STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675561	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE PLAZA NURSING CENTER	600 W 52ND ST TEXARKANA, TX 75501

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure treatment and care in accordance with professional standards of practice was provided for 1 of 1 resident reviewed for quality of care. (Resident #1) The facility did not: *identify Resident #1 as at risk for [MEDICAL CONDITION] when she returned from the hospital with a [DIAGNOSES REDACTED].*communicate Resident #1's medical history of [REDACTED]. *develop and implement a care plan with interventions to address Resident #1's history of [MEDICAL CONDITION] and urinary tract infections. *consult a urologist for Resident #1 per the hospital discharge recommendation. *obtain a KUB (x-ray of kidney, ureter, bladder which can detect [MEDICAL CONDITION]) and urinary analysis as ordered by healthcare providers for Resident #1. Resident #1 had a history of [REDACTED]. The resident was found unresponsive on 5/23/20 and admitted to the hospital with [REDACTED]. Resident #1 suffered [MEDICAL CONDITION], acute [MEDICAL CONDITION] and acute [MEDICAL CONDITION] requiring intubation (inserting a tube through the mouth into the airway). An Immediate Jeopardy (IJ) situation was identified on 6/10/20 at 3:52 p.m. While the IJ was removed on 6/11/20 at 3:50 p.m., the facility remained out of compliance at a severity level of actual harm and a scope of pattern, due to the facility's need to complete in-service training and evaluate the effectiveness of their plan of removal. Findings included: The physician order [REDACTED].#1 was [AGE] years old, admitted [DATE], readmitted [DATE] and had [DIAGNOSES REDACTED]. The report indicated an order for [REDACTED].#1 was to be administered 650 mg of Tylenol every 4 hours, as needed for pain or fever, via her PEG tube starting on 4/1/20. The summary did not indicate the resident had a Foley catheter. The MDS dated [DATE] indicated Resident #1 had unclear speech, was usually understood and understood others. The MDS indicated the resident had mild cognitive impairment and had fluctuations in disorganized thinking, required extensive assistance with bed mobility, toilet use, personal hygiene and bathing. The MDS indicated Resident #1 did not have an indwelling catheter or intermittent catheterization and was always incontinent of bowel and bladder. The MDS indicated the resident had received as needed pain medication and non-medication interventions for mild pain occasionally in the 5 day look back period. The MDS indicated Resident #1 received nutrition through a feeding tube and received 501cc/day or more of fluid intake via her feeding tube. The MDS indicated Resident #1 received antibiotics 4 days during the 7 day look back period. The care plan updated on 4/30/20 indicated Resident #1 had a urinary catheter. The care plan interventions included provide catheter care as ordered, monitor fluid intake/output and monitor urine appearance, amount, color, odor and clarity. The care plan did not address Resident #1 history of [MEDICAL CONDITION] or urinary tract infections. A hospital discharge summary dated 4/1/20 indicated Resident #1 had 2100 ml (the female urinary bladder can store up to 500 ml of urine and people feel the need to urinate when the bladder is between 200 and 350 ml) of urine drained from her bladder upon admission to the hospital on [DATE]. The summary indicated Resident #1 had acute [MEDICAL CONDITION] and recommended Resident #1 follow up with a urologist due to her acute [MEDICAL CONDITION]. A nursing note dated 4/1/20 at 9:36 p.m., written by LVN J indicated Resident #1 returned to the facility by ambulance at 6:30 p.m. The nursing note did not address Resident #1's [DIAGNOSES REDACTED]. She did not answer and the number indicated the voice mail was not set up to receive messages. The 24-hour report sheets (used to communicate nursing and medical information about a resident) dated 4/1/20 through 5/23/20 did not include Resident #1's history of [MEDICAL CONDITION]. The facility history and physical completed by the medical director on 4/4/20 indicated Resident #1's admitting [DIAGNOSES REDACTED]. The history and physical indicated Resident #1 had recently been sent to the hospital for fever and altered mental status and was found to have acute [MEDICAL CONDITION] and had a Foley catheter placed. A nursing note dated 4/30/20 indicated Resident #1's indwelling catheter was removed. The note did not address the reason for removing the indwelling catheter. The clinical record dated 4/1/20 through 4/30/20 for Resident #1 did not contain a physician order [REDACTED]. A nursing note dated 5/5/20 at 4:19 a.m., completed by RN C indicated Resident #1's abdomen was distended and firm when palpated. The note indicated Resident #1 voiced discomfort many times during the shift especially when incontinent care was provided. The note indicated Resident #1 had bowel sounds in all 4 quadrants (sections of the abdomen) and her bowels were moving with loose brown stools. During an interview on 6/10/20 at 11:25 a.m., RN C said she took care of Resident #1 often. She said Resident #1 reported abdominal pain approximately 1-2 times a week. She said Resident #1's pain was treated with Tylenol, a warm compress or position changes and the resident always reported pain relief. RN C said sometimes when Resident #1 complained, her abdomen was distended and at other times it was not. RN C said she thought the abdominal distention was gastrointestinal related. She said she never considered it was urinary tract related. She said she did not know about Resident #1's history of [MEDICAL CONDITION] and urinary tract infections. She said pertinent medical history was generally communicated on the 24-hour report sheet or in a verbal shift report. She said never received Resident #1's history of [MEDICAL CONDITION] or urinary tract infections in a verbal shift report. She said she was sure she reported Resident #1 was complaining of pain and had a firm and distended abdomen to the NP on 5/5/20, but must have forgotten to document it. A nursing note dated 5/5/20 at 2:31 p.m. completed by LVN D, indicated Resident #1 complained of lower abdominal pain and the NP was notified. The note indicated Resident #1 had bowel sounds in all 4 quadrants. A NP progress note dated 5/6/20 indicated nursing staff reported Resident #1 had abdominal firmness and tenderness to touch. The note indicated Resident #1 was lying in bed and was alert to person and place. The note indicated Resident #1 was able to verbalize her needs and stated her stomach felt tight. The note indicated Resident #1 reported she had a bowel movement on 5/5/20 but felt something was wrong. The note indicated the NP reviewed Resident #1's vital signs, laboratory test, diagnostic testing, nutrition, orders and history and physical. The progress note indicated Resident #1's abdomen was distended and bowel sounds were hypoactive (reduction in loudness, tone and regularity) in all four abdominal quadrants. The progress note indicated an abdominal x-ray was ordered for possible ileus (an obstruction of the intestine). A nursing note dated 5/6/20 at 12:33 p.m. completed by LVN D, indicated Resident #1 was seen by the NP and received a new order for an abdominal x-ray related to Resident #1's abdominal pain and distention. The note indicated the abdominal x-ray result was normal. During an interview on 6/9/20 at 4:15 p.m., LVN D said Resident #1 complained of lower abdominal pain approximately 2 times a week. LVN D said she administered Tylenol to Resident #1 when she complained of pain and the Tylenol was effective. She said the resident reported pain relief after having a bowel movement. She said she thought Resident #1's abdominal pain and distension was related to her gastrointestinal system. She said she called the NP on 5/5/20 and reported the resident was complaining of lower abdominal pain and the NP said she would see the resident the next day (5/6/20). She said the nurse practitioner ordered an abdominal x-ray on 5/6/20 and the results were normal. She said she called Resident #1's daughter the day the abdominal x-ray was ordered to let her know Resident #1 had abdominal pain and distension and the NP ordered an abdominal x-ray. LVN D said Resident #1's daughter mentioned the resident had a history of [REDACTED]. LVN D said she intended to notify the NP of the daughter reporting Resident #1 had a history of [REDACTED]. During an interview on 6/9/20

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

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) at 12:50 p.m., Resident #1's daughter said she received a call 5/6/20 from the facility at 9:34 a.m. to notify her Resident #1 had reported having abdominal pain and an x-ray had been ordered. Resident #1's daughter said she told the nurse Resident #1 had a history of [REDACTED]. There is no obstruction, free air, or any other finding. IMPRESSION: Normal two-view abdomen. A nursing note dated 5/8/20 at 5:48 a.m., completed by RN C, indicated Resident #1's lower abdomen was hard and she was crying in pain. The note indicated the NP was notified and ordered a STAT (urgent) KUB, BMP (basic metabolic panel), and CBC (complete blood count). The physician order [REDACTED].#1 had an order for [REDACTED]. The 24 hour reports from 5/8/20-5/23/20 did not indicate the results of a KUB were pending, received, reported to the NP, and followed up on by the facility. A nursing note dated 5/8/20 at 2:45 p.m., completed by LVN A indicated Resident #1 had been in bed all day complaining of hardness in her abdomen. The note indicated Resident #1 reported having a bowel movement and the discomfort seemed to be subsiding. During an interview on 5/30/20 at 1:15 p.m., LVN A said she took care of Resident #1 on many occasions. She said Resident #1 was voiding after her indwelling catheter was removed on 4/30/20. LVN A said the CNAs kept track of Resident #1's voiding by the number of incontinent episodes per shift. She said she was surprised to hear Resident #1 had a lot of urine in her bladder at the hospital. She said when she palpated Resident #1's lower abdomen, at times she felt a hard area in her lower abdomen. LVN A said she thought it was a bowel issue because Resident #1 would report not having a bowel movement for a couple of days. She said Resident #1 was treated with [MEDICATION NAME] and stool softeners. LVN A said the wound care nurse usually followed up on residents' laboratory orders. During an interview on 6/9/20 at 5:00 p.m., LVN A said it never occurred to her Resident #1's pain may have been related to her bladder. She said she did not know Resident #1 had a history or [MEDICAL CONDITION] or urinary tract infections. LVN A said she would normally find out about important medical information and needed monitoring of residents from the 24 hour shift report. She said she never saw anything on the shift report about Resident #1 having a history of [MEDICAL CONDITION] or urinary tract infections. She said Resident #1 complained of abdominal pain 1-2 times per week. She said Resident #1's pain was relieved with Tylenol or after having a bowel movement. LVN A said she was working when the x-ray tech came to perform the KUB on 5/8/20, but she did not know if the results were received. She said she asked the NP about collecting a UA on 5/14/20 and received an order to collect a urine sample for a UA. LVN A said she tried to collect the urine via in and out catheter, but was unable to get a return of urine and did not attempt again. She said she reported to LVN F, the on-coming nurse a UA needed to be collected. LVN A said she must have forgotten to put Resident #1 needed a urine sample collected on the 24 hour report. She said she must have forgotten to document the in and out catheter attempt. During an interview on 6/10/20 at 10:40 a.m., LVN F said she did not remember being told Resident #1 needed a UA collected. She said Resident #1 never complained of abdominal pain to her and the resident's abdomen was always distended. LVN F said she was not aware of Resident #1's history of [MEDICAL CONDITION]. The physician order [REDACTED].#1 had an order for [REDACTED].#1 did not contain a physician order [REDACTED]. The nursing notes dated 5/14/20 through 5/23/20 did not indicate an order for [REDACTED].#1 did not indicate there was an order for [REDACTED].#1 had a temperature of 100.2 degrees. The note indicated the on-call NP ordered a CBC, CMP, and a urinalysis with culture and sensitivity to be collected on the morning of 5/23/20. A nursing note dated 5/22/20 at 11:04 p.m., completed by LVN F indicated Resident #1 had a distended abdomen and one episode of vomiting while her temperature was elevated earlier in the shift. A nursing note dated 5/23/20 at 12:15 a.m., indicated Resident #1's abdomen was slightly distended. The note indicated the abdomen was soft and non-tender to the right upper quadrant, right lower quadrant, and the left upper quadrant. The note indicated there was a hard abdominal mass in the abdomen and the resident had a temperature of 99.1. The NP was notified and new orders for a chest x-ray and KUB later in the morning, Tylenol 650 mg for fever, check resident for impaction, and [MEDICATION NAME] suppository. The late entry nursing note dated 5/23/20 at 5:54 a.m., indicated at 12:40 a.m. Resident #1 was found with delayed respirations and was not rousable. The note indicated Resident #1 was having apneic episodes (temporary cessation of breathing), 911 was called and Resident #1 was transferred to the emergency room via EMS. A hospital emergency room visit note dated 5/23/20 indicated Resident #1 was hypotensive (had a low blood pressure of 89/51) and was minimally responsive. The note indicated Resident #1's laboratory work demonstrated possible urinary tract infection, acute kidney injury, and leukocytosis (an elevated amount of white blood cells in the blood). The note indicated Resident #1 had almost 2 liters (2000 ml) of urine output immediately after insertion of an indwelling catheter. A hospital history and physical dated 5/23/20 indicated Resident #1 was noted to have a very hard abdominal mass on arrival to the emergency room . The history and physical indicated the hard mass was gone after an indwelling catheter was placed and immediately drained over 2 liters of milky purulent (containing pus) urine. The hospital intensive care unit admission note dated 5/23/20 indicated Resident #1 was in septic shock secondary to a UTI. The note indicated Resident #1 had altered mental status secondary [MEDICAL CONDITION] from the UTI and suffered acute (abrupt onset) kidney failure. The note indicated Resident #1 had a history of [REDACTED]. The note indicated her creatinine was acutely elevated at 4.4 on admission to the hospital and supported the [DIAGNOSES REDACTED]. The note indicated Resident #1 had a distended bladder with approximately 2 liters of purulent urine immediately returned after indwelling catheter placement. The note indicated the physician suspected [MEDICAL CONDITION] (blockage of urine through the ureter, bladder, or urethra due to some type of obstruction). The hospital discharge summary dated 5/27/20 indicated Resident #1's discharge [DIAGNOSES REDACTED]. The discharge summary indicated Resident #1 was admitted for acute [MEDICAL CONDITION] secondary to [MEDICAL CONDITION]ly due [MEDICAL CONDITION] from a urinary tract infection. The summary indicated Resident #1 was intubated, started on antibiotics and treated with medications to improve her low blood pressure. The summary indicated a urologist was consulted due to her severe [MEDICAL CONDITION] upon admission to the hospital. The urologist recommended Resident #1 keep a urinary catheter in place. During an interview on 6/9/20 at 12:40 p.m., Resident #1 was at a rehabilitation facility. She said she was urinating after her catheter was removed, but she could not remember if she had pain at the other facility. During an interview on 6/9/20 at 4:00 p.m., an unidentified CNA said Resident #1 had an indwelling catheter, but it was removed. The CNA said Resident #1 had wet briefs and said she never had to report to the nurse Resident #1 did not have a wet brief or did not have a bowel movement. The CNA said the last time she took care of Resident #1 on 5/23/20, the resident complained about abdominal pain and vomited. She said she was not sure how often Resident #1 complained of abdominal pain but said it was not daily. During an interview on 6/10/20 at 11:24 a.m., CNA I said she took care of Resident #1 often. She said the resident initially had a catheter but it was taken out. She said Resident #1 regularly voided and regularly had bowel movements when she took care of her. She said Resident #1 mentioned approximately twice a week she had abdominal pain and she always reported it to the nurse. During an interview on 5/30/20 at 5:28 p.m., LVN D said the treatment nurse or floor nurse were responsible for following up on laboratory work or tests ordered for residents. LVN D said if a laboratory or other test had been ordered and results had not been received she passed that on during shift report. During an interview on 5/30/20 at 5:21 p.m., RN C said she was the wound care nurse. She said she had been in the position of wound care nurse since 5/6/20. She said she was responsible for getting laboratory and x-ray results off the printer and faxing them to the physician or NP. She said she was not sure who's responsibility it was to follow up on laboratory tests for which no results had been received. RN C said if she was supposed to follow up on laboratory work or test for which results were not received she was never told it was part of her job. She said she remembered entering the order for a KUB on 5/8/20 in Resident #1's electronic health record. She said she did not know if the KUB was completed or if results were received. During an interview on 5/30/20 at 5:03 p.m., the medical director said a KUB might show bladder distension and urinary obstructions. During an interview on 6/10/20 at 12:21 p.m., the medical director said if abdominal pain and distention were reported to him he would typically order CBC, BMP, and UA. The medical director said he might also order an abdominal x-ray and have the resident checked for impaction. He said if a resident had recently been diagnosed with [REDACTED]. The medical director said there were many variables and depending on the resident's vital signs he may send the resident directly to the hospital. During an interview on 5/30/20 at 5:15 p.m., NP E said she ordered a KUB on 5/8/20 because it was reported to her that Resident #1 was having pain and abdominal distention. NP E said a KUB could show bladder distension, especially if it was significant. NP E said a KUB could show a urinary obstruction. During an interview on 5/30/20 at 5:30 p.m., the ADON said she could not say for sure the KUB ordered 5/8/20 was ever completed. She said she could not find results for the KUB. She said the X-ray company told her the orders/results for 5/8/20 would be in the old system and were not available. The ADON said the wound care nurse was responsible for following up on orders for which no results have been received. She said the floor nurse should also communicate during shift report with other nurses if they were waiting on results. During an interview on 6/10/20 at 12:00 p.m., the ADON said when a resident was admitted from or returning from the hospital, the discharge summary, history and physical and any orders were sent to the NP. The ADON said pertinent medical information from the hospital discharge summary, orders and/or history and physical should be documented on the 24 hour report. She said

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) pertinent medical history should also be communicated during the oral shift report. She said she was not aware of Resident #1 having abdominal pain or distension until she went to the hospital on [DATE]. The ADON said she was not aware of Resident #1's history of [MEDICAL CONDITION]. The ADON said she was not aware Resident #1 had over 2 L of urine drained from her bladder on 3/28/20. She said there was no order or results for a UA for 5/14/20. The ADON said as far as she knew Resident #1 did not see a urologist. She said the admitting nurse should have communicated Resident #1 had a [DIAGNOSES REDACTED]. During an interview on 5/30/20 at 5:35 p.m., the administrator said it was generally the responsibility of the wound care nurse to follow up on laboratory and other tests ordered for which results had not been received. The administrator said she expected nursing staff to follow up on laboratory and other tests results. She said she expected staff to be aware of and communicate pertinent medical history to other staff members. The website https://www.aafp.org/afp/2008/0301/p643.html accessed on 6/19/20 indicated the following: .[MEDICAL CONDITION] is the inability to voluntarily void urine .acute [MEDICAL CONDITION] is the sudden and often painful inability to void despite having a full bladder .initial management includes bladder catherization and prompt and complete decompression .complications include infection and [MEDICAL CONDITION] . The website https://www.bcm.edu/healthcare/specialties/womens-health-maternity/urogynecology/conditions/urinary-retention accessed 6/19/20 indicated the following: .symptoms of acute bladder retention include severe discomfort, pain in lower abdomen, bloated lower belly .medical professionals may be able to feel your distended bladder by lightly tapping on the lower belly .additional testing includes a urine sample, X-ray or CT .for acute bladder retention, initial treatment will involve catherization, a small tube inserted into the bladder through the urethra to drain the urine and relieve immediate pain and distention .complications of [MEDICAL CONDITION] may include urinary tract infections. When urine stays in the bladder bacteria can grow and infect the urinary tract, bladder damage, [MEDICAL CONDITION] . The administrator and DON were notified 6/10/20 at 4:18 p.m., an immediate jeopardy situation had been identified due to the above failures. The IJ template was provided to the administrator. The Plan of Removal was accepted 6/10/20 at 7:04 p.m. and included the following: 1. Nursing staff will be in-serviced on lab/x-ray process including ordering, reporting and communicating with physician/nurse practitioner with results. Due Date 6/11/20. Team member responsible: ADON. 2. Establish and in-service clinical staff on a diagnostic tracking log. All new orders, including labs & X-rays will be reviewed during morning clinical meeting and cross referenced with diagnostic tracking log to ensure follow-though. Additionally, the diagnostic tracking log will be reviewed during weekly SOC meeting. Due Date 6/11/20. Team member responsible: ADON. 3. Nurses will be in-serviced on importance of passing on resident pertinent medical history on each new admission. Admission / readmission audit tool will be completed and reviewed during morning clinical meeting daily and weekly during SOC meeting. Due Date 6/11/20. Team member responsible: ADON. 4. Compliance of new admission / readmission audit tool and diagnostic tracking log will be reported to QA Committee monthly to ensure ongoing compliance. Due Date 6/11/20 and on-going. Team member responsible: ADON. 5. All current resident records will be reviewed for most recent labs/x-rays to be acted upon and physician notified. Due Date 6/11/20. Team member responsible: ADON. 6. Assess all current residents for bladder distention. Document and notify physician if noted. Due Date 6/11/20. Team member responsible: ADON. On 6/11/20 the investigator confirmed the plan of removal had been implemented sufficiently to remove the immediate threat by: *All resident medical records were reviewed and contained bladder assessments and no resident reported abdominal pain, tenderness or distension. *Six residents indicated a nurse palpated their abdomen and asked them if they were having any pain. *During an interview on 6/11/20 at 11:30 a.m., the regional nurse said an audit was underway of all diagnostic and laboratory orders to ensure they have been completed and reported to the NP or physician. *An order audit document dated 5/11/20-6/11/20 indicated all diagnostic and laboratory orders were audited with no discrepancies noted. *A Daily Diagnostic Tracking Log dated 6/10/20 was reviewed and found to have all recent diagnostic orders logged. For 3 of the 5 residents listed, results had been received, the provider notified, and new orders documented. *The Daily Stand Up Guideline dated 6/11/20 indicated the new admission audit tool and the daily diagnostic tracking log was reviewed and discussed during the daily stand up meeting. *An off-cycle Quality Assurance Committee Meeting sign in sheet dated 6/11/20 indicated a QA meeting was held to address further implementation of corrective actions. *A facility in-service sign in sheet titled Clinical Stand Up dated 6/10/20 indicated the 5 members of clinical management was instructed on the new admission audit tool and the daily diagnostic tracking log and would be reviewed daily in the stand-up meeting. *A facility in-service sign in sheet titled Admission Audit dated 6/10/20 indicated 8 nurses was in-serviced over the new admission audit tool to be completed by the admitting nurse and on-coming nurse. The in-service also indicated the admission tool would be reviewed in the daily stand up meeting with clinical management. *A facility in-service titled Reporting Lab and X-ray reports to NP and MD dated 6/1/20 indicated 15 nurses had been in-serviced to place all orders for labs and x-rays on the 24 hour report sheet to ensure the following shift would follow up. *During an interview on 6/11/20 at 2:00 p.m. the ADON said the facility had started in-servicing regarding placing pending laboratory and x-rays on the 24 hour report sheet prior to the IJ being identified. The ADON said additional in-services over the new admission audit tool and the daily diagnostic tracking log were initiated and all nurses would be in-serviced before returning to work. The ADON said the new admission audit tool was completed on 1 resident since the previous day. *An admission audit tool dated 6/10/20 for a resident contained the medical history of [REDACTED]. *Nine nurses (4 from the 6p-6a shift and 5 from the 6a-6p shift) indicated they received in-service training on the admission audit tool and the daily diagnostic tracking log. They said the admitting nurse must initiate the admission audit tool and the on-coming nurse must complete the admission audit tool if the admitting nurse was unable to complete it on their shift. They said any pertinent medical information obtained from the hospital discharge summary and/or hospital history and physical was to be recorded on the admission audit tool and placed on the 24 hour report sheet to ensure effective communication. The nurses said they were to place any laboratory or diagnostic order on the daily diagnostic tracking log and the 24 hour report. The nurses said they were to do this to ensure the on-coming shift was aware of pending orders and to ensure all diagnostic orders were followed up on during the daily stand up meeting. *During an interview on 6/11/20 at 3:00 p.m., the ADON said nurses would not be allowed to start their shift until they were in-serviced over the new admission audit tool and the daily diagnostic tracking log requirements and documentation. *During an interview on 6/11/20 at 3:10 p.m., the administrator said nurses would not be allowed to start their shift until they were in-serviced over the new admission audit tool and the daily diagnostic tracking log requirements and documentation. The administrator was notified the IJ was lifted on 6/11/20 at 3:50 p.m., however the facility remained out of compliance at a severity level of actual harm and a scope of pattern, due to the facility's need to complete in-service training and evaluate the effectiveness of their plan of removal.