STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	02/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00251595, IN00241012, IN00251614, IN00252821, IN00246206 and IN00240869. Complaint IN00251595-Substantiated. No deficiencies related to the allegations are cited. IN00241012- Substantiated. No deficiencies related to the allegation are cited. IN00251614-Unsubstantiated due to lack of evidence. IN00252821-Substantiated. State deficiencies related to the allegations are cited at F690. IN00246206-Substantiated. State deficiencies related to the allegations are cited at F580. IN00240869-Substantiated. State deficiencies related to the allegations are cited at F584 and F684. Survey dates: February 12, 13, 14, 15, 16, 17, 18, and 19, 2018 Facility number: 000195 Provider number: 155298 AIM number: 100267690 Census bed type: SNF/NF: 38 Total: 38 Census payor type:	F 0000	The plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the health and sfaty code section 1280 and 42 CFR 483.	

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

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	Medicare: 5 Medicaid: 32 Private: 1 Total: 38 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on February 26, 2018			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review the facility failed to accommodate communication needs for 1 of 1 non-English speaking resident reviewed for communication deficit. (Resident 2) Findings include: The record for Resident 2 was reviewed on 02/14/18 at 2:40 p.m. Diagnoses included, but were not limited to, cognitive communication deficit, major depressive disorder and dementia without behavioral disturbance. During an observation on 02/13/18 at 10:34 a.m., Resident 2 was sitting in the television room watching the television, in English, LPN 2 entered the activity room, approached the resident and began speaking to her. When the resident began to respond in Russian, LPN 2 requested the	F 0558	**F558: Reasonable accommodations for Needs/Preferences: R/T resident #2 non-English speaking resident** 1. On 3/6/2018 and 3/7/2018, resident #2 care plan, CNA task were revised to include interventions to address language barrier 2. An audit of the facility residents was done on 3/5/2018 to identify any other residents affected by the same alleged deficient practice. No other residents were identified. This audit was signed and dated by the Interim DON and MDS 3. Systemic changes: Assessments, care plan, and CNA task reviewed at the initial	03/21/2018

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	resident to speak in English. On 02/13/18 at 4:27 p.m., Resident 2 was observed in the television room watching television in English. On 02/15/18 at 2:59 p.m., Resident 2 was observed sitting in her room, there were no lights on, the television was on but the screen was blue, and there was no sound coming from the television. On 02/15/18 at 3:05 p.m., CNA 3 went to room and checked on her. The resident began speaking in Russian. CNA 3 told her to use English. At that time CNA 3 indicated if Resident 2 does not use English, she (CNA 3) thinks Resident 2 does not understand her so she does not talk to the resident anymore. She usually turns on the television but Resident 2 does not understand the English programs, so she will return later and change channel for the resident. CNA 3 indicated she was not aware of any special channels for the resident to watch or any music preferences. During an interview on 02/16/18 at 01:33 p.m. the CSN (Corporate Support Nurse) indicated the resident had a Fire Stick (A device that plugs into a television and enables the user to access their subscription channels) for her television that could access classical music and Russian Television. During an interview on 02/16/18 at 2:40 p.m., with the assistance of an electronic translator, Resident 2 indicated she was so happy to be able to talk to someone in her native language of Russian and she was lonely without anyone to talk to. During an observation on 02/19/18 at 11:33 a.m.,		72 hour IDT Staff educated by compliance date and protocol included in staff orientation 4. Monitored: 5 times a week per quality monitoring rounds, any concerns will be brought to the ED and over compliance will be monitor through QAPI 5. Date of compliance March 21, 2018	

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	the resident was sitting on side of bed in dark room, the television was not on and no music playing. A careplan, revised on 01/15/18, provided by the CSN on 02/19/18 at 12:00 p.m., indicated the resident was dependent on staff for emotional, intellectual and social stimulation. Interventions included but were not limited to, all staff to converse with resident while providing care and activities were to be compatible with known interests and preferences and adapted as needed. Also noted in the care plan, resident prefers Russian TV A careplan, revised on 01/31/18, provided by the CSN on 02/19/18 at 12:00 p.m., indicated the resident should be encouraged to engage in her preference of classical music and Russian television. 3.1-3(v)(1)			
F 0580 SS=E Bldg. 00	483.10(g)(14)(i)-(iv) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly			

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	(that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on observation, interview and record review the facility failed to notify the physician of changes in vital signs, outside the normal parameters, for 4 of 4 residents reviewed for notification of change. (Residents 7, 31, 35 and 29)	F 0580	**F580: Notifications of Resident Changes: R/T following allegations: resident #7 weights not reported to MD, resident #35 blood sugars not**	03/21/2018

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	Findings include: 1. The record for Resident 7 was reviewed on 02/14/18 at 8:48 a.m. Diagnoses included, but were not limited to, heart failure, hypertension and atrial fibrillation. A physician's order, written on 08/18/17, provided by the CSN (Corporate Support Nurse) on 02/14/18 at 1:31 p.m., indicated the resident was to have daily weights and to notify the doctor of any weight gain of 3 pounds in one day and/or 5 pounds or greater in three days. A careplan revised on 08/17/17, provided by the CSN on 02/14/18 at 1:31 p.m., indicated Resident 7's body weight was to remain within normal limits and to report weight gain. A review of the weights for the resident indicated the following, October 19, 2017 weight 197.2 pounds October 20. 2017 weight 215.8 pounds December 2, 2017 weight 202.8 pounds December 3, 2017 weight 214.2 pounds December 31, 2017 weight 215.4 pounds January 1, 2018 weight 230.3 pounds During an interview with LPN 7, she indicated the weights were concerning, the physician should have been notified and physician contact should have been documented. A review of staff charting indicated the physician was not informed of the increase in Resident 7's weights. 2. The record for Resident 35 was reviewed on		**reported to MD when outside of perimeters, resident # 31 did not have B/P perimeters and B/P of 183/89 on 1/3/2018 and B/P of 189/111 on 1/15/2018 not reported to MD, resident #29 had orders of blood sugar qid with perimeters to report to MD if less than 70 or over 300 which on 1/8/2018 blood sugar was 66 and no notification documented** 1. No negative outcome from alleged deficiency practice 2. Audit of residents identified as diabetic, hypertensive, and weights done to identify residents affected by alleged practice. Perimeters to notify MD for the following: weight variance, B/P outside of perimeters, and blood sugar documentation/perimeters. 3. Residents that receive antihypertensive medications include orders for B/P monitoring and perimeters for MD notification. Residents that are insulin dependent diabetic will have routine blood sugars with perimeters for MD notification. MD will be notified of resident's weights of the following variances: daily (3 pounds), or 5 pounds in 3 days for the residents on the CHF program, monthly (5 percent), 6 months (10 percent). Education of current staff will be completed by the compliance date and included in future orientation for	

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	02/14/18 at 2:40 p.m. Diagnoses included, but were not limited to, diabetes, hypertension and diabetic neuropathy. A physician's order, written on 08/09/17, provided by the CSN on 02/15/18 at 2:00 p.m., indicated to call the MD (physician) if the resident's blood sugar level was under 70 or over 350. A review of the blood sugars for Resident 35 indicated the following, On August 12th, 2017 at 7:35 a.m. the blood sugar result was 66. On August 13th, 2017 at 5:36 p.m. the blood sugar result was 64. On August 13th, 2017 at 9:30 p.m. the blood sugar result was 64. On August 18th, 2017 at 5:15 p.m. the blood sugar result was 66. On August 19th, 2017 at 10:01 p.m. the blood sugar result was 68. On August 20th, 2017 at 8:26 a.m. and 8:27 a.m. the blood sugar result was 62. On August 28th, 2017 at 8:20 a.m., the blood sugar result was 69. On August 28th, 2017 at 12:37 p.m. the blood sugar result was 68. No documentation was found to indicate the physician was notified of abnormal blood sugar levels. 3. The medical record for Resident 31 was reviewed on 02/14/2018 at 10:00 a.m. Diagnoses included, but were not limited to, paraplegia (a condition in which the voluntary movement of two extremities are permanently disabled), hypertension (elevated blood pressure) and chronic kidney disease.		licensed nurses. Initial education done by CNS on 2/14/2018 4. IDT meeting to review dashboard, physician orders, S-Bar, MAR and progress notes. Audits: For MD notification will be done by reviewing 5 residents a week x 4 weeks then monthly x2 then Q x2 and over compliance will be monitor through QAPI 5. Date of compliance: March 21, 2018	

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	A physician's order, dated 12/22/2017, indicated to take the resident's blood pressure every shift. A medication administration record for January 2018 indicated the residents blood pressure was 183/89 on 01/03/2018, 113/111 on 01/07/2017 and 180/111 on 01/15/2018. A current plan of care had a problem of hypertension with approaches that included, but were not limited to, monitor vital signs as ordered. During an interview with the Corporate Support Nurse on 02/19/2018 at 10:45 a.m., she indicated she could not provide documentation that indicated the physician was notified of the residents elevated blood pressure. 4. The record for Resident 29 was reviewed on 02/14/18 03:41 PM Diagnoses included, but were not limited to, long term insulin use. A current plan of care had a problem of Diabetes Mellitus with approaches that included, but were not limited to, monitor and report any signs and symptoms of hypoglycemia. Current physician orders included, but were not limited to, accucheck 4 times daily and to notify the physician if under 70 or over 300. The Medication Administration Record (MARs) for January 8, 2018 indicated the resident's accucheck was 66 at 5 p.m. On 02/16/18 at 11:38 a.m., information regarding notification of the blood sugar of 66 to the physician was requested from the Corporate Support Nurse (CSN). On 2/16/18 at 12:05 p.m., the CSN indicated there			

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	was no documentation of physician notification or follow-up for the blood sugar of 66. A current policy provided by the CSN (Corporate Support Nurse) on 02/19/18 at 11:28 a.m., titled "Change of Condition" indicated, " ...Purpose ...To appropriately ...communicate changes of condition ...to the primary care provider ...May include, but not limited to: Vital Signs ...2. Notify physician ...as soon as possible ...." A Policy titled "Blood Sugar Monitoring" was provide by the Corporate Nurse Consultant on 2/14/18 at 10:54 a.m., and deemed as current. The policy indicated: "...If the blood glucose level is above or below the normal range, document the time the physician was notified." This Federal tag relates to Complaint IN00246206. 3.1-5(a)(2)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including			

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	the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview and record review, the facility failed to maintain confidentiality of resident health information for 1 of 1 random observation for confidentiality. (Resident 85) Findings include: During an observation in the third floor dining room on 02/12/18 at 12:26 p.m., the facility Psychiatrist came into the dining room and asked a CNA where Resident 85 was located. He was pointed out to the physician. There were 10 residents in the dining area. The physician the went to stand by the resident while he was eating his lunch and began asking him questions. She asked "Do you know where you are?" "What is this place?" The resident was unable to answer	F 0583	**F583: Personal Privacy /Confidentiality: R/T alleging psychiatrist asked personal questions of resident #85 in the dining room during lunch** 1. The physician was notified by the IDON to refrain from personal questions in a public area. Physician was educated about the importance of promoting the resident's privacy in regard to personal questions and immediately ceased the questioning. 2. No other residents were affected by this practice 3. Education to the staff regarding maintaining and promoting the privacy and	03/21/2018

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	the questions. She then asked "How old are you?" The resident answered his age. "How long have you been here, what is the year and month?" The resident was able to state the year but missed the month and the physician informed him he was off by one month. The physician asked the resident how he was sleeping, eating and about his appetite, if anything was bothering him, giving him pain or discomfort. The resident did not not clearly answer all the questions. He tried to talk to the physician but his voice was low and there was staff and residents talking and music was playing. The Physician then moved to another resident and began asking questions. At this time, the Interim Director of Nursing (IDON) was notified the physician was discussing personal information in the dining room and she indicated at that time, the physician should not be doing this. The IDON then entered the dining room and had a discussion with the physician and they both exited the dining room. The record for Resident 85 was reviewed on 2/14/18 at 11:19 a.m. Diagnoses included, but were not limited to, anxiety and major depressive disorder. A 1/20/18 Admission Minimum Date Set (MDS) Assessment indicated the resident was not cognitively impaired. A 6/2015 Policy titled "Resident Rights" was provided by the Corporate Support Nurse on 2/14/18 at 10:54 a.m., and deemed as current. The policy indicated: "Policy It is the policy of Covenant Care...to provide our residents with a comfortable, private and safe environment in which to live...B. Each resident is entitled to their		confidentiality of resident interviews 4. Resident will be ask during monthly resident council if there privacy is being maintained during physician visits 5. Date of compliance March 21, 2018	

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	privacy. All medical and personal records must be kept confidential...." 3.1-3(o)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable			

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	lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview and record review the facility failed to ensure the resident environment was clean and in good repair for 3 of 12 resident rooms observed for cleanliness and good repair. (Room 305, 329 and 333) Findings include: The environmental tour was conducted on 2/14/18 at 2:06 p.m., with the Maintenance Director and Housekeeping Supervisor. The following was observed: 1. Room 305: there was a build up of debris/dark residue around the cove board in the room, 5 slats were missing from the vertical blind on the window and the cove board by the wall at the closet was missing. At that time, the Housekeeping Supervisor indicated the residue needed to be cleaned up and the blind slats replaced. 2. Room 329: there was one plate size brown spot on ceiling and the cove board was pulling away from the wall by bathroom door. At that time during interview, the Maintenance Director indicated the ceiling tiles needed to be replaced. 3. Room 333: there were 2 ceiling tiles with brown stained areas.	F 0584	F-584: 1 It is the policy of Pyramid Pont Rehab to provide a safe/clean/Compatible home-like environment. Room 305 had corner s cleaned and blinds replaced on 2/15/18, Rooms 329 and 333 had ceiling tiles replaced as of 2/15/18. 2. All residents have potential for the identified issues. Identified rooms on the third (3rd) floor to be audited by Housekeeping Supervisor and Maintenance for compliance issues cited. 3. Rooms will be randomly audited 3 times a week by Housekeeping or Maintenance for potential issues. Any issues identified on audits will be corrected that day. 4. Audit findings will be presented to the QAA Committee monthly x 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process. Compliance will be determined based on results of audits.	03/21/2018

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	155298	A. BUILDING 00 B. WING	02/19/2018

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	A cleaning schedule was provided by the Clinical Support Nurse on 2/16/18 at 12 p.m. The schedule indicated room 305 was deep cleaned February 4, 2018. This Federal tag relates to Complaint IN00240869. 3.1-19(f)			
F 0604 SS=D Bldg. 00	483.10(e)(1); 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use			

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	the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, interview and record review the facility failed to ensure a resident remained free from unnecessary restraints, and failed to complete the necessary assessments of a potential restraint for 2 of 2 Residents reviewed for physical restraints. (Resident 20 and 10) Findings include: 1. During an observation of Resident 20 on 02/12/18 at 9:59 a.m., LPN 1 entered the resident's room and placed a wander guard (a departure alert system for residents with dementia) on Resident 20's ankle she then requested he not remove the device again. LPN 1 left the room. Resident 20 indicated he had been caught by staff smoking marijuana outside the facility and they placed a wander guard on him to prevent him from going outside to smoke. He indicated he no longer had smoking materials and had no way to get any. He did not wish to wear the device and had cut it off his ankle. The record for resident 20 was reviewed on 02/14/18 at 1:13 p.m. Diagnoses included, but were not limited to, type two diabetes, chronic kidney disease and hypothyroidism. An MDS assessment, dated 12/29/17, indicated the resident was cognitively in tact. During an interview on 02/14/18 at 10:40 a.m., the resident indicated he never gave his consent to wear a wander guard and he did not wish to, but did not know who to talk to about removing it. He wanted to go outside to walk and sit on the bench, but was not supposed to because he had a	F 0604	**F604: Right to be Free of Physical Restraints: R/T a wander guard on resident #20 and a self releasing seat belt on resident # 10 that she could not release upon request** 1. The wander guard was removed from resident #20 as well as social services assisting resident per his wishes for alternate LTC placement in a smoking facility. On 2/16/2018, a complete physical restraint assessment was done on resident #10. The seat belt is utilized as a positioning device to enhance and enable resident to self propel self in wheel rule out chair. 2. Audit of residents with no other residents identified with a physical restraint 3. Physical restraints assessments to be done as indicated in order to distinguish between restraining vs. enhancing resident's mobility and/or ADL independence/quality of life. Education staff about restraints and assessments was done by CNS on 2/16/2018, IDT rounds, physician order reviews 4. Audits weekly x4 then monthly x2 then Q x 2 will review 5 residents for proper assessments for physical restraints and over compliance will be monitor through QAPI	03/21/2018

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	wander guard. During an interview on 02/15/18 at 02:10 p.m. the CSN (cooperate support nurse) indicated the interim social services director spoke with the resident concerning his preference not to wear a wander guard, and the facility had discontinued its use. The interim Social Services director (SSD) informed the resident of the facility's decision to discontinue his wander guard. Resident 20 indicated he was happy to have it removed & agreed with the SSD to sign out before leaving the building. A facility document titled, "Physical Restraint Assessment" dated 12/04/17, received by CSN on 02/15/18 at 10:30 a.m., indicated, "...Restraint use is only mandated if the resident is in imminent danger of injuring himself or others...." The assessment failed to identify imminent danger of injury, indicated no alternative interventions had been tried before the application of a wander guard. A facility document titled, "...Informed consent for the use of ...Physical Restraints...." dated 12/04/17, received by CSN on 02/15/18 at 10:30 a.m., indicated, the facility recommended Resident 20 wear a wander guard at all times, and was signed by Resident 20's daughter. The Admission Record for Resident 20, dated 09/23/17, provided by the CSN on 02/19/18 at 3:42 p.m., indicated Resident 20 was his own responsible party to make health care and financial decisions. During an interview on 02/19/18 at 2:29 p.m., the		5. Date of compliance: March 21, 2018	

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	CSN indicated she had no way of knowing why the restraint consent form was signed by Resident 20's daughter and not by Resident 20 himself, because the DON (director of nursing) who obtained consent no longer worked for the facility. 2. During an observation on 02/12/18 at 10:24 a.m., Resident 10 was sitting in her wheelchair by nurses cart with a seatbelt fastened at her waist. At that time LPN 1 indicated Resident 10 was not able to release her seat belt independently. Resident 10 attempted and was unable to remove the device. On 02/13/18 at 9:48 a.m., Resident 10 was observed sitting in her wheelchair with her seatbelt on in her room watching TV. On 02/13/18 at 4:40 p.m., Resident 10 was observed sitting in her wheelchair with her seatbelt on in her room watching TV. On 02/14/18 at 10:38 a.m., Resident 10 was observed sitting in her wheelchair with her seatbelt on in her room watching TV. During an interview on 02/14/18 at 3:39 p.m., The CSN indicated restraint assessments were done quarterly in conjunction with an IDT assessment. The record for the resident was reviewed on 02/14/18 at 1:38 p.m. Diagnoses included, but were not limited to, intellectual disabilities, osteoporosis and anxiety disorder. The resident was cognitively impaired. A care plan revised on 01/11/16 indicated, "Resident is at risk for falls related to gait/balance problems, incontinence, osteoporosis ...."			

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	Interventions included, but were not limited to, you seatbelt to win in wheelchair to assist a resident while propelling self in hallway, room. A facility document titled, "IDT Assessment & Progress Note V7," dated 09/19/17, provided by the CSN on 02/15/18 at 12:33 p.m., indicated Resident 10 did not have restraints or safety devices in use and Resident 10's wheelchair seatbelt was not assessed at that time. A facility document titled, "IDT Assessment & Progress Note V7," dated 12/11/17, provided by the CSN on 02/15/18 at 12:33 p.m., indicated the resident had a seatbelt for positioning while in wheelchair. There was no documentation of measures used to prevent functional decline, or the facilities plan to use the least restrictive device. The assessment box 1h was checked indicating, "...If the safety device cannot be self released or restricts freedom of movement or access to self and IDT recommends continued use of current device COMPLETE PHYSICAL RESTRAINT ASSESSMENT. The facility was not able to provide a current physical restraint assessment. During an interview on 02/15/18 at 2:10 p.m., the CNS indicated the resident's seatbelt was used as a positioning device to enable her to use her feet to propel her wheelchair without sliding out on to the floor. During an interview on 02/15/18 at 3:50 p.m., the MDS coordinator indicated the facility did not complete the physical restraint assessment as recommended by the IDT assessment because they did not consider Resident 10's seatbelt to be a restraint.			

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	3.1-3(w) 3.1-26(a) 3.1-26(o)			
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review and interview, the facility failed to ensure Minimum Data Set (MDS) Assessments were coded accurately to reflect the status of the resident for 3 of 12 MDS's reviewed for accuracy. (Resident 13, 26 and 10) Findings include: 1. The record for Resident 13 was reviewed on 02/13/18 at 09:44 a.m. Resident weights were reviewed with an August 10, 2017 weight of 182 and a January 3, 2018 weight of 178, a 2.2 % loss in 6 months. A Quarterly Minimum Data Set (MDS) Assessment dated 9/21/17 indicated a weight of 182, with no change. A Quarterly MDS Assessment dated 12/13/17 indicated: Weight 181 Loss of 5% or more in the last month or loss of 10% or more in last 6 months answered as yes. Gain of 5% or more in the last month or gain of 10% or more in last 6 months answered as yes. Parenteral/Intravenous feeding marked yes and feeding by naso-gastic or abdominal marked as yes.	F 0641	**F641: Accuracy of Assessments:** R/**T weights inaccurately coded as well as NG coded yes which was incorrect on the MDS assessments for resident # 13. MDS PASRR coded inaccurately for resident #13 and #26. Quarterly MDS dated 12/11/2017 coded as no physical restraints on resident #10.** **1.** On 2/16/2018, a physical restraint assessment was completed on resident #10. On 2/16/2018, the MDS for resident #13 was modified. **2.** No other residents were affected by this practice **3.** Dietary manger and MDS in-service on MDS coding on 2/19/2018 by CNS **4.** Audits weekly x4 then monthly x2 then Q x 2 will review 5 MDS to ensure MDS coding accuracy and over compliance will be monitor through QAPI **5.** Date of compliance: March 21 2018	03/21/2018

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	During an interview on 2/16/18 at 11:51 a.m., the Corporate Support Nurse (CSN) indicated the resident did not have a gastic-tube and ate all foods by mouth. 2. The record for Resident 26 was reviewed on 02/13/18 at 11:25 a.m. Diagnoses included, but were not limited to, mood disorder, delusions, anxiety and dementia. A 1/10/18 Annual MDS Assessment indicated in section A1500 "... Is the resident currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?..." This section was answered as no. A level II PASRR was completed on 4/25/16, and indicated the resident had a major mental illness and to continue with mental health services, and to repeat the level II if the resident decompensates. During an interview on 02/16/18 at 01:51 p.m. the CSN indicated Resident 13 and 26 MDS Assessments were coded incorrectly.3. On 02/13/18 at 9:48 a.m., Resident 10 was observed sitting in her wheelchair with her seatbelt on in her room watching TV. On 02/13/18 at 4:40 p.m., Resident 10 was observed sitting in her wheelchair with her seatbelt on in her room watching TV. On 02/14/18 at 10:38 a.m., Resident 10 was observed sitting in her wheelchair with her seatbelt on in her room watching TV.			

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	The record for resident 10 was reviewed on 02/14/18 at 1:38 p.m. Diagnoses included, but were not limited to, intellectual disabilities, osteoporosis and anxiety disorder. A quarterly MDS assessment dated 12/11/17 section P indicated no restraints were used on Resident 10. A Physician's order dated 04/17/2017 indicated Resident 10 was to have seatbelt on at all times when up in the wheelchair. During an interview on 02/19/18 at 03:35 p.m. the CSN indicated there was no policy on MDS Accuracy and the facility followed the Resident Assessment Instrument (RAI) manual. The October 2017 RAI Manual indicated: "...A1500: Preadmission Screening and Resident Review (PASRR)... Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness...or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions...."			
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,			

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	and the residents' choices. Based on observation, interview and record review the facility failed to apply palm protectors in accordance with the resident's care plan for 1 of 1 resident observed for splints and braces. (Resident 16) Findings include: Resident 16's record was reviewed on 02/14/2018 at 10:23 a.m. Diagnoses included, but were not limited to, degenerative diseases of the nervous system, contractures (abnormal shortening of muscle tissue rendering the muscle highly resistant to stretching), muscle weakness and moderate intellectual disabilities. On 02/12/2018 at 10:31 a.m., Resident 16 was observed in his wheelchair without palm protectors in bilateral hands. On 02/12/2018 at 12:36 p.m., Resident 16 was observed in bed without palm protectors in bilateral hands. On 02/13/2018 at 09:43 a.m., Resident 16 was observed in his wheelchair without palm protectors in bilateral hands. On 02/14/2018 at 10:35 a.m., Resident 16 was observed in bed without palm protectors in bilateral hands. On 02/14/2018 at 3:22 p.m., Resident 16 was observed in bed without palm protectors in bilateral hands. On 02/15/2018 at 10:15 a.m., Resident 16 was observed in bed without palm protectors in	F 0684	**F684: Quality of Care: R/T resident #16 had a care plan for palm protectors which were not in place secondary to a physician order dated 8/23/2015 to wear palm protectors at all times except with care** 1. Resident # 16 had wash cloths placed in their hands as per MD order dated 2/13/2018 2. Residents were assessed to ensure any palm protectors were in place as per MD orders 3. Nursing staff in-serviced by IDON by 3/21/2018, ensuring any orders for palm protectors are in place. Kardex informs staff on what residents need any protectors in their hands 4. Audits weekly x4 then monthly x2 then Q x 2 will review 5 residents for proper appliance of any palm protectors as ordered and over compliance will be monitor through QAPI 5. Date of compliance: March 21, 2018	03/21/2018

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	bilateral hands. On 02/15/2018 at 3:46 p.m., Resident 16 was observed in bed without palm protectors in bilateral hands. On 02/16/2018 at 9:06 a.m., Resident 16 was observed in bed without palm protectors in bilateral hands. A physician's order, dated 08/23/2015, indicated the resident was to wear palm protectors in bilateral hands at all times except during care. A physician's order, dated 02/13/2018, indicated the resident was to wear washcloths in bilateral hands at all times except during care. The medication administration record for February 2018 indicated palm protectors were in place on all shifts for 02/01/2018 thru 02/13/2018. A care plan, dated 08/17/2015, indicated Resident 16 had a self care deficit related to contractures and was to wear bilateral palm protectors at all times except during care. An undated CNA kardex report provided by the Clinical Support Nurse on 02/16/2018 at 9:00 a.m., indicated Resident 16 was to wear bilateral palm protectors on at all times except for care. During an interview with LPN 4 on 02/14/2018 at 10:51 a.m., she indicated she was not aware of any palm protectors Resident 16 was supposed to wear. During an interview with CNA 5 on 02/14/2018 at 03:24 p.m., she indicated she had never seen Resident 16 wear palm protectors.			

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	During an interview with the Clinical Support Nurse on 02/14/2018 at 3:30 p.m., she indicated Resident 16 was supposed to wear bilateral palm protectors according to the physician's order and care plan. During an interview with Occupational Therapist 6 on 2/16/2018 at 11:00 a.m., she indicated palm protectors were in the stock room located in the physical therapy department. No further information was provided prior to exit. This Federal tag relates to Complaint IN00240869. 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			

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	as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review the facility failed to provide routine incontinence care for 2 of 2 residents reviewed for incontinence care. (Resident B and Resident K) Findings include: 1. During an observation of a.m. care on 02/12/18 at 7:52 a.m., with CNA 10 and CNA 11 in attendance Resident B's brief was observed to be clean and dry. On 02/12/18 at 8:16 a.m., Resident B was observed being assisted to dining room for breakfast. On 02/12/18 at 8:28 a.m., Resident B was observed sitting at a dining room table visiting with staff. On 02/12/18 at 9:34 a.m., Resident B was observed being assisted to the lounge for activities. On 02/12/18 at 10:55 a.m., Resident B was observed in activities. On 02/12/18 at 12:09 p.m., Resident B was	F 0690	**F690: Bowel/Bladder Incontinence: R/T resident # B observed to not be checked and changed after 7:52am until 1:16pm when resident was changed and noted to be saturated with urine. Care plan dated 1/29/17 for resident #B implemented for excoriated coccyx. Resident #K observed on 2/12/2016 at 7:03am to be saturated with urine and feces.** 1. Resident B and K were changed with no negative outcome 2. Other residents were assessed to ensure toileting plans were being carried out 3. Nursing staff in-service on toileting residents per toileting plan by the IDON by 3/21/2018. 4 Audits weekly x4 then monthly x2 then Q x 2 will review 5 residents to ensure toileting has been carried out per resident toileting plan over compliance will	03/21/2018

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	155298	A. BUILDING 00 B. WING	02/19/2018

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	observed being assisted to dining room for activities. On 02/12/18 at 12:22 p.m., Resident B Received her lunch tray and began eating on her own using her hands at times. On 02/12/18 at 1:04 p.m., a CNA assisted Resident B to the lounge to watch TV. On 02/12/18 at 1:12 p.m., CNA 10 indicated Resident B's brief was last checked at 7:52 a.m., during surveyor observation of am care. During an observation of incontinence care on 02/12/18 at 1:16 p.m., with CNA 10 and CNA 11 in attendance, Resident B's brief was soiled and saturated with urine. The cushion on resident B's wheelchair was also wet. At that time, CNA 11 indicated Resident 18 had not been changed since 8 a.m.. During an interview on 02/12/18 at 1:28 p.m.,, LPN 1 indicated Resident B should have been checked and changed a minimum of every two hours. The record for resident B was reviewed on 02/14/18 at 1:54 p.m. Diagnoses included, but were not limited to, kidney failure, hypertension and anxiety disorder. A care plan, dated 01/29/18, provided by the CSN (corporate support nurse) on 02/19/18 at 4:32 p.m., indicated, "Resident had excoriation to coccyx" Interventions included, but were not limited to, keep resident clean and dry. A care plan revised on 04/11/17, provided by the CSN on 02/19/18 at 4:32 p.m., indicated, " Resident was incontinent of bowel and bladder related to		be monitor through QAPI 5. Date of compliance: March 21, 2018	

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	dementia, confusion, weakness...." Interventions included, but were not limited to, incontinence management, check resident every two hours. 2. During a bed check with CNA 11 on 02/12/18 at 7:03 a.m., Resident K was observed lying in his bed with his brief saturated with urine and feces. The folded draw sheet directly underneath resident K was observed to be wet with a brown ring around the edge, the fitted sheet of the bed was also observed to be wet. During an interview at that time CNA 11 indicated she was unsure when the resident had been changed last because her shift had just begun. During an interview on 02/12/18 at 7:20 a.m., The Director of Nursing indicated she expected CNAs to check residents for incontinence every two hours. The record for Resident K was reviewed on 02/14/18 at 2:26 p.m. Diagnoses included, but were not limited to, Cerebral Palsy, dysphagia and cognitive impairment. A care plan revised on 02/15/17, provided by the CSN on 02/19/18 at 4:23 p.m., indicated, Resident was incontinent of Bladder related to Cerebral Palsy. Interventions included, but were not limited to, check resident every 2 hours for incontinence management. This Federal tag relates to Complaint IN00252821. 3.1-41(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy			

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	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview and record review the facility failed to provide necessary care to a G-tube site to prevent skin breakdown for 1 of 2 residents reviewed for G-tube care. (Resident K) Findings include: During a bed check with CNA 11 on 02/12/18 at 7:03 a.m., Resident K was observed lying in his bed with his brief saturated with urine and feces. The folded draw sheet directly underneath resident K was observed to be wet with a brown ring around the edge, the fitted sheet of the bed was also observed to be wet. During an interview at that time CNA 11 indicated she was unsure when the resident had been changed last because her shift had just begun. She then left the room to gather supplies needed to change the residents with bed linens. As CNA 11 was removing the	F 0693	**F693: Tube Feeding Management/Restore Eating Skills: R/T failure to provide necessary care to a G-tube site to prevent breakdown on resident #K** 1. Dressing was changed for resident K at the time it was noted 2. Residents were assessed to ensure MD orders were being followed for any dressing orders 3. Nurses in-serviced on dating dressing and following MD orders by IDON by 3/21/2018 4. Audits weekly x4 then monthly x2 then Q x 2 will review 5 residents with dressings to ensure dressing is dated and has been changed per MD order and	03/21/2018

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	soiled bed linens, Resident K's G-tube site was observed to have a copious amount of thick brown, black and yellow drainage saturating the dressing and crusted around the G-tube insertion site. The dressing was undated. CNA 11 lifted the bottom left corner of the dressing exposing the G-tube site and surrounding skin which was red and raw. The dressing was placed on top of the balloon port (a hard plastic valve that can be accessed by a syringe and used to inject saline into a balloon to prevent the G-tube from falling out). At that time DON (director of nursing) and the ED (executive director) were notified and asked to observe the resident's condition. During an interview on 02/12/18 at 7:20 a.m., The DON indicated she would have expected the dressing to be dated and changed daily. The record for Resident K was reviewed on 02/14/18 at 2:26 p.m. Diagnoses included, but were not limited to, Cerebral Palsy, dysphagia and cognitive impairment. A Physician's order dated 02/12/2018, indicated to apply Cavilon film (a medication used to create a protective barrier on sensitive skin) to wound of g-tube and cover with drain gauze daily. 3.1-44(a)(2)		over compliance will be monitor through QAPI 5. Date of compliance: March 21, 2018	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.			

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	(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure the kitchen was clean, food was dated when opened, and food temperatures were checked pre meal service. This deficient practice had the potential to affect 35 of 38 residents who received food from the kitchen. Findings Include: During the initial kitchen tour on 02/12/18 at 06:54 a.m., with Dietary Aide 30, the following was observed: 1. 12 ounce spices opened and not dated when opened: chili powder, cumin, poultry seasoning 2. Main Freezer: beef steaks in a plastic bag in a box with the bag opened and not dated. 3. Refrigerator: a can of pears opened and not dated, large cans of cream of celery and cream of mushroom opened, covered in plastic wrap, not dated when opened.	F 0812	F-812: 1. It is the policy of Pyramid Point Rehab to procure, store and prepare food in a safe and clean environment. All areas identified were corrected at the time of survey. 2. Potentially all residents could be affected by the practice. 3. Staff were in-serviced in handling, preparing, and storing of items in accordance with policy and procedure. Staff were also in-serviced on proper documentation of food temps at each meal service. 4. Audits are to be performed by the Food Service Manager or designee no less than 3 times a week, times 2 weeks. Audit findings will be presented to the QAA Committee monthly x 6 months. The QAA Committee will	03/21/2018

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	4. Reach in cooler: 25 individual servings in small container of salad dressings and ketchup was not covered or dated when prepared, or use by date. There was 10 glasses of juice not dated when prepared, or use by date. The was also a pitcher of fruit punch not dated when prepared, or use by date. 5. There was debris on floor in freezer and in the dish room. During interview, on 2/12/18 at 7:12 a.m., Dietary Aide 30 indicated all items in the refrigerator and freezer should be dated when prepared or placed for storage. 6. The meal specific food temperature logs were reviewed and the following meals did not have documentation of food temperatures prior to meal service: a. 1/24/18 lunch b. 1/29/18 dinner c. 12/2 and 3/17 dinner d. 12/11 and 12/17 lunch e. 12/18/17 breakfast and lunch f. 12/26/17 breakfast and lunch On 12/14/18 at 10 a.m., during an interview with the Dietary Manager, he indicated all opened items should be dated and he was aware the temperature logs for food items were not all completed. A policy titled "Safe Food Temperatures" was provided by the Corporate Support Nurse on 2/16/18 at 8:15 a.m., and deemed as current. The policy indicated: "...All tray line food temperatures are checked and recorded on the food temperature log...."		review findings and determine the need for further monitoring and/or education per the QAA process. Compliance will be determined based on results of audits.	

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	A policy titled "Food Safely in Receiving and Storage" was provided by the Corporate Support Nurse on 2/16/18 at 8:15 a.m., and deemed as current. The policy indicated: "...Food is received and stored by methods to minimize contamination and bacterial growth...Expiration dates and use-by dates will be checked to assure the dates are within acceptable parameters...." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=D 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 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;			

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	§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 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.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review the facility failed to transport clean linen in a sanitary manner to prevent cross contamination, failed to secure an anchored catheter off the floor to minimize risk of infection and failed to maintain infection control standards during a dressing change for 3 of 3 residents reviewed for infection control(Residents 15, 27 and K). Findings include: 1. During an observation on 02/15/18 at 09:45 a.m., CNA 9 carried towels and sheets pressed up against her shirt in to Resident 15. At that time CNA 9 indicated clean linens are not to be carried against the body. In an interview with LPN 2, she indicated linen is carried away from the body when transporting it. A current policy provided by the CSN (Corporate Support Nurse) on 02/15/18 at 4:30 p.m., titled "Clean Linen" indicated, " ...Clean linen shall be ...handled and transported in a manner that prevents cross-contamination ...."2. On 02/12/2018 at 10:55 a.m., Resident 27's urinary catheter bag and tubing was observed resting on the floor. During an interview with LPN 8 at that time she indicated the resident's Foley catheter bag and tubing should not be touching the floor. On 02/14/2018 at 10:44 a.m., Resident 27's urinary catheter tubing was observed on the floor.	F 0880	**F880: Infection Prevention & Control: R/T CNA carried linens for resident #15 pressed up against her shirt. Resident #27 catheter's tubing was observed on floor. During a dressing change observation on resident #K the nurse did not follow Clean Dressing Change protocol in regard to washing hands and changing gloves.** 1. No negative outcome from alleged deficiency practice 2. Residents were assessed to ensure tubing no on the floor and staff assessed to ensure lines were being carried appropriately and treatment procedures were being carried out 3. Nurses in-served on proper procedure for completing treatments, nursing staff in-serviced on proper linen handing and positioning Foley Catheters tubing by IDON by 3/21/2018 4. Audits weekly x4 then monthly x2 then Q x 2 will review residents with Foley Catheters to ensure tubing is not on the floor, will random check 5 C.N.A to ensure lines are properly being handled, will watch 2 nurses to ensure proper treatment procedures are being carried out	03/21/2018

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	On 02/14/2018 at 3:59 p.m., Resident 27's urinary catheter tubing was observed on the floor. On 02/15/2018 at 3:21 p.m., Resident 27's urinary catheter tubing was observed on the floor. The record for Resident 27 was reviewed on 02/13/2018 at 3:42 p.m. Diagnoses included, but were not limited to, multiple sclerosis, neurogenic bladder (a condition which inhibits the ability to voluntarily control the bladder) and seizures. A physician's order dated 08/18/2017, indicated Resident 27 had a Foley catheter to gravity drainage. A care plan dated 11/15/2016, indicated Resident 27 had a Foley catheter for a neurogenic bladder and was at risk for infection. Interventions included, but were not limited to, catheter care every shift. During an interview with the Clinical Support Nurse on 02/15/2018 at 4:39 p.m., she indicated Resident 27's Foley catheter bag and tubing should be arranged so it did not rest on the floor to help prevent infection. An undated policy and procedure titled, "Catheter Care, Indwelling Catheter" provided by the Clinical Support Nurse on 02/13/2018 at 4:30 p.m., indicated "...Purpose to prevent infection...." No further policies could be provided upon request..3. During a dressing change observation for Resident K on 02/12/18 at 7:27 a.m., LPN 1 gathered supplies, performed hand hygiene and put on clean gloves. She then removed the soiled dressing and discarded it. At that time LPN 1		and over compliance will be monitor through QAPI 5. Date of compliance: March 21,2018	

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	indicated the dressing was placed on top of the balloon port in an effort to keep resident K from pulling the tube out. LPN 1 applied saline to a gauze pad which she used to clean the resident's g-tube site. Without changing gloves, she then applied skin prep (a medication used to create a protective barrier on sensitive skin) covered the site with a clean dressing and secured it with tape. LPN 1 discarded unused supplies and soiled gloves before leaving the room. During an interview at that time LPN 1 indicated she should have washed her hands and changed her gloves before placing a clean dressing, dated the dressing, and washed her hands prior to exiting the room. The record for the resident was reviewed on 02/14/18 at 2:26 p.m. Diagnoses included, but were not limited to, Cerebral Palsy, dysphagia and cognitive impairment. A Physician's order dated 02/12/2018, indicated to apply Cavilon film (a medication used to create a protective barrier on sensitive skin) to wound of g-tube and cover with drain gauze daily. A care plan revised on 02/15/17, provided by CSN (corporate support nurse) on 02/19/18 at 4:23 p.m., indicated, Resident was incontinent of Bladder related to Cerebral Palsy. Interventions included, but were not limited to, check resident every 2 hours for incontinence management. A facility document titled, " Hand Hygiene" revised November 2017, provided by the CSN on 02/19/18 at 4:23 p.m., indicated staff must perform hand hygiene before and after contact with the resident, after contact with bodily fluids or contaminated surfaces and after removing gloves.			

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	A facility document titled, "Clean Dressing Change Procedure" dated 2006, provided by the CSN on 02/19/18 at 4:23 p.m., indicated, "...Procedure ...5. put on first pair of disposable gloves. 6. Removed soiled dressing...7. Dispose of gloves...8. put on second pair of disposable gloves...10. Cleanse wound...11. apply prescribed medication...12. Applied dressing an secure with tape. 13. Remove gloves and discard with all unused supplies... Documentation guidelines... Date, time, dressing change...." 3.1-18(l)			