STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255243	A. BUILDING _____ B. WING _____	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLDORA SENIOR CARE	314 ENOCHS ST TYLERTOWN, MS 39667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey at the facility from 03/21/22 through 03/24/22. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F-567, F-641, F-690. The facility was licensed for 60 beds and had a census of 46 at the time of survey.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must	F 567		4/29/22

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

Electronically Signed | 04/08/2022

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F 567	Continued From page 1 maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure residents had readily available and reasonable access to personal funds seven days a week for seven (7) of 29 sampled residents reviewed for personal funds. Resident #2, Resident #3, Resident #4, Resident #17, Resident #19, Resident #20, and Resident #22. Findings include: A record review of the facility's policy "Resident Personal Funds/Personal Effect", undated, revealed "A. Policies: 1. Residents have the right to manage their own financial affairs ...10. Residents will have access to personal funds daily during normal business hours ..." On 03/21/22 at 3:14 PM, during an interview with Resident #3, she told the State Survey Agency (SSA) that she cannot get money on the weekend because there is no one at the facility to get her money. The Business Office Manager (BOM) is	F 567	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, it□s employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. F 567 1. The facility adopted a new policy to ensure that residents funds are available at all times on 4/4/2022. The Quality Assurance Performance Improvement Committee met on 4/6/2022 to review the policy titled Availability of Residents Funds after Business Hours. Resident□s # 2,3,4,17,19,20,22 were informed by the	

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F 567	Continued From page 2 the only one that gives the residents their money and she is not here on the weekends. On 03/22/22 at 10:00 AM, during the Resident Council Meeting, Resident #3, who is the Resident Council President, reported the personal funds are only available Monday through Friday until 5 PM when the BOM is at the facility. She said she must ask for money either on Friday or Thursday before the weekend to assure she has money if needed. She explained no one has ever told her she could have someone call the BOM when she is not here, and she would come give her money from her personal funds. During the meeting, all residents in attendance confirmed that money is only available from the BOM and is not available on evenings or weekends. The residents reported that no one has ever told them that personal funds should be available every day. At 10:10 AM on 03/22/22, Resident #2 was present in the Resident Council meeting. She explained she was told she could not get money on weekends because nobody is available to give out the money. The BOM had told her if she needs money for the weekend, to get it on Friday. She explained she was never told to have a nurse to call the BOM to come to the facility and give them money on the weekend. On 03/22/22 at 10:15 AM, Resident #4 was in attendance in the Resident Council meeting. He reported he has a personal fund account at the facility and gets money only on weekdays because the BOM is the only one who gives out money and she is not at the facility after 5 o'clock on weekdays and not at the facility at all on the weekends.	F 567	Business Office Manager that their funds would be available to them at all times on 4/5/2022. The facility purchased a lock box that will contain funds. The lock box will be taken to the nursing supervisor at the end of each business day. The nursing supervisor will keep the lock box on the medication cart. Resident Council meeting was held on 4/5/2022 to explain the process to obtain their funds after hours. 2. All facility residents that have personal funds managed by the facility have the potential to be affected by this practice. No residents have voiced any complaints regarding their funds. 3. The business office manager was educated on the policy for Availability of Residents funds after hours by the Corporate Business Office Manager on 4/4/2022. The lock box should also include the transaction history to ensure the resident has funds available in their account. The education also reviewed that the nursing supervisor should return the lock box at the start of the business day and the business office manager should reconcile any transactions. The facility nurses were educated starting on 4/4/2022 through 4/8/2022 by the Quality Assurance Nurse on the policy for Availability of Residents Funds after hours. Any nurse not scheduled will be educated on policy for Availability of Residents Funds after hours on next scheduled shift. If a resident request funds the nursing supervisor will review the transaction history report to ensure that the resident has the funds available	

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F 567	Continued From page 3 On 03/22/22 at 10:20 AM, Resident #17 attended the Resident Council meeting. During the resident council meeting, he confirmed he has a personal fund account at the facility, but can only get his money while the BOM is working. At 10:25 AM on 03/22/22, Resident #19 was present in the Resident Council meeting. She explained she has a trust fund account at the facility, but she is not able to get her money on the weekends because the business office is closed. She reported she must get any money she wants for the weekend by Friday. On 03/22/22 at 10:30 AM, during an interview with Resident #20, she explained she can get her money during the weekdays only and not on the weekends. At 10:35 AM on 03/22/22, Resident #22 explained she has always had a personal fund account at the facility and can get money when she asks for it on the weekdays. She reported the BOM is the only one who gives out money and she is not available in the evening or on weekends. On 03/23/22 at 11:05 AM, during an interview with the BOM, she reported currently she is the only staff member at the facility that residents can get personal funds from. She confirmed residents don't have access to their personal funds after 5:00 PM on the weekdays and not on weekends. But, if someone would call her, she would come to the facility and get the resident their money because she doesn't live far way. She explained she has never told any residents or nurses to call her if they needed money on a weekend. If she is off work for any reason, the Administrator or a	F 567	and will disperse the money requested. The resident will also sign acknowledging they received the funds. The next business day the lock box will be taken to the business office manager and any transactions will be reconciled. 4. Starting 4/4/2022 and continuing indefinitely the Business Office Manager, Administrator, or Director of Nursing will review the transactions each business day and will follow normal accounting principles. The Activities Director will review this process monthly in the resident council meeting times three months starting 4/28/2022 to ensure that residents have access to their personal funds at all times. Information obtained through monitoring will be reviewed by the Quality Assurance Performance Improvement Committee monthly starting 4/28/2022 and continue times three months. Changes will be made as found necessary to maintain substantial compliance. 5. Completion Date 4/29/22	

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F 567	Continued From page 4	F 567		

staff member will step in and give residents their money per request.

On 03/23/22 at 3:35 PM, during an interview with the Director of Nursing, she confirmed the BOM has always been the only staff member that residents get personal funds from unless she is not here. She confirmed the residents do not have any access to personal funds after 5:00 PM on weekdays and not at all on weekends.

A record review of the facility's "Trust Transaction History" dated March 24, 2022, revealed all residents in attendance of the Resident Council meeting have personal trust fund accounts.

Record review of Resident #2's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 03/09/2022 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.

Record review of Resident #3's Quarterly MDS with ARD of 03/09/2022 revealed a BIMS score of 15, which indicated the resident is cognitively intact.

Record review for Resident #4's Quarterly MDS with ARD of 03/11/2022 revealed a BIMS score of 15, which indicated the resident is cognitively intact.

Record review of Resident #17's Quarterly MDS with ARD of 01/18/2022 revealed a BIMS score of 15, which indicated the resident is cognitively intact.

Record review of Resident #19's 5-day

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F 567	Continued From page 5 Prospective Payment System (PPS) MDS with an ARD of 01/17/2022 revealed a BIMS score of 15, which indicated the resident is cognitively intact. Record review of Resident #20's 5-day PPS MDS with ARD of 01/17/2022 revealed a BIMS score of 14, which indicated the resident is cognitively intact. Record review of Resident #22's 5-Day PPS MDS with ARD of 01/19/2022 revealed a BIMS score of 15 which indicated the resident is cognitively intact.	F 567		
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 observation, staff interviews, record reviews, and Resident Assessment Instrument (RAI) review, the facility failed to accurately code a Minimum Data Set (MDS) assessment for a resident with a Percutaneous Endoscopic Gastrostomy (PEG) tube for one (1) of 29 residents reviewed for MDS accuracy. Resident #43. Findings include: A record review of a typed letter presented by the facility, undated, with the facility stamp revealed "For MDS assessments, we follow the instructions of the RAI (Resident Assessment Instrument) manual".	F 641	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, it□s employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. F 641 1. On 03/24/2022, Director of Nurses, Minimum Data Set Coordinator and Dietary Manager reviewed Section K of Minimum Data Set for Resident # 43 for accuracy. On 04/04/2022, Minimum Data	4/29/22

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F 641	Continued From page 6 A record review of "Center of Medicare and Medicaid Services RAI Version 3.0 Manual dated October 2019, revealed "K0300: Weight Loss ... Steps for Assessment this item compares the resident's weight in the current observation period with his or her weight at two snapshots in time: At a point closest to 30-days preceding the current weight and At a point closest to 180-days preceding the current weight ... For Subsequent Assessments 1. From the medical record, compare's the resident's weight in the current observation period to his or her weight in the observation period 30 days ago ... Coding Instructions ... Code 2, yes not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the past 180 days, and the weight was not planned and prescribed by a physician ...K0510: Nutritional Approaches ... definitions ...feeding tube presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include but are not limited to nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes ... Coding instructions for Column 2 check all nutritional approaches performed after admission/entry or reentry to the facility and within the 7-day look back period. Check all that apply ... K0510B, feeding tube-nasogastric or abdominal (PEG) ... K0710: Percent intake by artificial route ... Steps for assessment 1. Review intake records to determine actual intake through parenteral or tube feeding routes ... Coding instructions select the best responses 1. 25% or less ..." On 03/21/22 at 10:47 AM, the State Survey	F 641	Set Coordinator corrected Section K0300; K0510; K0710 to accurately code for Resident #43 using the Resident Assessment Instrument instructions for the modification process of the Minimum Data Set. 2. All facility residents have the potential to be affected by this practice. 3. On 4/6/2022 Minimum Data Set Coordinator, Director of Nurses, Dietary Manager and Quality Assurance Nurse reviewed and completed a focused audit of Section K (K0510b, K0710a and K0710b) of Minimum Data Set assessments for remaining 2 residents with Percutaneous Endoscopic Gastrostomy (PEG) tube and no other inaccuracies identified in Section K. On 4/6/2022, Minimum Data Set Coordinator, Director of Nurses, Dietary Manager and Quality Assurance Nurse reviewed and completed a focused audit of Section K (K0300) of Minimum Data Set assessments for remaining 45 of 46 residents for presence of significant weight loss with no other inaccuracies identified in Section K. On 4/7/2022, a one-on-one in-service was done with Dietary Manager by Registered Dietician focusing on the accurate coding of significant weight loss and the presence of Percutaneous Endoscopic Gastrostomy tube in Section K in the Minimum Data Set using the manual for the Resident Assessment Instrument. On 4/5/2022, a one-on-one in-service was done with Minimum Data Set Coordinator	

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F 641	Continued From page 7 Agency (SSA) observed Resident #43 sitting in a high back wheelchair, with a PEG tube tube observed protruding from underneath his shirt. The resident explained he had a stroke and came to the facility for therapy and had the feeding tube inserted after the stroke. He reported that although he can now eat, he continues to have the feeding tube and receives water flushes through the tube. At 2:26 PM on 03/21/22, during an interview with Resident #43, he explained since he was admitted to the facility in November of 2021, he has lost maybe five (5) pounds. A record review of Resident #43's "Admission Record" revealed the facility admitted Resident #43 on 11/22/2021 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Dysphagia Oropharyngeal Phase, and Gastrostomy Status. A record review of Resident #43's Quarterly MDS with an Assessment Reference Date (ARD) of 02/21/2022, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated he is cognitively intact. For the question "Loss of 5% or more in the last month or 10% or more in the last 6 months" was checked as "yes", which indicated he had significant weight loss. "Feeding tube-nasogastic or abdominal (PEG)" was not checked, which would indicate Resident #43 did not have a PEG tube during the seven day look back period. A record review of Resident #43's "Weights and Vitals Summary" revealed on 11/22/2021, Resident #43 weighed 208.0 pounds (lbs.); on	F 641	by the Director of Nurses focusing on the accurate coding of Section K in the Minimum Data Set using the manual for the Resident Assessment Instrument. On 3/24/2022 education was provided with the Minimum Data Set Coordinator for section K of the Minimum Data Set 3.0 using the Resident Assessment Instrument Manual coding Instructions by the Corporate Clinical Consultant. On 4/6/2022, Quality Assurance Performance Improvement Committee reviewed current Minimum Data Set collection process for accurate coding of Section K with no recommendations to change the procedure. 4. Beginning 4/06/2022, Quality Assurance Nurse or Director of Nurses will monitor Section K of scheduled Minimum Data Set assessments for accurate coding of Section K items weekly x 4 weeks. After 4 weeks, Quality Assurance Nurse or Director of Nurses will monitor a minimum of 4 Minimum Data Set assessments monthly x 3 months to ensure accurate coding of Section K of Minimum Data Set assessments. On 4/28/2022 findings of monitoring results will be taken to the Quality Assurance Performance Improvement Committee to evaluate the process and will continue to be reviewed by the Quality Assurance Performance Improvement Committee monthly x 3 months for further evaluation and recommendations as needed to ensure substantial compliance. 5. Completion Date 4/29/22	

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F 641	Continued From page 8	F 641		

01/17/2022, he weighed 203.4 pounds which is a -2.21 % Loss; and on 12/13/2021, he weighed 204.4 lbs. On 01/17/2022, the resident weighed 203.4 pounds which is a -0.49 % Loss for a 30 day period.

A record review of Resident #43's "Order Summary Report" with "Active Orders as of : 3/24/2022" revealed a physician order dated 11/22/21 for "Enteral Feed Order every shift [Enteral] Flush feeding tube with 30 cubic centimeters (cc) of water (every) 4 hours..."

A record review of Resident #43's Medication Administration Record for February 2022 revealed he received PEG tube flushes as ordered.

On 03/21/22 at 3:30 PM, during an interview with the Director of Nursing (DON), she confirmed Resident #43 does have a PEG tube, but only receives water flushes and no feedings. The DON reviewed Resident #43's most recent MDS with and ARD of 02/21/2022 Section K510 and K0710 and confirmed the feeding tube assessment by artificial route was coded incorrectly. The DON verified the assessment is a MDS discrepancy.

On 03/21/22 at 3:34 PM, during an interview with the MDS Coordinator LPN #1, she explained she is new to MDS has only been working in MDS at the facility for one month. She reviewed Resident #43's quarterly MDS and confirmed the tube feeding by artificial route assessment was coded incorrectly.

On 03/24/22 at 09:10 AM, during an interview with the Dietary Manager, she explained she

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completes the section of the MDS for nutrition which is Section K, swallowing and nutritional status. She reviewed the Quarterly MDS with an ARD of 02/21/22 for Resident #43 and confirmed she completed the assessment on 2/02/2022. The Dietary Manager first reviewed section K0300 weight loss, which was coded weight loss not on prescribed weight-loss regimen. She reviewed Resident #43's weights and reported she used the weight for 01/17/22 of 203.4 and compared to the weight of admission on 208.0 and explained that is not a 5% weight loss and the assessment was coded in error. She also reviewed section K510 and confirmed it is also coded incorrectly because the resident does have a PEG tube in his stomach and was admitted with the PEG tube. She explained she would have included the water flushes on part K710. She reported she marked all the sections in error and must had been having a bad day. She reported the assessment for Quarterly MDS is a discrepancy and does not accurately reflect the resident's status. She explained after she completes her assessments for the MDS the MDS coordinator reviews her assessments and then the DON reviews and signs off before submitting MDS, and if there are any discrepancies noted they will come back to her and ask her to make corrections.

At 9:35 AM on 03/24/22, during an interview with the DON, she reported she had to train the MDS Coordinator, and she does not know everything about MDS, but both worked together to get MDS assessments completed and submitted. During training, she would review the MDS assessment for accuracy with the coordinator, but now the MDS Coordinator reviews the MDS assessments herself and then she will sign off for completion.

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F 641	Continued From page 10 She confirmed the assessment for Resident #43's nutrition was coded incorrectly and is a MDS discrepancy. She confirmed Resident #43 has not had a significant weight loss of 5% in a month, after reviewing the resident's weights since admission. She reported the facility uses the RAI manual for instructions on completing MDS assessments.	F 641		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		4/29/22

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	255243	A. BUILDING _____ B. WING _____	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLDORA SENIOR CARE	314 ENOCHS ST TYLERTOWN, MS 39667

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F 690	Continued From page 11 §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 observations, staff interviews, record reviews, and facility policy review, the facility failed to secure the catheter strap and failed to use the correct technique to insert an indwelling catheter for one (1) of five (5) care observations. Resident #1. Findings include: Record review of the facility's policy, "Policy: Catheterization of Female", dated 2021, revealed, "Urinary catheterizations will be performed in accordance with current standards of practice to minimize risk for bacterial contamination or urethral trauma. Policy Explanation and Compliance Guidelines...Procedure for Catheterization of a Female...7.g. Place the catheter tray on the sterile towel (under pad) and open the lubricant container. Avoid contamination...u. For indwelling catheterization:...ii. Secure the catheter to the resident's thigh..." On 3/23/22 at 9:25 AM, the State Agency (SA) observed indwelling catheter care performed by Certified Nursing Assistant #1 (CNA) and CNA #2. There was no leg strap to secure the catheter. CNA #1 stated that she always tells the nurse when the resident does not have a leg	F 690	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, it□s employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. F 690 1. CNA # 1 and CNA # 2 was educated on the importance of resident□s having a leg strap in place when a catheter is inserted on 4/6/2022 by Quality Assurance Nurse. RN #1 was educated on the policy for urinary catheter insertion and the importance of having a leg strap in place, by Quality Assurance Nurse on 4/6/2022. RN #1 performed return demonstration on catheter insertion and placement of the leg strap on 4/6/2022. The Quality Assurance Performance Improvement Committee met on 4/6/2022 to review the policy and procedure for urinary catheter insertion with no recommendations made to change the policy at that time. 2. On 3/24/22 observations rounds were	

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F 690	Continued From page 12 strap on. On 03/23/22 09:28 AM, in an interview with RN #2, she confirmed there was no leg strap on the catheter tubing last night or this morning. She stated she forgot to get one and put it on. She confirmed the purpose of the leg strap is to keep the catheter in place and to keep it from becoming dislodged and causing trauma or discomfort by tugging on the tubing. On 3/23/22 at 10:10 AM, the SA observed Resident # 1's indwelling catheter being inserted per physician orders, by Registered Nurse #1 (RN)/Charge Nurse. RN #1 did not open the lubricant and add it to the sterile tray. She asked CNA #1 to open the packet of lubricant. As CNA #1 held the lubricant packet in her hand, RN #1 attempted to insert the catheter tip into the lubricant packet. She allowed the sterile catheter tip to come in contact with the contaminated outer portion of the lubricant packet. RN #1 did not secure the catheter with a leg strap. On 3/23/22 at 10:40 AM, in an interview with RN #1, she stated she probably did a lot of things wrong and she knows she messed up. She confirmed she did not inflate the balloon before she inserted the catheter. She also confirmed she should have put the lubricate in the sterile tray. She stated her actions could cause the resident to get a bacterial infection. On 3/23/22 at 4:33 PM, in an interview with the Director of Nursing (DON), she stated RN #1 did not follow policy on indwelling catheter insertion. She stated RN #1 could have caused the resident to get an urinary tract infection and she confirmed	F 690	completed by the Director of Nursing and no other residents were identified with a urinary catheter. 3. Facility nurse aides were educated on the importance of leg straps being present when a resident has a catheter on 3/23/2022 and continued through 4/8/2022 by the Staff Development Nurse, and the Quality Assurance Nurse. Any nurse aides not scheduled at this time will be educated on next scheduled shift. Facility nurses were educated on the policy and procedure for urinary catheter insertion for males and females on 3/23/2022 by Staff Development Nurse and Quality Assurance Nurse and continued through 4/8/2022. Any nurses not scheduled at this time will be educated on next scheduled shift. Facility nurses performed return demonstration for urinary catheter insertion starting on 4/5/2022 through 4/8/2022. Any nurses not scheduled at this time will have return demonstration for urinary catheter insertion on next scheduled shift. 4. The Director of Nursing or the Staff Development nurse will complete weekly rounds times one month then monthly to ensure residents with urinary catheters have leg straps in place starting 3/24/2022 and will select 2 nurses a month times three months to perform return demonstration using a mannequin on proper technique for catheter insertion starting on 4/11/2022. Validation checklists will be reviewed by the Quality Assurance Performance Improvement Committee monthly times three months	

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F 690	Continued From page 13 the purpose of the leg strap is to keep the catheter in place and keep it from coming out. A record review of the "Admission Record" revealed the facility admitted Resident #1 on 10/7/2016. He had diagnoses including Chronic Kidney Disease Stage 3, Personal history of Urinary Tract Infection (UTI) and Acute Pyelonephritis. A record review of the "Medication Review Report" revealed a physician order dated 3/23/22 to "Foley Cath (Catheter) 16 FR(French)/10 ML (Milliliter) - change every 21 day sand prn (as needed) for obstruction, dislodgement, or leakage every 21 day(s)". A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/10/22 revealed a Brief Interview of Mental Status (BIMS) was not completed. A record review "BIMS Staff Interview - dated 12/15/21, revealed a BIMS score of 99. Resident was unable to participate in the cognition interview. A record review of the facility's "Inservice for the Month of January 2022" with topics including "Infection Control w(with)/Universal Precautions" revealed RN #1 signed the inservice on 1/20/22 which indicated she received training on infection control. A record review of the facility's "Inservice for the Month of October 2021" with topics including "Cath and G-tube Insertion" revealed RN #1 signed the inservice on 10/7/21 which indicated she received training on catheter insertion.	F 690	starting 4/28/2022. Changes will be made as found necessary to ensure substantial compliance. 5. Complete Date 4/29/22	

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