STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 00 B. WING	07/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-MISHAWAKA	811 E 12TH STREET MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00333243, IN00331779 and IN00327853. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00333243 - Unsubstantiated due to lack of evidence. Complaint IN00331779- Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F690. Complaint IN00327853- Substantiated. Federal/State deficiencies related to the allegation are cited at F684 and F695. Unrelated deficiencies are cited. Survey dates: July 28, 29 and 30, 2020 Facility number: 000045 Provider number: 155109 AIM number: 100291400 Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 5 Medicaid: 50 Other: 3 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Quality Review was completed on August 10, 2020.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review, interview and observation, the facility failed to ensure physician's orders were followed for notification of low blood oxygen saturation levels for 1 of 3 residents reviewed for respiratory care, failed to apply a urinary drainage leg bag for 1 of 3 residents reviewed for catheters and failed to apply geri sleeves for 1 of 1 residents reviewed for skin conditions. (Resident G, E and C) Findings include: 1. A clinical record review was completed on 7/28/2020 at 3:15 P.M., and indicated Resident G's diagnoses included, but were not limited to: heart failure, chronic obstructive pulmonary disease, diabetes and emphysema. A physician's order, dated 6/22/2020, indicated Resident G was to receive oxygen at 1-2 liters via nasal cannula if oxygen saturation was below 90% and to check the oxygen (BIOX) saturation every shift and to notify the physician if below 90%. An admission MDS (Minimum Data Set)	F 0684	**1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident G MD notified with no adverse effects noted. Resident E had leg bag put on as ordered no adverse effects noted. Resident C had geri sleeves applied as ordered with no adverse effects. **2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All other residents have the potential to be affected. A review of all residents was completed with no other residents noted to be affected.	08/31/2020

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	assessment, dated 6/26/2020, indicated Resident G had a BIMS (Brief Interview for Mental Status) score of 12, moderate cognitive impairment. The Medication Administration Record, dated July 2020, indicated on July 13th and July 14th, Resident G had documented oxygen saturation levels of 86%. Nurses notes dated July 13, 14 and 15 lacked documentation to indicate the physician was notified of the low oxygen saturation levels. On 7/29/2020 at 2:26 P.M., the Director of Nursing indicated the physician should have been notified of the abnormal levels. 2. On 7/28/2020 at 11:40 A.M., 12:15 P.M., 12:30 P.M. and 12:51 P.M., Resident E's large urinary drainage bag was observed on the floor while the resident was sitting in his wheel chair. A clinical record review was completed on 7/28/2020 at 2:55 P.M., indicating Resident E's current diagnoses included, but were not limited to: hypokalemia, bacteremia, retention of urine and obstructive and reflux uropathy. A physician's order, dated 2/23/2020, indicated: Foley catheter use leg bag during the day and large UD (urinary drainage) bag to bedside drainage at night. A quarterly MDS (Minimum Data Set) assessment, dated 7/11/2020, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 8, moderate cognitive impairment. He required extensive assist of 1 staff for bed mobility and toilet use.		**3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The DCE/designee will educate all licensed nursing staff on following physician orders prior to the date of compliance. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The DNS/designee will perform audits 5x per week for two weeks, then weekly x two weeks, then monthly x 3 months. Results of audits will be reviewed in monthly QAPI x 4 months.	

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	A current, 7/6/2020, care plan indicated the resident had the potential for urinary tract infections related to indwelling catheter. The resident refuses at times to use the urinary leg bag. Interventions included, but were not limited to: Secure catheter tubing and catheter appropriately and use leg bag during the day and large UD bag to bedside at night. The TAR (Treatment Administration Record), dated July 2020, indicated the leg bag was initialed as being applied on 7/28/2020. During an interview, on 7/29/2020 at 2:26 P.M., the Director of Nursing indicated there was no documentation of why Resident E did not get a leg bag applied on 7/28/2020. 3. On 7/30/2020 at 9:40 A.M., Resident C was observe to have blood on his left forearm and on his right fingers. A physicians' order, dated 2/4/2020, indicated Resident C was to wear geri sleeves on bilateral upper extremities every shift to help prevent bruising. A care plan, dated 6/26/2020, indicated the resident was at risk for altered skin integrity related to senile purpura-scratches at skin often. Interventions included, but were not limited to: Geri sleeves to BUE (both upper extremities) as resident will allow. I will take off my geri sleeves off and not allow staff to put them back on. At 9:43 A.M., RN 5 was observe to take geri sleeves into Resident C's room.			

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	During an interview, on 7/30/2020 at 9:44 A.M., RN 5 indicated Resident C should have had the geri sleeves on. On 7/29/2020 at 3:42 P.M., the Corporate Nurse indicated they did not have a policy for following physicians orders. This Federal tag relates to Complaints IN00331779 and IN00327853. 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services			

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	to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to assess for incontinence and to prevent a decline in urinary incontinence for 1 of 3 residents reviewed for urinary incontinence. (Resident B) Finding includes: A clinical record review was completed on 7/30/2020 at 10:17 A.M., indicating Resident B had returned from a hospital stay on 6/20/2020. Her current diagnoses included, but were not limited to: hypertension, recurrent dislocation of right shoulder, retention of urine and dementia. A Quarterly Interdisciplinary Resident Review, dated 7/7/2020, indicated the resident was incontinent and no assessment should be completed. A Significant Change MDS (Minimum Data Set) assessment, dated 6/24/2020, indicated Resident B required extensive assist of one staff for toileting, was frequently incontinent of urine and no trial of a toileting program (scheduled toileting, prompted voiding, or bladder training) had been attempted on admission/readmission or reentry or since incontinence was noted in the facility. A Bowel and Bladder evaluation grid, with a completion date 4/3/2018, indicated Resident B	F 0690	**1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B has been assessed and put on incontinence program. **2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All other residents have the potential to be affected. An audit has been completed to identify other residents. Residents identified who need program will be placed on urinary incontinence program. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The DCE/designee will educate all	08/31/2020

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	was always continent with no leakage/dribbling. The total score was 17. Scores ranging from 16-23 indicated: good candidate for an RNP (Restorative Nurse Program). The form also had the dates of 7/12/2018 no changes, 10/20/2018 no changes and 1/5/2019 no changes. The form lacked any documentation to show the incontinence status had been evaluated since return from the hospital on 6/20/2020. A care plan, dated 6/18/2020, indicated the resident was at risk for alteration in bladder function related to incontinence, history of urinary tract infections and urine retention. Current interventions included, but were not limited to: check and change before and after meals, upon rising and at hs (hour of sleep) date initiated 6/19/2019, and monitor and report changes in ability to toilet or continence status, date initiated 6/16/2019. Resident B's toileting documentation indicated she had been toileted on: 7/3 at 12:46 PM, 6:00 P.M. 7/4 at 1:48 A.M., 1:57 A.M., and 3:49 P.M. 7/5 at 3:17 A.M., 1:59 P.M. and 4:01 P.M. 7/6 at 3:28 A.M.,12:35 P.M., 9:06 P.M., and 11:42 P.M. 7/7/ at 1:59 A.M., 10:43 A.M., and 11:19 P.M. 7/8 at 9:46 A.M. and 3:53 P.M. 7/9 at 12:34 A.M., 7:25 A.M., and 10:28 P.M. During an interview, on 7/30/2020 at 9:55 A.M., CNA (certified nursing assistant) 12 indicated she toilets Resident B when she gets her up in the morning, and at 10:00 A.M. and after lunch. CNA 12 indicated the resident is usually wet but she will also go on the bed side commode. During an interview, on 7/30/2020 at 11:50 A.M.,		licensed nursing staff on bowel and bladder evaluation that will happen for all new admission and quarterly for long term residents. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The DNS/designee will perform audits 5x per week for two weeks, then weekly x two weeks, then monthly x 3 months. Results of audits will be reviewed in monthly QAPI x 4 months.	

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	the Director of Nursing indicated there was no evaluation completed and or a Restorative Nursing Program completed since 1/5/2019. On 7/30/2020 at 11:30 A.M., the Director of Nursing provided the policy titled, "Incontinence Management/Bladder Function Guideline", dated 6/8/2015, and indicated the policy was the one currently used by the facility. The policy indicated"... Purpose: manage urinary incontinence, restore or maintain as much normal bladder function as possible. Procedure:Evaluation 1. Upon admission (if the resident has a history of incontinence) complete the Bowel and Bladder Tracking Tool. Completed to identify any trends or patterns that the resident may have in relation to incontinence. 2. Complete Bladder Evaluation Form....Upon completion of this evaluation as well as the Tracking Tool, the toileting/bladder program can be determined...." This Federal tag relates to Complaint IN00331779. 3.-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on record review, observation and interview, the facility failed to follow their policy	F 0695	**1. what corrective action(s) will be accomplished for those**	08/31/2020

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	on humidified oxygen therapy and failed to ensure residents requiring the use of oxygen did not have kinked tubing and nasal cannulas in place for 3 of 3 residents reviewed for respiratory care. (Resident F, G and J) Findings include: 1. On 7/28/2020 at 12:42 P.M., Resident J was observed sitting in her room playing with the oxygen tubing which was bunched up in her hand. The nasal cannula was not in place and an empty humidifier bottle was attached to the concentrator. On 7/28/2020 at 1:40 P.M., Resident J was observed trying to get up from her wheelchair and indicated, "help I need to go to the bathroom." Resident J had her oxygen tubing wound up and was holding it in her left hand. The nasal cannula was not in place and an empty humidifier bottle was attached to the concentrator. On 7/28/2020 at 1:44 P.M., Licensed Practical Nurse (LPN) 4 was summoned to Resident J's room. LPN 4 replaced the nasal cannula in Resident J's nose. During an interview, on 7/28/2020 at 1:45 P.M., LPN 4 indicated Resident J should have had her oxygen on, but she takes it off and the water bottle should have had water in it. On 7/28/2020 at 3:05 P.M., a clinical record review was completed and indicated Resident J was admitted on 7/22/2020. Her diagnoses included, but were not limited to: atrial fibrillation, heart failure, hypertension, dementia, fracture rib and hemothorax.		**residents found to have been affected by the deficient practice;** Resident F humidifier water bottle was filled and nasal cannula prong put in both nostrils with no adverse effects noted. Resident G received humidifier water bottle and tubing was unkinked and nasal cannula prongs put in both nostrils. No adverse effects noted. Resident J received water in humidifier bottle, nasal cannula prong put in place with no adverse effects noted. **2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All other residents have the potential to be affected. A review of all residents was completed with no other residents noted to be affected. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The DCE/designee will educate all licensed nursing staff on humidified oxygen therapy prior to the date of compliance.	

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	An admission MDS (Minimum Data Set) assessment, dated 7/26/2020, indicated Resident J had a BIMS (Brief Interview for Mental Status) score of 8, moderate cognitive impairment. Current physician orders indicated Resident J was to receive oxygen at 3 liters via nasal cannula. 2. On 7/28/2020 at 1:03 P.M., Resident F was observe to have an empty humidifier water bottle attached to the concentrator and the nasal cannula prong was only in one nostril. On 7/28/2020 at 1:40 P.M., Resident F's concentrator humidifier water bottle was empty and the nasal cannula was only in one nostril. On 7/28/2020 at 1:51 P.M., LPN 4 was observed to reapply Resident F's cannula correctly. During an interview, on 7/28/2002 at 1:52 P.M., LPN 4 indicated the oxygen should be applied to both nostrils and the humidifier bottle should have had water in it. A clinical record review was completed on 7/28/2020 at 3:30 P.M., and indicated Resident F's diagnoses included, but were not limited to: dementia, hypertension, chronic obstructive pulmonary disease and macular degeneration. An admission MDS (Minimum Data Set) assessment, dated 5/1/2020, indicated Resident F had a BIMS (Brief Interview for Mental Status) score of 14, cognition intact. A physicians' order, dated 5/11/2020, indicated Resident F was to use 02 continuously via nasal cannula at 4 liters.		**4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The DNS/designee will perform audits 5x per week for two weeks, then weekly x two weeks, then monthly x 3 months. Results of audits will be reviewed in monthly QAPI x 4 months.	

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	3. On 7/28/2020 at 1:03 P.M., Resident G's concentrator was observed to have no humidifier bottle attached to the concentrator. During an interview, on 7/28/2020 at 1:50 P.M., Registered Nurse (RN) 5 indicated she was unsure why there was no water bottle attached to the concentrator, but there should have been one. A clinical record review was completed on 7/28/2020 at 3:15 P.M., and indicated Resident G's diagnoses included, but were not limited to: heart failure, chronic obstructive pulmonary disease, diabetes and emphysema. A physician's order, dated 6/22/2020, indicated Resident G was to receive oxygen at 1-2 liters via nasal cannula if oxygen saturation is below 90% and to check the oxygen (BIOX) saturation every shift and to notify the physician if below 90%. An admission MDS (Minimum Data Set) assessment, dated 6/26/2020, indicated Resident G had a BIMS (Brief Interview for Mental Status) score of 12, moderate cognitive impairment. On 7/30/2020 at 9:43 A.M., Resident G was in bed with her nasal cannual on top of her head. The oxygen tube connected from the concentrator to the humidifier bottle was kinked and the humidifier bottle was not bubbling (indicating air was not passing into the bottle). On 7/30/2020 at 9:45 A.M., RN 5 was observed to remove the kink from the oxygen tubing for Resident G. On 7/29/2020 at 3:11 P.M., the Director of Nursing provided the policy titled, "Oxygen			

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	Administration (via nasal Cannula)", dated 8/29/2016, and indicated the policy was the one currently used by the facility. The policy indicated"...To standardize delivery of low flow concentration of oxygen via nasal cannula to achieve and maintain the desired FiO2 range. Connect the nasal cannula to the oxygen source and turn flow meter to the appropriate flow as ordered by the physician. Ensure good flow through nasal cannula. Ensure tubing is secure to face but not leaving indentations on cheeks or ear areas. Check periodically. Observe for patient sensitivity to oxygen administration, such as nasal dryness, which may indicate the need for humidification. All oxygen administered at 4 liters, or greater will be humidified. Oxygen between 2-4 liters may be humidified according to resident preference/comfort. This Federal tag relates to Complaint IN00327853. 3.1-47(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-MISHAWAKA	811 E 12TH STREET MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation and interview, the facility failed to follow standards of care of visually observing a resident take their medications for 1 of 1 randomly observed residents. (Resident D) Finding includes: On 7/28/2020 at 11:53 A.M., a plastic medication cup containing 2 white round pills was observed on Resident D's bed side table with the resident sitting in his wheelchair sleeping. During an interview, on 7/28/2020 at 11:58 A.M., Resident D indicated "they just brought them in and I take them after my lunch." He indicated his lunch tray would be there in a few minutes." A clinical record review was completed on 7/28/2020 at 2:26 P.M., indicating Resident D's current diagnoses included, but were not limited to: Parkinson's disease, anxiety, depression,	F 0755	**1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident D received his medications. No adverse effects were noted. **2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All other residents have the potential to be affected. A review of all residents was completed with no other residents noted to be	08/31/2020

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	chronic obstructive pulmonary disease and hypertension. A significant change MDS (Minimum Data Set) assessment, dated 5/11/2020, indicated Resident D had a BIMS (Brief Interview for Mental Status) score of 15, cognitively intact. Resident D's current physician orders indicated he received Acetaminophen (Tylenol) 325 mg (milligrams) 2 tablets three times a day at 6:00 A.M., 2:00 P.M., and 8:00 P.M. On 7/28/2020 at 12:48 P.M., Resident D's lunch tray was delivered. The medication cup with the pills remained on the bed side table. During an interview, on 7/28/2020 at 12:49 P.M., in Resident D's room, QMA (qualified medication aide) 2 indicated the resident takes his medication on his own and she had just brought them in. QMA 2 indicated the medication should not have been left at the bedside and requested Resident D to take the pills then left the room. Resident D took the medication cup and consumed the pills. QMA 2 had already left the room prior to the resident consuming the pills. During an interview, on 7/28/2020 at 12:52 P.M., QMA 2 indicated she should have watched the resident take the pills. On 7/29/2020 at 10:29 A.M., a policy was requested, but one was not provided. 3.1-25(b)(1)		affected. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The DCE/designee will educate all licensed nursing staff on the Medication Administration general guidelines prior to the date of compliance. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The DNS/designee will perform audits 5x per week for two weeks, then weekly x two weeks, then monthly x 3 months. Results of audits will be reviewed in monthly QAPI x 4 months.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals			

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	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure a medication cart was locked when not in view of a licensed staff member for 1 of 1 medication carts randomly observed. (Unit 100) Finding includes: On 7/29/2020 at 9:41 A.M., the medication cart for the 100 hallway was observed to be unlocked with no licensed nursing staff within sight of the medication cart. At 9:42 A.M. RN (Registered Nurse) 10 came out	F 0761	**1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No adverse effects were noted. Cart was locked immediately. **2. how other residents having the potential to be affected by the same deficient practice will be identified and what**	08/31/2020

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	of room 110 and walked to the medication cart and locked it. During an interview, on 7/29/2020 at 9:43 A.M., RN 10 indicated the medication cart should have been locked when not in sight. On 7/29/2020 at 3:11 P.M., the Administrator provided the policy titled, "Administration Procedures For All Medications", undated, and indicated the policy was the one currently used by the facility. The policy indicated"... A. Security: All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide...." 3.1-25(m)		**corrective action(s) will be taken;** All other residents have the potential to be affected. A review of all residents was completed with no other residents noted to be affected. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The DCE/designee will educate all licensed nursing staff on the medication cart general guidelines prior to the date of compliance. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The DNS/designee will perform audits 5x per week for two weeks, then weekly x two weeks, then monthly x 3 months. Results of audits will be reviewed in monthly QAPI x 4 months.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and			

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	comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be			

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	the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review and interview, the facility failed to ensure urinary catheter tubing and drainage bags were not touching the floor for 4 of 4 residents reviewed for catheters. (Resident E, G, H and K) Findings include: 1. On 7/28/2020 at 11:40 A.M., 12:15 P.M., 12:30 P.M. and 12:51 P.M., Resident E's large urinary drainage bag was observed on the floor while the resident was sitting in his wheel chair. During an interview, on 7/28/2020 at 12:51 P.M.,	F 0880	**1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents E, G, H and K had catheter bag and tubing assessed with no negative findings noted. Patients had tubing and bags immediately adjusted to meet regulatory guidelines. **2. how other residents having**	08/31/2020

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	CNA (Certified Nurses Aide) 3 indicated the urinary drainage bag should not be on the floor. A clinical record review was completed on 7/28/2020 at 2:55 P.M., indicating Resident E's current diagnoses included, but were not limited to: hypokalemia, bacteremia, retention of urine and obstructive and reflux uropathy. A physician's order, dated 2/23/2020, indicated: Foley catheter - use leg bag during the day and large UD (urinary drainage) bag to bedside drainage at night. A quarterly MDS (Minimum Data Set) assessment, dated 7/11/2020, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 8, moderate cognitive impairment. He required extensive assist of 1 staff for bed mobility and toilet use. A current, 7/6/2020, care plan indicated the resident had the potential for urinary tract infections related to indwelling catheter. The resident refuses at times to use the urinary leg bag. Interventions included, but were not limited to: Secure catheter tubing and catheter appropriately and use leg bag during the day and large UD bag to bedside at night. 2. A clinical record review was completed on 7/28/2020 at 3:15 P.M., and indicated Resident G's diagnoses included, but were not limited to: heart failure, chronic obstructive pulmonary disease, diabetes and emphysema. Current physician's orders indicated, Resident G had a Foley catheter with 10 cc (cubic centimeter) balloon, maintain to bedside drainage.		**the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All other residents with Catheters were observed and no negative findings were noted. **3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Facility conducted route cause analysis and directed in servicing completed by Golden Living Infection Control Consultant for all licensed clinical staff. **4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Facility DNS/designee will audit for infection control to include Catheter bags and tubing. The audit will be performed daily for 6 weeks, then monthly x 4 months. Results of audits will be reviewed in monthly QAPI x 6 months.	

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	On 7/29/2020 at 10:50 A.M., Resident G's catheter tubing was observed on the floor under her wheelchair. A care plan, dated 6/22/2020, indicated the resident has an indwelling urinary catheter related to surgical wounds. Interventions included, but were not limited to: keep drainage bag of catheter below the level of the bladder at all times and off the floor. During an interview on 7/3/2020 at 10:51 A.M., CNA 8 indicated the tubing should not be on the floor. 3. On 7/28/2020 at 11:28 A.M., Resident H's urinary drainage bag was observed on the floor. On 7/30/2020 at 9:52 A.M., Resident H's urinary catheter tubing was observed on the floor. A clinical record review was completed on 7/30/2020 at 11:40 A.M., and indicated Resident H's current diagnoses included, but were not limited to: diabetes, obstructive and reflux uropathy, dementia and retention of urine. A current, 4/9/2020, care plan problem indicated the resident was at risk for urinary tract infections. Interventions included, but were not limited to: secure catheter and tubing appropriately. During an interview, on 7/30/2020 at 9:54 A.M., CNA 3 indicated the tubing should not be on the floor. 4. On 7/28/2020 at 11:41A.M., 12:15 P.M., 12:30 P.M., and 12:51 P.M., Resident K's urinary drainage bag was observed on the floor.			

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	During an interview, on 7/28/2020 at 12:51 P.M., CNA 3 indicated the drainage bag should not be on the floor. A clinical record review was completed on 7/28/2020 at 2:45 P.M., indicating Resident K's current diagnoses included, but were not limited to: diabetes, chronic obstructive pulmonary disease, retention of urine, prostate cancer and hypertension. On 7/29/2020 at 12:49 P.M., Resident K's catheter tubing and urinary drainage bag was on the floor. During an interview, on 7/29/2020 at 12:50 P.M., CNA 7 indicated the drainage bag and tubing should not be on the floor. On 7/30/2020 at 9:15 A.M., the Administrator provided the policy titled, "Preventing Catheter Associated UTI's (CAUTI)," dated 8/20/2018, and indicated the policy was the one currently used by the facility. The policy indicated"...6. Maintain unobstructed urine flow. a. Keep catheter and tubing free of kinks. b. Secure catheter after insertion to prevent movement. c. Keep drainage bag below the level of the bladder at all times. Do not place the drainage bag on the floor...." 3.1-18(b)(1)			