STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045458	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COTTAGE LANE HEALTH AND REHAB	800 BROOKSIDE DRIVE LITTLE ROCK, AR 72205

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation of resident dining on [DATE]20 at 12:54 p.m., the facility failed to ensure residents were consecutively served meals for 5 (Residents #5, #22, #52, #61, and #79) of 13 (Residents #5, #8, #17, #19, #20, #22, #43, #48, #52, #61, #62, #78, and #79) sampled residents who received meals in the Dining Room. This failed practice had the potential to affect 13 residents who received meals in the Dining Room. The findings are: 1. On [DATE]20 at 12:54 p.m., Resident #19 self-propelled a wheelchair into the Dining Room and settled at the table, to the right of the 100 Hall entrance to the Dining Room with Resident #61. Resident #19 was immediately served the first meal in the Dining Room. Resident #19 completed intake of the meal and left the Dining Room at 1:07 p.m. Resident # 61 was served at 1:10 p.m. 2. On [DATE]20 at 12:55 p.m., Resident #20 was sitting at the table in the center of the 100 Hall entrance of the Main Dining Room and was served. Resident #5 and Resident #52 were also seated at the table and were not served at this time. Resident #52 was served at 1:11 p.m. and Resident #5 was served at 1:12 p.m. 3. On [DATE]20 at 12:55 p.m., Resident #78 and Resident #48 were sitting at the first table in the second row to the right of the 100 Hall entrance and were served. Resident #79 was also seated at the table and was not served at this time. Resident #79 was served at 12:58 p.m. 4. On [DATE]20 at 12:55 p.m., Resident #17 was sitting at the center table in the second row of the 100 Hall entrance of the Main Dining Room and was served. Resident #22 was also seated at the table and was not served at this time. Resident #22 was served at 1:07 p.m.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure comprehensive care plans were updated to include diabetic foot care for 1 (Resident #25) of 1 sampled resident who was Diabetic and required foot care, and 1 (Resident #36) of 2 (Residents #36 and #47) sampled residents who required assistance with oral care and resided on the 300 Hall. This failed practice had the potential to affect 2 residents who resided on the 300 Hall, based on a list provided by the Director of Nursing (DON) on 3/13/2020 at 11:15 a.m. The findings are: 1. Resident #25 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 12/23/19 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; required extensive assistance of one person for transfer and dressing; and was totally dependent on one person assistance for eating, personal hygiene, and bathing. a. On 3/11/20 at 1:30 p.m., the Director of Nursing (DON) was asked, Why is the resident without any footwear? She stated, He likes to go bare-footed. She was asked if he was Care Planned for that. She stated, No. She was asked if the resident's feet should be dirty. She stated, No. b. A facility policy titled Nursing Care of a Resident with Diabetes Mellitus provided by Licensed Practical Nurse (LPN) #4 on 3/13/2020 at 9:30 a.m. documented, .Skin and Foot Care .1. Skin should be kept as dry and clean as possible . 4. Bathe feet in warm (not hot) water as necessary to keep clean . 6. Encourage the use of non-constricting, well-fitting shoes, slippers and hose . 7. Keep feet warm without the use of external heat sources (e.g. (such as) heating pads) . c. As of 3/10/2020 at 2:04 p.m., the Care Plan contained no documentation related to diabetic foot. d. A facility policy titled Goals and Objectives for Care Plans provided by the Administrator on 3/13/2020 at 9:18 a.m. documented, .4. Goals and objectives are entered on the resident's Care Plan so that all disciplines have access to such and are able to report whether or not the desired outcomes are being achieved . 2. Resident #36 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 1/6/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); was totally dependent on two-person assistance for bed mobility and transfers; was totally dependent on one-person assistance for locomotion on and off the unit, dressing, eating, personal hygiene, and bathing; required oxygen therapy, suctioning, and [MEDICAL CONDITION] care, and received [MEDICATION NAME] feeding via a Percutaneous Endoscopic Gastrostomy (PEG) tube. a. A Care Plan with a revised date of [DATE] documented, . is dependent on staff for . r/t (related to) [MEDICAL CONDITION] . Interventions . needs assistance with ADLs (Activities of Daily Living) as required during the activity . potential for a communication problem r/t [MEDICAL CONDITION] . Goal . Needs will be anticipated and met . Intervention . Anticipate and meet needs . Staff must anticipate all of her needs and render care as appropriate . Personal Hygiene . (Resident) requires total assistance (times) 1 staff with personal hygiene care . b. A physician's orders [REDACTED]. [MEDICATION NAME] Solution ([MEDICATION NAME]) 15 ml (milliliters) dental two times a day related to Deposits (Accretions) on teeth . c. On 3/11/2020 at 2:12 p.m., Licensed Practical Nurse (LPN) #1 was asked, How often does a resident receive oral care? LPN #1 stated, We are not doing that right now. We swab her BID (twice a day) early in the morning and again in the day for gingivitis. She was asked, Does she have her own teeth? LPN #1 stated, Yes. LPN #1 was asked to lift the resident's upper and lower lip so the residents' teeth were visible. The resident's tongue was clear, the upper gums were red and inflamed, and the resident was missing numerous upper teeth. The resident's lower teeth had thick, white, semicircular areas following the gum line around the lower aspect of teeth, and the lower gums were red and inflamed. (The Surveyor took a photograph of the resident's upper and lower teeth at this time.) LPN #1 was asked, How much assistance does the resident need with ADLs? LPN #1 stated, She is totally dependent with one to two-person assistance. She was asked, Is assistance with ADLs provided in a timely manner, according to the resident's preferences and the Care Plan? LPN #1 stated, Yes.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure diabetic foot care was provided for 1 (Resident #25) of 1 sampled resident who was dependent for assistance with diabetic foot care; failed to ensure oral care was provided for 1 (Resident #36) of 2 (Residents #36 and #47) sampled residents who required assistance with oral care; and failed to ensure facial hair was removed for 1 (Resident #36) of 1 sampled resident who was dependent for facial hair removal. This failed practice had the potential to affect 70 residents who required assistance with activities of daily living, according to the Resident Census and Condition of Residents form dated [DATE]20. The findings are: 1. Resident #25

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

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set Assessment with an Assessment Reference Date of 12/23/19 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status, required extensive assistance of one person for transfer and dressing, and was totally dependent of one person for eating, personal hygiene, and bathing. a. On [DATE]20 at 2:39 p.m., Resident #25 was sitting in a wheelchair and had no shoes or socks on his feet. The bottom of the resident's right foot had multiple areas of varying brownish-blackish discoloration. The bottom of the resident's left foot was not visible due to the residents' position while sitting on the Day Room couch. b. On 3/11/2020 at 1:13 p.m., the resident's feet had a brownish discoloration on the bottom of both feet. c. On 3/11/2020 at 1:30 p.m., the Director of Nursing (DON) was asked, Why does the resident not have any footwear on? She stated, He likes to go bare-footed. She was asked if he was Care Planned for that. She stated, No. She was asked if the resident's feet should be dirty. She stated, No. d. A facility policy titled Nursing Care of a Resident with Diabetes Mellitus provided by Licensed Practical Nurse (LPN) #4 on 3/13/2020 at 9:30 a.m. documented, .Skin and Foot Care .1. Skin should be kept as dry and clean as possible . 4. Bathe feet in warm (not hot) water as necessary to keep clean . 6. Encourage the use of non-constricting, well-fitting shoes, slippers and hose . 7. Keep feet warm without the use of external heat sources (e.g. heating pads) . 2. Resident #36 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 1/6/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); was totally dependent on two-person assistance for bed mobility and transfers; was totally dependent on one-person assistance for dressing, eating, personal hygiene, and bathing; required oxygen therapy, suctioning, and [MEDICAL CONDITION] care; and received enteral feeding via a Percutaneous Endoscopic Gastrostomy (PEG) tube. a. A Care Plan with a revised date of 12/2/2019 documented, . is dependent on staff for ADLS (activities of daily living) . r/t (related to) [MEDICAL CONDITION] . Interventions . needs assistance with ADLs (Activities of Daily Living) as required during the activity . potential for a communication problem r/t [MEDICAL CONDITION] . Goal . Needs will be anticipated and met . Intervention . Anticipate and meet needs . Staff must anticipate all of her needs and render care as appropriate . Personal Hygiene . requires total assistance (times) 1 staff with personal hygiene care . b. A physician's orders [REDACTED]. [MEDICATION NAME] Solution ([MEDICATION NAME]) 15 ml (milliliters) dental two times a day related to Deposits (Accretions) on Teeth . c. On 3/10/2020 at 4:37 p.m., Licensed Practical Nurse (LPN) #1 was asked, Who is responsible for the hair removal on her (the resident's) chin? LPN #1 stated, We try to do that daily, but for sure on days she gets a shower. Several gray hairs were on the left side of the resident's chin, approximately 1/4 inch in length. LPN #1 was asked, How often does the resident receive oral care? LPN #1 stated, We are not doing that right now. We swab her BID (twice a day) early in the morning and again in the day for gingivitis. She was asked, Does she have her own teeth? LPN #1 stated, Yes. LPN #1 was asked to lift the residents' upper and lower lip so the Surveyor could view the resident's teeth. The resident's tongue was clear, the upper gums were red and inflamed, and the resident was missing numerous upper teeth. The resident's lower teeth had thick, white, semicircular areas following the gum line around the lower aspect of her teeth, and the lower gums were red and inflamed. (The Surveyor took a photograph of the resident's upper and lower teeth at this time.) d. On 3/11/2020 at 2:12 p.m., LPN #1 was asked, How much assistance does the resident need with ADLs (activities of daily living)? LPN #1 stated, She is totally dependent with one to two-person assist. She was asked Is assistance with ADLs provided in a timely manner, according to the resident's preferences and the Care Plan? LPN #1 stated, Yes. She was asked, Are all procedures explained and the resident given time to respond to changes in care? LPN #1 stated, A lot of them know her and know everything about her and give her more attention. She don't like nobody messing with her mouth and they are aware of that. She was asked, Has the resident had a decline in ability to independently perform any ADLs? LPN #1 stated, The resident has been like this for two years. Movement in her neck has improved, and I have seen her move her limbs which may be a spasm but sometimes I feel like she is improving with the passive range of motion. She was asked, How do you monitor staff to ensure they are implementing Care-Planned interventions? LPN #1 stated, One thing is looking to see, and since the resident cannot speak, I have to check behind them. She has never had any skin breakdown. She was asked, What about (Resident #36's) oral care? LPN #1 stated, We use the soft pink swabs to clean them and she tolerates that better than some. She was asked, Has the dentist been in to see her? LPN #1 stated, The dentist has not seen her in three months, since I have been on days. Before that, I cannot answer that question. e. On 3/13/2020 at 8:14 a.m., the Director of Nursing (DON) was asked, Can you tell me why (Resident #36) has not seen a dentist? The DON stated, She should have seen one because she has an order for [REDACTED]. A Progress Note dated 3/13/2020 at 8:43 a.m. provided by the DON on 3/13/2020 at 9:00 a.m. documented, . Note Text . This nurse consulted with Medical Director, APN (Advanced Practice Nurse), and a general dentist regarding the possibility of (Resident #36) being seen by an on-site dentist. All practitioners state that being seen by a dentist would not be recommended for (Resident #36). She is resistant to care, or anything being inserted into her mouth . g. A Clinical Note dated 1/13/2020 and provided by the DON on 3/13/2020 at 9:21 a.m., documented, . Assessment and Plan . 2. [MEDICAL CONDITION] secretions . [MEDICATION NAME] solution 15ml (milliliters) for oral care BID (twice daily) . 3. A facility policy titled Mouth Care provided by the Director of Nursing on 3/13/2020 at 9:00 a.m., documented, .Preparation 1. Review the resident's Care Plan to assess for any special needs of the resident . Steps in the Procedure . 3. Allow the resident who is able to provide his / her own mouth care to do so . 12. Thoroughly wipe the roof of the resident's mouth, inside the cheeks, the tongue and the teeth with the applicator . a. A facility policy titled Teeth, Brushing provided by the Director of Nursing on 3/13/2020 at 9:00 a.m., documented, . General Guidelines . 1. A resident should be assisted with brushing his or her teeth based on his or her individual needs . 5. Should the resident be unable to sit up, position the resident so that his or her face extends over the edge of the pillow, facing you .
F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents consistently received enteral nutrition as ordered by a physician to ensure adequate nutritional and caloric intake for 1 (Resident #36) of 3 (Residents #36, #49 and #86) sampled residents who had physician's orders [REDACTED]. This failed practice had the potential to affect 7 residents who had physician's orders [REDACTED]. The findings are: Resident #36 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 1/6/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); was totally dependent on two-person assistance for bed mobility and transfers; was totally dependent on one-person assistance for dressing, eating, personal hygiene, and bathing; required oxygen therapy, suctioning, and [MEDICAL CONDITION] care, and received enteral feeding via a Percutaneous Endoscopic Gastrostomy (PEG) tube. a. A Care Plan dated 11/15/2019 documented, . is at risk for decline in nutrition and is at risk for dehydration as evidenced by . she requires tube feeding . Interventions . Flushes and Feedings as per orders . b. A physician's orders [REDACTED].Enteral Feed Order every shift [MEDICATION NAME] 1.5 (at) 40 cc/hr (cubic centimeters per hour) via [DEVICE] (gastrostomy tube) (times) 23 hr/day (hours per day) . Flush with 40cc water every two hours (times) 23 hr/day . Flush with 60cc water when going on / off of pump . Flush with 60cc water before and after med (medication) pass . Monitor for tolerance of formula / feeding regimen . c. On 3/11/2020 at 11:32 a.m., the resident's tube feeding pump was not running. (The surveyor took a photograph of the feeding pump at this time.) d. On 3/11/2020 at 11:46 a.m., Licensed Practical Nurse (LPN) #1 was asked, Should the tube feeding pump be running? LPN #1 stated, Yes. I turned it off earlier during care and forgot to restart it. LPN #2 restarted the resident's feeding pump. LPN #1 was asked, Can you explain how you know the flush is set and running? LPN #1 stated, You push this button to switch it and it shows you on the screen what it will run at; and see this green light, that indicates it will turn on when it is supposed to. It is set to go. e. On 3/11/2020 at 2:59 p.m., LPN #1 was asked, What are the specific care needs for the resident such as feeding taken in? LPN #1 stated, Her tube feeding is based upon her calorie count, and that comes from the recommendation from the dietitian. She was asked, How did you decide whether the tube feeding was adequate to maintain acceptable nutrition and hydration parameters or when to reevaluate and make adjustments? LPN #1 stated, We weigh her, and also like labs (laboratory tests) are performed; and one time, sodium was high, and the doctor wrote order to adjust for that and monitor skin issues. She was asked, How do you ensure the Care Plan is implemented correctly? LPN 1 stated, One thing is looking and see, and since resident cannot speak, I have to check behind them. She has never had any skin

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F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) breakdown. She was asked, How do you manage and monitor the rate of flow of the amount of feeding being administered for consistency with orders? LPN #1 stated, Her overall health status, dietician review of weights and labs, and physician review of weights and labs. f. On 3/13/2020 at 8:49 a.m., LPN #1 was asked, Is it important for someone who cannot eat to receive physician ordered nutrition as ordered? LPN #1 stated, It is all monitored by the dietician. She was asked, If the resident does not receive nutrition consistently, what would the negative outcome be? LPN #1 stated, Skin breakdown and weight loss. She was asked, Is the resident experiencing weight loss? LPN #1 stated, (Resident #36 is not prone to weight loss. g. A facility policy titled Gastric Tube feeding via Continuous Pump provided by the Director of Nursing (DON) on 3/13/2020 at 9:00 a.m. documented, . The purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally . Steps in the Procedure . 10. Connect the infusion pump, set the rate and push start to begin continuous feedings .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure oxygen was consistently administered at the flow rate ordered by the physician, to minimize the potential for [MEDICAL CONDITION] or other respiratory complications for 1 (Resident #36) of 2 (Residents #36 and #52) sampled residents who had physician's orders [REDACTED]. The findings are: Resident #36 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 1/6/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); was totally dependent on two-person assistance for bed mobility and transfers; was totally dependent on one-person assistance for dressing, eating, personal hygiene, and bathing; required oxygen therapy, suctioning, and [MEDICAL CONDITION] care, and received enteral feeding via a Percutaneous Endoscopic Gastrostomy (PEG) tube. a. A Care Plan dated 10/13/2016 documented, .Focus . has a [MEDICAL CONDITION] and is at risk Impaired breathing mechanics r/t (related to) (chronic [MEDICAL CONDITION]) . Interventions . give humidified oxygen . [MEDICAL CONDITION] 02 (oxygen) at 4 liters . b. A physician's orders [REDACTED].Oxygen (at) 2 Liters [MEDICAL CONDITION] every shift . c. On [DATE]20 at 1:51 p.m., the resident's oxygen concentrator was set at 2.5 liters per minute (LPM). (The Surveyor took a photograph of the oxygen flow rate setting at this time.) d. On 3/11/2020 at 11:32 a.m., the resident's oxygen concentrator flow rate was set at 4 LPM. (The Surveyor took a photograph of the oxygen flow rate setting at this time.) e. On 3/11/2020 at 11:46 a.m., Licensed Practical Nurse (LPN) #1 was asked, What should the oxygen flow rate be set on? LPN #1 stated, 2 liters (per minute). She was asked, What is it set on? LPN #1 stated, 4 liters. f. On 3/11/2020 at 2:32 p.m., LPN #1 was asked, How are correct settings communicated from one staff person to another? LPN #1 stated, The oxygen is per her orders. We can leave it up if it goes below 93%, we can adjust it up to where it needs to be. g. On 3/13/2020 at 8:49 a.m., LPN #1 was asked, Was (Resident #36) having respiratory issues this week? LPN #1 stated, No. None. She was asked, Was there a reason her oxygen was at 4 liters per minute (LPM) on Tuesday? LPN #1 stated, We had to lay her down and give her better oxygenation during care. She was asked, Why did you not check her oxygen level before turning it back to 2 LPM? LPN #1 stated, I don't check it all the time. It is mostly under precautionary measures. h. A facility policy titled [MEDICAL CONDITION] Care - Suctioning provided by the Director of Nursing on 3/13/2020 contained no documentation related to oxygenation.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of the 4:00 p.m. medication pass on 3/10/2020, record reviews and interview the facility failed to ensure physician's orders were followed to maintain a medication error rate of less than 5% to prevent potential complications for 2 (Residents #24 and #61) of 8 residents observed during the medication pass resulting in medication errors. Medication errors were made by 1 Licensed Practical Nurse (LPN), LPN #2 of 3 LPNs observed administering medications in the facility. This failed practice had the potential to affect 26 residents who received medications administered by LPN #2 on 100 hall, based upon the Daily Census by Hall List provided by the Administrator on [DATE]20 at 12:03 p.m. The medication error rate was 8% based on observation of 25 medications administered, and a total of 2 medication errors detected. The findings are: 1. Resident #61 had a [DIAGNOSES REDACTED]. a. A Physician's Order dated 3/5/2020 documented, .[MEDICATION NAME] N Suspension 100 Units/ml (units per milliliter) ([MED] NPH (Human) ([MEDICATION NAME])) Inject as per sliding scale . if 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units, subcutaneously before meals and at bedtime . for blood sugar greater than 400 or less than 60 call MD (Medical Doctor) . b. On 3/10/2020 at 3:51 p.m., Licensed Practical Nurse (LPN) #2 removed a glucometer from the 100 Hall medication cart. She stated, I have to get the strips (for capillary blood glucose check) from storage. LPN #2 left the floor and returned with test strips for the glucometer. c. On 3/10/2020 at 3:57 p.m., LPN #2 entered Resident #61's room. LPN #2 obtained an accu-check reading of 236 prior to the [MED] administration. The resident was sitting in a wheelchair, watching television. Upon turning to exit room, the resident asked LPN #2, What was my reading? LPN #2 stated, 236. d. On 3/10/2020 at 3:59 p.m., LPN #2 performed hand hygiene, removed a 100-unit [MED] syringe and a vial of [MEDICATION NAME] N Suspension 100/10 ml, labeled for Resident #61 from the Medication Cart. LPN #2 removed the cap from the vial and used an alcohol wipe on the top of the vial. LPN #2 drew the [MED] into the syringe. LPN #2 did not agitate the vial. LPN #2 attempted to hand the [MED] syringe to the Surveyor. LPN #2 was asked for the [MED] vial prior to taking the syringe. LPN #2 handed the vial of [MED] to the surveyor. There was a thick white substance, approximately inch, at the bottom of the [MED] vial, with a cloudy white liquid in the remainder of the [MED] in the vial. e. On 3/10/2020 at 4:01 p.m., LPN 2 was asked, Does this look mixed to you? The Surveyor handed vial of [MED] back to LPN #2. LPN #2 handed the [MED] syringe to the surveyor and took [MED] vial. LPN 2 stated, Oh no, it isn't. LPN #2 rolled the [MED] vial in her hands and agitated the vial. LPN #2 took the syringe from the Surveyor and placed it in a biohazard box on the medication cart and walked to the nurse's station. f. On 3/10/2020 at 4:03 p.m., LPN #2 returned to the medication cart, opened the medication cart, and removed a 100-unit [MED] syringe. She drew 4 units of [MEDICATION NAME] N Suspension into the syringe. There was no hand hygiene performed. LPN #2 handed the Surveyor the [MED] syringe for inspection. LPN #2 was asked, Can you tell me what you see? LPN #2 stated, A bubble. LPN #2 tapped the syringe on the medication cart and reentered the vial with the same needle without using an alcohol swab on the top of the [MED] vial, pushed [MED] into, and redrew [MED] into the syringe. LPN #2 donned gloves, entered the resident's room and administered 4 units of [MEDICATION NAME] N Suspension. The physician ordered sliding scale (SS) indicated resident should have received 2 units for the capillary blood glucose reading of 236, which was obtained by LPN #2. g. On 3/10/2020 at 8:47 a.m., the Medication Administration Record [REDACTED]. 2. Resident #24 had [DIAGNOSES REDACTED]. a. A Physician's Order dated 9//2019 documented, .[MEDICATION NAME] Tablet 25 mg Give 0.5 tablet by mouth two times a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday), Sun (Sunday) related to Essential (Primary) Hypertension . Give 1/2 tablet to equal 12.5mg . Hold if blood pressure less than 90/60 . Give with Food . A Physician's Order dated 2/28/2020 documented, .[MEDICATION NAME] Tablet 800 mg(milligrams) ([MED] [MEDICATION NAME]) Give 2 tablets by mouth three times a day related to End Stage [MEDICAL CONDITION] . Give 2 tablets to equal 1600mg. Give with meals and HS (hour of sleep) snack . b. On 3/10/2020 at 4:11 p.m., LPN #2 administered [MED] 800 mg tablets, two tablets, to equal 1600 mg, and [MEDICATION NAME] 25 mg, one-half () tablet, to equal 12.5 mg, with 8 ounces of water. LPN #2 provided no meal or snack for the resident with the medications, and the resident was not encouraged to consume any food or snack.

F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure physician's orders were followed to prevent a significant medication error which could result in complications for 1 (Resident #61) of 3 sampled residents who received [MED] injections. The findings are: Resident 61 had a [DIAGNOSES REDACTED]. a. A Physician's Order dated 3/5/2020 documented, .[MEDICATION NAME] N Suspension 100 Units/ml (units per milliliter) ([MED] NPH (Human) ([MEDICATION NAME])) Inject as per sliding scale . if 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units, subcutaneously before meals and at bedtime . for blood sugar greater than 400 or less than 60 call MD (Medical Doctor) . b. On 3/10/2020 at 3:51 p.m., Licensed Practical Nurse (LPN) #2 removed a glucometer from the 100 Hall medication cart. She stated, I have to get the strips (for capillary blood glucose check) from storage. LPN #2 left the floor and returned with test strips for the glucometer. c. On 3/10/2020 at 3:57 p.m., LPN #2 entered Resident #61's room. LPN #2 obtained an accu-check reading of 236 prior to the [MED] administration. The resident was sitting in a wheelchair, watching television. Upon turning to exit room, the resident asked LPN #2, What was my reading? LPN #2 stated, 236. d. On 3/10/2020 at 3:59 p.m., LPN #2 performed hand hygiene, removed a 100-unit [MED] syringe and a vial of [MEDICATION NAME] N Suspension 100/10

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	045458	A. BUILDING _____ B. WING _____	03/13/2020

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) ml, labeled for Resident #61 from the Medication Cart. LPN #2 removed the cap from the vial and used an alcohol wipe on the top of the vial. LPN #2 drew the [MED] into the syringe. LPN #2 did not agitate the vial. LPN #2 attempted to hand the [MED] syringe to the Surveyor. LPN #2 was asked for the [MED] vial prior to taking the syringe. LPN #2 handed the vial of [MED] to the surveyor. There was a thick white substance, approximately inch, at the bottom of the [MED] vial, with a cloudy white liquid in the remainder of the [MED] in the vial. e. On 3/10/2020 at 4:01 p.m., LPN 2 was asked, Does this look mixed to you? The Surveyor handed vial of [MED] back to LPN #2. LPN #2 handed the [MED] syringe to the surveyor and took [MED] vial. LPN 2 stated, Oh no, it isn't. LPN #2 rolled the [MED] vial in her hands and agitated the vial. LPN #2 took the syringe from the Surveyor and placed it in a biohazard box on the medication cart and walked to the nurse's station. f. On 3/10/2020 at 4:03 p.m., LPN #2 returned to the medication cart, opened the medication cart, and removed a 100-unit [MED] syringe. She drew 4 units of [MEDICATION NAME] N Suspension into the syringe. There was no hand hygiene performed. LPN #2 handed the Surveyor the [MED] syringe for inspection. LPN #2 was asked, Can you tell me what you see? LPN #2 stated, A bubble. LPN #2 tapped the syringe on the medication cart and reentered the vial with the same needle without using an alcohol swab on the top of the [MED] vial, pushed [MED] into, and redrew [MED] into the syringe. LPN #2 donned gloves, entered the resident's room and administered 4 units of [MEDICATION NAME] N Suspension. The physician ordered sliding scale (SS) indicated resident should have received 2 units for the capillary blood glucose reading of 236, which was obtained by LPN #2. g. On 3/10/2020 at 8:47 a.m., the Medication Administration Record [REDACTED]. h. This was a significant medication error due to the condition of the resident and the class of medication, antidiabetic.
F 0790 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide routine and 24-hour emergency dental care for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure dental examination by a dental professional was provided for 1 (Resident #36) of 2 (Residents #36 and #47) sampled residents who required assistance with oral care. The findings are: 1. Resident #36 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 1/6/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); was totally dependent on two-person assistance for bed mobility and transfers; was totally dependent on one-person assistance for dressing, eating, personal hygiene, and bathing; required oxygen therapy, suctioning, and [MEDICAL CONDITION] care, and received enteral feeding via a Percutaneous Endoscopic Gastrostomy (PEG) tube. a. A Care Plan dated [DATE] documented, . is dependent on staff for ADLs . r/t (related to) [MEDICAL CONDITION] . Interventions . needs assistance with ADLs (Activities of Daily Living) as required during the activity . potential for a communication problem r/t [MEDICAL CONDITION] . Goal . Needs will be anticipated and met . Intervention . Anticipate and meet needs . Staff must anticipate all of her needs and render care as appropriate . Personal Hygiene . requires total assistance (times) 1 staff with personal hygiene care . b. A physician's orders [REDACTED]. [MEDICATION NAME] Solution ([MEDICATION NAME]) 15 ml (milliliters) dental two times a day related to Deposits (Accretions) On Teeth . c. On 3/11/2020 at 2:12 p.m., Licensed Practical Nurse (LPN) # 1 was asked, How often does the resident receive oral care? LPN #1 stated, We are not doing that right now. We swab her BID (twice a day) early in the morning and again in the day for gingivitis. She was asked, Does she have her own teeth? LPN #1 stated, Yes. LPN #1 was asked to lift the residents upper and lower lip so the Surveyor could view the resident's teeth. The resident's tongue was clear, upper gums were red and inflamed, and the resident was missing numerous upper teeth. The resident's lower teeth had thick, white, semicircular areas following the gum line around the lower aspect of the teeth, and the lower gums were red and inflamed. (The Surveyor took a photograph of resident's upper and lower teeth at this time.) LPN #1 was asked, Has the dentist been in to see her? LPN #1 stated, The dentist has not seen her in three months, since I have been on days. Before that, I cannot answer that question. d. On 3/12/2020 at 5:04 p.m., the Director of Nursing (DON) was asked, How does the facility ensure that a dentist is available for residents in accordance with professional standards of quality and timeliness? The DON stated, We have a social networking dentist who comes to the facility at least every 3 months and ((Dental Office) if there is an emergency. They do extractions and dentures for us. The Social Director sets up any appointments they need. e. On 3/13/2020 at 8:14 a.m., the DON was asked, Can you tell me why (Resident #36) has not seen a dentist? The DON stated, She should have seen one because she has an order for [REDACTED]. A Progress Note dated 3/13/2020 at 8:43 a.m. and provided by the DON on 3/13/2020 at 9:00 a.m. documented, . Note Text . This nurse consulted with Medical Director, APN (Advanced Practice Nurse), and a general dentist regarding the possibility of (Resident 36) being seen by an on-site dentist. All practitioners state that being seen by a dentist would not be recommended for (Resident #36). She is resistant to care, or anything being inserted into her mouth .
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served in accordance with the planned, written menu and quantified recipes were consistently utilized for preparation of altered consistency diets, and failed to ensure food was served at temperatures that were acceptable to the residents who received meals to meet the nutritional needs of the residents for 2 of 2 meals observed. This failed practice had the potential to affect 9 residents who received pureed diets, 19 residents who received mechanical soft diets, and 23 residents who received their meals in the Secured Unit Dining Room on the 400 Hall, according to a list provided by Dietary Employee #4 on 3/10/2020. The findings are: 1. The facility's menu for the noon meal documented the residents who received regular diets, mechanical soft diets, and who received a pureed diet were to receive carrot cake with cream cheese frosting and cornbread. 2. On [DATE]20 at 11:52 a.m., the following observations were made when the temperature of the food items were obtained on the steam table: a. There was no pureed cornbread prepared to be served to the residents for noon meal. b. There was carrot cake with cream cheese frosting prepared to be served to the residents for the lunch meal. c. The temperature of the chicken and rice soup was 100 degrees Fahrenheit when checked and tested and read by Dietary Employee #1 on the steam table. 3. On [DATE]20 at 1:12 a.m., the following observations were made during meal service: a. All residents were served yellow cake with no frosting. b. The residents who received pureed diets were not served pureed pork loin, pureed rice, pureed peas and pureed yellow cake. There was no pureed bread or pureed cornbread served to the residents who received pureed diets and there was nothing provided in place of the pureed bread. On 3/10/2020 at 8:38 a.m., Dietary Employee #1, who prepared the lunch meal on [DATE]20, was asked the reason pureed bread / cornbread was not prepared and served to the residents who received a pureed diet. She stated, I forgot to puree bread. c. On 3/10/2020 at 9:39 a.m., Dietary Employee #3 stated, I made yellow sweet bread. I never make cake with frosting. Dietary Employee #3 was asked, Did you look at the menu to see what type of cake to prepare? Dietary Employee #3 stated, I didn't even look at the menu. d. On 3/10/2020 at 12:30 p.m., Resident #86 was served melted ice cream with his lunch meal. 4. On [DATE]20, the facility's menu for the supper meal documented the residents who received regular diets, mechanical soft diets, and who received a pureed diet were to receive 3 ounces of roast turkey. a. On [DATE]20 at 4:09 p.m., Dietary Employee #5 removed a pan from the oven that contained small slices of turkey and placed the pan on the counter. She placed 8 small slices of turkey in a blender and ground the mixture. She poured the ground turkey into a pan. At 4:10 p.m., she placed another 8 small slices of turkey into a blender and ground the mixture. She poured the ground turkey in the same pan. At 4:11 p.m., she placed 3 more slices of small turkey into a blender and ground the mixture. She poured the ground turkey into the same pan. She covered the pan with a piece of foil and placed the pan in the oven to be served to the residents who received a mechanical soft diet. b. On [DATE]20 at 4:14 p.m., Dietary Employee #5 placed 9 small slices of turkey into a blender, added its juice and pureed the mixture. She poured the pureed turkey into a pan. She covered the pan with a piece of foil and placed it in the oven to be served to the residents who received a pureed diet. c. On [DATE]20 at 6:03 p.m., Dietary Employee # 4 was asked to weigh a slice of turkey served to the residents who received mechanical soft diets and the residents who received pureed diets for the supper meal from the pan with small slices of turkey. He did so, and the portion of turkey weighed 2 ounces. The turkey slices also served to 14 residents who received regular diets and received their meals in the Dining Room on the 400 Hall came from the same pan with the small slices of turkey. The menu specified a 3-ounce portion of roast turkey was to be served to each resident. d. On 3/10/2020 at 8:41 a.m., Dietary Employee #4 was asked, Who sliced the turkey? He stated, I sliced the meat for her. She was supposed to serve 2 apiece. They were cut small.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare,**

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) **distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure dietary staff washed their hands before handling clean equipment or food items; failed to ensure hot food was maintained at 135 degrees Fahrenheit or above while awaiting the meal service; failed to ensure staff completely covered their hair while assisting with the lunch meal service; failed to ensure foods stored in the refrigerator, freezer, or storage room were sealed / covered; failed to ensure expired food items were promptly removed / discarded on or before the expiration or use by dates; and failed to ensure an ice scoop holder was maintained in clean and sanitary condition to prevent potential cross-contamination and prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 89 residents who received meals from the kitchen (total census: 89), as documented on a list provided by Dietary Employee #4 on [DATE]. The findings are: 1. On [DATE] at 11:45 a.m., Dietary Employee #1 was wearing gloves on her hands. She picked up the cover to the temperature gauge from the floor and placed it on the counter, contaminating the gloves. Without changing gloves and washing her hands, she removed an alcohol pad from the packet and used it to wipe off the temperature stem to be used in testing food items on the steam table to be served to the residents for the lunch meal. Dietary Employee #1 was immediately asked, What should you have done after you picked up an object from the floor and before handling clean equipment? She stated, I should have removed the gloves and washed my hands. 2. On [DATE] at 12:01 p.m., an open box of iodized salt was on the counter in the kitchen. The box was not covered. 3.On [DATE] at 12:03 p.m., the following observations were made in the refrigerator in the kitchen: a. One open box of bacon was stored on a shelf in the refrigerator. The box was not covered or sealed. b. One open box of sausage was stored on a shelf in the refrigerator. The box was not covered or sealed. 4.On [DATE] at 12:06 p.m., the following observations were made in the first freezer in the storage room: a. Two opened boxes of cinnamon rolls were stored on a shelf in the freezer. The boxes were not covered or sealed. b. One open box of green beans was stored on a shelf in the freezer. The box was not covered or sealed. 5. On [DATE] at 12:11 p.m., the following observations were made in the second freezer in the storage room: a. One open box of hamburger patties was stored on a shelf in the freezer. The box was not covered or sealed. b. One open box of pizza was stored on a shelf in the freezer. The box was not covered or sealed. 6. On [DATE] at 12:13 p.m., one open box of taco shells was stored on a shelf in the storage room. The box not covered or sealed. 7. On [DATE] at 12:16 p.m., the following observations were made on a shelf in the storage room: a. One 105-ounce container of yellow mustard was stored on a shelf in the storage room. The container of yellow mustard had an expiration date of [DATE]. b. Seventeen (17) 15-ounce boxes of raisins were stored on a shelf in the storage room. Each of the boxes of raisins had an expiration date of [DATE]. 8. On [DATE] at 12:28 p.m., Dietary Employee #1 was on the tray line serving the lunch meal. She used tongs to pick up French fries from the deep fryer and placed them on a plate. She placed gloves on her hands, contaminating the gloves. She opened the buns and placed hot dogs in the buns to be served to the residents who requested hot dogs with their lunch meal. 9. On [DATE] at 12:29 a.m., two (2) tomatoes were on the cutting board and had black discolorations on them. Dietary Employee #3 was asked to describe the appearance of the tomatoes. She stated, They are going bad. 10. On [DATE] at 1:18 p.m., the ice scoop holder on the wall by the ice machine on a hall leading to the outside had a wet, corroded, black / red residue on it. The ice scoop was stored in the scoop holder in direct contact with the residue. Dietary Employee #4 was asked to wipe the residue in the ice scoop holder. He did so, and the black and red substance easily transferred to the tissue. Dietary Employee #4 was asked to describe the appearance of the residue in the ice scoop holder. He stated, There was black and red residue in the ice scoop holder. Dietary Employee #4 was asked who used the ice from the machine, and how often do you clean the ice machine and the ice scoop holder? He stated, The Maintenance Man cleans it. We use it to fill beverages served to the residents in the Dining Room. That's the ice the CNAs (Certified Nursing Assistants) use for the water pitchers in the residents' rooms. On [DATE] at 1:20 p.m., the Maintenance Man was asked, How often do you clean the ice scoop holder? He stated, I don't. I only clean the ice machine. 11. On [DATE] at 4:08 p.m., Dietary Employee #5 removed a pan of turkey from the oven and placed it on the counter. She took a pan of dressing and placed it in the oven. Without washing her hands, she adjusted a clean blade at the base of the blender to be used in pureeing and grounding food items to be served to the residents. 12. On [DATE] at 4:51 p.m., Dietary Employee #6 removed an opened can of fruit cocktail from the refrigerator and placed it on the counter. Without washing her hands, she adjusted a clean blade to the base of the blender to be used in pureeing food items to be served to the residents who received pureed diets. At 6:05 p.m., Dietary Employee #6 was asked, What should you have done after touching dirty objects and before you handled clean objects? She stated, Wash my hands.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure nursing staff followed clean technique and washed their hands appropriately during medication administration to prevent the potential for cross-contamination that could result in infection for (Resident #61) of 1 sampled resident who had physician's orders [REDACTED].#86) of 1 sampled resident who had physician's orders [REDACTED]. These failed practices had the potential to affect 26 residents who received medications administered by Licensed Practical Nurse (LPN) #2 on the 100 Hall based on the list provided by the Director of Nursing on 3/10/2020, and 5 residents who had physician's orders [REDACTED]. The findings are: 1. Resident #61 had a [DIAGNOSES REDACTED]. a. A physician's orders [REDACTED].[MEDICATION NAME] N Suspension 100 Units / ML (Units per milliliter) ([MED] NPH (Human) ([MEDICATION NAME])) Inject as per sliding scale . if 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units, subcutaneously before meals and at bedtime . for blood sugar greater than 400 or less than 60 call MD (Medical Doctor) . b. On 3/10/20 at 3:57 p.m., LPN #2 knocked on the resident's door, entered the resident's room and donned gloves. LPN #2 performed no hand hygiene. She obtained a Capillary Blood Glucose reading of 236 prior to the [MED] administration. LPN #2 turned to exit the room and the resident asked LPN #2, What was my reading? LPN #2 stated, 236. LPN #2 did not wash or sanitize her hands. c. On 3/10/20 at 4:03 p.m., LPN #2 returned to the Medication Cart, opened the cart, and removed a 100-unit syringe, and drew up 4 units of [MEDICATION NAME] N Suspension. LPN #2 did not wash or sanitize her hands. LPN #2 handed the Surveyor the syringe for inspection. LPN #2 was asked, Can you tell me what you see? LPN #2 stated, A bubble. LPN #2 tapped the syringe on the medication cart and reentered the vial with the same needle without using an alcohol swab on the top of the vial. d. A facility policy titled Handwashing / Hand Hygiene provided by the Director of Nursing on 3/13/2020 at 9:00 a.m. documented, . Policy Interpretation and Implementation . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections . 4.a. Before and after direct contact with resident . d. After removing glove . 5.d. Before preparing or handling medications . 7. The use of gloves does not replace handwashing/hand hygiene . e. A facility policy titled [MED] Administration provided by the Director of Nursing on 3/13/2020 at 9:00 a.m. documented, . Steps in the Procedure . 1. Wash hands . 6. Gently roll the [MED] vial between the palms of both hands to re-suspend the [MED] . 9. Disinfect the top of the vial with an alcohol wipe . 13. Insert syringe into the vial and pull back on the plunger until the ordered amount of [MED] is in the syringe . 14. Inspect the syringe for air bubbles . Tap gently on the upright syringe to remove air . 2. Resident #86 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/2020 documented the resident was moderately impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); was totally dependent on two-person assistance for transfers; was totally dependent on one-person assistance for bed mobility, dressing, eating, personal hygiene, and bathing; and had an indwelling urinary catheter. a. A Care Plan with a revised date of 6/28/2018 documented, . Focus . (Resident) has Indwelling Foley Catheter . Neuromuscular Dysfunction of the Bladder and is at increased risk for infection . Goal . will be / remain free from catheter-related trauma and infection . Intervention . Position Foley catheter bag and tubing below the level of the bladder . is at risk for recurrent UTIs (Urinary Tract Infections) d/t (due to) indwelling F/C (Foley catheter) . He also has a Foley, and is dependent on staff with care, changes and flushes . b. A physician's orders [REDACTED]. 16 FR (French) 10cc (cubic centimeters) Foley Cath (catheter) change Q (every)3 weeks and PRN (as needed) . c. On [DATE]20 at 1:15 p.m., Resident #86 was sitting in a wheelchair in the Assist Dining Room. The resident's indwelling urinary catheter drainage bag was on the floor under the resident ' s wheelchair. (The Surveyor took a photograph of the catheter bag on the floor at this time.) d. On [DATE]20 at 1:32 p.m., Certified Nursing Assistant (CNA) #2 assisted Resident #86 back to his room via the wheelchair. The catheter drainage bag was dragging the floor from the assistive Dining Room to the resident's room. The door of the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) resident's room was approximately 30 steps from the Dining Room table. e. On 3/12/2020 at 5:15 p.m., Registered Nurse (RN) #1 was asked, How do you monitor the implementation of Care Plan interventions based upon standards of practice, including infection control procedures for catheter care? RN #1 stated, Any of our residents should be a q (every) shift check. That is on the MAR (Medication Administration Record). Output, that is a nightly check. We have a Weekly Skin Assessment on every resident. Our Wound Care Nurse has the infection control book to track, and we have a tracking board in our office that we follow, check, and discuss on mornings during our meetings. She was asked, Who is allowed to insert, provide care for, and remove indwelling urinary catheters? RN #1 stated, Our Treatment Nurse does that. Floor Nurses can do in-and-out (catheters) if needed. She was asked, What type of training has been provided to staff regarding the care of catheters and infection control? RN #1 stated, The other ADON (Assistant Director of Nursing) maintains competencies for the nurses. I believe there is competency care for the CNAs (Certified Nursing Assistants), as well. She may be able to give you more guidance. We do frequent education reference maintaining the level of the bag (drainage bag) below the bladder, no kinks in tubing, making sure it is not touching the floor, making sure the flow is downward and not staying in the tube, and checking the suprapubic site daily. She was asked, Does the resident currently have a UTI (Urinary Tract Infection)? RN #1 stated, I do not know that. She was asked, Should a resident's catheter bag drag the floor under their wheelchair? RN #1 stated, No. She was asked, If the catheter bag or tubing is touching the floor, what should you do? RN #1 stated, We should do education on staff immediately and the catheter bag should be changed. f. On 3/12/2020 at 5:24 p.m., RN #2 was asked, What type of training has been provided to staff regarding the care of catheters and infection control? RN #2 stated, We do quarterly assessments and all nurses and CNAs have to be checked off and all new hires are trained. Our lead CNAs go in and do all of that. They go in and make sure they are doing it correctly. She was asked, Should a resident's catheter bag drag the floor under their wheelchair? RN #2 stated, No. She was asked, If the catheter bag or tubing is touching the floor, what should you do? RN #2 stated, We have to adjust the bag, so it is no longer touching the floor. g. On 3/12/2020 at 6:01 p.m., CNA #3 was asked, What type of training did you receive on how to handle catheters, tubing, drainage bags, and other devices during the provision of care? CNA #3 stated, I have had years of experience and was trained when I got hired. I have been here since January (2020). CNA #3 was asked, What, when, and to whom do you report changes or concerns related to catheter use, including potential symptoms for a UTI? CNA #3 stated, My nurse. CNA #3 was asked, Should a residents' catheter drag the floor under their wheelchair? CNA #3 stated, No. CNA #3 was asked, Should it be on the floor at all? CNA #3 stated, No. CNA #3 was asked, If the catheter bag or tubing is touching the floor, what should you do? CNA #3 stated, Well, make sure it is in the proper place, empty if it needs emptying, and some use personal bags. h. A facility policy titled Catheter Care, Urinary provided by the Director of Nursing on 3/13/2020 at 9:00 a.m., documented, . General Guidelines . 11. Be sure the catheter tubing and drainage bag are kept off the floor .