STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A178	A. BUILDING _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey from 01/23/19 through 01/25/19. 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-558 F-585, F-604, F-656, F-690 and F-695. The facility was licensed for 120 beds, and had a census of 108 at the time of survey	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and policy review, the facility failed to keep the call light within the resident's reach for two (2) of three (3) observations, for Resident #99. Findings include: Review of the faciliy's policy titled, "Call Light Policy", no date. revealed it is the policy of this facility that the call light will be kept within the resident's reach when the resident is in their room as follows: The call light may be secured to The pillow, The bed linens, The side rail, The resident's clothing, If the resident is in bed, the resident wishes, The Call light will not cause injury to the resident, The bedside chair, The	F 558	1. Resident #99 was identified during the survey process, toileted by Certified Nursing Assistant #8 and call light placed in reach by the Licensed Practical Nurse. The Certified Nursing Assistant was made aware of resident inability to access call light by the Licensed Practical Nurse and Registered Nurse. Resident #99 was assessed by the Registered Nurse Supervisor on 01/24/19 at approximately 3:45PM. Resident #99 denied ill effects from deficient practice. 2. All residents in facility have the potential to be affected by the deficient practice. 3. On 01/25/2019 Nursing Home Administrator posted a memo for all	3/6/19

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

Electronically Signed | 02/28/2019

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F 558	Continued From page 1 cubical curtain. Reminders: The call lights should be within easy reach for the resident if he/she is able to use it. On 01/24/19 at 3:20 PM, an obsrvation and interview revealed the surveyor entered Resident #99's room, and the resident asked for assistance to go to the bathroom. Resident #99 was in a wheelchair (wc) with a lap tray secured to the back of the wc. The resident's call light was hanging on the wall across the bed. The surveyor stepped outside into the hallway, and informed staff that Resident #99 requested assistance. Certified Nursing Assistant (CNA) #8 entered the room, and stated we have to take your restraint off. CNA #8 pushed Resident #99 into the bathroom (BR), and assisted the resident with toileting. During this time, Resident #99 stated her call light is not where she can reach it a third of the time. On 01/23/19 at 11:51 AM, and on 01/25/19 at 2:25 PM, an observation revealed Resident #99's call light was on the bed. Resident #99 was in a wc with a lap tray in place, and was unable to reach the call light. On 01/24/19 at 3:25 PM, an interview with CNA #8 revealed the call light was not where Resident #99 could reach it. On 01/24/19 at 3:26 PM, an interview with Licensed Practical Nurse (LPN) #2 confirmed Resident #99 was not able to reach her call light. LPN #2 stated this is a problem, she makes rounds when she gets here, and every day call lights are not where the residents can reach them.	F 558	employees to see regarding proper call light placement. The facility policy on call lights was reviewed with no revision necessary. Director of Nurses met with the Certified Nursing Assistant assigned to the resident at the time of the deficient practice regarding proper call light placement. Director of Nurses reviewed proper call light placement during monthly nursing service meeting on 02/11/2019. Proper call light placement has been placed on every resident s Medication/Treatment Administration Record as of 02/22/2019. Medication/Treatment Nurse will record the monitoring of call light proper placement every shift. Director of Nurses will make rounds weekly to monitor for correct call bell placement. 4. Proper call light placement focus will be reported by the Director of Nurses to the Quality Assurance committee on a monthly basis, beginning March 2019 until achievement obtained, for recommendations for improvement. Negative findings (failure to have access to call light) will be reported immediately to Director of Nurses or Nursing Home Administrator for disciplinary action.	

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F 558	Continued From page 2 On 01/25/19 at 9:18 AM, Resident #99 was in her room, in a wc with a lap tray in place. The resident's call light was laying on the bed . Resident #99 demonstrated she was able to reach her call light. Resident #99 stated she could reach it today, but most of the time it way over there, resident pointed to the far side of the bed and wall. On 01/25/19 at 1:44 PM, an interview with the Director of Nurses (DON) confirmed Resident #99 was able to use her call light if she could reach it. The DON stated the call light should be where she can get to it, and whoever puts the resident in their room knows to put the call light where the resident can reach it. On 01/25/19 at 1:59 PM, an interview with the DON confirmed the care plan concerning the Resident #99's call light was not followed. Review of the Face Sheet revealed Resident #99 was admitted by the facility, on 01/31/12, with the included diagnoses Anemia, Unspecified Dementia with Behavioral Disturbance, Recurrent Depressive Disorders. Review of Resident #99's Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/03/19, revealed a Basic Interivew for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. Resident #99 was also coded for limited assistance with one person physical assist with transfers, and locomotion on the unit. Resident #99 was coded for total assistance of one person for locomotion off the unit. Resident #99 was coded for no Range of Motion (ROM) limitations for all four extremities.	F 558		

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F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	F 585		3/6/19

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F 585	Continued From page 4 completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be	F 585		

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F 585	Continued From page 5 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interview, and and facility policy review, the facility failed to make prompt efforts to resolve a resident's grievance for one (1) of 24 residents reviewed, for Resident #44. Findings Include: A review of the facility's policy titled, "Grievance/Complaint Policy", no date, revealed it was the policy of the facility that residents had the right to voice grievances, oral or written, and grievances should be reported to the Director of Nursing (DON) or Administrator. The policy further revealed grievances could be considered any problems or concerns affecting the resident, and when grievances were reported a grievance complaint form should be completed and maintained by the DON or designee. An interview and observation, on 01/23/19 at 11:45 AM, revealed Resident #44 was seated in the hallway in her wheelchair. The resident	F 585	1.Resident #44 grievance was identified during survey process. Resident #44 was assessed by the Registered Nurse Supervisor immediately upon notification 01/23/2019. Resident denied and no evidence of actual harm, nor did resident feel there was intent to harm. Chief Executive Officer met with Resident #9 in Officer' s office on 01/23/2019 regarding touching other residents without their permission. Nursing Home Administrator met with Resident #9 on 01/25/2019 regarding abstaining from touching other residents without their permission. Nursing Home Administrator met with Resident #44 on 01/25/2019 in resident s private room. Reviewed with Resident #44 reporting grievances and procedure of notifying the Director of Nurses, Administrator, or Social Worker if concerns/grievances are not addressed promptly or to resident s satisfaction. Nursing Home Administrator reconfirmed	

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F 585	Continued From page 6 stated she didn't want to cause any trouble, but she had a problem with Resident #9 attempting to touch her when she did not want him to. Resident #44 stated she had told the nursing staff numerous times, and she wasn't the only person who felt this way. Resident #44 stated Resident #9 also went into resident's rooms uninvited. An interview, on 01/23/19 at 12:08 PM, with Certified Nursing Assistant (CNA) #6 revealed Resident #9 liked women, and was "flirty" with them. CNA #6 stated residents had complained about him coming in their rooms uninvited, and they didn't want him in their room. An interview, on 01/23/19 at 12:23 PM, with CNA #7 revealed Resident #44 had complained to her frequently that she didn't like Resident #9 touching her. CNA #7 stated Resident #44 liked to pick at people, went in other resident's rooms, and hugged on all the women. It was just his personality. An interview, on 01/23/19 at 3:14 PM, with Licensed Practical Nurse (LPN #1) revealed this morning Resident #44 had complained to her that Resident #9 touched her and she did not like it. LPN #1 stated she was aware of another time Resident #44 complained about Resident #9. LPN #1 stated on that occasion she was working, and Resident #44 approached her stating Resident #9 was trying to hug on her and she did not want him to. LPN #1 stated she encouraged Resident #9 to leave Resident #44 alone, but he continued to attempt to hug her. LPN #1 stated she stepped between the residents, both in wheelchairs, and Resident #9 reached around her to touch Resident # 44 who backed up to get away from him. LPN #1 stated she reported this	F 585	with Resident #44 that no actual harm or sense of threat/danger was felt. 2.All residents in the facility have the potential to be affected by this deficient practice. 3.The Grievance Policy and the Abuse, Neglect, and Exploitation of Vulnerable Adult Policy were reviewed with no revision necessary. Meeting held on 01/28/2019 by Nursing Home Administrator with Chief Executive Officer, Director of Nurses, Assistant Director of Nurses, and all Registered Nurse Supervisors regarding grievance reporting/handling procedure/policy and review of documentation forms. Registered Nurse Supervisor will visit residents daily and allow reporting of problems/grievances. Director of Nurses, Nursing Home Administrator, and Chief Executive Officer maintain open door policy for staff, residents, families, and public. A notice of all department directors involved in care and environment with office numbers, in addition to the home phone number of Nursing Home Administrator, is posted exit side of all resident room doors. On 03/01/2019, memo posted by Nursing Home Administrator regarding proper reporting of resident grievances. Grievances will be addressed/handled when reported to facility staff. Social Worker will remind residents at monthly Resident Council meetings of the proper way to report grievances. 4.The Director of Nurses will report to the Quality Assurance committee monthly of monitoring and negative findings reported	

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F 585	Continued From page 7 to the DON. LPN #1 stated she was unsure how long ago this happened, but it was at least three months ago. An interview, on 01/24/19 at 3:49 PM, with Social Services Staff (SS #1) revealed she generally handled grievances, and she or Administrative staff (Administrator or DON) would investigate and resolve grievances. SS #1 was not aware that Resident #44 did not want Resident #9 touching her. SS #1 stated she would expect that if there was an issue with touching, she or the Administrator would be told. SS #1 stated if a resident voiced a grievance to a nurse she would expect the nurse to report it. SS #1 stated there had been a grievance voiced to her by Resident #39 several months ago that she did not want Resident #9 coming to her room or touching her. SS #1 stated this had been addressed in a meeting with Resident #9 and #39, SS #1 and the Administrator. SS #1 stated the Administrator had spoken to Resident #9 many times regarding his behavior. An interview, on 01/25/19 at 9:01 AM, revealed the DON and Administrator confirmed the DON was informed by LPN #1 Resident #44 voiced a complaint that she did not want to be touched by Resident #9, and that Resident #9 continued to attempt to touch Resident #44 after redirection. The DON stated at the time she reviewed video surveillance of the area the incident occurred, and was not able to confirm the report because the residents were in an area without a good camera angle. The DON stated she did not interview Resident #44 or Resident #9 at the time, and she should have. The DON stated she would consider the report to be a grievance and should have investigated further.	F 585	until compliance achieved. Nursing Home Administrator or Chief Executive Officer will be notified of all grievances. Negative findings will be reported to and handled by the Nursing Home Administrator or Chief Executive Officer.	

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F 585	Continued From page 8 Review of Resident #44's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/21/18, revealed a Basic Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.	F 585		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for	F 604		3/6/19

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F 604	Continued From page 9 restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to ensure Resident #306 was free from the use of a physical restraint device for one (1) of three (3) residents observed for restraint devices. Findings include; Review of the facility's policy titled, "Restraint Policy", with an updated and review date of 09/18/14, revealed it is the policy of this faciilty that restraints will be used as follows: Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Restraints will be checked every 30 minutes and loosened and released every 2 (two) hours for a minimum of 5 (five) minutes. Code the Minimum Data Set (MDS) for restraint only if the device has the effect of restricting the resident's freedom of movement. If resident is immobile and cannot voluntarily get up,. a device should not be coded as a restraint. Reminders: Must have valid justification for the use of restraints. The use of restraints must be addressed on the Total Care Plan. Restraint usage should be reviewed at least quarterly for possible reduction. Must have a restraint consent signed by the resident or the responsible party. The possible negative outcomes of restraint use must be explained to the resident and/or responsible (party) before the restraint is applied except in emergency situation. Prior to the	F 604	1. Resident #306 was identified during the survey process; lap tray was removed by Director of Nurses. Resident #306 was then assisted to toilet by the Director of Nurses and the assigned Certified Nursing Assistant. She was then assisted by Director of Nurses and Certified Nursing Assistant to ambulate to the dining room for her lunch meal, where she sat in a regular dining chair with direct supervision by the Director of Nurses. After she finished her meal, she was assisted by the Director of Nurses into a wheelchair and taken to physical therapy department by the Director of Nurses for evaluation of the need for lap tray. Nursing Home Administrator assessed resident and found no ill effects of deficient practice. 2. All residents with positioning devices have the potential to be affected by cited deficient practice, 14 residents identified to have positioning devices at time of survey. There were no residents with physician ordered restraint devices at time of survey. 3. All residents with positioners have been evaluated by the Registered Nurse Supervisor, physical therapy/occupational therapy, and Director of Nurses, for the need for the device, and that the devices do not act as a restraint for the resident. A new evaluation form has been developed and will be completed on a resident prior to the application of a positioner/restraint device. The evaluation will include what	

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F 604	Continued From page 10 application of restraints the following should be done: Consider less restrictive measures-Positioning devices, Recliners, Diversional activities, Lowest chair height. On 01/23/18 at 11:45 AM, an observation revealed Resident #306 was in the dining room for lunch. Resident #306 was sitting in a Geri-chair with a lap tray in place on the Geri-chair. On 01/23/19 at 12:56 PM, an observation revealed Resident #306 was in the day room, and she was sitting in the Geri-chair with a lap tray in place. Resident #306 slid down in chair, but was able to push herself back up in the chair unassisted. On 01/24/18 at 12:05 PM, an observation revealed Resident #306 was in the dining room for lunch. Resident #306 was sitting at the table in a Geri-chair with the lap tray off. On 01/24/19 at 4:34 PM, an observation and interview revealed Resident #306 was in the TV room talking with an Activity staff person. Resident #306 asked why she has this tray on. Resident #306 stated I can't get up to do anything, and nobody else in here has one on. I can't go forward, I can't go backwards, I can't go sideways, I can't do anything with this thing on. On 01/25/19 at 8:15 AM, an observation revealed Resident #309 was sitting in a Geri- chair at a table in the dining room with the lap tray off. Resident #306 was alert, and conversing with other ladies at the table. On 01/25/19 at 8:30 AM, an observation revealed Resident #306 was sitting in the TV room in a	F 604	interventions were tried prior to applying any device, and ensure that the least restrictive approach is attempted first. The evaluation will be completed by a Registered Nurse. All positioners and restraint devices require a physician order. On 01/25/2019 Nursing Home Administrator reviewed records on all residents using positioners. None were found to be in violation of policy. The lap tray on Resident #306 was discontinued on 01/25/2019. 4. The presence of a positioner/restraint is observed/documented every shift by the Treatment Nurse on the Electronic Treatment Administration Record, and by the Certified Nursing Assistant in eCare kiosk. The device will be monitored on a monthly basis by a Registered Nurse, physical or occupational therapist, and the Director of Nurses or Administrator for continued need/appropriate purpose. The Director of Nurses will give a report of device monitoring results monthly to Quality Assurance committee until compliance achieved and for recommendations for improvement. Devices will be removed or changed per physician order at the time a change/removal is indicated/recommended.	

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F 604	Continued From page 11 Geri chair with the lap tray off. Resident #306 was calm, her eyes were closed, with her head down. On 01/25/19 at 9:44 AM, an observation and interview revealed Resident #306 stood up from the Geri- chair, this surveyor walked toward her as she stumbled, and held her arm to steady her. The Activity Assistant walked through the TV room at this time, and assisted the resident to sit down. Further observation revealed the resident's lap tray was hanging on the side of the chair. Resident #306 stated don't put that on me. The Activity Assistant stated she would check with someone. On 01/25/19 at 10:12 AM, an observation revealed Resident #306 stood up from the Geri-chair again as Certified Nursing Assistant (CNA) #9 walked by pushing the ice cart, and was alerted Resident #306 was standing. CNAs #9 and #10 assisted Resident #306 to sit back down, and reclined the Geri-chair. On, 01/25/19 at 11:13 AM, during an interview with the Administrator (ADM) she stated a restraint assessment was not done because the Geri-chair was not a restraint. The Administrator stated the resident can remove the tray. The ADM confirmed there was no documentation of measures taken prior to placing Resident #306 in a wheelchair (w/c) with a lap buddy, nor the Geri-chair with a tray. On 01/25/19 at 11:45 AM, an observation and interview revealed Resident #306 was sitting in a Geri-chair with the lap tray in place. The DON was present. Resident #306 stated she did not like the tray on her, it is uncomfortable and it makes her smother. The DON asked Resident	F 604		

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F 604	Continued From page 12 #306 if she could remove the tray, and the resident stated she could not remove it, and didn't have any idea how to get it off. The DON and a CNA asked Resident #306 if she would like to walk, and she said yes, just get me out of this thing. Resident #306 ambulated with minimal assistance greater than 100 feet to the dining room. On 01/25/19 at 3:00 PM, an interview with the DON revealed Resident #306 ambulated over 100 feet with assistance. The DON stated Resident #306 was able to bear her own weight, and felt she could ambulate with the assistance of one person. On 01/25/19 at 1:37 PM, an interview with the Licensed Physical Therapy Assistant confirmed that therapy was not consulted prior to Resident #306 being placed in a w/c with lap buddy or the Geri chair with the tray. She confirmed if the resident could not rise from the chair it would be considered a restraint. Review of Resident #306's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/23/19, revealed a Basic Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. Resident #306 was not coded for the use of a Restraint Device. Resident #306 required limited assistance with one person physical assistance with transfers, extensive assistance with one person assist for locomotion on the unit, and total assistance of one person off the unit, extensive assistance of one person for walking in the room/corridor, extensive assistance with one person assist with dressing, toilet use, and personal hygiene. For walking (with assistive	F 604		

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F 604	Continued From page 13 device if needed) she was coded a 2, which indicated Resident #306 was not steady, and only able to stabilize with one person assistance. Resident #306 did not have any Range of Motion (ROM) impairments to any of her four extremities, and used a wheelchair for locomotion.	F 604		
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 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	F 656		3/6/19

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F 656	Continued From page 14 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, record review, staff interview, and facility policy review, the facility failed to develop the Comprehensive Care Plan related to behaviors for Resident #9, restraint usage for Resident #306, and failed to implement the Comprehensive Care Plan related to catheter care for Residents #46, #65, and #77. This concern was identified for five (5) of 26 resident care plans reviewed. Findings Include: A review of the facility's policy titled, "Total Care Plan Policy," no date, revealed that it is the policy of this facility that the Interdisciplinary Care Plan will be done by the Interdisciplinary Team. The facility policy stated that the Care Plan will identify problems that affect the resident and his/ her care needs. The facility policy stated that the Care Plan will also identify the interventions related to the specific problems. The facility policy also stated that the Care Plan will also identify the discipline responsible for performing the intervention. The Total Care Plan policy did not address implementation of the care plan.	F 656	1.Resident #9 s comprehensive care plan was reviewed during survey. Resident #9 s comprehensive care plan was revised on 01/25/2019 by the Minimum Data Set (MDS) Nurse to reflect behaviors of touching residents or entering residents rooms uninvited. Resident #306 s comprehensive care plan was reviewed during survey. Resident #306 s care plan was revised by the Minimum Data Set (MDS) Nurse to reflect changes regarding restraints and geri-chair with lap tray usage. The geri-chair with lap tray intervention was discontinued on 01/25/2019. Resident #77, #65, and #46 s care plans were reviewed during survey. Resident #77, #65, and #46 s care plans have been reviewed/revised by the Minimum Data Set (MDS) nurse to include interventions to reflect catheter anchor placement, completed on 02/25/2019.	

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F 656	Continued From page 15 Resident #9 A review of Resident #9's Comprehensive Care Plan revealed no Problem/Need, Goals, or Approaches to address Resident #9's behaviors of touching residents, or entering resident rooms uninvited. Further review of the Care Plan revealed a Problem/Need, dated 12/26/18, that Resident #9 desired companionship of female resident. The Goal: Resident #9's privacy will be provided for desired companionship by 3/26/19. Approaches included: Allow resident to have companionship in room as desired, knock on door before entering room, respect resident's wishes related to female companionship, and answer call light as needed. An interview, on 01/23/19 at 11:45 AM, with Resident #44, revealed the resident reported a problem with Resident #9 attempting to touch her when she did not want him to. Resident #44 stated Resident #9 went into resident's rooms uninvited. An interview, on 01/23/19 at 12:08 PM, with Certified Nursing Assistant (CNA) #6, revealed Resident #9 liked women, and was "flirty" with them. CNA #6 stated residents had complained about him coming in their rooms uninvited, and they didn't want him in their room. An interview, on 01/23/19 at 12:23 PM, with CNA #7 revealed Resident #44 had complained to her frequently that she didn't like Resident #9 touching her. CNA #7 stated Resident #44 liked to pick at people, went in other resident's rooms, and hugged on all the women. It was just his personality.	F 656	2.All residents have the potential to be affected by the cited deficient practice. Fourteen residents having physician orders for positioners have the potential to be affected by the cited deficient practice. All residents with foley catheters, four, have the potential to be affected by the cited deficient practice. 3.All residents will be monitored for behavior deficits by staff and reported to the Medication/Treatment Nurse for documentation on a daily basis. All residents with behavioral deficits identified will have the behavioral deficit reflected on the comprehensive person-centered care plan. All Minimum Data Set (MDS) nurses have been in-serviced by the MDS Coordinator regarding comprehensive care plan components, completed on 2/15/2019. Minimum Data Set (MDS) nurses have reviewed Total Care Plan Policy to ensure compliance. All residents who are identified to require a restraint or having physician orders for positioners will have their comprehensive care plan reviewed by the Minimum Data Set(MDS) Nurse, and will be revised as deemed necessary to reflect goals and interventions specific to their individual needs/requirements. All Minimum Data Set (MDS) nurses have been in-serviced by the MDS Coordinator regarding comprehensive care plan components, completed on 2/15/2019. Minimum Data	

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F 656	Continued From page 16 An interview, on 01/24/19 at 3:49 PM, with Social Services Staff (SS#1) confirmed Resident #9 exhibited behaviors including touching residents, and entering resident rooms uninvited. SS #1 stated the Administrator had spoken to the resident about his behavior, and the staff knew of the behaviors, and were instructed to redirect him when they saw the behavior. SS #1 stated these behaviors had not been addressed on the comprehensive care plan, but should have been when the behavior occurred. An interview, on 01/24/19 at 4:21 PM, with the Director of Nursing (DON), revealed she had been informed Resident #9 had been accused of touching Resident #44 when she did not want to be touched, and it happened months ago. The DON stated Resident #9 did have something on the care plan about female companionship, but agreed the care plan did not address the behavior of touching other residents when they did not want to be touched. An interview, on 01/24/19 at 4:49 PM, with the Administrator revealed she was aware of Resident #9 entering other resident's rooms uninvited, and had a meeting with a resident who complained several months ago, and she felt the issue was resolved. The Administrator stated she had not been told Resident #44 did not want Resident #9 touching her until yesterday, but the facility would definitely address the behaviors on the care plan. A review of documentation provided by the Administrator indicated the date of behaviors addressed with Resident #9 of going into resident rooms uninvited and unwanted touching was on 09/28/18.	F 656	Set (MDS) nurses have reviewed Total Care Plan Policy to ensure compliance. The care plans of all residents with foley catheters has been reviewed/revised by the Minimum Data Set nurse to reflect an intervention to make sure that a catheter anchor is in place every shift, to be checked by the Medication/Treatment Nurse each shift, completed on 02/25/2019. All Minimum Data Set (MDS) nurses have been in-serviced by the MDS Coordinator regarding comprehensive care plan components, completed on 2/15/2019. Minimum Data Set (MDS) nurses have reviewed Total Care Plan Policy to ensure compliance. 4.The Minimum Data Set (MDS) Coordinator will review care plans on residents with behavioral deficits identified/reported and revise the comprehensive care plan to reflect the behavior identified on a monthly basis starting 02/18/2019 until compliance is achieved. Reports of care plan monitoring and findings will be submitted to the Quality Assurance committee on a monthly basis until compliance is achieved or for recommendations for improvement. The Minimum Data Set (MDS) coordinator will review care plans on residents with restraints or positioning devices on a monthly basis starting 02/18/2019 until compliance is achieved. Reports of care plan monitoring and findings will be submitted to the Quality Assurance	

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F 656	Continued From page 17 Review of Resident #9's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/17/19, revealed a Basic Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Resident #9 was not coded for any behavior concerns/problems. The Quarterly MDS also revealed a BIMS of 15, and no behaviors. Resident #306 Review of Resident #306's Care Plan revealed the Problem/Need, dated 01/23/19, for an unsteady gait, tried to ambulate alone, putting resident at risk for falls, and resident has no history of falls. The Approaches included the use of a Geri-chair with a lap tray as a positioner only. An observation, on 01/23/18 at 11:45 AM, revealed Resident #306 was in the dining room for lunch sitting in a Geri-chair with a lap tray in place, and again at dinner with a lap tray in place on the Geri-chair. An observation, on 01/23/19 at 12:56 PM, revealed Resident #306 was in the TV day room sitting in a Geri chair with a lap tray in place. The resident had slid down in the chair but, was able to push herself up in the chair unassisted. An observation, on 01/24/18 at 3:15 PM, revealed Resident #306 was brought from an activity to the TV room. Resident #306 was sitting in a Geri-chair with a lap tray in place. An observation, on 01/24/19 at 4:34 PM, revealed Resident #306 was in the TV room talking with an Activity Assistant. Resident #306 asked why	F 656	committee on a monthly basis until compliance is achieved or for recommendations for improvement. The Minimum Data Set (MDS) coordinator will review care plans on residents with foley catheters on a monthly basis starting 02/18/2019 until compliance is achieved. Reports of care plan monitoring and findings will be submitted to the Quality Assurance committee on a monthly basis until compliance is achieved or for recommendations for improvement.	

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F 656	Continued From page 18 she had this tray on. She stated I can't get up to do anything, and nobody else in here has one on. I can't go forward, I can't go backwards, I can't go sideways, I can't do anything with this thing on. During an interview, on 01/25/19 at 11:13 AM, with the Administrator (ADM), she stated a restraint assessment was not done for Resident #306 because the Geri chair with the lap tray was not a restraint, it was a positioning device. The Administrator stated the resident can remove the tray. The ADM confirmed there was no documentation of alternative measures taken prior to placing the resident in the w/c with a lap buddy, nor the Geri-chair with a tray. An observation and interview, on 01/25/19 at 11:45 AM, with the Director of Nursing (DON), revealed Resident #306 sitting in the Geri-chair with the lap tray in place. The DON asked the resident if she could take the lap tray off. Resident #306 stated she did not like the tray on her, it is uncomfortable and it made her smother. The resident stated she could not remove it, and didn't have any idea how to get it off. The DON and a Certified Nursing Assistant (CNA) asked the resident if she would like to walk, and she said yes, just get me out of this thing. Resident #306 ambulated with minimal assistance of the DON and a CNA greater than 100 feet to the dining room. An interview, on 01/25/19 with the DON, revealed Resident #306 ambulated over 100 feet with minimal assistance. The DON stated the resident was able to bear her own weight, and felt she could ambulate with the assistance of one person. The DON stated she felt they needed to get the resident out of the Geri-chair. The DON	F 656		

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F 656	Continued From page 19 confirmed Resident #306 could not remove the lap tray from the Geri-chair, and confirmed it was a restraint. The resident was not care planned for a restraint. Review of the Face Sheet revealed Resident #306 was admitted by the facility, on 01/10/19, with the included diagnoses Hallucintations, Other Seizures, Repeated Falls, Dementia, and Major Depressive Disorder. Review of Resident #306's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/23/19, revealed a Basic Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. Resident #306 was not coded for the use of a Restraint Device. Resident #306 required limited assistance with one person physical assistance with transfers, extensive assistance with one person assist for locomotion on the unit, and total assistance of one person off the unit, extensive assistance of one person for walking in the room/corridor, extensive assistance with one person assist with dressing, toilet use, and personal hygiene. For walking (with assistive device if needed) she was coded a 2, which indicated Resident #306 was not steady, and only able to stabilize with one person assistance. Resident #306 did not have any Range of Motion (ROM) impairments to any of her four extremities, and used a wheelchair for locomotion. Resident #77 Review of Resident #77's Care Plan revealed an onset date, of 06/30/2018, for the Problem/Need requiring a Foley catheter due to urinary retention secondary to to a Neurongenic Bladder. The	F 656		

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F 656	Continued From page 20 Appoaches included to provide peri/incontinent care for incontinent episodes, and catheter care twice a day (BID). An observation, on 01/24/18 at 11:10 AM, during catheter care, revealed Resident #77 did not have an anchor to secure her catheter to prevent pulling, pain, or trauma. An interview, 01/25/19 at 8:55 AM with Resident #77, revealed she does have discomfort due to her catheter pulling at times. She stated it is worse when they are pulling up her brief. An interview, on 01/25/19 at 1:23 PM, with the Director of Nursing (DON) confirmed the care plan did not address securing the catheter to Resident #77's leg to prevent discomfort or trauma. Review of Resident #77's Quarterly MDS, with an ARD of 12/22/18,, revealed a BIMS score of 8, which indicated moderate cognitive impairment. Resident #77 was also coded for the use of an indwelling catheter. Review of the Face Sheet revealed Resident #77 was admitted by the facility, on 03/07/13, with the included diagnoses Retention of Urine, Diabetes Mellitus Type I, and unspecified Psychosis not due to a substance or known physical source. Resident #65 A review of Resident #65's Care Plan, revealed a Problem/Need, dated 12/18/18, for urinary incontinence with the use of a Foley catheter. The Approaches included catheter care should be performed twice a day (BID).	F 656		

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F 656	Continued From page 21 An observation during Resident #65's catheter care, on 01/23/2019 at 4:03 PM, revealed the catheter care was provided by Certified Nursing Assistant (CNA) #3. Further observation revealed there was no device in place to secure the catheter tubing to prevent tugging or dislodgement of the catheter. During an interview, on 01/23/2019 at 4:12 PM, CNA #3 confirmed there was no securing device in place for Resident #65's catheter tubing during the catheter care. During an interview, on 01/24/19 at 12:00 PM, Registered Nurse (RN) #4/Minimum Data Set (MDS) /Care Plan Coordinator, revealed it was a reasonable expectation the staff was to follow the Care Plan interventions for catheter care procedures. RN #4 stated the use of a catheter strap, is included in the catheter care protocol. RN #4 stated it is the facility's practice to use a catheter tubing strap for all residents with catheters, to prevent tugging and possible injury. RN #4 stated Resident #65 should have had a catheter strap. RN #4 stated all CNAs should make sure catheter straps are in place. During an interview, on 01/25/2019 at 8:29 AM, the Director of Nursing (DON), revealed the facility's staff should be following the Care Plan interventions, as stated on each resident's individual Care Plan. The DON stated that while providing catheter care, it is a standard practice of the facility to use a catheter strap. The DON stated a catheter strap should be in place for all residents with catheters, to prevent possible dislodgement or trauma.	F 656		

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F 656	Continued From page 22 Review of the Face Sheet revealed Resident # 65 was admitted by the facility on 12/05/2014 with diagnoses to include Alzheimer's disease and Neuromuscular Dysfunction of Bladder. Review of Resident #65's Significant Change MDS, with an ARD of 12/11/18, revealed she was coded a 3 for Cognitive Skills for Daily Decision Making, which indicated rarely or never makes decisions. Resident #65 was checked for the use of an indwelling catheter. Resident #46 Review of Resident #46's Care Plan revealed the Problem/Need, dated 12/22/18, for the use of a Foley catheter due to obstructive uropathy with urinary retention. The Approaches included: When incontinent episodes occur, provide peri/incontinent care. Provide catheter care twice a day (BID), CNA may perform. Nurse and CNA was identified as the person to provide the care. On 01/23/19 at 11:49 AM, an observation revealed, Resident #46 was sitting in his wheelchair at his bedside with an indwelling urinary catheter in place. Resident #46 stated he has the urinary catheter because he started having trouble urinating. Resident #46's urinary catheter bag was in a dignity bag, and hanging to gravity drainage. On 01/23/19 at 11:55 AM, an interview with Licensed Practical Nurse (LPN) #2, revealed Resident #46 has an indwelling urinary catheter because he has a diagnosis of Prostate Cancer. On 01/23/19 at 2:30 PM, an observation revealed Resident #46 was lying in bed awake and talking	F 656		

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F 656	Continued From page 23 to Certified Nursing Assistant (CNA) #1. The Surveyor observed CNA #1 and CNA #2 perform catheter care on Resident #46 at this time. CNA #1 washed her hands, applied clean gloves, set up materials on a clean barrier, and pulled the covers back on Resident #46. Using these same gloved hands CNA #1 wiped Resident #46 with a downward stroke on each side of his penis, in the groin areas. CNA #1 then wiped Resident #46's catheter tubing in an outward motion from the base of the penis towards the meatus without securing the catheter tubing. CNA #1 then wiped the catheter tubing from the meatus area towards the base of Resident #46 penis. CNA #1 then pulled the cloth brief back up on Resident #46, covered him up, removed her soiled gloves and washed her hands. On 01/24/19 at 11:55 AM, an interview revealed Registered Nurse (RN) #4 stated she would expect the staff to follow thru with the interventions on the care plan. RN #4 also stated she would expect the CNAs to follow the policy on providing catheter care. A review of the Face Sheet revealed Resident #46 was admitted by the facility, on 02/10/98, with the included diagnoses of Hemiplegia/Hemiparesis and Retention of Urine. Review of Resident #46's Quarterly MDS, with an ARD of 12/1/18, revealed a BIMS score of 12, which indicated moderate cognitive impairment. Resident #46 was coded for the use of an indwelling catheter.	F 656		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		3/6/19

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F 690	Continued From page 24 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide catheter care in a manner to prevent	F 690	1. Upon notification of deficient practice during survey process, the Certified Nursing Assistant responsible for the care	

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F 690	Continued From page 25 the possibility of cross contamination, and to provide securing devices for the catheter tubing to prevent the possibility of pain/discomfort, and trauma to the urethra for three of four (3 of 4) residents observed with urinary catheters. Residents #46, #65, and #77. Findings include: A review of the facility's policy titled, "Catheter Care Policy", undated revealed, it is the policy of this facility that catheter care will done as follows: Wash hands. Don gloves. Remove and clean any bowel movement (BM). Remove soiled gloves and dispose. Wash hands. Cleanse the catheter from the body to the end of the catheter, never from the end of the catheter toward the body and do not pull the catheter. Pat peri-area dry with towel, unless Disposable Wipes are used. Remove gloves and dispose. Review of the facility policy titled, "Catheter Placement Policy", no date, revealed it is the policy of this facility that urinary catheters and drainage bags will be properly placed to ensure adequate drainage as follows: Always position the drainage bag lower than the residents thigh at all times using a catheter leg strap, tape or other method. A review of the facility's policy titled. "Incontinent Care Policy", undated, revealed it is the policy of this facility that incontinent care will be handled to ensure that all incontinent residents will receive appropriate treatment and services to prevent urinary tract infections. The Procedure included: Don gloves, if BM present, cleanse BM before starting incontinent care. Remove gloves and dispose. Don gloves. Cleanse perineal area from	F 690	of Resident #65 and Resident #77 was instructed to apply catheter strap immediately. Registered Nurse Supervisor confirmed that this was completed and that the resident showed no signs of ill effects. Certified Nursing Assistant for Resident #46 was verbally counseled by Registered Nurse Supervisor, discussing the identified deficient practice, and reviewing the facility policy and procedure for catheter care. The residents were checked by their primary physicians on 01/29/2019, and were found to have no adverse effects resulting from deficient practice. 2. At the time of survey, there were four residents with indwelling catheters, all of which were at risk to be affected by deficient practice. 3. Statement was added to Certified Nursing Assistant electronic charting on 02/25/2019, reminding them to check for catheter strap placement and documented each shift. Order was also added to Treatment Administration Record on 02/25/2019, for medication/treatment nurse to check for catheter strap placement each shift. All newly hired Certified Nursing Assistants will be checked off on proper catheter care during their initial orientation by the Assistant Director of Nurses. All current Certified Nursing Assistants were divided among 5 Registered Nurses and will be checked off on catheter care through direct observation beginning 01/31/2019, and all check offs will be completed by 03/06/2019. Check offs will be done quarterly by the Registered Nurses	

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F 690	Continued From page 26 front to back. Rinse well using clean cloth and water. Remove gloves and dispose properly. Wash hands. Don gloves. Apply incontinent care product. Remove gloves and dispose of properly. Wash hands. Don gloves. Use diapers or pad, as indicated. Cover resident. Remove gloves and dispose of properly. Resident #46 On 01/23/19 at 11:49 AM, an observation revealed, Resident #46 was sitting in his wheelchair at his bedside. Resident #46 had an indwelling urinary catheter in place. Resident #46 stated he had the urinary catheter because he started having trouble urinating. Resident #46's urinary catheter bag was observed in a dignity bag and hanging to gravity drainage. On 01/23/19 at 11:55 AM, an interview with Licensed Practical Nurse (LPN) #2, revealed Resident #46 had an indwelling urinary catheter because he had a diagnosis of Prostate Cancer. On 01/23/19 at 2:30 PM, an observation revealed Resident #46 was lying in bed, awake and talking to Certified Nursing Assistant (CNA) #1. The Surveyor observed CNA #1 and CNA #2 provide catheter care for Resident #46. CNA #1 washed her hands, applied clean gloves, set up supplies on a clean barrier, and pulled the covers back on Resident #46. Wearing these same gloves, CNA #1 wiped Resident #46 with a downward stroke on each side of his penis, in the groin areas. CNA #1 then wiped Resident #46's catheter tubing in an outward motion from the base of the penis towards the meatus without securing the catheter tubing. CNA #1 then wiped the catheter tubing from the meatus area towards the base of	F 690	assigned to this task. For those residents with indwelling catheters, Registered Nurse Supervisors will monitor direct care once per month at random unscheduled times until compliance is achieved. 4. Registered Nurse Supervisors will report monthly findings to the Quality Assurance nurse. Any Certified Nursing Assistant found to be performing care improperly will be counseled and disciplined accordingly by the Registered Nurse Supervisor. Quality Assurance nurse will report monthly to the Quality Assurance committee for recommendations for improvement. Registered Nurse Supervisors will report status of quarterly check off completion to Director of Nurses.	

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F 690	Continued From page 27	F 690		

Resident #46's penis. CNA #1 then pulled the cloth brief back up on Resident #46, covered him up, removed her soiled gloves, and washed her hands.

On 01/24/19 at 3:35 PM, an interview with the Director of Nurses (DON), revealed the gloves the CNA #1 was wearing touched Resident #46's linens, and she (CNA #1) should have changed her gloves after she (CNA #1) touched his (Resident #46) linens. The DON also stated, CNA #1 should have held the catheter tubing while wiping it to prevent trauma to the prostate. The DON stated when CNA #1 wiped from the base of the penis to the meatus, the CNA was pushing the bacteria back into the meatus which can cause an infection.

On 01/24/19 at 3:40 PM, an interview with Registered Nurse (RN) #2 revealed, CNA #1 did not hold the catheter tubing, and she should have held the catheter tubing while wiping, because she could cause pulling on the tube. RN #2 also stated, using the same glove hands to provide catheter care that she used to pull Resident #46's covers back, contaminated the gloves, and she (CNA #1) should have taken the gloves off, washed her hands and applied clean gloves. RN #2 also stated instead of wiping from the base of the penis towards the meatus, CNA #1 should have wiped from the meatus towards the base to prevent bacteria from entering the meatus.

On 01/25/19 at 8:50 AM, an interview with CNA #1, revealed the catheter could come out if it is not held while wiping it. CNA #1 also stated she should have changed her gloves after pulling the covers back.

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F 690	Continued From page 28 Review of the Physician Orders, for January 2019, revealed an order to change the Foley catheter every six weeks; 18 French (Fr) 5 Cubic Centimeter (cc) Coude Catheter, catheter care twice a day, change Foley drainage bag every 2 weeks and as needed. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/01/18, and the Comprehensive MDS, with an ARD of 09/03/18, revealed Resident #46 was coded for an indwelling urinary catheter. The Quarterly MDS, with an ARD of 12/01/18, revealed a Basic Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. A review of the Face Sheet revealed Resident #46 was admitted by the facility, on 02/10/98, with the included diagnoses of Hemiplegia/Hemiparesis and Retention of Urine. Resident #65 During an observation, on 01/23/2019 at 4:03 PM, of Resident #65's catheter care provided by Certified Nursing Assistant (CNA) #3, it was observed there was no device in place to secure the catheter tubing to prevent tugging on or dislodgement of the catheter.. Review of the Resident #65's Physician's Orders, for January 2019, revealed an order dated 09/09/2018 for catheter care to be performed twice daily (BID), Certified Nursing Assistant (CNA) may perform. During an interview on, 01/23/2019 at 4:12 PM, CNA #3 confirmed there was no securing device	F 690		

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F 690	Continued From page 29	F 690		

in place for Resident #65's catheter tubing during the catheter care. CNA #3 stated, if one of her residents didn't have a leg strap for their catheter, she would go get one and put it on. CNA #3 stated she was responsible for placing catheter straps on residents with catheters.

During an interview, on 01/24/19 at 12:00 PM, with Registered Nurse (RN) #4/Minimum Data Set (MDS) /Care Plan Coordinator, revealed the use of a catheter strap, is included in the catheter care protocol. RN #4 stated it is the facility's practice to use a catheter tubing strap for all residents with catheters, to prevent tugging and possible injury. RN #4 stated that Resident #65 should have had a catheter strap. RN #4 stated that all CNAs should make sure catheter straps are in place.

During an interview, on 01/24/2019 at 3:53 PM, with RN #3/ Station Three (3) Supervisor, she stated she conducts unplanned catheter care observations with CNAs to check off the CNA's skills. RN #3 also stated she does not keep a record of the CNA skills check offs.

During an interview, on 01/24/2019 at 3:58 PM, with RN #5/ Restorative Nurse, she stated she does random, and as needed, inservices related to CNA duties. RN #5 stated that catheter care was included in the inservices provided.

During an interview, on 01/25/2019 at 8:45 AM, RN #3/ Station 3 Supervisor revealed that part of the skills check-offs she does for the CNAs, is to check for the catheter strap during the catheter care task. RN #3 confirmed that a catheter strap should have been applied for Resident #65, when the CNA noticed that it was missing.

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F 690	Continued From page 30	F 690		

During an interview, on 01/25/2019 at 8:29 AM, the Director of Nursing (DON) stated that while providing catheter care, it a standard practice of the facility to use a catheter strap. The DON stated that a catheter strap should be in place for all residents with catheters to prevent possible dislodgement or trauma. The DON confirmed that in-services and skills check-offs are provided to the Nursing staff, no less than annually, and as needed.

During an interview, on 01/25/2019 at 8:59 AM, CNA #4 revealed catheter straps should be used for all residents who have catheters. CNA #4 stated, part of doing catheter care is to make sure the strap is in place. CNA #4 stated if there is not a strap, straps are available to get one.

Review of the Face Sheet revealed Resident # 65 was admitted by the facility, on 12/05/2014, with diagnoses to include Alzheimer's disease and Neuromuscular Dysfunction of Bladder.

Review of Resident #65's Significant Change MDS, with an ARD of 12/11/18, revealed she was coded a 3 for Cognitive Skills for Daily Decision Making, which indicated rarely or never makes decisions. Resident #65 was checked for the use of an indwelling catheter.

Resident #77

An observation during Resident #77's catheter care, on 01/24/18 at 11:10 AM, revealed Resident #77 did not have an anchor for the catheter to prevent pulling. The catheter care was provided by CNAs #11 and #12.

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F 690	Continued From page 31 An interview, on 01/25/19 at 08:50 AM, with CNA #12 confirmed Resident #77 did not have a leg strap on. CNA #12 stated Resident #77 does not like to wear them. An interview, on 01/25/19 at 8:55 AM, with Resident #77, revealed the strap irritated her leg, so she usually does not wear one. She stated she does have discomfort due to her catheter pulling at times. She stated it is worse when they are pulling up her brief. Resident #77 confirmed they have not tried any another kind of device to secure the catheter to her leg. An interview, on 01/25/19 at 8:55 AM, with the Director of Nursing (DON), confirmed Resident #77 should have her catheter secured to her leg. She stated she was not aware the leg strap bothered her, but stated she needs something to secure it. The DON stated the resident could experience pulling, irritation, or pain if the catheter is not secured. Review of Resident #77's Quarterly MDS, with an ARD of 12/22/18, revealed a BIMS score of 8, which indicated moderate cognitive impairment. Resident #77 was also checked for the use a an indwelling catheter.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 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	F 695		3/6/19

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F 695	Continued From page 32 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, record review, resident interview and facility policy review, the facility failed to store the resident Continuous Positive Airway Pressure (CPA) mask in a manner to prevent possible infection for one (1) of seven (7) residents observed for respiratory care. Findings include: A review of the facility's policy titled, "Infection Control Program Policy", undated, revealed, it is the policy of this facility that the Infection Control Program will be designed to help prevent the development and transmission of disease and infection. On 1/23/19 at 10:57 AM, an observation of Resident #94'S CPA mask revealed, the mask was uncovered, un-bagged, and lying on a white wash cloth on top of his CPA machine, on his nightstand. Resident #94 was lying in bed with his oxygen (O 2) in place, and the head of his bed (HOB) was up. On 1/23/19 at 2:20 PM, an observation of Resident #94's CPA mask revealed, the CPAP was lying un-bagged on a white washcloth on top of his CPAP machine on his nightstand. On 1/24/19 at 11:45 AM, an observation of Resident #94's CPAP mask revealed the CPAP mask continued to be un-bagged, and laying on the white washcloth on top of the CPAP machine.	F 695	1. Resident #94 s CPAP mask was cleaned and properly stored in plastic bag at bedside by Registered Nurse Supervisor at the time the deficient practice was identified during survey process. Resident #94 was seen by primary physician on 01/29/2019 and found to have no adverse respiratory conditions related to deficient practice. 2. Twenty-four residents identified to have respiratory masks/equipment at time of survey, all with the potential to be affected by deficient practice. 3. The twenty-four residents identified were checked by the Medication/Treatment nurses on duty at the time of survey to ensure all respiratory supplies were appropriately bagged. The supplies of all other residents were found to be appropriately placed in plastic bags. An order was placed on the Medication Administration Record on 02/25/2019 for all residents with respiratory treatments for the Medication Nurse to document at the end of each shift that supplies were appropriately bagged during their shift. Registered Nurse Supervisors were notified by Director of Nurses on 02/25/2019 to include same orders for any resident who receives new order for respiratory treatments. Registered Nurse Supervisors will make weekly checks at various times to ensure that supplies are being bagged appropriately. 4. Registered Nurse Supervisors will	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 33 On 1/24/19 at 4:45 PM, an observation of Resident #94's CPAP mask revealed the CPAP mask was un-bagged, and laying on the white washcloth on top of the CPAP machine. Review of the Physician Orders, for January 2019, revealed an order dated 09/09/16. to apply CPAP (nasal) 13 centimeter (CM) with O2 at 2 liters per minute (L/Min), clean CPAP mask with water after removal and let air dry, clean CPAP water chamber and tubing with solution of 1/3 vinegar to 2/3 water, rinse thoroughly with clean water and air dry, empty CPAP water and refill with fresh water. Review of Resident #94's Care Plan revealed the Problem/Need, dated 10/03/19, for the diagnoses Sleep Apnea, Chronic Obstructive Pulmonary Disease (COPD), Acute Respiratory Failure, and Episodes of Respiratory Distress. The Approaches included CPAP as ordered at HS (hour of sleep). On 1/23/19 at 10:57 AM, an interview with Resident #94 revealed the nurse put the CPAP mask there when she took the CPAP mask off and cleaned it. Resident #94 stated it was a female nurse because there are no male nurses working here (at the facility). On 1/24/19 at 3:25 PM, an interview with Registered Nurse (RN) #1 revealed, "I think we leave the CPAP mask on the bedside table." RN #1 stated, the CPAP mask should be stored in a plastic bag to keep germs from getting on the mask. On 1/24/19 at 3:35 PM, an interview with the Director of Nurses (DON) revealed the CPAP	F 695	report monthly findings to Quality Assurance nurse. Quality Assurance nurse will report monthly to the Quality Assurance committee for recommendations for improvement until compliance achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A178	A. BUILDING _____ B. WING _____	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

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F 695	Continued From page 34 mask should be put in a zip lock bag. The DON stated she was not sure why that is not being done. Review of the Face Sheet revealed Resident #94 was admitted by the facility, on 02/06/15, with the included diagnoses of Sleep Apnea, COPD, Morbid Obesity, and other Diseases of the Respiratory System. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/01/19, revealed a Basic Interview for Mental Status (BIMS) of 15, which indicated no cognitive impairment.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A178	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	**15 A SOUTH SIXTH STREET** **BAY SPRINGS, MS 39422**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide a properly maintained fire alarm system as required by NFPA 72 Table 14.3.1. This deficiency affected all 110 residents in the facility at the time of survey. Findings include: On January 24, 2019 at 11:30 AM, observation and record review revealed the facility was unable to provide the current year (2018) documentation of annual and sensitivity inspection of the fire alarm system. Record review also revealed the last annual and sensitivity inspection of the fire alarm system was conducted on June 2017. The administrator was made aware of the issue	K 345	American Fire and Safety conducted annual sensitivity inspection of the facility fire alarm system. All residents had the potential to be affected by this deficient practice. The facility recently experienced a turn over in Maintenance Director position. The new Director has added this annual inspection to the preventive maintenance schedule and will be completed prior to annual due date. Maintenance Director will update to the facility safety committee at least quarterly on the status of preventive maintenance items due to be completed. Maintenance director will report on annual basis to QAPI of completion of this	2/27/19

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

Electronically Signed — 02/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A178	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER CO NH	**15 A SOUTH SIXTH STREET** **BAY SPRINGS, MS 39422**

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K 345	Continued From page 1 during the exit conference.	K 345	testing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A178	A. BUILDING _____ B. WING _____	01/24/2019

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 1/24/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 02/28/2019

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