STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345340	A. BUILDING _____ B. WING _____	C 01/10/2019

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MAPLE LEAF HEALTH CARE	1101 MAPLE CARE LANE STATESVILLE, NC 28625

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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		2/7/19

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

Electronically Signed | 01/28/2019

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to share resident information in a private manner, which resulted in the resident overhearing a conversation, regarding her personal information, which made the resident cry and feel very upset for 1 of 1 resident reviewed for dignity (Resident #285). The findings included: Resident #285 admitted to the facility on 12/27/18 with diagnoses that included: urinary tract infection, lack of coordination, and hypokalemia. The resident s comprehensive minimum data set (MDS) dated 01/03/19 revealed that Resident #285 was cognitively intact, and no behaviors were identified. The MDS further revealed that Resident #285 required extensive assistance with bed mobility, transfers, dressing and required set up assistance only with eating. An interview was conducted with Resident #285 on 01/07/19 at 3:32 PM. Resident #285 stated that she had been at the facility since 12/27/18. She stated that she had an allergy to gluten and the other day in the dining room she overheard the Activity Assistant (AA) tell a member of the dietary staff that she was not allergic to gluten. Resident #285 stated that the AA did not realize that she had overheard the conversation. She added that she also heard the AA state that it was more of a behavior issue with eating and that the doctor had indicated she was not actually allergic	F 550	F 550 1. Corrective action was accomplished for the alleged deficient practice by the Administrator re-educating the Activity Assistant and Dietary Manager on 1/29/19 regarding sharing resident information in a private manner with respect and dignity. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The Director of Nursing re-educated all staff regarding sharing resident information in a private manner with respect and dignity on 1/11/19. The Director of Nursing will randomly interview five residents per week for 12 weeks to ensure resident information is being shared in a private manner with respect and dignity. New employees will be educated regarding sharing resident information in a private manner with respect and dignity during orientation. Opportunities will be corrected as identified. 4. To monitor the effectiveness of the above action plan, the Director of Nursing will review the findings of the interviews in the QAPI meeting monthly for 3 months beginning 2/7/19. The QAPI Committee will evaluate the effectiveness of the plan for 3 months beginning 2/7/19 and make recommendations for changes in the plan as indicated. Jennifer Simon, LNHA will be responsible for the completion of this plan of correction.	

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F 550	Continued From page 2	F 550		

to gluten. Resident #285 also overheard the AA also tell the dietary staff that the snacks she consumed were not gluten free. Resident #285 stated that she overhead the entire conversation and got very upset because it made her feel like they did not believe her when she told them she was allergic to gluten. Resident #285 stated that if she ate gluten she would get bumps all over her skin and had trouble breathing. Resident #285 further stated that when the AA noted she was crying she asked her what was wrong, she indicated she did not tell her that she had overheard the conversation. Resident #285 stated that the staff needed to be careful of what they said because she could hear the conversation and so could anyone else that was in the dining room that day.

An observation was made on 01/08/19 at 12:12 PM of the AA pushing a resident to the dining room for lunch. Another resident stopped the AA and asked her to push him to the dining room. The AA replied that she would come back and get him and then turned to the resident she was pushing and stated, "he is just trying to get out of doing his exercise" and proceed to the dining room with the resident she was pushing.

An interview was conducted with the AA on 01/10/19 at 11:47 AM. The AA stated that she managed the dining room at lunch and that Resident #285's meal ticket indicated that she had an allergy to gluten. The AA stated that the other day she had a conversation with the Dietary Manager (DM) in the dining room near the kitchen entrance about the snacks that Resident #285 was eating in her room were not gluten free but when her family brought them to her she would eat them. She added that Resident #285 may

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F 550	Continued From page 3 have been in the dining room and may have overheard the conversation. She stated that she noted Resident #285 had her head was down and was "weepy" and she did ask her if she was feeling ok. The AA stated that the resident should never overhear staff conversations that was inappropriate. The AA stated that she should have had that conversation in a private place where residents were not able to hear the conversation. An interview was conducted with the Administrator and the Director of Nursing (DON) on 01/10/19 at 6:17 PM. The Administrator stated that she would want her staff to treat each resident with respect and dignity but did not wish to comment on the specific conversation.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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.	F 584		2/7/19

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F 584	Continued From page 4 §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 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to label personal items on 1 of 4 hallways (rooms #308 and #310). The findings included: 1. An observation of Room #308 was made on 01/07/19 at 10:13 AM. There were 2 clear plastic cups that contained a toothbrush in each cup. No name could be identified on either cup or toothbrush. There was also a denture cup that contained a set of upper dentures. No name could be identified on the denture cup or dentures.	F 584	F 584 1. Corrective action was accomplished for the alleged deficient practice by the Quality of Life Director providing new labeled toothbrushes and holders and by properly labeling the denture cups in Rooms #308 and #310 on 1/10/19. 2. All residents on the 300 hall have the potential to be affected by the alleged deficient practice. The Quality of Life Director completed an initial round of all rooms on 300 hall to ensure toothbrush and denture labeling. 3. The Director of Nursing re-educated the staff regarding labeling of personal items specifically toothbrushes and	

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F 584	Continued From page 5 An observation of Room #308 was made on 01/08/19 at 9:16 AM. There were 2 clear plastic cups that contained a toothbrush in each cup. No name could be identified on either cup or toothbrush. There was also a denture cup that contained a set of upper dentures. No name could be identified on the denture cup or dentures. An observation of Room #308 was made on 01/09/19 at 2:13 PM. There were 2 clear plastic cups that contained a toothbrush in each cup. There was a name located on one of the cups but not on the other cup or toothbrush. There was also a denture cup that contained a set of upper dentures. No name could be identified on the denture cup or dentures. An interview was conducted with Nursing Assistant (NA) #1 on 01/09/19 at 2:35 PM. NA #1 observed the cups in Room #308 and could not identify which cup belonged to which resident in the room. NA #1 also could not identify which resident the set of upper dentures belonged to in the room. NA #1 stated that each cup with toothbrush and denture cup should be labelled with the resident's name so that the staff knew which resident each personal item belonged too. An interview was conducted with the Director of Nursing (DON) on 01/10/18 at 6:00 PM. The DON stated that each personal item should be clearly labelled with the resident's name. 2. An observation of Room #310 was made on 01/07/19 at 10:19 AM. There were 2 clear plastic cups that contained a toothbrush in each cup. No name could be identified on either cup or toothbrush. There was also a denture cup that	F 584	denture cups on 1/11/19. New employees will be educated about staff labeling of personal items specifically toothbrushes and denture cups during orientation. The Director of Nursing will randomly audit five 300 hall resident rooms per week for 12 weeks to ensure that toothbrushes and denture cups are properly labeled. Opportunities will be corrected as identified. 4. To monitor the effectiveness of the above action plan, the Director of Nursing will review the findings of the audits in the QAPI meeting monthly for 3 months beginning 2/7/19. The QAPI Committee will evaluate the effectiveness of the plan for 3 months beginning 2/7/19 and make recommendations for changes in the plan as indicated. Jennifer Simon, LNHA will be responsible for the completion of this plan of correction.	

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F 584	Continued From page 6	F 584		

contained a set of dentures. No name could be identified on the denture cup or dentures.

An observation of Room #310 was made on 01/08/19 at 9:17 AM. There were 2 clear plastic cups that contained a toothbrush in each cup. No name could be identified on either cup or toothbrush. There was also a denture cup that contained a set of dentures. No name could be identified on the denture cup or dentures.

An observation of Room #310 was made on 01/09/19 at 2:17 PM. There were 2 clear plastic cups that contained a toothbrush in each cup. No name could be identified on either cup or toothbrush. There was also a denture cup that contained a set of dentures. No name could be identified on the denture cup or dentures.

An interview was conducted with Resident #3 on 01/09/19 at 2:17 PM. Resident #3 confirmed that she resided in Room #310 and when asked if she knew which tooth brush was hers she replied "I have already used that to clean my mouth with." Resident #3 could not identify which toothbrush she had used to clean her mouth out.

An interview was conducted with Nursing Assistant (NA) #1 on 01/09/19 at 2:35 PM. NA #1 observed the cups in Room #310 and could not identify which cup belonged to which resident in the room. NA #1 also could not identify which resident the set of dentures belonged to in the room. NA #1 stated that each cup with toothbrush and denture cup should be labelled with the resident's name so that the staff knew which resident each personal item belonged too.

An interview was conducted with the Director of

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F 584	Continued From page 7 Nursing (DON) on 01/10/18 at 6:00 PM. The DON stated that each personal item should be clearly labelled with the resident's name.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of discharge for 1 of 3 closed records (Resident #85) reviewed for MDS accuracy. The findings included: Resident #85 was admitted to the facility on 03/11/2015 with multiple diagnoses including Diabetes Mellitus, Hypertension, Hyperlipidemia and Hemiplegia. Review of the Discharge Minimum Data Set (MDS) dated 11/01/18 revealed Resident #85 was discharged to acute hospital with return not anticipated. A review of the nursing notes dated 11/01/18 revealed Resident #85 was not discharged to the hospital. Further review of Resident #85's medical record revealed the resident was transferred into assisted living care on the date of 11/01/18. On 01/09/19 at 9:33AM an interview was conducted with MDS Nurse #1. During the	F 641	F641 1. Corrective action was accomplished for the alleged deficient practice by the MDS Coordinator updating the MDS on 1/9/19 for Resident #85 indicating the correct discharge location. 2. All discharged residents have the potential to be affected by this alleged deficient practice. The RCMD and MDS Coordinator will complete an audit of all residents discharged within the last 3 months to ensure accurate coding of the MDS. This audit will be completed by 2/7/19. 3. The Administrator re-educated RCMD and MDS Coordinator on 1/25/19 regarding accurate cording of the MDS specifically in the area of discharge. The RCMD will randomly audit five discharge MDS□s per week for 12 weeks to ensure that the discharge assessments have been accurately coded. Opportunities will be corrected as identified. 4. To monitor the effectiveness of the above action plan for accurate coding of the discharge MDS, the RCMD will review the findings of the discharged MDS	2/7/19

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F 641	Continued From page 8 interview she stated Resident #85 was not discharged to the hospital on the date 11/01/18 but was discharged to assisted living, rest home care. The interview revealed the MDS dated 11/01/18 should have reflected Resident #85 was discharged to the community instead of acute hospital. The interview revealed the information was coded in error. On 01/09/19 at 9:46 AM an interview was conducted with the Director of Nursing. The interview revealed Resident #85 was never discharged to the hospital. The interview revealed the MDS should have shown Resident #85 had been discharged to community and was coded by mistake. She stated, "My expectations were for the MDS Coordinator to do the best she could possibly do, I understand mistakes are human nature".	F 641	reviews in the QAPI meeting monthly for 3 months beginning 2/7/19. The QAPI Committee will evaluate the effectiveness of the plan for accurate coding of the discharge MDS and make recommendations for changes in the plan as indicated. Jennifer Simon, LNHA will be responsible for the completion of this plan of correction.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		2/7/19

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F 655	Continued From page 9 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a baseline care plan in the area of nutrition within 48 hours of admission to the facility for 2 of 3 residents reviewed for nutritional services (Resident #74 and #285). The findings included: 1. Resident #74 admitted to the facility on 12/05/18 with diagnoses that included: fall, wedge compression fracture of lumbar vertebrae,	F 655	F655 1. Corrective action was accomplished for the alleged deficient practice by the RCMD updating the care plans of Resident # 74 and #285 to reflect dietary requirements and restrictions. 2. All current residents have the potential to be affected by this alleged deficient practice. The RCMD and MDS Coordinator will complete an audit of all baseline care plans of residents admitted	

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F 655	Continued From page 10 weakness, diverticulitis, and history of liver transplant. Review of a physician's order dated 12/05/18 read, regular diet no added salt. Review of a facility document titled, Resident Preferences Evaluation and dated 12/06/18 read in part, Resident #74 requested to self-manage her diet due to a new onset of diverticulitis. The document indicated that her dislikes included spinach, kale, collard greens, and Mexican food. The document was signed by the Unit Manager (UM). Review of Resident #74's baseline care plans initiated on 12/06/18 revealed no focus or problem in the area of nutritional and no interventions that indicated she wanted to self-manage her diet due to a new onset of diverticulitis or her food dislikes. Review of Resident #74's minimum data set (MDS) dated 12/12/18 revealed that she was cognitively intact and required set up assistance with eating. The MDS further revealed that Resident #74 required a therapeutic diet and no problems with chewing or swallowing were identified. An interview was conducted with the UM on 01/10/19 at 5:09 PM. The UM stated that the nurse that was admitting Resident #74 would complete the assessment and then initiate the baseline care plans based off that assessment. The UM stated she completed the Resident Preference Evaluation on Resident #74 the day after her admission to the facility and gave a copy to MDS Nurse #2 and she would be responsible	F 655	within the last month to ensure baseline care plans included dietary requirements and restrictions. This audit will be completed by 2/7/19. 3. The Director of Nursing re-educated the hall nurses on 1/16/19 and the RCMD, MDS Coordinator, Unit Manager and Assistant Director of Nursing on 1/22/19 regarding the inclusion of dietary requirements and restrictions on baseline care plans. The Director of Nursing will randomly audit three baseline care plans per week for 12 weeks to ensure that the dietary requirements and restrictions have been included on the baseline care plan. Opportunities will be corrected as identified. 4. To monitor the effectiveness of the above action plan for including dietary requirements and restrictions on baseline care plans, the Director of Nursing will review the findings of the baseline care plan reviews in the QAPI meeting monthly for 3 months beginning 2/7/19. The QAPI Committee will evaluate the effectiveness of the plan for 3 months beginning 2/7/19 for including dietary requirements and restrictions on baseline care plans and make recommendations for changes in the plan as indicated. Jennifer Simon, LNHA will be responsible for the completion of this plan of correction.	

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for implementing any further baseline care plans that needed to be initiated.

An interview was conducted with MDS Nurse #2 on 01/01/19 at 5:23 PM. MDS Nurse #2 confirmed that she received the Resident Preference Evaluation from the UM and she reviewed them for anything vital that needed to be on the baseline care plan. MDS Nurse #2 stated she did not recall seeing that Resident #74 was going to self-manage her diet due to her diverticulitis or her food likes/dislikes. She indicated if she would have seen them she would have implemented a baseline care plan for those problems.

An interview was conducted with the Administrator and Director of Nursing (DON) on 01/10/19 at 6:10 PM. The DON stated that baseline care plans should encompass all resident care needs including dietary requirements and restrictions.

2. Resident #285 admitted to the facility on 12/27/18 with diagnoses that included: urinary tract infection, lack of coordination, and hypokalemia.

Review of a physician's order dated 12/27/18 read, regular diet with regular consistency.

Review of Resident #285's physician order sheet dated 12/27/18 revealed an allergy to gluten.

Review of a facility document titled, Resident Preference Evaluation and dated 12/28/18 read in part, Resident #285 followed a gluten free diet and was a vegetarian. The evaluation also indicated that Resident #285 only ate 2 meals a

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	345340	A. BUILDING _____ B. WING _____	C 01/10/2019

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F 655	Continued From page 12	F 655		

day and did not eat the evening meal. The form was signed by the Unit Manager (UM) and indicated she had communicated the dietary information to the dietary department.

Review of Resident #285's baseline care plan that were initiated on 12/28/18 revealed no problem or focus for nutrition or any interventions that indicated she followed a gluten free diet, was a vegetarian, or only ate 2 meals a day.

The resident's comprehensive minimum data set (MDS) dated 01/03/19 revealed that Resident #285 was cognitively intact and had no behaviors. The MDS further revealed that Resident #285 required set up assistance only with eating.

An interview was conducted with the UM on 01/10/19 at 5:09 PM. The UM stated that the nurse that was admitting Resident #285 would complete the assessment and then initiate the baseline care plans based off that assessment. The UM stated she completed the Resident Preference Evaluation on Resident #285 the day after her admission to the facility and gave a copy to MDS Nurse #2 and she would be responsible for implementing any further baseline care plans that needed to be initiated.

An interview was conducted with MDS Nurse #2 on 01/01/19 at 5:23 PM. MDS Nurse #2 confirmed that she received the Resident Preference Evaluation from the UM and she reviewed them for anything vital that needed to be on the baseline care plan. MDS Nurse #2 stated she did not catch that Resident #285 was gluten free and a vegetarian because her diet was ordered as regular. MDS Nurse #2 also indicated she did not catch that Resident #285 only ate 2

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F 655	Continued From page 13 meals as stated on the Resident Preference Evaluation or she would have included that in the baseline care plan as well. She indicated if she would have seen them she would have implemented a baseline care plan for those problems. An interview was conducted with the Administrator and Director of Nursing (DON) on 01/10/19 at 6:10 PM. The DON stated that baseline care plans should encompass all resident care needs including dietary requirements and restrictions.	F 655		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI 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	F 690		2/7/19

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F 690	Continued From page 14 (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 observations, record review and staff interviews, the facility failed to prevent a catheter bag and catheter tubing from draping on the floor for 1 of 2 residents (Resident #56) reviewed for catheter care. Resident #56 was admitted to the facility on 06/07/18 with diagnoses that included neuromuscular dysfunction on bladder, benign neoplasm of bladder, presence of urogenital implants, other specified disorders of bladder, UTI and extended spectrum beta lactamase (ESBL) resistance. A review of Resident #56's most recent Minimum Data Set (MDS) Assessment revealed Resident #56 to be moderately impaired cognitively. He was coded as requiring extensive use with toilet use and personal hygiene. Further review of the MDS Assessment revealed Resident #56 was coded as having an indwelling catheter and was always incontinent of bowel. On 01/08/19 at 3:40 PM, an observation was completed of Resident #56 sitting in his	F 690	F690 1. Corrective action was accomplished for the alleged deficient practice by the Director of Nursing adjusting the catheter tubing and bag for Resident #56 to ensure no contact with the floor. 2. All current residents with foley catheters have the potential to be affected by this alleged deficient practice. The Director of Nursing completed an intial round on 1/10/19 to review all residents with foley catheters to ensure that catheter tubing or bags were not contacting the floor. Any findings were corrected by the Director of Nursing. 3. The Director of Nursing re-educated the nursing staff on the policy of foley catheter tubing or bags not contacting the floor on 1/11/19. The Director of Nursing will randomly observe three residents with foley catheters per week for 12 weeks to ensure their catheter tubing or bags are not contacting the floor. Opportunities will be corrected as identified. 4. To monitor the effectiveness of the	

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F 690	Continued From page 15 wheelchair facing the nurse's station at the intersection of the 100, 200 and 300 halls. Further observation of Resident #56 at this time revealed that Resident #56's catheter tubing was resting on the floor underneath his wheelchair. An observation of Resident #56 on 01/10/19 at 8:16 AM revealed Resident #56 to be sitting in the facility's main dining room at a table by himself, waiting on his breakfast to be served. Further observation at this time revealed Resident #56's catheter tubing and bag to be in contact with the floor. Resident #56's catheter tubing was observed to be running down his pant leg, out the bottom of his pants, traveling underneath the heel of his foot, which was resting flat on the floor, before rising back up to the catheter bag. An observation of the catheter bag at this time revealed it to be full and resting on the ground, causing the bag to be tear shaped. During an observation of Resident #56 on 1/10/19 at 2:33 PM it was noted that Resident #56's catheter tubing continued to rest on the floor. A review of a facility provided policy entitled "Indwelling Urinary Catheter (Foley) Care and Management" dated 12/14/18 revealed facility staff were expected to keep the drainage bag below the level of a patient's bladder but ensure the placement of the drainage bag did not come into contact with the floor. A review of physician orders for Resident #56 revealed the following orders: - 16 FR/10cc Foley catheter due to urinary retention related to neurogenic bladder - Change Foley catheter every 30 days on night shift for neurogenic bladder	F 690	above action plan for foley catheter tubing and bags not contacting the floor, the Director of Nursing will review the findings of the reviews in the QAPI meeting monthly for 3 months beginning 2/7/19. The QAPI Committee will evaluate the effectiveness of the plan and make recommendations for changes in the plan as indicated. Jennifer Simon, LNHA will be responsible for the completion of this plan of correction.	

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F 690	Continued From page 16 - Rotate Foley catheter strap daily every day shift for neurogenic bladder - Foley catheter care every shift for neurogenic bladder In an interview with the Director of Nursing on 01/10/19 at 2:38 PM she indicated that catheter tubing and catheter bags should not come into contact with the floor. During an interview with the Administrator on 01/10/19 at 3:00 PM she indicated that residents who have catheters should not have their catheter tubing or bags come into contact with the floor.	F 690		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 842	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 842	Continued From Page 1

(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to document the date, time, and events of a resident's death for 1 of 3 residents investigated for closed record review (Resident #87).

The findings included:

Resident #87 admitted to the facility on 10/01/18 and expired in the facility on 10/25/18. Her diagnoses included: diskitis, intraspinal abscess, urinary tract infection, bacteremia, clostridium difficile colitis (Cdiff) and others.

Review of Resident #87's comprehensive minimum data set (MDS) dated 10/08/18 revealed that she was severely cognitively impaired for daily decision making and required extensive assistance with activities of daily living. The MDS further indicated that Resident #87 received intravenous (IV) antibiotics during the assessment reference period.

Review of a skilled nursing note dated 10/25/18 read in part, Resident #87 was being treated with IV antibiotics for Cdiff and her white blood count had risen to 20 and the physician was notified on 10/22/18. No mention of her death or eminent death.

Review of Resident #87's medical record revealed no record of her eminent death, time of her death, who pronounced her death, or if the family and physician were notified.

Review of a physician's order dated 10/25/18 read, may pronounce resident deceased and may release body to funeral home.

An interview was conducted with Nurse #1 on 01/09/19 at 4:17 PM. Nurse #1 confirmed that she was the nurse that was taking care of Resident #87 on 10/25/18 when she expired. She stated that Resident #87 had been sick for a while and was on IV antibiotics and eventually was placed on morphine sulfate and Ativan for comfort. Nurse #1 indicated her death was not a "real surprise." Nurse #1 stated that she could not recall what time she passed away or if she called the physician or not but added she believed that the physician was in the facility and was verbally made aware. She indicated that Resident #87's family was at bedside when she expired, and she should have documented that. Nurse #1 stated that she should have documented what was going on with Resident #87 and her death that included the time and who pronounced her death with me. She indicated she should have also completed the facility discharge paperwork that was completed when someone expired, and she had not done that.

An interview was conducted with the Administrator and Director of Nursing (DON) on 01/10/19 at 6:03 PM. The DON stated that when a resident passed away the staff should complete the necessary paperwork.