

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2019
NAME OF PROVIDER OR SUPPLIER HATTIESBURG HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 514 BAY STREET HATTIESBURG, MS 39401		
(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 recertification survey, and complaint survey for CI MS #15937 and CI MS #15956, at the facility from 07/09/2019 to 07/12/2019. During the survey the SA did not substantiate the complaint CI MS #15937 related to quality of care, or the complaint CI MS #15856 related to pest control. Therefore, there were no deficiencies cited related to the complaints. The SA did find the facility was not in substantial compliance with the requirements of participation for Medicare and Medicaid and cited F637, F645, F646, F656, F657, F690, F695, and F812. At the time of survey, the census was 173, and the facility held a license for 184 beds.	F 000			
F 637 SS=D	Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on facility policy review, staff interview, and record review, the facility failed to code a Significant Change in Status Assessment (SCSA)	F 637	1. On 7/12/19, an immediate in-service was provided by Director of Nursing to all Minimum Data Set staff as well as Unit		9/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/30/2019

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

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F 637	Continued From page 1 on the Minimum Data Set (MDS) for one (1) of eight (8) residents reviewed for Preadmission Screening and Resident Review (PASARR), Resident #157. Findings include: Review of facility's policy, titled "Resident Assessment Instrument", dated September 2010, revealed: The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: Within fourteen days of the residents admission to the facility; When there has been a significant change in the residents condition; at least quarterly; and once every 12 months. All persons who have completed any portion of the Minimum Data Set (MDS) Resident Assessment Form must sign such document attesting to the accuracy of such information. Record review of the Face Sheet revealed Resident #157 was admitted by the facility on 04/28/17. Record review of the Pre-Admission Screening (PAS) Level I, dated 05/10/17, revealed no Level II criteria was required at this time. Record review of the Diagnosis/History Report for Resident #157, revealed a Change in condition with a new diagnosis of Schizophrenia noted, on 11/07/18, with no PASARR Level II change in status found in the chart. Record review of the (Name of Healthcare Management Services Company)'s Level II Change in Status Request (case	F 637	Managers regarding significant changes, Level I, and Level II screening procedures and qualifying diagnosis. Resident #157's change of status form was verified complete on 2/28/19 and verified receipt by Department of Mental Health on 7/12/19. A significant change was not warranted however a change of status was required for the Level I assessment and was completed on 2/28/19, and resubmitted on 8/27/19. 2. All residents are at risk from this deficient practice. 3. On 8/29/19, preadmission screening and resident review was added to daily stand up review for daily monitoring. Weekly identifications will be reported to the Administrator. On 8/22/19, the quality assurance committee reviewed policy and procedures related to Pre-Admission Screening and resident review screening and significant changes were reviewed with no recommendation to change facility policies. 4. The Quality Assurance nurse will monitor weekly for six weeks starting 9/2/19 of residents with potential for significant change, implementing standard disease-related clinical interventions, and those that have an impact on more than one area of the residents health status thus requiring interdisciplinary review or revision of the plan of care and presented monthly to the Quality Assurance committee for review. Any discrepancies will be immediately assessed and		

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F 637	Continued From page 2 number-499344), dated 02/27/19, revealed the need for a Level II assessment for the diagnosis of Major Depressive Disorder. The Schizophrenia diagnosis obtained on 11/07/18 was not identified on the Level II request at this time. Record review of the Physician's Orders, dated 11/07/18, revealed Resident #157 was ordered Risperidone 0.5 milligram (mg) one (1) tablet twice a day by mouth for Mood Disorder/Aggressive behavior. Record review of a document provided and signed by Registered Nurse #2/Quality Assurance (QA) Nurse, as well as signed by the facility's Administrator, revealed: Regarding case number-499344, personnel at (Name of Healthcare Services Company) stated that a case number was located in the system, but it had not been processed, though it had been several months since it was submitted. Personnel stated that she was unsure why Level I outcomes and /or Level II outcomes were not completed and could not further assist. I was transferred to Level II division or (Name of Healthcare Management Company), however personnel stated that there was no profile in the level II division of the company. I spoke with the Department of Mental Health (DMH) Summary Reviewer regarding case number and she stated that the (Name of Healthcare Management Company) would have to send her department and as of date case number is not there". Record review of the current Physician's Order for July 2019, for Resident #157, revealed Risperdal 0.5 mg tablet give one-half (1/2) tablet by mouth every morning (Schizophrenia); Risperdal 0.5 mg tablet (1) one by mouth at bed	F 637	corrected by the Director of Nursing.		

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F 637	Continued From page 3 time (Schizophrenia). An interview, on 07/11/19 at 9:12 AM, with Registered Nurse (RN) #2/Quality Assurance (QA) Nurse, revealed that when she took the position in February, she did a wide spread audit of all charts and sent to (Name of Healthcare Management Company) those residents that were needing Level II assessments. RN #2 revealed Resident #157 was one of the residents that she found needing the Level II assessment. RN #2 revealed she felt the resident's change in status for the Schizophrenia Diagnosis just "fell through the crack". RN #2 revealed she sent Resident #157's need for a Level II to (Name of Healthcare Management Company) when she discovered that he had a change in status in November and the Level II request had not been done. The Level II request was sent to (Name of Healthcare Management Company) on 02/27/19. It was an abnormal length of time before his was sent to (Name of Healthcare Management Company). An interview, on 07/11/19 at 9:15 AM, with Licensed Practical Nurse (LPN)#3/Minimum Data Set (MDS) Coordinator, revealed she had just started in the MDS position not too long ago, but she remembered that they went way back and did a clean sweep to see who didn't have a Level II or a change of status. LPN #3 revealed she felt like the resident's change of status just fell through the crack because that is an abnormal length of time before it was discovered and reported. An interview, on 07/11/19 at 5:54 PM, with RN #2/QA Nurse, revealed she called (Name of Healthcare Management Company) for the resident's status on the Level II request sent	F 637			

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F 637	Continued From page 4 02/27/19, and was told by an (Name of Healthcare Management Company) employee that the resident had not had a Level II performed as of yet. She stated the lady at the company told her they were behind, and his paperwork was still in a pile to be processed. An interview, on 07/12/19 at 9:25 AM, with the facility's Administrator, revealed the facility realized in February they had several people who had not received a Level II assessment and several that requests had been sent to the (Name of Healthcare Management Company) with no visit from management company for some of these. He stated there were numerous requests sent at the same time and day by RN #2/QA Nurse, requesting these assessments. The Administrator revealed there should have been a process to follow up on the requests, but there wasn't a process really in place since the healthcare management company usually comes quickly for the assessments. He stated he knew (Name of the Healthcare Management Company) was behind because they had even come on weekends before to do assessments. After they realized there was a problem, in February, the facility then took the problem to the Quality Assurance team to be placed on their QA list. The Administrator stated the facility now has a process in place to follow up with the healthcare management company's requests. The process is the Transitional Care Nurse will do the Level I requests on Admission, and then the MDS Nurse will pick up if there is a change of status and file a request with the healthcare management company. The Administrator stated he was going to add a log for the healthcare management company requests so they could better follow along with the process of who has received the	F 637			

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F 637	Continued From page 5 Level II assessments, and who had not yet received the assessment. An interview, on 07/12/19 at 11:39 AM, with the Director of Nursing (DON) revealed at the time that Resident #157 had a change in status, with a new diagnosis of Schizophrenia and a new medication given, the MDS nurse was responsible to put the information into the computer for a Level II assessment as well as putting it into the MDS and she just dropped the ball.	F 637			
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645		9/18/19	

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

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F 645	Continued From page 7 intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide an accurate Preadmission Screening and Resident Review (PASARR) for one (1) of eight (8) residents reviewed for PASARR. Resident #76. Findings Include: Review of the facility's Admission Policy titled, "Admission Criteria", revised December 2016, revealed our facility will admit only those residents whose medical and nursing care needs can be met. Nursing and medical needs of individual with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-Admission Screening and Resident Review Program (PASSAR) to the extent practicable. Review of the PASSAR, dated 02/25/2019, revealed Resident #76 did not have a mental illness. The PASSAR also stated the resident did not have a recent history of mental illness. This PASSAR was done prior to admission. Review of the Admission History and Physical upon admission, dated 02/21/2019, revealed the Resident #76 was admitted with a diagnosis of Psychosis. The History and Physical also stated Resident #76 had some severe behavioral disturbances where he became very angry and agitated requiring an injection of Haldol. It took several hours for the resident to become	F 645	1. On 7/12/19, an immediate in-service was provided by Director of Nursing to Transitional Care Nurse regarding preadmission screening and resident review for all patients including accuracy. Resident #76 had a update to the criteria for minimum data set, also known as a change of status request form completed on 8/27/19. 2. A facility wide audit of preadmission screening and resident review, level I screening as well as level II screening will be completed by 9/4/19 by Quality Assurance Nurse to correct any discrepancies. Minimum Data Set staff, Quality Assurance, and Transitional Care staff were in-serviced on 7/12/19, by the Director of Nursing, regarding preadmission screening as well as Level II qualifications along with policy and procedure. All Residents have potential to be affected by this deficient practice. 3. On 7/12/19, Transitional Care Nurse was in-serviced by Director of Nursing regarding accuracy along with timeliness of screenings. Quality Assurance will monitor weekly and bring any findings to the interdisciplinary team meeting while making an immediate corrective action starting 8/27/19. On 8/22/19, the QA committee reviewed the policy on preadmission screening as well as		

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F 645	Continued From page 8 manageable. During an interview with the doctor, Resident #76 became agitated, yelling and then immediately apologized. the doctor said Resident #76 exhibited very spontaneous anger and agitation. Resident #76 had rapid speech, and was easily agitated. Resident #76 was ordered Haldol twice a day. On 07/12/19 1:55 PM, an interview with Registered Nurse (RN) #2/Quality Assurance (QA) Nurse confirmed the PASSAR wasn't accurate upon admission. The facility did not send the resident's PASSAR to (Name of Healthcare Management Company) to be evaluated because the Level 1 was not done accurately.	F 645	accuracy, to which no changes were recommended. 4. Screenings will be reviewed daily during stand up meeting to verify hospital returns and new admissions are completed accurately and timely effective 8/27/19. A 100 percent audit of Preadmission screening for resident review, Level 1, and Level II assessments will be completed by 9/4/19 by the Quality Assurance Nurse and will also be completed quarterly to monitor. The Quality Assurance nurse will submit to the Quality Assurance committee all findings and discrepancies will be immediately rectified on a monthly basis and will monitor for two months for compliance.		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on facility policy review, staff interview, and record review, the facility failed to identify the need for a Level II referral in a timely manner for one (1) of eight (8) residents reviewed for Level II review. Resident #157. Findings include: Review of facility's policy titled, "Admission	F 646	1. On 7/12/19, an immediate in-service was provided by Director of Nursing to Transitional Care Nurse regarding Preadmission Screening for all patients including Preadmission screening and resident review for accuracy. Resident #157 had an update to the criteria for minimum data set also know as a change of status form completed on 2/28/19.	9/18/19	

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F 646	Continued From page 9 Criteria", dated December 2016, revealed: The objective of our admissions criteria policy is to admit residents who can be cared for adequately by the facility; Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-Admission Screening and Resident Review Program (PASARR) to the extent practicable. Potential residents with mental disorders or intellectual disabilities will only be admitted if the State Mental Health Agency has determined (through the preadmission screening program) that the individual has a physical or mental condition that requires a level of services provided by the facility. Review of the Minimum Data Set (MDS) Summary Report, dated 07/11/19 for Resident #157, revealed no significant change for the diagnosis of Schizophrenia, which identified on 11/07/18, was entered into the MDS between the dates of 09/24/18 and 06/17/19. An interview, on 07/12/19 at 11:39 AM, with the Director of Nursing (DON) revealed, "at the time that Resident #157 had a change in status with a new diagnosis of Schizophrenia and a new medication given, the MDS nurse was responsible to put the information into the computer for a Level II assessment as well as putting it into the MDS, and she just dropped the ball". An interview, on 07/12/19 2:20 PM, with Licensed Practical Nurse (LPN) #3/MDS Coordinator, revealed, "The resident should have had a significant change after he received the diagnosis of Schizophrenia, and there was not one done. Him having a new diagnosis and having a new	F 646	2. A facility wide audit of Preadmission screening and resident review, Level I, and Level II assessments will be completed by 9/4/19 by Quality Assurance Nurse to correct any discrepancies. Minimum data set staff, Quality Assurance, and Transitional Care staff were in-serviced on 7/12/19, by Director of Nursing, regarding Level II qualifications along with policy and procedure. All residents have potential to be affected by this deficient practice. 3. On 7/12/19, MDS Staff members were in-serviced regarding accuracy along with timeliness of screenings by Director of Nursing. Quality Assurance Nurse will monitor weekly and bring any findings to the interdisciplinary team meeting while making an immediate corrective action starting 8/27/19. On 8/22/19, the Quality Assurance committee reviewed the policy on preadmission screening as well as accuracy, to which no changes were recommended. 4. Screenings will be reviewed daily during stand up meeting to verify hospital returns and new admissions are completed accurately and timely effective 8/27/19. Any adverse findings will be corrected immediately by the Quality Assurance Nurse and findings will be addressed by Quality Assurance committee. A 100 percent audit of preadmission screening for resident review, Level I, and Level II assessments will be completed by 9/4/19 and will also be completed quarterly to		

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F 646	Continued From page 10 medication, it should have been a significant change".	F 646	monitor. The Quality Assurance Nurse will submit findings to the Quality Assurance committee who will monitor for two months for compliance. Any discrepancies will be immediately rectified by the Quality Assurance Nurse.		
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		9/18/19	

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F 656	Continued From page 11 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, facility policy review, resident interview, and staff interview, the facility failed to follow the Comprehensive Care Plan related to tracheostomy care for two (2) of three (3) residents observed for tracheostomy care, Resident #22 and Resident #88, for nebulizer treatments for one (1) of two (2) resident nebulizer treatment observations, Resident #86, and for catheter care for one three (3) of five (5) residents observed for catheter care, Resident #7, Resident #88, and Resident #139. Finding include: Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," dated December 2016, revealed it is the policy of this facility that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The facility policy also stated the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and	F 656	1. On 7/12/19, care plans were immediately reviewed for accuracy for Resident #88, Resident #7, Resident #139, Resident #86, and Resident #22. Licensed Practical Nurse (LPN) #4, Respiratory Therapist (RT), Certified Nursing Assistant (CNA) #1, CNA #2, CNA #3, CNA #4, CNA #5, CNA #6, LPN 1, LPN #2, and LPN #4 were immediately in-serviced by Director of Nursing regarding policy and procedure with following care plan as well as tracheostomy care, Nebulizer treatments, and Catheter care. Residents #88, Resident #7, Resident #139, Resident #86, and Resident #22 were assessed by Director of Nursing on 7/12/19, as well as monitored for one week by Director of Nursing for any negative outcomes to which none were identified. 2. Ten Residents with Tracheostomy tubes, Twenty six Residents receiving respiratory treatments, and eleven Residents with indwelling or external catheters are at risk from this deficient		

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F 656	Continued From page 12 implements a comprehensive, person-centered care plan for each resident. Resident #86 Review of Resident #86's Care Plan revealed a Focus problem, with an Onset Date of 05/20/2019, for the risk of respiratory distress and discomfort related to a diagnosis of Chronic Obstructive Pulmonary Disease (COPD. The Care Plan revealed an Approach to this focused problem included the nebulizer treatment to be given as ordered; monitor for effectiveness; adverse side effects and document; report as needed. An observation, on 07/10/2019 at 9:30 AM, revealed Resident #86 was her room, lying in bed, with a nebulizer treatment in progress. Further observation revealed there was no staff present in the room, or nearby in the hallway. During an interview, on 07/10/2019 at 9:30 AM, with Resident #86, revealed she stated the nurse never stays in the room for the entire treatment time. Resident #86 stated, "Sometimes when it is finished, I just take the mask off myself." During an interview, on 07/11/2019 at 3:44 PM, Licensed Practical Nurse (LPN) #2/ Transitional Care Nurse, stated he was supervising the morning of 07/10/2019. LPN #2 stated he was aware that Resident # 86 was receiving a nebulizer treatment, but he had left the room to go check on something and left the resident alone with a nebulizer treatment in progress. LPN #2 stated he was aware that a nurse should remain with the resident for the duration of the treatment to monitor response and effectiveness	F 656	practice. 3. A facility wide in-service was initiated on 7/12/19 and completed by 7/25/19 by Administrator and Education Nurse regarding following comprehensive care plans. Education Nurse will complete one to one check off's for tracheostomy care, respiratory treatments, and catheter care initiated on 7/12/19 to be completed by 9/18/19. On 8/22/19 Quality Assurance committee reviewed policy and procedure for comprehensive care plans to which no changes were recommended. 4. Education nurse will observe three tracheostomy care procedures, three respiratory treatments, and four catheter care procedures per month for two months for accuracy and proper procedure per facility policy. Quality Assurance Committee will review findings of Education Nurse monthly for two months. All findings will be submitted to Quality Assurance Committee for review and any further discrepancies will be immediately rectified by Quality Assurance Nurse.		

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F 656	Continued From page 13 of the treatment. During a telephone interview, on 07/11/2019 at 4:26 PM, Licensed Practical Nurse (LPN) #1 revealed she was the nurse who started the nebulizer treatment for Resident #86 on 07/10/2019. LPN #1 stated she got very busy preparing the rest of Resident #86's medications and did not stay with the resident for the duration of her nebulizer treatment. LPN #1 stated she knew it was the facility's policy for the nurse to stay with a resident during a nebulizer treatment until it's finished. During the interview, on 07/12/2019 at 10:07 AM, with Licensed Practical Nurse (LPN) #3/Care Plan Coordinator, it was confirmed there was a Focused problem on Resident #86's Care Plan regarding the resident being at risk for respiratory distress and discomfort, related to the diagnosis of Chronic Obstructive Pulmonary Disease (COPD). LPN #3 also confirmed that an approach to this Focus problem was to provide nebulizer treatments as ordered, and monitor for effectiveness. LPN #3 stated the Care Plan had not been followed by the nurse administering the treatment, because she left the resident's room before the breathing treatment was done. During an interview, on 07/12/2019 at 10:19 AM, with the Director of Nursing (DON), it was confirmed the nurse should have stayed with the resident for the duration of the respiratory treatment. The DON stated that the correct way for administering nebulizer treatments is in the facility's policy for nebulizer treatments administration. The DON stated the nurse should have stayed with the resident. The DON stated Resident #86's Care Plan was not followed as	F 656			

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F 656	Continued From page 14 what was intended for the administration of the nebulizer treatment. Review of the Face Sheet revealed Resident #86 was admitted by the facility, on 06/3/2015 and re-admitted on 12/15/2015, with diagnoses to include Pressure Ulcer of the Sacral Region and Chronic Obstructive Pulmonary Disease (COPD). Resident #7 Review of the Comprehensive Care Plan revealed Resident #7 had a potential for complications related to the presence of a Suprapubic Catheter, related to a Stage 4 Pressure Ulcer to the sacrum, and a diagnosis of Neurogenic Bladder. Interventions included: Place drainage bag in a privacy bag, catheter care every shift and as needed, observe for signs and symptoms of a Urinary Tract Infection, secure catheter to thigh with catheter strap to prevent pulling on tubing, keep collection bag below bladder level, and check tubing for kinks. An observation, on 07/10/19 at 2:24 PM , revealed Resident #7 was provided catheter care by Certified Nursing Assistant (CNA) #2. CNA #2 washed her hands, applied gloves and applied soap to a wet wipe CNA #2 cleansed the right side of the catheter tubing, and cleaned the left side of catheter tubing with the same wipe. CNA #2 did not rotate the wipe. CNA #2 rinsed the catheter tubing with a wet wipe without rotating the wipes. During an interview, on 07/10/19 at 3:46 PM, Registered Nurse (RN) #3/Staff Development Nurse revealed the CNAs are trained upon hire and annually on the appropriate way to provide	F 656			

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F 656	Continued From page 15 catheter care in a manner to prevent infection. During an interview, on 07/10/19 at 3:49 PM, the Director of Nursing (DON) revealed CNA #2 should have rotated the wipe during catheter care. The DON said the staff was trained annually how to provide catheter care. During an interview, on 07/11/19 at 9:42 AM, CNA #2 confirmed the she failed to rotate the wipes during Resident #7's catheter care. CNA #2 said she was nervous and did not realize she didn't rotate or change the wipes. During an interview, on 07/12/19 at 3:19 PM, LPN #3 revealed she expected the staff to provide catheter care according to the standards of practice and to follow the care plan. Review of the Face Sheet revealed the facility admitted Resident #7, on 01/29/201), with diagnoses which included Neurogenic Bladder, Urinary Retention and Stage 4 Pressure Ulcers. Review of Resident #7 Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/2/2019, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident was cognitively impaired. Resident #139 Record Review of the Care Plan revealed Resident #139 was at risk for a Urinary Tract Infection related to the presence of an indwelling catheter for the diagnosis of Neuromuscular Dysfunction. Interventions included: Place the catheter drainage bag in a privacy bag, catheter	F 656			

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F 656	Continued From page 16 care every shift and as needed per policy, obtain labs as ordered, observe for signs and symptoms for a Urinary Tract Infection, keep the drainage bag below the bladder level, and check for kinks in the tubing. An observation, on 07/10/19 at 2:30 PM, revealed CNA #1 provided Resident #139's catheter/peri care. CNA #1 washed her hands, applied gloves and cleaned the catheter tubing with wet wipes. No concerns were noted. CNA #1 left the room to get more wipes. On her return to the room, CNA #1 placed the wipes on the table without a surface barrier. CNA #1 did not wash her hands, and then placed gloves on her hands. CNA #1 wiped the shaft of the penis three times and dried the shaft of the penis. CNA #1 did not clean the head of the penis. During an interview, on 07/10/19 at 2:31 PM, RN #3/Staff Development Nurse said the staff was trained upon hire and annually to clean the head of the penis while performing catheter and peri care. RN #3 said CNA #1 should have cleaned the head of the penis by pulling the skin back, and then wipe the right and left side in a circular motion with the wipe. During an interview, on 07/10/19 at 2:35 PM, the DON revealed CNA #1 should have cleaned the head of the penis to prevent infection. During an interview, on 07/11/19 at 9:26 AM, CNA #1 confirmed she forgot to wash the head of Resident #139's penis because she was in a hurry. CNA #1 also said she forgot to put down her barrier. During an interview, on 07/12/19 at 3:16 PM, LPN	F 656			

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F 656	Continued From page 17 #3 revealed she expected the CNAs to follow the care plan to provide catheter care in a manner to prevent infection, A review of the facility's Face Sheet revealed the facility admitted Resident #139, on 06/03/2019, with diagnoses which included Neuromuscular Dysfunction of the Bladder, Diabetes Mellitus and Major Depressive Disorder. A review of Resident #139's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2019, revealed Resident #139 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #22 Review of the Comprehensive Care Plan revealed a Problem/Need, dated 01/11/2019, for a tracheostomy related to Traumatic Brain Injury with Encephalopathy. At risk for respiratory distress, decreased oxygen saturation (O2 sat). Goals included the resident would not experience acute respiratory failure/distress with appropriate interventions next 90 days, 07/20/19. Interventions included: Provide tracheostomy care as ordered (per protocol). Monitor oxygen sats every shift and as needed. On 07/10/19 at 11:42 AM, an observation revealed LPN #4 provided Resident #22's tracheostomy care. LPN #4 washed her hands and applied the sterile gloves just like they were regular gloves. She removed the tracheostomy dressing and inner cannula, washed her hands and applied clean gloves. She then cleaned around the tracheostomy plate area and around	F 656			

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F 656	Continued From page 18 the inner cannula with a sterile water moistened 4x4 using a back and forth motion x 6. She moistened a Q-tip with the sterile water and cleaned the inner cannula area in a back and forth motion multiple times and discarded the Q-tip. She retrieved another Q-tip, moistened it with sterile water and cleaned the inner cannula area in a back and forth motion and discarded it. She then moistened a 4x4 gauze with sterile water and cleaned the neck plate in a back and forth motion multiple times and discarded it. She washed her hands, applied clean gloves, and placed a new inner cannula. She discarded all of the used/soiled supplies. On 07/12/19 at 10:15 AM, an interview with LPN #4 revealed she should have wiped in one direction and thrown the 4x4 gauze and Q-tip away when providing the tracheotomy care to Resident #22. She also stated wiping in a back and forth motion would cause cross contamination. On 7/12/19 at 10:35 AM, an interview with the DON, revealed the nurse should not have gone from dirty to clean, because that is cross contamination and could cause an infection. She also stated the nurse should have maintained a sterile technique while handling the inner cannula. The DON also stated the oxygen sat should have been checked prior to the nurse providing tracheostomy care. She stated she has never known of hyper-oxygenating the resident before providing tracheostomy care. On 7/12/19 at 3:10 PM, an interview with LPN #3/MDS-Care Plan Nurse, revealed, she would expect the staff to do what the care plan states to do to take care of the resident. She also stated	F 656			

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F 656	Continued From page 19 when the care plan indicates tracheostomy care as ordered, she would expect the staff to provide care according to the facility protocol. Resident #88 Tracheostomy Care Review of Resident #88's Comprehensive Care Plan revealed a Problem/Need, dated 05/22/2019, for a tracheostomy related to Anoxic Brain Injury with Hypoxia and Hypercapnia. At risk for respiratory distress, decreased oxygen saturation. Interventions included: Provide tracheostomy care as ordered (per protocol). On 07/09/19 at 10:50 AM, an observation revealed the Respiratory Therapist (RT) provided Resident #88's tracheostomy care. The RT entered resident's room, set up his tracheostomy care supplies on the bedside table without wiping the table off, or placing a surface barrier. The RT attempted to put on the sterile gloves that were in the Tracheostomy Care Tray Kit, but changed his mind and wrote the current date on the sterile water bottle. The RT organized his supplies, poured the sterile water into a clear plastic basin that he removed with the sterile gloves and other tracheostomy supplies from the Tracheostomy Care Tray kit and placed the items on the barrier. He applied the sterile gloves that he had bought into the room with him, moistened a 4x4 gauze with the sterile water, and cleaned around the tracheostomy neck plate x eight (8) in a back and forth motion using the same 4x4 gauze without	F 656			

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F 656	Continued From page 20 rotating the gauze. He then retrieved another gauze, moistened it with the sterile water and cleaned around the tracheostomy neck plate again using a back and forth motion x 10 and not rotating the 4x4 gauze. He removed the inner disposable cannula and changed his gloves. The RT cleaned around the tracheostomy inner cannula area using a 4x4 moistened with sterile water wiping in a back and forth motion x six (6) and not rotating the gauze. He then used a Q-tip moistened with sterile water and cleaned around the tracheostomy inner cannula area in a back and forth motion x 10. The RT retrieved another Q-tip, moistened it with sterile water, and cleaned again around the tracheostomy inner cannula area using a back and forth motion x eight (8). He obtained a 4x4 gauze, moistened it with sterile water and wiped around the tracheostomy inner cannula area in a back and forth motion x 4. He retrieved another 4x4 gauze, moistened it with sterile water and wiped around the tracheostomy inner cannula area in a back and forth motion x eight (8) without rotating the gauze. He placed a new inner cannula in the tracheostomy and disposed of the soiled supplies in the biohazard trash can in the resident's room. On 07/11/19 at 1:45 PM, an interview with the RT, revealed he probably should have washed his hands during glove changes. He also stated he did not have his "bag" and likes to have his soiled utility bag. The RT stated, he has an injury to his left smallest finger, so he could not wear the sterile gloves that were in the Tracheostomy kit. He stated because he knew this resident, he felt like he could provide tracheostomy care to the resident on room air and did not need to pre-oxygenate the resident prior to providing tracheostomy care. He also stated he had	F 656			

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F 656	Continued From page 21 checked the O2 sat, but forgot to tell the surveyor. The RT stated you could contaminate the area by not rotating your gauze or throwing away your gauze after wiping one time. He stated he would have most definitely did things differently, such as letting the surveyor know that he had checked the O2 sat, he would pre-oxygenate before providing tracheostomy care, and he would wipe once and discard the 4x4s and/or Q-tips. On 07/11/19 at 2:05 PM, an interview with Registered Nurse (RN) #1/Infection Control Nurse, revealed the RT should have wiped the area once and thrown the 4x4 gauze away and wiped with a circular motion with the Q-tip once, thrown it away, and got another one to wipe again. On 07/12/19 at 3:10 PM, an interview with Licensed Practical Nurse (LPN) #3/MDS-Care Plan Nurse, revealed she would expect the staff to do what the care plan states to do to take care of the resident. She also stated when the care plan indicates tracheostomy care as ordered, she would expect the staff to provide care according to the facility protocol. On 07/10/19 at 8:36 AM, an interview with the Physician revealed, the resident coded as a result of respiratory failure, and had to receive the tracheostomy. Review revealed, the Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/28/19, revealed the MDS was coded to include tracheostomy care. The physician orders dated July 2019 revealed	F 656			

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F 656	Continued From page 22 the following orders: Orders to suction tracheostomy site per policy and procedure prn and as ordered by a physician. Change tracheostomy tubing, oxygen delivery, mask, T-tube and oxygen humidifier bottles and tubing prn (as needed). Change tracheostomy tubing, oxygen delivery, mask, T-tube and oxygen humidifier bottles and tubing prn. Oxygen sign on front and back of door. Check O2 sats prn notify MD if sats < (less than) 88%. Check O2 sats Q (every) shift, notify MD (Medical Doctor) if O2 sat is < 88%. Humidified O2 (oxygen) @ 2 liters per trach mask T-tube. Chest physiotherapy (CPT) or positive expiratory pressure (PEP) therapy prn airway clearance, prevent or treat atelectasis. Pulmonary lavage with sterile normal saline per tracheostomy per licensed nurse or Registered Respiratory Therapist. May use 2-4 ML (two to four milliliters) 20% mucomyst nebulized or via instillation with pulmonary lavage Q 4 hrs prn. Trach HME (heat and moisture exchanger) applied to trach as needed for humidification when out of bed (use only if resident's secretions are thick). EzPAP (positive airway pressure therapy) via trach x 15 minutes prn lung expansion, airway clearance per licensed nurse or respiratory therapist. May use 3 ML 7% NaCL(Sodium Chloride)/duoneb 2 ML mucomyst. Mouth care every shift. Suction secretions from oral cavity prn. Notify MD if trach is dislodged. Type and size of tracheostomy, #8 Shiley DCT. Document characteristics and amount of sputum secretions. Catheter Care Review of the Comprehensive Care Plan revealed a Problem/Need for potential	F 656			

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F 656	Continued From page 23 complications related to the presence of an indwelling catheter due to a Unstagable Pressure Ulcer with eschar and slough to the coccyx. The Goals included there would be no signs and symptoms of a Urinary Tract Infection by the next review, 0820/19. The Interventions included: Catheter care every shift and as needed per the facility's protocol. On 07/09/19 at 2:45 PM, an observation revealed Certified Nursing Assistants (CNAs) #3 and #4 provided Resident #88's catheter care. CNA #3 and #4 washed their hands. CNA #3 set a clean barrier and placed a package of wipes, clean brief, and a box of clean gloves on the barrier. CNA #1 retrieved a clean wipe from the the package and cleaned around the resident's penis head x four (4) using the same wipe, did not rotate the wipe. CNA #3 discarded that wipe, retrieved another wipe from the package of wipes and cleaned around the resident's penis head x four (4) using the same wipe without rotating the wipe again. CNA #3 discarded that wipe, and CNA #3 retrieved another wipe from the package of wipes and cleaned around the resident's penis head x four (4) times using the same wipe and without rotating the wipe. Both CNAs positioned the resident onto his left side to remove the soiled brief and pad. They then positioned the resident onto his right side to finish removing soiled brief and pad. The CNAs applied a clean brief and pad to the resident. The CNAs discarded all of the soiled items into the biohazard trash and placed the linens in a biohazard linen hamper in the resident's room. Neither CNA cleaned the catheter tubing. The CNAs repositioned the resident on his left side, placed the catheter drainage bag on the left side of the bed, ensured the catheter securing device was in place,	F 656			

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F 656	Continued From page 24 covered the resident up, and washed their hands. On 07/10/19 at 9:15 AM, an observation revealed CNA #5 and #6 provided Resident #88's catheter care. CNA #5 set up her supplies; water basin, placed two clear trash bags on the foot of the resident's bed, a box of gloves, and a package of wipes. Both CNAs applied clean gloves, and CNA #5 removed several clean wipes from the package of wipes, and CNA #5 placed the wipes on the resident's bed. CNA #5 wet the washcloth with soap and water and wiped the resident's right groin area in a back and forth motion without rotating the washcloth. She then wiped the resident's left groin area in a back and forth motion multiple times. CNA #5 retrieved a wipe and anchored the resident's catheter tubing nearest the meatus, and wiped in an outward motion x four (4) in a back and forth motion and without rotating the wipe. She retrieved another wipe, and wiped the resident's catheter tubing in a back and forth motion x four (4), and without rotating the wipe. While using a dry towel, CNA #5 dried the area also using a back and forth motion four (4), and dried the catheter tubing again by patting around the catheter tubing and penis area x six (6) without rotating the dry towel. On 07/11/19 at 10:05 AM, an interview with CNA #5, revealed she should have wiped in a downward motion and should have rotated her washcloth. She also stated wiping in a back and forth motion is cross contamination and could cause an infection. On 07/11/19 at 10:15 AM, an interview with CNA #6, revealed she placed the wipes on the resident's bed, and could have used a barrier before sitting them on the resident's bed covers	F 656			

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F 656	Continued From page 25 or placed them in the clean plastic bag. She also stated the wipes became contaminated by sitting them on the resident's bed covers. On 07/11/19 at 10:20 AM, an interview with Registered Nurse (RN) #4/Unit Manager, revealed the CNA should not have wiped in a back and forth motion. RN #4 stated the CNA should have wiped in a downward motion one time and discarded the wipe. Donna stated, if the CNA was using a towel, she should have rotated the towel. She also stated, it is not okay to wipe in a back and forth motion, because it introduces germs back up the catheter and into the bladder and could cause a Urinary Tract Infection. On 07/11/19 at 11:25 AM, an interview with CNA #3, revealed she should have rotated her wipe as she was cleaning the resident's penal area. She stated she should have made the wipe to fit around her hand like a glove so she could have rotated it. She also stated, she should have held the catheter tubing at the end near the penis and wiped away from the penis. On 07/11/19 at 11:35 AM, an interview with CNA #4, revealed when cleaning the catheter tubing the CNA should hold it at the end close to the penis and wipe away from the penis and throw the wipe away. On 07/11/19 at 2:05 PM, an interview with RN #1/Infection Control Nurse, revealed CNA #3 should have rotated or thrown that wipe away and obtained another one, and not use the same wipe. She also stated the CNA should have cleaned from the meatus area outward on the catheter tubing.	F 656			

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F 656	Continued From page 26 On 07/11/19 at 2:10 PM, an interview with RN #1/Infection Control Nurse, revealed when CNA #6 placed the wipes that was pulled from the package on the resident's covers with no barrier present, that contaminated the wipes. She stated CNA #6 should have used a barrier. She also stated CNA #5 should have wiped once or only used one wipe and rotated that wipe and never clean in a back an forth motion. She also stated she should have wiped the catheter tubing once in an outward motion from the meatus area and thrown the wipe away and never wipe in a back and forth motion. On 07/12/19 at 10:45 AM, an interview with the DON, revealed the CNAs should not have gone from dirty to clean because they can introduce bacteria which could cause an infection. On 07/12/19 at 3:10 PM, an interview with LPN #3/MDS-Care Plan Nurse, revealed she would expect the staff to do what the care plan states to do to take care of the resident. She also stated when the care plan indicates catheter care as ordered, she would expect the staff to provide care according to the facility's protocol.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657			9/18/19

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F 657	Continued From page 27 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to revise Resident #89's Comprehensive Care Plan for the use of a Foley Catheter for one (1) of 37 resident care plans reviewed. Findings include: Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," dated December 2016, revealed that it is the policy of this facility that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The facility policy stated that assessments of residents are ongoing and care plans are revised as information about the residents and the residents'	F 657	1. On 7/12/19, care plans were immediately reviewed for accuracy for Resident #89. Licensed Practical Nurse (LPN) #1 was in serviced by Director of Nursing on 7/15/19 for following comprehensive care plans by disciplinary action. Resident #89 was assessed by Director of Nursing on 7/12/19, and Resident #89's care plan was revised, as well as monitored by Director of Nursing for one week for any negative outcomes to which none were identified. 2. Ten residents with indwelling Foley catheter's have the potential to be affected by this deficient practice. On 7/12/19, each resident with an indwelling Foley catheter was assessed for comprehensive care plan's related to		

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F 657	Continued From page 28 conditions change. During the initial tour of the facility, on 07/09/2019 at 10:30 AM, it was observed, from the hallway Resident #89's catheter tubing was laying over the top of her bed's side rail, thus it was above the level of her bladder. It was observed that Resident #89's side rail on her bed was in an upright position. During a follow-up observation, on 07/09/2019 at 12:15 PM, it was observed that Resident #89's catheter tubing was still laying across the top of the bed's side rail, which was still in an upright position. Review of Resident #89's medical record document titled, "Care Plan," revealed the Care Plan had not been revised to include upon the resident's return from the hospital, on 06/13/2019, she now had an indwelling Foley catheter. During an interview, on 07/09/2019 at 12:18 PM, Licensed Practical Nurse (LPN) #1, revealed the catheter tubing should not be hanging over the bed's side rail, because it was above the level of Resident #89's bladder. LPN #1 stated that if the catheter tubing was higher than the bladder, it would cause the urine to back up into the resident's bladder causing a Urinary Tract Infection (UTI). During an interview, on 07/09/2019 at 3:11 PM, Registered Nurse (RN) #1/ Infection Control Officer, confirmed the catheter tubing should not be over the bed's side rail, above the level of Resident #89's bladder. RN #1 stated the Certified Nursing Assistants (CNA) know better. RN #1 stated they must have forgotten to	F 657	indwelling Foley catheter care to which no issues were identified. Resident #89's foley catheter was discontinued on 7/11/19 and care plan was updated on 7/11/19 by Minimum Data Set Nurse. 3. A facility wide in-service was initiated on 7/12/19 and completed by 7/25/19, to all nursing staff, by Administrator and Education Nurse, regarding following comprehensive care plans including indwelling Foley catheter policy and procedure. Education Nurse will complete one to one return demonstration for compliance for each staff member by 9/18/19. On 8/22/19 Quality Assurance committee reviewed policy and procedure for comprehensive care plans related to indwelling Foley catheters to which no changes were recommended. 4. Education nurse will observe four catheter care procedures per month for two months for accuracy and proper procedure per facility policy. Quality Assurance Committee will review findings of Education Nurse monthly for two months. All findings will be submitted to Quality Assurance Committee for review and any further discrepancies will be immediately rectified by Quality Assurance Nurse.		

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F 657	Continued From page 29 re-position the catheter after giving her a bath. RN#1 also stated it could have been the hospice CNA. During an interview, on 07/12/2019 at 10:07 AM, Licensed Practical Nurse (LPN) #3/ Care Plan Coordinator, revealed the Care Plan, in regards to Resident #89's indwelling catheter, had not been revised when Resident #89 returned from the hospital on 06/13/2019. During an interview, on 07/12/2019 at 10:19 AM, the Director of Nursing (DON), confirmed Resident #89's Care Plan had not been updated and revised. The DON stated it should have been revised to reflect the resident's status change, regarding the use of a Foley catheter. Review of the Face Sheet revealed Resident #89 was admitted by the facility, on 08/15/2014, with diagnoses to include Cardiac Arrhythmia and Alzheimer's Disease (AD).	F 657			
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	F 690			9/18/19

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F 690	Continued From page 30 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 observations, record review, staff interview, and facility policy review, the facility failed to provide catheter/perineal care in a manner to prevent the possible spread of infection for four of six (4 of 6) catheter care observations, for Resident #7, Resident #88, Resident #89 and Resident #139. Findings include: Review of the facility's policy titled, "Catheter Care, Urinary," dated September 2014, revealed it is the policy of this facility that the purpose of this procedure is to prevent catheter-associated Urinary Tract Infections (UTI). The policy also stated under the general guidelines, that when	F 690	1. On 7/12/19, an immediate in-service was started with the Licensed Practical Nurse (LPN) #1 by disciplinary action. Certified Nursing Assistant (CNA) #1, CNA #2, CNA #3, CNA #4, CNA #5, and CNA #6, including hospice and agency staff members, were in-serviced regarding providing care for Resident #89, Resident #7, Resident #88, and Resident #139. Each resident was assessed for any negative outcomes by Director of Nursing, on 7/12/19 and monitored daily for seven days, to which no negative outcome was found. 2. Eleven residents with Foley catheters		

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F 690	Continued From page 31 maintaining unobstructed urine flow, the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Further review of the policy revealed to prevent catheter-associated Urinary Tract Infections the Steps included in the procedure for a male resident: Use a washcloth with warm water and soap/or cleansing wipe to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth/wipe with each stroke. With a clean wash cloth, if used, rinse with warm water using the above technique. Return foreskin to normal position. Use clean washcloth with warm water and soap/or cleansing wipe to cleanse and rinse the catheter from insertion site to approximately four inches outward. Resident #89 During the initial tour of the facility, on 07/09/2019 at 10:30 AM, it was observed, from the hallway Resident #89's catheter tubing was laying over the top of her bed's side rail, thus it was above the level of her bladder. It was observed that Resident #89's side rail on her bed was in an upright position. During a follow-up observation, on 07/09/2019 at 12:15 PM, it was observed that Resident #89's catheter tubing was still laying across the top of the bed's side rail, which was still in an upright position. Review of Resident #89's medical records document titled "New Physician's Orders	F 690	have potential to be affected by this deficient practice. All eleven residents were assessed on 7/12/19 by Director of Nursing for potential negative outcomes as well as monitored for 7 days, no negative outcomes were found. 3. On 7/12/19, an in-service was initiated by the Quality Assurance Nurse to Nursing and Certified Nursing Assistant staff members who were in-serviced by 7/25/19 regarding Bowel/Bladder Incontinence, Catheter, and urinary tract infection prevention. Education Nurse will complete return demonstration for compliance for Nursing staff, Certified Nurses Assistants, agency staff, and hospice staff by 9/18/19. On 8/22/19, Quality Assurance committee reviewed policy and procedure for catheter and incontinent care for comprehensive care plans to which no changes were recommended. 4. Education nurse will observe four catheter care procedures per month for two months for accuracy and proper procedure per facility policy. Quality Assurance Committee will review findings of Education Nurse monthly for two months. All findings will be submitted to Quality Assurance Committee for review and any further discrepancies will be immediately rectified by Quality Assurance Nurse.		

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NAME OF PROVIDER OR SUPPLIER HATTIESBURG HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 514 BAY STREET HATTIESBURG, MS 39401		
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F 690	Continued From page 32 (Physician Visits and Telephone Orders," dated 06/13/2019, revealed an order for a Foley Catheter for Resident #89. The telephone orders also revealed that catheter care is to be done every shift (Q-shift) and as needed (PRN) per facility policy and procedure. During an interview, on 07/09/2019 at 12:18 PM, Licensed Practical Nurse (LPN) #1, revealed the catheter tubing should not be hanging over the bed's side rail, because it was above the level of Resident #89's bladder. LPN #1 stated that if the catheter tubing was higher than the bladder, it would cause the urine to back up into the resident's bladder causing a Urinary Tract Infection (UTI). During an interview, on 07/09/2019 at 3:11 PM, Registered Nurse (RN) #1/ Infection Control Officer, confirmed the catheter tubing should not be over the bed's side rail, above the level of Resident #89's bladder. RN #1 stated the Certified Nursing Assistants (CNA) know better. RN #1 stated they must have forgotten to re-position the catheter after giving her a bath. RN#1 also stated it could have been the hospice CNA. Review of the Face Sheet revealed Resident #89 was admitted by the facility, on 08/15/2014, with diagnoses to include Cardiac Arrhythmia and Alzheimer's Disease (AD). Resident #7 Record review of the facility's training titled, CNA (Certified Nursing Assistant) Performance And Skills Evaluation revealed the Certified Nursing	F 690			

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F 690	Continued From page 33 Assistants (CNAs) were in-serviced 12/06/2018, 02/14/2019 and 04/15/2019 on providing appropriate catheter care. An observation, on 07/10/19 at 2:24 PM, revealed CNA #2 provided Resident #7's catheter care. CNA #2 washed her hands and applied gloves. CNA #2 applied soap to the wet wipe, and cleansed the right side of the catheter tubing, and then cleansed the left side of the catheter tubing with the same wipe. CNA #2 did not rotate the wipe. CNA #2 rinsed the catheter tubing with a wet wipe without rotating the wipes. During an interview, on 07/10/19 at 3:46 PM, Registered Nurse (RN) #3/Staff Development Nurse revealed the CNAs are trained upon hire and annually on the appropriate way to provide catheter care in a manner to prevent infection. During an interview, on 07/10/19 at 3:49 PM, the Director of Nursing (DON) revealed CNA #2 should have rotated the wipe during the catheter care. The DON said the staff was trained annually how to provide catheter care. An interview, on 07/11/19 at 9:42 AM, CNA #2 confirmed the she failed to rotate the wipes during the catheter care. CNA #2 said she was nervous and did not realize she didn't rotate or change the wipes. Review of the Face Sheet revealed the facility admitted Resident #7, on 01/29/2018, with diagnoses, which included Neurogenic Bladder, Urinary Retention and Stage 4 Pressure Ulcers. A review of Resident #7's Quarterly Minimum Data Set (MDS), with an Assessment Reference	F 690			

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F 690	Continued From page 34 Date (ARD) of 04/2/2019, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident was cognitively impaired. Resident #139 An observation, on 07/10/19 at 2:30 PM, revealed Resident #139's catheter/peri care was provided by CNA #1. CNA #1 washed her hands, applied gloves, and then began to clean the catheter tubing with wet wipes. No concerns were noted. CNA #1 left the room to get more wipes. CNA #1 returned to the room and placed the wipes on the table without a barrier. CNA #1 did not wash her hands, placed gloves on her hand and wiped the shaft of the resident's penis three times and dried the shaft of the penis. CNA #1 did not clean the head of the penis. During an interview, on 07/10/19 at 2:31 PM, RN #3 Staff Development Nurse said the staff was trained upon hire and annually to clean the head of the penis while performing catheter and peri care. RN #3 said CNA #1 should have cleaned the head of the penis by pulling the skin back, and wipe the right and left side in a circular motion with the wipe. During an interview, on 07/10/19 at 2:35 PM, with the DON revealed CNA #1 should have cleaned the head of the penis to prevent infection. During an interview, on 07/11/19 at 9:26 AM, CNA #1 confirmed she forgot to wash the head of Resident #139's penis because she was in a hurry. CNA #1 also said she forgot to put down her barrier.	F 690			

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F 690	Continued From page 35 A review of the Face Sheet revealed the facility admitted Resident #139, on 06/03/2019, with diagnoses which included Neuromuscular Dysfunction of the Bladder, Diabetes Mellitus and Major Depressive Disorder. A review of Resident #139 Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2019, revealed Resident #139 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #88 On 07/09/19 at 2:45 PM, an observation revealed Certified Nursing Assistants (CNAs) #3 and #4 provided Resident #88's catheter care. CNA #3 and #4 washed their hands. CNA #3 set a clean barrier and placed a package of wipes, clean brief, and a box of clean gloves on the barrier. CNA #1 retrieved a clean wipe from the the package and cleaned around the resident's penis head x four (4) using the same wipe, did not rotate the wipe. CNA #3 discarded that wipe, retrieved another wipe from the package of wipes and cleaned around the resident's penis head x four (4) using the same wipe without rotating the wipe again. CNA #3 discarded that wipe, and CNA #3 retrieved another wipe from the package of wipes and cleaned around the resident's penis head x four (4) times using the same wipe and without rotating the wipe. Both CNAs positioned the resident onto his left side to remove the soiled brief and pad. They then positioned the resident onto his right side to finish removing soiled brief and pad. The CNAs applied a clean brief and	F 690			

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F 690	Continued From page 36 pad to the resident. The CNAs discarded all of the soiled items into the biohazard trash and placed the linens in a biohazard linen hamper in the resident's room. Neither CNA cleaned the catheter tubing. The CNAs repositioned the resident on his left side, placed the catheter drainage bag on the left side of the bed, ensured the catheter securing device was in place, covered the resident up, and washed their hands. On 07/10/19 at 9:15 AM, an observation revealed CNA #5 and #6 provided Resident #88's catheter care. CNA #5 set up her supplies; water basin, placed two clear trash bags on the foot of the resident's bed, a box of gloves, and a package of wipes. Both CNAs applied clean gloves, and CNA #5 removed several clean wipes from the package of wipes, and CNA #5 placed the wipes on the resident's bed. CNA #5 wet the washcloth with soap and water and wiped the resident's right groin area in a back and forth motion without rotating the washcloth. She then wiped the resident's left groin area in a back and forth motion multiple times. CNA #5 retrieved a wipe and anchored the resident's catheter tubing nearest the meatus and wiped in an outward motion x four (4) in a back and forth motion and without rotating the wipe. She retrieved another wipe and wiped the resident's catheter tubing in a back and forth motion x four (4), and without rotating the wipe. While using a dry towel, CNA #5 dried the area also using a back and forth motion four (4), and dried the catheter tubing again by patting around the catheter tubing and penis area x six (6) without rotating the dry towel. On 07/11/19 at 10:05 AM, an interview with CNA #5, revealed she should have wiped in a downward motion and should have rotated her	F 690			

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F 690	Continued From page 37 washcloth. She also stated wiping in a back and forth motion is cross contamination and could cause an infection. On 07/11/19 at 10:15 AM, an interview with CNA #6, revealed she placed the wipes on the resident's bed, and could have used a barrier before sitting them on the resident's bed covers or placed them in the clean plastic bag. She also stated the wipes became contaminated by sitting them on the resident's bed covers. On 07/11/19 at 10:20 AM, an interview with Registered Nurse (RN) #4/Unit Manager, revealed the CNA should not have wiped in a back and forth motion. RN #4 stated the CNA should have wiped in a downward motion one time and discarded the wipe. Donna stated, if the CNA was using a towel, she should have rotated the towel. She also stated, it is not okay to wipe in a back and forth motion, because it introduces germs back up the catheter and into the bladder and could cause a Urinary Tract Infection. On 07/11/19 at 11:25 AM, an interview with CNA #3, revealed she should have rotated her wipe as she was cleaning the resident's penal area. She stated she should have made the wipe to fit around her hand like a glove so she could have rotated it. She also stated, she should have held the catheter tubing at the end near the penis and wiped away from the penis. On 07/11/19 at 11:35 AM, an interview with CNA #4, revealed when cleaning the catheter tubing the CNA should hold it at the end close to the penis and wipe away from the penis and throw the wipe away.	F 690			

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F 690	Continued From page 38 On 07/11/19 at 2:05 PM, an interview with RN #1/Infection Control Nurse, revealed CNA #3 should have rotated or thrown that wipe away and obtained another one, and not use the same wipe. She also stated the CNA should have cleaned from the meatus area outward on the catheter tubing. On 07/11/19 at 2:10 PM, an interview with RN #1/Infection Control Nurse, revealed when CNA #6 placed the wipes that was pulled from the package on the resident's covers with no barrier present, that contaminated the wipes. She stated CNA #6 should have used a barrier. She also stated CNA #5 should have wiped once or only used one wipe and rotated that wipe and never clean in a back and forth motion. She also stated she should have wiped the catheter tubing once in an outward motion from the meatus area and thrown the wipe away and never wipe in a back and forth motion. On 07/12/19 at 10:45 AM, an interview with the DON, revealed the CNAs should not have gone from dirty to clean because they can introduce bacteria which could cause an infection.	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 care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695			9/18/19

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F 695	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, resident interview, and staff interview, the facility failed to provide tracheostomy care in a manner to prevent cross contamination for two (2) of three (3) residents observed for tracheostomy care, (Resident #22 and Resident #88) and failed to provide nebulizer treatment under staff supervision for one (1) of two (2) resident nebulizer treatment observations. (Resident #86) Findings include Review of the facility's policy titled, "Administering Medications Though a Small Volume (Handheld) Nebulizer," dated October 2010, revealed it is the policy of this facility that the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into resident's airway. The facility policy stated that one of the steps in the procedure was to remain with the resident for the treatment. Resident #86 During an observation, on 07/10/2019 at 9:30 AM, revealed Resident #86 was in her room, lying in bed, with a nebulizer treatment in progress. Further observation revealed there was no staff or nurse present in the room, or nearby in the hallway. Review of Resident #86's medical record documentation titled, "Physician's Orders" dated July 2019, revealed an order, dated 11/27/2018, for one (1) vial containing 0.25 milligrams (mg) of the medication budesonide (a steroid) to be	F 695	1. On 7/12/19, an immediate assessment was done on Resident #22 and Resident #88 to verify no adverse effects. Both residents were assessed on 7/12/19 and monitored for seven days by Assistant Director of Nursing along with Nurse Practitioner and Physician Assistant, to which no adverse effects were found. Nurses and Respiratory Therapist providing care for tracheostomy patients were in-serviced on 7/12/19 from Director of Nursing regarding tracheostomy care and tracheal suctioning. 2. Ten tracheostomy residents and twenty-six residents receiving nebulizer treatments have potential to be affected by this deficient practice. On 7/12/19, all tracheostomy residents and nebulizer residents were assessed by Director of Nursing for any issues regarding negative outcomes and were monitored for seven days by Quality Assurance nurse. No adverse affects were found. 3.. All Nurses and Supervisors who care for tracheostomy patients were in-serviced by outside Respiratory Therapist on 7/31/19 including competency return demonstrations. Nursing and certified nursing assistant staff members were in-serviced by Education Nurse regarding nebulizer treatments and correct policy and procedure regarding the plan of care. On 8/22/19, the Quality Assurance committee reviewed the tracheostomy care policy		

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F 695	Continued From page 40 suspended in a Two (2) milliliters (ml) of saline solution, given via a Nebulizer, two (2) times (x) a day (BID). Review of Resident #86's medical record documentation titled, "E-Mar" (Electronic Medication Administration Record), revealed that one (1) vial containing 0.25 milligrams (mg) of the medication budesonide (a steroid) to be suspended in a Two (2) milliliters (ml) of saline solution, given via a Nebulizer was administered on 7/10/2019 at 9:30 AM, by Licensed Practical Nurse (LPN) #1. During an interview, on 7/10/2019 at 9:30 AM, with Resident #86, she stated the nurse never stays in the room for the entire treatment time. Resident #86 stated, sometimes when it is finished, I just take the mask off myself. An interview, on 07/11/2019 at 3:44 PM, revealed License Practical Nurse (LPN) #2/ Transitional Care Nurse, stated he was supervising the morning of 07/10/2019. LPN #2 said he was aware Resident # 86 was receiving a nebulizer treatment, but he had left the room to go check on something and left the resident alone with a nebulizer treatment in progress. LPN #2 stated he was aware that a nurse should remain with the resident for the duration of the treatment to monitor response and effectiveness of the treatment. A telephone interview, on 07/11/2019 at 4:26 PM, with Licensed Practical Nurse (LPN) #1, revealed she was the nurse who started the nebulizer treatment for Resident #86 on 7/10/2019. LPN #1 stated she got very busy preparing the rest of Resident #86's medications and did not stay with	F 695	and procedure and no changes were recommended. 4. Education nurse will observe three tracheostomy care procedures and three respiratory treatments for compliance every month for two months for accuracy. Quality Assurance Committee will review findings of Education Nurse monthly for two months. All findings will be submitted to Quality Assurance Committee for review and any further discrepancies will be immediately rectified by Quality Assurance Nurse.		

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F 695	Continued From page 41 the resident for the duration of her nebulizer treatment. LPN #1 said she knew it was the facility's policy for the nurse to stay with a resident during a nebulizer treatment until it was finished. An interview, on 07/12/2019 at 10:19 AM, with the Director of Nursing (DON), confirmed that the nurse should have stayed with the resident for the duration of the nebulizer treatment. The DON stated that the correct way for administering nebulizer treatments is in the facility's policy for nebulizer treatments administration. The DON said the nurse should have stayed with the resident Review of the Face Sheet revealed Resident #86 was admitted by the facility on 06/3/2015 and re-admitted the resident on 12/15/2015, with diagnoses to include Pressure Ulcer of the Sacral Region and Chronic Obstructive Pulmonary Disease (COPD). Resident #22 On 07/10/19 11:42 AM, an observation revealed Licensed Practical Nurse (LPN) #4 provided Resident #22's tracheostomy care. LPN #4 washed her hands and applied the sterile gloves just like they were regular gloves. She removed the tracheostomy dressing and inner cannula. LPN #4 washed her hands and applied clean gloves. She then cleaned around the tracheostomy plate area and around the inner cannula with a sterile water moistened 4x4 using a back and forth motion x six (6). She moistened a Q-tip with the sterile water and cleaned the inner cannula area in a back and forth motion multiple times and discarded the Q-tip. LPN #4 retrieved another Q-tip, moistened it with sterile	F 695			

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F 695	Continued From page 42 water and cleaned the inner cannula area in a back and forth motion and discarded it. She then moistened a 4x4 gauze with sterile water and cleaned the neck plate wiping it in a back and forth motion multiple times and discarded it. She washed her hands, applied clean gloves, and placed a new inner cannula. She discarded all the soiled supplies. On 07/12/19 10:15 AM, an interview with LPN #4, revealed she should have wiped in one direction and thrown the 4x4 gauze and Q-tip away while providing tracheotomy care to Resident #22. She also stated wiping in a back and forth motion would cause cross contamination. On 7/12/19 at 10:35 AM, during an interview with the Director of Nursing (DON), the DON revealed LPN #4 should not have gone from dirty to clean, because that is cross contamination and could cause an infection. She also stated the nurse should have maintained a sterile technique with handling the inner cannula Resident #88 On 7/9/19 at 10:50 AM, an observation revealed the Respiratory Therapist (RT) entered the resident's room to provide Resident #88's tracheostomy care. The RT set up his supplies. He attempted to put on the sterile gloves that were in the packet but changed his mind and wrote the current date on the sterile water bottle. He organized his supplies, poured the sterile water into a clear plastic basin that he removed the sterile gloves and other tracheostomy supplies from the Tracheostomy Care Tray kit and placed the items on the barrier. He applied the sterile gloves that he had bought into the	F 695			

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F 695	Continued From page 43 room with him, moistened a 4x4 gauze with the sterile water, and cleaned around the tracheostomy neck plate x eight (8) in a back and forth motion using the same 4x4 gauze without rotating the gauze. He then retrieved another gauze, moistened it with the sterile water and cleaned around the tracheostomy neck plate again using a back and forth motion x 10, and did not rotate the 4x4 gauze. He removed the inner disposable cannula and changed his gloves. The RT cleaned around the tracheostomy inner cannula area using a 4x4 moistened gauze with sterile water wiping in a back and forth motion x six (6) and again did not rotate the gauze. He then used a Q-tip moistened with sterile water and cleaned around the tracheostomy inner cannula area in a back and forth motion x 10. The RT retrieved another Q-tip, moistened it with sterile water, and cleaned again around the tracheostomy inner cannula area using a back and forth motion x eight (8). He obtained a 4x4 gauze, moistened it with sterile water and wiped around the tracheostomy inner cannula area in a back and forth motion x four (4). He retrieved another 4x4 gauze, moistened it with sterile water and wiped around the tracheostomy inner cannula area in a back and forth motion x eight (8) without rotating the gauze. He placed a new inner cannula in the tracheostomy and disposed of the soiled supplies in the biohazard trash can in the resident's room. On 7/11/19 at 1 45 PM an interview with the RT, revealed, he probably should have washed his hands during glove changes. He also stated he did not have his "bag" and likes to have his soiled utility bag. The RT stated, he has an injury to his left smallest finger, so he could not wear the sterile gloves that were in the Tracheostomy kit.	F 695			

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NAME OF PROVIDER OR SUPPLIER HATTIESBURG HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 514 BAY STREET HATTIESBURG, MS 39401		
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F 695	Continued From page 44 He stated because he knew Resident #88, he felt like he could provide tracheostomy care to the resident on room air and did not need to pre-oxygenate the resident prior to providing tracheostomy care. He also stated he had checked the O2 sat but forgot to tell the surveyor. The RT stated he could contaminate the area by not rotating the gauze or throwing away the gauze after wiping one time. He stated he would have most definitely done things differently, such as letting the surveyor know that he had checked the 2 sat, he would pre-oxygenate before providing O tracheostomy care, and he would wipe once and discard the 4x4s and/or Q-tips. On 7/11/19 at 2:05 PM an interview with Registered Nurse (RN) #1/Infection Control Nurse revealed, the RT should have wiped the area once and thrown the 4x4 gauze away and wiped with a circular motion with the Q-tip once, thrown it away, and gotten another one to wipe again. An interview, on 07/10/19 8:36 AM with the Doctor revealed, the resident coded as a result of respiratory failure and had to receive the tracheostomy. Review of the Physician's Orders, dated July 2019, revealed the following orders: Suction tracheostomy site per policy and procedure prn (as needed) and as ordered by a physician. Change tracheostomy tubing, oxygen delivery, mask, T-tube (tracheostomy tube) and oxygen humidifier bottles and tubing prn. Change tracheostomy tubing, oxygen delivery, mask, T-tube and oxygen humidifier bottles and tubing prn. Oxygen sign on front and back of door.	F 695			

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F 695	Continued From page 45 Check O2 sats (oxygen saturations) prn notify MD if sats < (less than) 88% (percent). Check O2 sats Q (every) shift, notify MD (Medical Doctor) if O2 sat is < 88%. Humidified O2 @ (at) 2 liters per trach mask T-tube. Chest physiotherapy (CPT) or positive expiratory pressure (PEP) therapy prn airway clearance, prevent or treat atelectasis. Pulmonary lavage with sterile normal saline per tracheostomy per licensed nurse or Registered Respiratory Therapist. May use 2-4 ML (milliliters) 20% mucomyst nebulized or via instillation with pulmonary lavage Q 4 hrs prn. Tracheostomy HME (heat and moisture exchanger) applied to tracheostomy as needed for humidification when out of bed (use only if resident's secretions are thick). EzPAP (positive airway pressure therapy) via (by) tracheostomy x15 minutes prn lung expansion, airway clearance per licensed nurse or respiratory therapist. May use 3 ML 7% NaCL/duoneb (sodium chloride/dual nebulizer) 2 ML mucomyst. Mouth care every shift. Suction secretions from oral cavity prn. Notify MD if tracheostomy is dislodged. Type and size of tracheostomy, #8 Shiley DCT (disposable cuff tube). Document characteristics and amount of sputum secretions. A review of the Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/28/19, revealed the MDS was coded to include tracheostomy care.	F 695			
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		9/18/19	

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F 812	Continued From page 46 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to clean the drip pan under the stove burners in a timely manner to prevent the potential for fire, for one (1) of three (3) days Kitchen observations. Findings Include: Review of the facility's policy titled, "Cleaning Instructions Range and Griddle Ovens", with an originated date of 09/04, revealed it is the facility's policy that the equipment shall be maintained in a clean and sanitary condition. Empty the broiler grease pan daily, or whenever it is 1/2 full. The drip shield, grids and grease pan/trough should be washed with a mild grease dissolving solution. Scrub the broiler chamber and body front frequently to reduce smoking. Review of the Cleaning Schedule revealed the back stove was scheduled to be cleaned on	F 812	1. On 7/12/19, an immediate in-service was initiated by the Dietary Manager to all dietary staff members, and completed by 7/30/19, regarding cleaning assignments. On 7/10/19, the identified drip pan was immediately cleaned by Dietary Manager Assistant. 2. All facility residents have potential to be affected by this deficient practice. A complete audit of cleaning logs were completed on 7/12/19 by the Dietary Manager and no other areas were identified as not completed in a timely manner. 3. On 7/12/19, the Dietary Manager implemented revised and more detailed staff cleaning assignments designating specific employees to specific duties. On 8/22/19, the Interdisciplinary Team		

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F 812	Continued From page 47 07/02/2019. The schedule was not signed by the Cook. An observation of the Kitchen, on 07/10/19 at 10:42 AM, revealed the back stove drip pan had a large amt of thick black carbon build up. The Cook immediately removed the pan and cleaned it. During an interview, on 07/10/19 at 12:46 PM, the Dietary Manager revealed the Cook did not clean the stove the day it was due because they were short of staff. The Cook said she did not get a chance to clean the stove. The Dietary Manager said the stove could catch on fire if it's not cleaned in a timely manner.	F 812	reviewed the policy on kitchen cleaning policies and procedures and no recommendations to change the policy were made. 4. Effective 7/12/19 he Dietary Manager will monitor weekly for six weeks to verify staff are completing log as well as specific duties in a timely manner. Any findings will be reported to the Administrator immediately and addressed at the next monthly Quality Assurance meeting for review. Any discrepancies will be immediately rectified by the Dietary Manager and reported to the Administrator.		

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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 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to properly maintain exit egress in accordance to NFPA sections 19.2.1 and 7.1.10.1. This condition affected one (1) of eight (8) exits on the day of survey. Findings include: On July 10, 2019 at 10:55 AM, observation revealed B Hall exit door near Room B13 did not release and open to the public way upon activation of the fire alarm and sprinkler systems. This exit door was obstructed by a magnetic holding device, which shall release upon activation of the fire alarm and sprinkler systems. The finding was acknowledged by the Administrator and verified by the Maintenance	K 211	1. On 7/10/2019 the exit door on B hall near room B13 was immediately repaired by the maintenance supervisor to release upon activation of the fire alarm and sprinkler system. 2. 17 residents have the potential to be effected by this exit door malfunction. 3. 7/10/2019 Maintenance supervisor and maintenance workers were in-serviced on the importance of exit door release with the fire alarm and sprinkler system activation. 4. The maintenance supervisor will monitor all exit doors for proper working conditions with activation of the fire alarm		7/29/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/30/2019

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

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K 211	Continued From page 1 Supervisor during the exit interview on 7/10/19.	K 211	system, 3X per X4 months. Any malfunctions will be repaired immediately. Any malfunctions will be reported immediately to administration and the safety committee.		

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E 000	Initial Comments ***** Survey conducted on 07/09/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000			

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