STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115638	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARROLLTON MANOR, INCORPORATED	2455 OAK GROVE CHURCH ROAD CARROLLTON, GA 30117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility policy titled, Advance Directives (AD), the facility failed to ensure that the process for documenting and communicating the resident's wishes related to advance directives, to facility staff, was consistent and accurate for four (4) Residents (R) (R#57, R#31, R#50 and R#74 of 40 sampled residents. Findings include: A review of the facility's policy titled, Advance Directives revised 12/2016, documented under section Policy Interpretation & Implementation at No. 6, that prior to or upon admission of a resident, the Social Service Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. At No. 7, documentation reflects that information about whether-or-not the resident has executed an advance directive shall be displayed prominently in the medical record. At No. 10, documentation reflects that the plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. 1. Record review revealed that R#57 was admitted with diagnoses, that included, but was not limited to; long term use of anticoagulants, history of urinary tract infections, [MEDICAL CONDITION], general anxiety disorder, hypertension, [MEDICAL CONDITIONS], chronic [MEDICAL CONDITION] fib, gastro-[MEDICAL CONDITION] reflux disease (GERD), low back pain, [MEDICAL CONDITION] and [MEDICAL CONDITION] following cerebral infarction affecting left non dominant side, dysuria, retention of urine unspecified. Review of the Quarterly Minimum Data Set (MDS) assessment dated , 1/16/2020 revealed: A Brief Interview for Mental Status (BIMS) of 15, indicating the resident was cognitively intact. Record review of the hard copy record for R#57 revealed a yellow condition alert sticker, located just inside the cover of the record with Full Code status check marked. Record review of the hard copy record revealed the form titled, Physician Orders for Life-Sustaining Treatment (POLST) signed by the resident and the facility's Nurse Practitioner on 1/29/2020 and the Physician on 2/5/2020. The POLST form reflected to allow a natural death, and do not attempt resuscitation (DNR) code status. Review of the electronic health record (EHR), revealed that the active Physician's Orders as of 3/5/2020 for R#57 does not reflect a code status. Review of the EHR care plan for R#57 does not reflect a code status. An interview on 3/4/2020 at 4:00 p.m. with the Social Services Director (SSD) confirmed R#57 has a DNR code status. 2. Record review for R#31 revealed that the resident was admitted with [DIAGNOSES REDACTED]. tract infection, obstructive sleep apnea (OSA), [MEDICAL CONDITIONS], essential hypertension. Review of the Quarterly MDS assessment, dated 12/20/2019, reflected a BIMS score of 12 indicating the resident is cognitively intact. Review of the hard copy record R#31 revealed no Advance Directive Checklist form or other determination information was found. There was no yellow condition alert sticker that would indicate a code status for the resident was found. Review of the EHR active Physician's Orders did not contain an AD determination. Review of the EHR care plan, last reviewed/updated 4/4/2019, revealed no AD determination. An interview on 3/4/2020 at 10:20 a.m. with the Social Service Director (SSD) who explained the Advance Directive (AD) process is started in admission where the Advance Directive Checklist form is filled out, and if desired, the resident and family will be given information regarding choices for the full code status and DNR code status information to review at that time. She confirmed the Director of Nursing (DON) and the facility's Nurse Practitioner (NP) will follow up with the resident and/or family for their final decision, and the nurses will follow up with the order and confirm with the family. Further interview with the SSD revealed that at some point the resident's record must have been thinned and that a copy of the Advance Directive Checklist form, dated 7/22/2014 for R#31, had been found it in the thinned chart. An interview on 3/3/2020 at 8:40 a.m. with Licensed Practical Nurse (LPN) AA, for the 200 hall/500 hall revealed that if a resident arrest then she will look in the hard copy chart at the sticker for the code status. An interview on 3/3/2020 at 9:00 a.m. with LPN FF, for the 300 Hall, revealed that in an emergency, she would look in the hard copy chart for the sticker or for the paper chart for AD information. An interview on 3/3/2020 at 9:05 a.m. with LPN GG, for the 400 Hall, revealed he was new to the facility, starting four days prior, but he would look in the front of the resident's chart kept at the nurse's station. An interview on 3/3/2020 at 3:00 p.m. with the DON revealed that he was not aware that there was conflicting advance directive information on a few of the records. 3. During a review of the clinical record for Resident (R)#50 on 3/3/2020 at 1:19 p.m., the undated Condition Alert page of the Admissions section documented the resuscitation status (Code Status) as Full Code, which requires cardiopulmonary resuscitation to be performed in the event of cardiopulmonary arrest. However, review of the Physician's Orders for Life-Sustaining Treatment (POLST) dated 11/6/19 documented the Code Status as Do Not Resuscitate (DNR) which would allow natural death to occur. 4. Review of the clinical record for R#74 on 3/3/2020 at 1:24 p.m., revealed the undated Condition Alert page of the Admissions section documented the Code Status for R#74 as Full Code but the POLST, dated 1[DATE]19, documented the Code Status as DNR.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of the facility policies titled, Catheter Care, Urinary, and Emptying a Urinary Drainage Bag, the facility failed to ensure that one (1) Resident (R) (R#8) of eight (8) residents with indwelling catheters, maintained and secured the catheter appropriately during and after catheter care. Findings Include: Record review of the facility's policy titled, Catheter Care, Urinary, last revised 9/2014, that documented the propose of the procedure is to prevent catheter-associated urinary tract infections. Section titled, General Guidelines at No. 2, documents that if breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment as ordered. Section titled, Maintaining Unobstructed Urine Flow, at No. 3, documents the urinary bag must be held or positioned lower than the bladder at all time to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Section titled, Changing Catheters, documents at No. 2, to ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: catheter tubing should be strapped to the resident's inner thigh.) Section titled, Steps in the Procedure, documents after peri care and cleaning of the catheter tubing at No. 18, to secure catheter utilizing a leg band, and at No. 19 to check the drainage tubing and bag to ensure that the catheter is draining properly. Record review of the facility's policy

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 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) titled, Emptying a Urinary Drainage Bag, revised date 10/2010 that documents under section General Guidelines, at No. 3, do not allow the drain spout to come into contact with the measuring container, hands, or any other object. (Note: if accidental contaminations occur, wipe the drain spout with an alcohol sponge or swab.) No. 8 documents to keep the drainage bag below the level of the resident's bladder. No. 9 documents to keep the drainage bag and tubing off the floor always, to prevent contamination and damage. Record review for R#8 that revealed resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the following: Section C. Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impaired. Section H. Bowel & Bladder- incontinent for bladder/indwelling catheter, occasional incontinence for bowel. Section N. Medications- antibiotic. Review of the (NAME)2020 Physician order [REDACTED]. Review of the resident's care plan lists a problem/risk onset on 3/27/2019 for the potential injury and complications related to the presence of an indwelling catheter, due to chronic [MEDICAL CONDITION], and a goal that R#8 will be free from trauma related to presence of indwelling Foley catheter on 6/25/19. Approaches are to empty the Foley (catheter) and provide catheter care every shift and as needed, position the catheter tubing below the level of the bladder, and position the urine collection bag below the level of the bladder. Resident has history of frequent urinary tract infections (UTIs) and remains at risk for same issue- monitor for signs and symptoms of a UTI, notify Physician for complications or worsening of symptoms; monitor/record and report any adverse effects of medications used to treat UTIs. Further review revealed that the resident is at risk for dehydration due to recent and frequent UTIs- monitor for signs and symptoms of dehydration, provide water and favorite beverages at bedside and offer frequently. Problem onset 3/27/2019, resident complains often of pain, pressure, burning, itching and general discomfort related to an indwelling Foley catheter, urethral/vaginal discomfort dominates her thoughts daily, has been seen by medical doctors regarding this complaint- goal to continue treatment as ordered in attempts to reduce resident's daily discomfort 6/25/19. Give pain medications as ordered/indicated, including creams and gels to peri area, pain assessment every shift, assist with appointments and transports to urology and gynecology appointments. Resident has potential for skin breakdown and increased risk for UTI related to bowel incontinence, has very thin dry skin that tears and bruises easily. Bleeds easily related to use of [MEDICATION NAME] and Aspirin. Goal to maintain intact skin integrity, the goal is to be free of untreated signs and symptoms of an UTI, cleanse perineal area after each incontinent bowel episode. Observation on [DATE] at 10:20 a.m. revealed that R#8 was in her shared room, sitting in her wheelchair next to her bed. The resident was well-groomed with no odors detected. The catheter bag was observed in a blue privacy bag attached to the wheelchair, free from touching the floor although a catheter tubing leg strap was not in use. An observation of catheter care on 3/5/2020 at 12:00 p.m. by Certified Nurse Assistant (CNA) DD revealed the resident was initially observed lying supine on top of her bed and the head of the bed was flat. The catheter drainage bag was observed attached to the bed, out of the blue privacy bag, with the bag lying on the floor, the drainage spout was clamped, but out of the its holder/cover, and was touching the floor. Prior to the cleaning of the peri area, the CNA lifted the catheter bag and placed it alongside the resident's leg, where the catheter was observed not to be lower than bladder level. The CNA provided catheter care appropriately with cleaning the peri area and tubing. However, after catheter care was performed, CNA DD attached the catheter bag to the bed without the privacy bag, the bag was observed touching the floor mat, with the drainage spout clamped, but not in the spout holder, and observed to be touching the floor mat and there was no leg strap in place. At this time, CNA DD revealed that they don't use leg straps and left the room. Immediately after, Licensed Practical Nurse EE was notified of a new skin tear observed by the surveyor on the resident's foot during catheter care and about the catheter bag on the floor. The LPN EE entered the room, placed the urine drainage spout into its covering without cleaning it, then placed the catheter bag into the blue privacy bag. LPN EE confirmed the resident should have a leg strap applied, and then asked CNA DD when she returned to the room, to obtain one. Both CNA DD and the LPN EE confirmed having had training in catheter care. An interview on 3/5/2020 at 11:00 a.m. with the Director of Nursing (DON) revealed that catheter bags and tubing should not touch the floor. He confirmed that the facility had in-services on infection control throughout the year and provided a list of in-services provided including an in-service on 4/26/2019 subject titled, Blood or Body Fluids (catheter change and care, sharps handling).
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and the facility policy titled Administering Medications the facility failed to label three medications with an open date and expiration date for two [MED] multi-use bottles and one [MED] pen in one medication cart out of three medication carts. And the facility failed to secure one medication cart out of three carts. Findings include: Review of the policy and procedure document titled Administering Medications (December 2012) revealed medications shall be administered in a safe and timely manner, and as prescribed. Policy interpretation and implementation revealed number nine stated; When opening a multi-dose container, the date opened shall be recorded on the container. Number 16 stated; The medication cart will be kept closed and locked when out of sight of the medication nurse or aide. An inspection was conducted on medication cart for the 400 hall along with Licensed Practical Nurse (LPN) CC on 3/3/2020 at 11:15 a.m. The medication cart revealed one [MEDICATION NAME] multi-use bottle with no open date or expiration date labeled, one [MED] [MED] multi-use bottle with no open date or expiration date labeled, and one [MEDICATION NAME] pen with no open date or expiration date labeled. LPN CC revealed she could not find an opened date or expiration dated written on the [MED] bottles or pen. Resident Care Coordinator (RCC) BB acknowledged no documentation of an opened date or expiration date on two bottles of [MED] and one [MED] pen. An interview was conducted with LPN CC on 3/3/2020 at 11:16 a.m. LPN revealed she did not know why the [MED] bottles and pen did not have an expiration date written on them and this was the first time she noticed it. LPN revealed when a new [MED] bottle or pen is opened by the nurse, the nurse is supposed to write the open date and expiration or use by date on the bottle. An observation of the medication cart for 500 hall was made on 3/4/2020 at 12:02 p.m. The medication cart was sitting in the hallway against the wall unlocked, the nurse was not around the cart. At 12:03 p.m. an observation of the medication cart was made along with RCC BB. RCC acknowledged the cart was unlocked. An interview was conducted with RCC on 3/4/2020 at 12:03 p.m. RCC revealed the medication cart is always supposed to be locked when the nurse steps away from the cart. RCC stated she is not sure why the nurse did not lock the cart. RCC revealed the nurses receive training on the policy and procedures of medication pass upon being hired. An interview was conducted on 3/4/2020 at 12:05 p.m. with LPN AA. LPN revealed she had to leave her medication cart in a hurry to a resident's room and stated she pushed the lock but must not have pushed the lock hard enough. LPN stated she usually always locks the medication cart when she walks away from it. An interview was conducted with the Director of Nurses (DON) on 3/5/2020 at 12:00 p.m. DON revealed whichever nurse is on a particular medication cart, it typically is their responsibility for checking their medication cart for expired medications and making sure the [MED] multi dose vials and the [MED] pens have expired or good through dates written on them, and for securing their medication carts when they step away from it. DON stated he posted the [MED] expiration date guidelines in the front of the narcotic book on each medication cart. DON revealed the nurses receive medication pass training during orientation on the medication cart by a nurse preceptor. DON stated any time a nurse leaves their medication cart, that cart should be locked, and said that is an important part of the training process.
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, staff interview and review of facility's catheter care infection control policies, the facility failed to ensure catheters were maintained in a sanitary manner to prevent potential urinary tract infections for three residents (R) (R#31, #57 & R#50) of eight residents with indwelling catheters. Findings include: A review was conducted of the facility's policy titled, Catheter Care, Urinary, revised last 9/2014, that documented the propose of the procedure is to prevent catheter-associated urinary tract infections. Section titled, General Guidelines at No. 2, documents that if breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment as ordered. Section titled, Maintaining Unobstructed Urine Flow, at No. 3, documents the urinary bag must be held or positioned lower than the bladder at all time to prevent the urine in the tubing and drainage

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) bag from flowing back into the urinary bladder. A review was conducted of the facility's policy titled, Emptying a Urinary Drainage Bag, revised date 10/2010 documents under General Guidelines, at No. 3, do not allow the drain spout to come into contact with the measuring container, hands, or any other object. (Note: if accidental contaminations occur, wipe the drain spout with an alcohol sponge or swab.) No. 8 documents to keep the drainage bag below the level of the resident's bladder. No. 9 documents to keep the drainage bag and tubing off the floor always, to prevent contamination and damage. 1. Record review revealed that R#31 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set ((MDS) dated [DATE] revealed that in Section H, the resident was assessed with [REDACTED].#31 in her wheelchair in the hall near the nursing station watching activities. The resident's catheter bag was located in a blue privacy cover bag was attached to the wheelchair. Observation, at this time, revealed that the privacy bag and tubing were dragging on the floor as R#31 propelled herself. Observation on [DATE] at 3:28 p.m. of R#31 who was in her wheelchair at the Nurse's Station. Observation at this time revealed the catheter bag was in a in blue privacy bag, attached to the wheelchair, however, the privacy bag was lying on the floor. Observation on 3/3/2020 at 10:14 a.m. revealed that R#31 was participating in activities, with the assistance of staff, in her wheel chair with the catheter bag inside of the blue privacy bag. The catheter privacy bag and the tubing were dragging on the floor. Observation on 3/4/2020 at 9:58 a.m. revealed that R#31 was sitting in a wheelchair reading, in her shared room, with the catheter bag in a privacy bag attached to the wheelchair. The privacy bag was sitting on the floor beneath the wheelchair. Review of the resident's care plan reflected problems/risks with a onset date of 1/2/2018, for the potential for urinary tract infections [MEDICAL CONDITION] related to presence of an indwelling catheter- interventions to give catheter care every shift, Foley catheter to bedside drainage bag, secure with leg strap unless contraindicated. Position catheter tubing below level of bladder, and change catheter every 30 days as ordered. 2. Record review revealed that R#57 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment dated [DATE] revealed the resident was assessed in Section H. Bowel & Bladder- indwelling catheter, occasional incontinence for bladder, always continent for bowel. Observation on [DATE] at 2:42 p.m. revealed R#57 in her shared room, sitting in her wheelchair, with the catheter, in a privacy bag, and catheter tubing touching the floor. Observation on 3/3/2020 at 10:33 a.m. revealed R#57 sitting in a wheelchair in her room. The resident's catheter was in a blue privacy bag that was attached to her wheelchair with the catheter tubing was touching the floor. Observation on 3/4/2020 at 9:39 a.m. revealed R#57 sitting in her wheelchair, in the hallway, with the catheter bag and tubing on the floor. 3. Review of the Annual MDS dated [DATE] the R#50 was assessed with [REDACTED].#50 on 3/3/2020 at 11:49 a.m., revealed that she was seated in the hallway outside of her room, in her wheelchair, with the urinary catheter bag was rested on the floor underneath the wheelchair.