STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	C 09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS Recert was scheduled for week of 9/11/18 and was postponed due to hurricane Florence. BW	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623		10/15/18

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

Electronically Signed | 10/10/2018

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F 623	Continued From page 1	F 623		

allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and

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F 623	Continued From page 2 advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the responsible party (RP) in writing of the reason for the transfer to the hospital for 3 of 3 residents reviewed for hospitalization (Resident #199, #100 and #11). The findings included: 1a. Resident #199 was admitted to the facility on 6/7/18 and had a diagnosis of hypertension, congestive heart failure, chronic kidney disease and Alzheimer ' s disease. Review of the clinical record revealed Resident #199 was transferred to the hospital on 7/1/18. On 9/27/18 at 8:50 AM the Administrator stated in	F 623	Written Notification was provided by the Administrator to the three identified residents that were affected by not being provided written notification of discharge. Those identified were residents numbered 199, 100, and 11. This notification was provided to the resident and/or responsible party no later than 10/10/18. To insure no other residents were affected, an audit of the current resident population was completed the Administrator with assistance from the Business office Manager on October 5, 2018 and notifications were provided for those affected starting the month of	

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F 623	Continued From page 3 an interview they had not been notifying the resident/responsible party in writing of the reason for the transfer and thought a phone call was sufficient. 2b. Resident #199 was admitted to the facility on 6/7/18 and had a diagnosis of hypertension, congestive heart failure, chronic kidney disease and Alzheimer's disease. Review of the clinical record revealed Resident #199 was transferred to the hospital on 8/27/18. On 9/27/18 at 8:50 AM the Administrator stated in an interview they had not been notifying the resident/responsible party in writing of the reason for the transfer and thought a phone call was sufficient. 2. Resident #100 was admitted to the facility on 8/14/14 and had a diagnosis of chronic obstructive pulmonary disease and chronic respiratory failure. Review of the clinical record revealed Resident #100 was transferred to the hospital on 8/15/18. On 9/27/18 at 8:50 AM the Administrator stated in an interview they had not been notifying the resident/responsible party in writing of the reason for the transfer and thought a phone call was sufficient. 3. Resident #11 was originally admitted to the facility on 2/8/18 with diagnoses including Alzheimer's Disease, Dysphagia, Difficulty Walking, Chronic Obstructive Pulmonary Disease, Muscle Weakness and Cerebral Infarction. According to the most recent Admission Minimum Data Set dated 2/15/18, Resident #11 required extensive assistance to	F 623	September 2018. Any identified issues were corrected by 10/10/18. Education on the written notification of discharge policy was provided by the Administrator and the Director of Nursing to all licensed nursing staff as well as business office staff, to include Admissions, Business Office Manager, Assistant Business Office Manager and Social worker. This education will be complete by 10/15/18. This training will also be provided to all administrative staff and licensed nursing upon hire during orientation. Ongoing audits will be completed by the Administrator or Director of Nursing for observation and review of proper execution of notification of discharge. These audits will be conducted twice a week for four weeks, weekly for three weeks, and monthly for three months. These audits will also include all discharges for the first seven weeks of audit and then no less than 10% of the discharges from the center for the final two months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator,	

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F 623	Continued From page 4 total dependence in most areas of activities of daily. During an interview on 9/27/18 at 10:38 AM the Unit Manager revealed Resident #11 was discharged to the hospital on 7/30/18 through 8/2/18 for a gastrostomy (G-tube) replacement and he was kept in the hospital after the G-tube replacement and he returned to the facility. She also revealed Resident #11 was discharged sent to the hospital from 6/11/16 through 6/16/18 and 6/6/18 through 6/8/18 for pneumonia. During an interview on 9/27/18 at 11:30 AM, the Director of Nursing (DON) revealed the nurses on the unit notified the family when a resident was sent to the hospital. During an interview on 9/27/18 at 8:50 AM the Administrator stated they had not been notifying the resident/responsible party in writing of the reason for the transfer and thought a phone call was sufficient.	F 623	Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 625		10/15/18

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F 625	Continued From page 5 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide the bed hold policy at the time of transfer to the hospital for 3 of 3 residents reviewed for hospitalization (Resident #199, #100 and #11). The findings included: 1a. Resident #199 was admitted to the facility on 6/7/18 and had a diagnosis of hypertension, congestive heart failure, chronic kidney disease and Alzheimer's disease. Review of the clinical record revealed Resident #199 was transferred to the hospital on 7/1/18 where the resident was admitted. On 9/27/18 at 8:43 AM the Admissions Director stated in an interview if they send a resident to the hospital and the resident is admitted, they reach out to the family to see if they want to hold the bed. The Admissions Director further stated	F 625	Written notification was provided by the Administrator to the three identified residents that were affected by not being provided written bed hold policy. Those identified were residents numbered 199, 100, and 11. This notification was provided to the resident and/or responsible party no later than 10/10/18. To insure no other residents were affected, a full discharge audit was completed by the Administrator with assistance from the Business Office Manger on October 5, 2018 to insure bed hold policies were provided for those affected starting the month of September 2018. Any identified during this audit, were mailed a copy of the policy as well as bed hold agreement documents for reference by 10/10/18.	

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F 625	Continued From page 6 they did not provide the bed hold policy at the time of the transfer to the hospital. On 9/27/18 at 8:50 AM the Administrator stated in an interview the nurse on would contact the family regarding the resident's transfer to the hospital. The Administrator stated the resident/family was given a copy of the bed hold policy in the admission packet and explained to them during the admission process and upon discharge to the hospital the responsible party was called to ask if they wanted to hold the bed and the information was noted in the resident's financial folder. 1b. Resident #199 was admitted to the facility on 6/7/18 and had a diagnosis of hypertension, congestive heart failure, chronic kidney disease and Alzheimer's disease. Review of the clinical record revealed Resident #199 was transferred to the hospital on 8/27/18 and was admitted. On 9/27/18 at 8:43 AM the Admissions Director stated in an interview if they send a resident to the hospital and the resident is admitted, they reach out to the family to see if they want to hold the bed. The Admissions Director further stated they did not provide the bed hold policy at the time of the transfer to the hospital. On 9/27/18 at 8:50 AM the Administrator stated in an interview the nurse on duty would contact the family regarding the resident ' s transfer to the hospital. The Administrator stated the resident/family was given a copy of the bed hold policy in the admission packet and explained to them during the admission process and upon discharge to the hospital the responsible party was called to ask if they wanted to hold the bed	F 625	Education regarding provision of the written bed hold policy was provided by the Administrator and the Director of Nursing to all licensed nursing staff as well as business office staff, to include Admissions, Business Office Manager, Assistant Business Office Manager and Social worker. This education will be complete by 10/15/18. This training will also be provided to all administrative staff and licensed nursing upon hire during orientation. Ongoing audits were initiated on 10/5/2018 by the Administrator or Director of Nursing for observation and review of proper execution of bed hold policy with written notice as required. These audits will be conducted weekly for three weeks, monthly for three months and then audits each month for two months. The first three weeks and the first month of monthly audits will include all discharges. Following those audits, the audits will also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and	

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F 625	Continued From page 7 and the information was noted in the resident's financial folder. 2. Resident #100 was admitted to the facility on 8/14/18 and had a diagnosis of chronic obstructive pulmonary disease and chronic respiratory failure. Review of the clinical record revealed Resident #100 was transferred to the hospital on 8/15/18. On 9/27/18 at 8:43 AM the Admissions Director stated in an interview if they send a resident to the hospital and the resident is admitted, they reach out to the family to see if they want to hold the bed. The Admissions Director further stated they did not provide the bed hold policy at the time of the transfer to the hospital. On 9/27/18 at 8:50 AM the Administrator stated in an interview the nurse on duty would the family regarding the resident ' s transfer to the hospital. The Administrator stated the resident/family was given a copy of the bed hold policy in the admission packet and explained to them during the admission process and upon discharge to the hospital the responsible party was called to ask if they wanted to hold the bed and the information was noted in the resident's financial folder. 3. Resident #11 was originally admitted to the facility on 2/8/18 with diagnoses including Alzheimer's Disease, Dysphagia, Difficulty Walking, Chronic Obstructive Pulmonary Disease, Muscle Weakness and Cerebral Infarction. According to the most recent Admission Minimum Data Set dated 2/15/18, Resident #11 required extensive assistance to total dependence in most areas of activities of daily.	F 625	Environmental Services. Other members may be assigned as the need should arise.	

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F 625	Continued From page 8	F 625		

During an interview on 9/26/18 at 4:22 PM with Staff Nurse #1 and the Unit Manager, Staff Nurse #1 revealed when residents were discharged to the hospital she sent a face sheet, medication administration record (MAR) and Do Not Resuscitate (DNR) order. She said she did not know anything about a bed hold policy. The Unit Manager revealed they took care of the bed hold policy up front.

During an interview on 9/27/18 at 10:38 AM the Unit Manager revealed Resident #11 was discharged to the hospital on 7/30/18 through 8/2/18 for a gastrostomy (G-tube) replacement and he was kept in the hospital after the G-tube replacement and he returned to the facility. She also revealed Resident #11 was discharged sent to the hospital from 6/11/16 through 6/16/18 and 6/6/18 through 6/8/18 for pneumonia.

During an interview on 9/27/18 at 11:30 AM, the Director of Nursing (DON) revealed the Admissions Coordinator was notified when residents were discharged to the hospital and from her understanding a copy of the bed hold policy was provided upon the resident's discharge to the hospital.

During an interview on 09/27/18 at 08:43 AM, the Admission' s Coordinator stated when a resident was discharged to the hospital, they reached out to the family to see if they wanted to hold the bed. She revealed a bed hold policy was not sent to the hospital with the resident.

During an interview on 9/27/18 at 8:50 AM, the Administrator stated residents/responsible persons were given a copy of the bed hold policy

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F 625	Continued From page 9 in the admission packet and the bed hold policy was explained during the admissions process.	F 625		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment.	F 640		10/15/18

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F 640	Continued From page 10 (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit Quarterly Minimum Data Set (MDS) assessments and a Death in Facility tracking record for 2 of 3 residents (Resident #1 and #2) selected to be reviewed for Resident Assessments. Findings included: 1. Resident #1 had been admitted on 8/12/14. Her diagnoses included cancer, anemia and hypertension. a. A Significant Change in Status assessment dated 4/3/18 for Resident #1 was the most recent assessment transmitted to the Centers for Medicare and Medicaid Services (CMS) database. A review of the facility documentation revealed Resident #1 had a Quarterly MDS assessment dated 6/27/18 completed and marked as accepted on 7/20/18.	F 640	MDS assessments for affected residents, #1 and #2 were corrected and resubmitted by the MDS Coordinator through Simple LTC for validation and acceptance on 9/26/18. A review and audit of all past MDS validation reports from 7/1/18 through 9/25/18 will be completed to insure no other residents were affected. This audit will be completed by the lead Minimum Data Set Coordinator (MDSC) and validated by the Administrator and/or the Clinical Reimbursement Consultant by 10/15/18. For any identified errors, corrections were made and were resubmitted by 10/15/2018. Education to all MSDC Nurses completed 10/04/18 by the Regional Clinical Reimbursement Specialist for the region. This training will also be provided to all MSDC Nurses upon hire during	

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F 640	Continued From page 11 On 9/26/18 at 12:12 PM an interview was conducted with the MDS nurse. She stated a previous MDS nurse had submitted this assessment. According to the transmission report, the resident's quarterly assessment dated 6/27/18 had an error and had been rejected by the CMS database. A modification had been done for this assessment but did not correct the problem and it had been rejected a second time. The error had not been corrected and the nurse must have marked the whole batch of transmitted assessments as "accepted" in the facility system. On 9/26/18 at 1:44 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation of the MDS nurse to transmit assessments within the time frames set by CMS, to correct any known inaccuracies and resubmit the assessment. The DON also stated it would be her expectation of the MDS nurse to not mark an assessment as accepted if it had not been accepted into the CMS database. b. A Significant Change in Status assessment dated 4/3/18 for Resident #1 was the most recent assessment transmitted to the Centers for Medicare and Medicaid Services (CMS) database. A review of the facility documentation revealed Resident #1 had a Death in Facility tracking record dated 7/7/18 had been completed and noted as accepted on 7/20/18. On 9/26/18 at 12:12 PM an interview was conducted with the MDS nurse. She stated a previous MDS nurse had submitted this	F 640	orientation and annually for review. Ongoing audits will be initiated on 10/4/18 by the Clinical Reimbursement Consultant as well as validation by the Administrator following transmissions of MDS assessments. These audits will be conducted weekly for two weeks, then monthly for three months. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

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	345336	A. BUILDING _____ B. WING _____	C 09/27/2018

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F 640	Continued From page 12	F 640		

assessment. According to the transmission report, the resident's 7/7/18 Death tracker had an error and had been rejected by the CMS database. The error had not been corrected and the nurse must have marked the whole batch of transmitted assessments as "accepted" in the facility system.

On 9/26/18 at 1:44 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation of the MDS nurse to transmit assessments within the time frames set by CMS, to correct any known inaccuracies and resubmit the assessment. The DON also stated it would be her expectation of the MDS nurse to not mark an assessment as accepted if it had not been accepted into the CMS database.

2. Resident #2 had been admitted on 1/16/17. His diagnoses included anemia, hypertension, peripheral vascular disease and diabetes. An Annual MDS assessment dated 5/2/18 was the most recent assessment transmitted to the Centers for Medicare and Medicaid Services (CMS) database.

A review of the facility documentation revealed a Quarterly MDS assessment dated 7/27/18 had been completed for Resident #2 and marked as accepted on 8/17/18.

On 9/26/18 at 12:12 PM an interview was conducted with the MDS nurse. She stated a previous MDS nurse had submitted this assessment. According to the transmission report, the assessment had an error and had been rejected by the CMS database. The error had not been corrected and the nurse must have

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F 640	Continued From page 13 marked the whole batch of transmitted assessments as "accepted" in the facility system. On 9/26/18 at 1:44 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation of the MDS nurse to transmit assessments within the time frames set by CMS, to correct any known inaccuracies and resubmit the assessment. The DON also stated it would be her expectation of the MDS nurse to not mark an assessment as accepted if it had not been accepted into the CMS database.	F 640		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		10/15/18

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F 657	Continued From page 14 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to update a resident's Care Plan to include the care for an indwelling urinary catheter for 1 of 1 resident reviewed for a urinary catheter (Resident #199). The findings included: Resident #199 was admitted to the facility on 6/7/18 and re-admitted to the facility on 9/12/18 with a diagnosis of Stage 3 pressure ulcer. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 9/13/18 revealed the resident had severe cognitive impairment and required extensive to total assist with activities of daily living. Review of the clinical record revealed a physician ' s order dated 9/18/18 to place an indwelling urinary catheter. On 9/24/18 at 12:05 PM, Resident #199 was observed to have a urinary catheter. On 9/25/18 at 8:14 AM the resident was observed to have a urinary catheter. Review of the resident's Care Plan dated 6/7/18 and reviewed on 9/25/18 did not include information regarding the resident ' s urinary catheter. Review of the Care Kardex used to provide information regarding resident care for	F 657	The care plan and care card were immediately updated by the Minimum Data Set Coordinator to include a care plan for an indwelling catheter as well as indication for catheter care and to use a leg band for placement on the care card 9/26/18 for the affected resident, #199. In house review completed the Director of Nursing on 10/01/18 of all residents with a catheter that have the potential to be affected by the deficient practice. It was found that no other residents were found to be without a care plan and care cards were in place with correct information regarding care needs. Education was completed for all licensed nurses and MDS nurses, provided by the Director of Nursing. This education was complete by 10/15/2018. This training will also be provided to all nurses and MDS coordinators upon hire during orientation and at least annually. Ongoing audits will be completed by the Director of Nursing or Unit Managers for observation and review of care cards and care plans through daily Clinical White Board meetings as well as through audits to ensure care plans and care cards appropriately identify the resident□s care	

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F 657	Continued From page 15 the nursing assistants (NAs) revealed no information about the care for a urinary catheter for Resident #199. On 9/26/18 at 2:51 PM an interview was conducted with the MDS Nurse who stated they had a care plan meeting with the family yesterday and talked about the catheter and thought she had a care plan for the catheter. The MDS Nurse further stated they had a clinical meeting on weekday mornings and discussed the orders and add to the care plan if needed during this meeting. The MDS Nurse stated the nurse on the unit that attended the morning meetings was supposed to update the NAs Care Kardex. On 9/26/18 at 4:50 PM the MDS Nurse provided a Care Plan dated 9/26/18 for an indwelling urinary catheter for Resident #199. The Care Plan noted the resident had a urinary catheter due to a Stage 3 or 4 pressure ulcer in an area affected by incontinence. One of the approaches read: "Secure catheter." On 9/27/18 at 12:44 PM the Director of Nursing (DON) stated in an interview the care plan should have been done as soon as the catheter was placed. On 9/27/18 at 1:18 PM the DON stated in an interview she had reviewed her notes from the clinical meeting dated 9/19/18 and the resident's name was in her notes and she had checked that the care plan had been done. The DON further stated she did not know what happened to the care plan or why it was not on the chart with the resident's Care Plan.	F 657	needs. These audits will be conducted 5 days per week for two weeks, then weekly for two weeks, then monthly for three months. These audits will include any affected residents that are admitted with or have a catheter placed during their stay. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or Staff Development Coordinator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	
F 690	Bowel/Bladder Incontinence, Catheter, UTI	F 690		10/15/18

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F 690 SS=D	Continued From page 16 CFR(s): 483.25(e)(1)-(3) §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 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 690	The affected resident, #199, was	

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F 690	Continued From page 17 interviews, the facility failed to secure an indwelling urinary catheter for 1 of 1 residents reviewed for an indwelling urinary catheter (Resident #199). The findings included: Resident #199 was admitted to the facility on 6/7/18 and re-admitted to the facility on 9/12/18 with a diagnosis of Stage 3 pressure ulcer. The most recent Minimum Data Set (MDS Assessment (Quarterly) revealed the resident had severe cognitive impairment, required extensive to total assistance with activities of daily living and was incontinent of bowel and bladder. There was a physician's order dated 9/18/18 to place an indwelling urinary catheter. The Care Plan for Resident #199 reviewed by the facility on 9/25/18 for activities of daily living noted the resident was incontinent of bowel and bladder. The Care Plan did not include information regarding a urinary catheter. On 9/26/18 at 2:13 PM, nursing assistant (NA) #1 and NA #2 were observed to provide incontinence care for Resident #199. There was not a catheter strap present to secure the catheter. When the care was complete the NAs were asked if they used a device to secure a urinary catheter. NA #2 stated some residents had a catheter strap and some did not but could not explain why some residents had a catheter strap and other residents did not. On 9/26/18 at 2:35 PM the Director of Nursing (DON) stated in an interview she had observed	F 690	provided a leg band by the charge nurse on the unit immediately on 9/26/18 for the catheter tubing to be secured to the body. In house review of all residents with a catheter that have the potential to be affected by the deficient practice was completed by Unit Managers on 09/26/18. It was found that no other residents were without a catheter leg band. Education regarding placement of a leg band for residents who require the use of a catheter to all certified nursing assistants and licensed nurses provided by the Director of Nursing and/or the Unit Manager. This education to be complete by 10/15/18. This training will also be provided to all nurse assistants and licensed nurses upon hire during orientation and at least annually through a skills review. Ongoing audits were initiated on 10/01/18 and will be continued by the DON, Administrator, or Staff Development Coordinator to include observations and review of proper placement of the catheter leg bands for any affected residents. These audits will be conducted 5 days per week for two weeks, then weekly for two weeks, then monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued	

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F 690	Continued From page 18 Resident #199 with a catheter strap over the weekend. The DON further stated that all residents with an indwelling urinary catheter were supposed to have a leg strap to secure the catheter to prevent pulling on the catheter and the NAs could put these on.	F 690	compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide full visual privacy for residents whose privacy curtains were not wide enough for 2 of 3 halls. The findings included: 1. On 9/24/18 at 2:34 PM in Room # 64 Bed A's closed privacy curtain was observed with a 6 foot gap between the end of the curtain to Bed B. On 9/27/18 at 10:47 AM in Room # 64 Bed A's closed privacy curtain was observed with a 6 foot gap between the end of the curtain to Bed B. 2. On 9/24/18 at 2:37 PM in Room # 59 Bed A's closed privacy curtain was observed with a 6 foot gap between the end of the curtain to Bed B.	F 914	Upon identification of deficient practice, affected rooms were fitted with the most appropriate sized privacy curtains by the Housekeeping supervisor and the Administrator to insure full visual privacy of residents. Facility rounds completed by the housekeeping supervisor, maintenance director and administrator to measure each room to ensure the most appropriate sized privacy curtain. Full measures provided to DSSI on 10/04/18 to obtain a quote and timeline for shipping of necessary new privacy curtains. Estimated return of goods, likely 6 to 8	10/15/18

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F 914	Continued From page 19 On 9/26/18 at 3:57 PM in Room # 59 Bed A's closed privacy curtain was observed with a 6 foot gap between the end of the curtain to Bed B. 3. On 9/26/18 at 4:00 PM in Room # 52 Bed A's closed privacy curtain was observed with a 5 foot gap between the end of the curtain to Bed B. On 9/27/18 at 10:50 AM in Room # 52 Bed A's closed privacy curtain was observed with a 5 foot gap between the end of the curtain to Bed B. 4. On 9/26/18 at 4:02 PM in Room # 48 Bed A's closed privacy curtain was observed with a 3 foot gap between the end of the curtain to Bed B. On 9/27/18 at 10:51 AM in Room # 48 Bed A's closed privacy curtain was observed with a 3 foot gap between the end of the curtain to Bed B. 5. On 9/26/18 at 4:04 PM in Room # 41 Bed A's closed privacy curtain was observed with a 3 foot gap between the end of the curtain to Bed B. On 9/27/18 at 10:55 AM in Room # 41 Bed A's closed privacy curtain was observed with a 3 foot gap between the end of the curtain to Bed B. 6. On 9/26/18 at 4:07 PM in Room # 36 Bed B's closed privacy curtain was observed with a 3 foot gap from the end of the curtain to the wall. 7. On 9/27/18 at 8:59 AM in Room # 56 Bed A's closed 4 foot privacy curtain was not wide enough to provide full visual privacy. In an interview on 9/27/18 at 11:00 AM the housekeeping manager stated that on rounds he checked to make sure full curtains were in place. During an interview on 9/27/18 at 11:10 AM the Administrator stated she expected full visual	F 914	weeks from time of approved order to receive new curtains in the center. Education was provided by the Administrator, the Director of Nursing and the Housekeeping Supervisor to staff members of the housekeeping, maintenance, and nursing departments by 10/15/2018 to insure understanding of appropriate sized privacy curtains are in place for residents that live in the center. This training will also be provided to housekeeping, maintenance and nursing staff upon hire during orientation. Ongoing audits were started on 10/01/18 and will be completed by the Administrator and Housekeeping supervisor to insure all curtains meet expectations of privacy are met. These audits will be conducted 3 times per week for two weeks, then weekly for two weeks, then monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Director Of Nursing or Staff Development Coordinator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

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F 914	Continued From page 20 privacy curtains were in place to provide residents with their full privacy. She stated she would speak with housekeeping to hang more curtains.	F 914		