red biohazard bag on the floor. LPN #3 removed her gloves, and without performing hand hygiene, applied clean gloves, cleaned and dried the stoma, discarding the gauze in the red biohazard bag on the floor. LPN #3, without changing her gloves or washing her hands, applied the clean split sponge dressing to the stoma and secured it with tape.

During an interview on 10/02/19 at 3:59 PM, LPN #3 stated the she was trained to put the red bag on the floor. She stated, "I didn't know that it was wrong to do it".

During an interview on 10/03/19 at 12:40 PM, the Director on Nursing (DON) stated that up until now, the facility had always had a Registered Nurse (RN) to provide wound treatments. She stated the lack of training was an issue. She stated technique and proper hand hygiene/gloving appropriately is an Infection Control Issue. The DON stated that LPN #3 dragging the biohazard bag across the floor could cause germs to get on the bottom of the shoes and be transported from room to room causing other residents problems.

Resident #20-Stoma care
On 10/02/19 at 11:24 AM, an observation revealed LPN #1 placed her red biohazard bag on Resident #20's floor beside the resident's bed, washed her hands, and applied clean gloves. After performing stoma site care, she removed her gloves and discarded all soiled supplies.

On 10/03/19 at 10:40 AM, an interview with LPN #1 revealed she should have placed her wound

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F 880	Continued From page 25 care bag in a container as opposed to putting it on the resident's floor. She stated it is unsanitary to put the red bag on the resident's floor. On 10/03/19 at 11:28 AM, an interview with LPN #2 revealed when performing gastric tube site care, she would expect the nurses to use aseptic technique. Resident #11-Stoma care Observation of Resident #11's PEG stoma care on 10/02/19 at 10:11 AM, revealed LPN #3 did not use appropriate hand hygiene practices, during the care. She did not wash her hands throughout the entire procedure, and changed gloves twice. During an interview on 10/03/19 at 10:39 AM, LPN #3 stated she should have washed her hands, when she changed gloves, and during PEG Tube care, because it could have caused cross contamination. Resident #3-Catheter care An observation on 10/01/19 at 5:11 PM, revealed Certified Nursing Aide (CNA) #3 entered Resident #3's room to perform catheter care. CNA #3 washed her hands, gloved and touched her uniform as if she was wiping her hands. CNA #3 obtained a cloth and wiped the head of the penis moving the cloth from place to place around the head of the penis. CNA #3, using the same cloth and without turning the cloth, wiped up and down the shaft of the penis. CNA #3 removed her gloves, and re-gloved without washing her hands. CNA #3 dried the groin area and the penis with the same area of towel.	F 880		

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F 880	Continued From page 26 During an interview on 10/02/19 at 3:04 PM, CNA #3 revealed that she should have wiped the head of the penis once, discarded the cloth, and got a clean cloth to wipe the penis again. CNA #3 stated she remembered wiping the head of the penis more than once with the same cloth. CNA # 3 stated she should have not wiped the shaft of the penis with the same cloth that she used to wipe the head of the penis, and she should have dried each area separately, instead of wiping the whole area with the same towel. CNA #3 stated that she should have washed her hands after removing her gloves and before gloving again. During an interview on 10/03/19 at 12:45 PM, Registered Nurse (RN) #2, Infection Control Nurse, stated CNA #3 not performing catheter care correctly could be considered an Infection control issue, sending germs straight to the bladder and not washing hands and gloving properly is also an infection control issue. During an interview on 10/03/19 at 12:55 PM, the Director of Nursing (DON) stated that the lack of training was an issue as well as technique with Infection Control. The DON stated that CNA #3 wiping the head of the penis and the shaft of the penis with the same cloth could have caused germs to enter the head of the penis, causing an infection, which is a big UTI risk. She stated, by not doing hand hygiene/gloving properly you can spread germs and infection.	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 | 10/24/2019

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 10/03/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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