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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVER LAUREL, MS 39440

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 02/24/2020 to 02/27/2020. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited deficiencies at F641, F656, F658, F686, F690, F693, F695, and F880. At the time of the survey, the facility had a census of 119, and held a license for 126 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessment related to oxygen therapy, for one (1) of 26 MDS assessments reviewed, Resident #35. Findings include: A review of the facility's "MDS, CAA, and Care Plan Documentation Policy", dated 01/23/2020, revealed: "The staff completing each portion of the MDS was responsible for ensuring that documentation is found in the medical record to support the coding they perform. This documentation can be found anywhere in the medical record." A review of Resident #35's Quarterly MDS assessment, with an Assessment Reference Date	F 641	Statements contained herein are intended for purposes of compliance with federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. F641 1) Resident #35 was reassessed by the Director of Nursing (DON) for PRN (as needed) use of oxygen from 03/01/20 to 04/09/20. After oxygen usage assessment, and discussion with the	4/1/20

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

Electronically Signed | 04/16/2020

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 641	Continued From page 1 (ARD) of 11/26/2019, Section O (Special Treatments, Procedures and Programs), was not checked to indicate Oxygen usage. A review of Resident #35's "Physician Order List", dated February 2020, revealed, with an order dated 06/07/2016, for Oxygen at two (2) liters per minute per nasal bi-prongs as needed (PRN) related to Respiratory Distress. During an observation, on 2/25/20 at 8:10 AM, revealed Resident #35 was lying in bed with oxygen at two (2) liters per minute. On 02/26/2020 at 8:30 AM, during an observation, Resident #35 was noted lying in bed with oxygen infusing at two (2) liters per minute. During an interview, on 2/27/2020 at 12:30 PM, Resident #35 stated that she wears the oxygen every night or whenever she is in the bed and sometimes when she is up in her wheelchair. Resident #35 also stated there was not a day that goes by that she doesn't need her oxygen. Review of Resident #35's Quarterly MDS assessment, with an Assessment Reference Date (ARD) of 11/26/2019, revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognitive status. On 2/27/2020 at 10:35 AM, during an interview, Licensed Practical Nurse (LPN) #2 revealed oxygen was not coded on Resident #35's Quarterly MDS. LPN #2 stated she had seen Resident #35 wearing her oxygen. LPN #2 stated she had spoken to the nurses before about documenting that Resident #35 was wearing her oxygen, but the nurses failed to document the	F 641	resident, a physician order was written on 04/09/20 as follows: " Oxygen@ 2 Liters per Minute per Nasal Bi-Prong at Bedtime 2) All residents with PRN oxygen usage have the potential to be affected. A 100% audit of all residents in the facility was conducted by the DON on 04/15/20, to identify residents using PRN oxygen. Facility identified two (2) residents using PRN oxygen. A 100% audit of the Minimum Data Set (MDS) for those residents identified with PRN oxygen usage was conducted by the MDS Nurses from 04/10/20 to 04/15/20, to ensure accuracy of assessment. Only Resident #35 was affected. 3) The MDS, Care Area Assessment (CAA), and Care Plan Documentation Policy was reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20, and approved with no revisions at that time. An in-service was conducted on 03/02/20, for the MDS Nurses by the Director of Nursing (DON) regarding the MDS, CAA, and Care Plan Documentation policy, proper documentation, and accurate assessment. All Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) were in-serviced by the DON from 02/28/20 to 03/06/20, regarding proper documentation of	

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F 641	Continued From page 2 use of the oxygen. LPN #2 stated that they were having a lot of issues with the nurses not documenting the use of PRN oxygen. LPN #2 stated she was told she could not code the MDS based only on what she observed, and that she could not code Resident #35's MDS for oxygen, if it wasn't documented by the nurses. During an interview, on 02/27/2020 at 11:10 AM, the Director of Nursing (DON) revealed that Resident #35's MDS not being coded for the oxygen was an issue. The DON confirmed Resident #35 wears her oxygen, and it should have been documented by the nurses, and also by the MDS nurse.	F 641	oxygen usage. New hires will be in-serviced upon hire. 4) To ensure accurate coding of the MDS assessment related to oxygen therapy, the DON will audit three (3) residents per week receiving oxygen for three (3) consecutive months. These residents and their medical records will be assessed to ensure proper documentation of oxygen usage in the medical record, and accurate assessment on the MDS. Any issues identified will be addressed at that time. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		4/1/20

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F 656	Continued From page 3 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 observation, interviews, record review, and facility policy review, the facility failed to develop a comprehensive care plan related to Urinary Incontinence for Resident #15, and failed to implement the care plan for Urinary Incontinence for Resident # 87, pressure ulcers for Resident #84, and for catheter care and pressure ulcers for Resident #52, for four (4) of 26 resident care plans reviewed. Findings include:	F 656	Statements contained herein are intended for purposes of compliance with federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid.	

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F 656	Continued From page 4 Review the facility's "Care Planning" policy, with a review date of 01/02/2020, revealed: Care, treatment, and services, are planned to ensure that they are individualized to the resident's needs. The facility's policy revealed all staff using the computerized plan of care is responsible for interdisciplinary collaboration to establish goals and appropriate interventions, as well as ongoing evaluations and revisions. Resident #15 Review of Resident #15's Comprehensive Care Plan, revealed there was not a focused problem related to Resident #15's incontinence status or the need for incontinent care listed. A review of Resident #15's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2019, revealed, Section H (Bladder and Bowel) was coded to indicate Resident #15 was frequently incontinent of urine, and always incontinent of bowel. Section G (Functional Status) revealed Resident #15 required extensive assistance of two persons with toileting. Review of Resident #15's most current Annual Comprehensive MDS, with an ARD of 09/04/2019, revealed Sections H0300 and H0400 were coded for the resident being always incontinent of bladder and bowel. Section V (Care Area Assessment (CAA) Summary of the Annual Comprehensive MDS, indicated that Urinary Incontinence had triggered, and the decision was made to include Urinary Incontinence on the care plan. On 02/26/2020 at 2:39 PM, during an interview,	F 656	F656 1) For Resident #15, a comprehensive care plan was developed on 02/28/20, related to Urinary Incontinence by the Minimum Data Set (MDS) Nurse. For Residents # 87, 84, and 52, a 1-1 in-service was provided on 02/28/20, to Licensed Practical Nurse (LPN) #1 by the Director of Nursing (DON) and included the following: " Urinary Incontinence care plan review for Resident #87 " Pressure Ulcer care plan review for Resident #84 " Catheter care and pressure ulcer care plan review for Resident #52 " Implementation of the resident□s comprehensive care plan " Following the proper procedure for cleaning wounds and for clean dressing changes For Resident #87, a 1-1 in-service was provided on 02/28/20, to Certified Nursing Assistant (CNA) #1 and CNA #2 by the DON. The in-service included: " Following the resident□s comprehensive care plan " Following the proper procedure for perineal care " Following the proper procedure for catheter care 2) All residents with Urinary Incontinence, Urinary Catheters, or Pressure Ulcers have the potential to be affected.	

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F 656	Continued From page 5 Licensed Practical Nurse (LPN) #7, confirmed Resident #15 comprehensive care plan did not have a focused problem, with measurable goals and interventions, related to Resident #15's bowel and bladder incontinence. LPN #7 stated Resident 15's Annual Comprehensive MDS Assessment, dated 09/04/2019, Section H had been coded for "always incontinent" of bladder and bowel. LPN #7 confirmed that Section V (Care Area Assessment Summary) of the Annual MDS Assessment, dated 09/04/2019, had triggered in the Care Area for Urinary Incontinence, and the decision to include incontinence on the care plan was indicated. During an interview, on 02/26/2020 at 3:01 PM, LPN #2 confirmed Resident #15 had been assessed and was frequently incontinent of the bladder and always incontinent of the bowel. LPN #2 stated Resident #52's Quarterly MDS, dated 11/27/2019 was coded to confirm the assessment made of the resident's incontinence status. LPN #2 confirmed there was not a focus problem related to Resident #15's incontinence status on the care plan. LPN #2 stated providing proper incontinent care should be one of the interventions for that problem. LPN #2 stated it was the expectation that the CNAs follow proper incontinent care when it is provided. During an interview, on 02/27/2020 at 10:24 AM, the Director of Nursing (DON) stated she was informed by the MDS staff that bowel and bladder incontinence was not on Resident #15's care plan. The DON confirmed the resident's care plan needed to have included the resident incontinence status with appropriate interventions, which would include incontinent care.	F 656	A 100% audit of the care plans for residents identified with Urinary Incontinence was conducted by the Minimum Data Set (MDS) nurses from 02/28/20 - 03/06/20 to ensure the care plan addressed Urinary Incontinence and incontinent care. A 100% audit for residents with catheters and pressure ulcers was conducted by the DON on 02/28/20. Facility identified one hundred twenty (120) residents with problems related to Urinary Incontinence, seven (7) residents with catheters, and six (6) residents with Pressure Ulcers. Only Residents #15, #87, #84, and #52 were affected. 3) The Comprehensive Person-Centered Care Plan policy was reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20, and approved with no revisions. A 1-1 in-service was conducted on 03/02/20, for the MDS Nurses by the DON regarding the development of comprehensive care plans , and with LPN #1 regarding implementing the care plan, and with CNA #1 and CNA #3 regarding implementing the care plan for catheter care. All CNAs were observed for proper implementation of the care plan for incontinent care and catheter care. Observation was conducted by the Quality Assurance Infection Preventionist, the	

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F 656	Continued From page 6 A review of the "Face Sheet", revealed, Resident #15 was admitted by the facility on 12/02/2016, with diagnoses to include Cerebral Infarction, Type 2 Diabetes Mellitus, and Chronic Kidney Disease. Resident #84 A review of the facility's, "Comprehensive Care Plan" policy, dated 01/24/2020, revealed: Services provided or arranged by the facility, as outlined by the Comprehensive Person-Centered Care Plan, shall be provided by qualified persons in accordance with each residents written plan of care, and meet current professional standards of quality and accepted standards of clinical practice. "Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made." Review of Resident #84's Care Plan revealed a focused problem for Pressure Ulcers, with a care plan goal of area will remain free of infection. The interventions included to clean wound to sacrum area with normal saline, pat dry, apply Mesalt to wound bed and cover with Aquacel foam daily until resolved. During an observation, on 02/25/2020 at 1:44 PM, Licensed Practical Nurse (LPN) #1 provided wound care treatment for Resident 84's Stage 4 sacral wound, with assistance from Registered Nurse (RN) #1. LPN #1 removed the soiled dressing, discarded the soiled dressing, and then cleaned the wound with gauze and normal saline. RN #1 took measurements of the wound. After the measurements were obtained, LPN #1	F 656	Treatment Nurse, or the Staff Development Coordinator via return demonstration and completion of competency checklist. Observations were conducted from 02/28/20 to 03/06/20, and all required staff have been observed at this time. LPN #1 was observed by the DON for proper implementation of the care plan for treatment of Pressure Ulcers. Observation was conducted on 02/28/20, via demonstration and completion of competency checklist. 4) The Assistant Director of Nursing (ADON), or the Quality Assurance Infection Preventionist (QA-IP) will audit three (3) care plans weekly for three (3) consecutive months to ensure residents with Urinary Incontinence have a care plan addressing incontinence. The Assistant Director of Nursing (ADON), the Quality Assurance Infection Preventionist (QA-IP) or designee will conduct a random audit of three (3) episodes of incontinent care, and three (3) episodes of pressure ulcer care weekly for three (3) consecutive months to ensure care is being implemented as identified in the care plan for incontinent care and pressure ulcer care. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as	

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F 656	Continued From page 7 applied the Mesalt dressing to the wound bed and covered the wound with the Aquacel foam dressing. LPN #1 did not clean her hands or change gloves after removing the dirty dressing and cleaning the wound. LPN #1 also failed to clean the wound a second time, after the wound measurements were taken by the RN #1. During an interview, on 02/26/2020 at 2:30 PM, with LPN #7, she revealed when Resident #84's care plan had been developed, with an identified focused problem related to a pressure ulcer, her expectation was that the care plan would be followed as outlined. LPN #7 stated it was expected that the nurse providing the wound treatment would do it correctly. During an interview, on 02/27/2020 at 10:03 AM, the Director of Nursing (DON) revealed when dealing with pressure ulcers, not changing gloves when going from dirty to clean, could possibly lead to an infection. The DON confirmed that following the Care Plan is part of providing the care. Review of the facility's "Face Sheet" revealed, the facility admitted Resident #84 on 03/08/2019 with diagnoses to include Heart Failure, Unspecified Dementia, and Essential Hypertension. Resident #87 Review of Resident #87's care plan revealed, a focused problem, with an onset date of 02/18/2019, which indicated Resident #87 was incontinent of bowel and bladder. The goal was for the resident to have maximal hygiene and odor control. Interventions included to check the resident every two (2) hours and as needed, change/clean when wet or soiled and provide perineal hygiene after each incontinent episode.	F 656	determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	

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F 656	Continued From page 8	F 656		

On 02/27/2020 at 10:23 AM, during an observation of incontinent care, Certified Nursing Assistant (CNA) #2 failed to clean Resident #87's penis.

On 02/27/2020 at 11:08 AM, during an interview with CNA #2, she confirmed that she failed to cleanse Resident #87 penis while providing incontinent care. CNA #2 stated she totally forgot. CNA #2 also stated this could cause a UTI if she did not cleanse around that area.

During an interview, on 02/27/2020 at 3:13 PM, LPN #10 revealed the care plan is to make sure the resident receives the best quality of care.

During an interview, on 02/27/2020 at 3:15 PM, the DON stated the CNAs were trained to clean the residents' penis when providing incontinent/perineal care. The DON confirmed CNA #2 failed to follow the care plan by not cleaning Resident #87's penis.

Resident #52
Pressure Ulcer
A review of Resident #52 ' s Comprehensive Care Plan, "Pressure Ulcer: Stage 4 to left heel", dated 01/23/2020, revealed an intervention to perform wound care as ordered, with a care plan goal indicating the area will remain free of infection. Review of the Comprehensive Care Plan, "Pressure Ulcer: Stage 4 to right ischium" dated 01/23/2020, revealed the goal was for the area to remain free of infection, with interventions which included to perform wound care as ordered.

Review of Resident #52 ' s "Physician Orders List" revealed, an order dated 11/01/2019, to clean wound to left heel with Normal Saline (NS),

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F 656	Continued From page 9	F 656		

pat dry, apply nickel thick Santyl, cover with Aquacel Extra, cover with heel foam, and secure with Kerlix daily. The Physician Orders List also revealed an order, dated 01/23/2020 to clean wound to right ischium with NS, pat dry, apply Puracol to wound bed, cover with Aquacel Foam daily until resolved.

During Resident #52 ' s wound care observation of the left heel, on 02/26/2020 at 2:15 PM, LPN #1 applied a barrier under Resident #52's left foot. LPN #1 removed the dirty dressing from the left heel, and laid the unclean heel onto the barrier. There was blood tinged drainage noted to the barrier under the resident's heel. After cleaning the left heel, LPN #1 laid the cleaned heel back onto the soiled barrier. RN #1 was handed a paper measuring tape by the LPN #1. RN #1 measured the wound by touching the tape to the wound, and laid the resident's left heel back onto the dirty barrier. RN #1 picked the resident's left heel up once again, and took a Q-tip applicator to measure the depth of the wound. RN #1 laid the left heel wound back onto the barrier. LPN #1 picked Resident #52's left heel up from the dirty barrier and applied the medication and clean dressings to the wound. LPN #1 failed to re-clean the wound after it was measured, after the heel was placed back onto the dirty barrier numerous times, and before the clean wound treatment and dressings were applied.

On 02/26/2020 at 2:28 PM, during the wound care observation of Resident #52's right ischium, after cleaning and drying the wound, LPN #1 handed RN #1 a paper measuring tape. RN #1 measured the wound by touching the tape to the wound, and applying a Q-tip into the wound for

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depth measurement. LPN #1 did not re-clean the wound, after RN #1 had measured the wound. LPN #1 applied Puracol into the wound bed, and then applied Aquacel Foam dressing to the right ischium.

During an interview, on 2/27/2020 at 11:00 AM, RN #1 stated she felt LPN #1 did not follow Resident #52's Care Plan for the left heel and right ischium, when she failed to perform the care correctly.

During an interview on 02/27/2020 at 11:10 AM, the DON stated Resident #52's Wound Care Plans were not followed, when LPN #1 failed to provide wound care according to nursing standards.

On 02/27/2020 at 1:22 PM, during an interview, LPN #1 revealed she felt that she did not follow Resident #52's Wound Care Plans for the left heel and right ischium, when the care was not performed correctly.

Catheter Care
A review of the Comprehensive Care plan, with a start date of 01/30/2020, revealed, Resident #52 was at risk for Urinary complications related to an indwelling catheter. The care plan interventions revealed Resident #52 required catheter care every shift.

During Resident #52's catheter care observation, on 02/26/2020 at 2:28 PM, CNA #1 wiped the head of the penis in a circular motion twice with the same area of the wipe. CNA #1 took a second wipe, and in the opposite direction, wiped the head of the penis in a circular motion twice with the same area on the wipe. CNA #1 wiped the

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tubing downwards away from the body twice using the same area on the wipe. CNA #1 obtained a second wipe and wiped the tubing away from the body twice with the same area of the wipe. CNA #1 did not dry the catheter tubing or the penis after cleaning with the wipe or before applying his brief. CNA #1 wore the same gloves throughout the catheter care process and used them to pull Resident #52's cover up.

During an interview, on 02/27/2020 at 10:10 AM, LPN #2/MDS Care Plan Nurse stated the care plan directs the care for a resident. LPN #2 stated the care plan directs the Interdisciplinary Team to be able to know how to care for a resident. LPN #2 revealed, if the care plan is followed, then the care a resident receives should be done properly as directed by the care plan. LPN #2 confirmed the care plan for catheter care was not followed by CNA #1, when she did not perform catheter care properly for Resident #52.

During an interview on 2/27/20 at 10:50 AM, CNA #1 stated she remembered wiping the catheter tubing on the right side of the tubing twice with the same area of the wipe. She stated she remembered wiping the left side of the tubing twice with the same area on the wipe. CNA #1 stated wiping the area twice, with the same area on the wipe, could have caused contamination or an infection. CNA #1 stated she should have wiped only once down the catheter tubing and discarded the disposable wipe, prior to wiping the second time. CNA #1 confirmed she did not dry Resident #52's penis or his catheter tubing before applying a clean brief.

On 02/27/2020 at 11:10 AM, during an interview with the DON, she stated Resident #52 s

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F 656	Continued From page 12 Catheter Care Plan was not followed, when the care was not performed properly. The DON stated CNA #1 should not have wiped the catheter tubing twice using the same area on the wipe. The DON further stated CNA #1 should have used the wipe once, discarded the wipe, and obtained another disposable wipe before wiping the second time. The DON revealed it could have caused a Urinary Tract Infection for Resident #52.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure an enteral feeding pump was operated by licensed staff one for (1) of three (3) residents observed with Percutaneous Endoscopic Gastrostomy (PEG) tube feedings, Resident #15. Findings include: Review of the facility's "Feeding Tube Management" policy, dated 01/30/2020, revealed, the facility's purpose was to utilize feeding tubes in accordance with current clinical standards of practice and to ensure appropriate use and care of feeding tubes by medical and nursing staff. The facility's policy revealed it was the responsibility of the Physician, Registered Nurse, Licensed Practical Nurse, and Student Nurse with	F 658	Statements contained herein are intended for purposes of compliance with federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. F658 1) For Resident #15, a 1-1 in-service was conducted by the Director of Nursing (DON) on 03/02/20, with Certified Nursing Assistant (CNA) #3 regarding operation of feeding pumps by appropriate qualified	4/1/20

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F 658	Continued From page 13 Instructor supervision to adhere to this policy. During an observation, on 02/24/2020 at 10:36 AM, Certified Nurse Assistant (CNA) #3, entered Resident #15's room to provide incontinent care. CNA #3 placed the resident's enteral feeding pump on hold. After the incontinent care was completed, CNA #3 turned Resident #15's enteral feeding pump back on. On 02/24/2020 at 10:55 AM, during an interview with CNA #3, she stated that she had put Resident #15's feeding pump on hold and then restarted it, because she thought it was okay to do so. CNA #3 stated she believed CNAs could put the feeding pumps on hold, and turn them back on, but could not turn the feeding pumps off. During an interview, on 02/24/2020 at 11:10 AM, the Director of Nursing (DON stated CNAs cannot do anything with the feeding pumps, as in, turning them off, putting them on hold, or not even turning a feeding pump on that has been turned off. During an interview, on 2/27/2020 at 10:03 AM, Licensed Practical Nurse (LPN) #4/Staff Development Nurse, stated CNAs are educated and in-serviced regarding the feeding pump. LPN #4 stated the CNAs are told that a nurse is the only person who can operate the feeding pump, and to always call the nurse if they need assistance. A review of the facility's "Face Sheet" revealed, the facility admitted Resident #15 on 12/02/2016 with diagnoses which included Cerebral Infarction, Type 2 Diabetes Mellitus, Chronic Kidney Disease, and Dysphagia.	F 658	licensed staff only. 2) Any resident using a feeding pump has the potential to be affected. A 100% audit was conducted on 02/28/20, by the DON to identify residents utilizing enteral feeding pumps. Facility identified seven (7) residents with an enteral feeding pump. 3) The Feeding Tube Management policy was reviewed and updated by the Quality Assessment and Assurance (QAA) Committee on 03/11/20, and approved changes to include only licensed staff to operate feeding pumps. All Licensed Practical Nurses (LPNs), Registered Nurses (RNs), and CNAs were in-serviced by the DON from 02/28/20 □ 03/06/20. The in-service included that only licensed staff are qualified to operate feeding pumps. This information regarding only licensed staff being qualified to operate feeding pumps will be included in training for newly hired nursing staff as well. 4) The Quality Assurance Infection Preventionist (QA-IP) or the Treatment Nurse will audit three (3) residents per week with a feeding pump in use during incontinent care to ensure the proper procedure is followed for feeding pump operation by licensed personnel only. Any issues identified will be addressed at that time.	

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F 658	Continued From page 14	F 658	Audits will continue for three (3) consecutive months. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review the facility failed to provide wound care in a manner to prevent the possible spread of infection for two (2) of three (3) residents observed for wound care, Resident #84 and Resident #52. Findings include: Resident #84	F 686	Statements contained herein are intended for purposes of compliance with federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid.	4/1/20

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F 686	Continued From page 15 Review of facility's "Clean Dressing Change" policy, dated 01/30/2020, revealed the purpose was to provide wound care in a manner to decrease the potential for infection and/or cross-contamination. The policy revealed the following steps included in the clean dressing change: Procedure: 5) Perform hand hygiene and put on clean gloves, 6) ensure the area is as clean as possible, place a barrier cloth or pad next to the resident to protect the bed linens and bed site, 7) remove soiled dressings and discard, 8) perform hand hygiene and put on clean gloves, 9) clean the wound as ordered, 10) discard soiled gauze and gloves, 11) perform hand hygiene and put on clean gloves, 12) apply ointments/creams and dress the wound as ordered. During an observation, on 02/25/2020 at 1:44 PM, Licensed Practical Nurse (LPN) # 1/Treatment Nurse provided wound care treatment for Resident 84's Stage 4 sacral wound, with assistance from Registered Nurse (RN) #1/Assistant Director of Nursing (ADON). LPN #1 removed the soiled dressing, discarded the soiled dressing, and then cleaned the wound with gauze and normal saline. RN #1 then measured the sacral wound. After the measurements were obtained by RN #1, LPN #1 applied the Mesalt dressing to the wound bed and covered the wound with the Aquacel foam dressing. LPN #1 failed to clean her hands or change gloves after removing the dirty dressing and cleaning the wound. LPN #1 also failed to clean the wound a second time, after the wound measurements were taken by the RN #1. During an interview, on 02/27/2020 at 10:03 AM, the Director of Nursing confirmed, during wound care, the nurse must change her gloves, when	F 686	1) For Resident #84, and Resident #52, a 1-1 in-service was provided to Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 by the Director of Nursing (DON) on 02/28/20. The in-service included providing wound care in a manner to prevent the possible spread of infection consistent with professional standards of practice to promote healing. 2) All residents with Pressure Ulcers have the potential to be affected. A 100% audit for residents with Pressure Ulcers was conducted by the DON on 02/28/20. Facility identified six (6) residents with Pressure Ulcers. Only Residents #84 and #52 were affected. 3) The Clean Dressing Change policy was reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20, and was approved with no changes. A new policy was developed and approved by the committee at that time titled Wound Assessment policy which gives guidance for wound measurement, assessment and documentation. An in-service with LPN #1 and RN #1 was conducted on 03/11/20, by the DON regarding the Wound Assessment policy, and proper procedures for clean dressing changes and wound care. LPN #1 and RN #1 were observed for proper procedure for wound care and measurement during clean dressing	

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F 686	Continued From page 16 going from dirty to clean. The DON stated that not doing so, would be an infection control concern. On 02/27/2020 at 10:32 AM, during an interview with RN #1, she stated when any wound care treatment was done, the nurse should always change her gloves after removing the dirty/soiled dressing and cleaning the wound. RN #1 stated this was an infection control concern. During an interview, on 02/27/2020 at 11:15 AM, LPN #1 confirmed she had not cleaned her hands and changed her gloves, between removing the soiled dressing and cleaning the wound. LPN#1 stated that she knew this could cause the wound to become infected. A review of Resident #84's Care Plan revealed a focused problem for Pressure Ulcers, with a care plan goal of area will remain free of infection. Interventions included to clean wound to sacrum area with normal saline, pat dry, apply Mesalt to wound bed and cover with Aquacel foam daily until resolved. Review of the "Face Sheet" revealed, Resident #84 was admitted by the facility on 03/08/2019, with diagnoses to include Heart Failure and Essential Hypertension. Resident #52 A review of the facility's "Clean Dressing Change" policy, dated 01/30/2020, revealed, to place a barrier cloth or pad next to the resident, under the wound if possible to protect the bed linens and the body site. Cleanse wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound. Review of the facility's "Pressure Injury Prevention and Management Policy", dated 01/30/2020, revealed, the purpose was for	F 686	change. Observation was conducted on 03/11/20, by the DON via return demonstration and completion of competency checklist. 4) The Director of Nursing (DON), or the Quality Assurance Infection Preventionist (QA-IP) will audit two (2) wound care treatments and measurements weekly for three (3) consecutive months to ensure residents with wounds are provided with wound assessment and care consistent with professional standards of practice and according to facility policy and procedure. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	

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prevention of avoidable pressure injury and promotion of healing of existing pressure injuries. Monitoring included to measure the wound and implement the initial treatment per physician's order or the skin care protocol. The policy revealed the Treatment Nurse and or Wound Nurse would modify interventions as needed as new risk factors are identified, resident goals or preference change, or for non-healing when appropriate.

A review of Resident #52's Physician Orders, revealed an order, with a start date of 11/01/2019, to clean the left heel with normal saline, pat dry, apply Nickel thick Santyl, cover with Aquacel Extra, and cover with heel foam. Secure with Kerlix and tape daily. An order dated, 01/23/2020, revealed, to clean the wound to right ischium with normal saline, pat dry, apply Puracol to wound bed, cover with Aquacel foam daily until resolved.

During an observation, on 02/26/2020 at 2:15 PM, Licensed Practical Nurse (LPN) #1 entered Resident #52's room to provide wound care to the left heel. LPN #1 placed a barrier on the bed, under Resident #52's left foot. LPN #1 removed the dirty dressing from Resident #52's left heel, and laid the unclean left heel onto the barrier. Blood tinged drainage was noted on the barrier under the resident's heel. LPN #1 picked Resident #52's left heel up off of the barrier and began to clean the heel. LPN #1 cleaned the right side of the left heel wound in a circular motion with a normal saline gauze and discarded the gauze, LPN #1 then cleaned the left side of the heel wound in a circular motion with a normal saline gauze and discarded the gauze. LPN #1 placed the cleaned heel wound back onto the

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soiled barrier. LPN #1 picked up the resident's left heel and using a clean gauze, she patted the wound dry. LPN #1 placed the left heel back onto the dirty barrier. Registered Nurse (RN) #1 was handed a paper measuring tape by LPN #1, who did not have gloves on at the time. RN #1 measured the wound and placed the heel back onto the dirty barrier. RN #1 removed her gloves, used hand foam and applied gloves. RN #1 picked Resident #52's left heel back up, and took a Q-tip applicator to measure the depth of the wound. RN #1 placed the left heel wound back onto the dirty barrier. LPN #1 picked the resident's heel up from the barrier and applied the dressing to the wound and secured it with Kerlix and tape. The wound was not cleaned after RN #1 measured the wound and before a clean dressing was placed onto the left heel wound.

On 02/26/2020 at 2:28 PM, during an observation of wound care to Resident #52's right ischium, LPN #1 put on gloves and placed a barrier under the left buttocks of the resident to protect the linen when cleaning the wound. LPN #1 obtained a normal saline gauze, wiped the wound once with the gauze in the middle of the wound and discarded the gauze. LPN #1 took a second normal saline gauze and wiped in the middle of the wound again. LPN #1 took the third gauze and patted the wound dry. LPN #1 handed RN #1 a measuring tape. RN #1 measured the wound by touching the tape to the wound. RN #1 obtained a Q-tip and placed it into the wound for depth measurement. LPN #1 obtained the Puracol and applied it to the wound bed by pressing it into the wound bed with her gloved fingers. Wearing the same gloves, LPN #1 applied Aquacel Foam dressing to the right ischium, and fastened the brief back onto

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Resident #52. LPN #1 proceeded to pull the bed covers over Resident #52, wearing the same gloves. LPN #1 did not re-clean the wound after RN #1 measured the wound and before the clean wound treatment and dressing was applied.

During an interview, on 02/27/2020 at 10:42 AM, LPN #1 stated she remembered placing Resident #52's left heel back on the dirty barrier pad after she cleaned the wound. LPN #1 revealed she remembered the resident's heel being placed on the dirty barrier on and off through the wound care process. LPN #1 stated that she remembered RN #1 placing Resident's left heel on the barrier after she measured the wound. LPN #1 stated that she went ahead and dressed the wound without re-cleaning it. LPN #1 further stated this could have caused an infection especially since Resident #52 had a history of infection in that left heel wound from September 2019. LPN #1 stated that she knew better and she should have recleaned the wound after RN #1 measured the wound and prior to dressing the wound. During an interview regarding Resident #52's ischium wound care, LPN #1 stated she remembered cleaning Resident #52's ischium and afterwards, RN #1 measured the wound. LPN #1 stated she dressed the resident's ischium without cleaning the wound again, after RN #1 had measured it. Both were cross contamination and had the potential to cause infection.

Record review of Resident #52's Physician orders, revealed Resident #52 had been prescribed Augmentin 500/125 milligrams (mg) one (1) by mouth three times a day for seven (7) days for heel infection back on 09/11/2019.

During an interview, on 02/27/2020 at 11:00 AM,

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RN #1 revealed LPN #1 should have re-cleaned the Resident #52's left heel wound after she measured the wound and before dressing the wound. RN #1 stated she remembered Resident #52's heel touching the dirty barrier several times throughout the wound care process. RN #1 revealed LPN #1 did not re-clean Resident #52's left heel nor the ischium wound. RN #1 stated with the wound not being re-cleaned after she measured the wound, and after the left heel retouched the dirty barrier, it could have caused an infection. RN #1 further stated that it was definitely a cross contamination issue. RN #1 revealed Resident #52 had a previous infection in his left heel. RN #1 stated after LPN #1 cleaned Resident #52's right ischium wound, she measured the wound, and LPN #1 then dressed the wound without cleaning it again. RN #1 revealed the wound procedure to the right ischium was cross contamination as well.

During an interview, on 02/27/2020 at 11:10 AM, the DON stated LPN #1 not cleaning Resident #52's wounds again, after they were measured by RN #1, was not proper procedure. She stated the left heel touching the dirty barrier, time and time again throughout the wound care process, was an infection control issue. The DON stated Resident #52 had a history of infection in his left heel and this was definitely an infection control and cross contamination issue. The DON further stated LPN #1 not cleaning the resident's ischium after RN #1 measured it and before she dressed the wound, was not proper procedure. The DON stated it was an infection control issue.

Review of the facility's "Face Sheet" revealed, Resident #52 was admitted on 06/05/2017, with diagnoses which included Osteomyelitis of

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F 686	Continued From page 21 Vertebra, Sacral, and Sacrococcygeal region and Diabetes Mellitus with Unspecified Complications. A review of the admission "Departmental Notes" for Resident #52, dated 06/05/2017, revealed Resident #52 was admitted to the facility with an unstageable wound to the left heel, which measured at 1.8 x 3.7 x 0 centimeters (cm), and a Stage 4 wound to the sacrum measuring at 11 x 9.5 x 3.0 cm. A review of the "Wound Healing Progress Report" for Resident #52, revealed, the right ischium wound (unstageable) was identified 08/27/2019 and measured in centimeters at 2.70 x 3.00 x 0.10. As of 02/25/2020, the wound was at a Stage 4 and measured 2.20 x 1.00 x 0.5 cm. A review of Resident #52's "Wound Healing Progress Report" for the left heel wound, revealed the wound reopened on 05/22/2019, and was identified as unstageable and measured at 1.00 x 1.00 x 0.10 cm. As of 02/25/2020, the left heel wound was at a Stage 4 and measured 1.60 x 3.00 x 0.10 cm.	F 686		
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	F 690		4/1/20

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F 690	Continued From page 22 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, interview, record review, and facility policy review, the facility failed to provide incontinent care in a manner to prevent urinary tract infections for three (3) of seven (7) catheter care observations, Resident #15, #87, and #52. Findings include: Review of the facility's "Perineal Care" policy, dated 01/23/2020, revealed the purpose of the policy is to provide guidelines for providing adequate body hygiene for all resident and to	F 690	Statements contained herein are intended for purposes of compliance with federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. F690	

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F 690	Continued From page 23 decrease the risk of Urinary Tract Infections (UTIs). The facility policy revealed staff must follow Infection Control practices for hand hygiene. The facility policy further revealed, the procedure for perineal care included, if a bowel movement is present, cleanse the resident with disposable wipes, remove gloves and dispose, perform hand hygiene, and put on clean gloves. Resident #15 During an observation of Resident #15's incontinent care, on 02/24/2020 at 10:36 AM, provided by Certified Nursing Assistant (CNA) #3 and CNA #4, Resident #15 was lying on her left side and CNA #3 wiped Resident #15's buttocks area from back to front on the last swipe. CNA #3 and CNA #4 turned Resident #15 on her right side, and CNA #4 wiped the resident's buttock area from side to side four (4) times and from back to front two (2) times using the soiled brief and no clean wipes. CNA #3 picked the trash can up off the floor, held it over the resident, leaned forward across the bed. CNA #4 tossed the soiled brief into the trash can. CNA #3 and CNA #4 continued to reposition the resident in the bed without washing their hands or changing gloves. During an interview, on 02/24/2020 at 10:55 AM, CNA #3 stated she was not aware that she had wiped the wrong way during Resident #15's incontinent care, but that it was possible. CNA #3 stated picking up the trash can and not cleaning the resident from front to back, could cause the resident to get an infection. On 02/24/2020 at 11:00 AM, during an interview with CNA #4, she confirmed that she had wiped in the wrong direction and did not use a clean wipe to clean Resident #15's buttocks area during the	F 690	1) The Certified Nursing Assistants (CNAs) caring for Residents #15, #87, and #52, which were CNAs #1, #2,#3 and #4, were immediately in-serviced by the Director of Nursing (DON) on 02/28/20. The in-service included following the facility policy for perineal and catheter care, including proper hand hygiene procedures. 2) All residents with Urinary Incontinence or indwelling catheters have the potential to be affected. A 100% audit was conducted on 02/28/20, by the DON for residents with Urinary Incontinence and Indwelling Catheters. Facility identified one hundred twenty(120) residents with problems related to Urinary Incontinence and seven (7) residents with an indwelling catheter. Only Residents #15, #87, and #52 were affected. 3) The Hand Hygiene, Catheter Care, and Perineal Care policies were reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20, and approved with no changes. All of the facility CNAs were in-serviced from 02/28/20 through 03/05/20, by the DON regarding the facility policy and proper procedures for hand hygiene, catheter care and perineal care. All CNAs were observed for proper hand hygiene, catheter care, and perineal care. Observation was conducted by the Quality Assurance Infection Preventionist (QA-IP)	

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F 690	Continued From page 24 incontinent care. CNA #4 confirmed she had not cleaned her hands or changed her gloves. CNA #4 stated that by not cleaning the right way and not using a clean wipe, this could cause the resident to get an infection. During an interview, on 02/27/2020 at 10:03 AM, Licensed Practical Nurse (LPN) #4/Staff Development Nurse, confirmed wiping from back to front is not the correct way to clean the perineal area when incontinent care is performed. LPN #4 stated the buttocks area should be cleaned with a clean wipe instead of a soiled brief. LPN #4 further stated, cleaning in the wrong direction using only the soiled brief, puts the residents at greater risk for a Urinary Tract Infection (UTI). LPN #4 revealed CNA #3 and #4 had completed and passed an incontinent skills check-off within the last six (6) months. During an interview, on 02/27/2020 at 10:24 AM, the Director of Nurses (DON) confirmed wiping from back to front was not the way perineal/incontinent care should be done. DON stated performing incorrect perineal care would increase the resident's risk for a UTI. Review of the facility's document, "Skills Competency for Catheter Care and Perineal Care", revealed CNA #3 had met the skills competency for perineal care. The document was signed by LPN #4 and dated on 10/18/2019. A review of the "Skills Competency for Catheter Care and Perineal Care" for CNA #4, signed and dated by LPN #4 on 11/27/2019, revealed she met the skills competency for perineal care. Review of the "Face Sheet", revealed, the facility admitted Resident #15 on 12/02/2016 with	F 690	and the Treatment Nurse via return demonstration and completion of competency checklist. Observations were conducted from 02/28/20 through 03/06/20. Training on proper hand hygiene procedures, catheter care, and perineal care, as well as competency verification, will be conducted annually at a minimum with all CNAs, and will be included during orientation for newly hired CNAs. 4) The QA-IP and the Staff Development Coordinator will conduct validation checks for three (3) CNAs weekly for three (3) consecutive months to ensure competency performing hand hygiene, catheter care, and perineal care according to facility policy. Any issues identified will be addressed at that time. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	

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F 690	Continued From page 25	F 690		

diagnoses which included Cerebral Infarction, Type 2 Diabetes Mellitus, and Chronic Kidney Disease.
Resident #87
Review of the facility's, "Perineal Care" policy, dated 01/23/2020, revealed, the procedure for performing male perineal care included: If the resident is uncircumcised, the foreskin should be retracted before cleaning and placed back in position after cleaning is complete. Gently, but securely hold the shaft of the penis in one hand. Using a clean disposable wipe, use circular motion and clean the end of the penis down toward the shaft and dispose of the wipe.

During an observation of Resident #87's incontinent care, on 02/27/2020 at 10:23 AM, CNA #2 cleaned the resident's groin areas and scrotum, but failed to cleanse Resident #87's penis while providing incontinent care.

On 02/27/2020 at 11:08 AM, during an interview, CNA #2 confirmed she failed to pull the skin back and cleanse Resident #87's penis. CNA #2 stated she totally forgot to do it. CNA #2 further stated by not cleaning Resident #87's penis could have caused him to get a UTI.

Review of CNA #2's "Skills Competency for Catheter Care and Perineal Care", dated 10/18/2019 and signed by LPN #4, revealed CNA #2 was trained to provide perineal and catheter care for a male resident and had met the skills competency.

During an interview, on 02/27/2020 at 11:16 AM, Licensed Practical Nurse (LPN) #3 confirmed CNA #2's failure to cleanse Resident #87's penis could cause a UTI.

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F 690	Continued From page 26	F 690		

On 02/27/2020 at 11:24 AM, during an interview with LPN #4/Staff Development Nurse, she revealed incontinent care training was done upon hire and once a year with return demonstration. LPN #4 stated the penis was the most important part of the perineal area for a male, and should be cleaned appropriately.

An interview on 02/27/2020 at 3:15 PM, with the DON, revealed, the CNAs are trained to clean the resident's penis when providing incontinent/perineal care.

A review of the "Face Sheet" revealed, the facility admitted Resident #87 on 02/18/2019, with diagnoses that included Unspecific Dementia with Behavioral Disturbance, Diabetes Mellitus and Metabolic Encephalopathy.
Resident #52
A review of the facility's "Care of Urinary Indwelling and Suprapubic Catheters" policy, dated 01/24/2020, revealed the procedure for performing male catheter care included: "Using a clean disposable wipe, clean the end of the penis using a circular motion and dispose of the wipe. Using a clean disposable wipe, clean the catheter tubing from the area nearest the resident's body away from the body and dispose of the wipe."

A review of the "Physician Orders List" for Resident #52, revealed an order, dated 06/06/2017, for a 16 French/10 cubic centimeter (cc) bulb Foley Catheter related to Paraplegia/Neurogenic Bladder.

During an observation of catheter care, for Resident #52, on 2/26/2020 at 2:28 PM, Certified Nursing Assistant (CNA) #1 wiped the head of the

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F 690	Continued From page 27	F 690		

penis in a circular motion twice with the same area of the disposable wipe. CNA #1 obtained a second wipe, and in a circular motion, wiped Resident #52's penis again twice, with the same area of the disposable wipe. Using a new wipe, CNA #1 wiped the left side of the catheter tubing away from the body, and used the same area of the disposable to clean it twice. CNA #1 took another disposable wipe and wiped the right side of the tubing away from the body, using the same area on the wipe twice. CNA #1 did not dry the catheter tubing, penis or groin area after cleaning with the wipes. Upon completing the catheter care, CNA #1 pulled up and fastened Resident #52's brief and pulled the covers back over the resident. CNA #1 did not change her gloves or perform hand hygiene during the entire catheter care process.

On 2/27/2020 at 10:50 AM, during an interview, CNA #1 stated she remembered wiping the catheter tubing on the right side of the tubing, twice with the same area of the wipe and the left side as well. She stated that could have caused contamination or an infection. CNA #1 stated she should have wiped only once down the tubing and then discarded the wipe prior to wiping the second time in the same area. CNA #1 confirmed she did not dry Resident #52's penis, groin or catheter tubing before applying his diaper. CNA #1 stated she knew that she should have changed her gloves and washed her hands before pulling Resident #52's covers back over him.

During an interview, on 2/27/2020 at 11:10 AM, the DON stated CNA #1 should not have wiped the same area on the tubing twice with the same area on the wipe. The DON stated she should

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F 690	Continued From page 28 have wiped the tubing once, discarded the wipe, and then obtained another wipe to continue. The DON further stated CNA #1 should have dried Resident #2 off and the catheter tubing, before applying the brief. The DON stated CNA #1 should have removed her gloves and washed her hands before she pulled the covers back over Resident #52.	F 690		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to label and date enteral feeding bags during three (3) of four (4)	F 693	Statements contained herein are intended for purposes of compliance with federal and State laws regarding	4/1/20

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F 693	Continued From page 29 observations of two (2) sampled residents with tube feedings, Resident #53 and Resident #83. Findings include: Review of the facility's "Feeding Tube Management" policy, dated 01/30/2020, revealed, the staff should label the enteral formula and tubing appropriately. Resident #53 A review of Resident #53's active "Physician Orders List" as of 02/27/2020, revealed an order dated, 10/07/2019 for Jevity 1.5 at 45 cubic centimeters (cc) per hour (45cc/hr) with 20 cc water flush every hour for 20 hours per Kangaroo pump. Turn pump off at 12:00 PM and turn back on at 4:00 PM. During an observation, on 02/25/2020 at 8:40 AM, Resident #53's tube feeding bag was not labeled to indicate the date and time of when the bag was hung. At 2:45 PM, Resident #53 was observed in the bed with the head of the bed elevated. The tube feeding bag was still noted to be without a label to indicate the date and time in which the bag was hung. During an observation, on 02/26/2020 at 8:15 AM, Resident #53's tube feeding bag was not labeled and dated to indicate the time the bag was hung. An interview with the Director of Nurses (DON), on 02/27/2020 at 11:25 AM, revealed, tube feedings are required to be labeled and dated when the bags are changed. The DON stated If the tube feeding bags are not labeled and dated, the resident could get the wrong rate.	F 693	responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. F693 1) On 02/27/20, the Assistant Director of Nurses (ADON) verified the enteral feeding bags for Residents #53 and #83 were labeled and dated correctly. 2) All residents with enteral feeding pumps have the potential to be affected. A 100% audit was conducted by the Director of Nursing (DON) on 02/28/20, for residents with enteral feedings bag sets. Facility identified seven (7) residents with enteral feeding sets. Only Residents # 53 and # 83 were affected. 3) The Feeding Tube Management policy was reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20, and was approved with no changes. All of the facility Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) were in-service from 02/28/20 through 03/06/20, by the DON regarding the facility policy and proper procedures for labeling and dating of enteral feeding bags.	

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F 693	Continued From page 30 Review of Resident #53's Annual Minimum Data Set (MDS), dated 9/24/2019, revealed, Section K (Swallowing/Nutritional Status), was coded to indicate Resident #53 received nutrition via feeding tube. Resident #83 A review of Resident #83's active "Physician Orders List, as of 02/27/2020, revealed an order dated 10/07/2019, for Jevity 1.0 at 60 cc/hr per PEG continuous feeding tube for 20 hours daily with water flush at 20 cc/hr per Kangaroo pump. Turn off pump from 10:00 AM to 2:00 PM. Review of Resident #83's care plan, dated 01/27/2020, revealed problem that addressed resident having special dietary needs related to receiving all nutrition via PEG tube. During an observation, on 02/25/2020 at 9:51 AM, Resident #83's tube feeding bag was not labeled, dated, and did not indicate what time the tube feeding bag was hung. During an interview, on 02/27/2020 at 11:41 AM, with Licensed Practical Nurse (LPN) #5, she stated, "When I come in, I do my rounds to check to verify things are labeled because the shift before me changes the tube feeding bags. I did not notice it." Review of Resident #83's Annual Minimum Data Set (MDS), dated 04/25/2019, revealed Section K (Swallowing/Nutritional Status) was checked to indicate Resident #83 received nutrition through tube feeding.	F 693	Training on proper labeling and dating of enteral feeding bags will be reviewed annually at a minimum with all RNs and LPNs, and will be included during orientation for newly hired LPNs and RNs. 4) The Quality Assurance □ Infection Preventionist (QA-IP) or the Treatment Nurse will conduct an audit of all enteral feeding bags weekly for three (3) consecutive months to ensure proper labeling and dating of bags according to facility policy. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		4/1/20

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F 695	Continued From page 31 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure proper storage of respiratory equipment to prevent the possible spread of infection for three (3) of 3 sampled residents, out of a total of 13 residents receiving respiratory care, Resident #35, Resident #38, and Resident #112. Findings include: A review of the facility's "Oxygen Administration Policy", dated 01/29/2020, revealed: "Unused tubing will be stored in a dated plastic bag." Review of the facility's "Infection Prevention and Control Program Policy", dated 01/24/2020, revealed the purpose was to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Each department, in partnership with clinical staff, would be responsible for it's role in infection prevention and control and will follow all facility wide infection control policies and procedures.	F 695	Statements contained herein are intended for purposes of compliance with federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. F695 1) On 02/27/20, the Treatment Nurse changed the oxygen tubing for Residents #35, #38, and #112. The tubing was dated and placed in a plastic bag at that time. 2) All residents using oxygen have the potential to be affected. A 100% audit of all residents using oxygen was conducted by the Treatment Nurse on 02/27/20, to ensure all tubing not in use by the resident at the time was properly stored in a plastic bag. Facility	

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F 695	Continued From page 32 Resident #35 A review of the active "Physician Orders List" for Resident #35, revealed an order dated 06/07/2016, for Oxygen (O2) at 2 liters per minute via Nasal Bi-Prongs (NBP) as needed (PRN) for Respiratory Distress. During an observation, on 02/24/2020 at 9:41 AM, Resident #35's oxygen tubing was lying across the oxygen tank, on the back of the wheelchair and unbagged. The nasal bi-prongs were touching the tank. An observation on 02/25/2020 at 10:46 AM, revealed, Resident #35's oxygen tank was located on the back of the wheelchair and the oxygen tubing was thrown over the oxygen tank and not bagged. The nasal bi-prongs of the oxygen tubing were touching the seat of the wheelchair. During an interview, on 02/27/2020 at 12:30 PM, Resident #35 stated she wore her oxygen every night or whenever she was in the bed. Resident #35 stated that she needed the oxygen sometimes when she was up in her chair. Resident #35 revealed not a day that goes by that she doesn't wear her oxygen. She stated that she has breathing issues and has to have the oxygen. During an interview, on 2/27/2020 at 11:10 AM, the Director of Nursing (DON) stated the oxygen tubing should have been stored in a plastic bag and not thrown across the back of the wheelchair when it was not in use. The DON stated not storing the tubing properly was an infection control issue, with it touching different things on the wheelchair. The DON further stated the facility teaches the staff to store the tubing in	F 695	identified fifteen (15) residents with oxygen usage. Only Residents #35, #38, and #112 were affected. 3) The Oxygen Administration policy was reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20. The committee recommended use of a new type of bag for storage of the oxygen tubing when not in use by the resident. The policy was updated and approved with recommended changes on 03/11/20. All of the facility Licensed Practical Nurses (LPNs), Registered Nurses (RNs) and Certified Nursing Assistants (CNAs) were in-serviced from 02/28/20 through 03/06/20, by the Director of Nursing (DON) regarding the proper use of oxygen storage bags, and the Oxygen Administration policy, specifically the proper storage of oxygen tubing when not in use by the resident. This information will be reviewed with all LPNs, RNs, and CNAs annually and will be included in orientation for all newly hired nursing staff. 4) The Quality Assurance □ Infection Preventionist (QA-IP) will conduct an audit of all oxygen tubing weekly for three (3) consecutive months to ensure proper storage of oxygen tubing when not in use by the resident. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA	

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	25A381	A. BUILDING _____ B. WING _____	02/27/2020

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F 695	Continued From page 33 plastic bags when it was not being used. Resident #38 A review of the active "Physician Orders List" for Resident #38, revealed, an order dated 08/16/2019, for O2 at two (2) liters per minute via NBP as needed (PRN) for Respiratory Distress. During an observation, on 02/24/2020 at 9:38 AM, Resident #38's oxygen tubing was observed lying across the top of the oxygen concentrator and touching floor. The oxygen tubing was not in a bag. On 02/25/2020 at 8:40 AM, during an observation, Resident #38's oxygen tubing was observed lying across the oxygen concentrator and unbagged. An observation, on 02/26/2020 at 11:13 AM ,revealed Resident #38's oxygen tubing was lying across the concentrator and not in a plastic bag. The oxygen tubing was touching floor. An interview on 2/27/20 at 11:10 AM, the Director of Nursing (DON) stated the oxygen tubing should have been stored in a plastic bag when not is use. She stated the oxygen tubing not being stored properly was an infection control issue. The DON stated the facility taught their staff to put the tubing in plastic bags when it was not being used. Resident #112 Review of the active "Physician Orders List" for Resident #112, revealed an order dated 12/18/2019, for O2 at 2.5 liters NBP PRN for Shortness of Breath (SOB).	F 695	committee will make any recommendations or changes if needed to ensure compliance.	

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F 695	Continued From page 34 A review of Resident # 112's care plan, dated 01/22/2020 revealed a problem related to the resident had a diagnosis of Emphysema and Chronic Obstructive Pulmonary Disease (COPD). Interventions included Oxygen at 2 liters per NBP as needed. During an observation, on 02/27/2020 at 9:15 AM, Resident #122 was observed in bed asleep. Resident #112's oxygen tubing was lying on the floor. On 02/27/2020 at 11:26 AM, during an interview, the DON stated oxygen tubing should not be of the floor because it is an infection control problem. A review of Resident #112's Significant Change (SC) Minimum Data Set (MDS) Assessment, dated 12/31/2019, revealed the resident had a BIMS score of 8, which indicated severe cognitive impairment. The SC MDS Assessment also revealed Section O (Special Treatments, Procedures, and Programs) was checked to indicate the resident was receiving oxygen therapy.	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		4/1/20

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F 880	Continued From page 35 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism 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	F 880		

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F 880	Continued From page 36 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and facility policy review, the facility failed to prevent the possible spread of infection during incontinent care, for two (2) of seven (7) incontinent care observations, Resident #15 and #52. Findings include: A review of the facility's "Infection Prevention and Control Program Policy", dated 01/24/2020, revealed the facility's purpose was to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Prevention of spread of infections is accomplished by the use of standard and transmission based precautions, as indicated and hand hygiene per established employee health policies and procedures.	F 880	Statements contained herein are intended for purposes of compliance with federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. F880 1) A 1-1 in-service was provided to Certified Nursing Assistant (CNA) #1, CNA #3 and CNA #4 by the Director of Nursing (DON) on 02/28/20, regarding failure to prevent the possible spread of infection during incontinent care for Resident #15 and Resident #52, and catheter care for Resident #52.	

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F 880	Continued From page 37 Review of the facility's "Perineal Care" policy, dated 01/23/2020, revealed the purpose of the policy is to provide guidelines for providing adequate body hygiene for all resident and to decrease the risk of Urinary Tract Infection (UTI). The facility policy revealed staff must follow Infection Control practices for hand hygiene. The facility policy further revealed if a bowel movement is present, cleanse the resident with disposable wipes, remove gloves and dispose, perform hand hygiene, and don clean gloves. Resident #15 During an observation of Resident #15's incontinent care, on 02/24/2020 at 10:36 AM, Certified Nursing Assistant (CNA) #3 picked up the trash can off the floor, held it over the top of the resident and leaned forward across the bed. CNA #4 tossed a soiled brief into the trash can. CNA #3 and CNA #4 continued to reposition Resident #15 in the bed without washing their hands or changing gloves. During an interview, on 02/24/2020 at 10:55 AM, CNA #3 stated not cleaning her hands after touching the trash can, holding it over the resident, and touching the resident's blanket, could cause the resident to get an infection. On 02/24/2020 at 11:00 AM, during an interview with CNA #4, she confirmed that she had not cleaned her hands or changed her gloves after cleaning the resident, throwing the brief in the trash can, positioning the resident, and pulling up her blanket. CNA #4 revealed what she had done could cause the resident to get an infection. During an interview, on 02/27/2020 at 10:03 AM, Licensed Practical Nurse (LPN) #4/ Staff	F 880	2) All residents with incontinence or indwelling catheters have the potential to be affected. A 100% audit was conducted on 02/28/20, by the DON for residents with Urinary Incontinence and Indwelling Catheters. Facility identified one hundred twenty (120) residents with problems related to Urinary Incontinence and seven (7) residents with Indwelling Catheters. Only Residents #15 and #52 were affected. 3) The Perineal Care policy and the Care of Indwelling and Suprapubic Catheters policy was reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20, and was approved with no changes. An in-service with all CNAs was conducted from 02/28/20 through 03/06/20, by the DON regarding proper procedures for hand hygiene, catheter care, and perineal care. All CNAs were observed for proper hand hygiene, catheter care, and perineal care. Observations were conducted by the Quality Assurance Infection Preventionist (QA-IP) and the Treatment Nurse via return demonstration and completion of competency checklist. Observations were conducted from 02/28/20 through 03/06/20. 4) The Staff Development Coordinator will conduct validation checks for three (3)	

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F 880	Continued From page 38 Development Nurse stated the CNAs have had a lot of Infection Control in-services. LPN #4 stated they should have known not to touch the resident's bed covers without cleaning their hands, after picking up the trash can and dirty brief. Review of the facility's "Face Sheet", revealed the facility admitted Resident #15 on 12/02/2016 with diagnoses which included Cerebral Infarction, Type 2 Diabetes Mellitus, and Chronic Kidney Disease. Resident #52 During an observation of catheter care, for Resident #52, on 2/26/2020 at 2:28 PM, upon completing the catheter care, without changing gloves or performing hand hygiene, CNA #1 applied Resident #52's brief. She then pulled the covers back over Resident #52's using the contaminated gloves. On 2/27/2020 at 10:50 AM, during an interview, CNA #1 stated she knew that she should have changed her gloves and washed her hands before pulling Resident #52's covers back over him. During an interview, on 2/27/2020 at 11:10 AM, the DON confirmed CNA #1 should have removed her gloves and washed her hands, before she pulled the covers back over Resident #52.	F 880	CNAs weekly for three (3) consecutive months to ensure competency performing hand hygiene, providing catheter care, and providing perineal care according to facility policy. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	

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	25A381	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2020**

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

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

Electronically Signed | 04/15/2020

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 02/25/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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