STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 11/22/2021

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PELICAN HEALTH RANDOLPH LLC	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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
E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 11/15/21 through 11/22/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #P74I11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/15/21 through 11/22/21. Event ID# P74I11. 1 of the 34 complaint allegations was substantiated but did not result in a deficiency. 10 of the 34 complaint allegations were substantiated resulting in deficiencies.	F 000		
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 record reviews, observations, and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for smoking for 1 of 2 residents reviewed for smoking (Resident #78). Findings included: Resident #78 was admitted to the facility 5/21/2020 and readmitted on 10/15/2021 with diagnoses to include heart disease, falls, and infection after a procedure. The most recent annual MDS assessment dated 4/23/2021 documented Resident #78 was cognitively intact, and no tobacco was used by Resident #78.	F 641	1. The facility failed to accurately code the Minimum Data Set (MDS) for Residents #78 in the area of smoking status. Resident #78 MDS was modified by MDS on 12/10/21. 2. MDS Coordinator will review residents that currently smoke for accuracy of MDS. If discrepancies are found MDS are to modify assessments. This review was completed 12/16/21.	12/17/21

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

Electronically Signed | 12/18/2021

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F 641	Continued From page 1 A care plan dated 6/10/2020 and a revision date of 11/15/2021 documented Resident #78 was a smoker. Resident #78 was observed on the smoking patio on 11/15/2021 at 3:26 PM smoking a cigarette. Resident #78 reported he was a smoker and had been for many years. Resident #78 reported he was able to smoke independently, and the nurses kept his smoking materials. An interview was conducted with the MDS Nurse on 11/18/2021 at 10:23 AM. The MDS Nurse reported she was not aware Resident #78 was coded as not using tobacco on the annual MDS dated 4/23/2021. The MDS Nurse reported that was an error and Resident #78 should have been coded as using tobacco. The Administrator was interviewed on 11/19/2021 at 10:27 AM. The Administrator reported the MDS Nurse made an error in coding the MDS for Resident #78 and tobacco use. The Administrator reported he expected the MDS assessments to be coded accurately for all residents.	F 641	3. Regional MDS Consultant will educate MDS nurses on completing MDS assessment accurately when a resident is a smoker. Education will be added to New Hire Orientation. This education was completed on 12/10/21. Director of Nursing or designee will audit 5 random resident 3x week x 4 weeks then 1x week x 8 weeks to ensure MDS assessment accurately reflects smoking status. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement committee (QAPI) by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Completion date is 12/17/21	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		12/17/21

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F 656	Continued From page 2 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to develop care plan	F 656	1. Facility failed to develop a comprehensive, individualized care plan	

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F 656	Continued From page 3 interventions for splinting recommendations for 2 of 6 residents (Resident #63 and Resident #80) reviewed for range of motion. The findings included: 1. Resident # 63 was admitted to the facility on 1/4/18 with a diagnosis that included Hemiplegia affecting left non-dominant side, muscle weakness, lack of coordination and contracture of the left hand, left elbow, left wrist and left hand. Review of Resident #63's care plan revised on 9/8/20 stated she had a limited physical mobility related to contractures. The goal stated Resident #63 would remain free of further complications related to immobility, contractures and thrombus formation. The intervention included provide gentle range of motion (ROM) as tolerated with daily care and invite resident to activity program that encourage physical mobility. The care plan did not indicate interventions regarding donning (to put on), doffing (to take off) or parameters regarding the application of splinting. Review of OT evaluation and plan of treatment signed by the physician on 4/16/21 stated Resident #63 would tolerate passive range of motion (PROM) to left upper extremity (LUE), 2 x 10 reps each joint/plain with complaints of pain. The evaluation continued that Resident #63 would require the treatment in order to maintain her joint mobility and reduce risk of contractures. Review of function maintenance program dated 4/21/21 stated donning left resting hand splint daily x 1 at least 4 hours or as tolerated for Resident #63. Do not wear overnight.	F 656	for Resident # 63 and Resident # 80 that addressed the area of splinting recommendations. Comprehensive, individualized care plan was completed for Resident #63 on 12/16/21 and Resident # 80 on 12/16/21 by the Regional MDS Coordinator. 2. All current residents with Splint will be audited by the Interdisciplinary Team (IDT) to include Executive Director, Director and Assistant Director of Nursing, Unit Coordinators, Wound Nurse, Social Worker, and MDS Coordinators to ensure a comprehensive, individualized care plan for these areas are completed. This audit will be completed by 12/17/21. 3. Regional MDS Consultant will educate MDS nurses on completing comprehensive, individualized care plans on or before the 21st day of stay for the resident and updating the care plan during the quarterly assessment, as well as individualizing care plans with changes. Education will be added to new hire orientation. This education was completed on 12/10/21. Director of Nursing or designee will audit 5 Residents with splints 3x per week x 4weeks then weekly x 8 weeks to ensure they have an accurate complete	

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F 656	Continued From page 4 Review of OT discharge summary dated 4/28/21 stated discharge recommendations to included splint and brace program established. Left resting hand splint as tolerated with skin checks every 2 hours. Quarterly Minimum Data Set (MDS) assessment dated 10/15/21 revealed Resident #63 was cognitively intact. The MDS assessment further coded Resident #63 as requiring extensive assistance with activities of daily living and impaired range of motion in one upper extremity. Interview with the MDS coordinator on 11/17/21 at 10:07 am revealed she became aware of care planning needs through management meetings. She would then update the care plan according to the resident's care needs. The care plan dated 2018 and revised 9/8/20 indicated Resident #63 had limited physical mobility related to contractures. She confirmed the interventions listed on Resident #63's care plan did not identify interventions that would have included donning, doffing and skin checks. She stated the care plan should have addressed interventions regarding splinting. The MDS Coordinator indicated she was not made aware of the splinting for Resident #63's hand contracture. She stated if she was aware she would have care planned Resident #63's splint to include parameters for care. 2. Resident #80 was admitted to the facility on 3/24/21 with a diagnosis that included hemiplegia and hemiparesis following cerebral infraction affecting left non-dominant side, contracture of right shoulder, right elbow, right wrist and right hand. Review of OT evaluation and plan of treatment	F 656	comprehensive individualized care plan and recommended splint interventions. 4. Administrator will review the results of the weekly audit to ensure the completion and individualization of the comprehensive care plans with recommended splint interventions. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Completion date is 12/17/21	

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F 656	Continued From page 5	F 656		

dated 10/4/21 stated Resident #80 had a right palm protector splint for right hand. The resident demonstrated independence with donning (to put on) and doffing (to take off), hand hygiene and splint care. The OT evaluation recommend Resident #80 continue to wear a right palm protector splint to reduce risk of further contracture/skin bread down. The reason identified for therapy stated Resident #80 was not currently a candidate for skilled OT services.

Review of Resident #80 MDS assessment dated 10/24/21 revealed Resident #80 was cognitively intact and impaired range of motion on one upper extremity.
had one upper body extremity impairment.

Review of Resident #80's medical record revealed no care plan interventions for splinting. The cardex/task sheet used by NAs as of 11/16/21 for Resident #80 stated Dressing/Splinting care. There were no interventions regarding the donning, doffing or parameters regarding splinting.

Interview with the MDS coordinator on 11/17/21 at 10:00 am stated therapy was to notify her when a resident required splinting. Once a resident had a care plan developed it would carry over the cardex/task sheet for the NAs. She stated has she been notified that Resident #80 had splinting recommended by therapy she would have care planned it to include parameters. She did not recall splinting being communicated during morning risk meetings for Resident #80.

Interview with the Director of Nursing (DON) on 11/19/21 at 11:12 am indicated the MDS coordinator was responsible for developing and

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F 656	Continued From page 6 updating care plans as needed. The MDS coordinator is kept abreast of changes or additions to resident care needs during morning risk meetings held every week. The DON stated the splinting devices should be care planned to include interventions with parameters around when to put the device on and take it off.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident/staff interviews and review of medical records, the facility failed to provide nail care to 2 of 8 sampled residents, who were dependent on staff for assistance with activities of daily living (Residents #32 and #43). The findings included: 1. Resident #32 was admitted to the facility on 9/30/21 with a diagnosis that included muscle weakness, cognitive deficits, macular degeneration, dementia without behavior, and osteoarthritis. A quarterly Minimum Data Set (MDS) assessment dated 10/6/21 assessed Resident #32 as having moderate cognitive impairment and required extensive staff assistance with personal hygiene. An observation of Resident #32 on 11/15/21 at 11:47 AM revealed the fingernails to both of her	F 677	1. The facility failed to provide nail care to Resident # 32 and #43. Nail Care was provided for Resident #32 and #43 on 11/16/21. 2. Audit of all current Residents nails was conducted on 11/17/21 by Interdisciplinary Team to include Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Director, Activities Director and residents received nail care as needed. 3. Director of Nursing and the Assistant Director of Nursing to educate nursing staff to include, Licensed Nurses, Certified Nursing Aids, and Contract nursing staff on providing nail care. Education will be	12/17/21

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F 677	Continued From page 7 right and left hand were jagged in various lengths that extended past the fingertips with a brown substance under the nail beds. An observation of Resident #32 on 11/16/21 at 4:00 PM revealed the fingernails to both of her right and left hand were jagged in various lengths that extended past the fingertips with a brown substance under the nail beds. An interview with Nurse Aide (NA) #1 on 11/16/21 at 4:05 PM indicated he usually performed nail care during 3-11pm shift. NA #1 stated he was assigned to Resident #32 at time of interview and he indicated he had not yet provided care to the resident that day. He stated he cleaned nails as needed during showers and personal care. He could not recall when he last provided nail care to Resident #32. An interview and observation was conducted with the Director of Nursing (DON) on 11/16/21 at 4:20 PM. The DON stated residents' fingernails were usually checked, cleaned and/or trimmed during personal care. Upon observation of Resident #32, the DON stated Resident #32's fingernails were uncleaned and untrimmed. 2. Resident #43 was admitted to the facility on 4/7/21 with diagnoses that included muscle weakness, sepsis due to pneumonia, dementia, and failure to thrive. A quarterly Minimum Data Set (MDS) assessment dated 10/15/21 assessed Resident #43 with severely impaired cognition and required total staff assistance for personal hygiene. Care plan dated 10/15/21 revealed Resident #43	F 677	added to New Hire Orientation. This education will be completed by 12/17/21. Director of Nursing or designee will audit 5 random residents for proper nail care 3x week x 4 weeks then 1x week x 8 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Completion date is 12/17/21	

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F 677	Continued From page 8 had an activities of daily living self-care performance deficit related to activity ntolerance. The interventions included the resident required assistance by staff with personal hygiene. An observation of Resident #43 on 11/15/21 at 2:44 PM revealed the fingernails to both of his right and left hand were jagged in various lengths that extended past the fingertips with a brown substance under the nail beds. An observation of Resident #43 on 11/16/21 at 10:35 AM revealed the fingernails to both of his right and left hand were jagged in various lengths that extended past the fingertips with a brown substance under the nail beds. An interview with NA #1 on 11/16/21 at 3:48 PM revealed that he usually performed nail care during showers. NA #1 was assigned to Resident #43 at time of interview and indicated he had not yet provided care to the resident that day. He stated he did not recall when he last provided nail care to Resident #43. An interview and observation was conducted with the DON on 11/16/21 at 4:15 PM. The DON stated resident's fingernails were usually checked, cleaned and/or trimmed during personal care. Upon observation of Resident #43, the DON stated Resident #43's fingernails were uncleaned and untrimmed. She further stated that there was no nail care schedule or documentation that would indicate nail care had been performed. The Activity Director assisted with nail care when necessary. The DON stated the condition of Resident #43's nails was unsatisfactory.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		12/17/21

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F 686	Continued From page 9 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to complete and document weekly skin assessments for 2 of 4 residents reviewed for skin conditions (Resident #6 and Resident #66). Findings included: 1. Resident #6 was admitted to the facility on 5/31/2019 with diagnoses to include lung disease and hypertension. The most recent quarterly Minimum Data Set (MDS) assessment dated 8/6/2021 assessed Resident #6 to be cognitively intact. The MDS assessment documented Resident #6 was occasionally incontinent of urine and frequently incontinent of bowels. A care plan dated 8/29/2019 with a revision date of 5/22/2020 addressed Resident #6's potential for bleeding or bruising due to the use of aspirin. Interventions included to perform a daily skin	F 686	1. The facility failed to complete and document weekly skin assessments for Resident #6 and #66. Resident #6 skin assessment completed on 12/15/21. Resident #66 skin assessment completed on 12/7/21. 2. Nursing Leadership to include Director of Nursing, Assistant Director of Nursing, Wound Nurse and Unit Managers conducted an audit of all current residents to ensure they have a current skin assessment. Any identified issues corrected immediately. This audit was completed on 12/15/21 3. Director of Nursing and the Assistant Director of Nursing to educate all Licensed Nursing staff on completing weekly skin assessments. Education will be added to New Hire Orientation. This	

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F 686	Continued From page 10	F 686		

inspection for bleeding or bruising and report to the nurse.

A care plan dated 5/17/2020 addressed the potential for skin breakdown of Resident #6 related to her disease process, incontinence episodes, and a previous Stage 4 pressure ulcer that had healed. Interventions included to educate Resident #6 on measures to prevent skin injury.

The weekly skin assessments were reviewed, and no skin assessment was completed for Resident #6 the week of 3/8, 3/22, 3/29, 4/5, 4/12, 4/26, 5/3, 5/10, 5/17, 5/24, 5/31, 6/7, 6/14, 6/21, 6/28/2021. The last completed weekly skin assessment was completed on 7/7/2021 and no weekly skin assessments were in the medical record after that date.

The Unit Manager (UM) #1 was interviewed on 11/16/2021 at 11:38 AM. UM #1 reported the skin assessments were completed by the nurses and they would get a notification from the documentation system to complete the skin assessment. UM #1 reported he was not aware Resident #6 had no weekly skin assessments completed after 7/7/2021.

Nurse #1 was interviewed 11/17/2021 at 4:51 AM. Nurse #1 reported she had not completed a skin assessment on Resident #6. Nurse #1 explained when assessments were due for residents, the electronic system would notify the nurse.

An interview was conducted with Nurse #3 on 11/17/2021 at 7:45 PM. Nurse #3 reported the electronic documentation system would show an alert for a skin assessment when it was due, and

education completed by 12/17/21.

Director of Nursing or designee will audit 5 random residents for complete weekly skin assessment 3x week x 4 weeks then 1x week x 8 weeks.

4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

5. Completion date is 12/17/2021

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F 686	Continued From page 11	F 686		

if the alert didn't show, he did not complete a skin assessment. Nurse #3 reported he had not completed a skin assessment on Resident #6, and he thought day shift completed the assessment.

UM #1 was interviewed on 11/18/2021 at 3:12 PM. UM #1 reported if a skin assessment was missed, the missed documentation prevented the system from populating a new notification for the next weekly skin assessment that was due. UM #1 stated once one skin assessment for Resident #6 was missed and the system did not populate the next due, staff nurses would not be aware a skin assessment was due.

The facility physician (MD) was interviewed on 11/19/2021 at 9:31 AM. The MD reported the facility should complete a weekly skin assessment on all residents to monitor for changes.

The Director of Nursing (DON) was interviewed 11/19/2021 at 10:17 AM. The DON reported the skin assessments were not populating in the documentation system due to an electronic documentation issue and she had reached out to company to notify of the documentation errors. The DON reported she was not aware Resident #6 had not had a weekly skin assessment completed since 7/7/2021. The DON reported it was her expectation that skin assessments were completed weekly by the nurses.

2. Resident #66 was admitted to the facility 6/9/2021 with diagnoses to include heart failure and retention of urine.

The most recent quarterly Minimum Data Set

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F 686	Continued From page 12	F 686		

(MDS) assessment dated 10/15/2021 documented Resident #66 was cognitively intact. The MDS documented Resident #66 had an indwelling urinary catheter and was always incontinent of bowels.

A care plan dated 6/10/2021 with a revision date of 9/27/2021 addressed Resident #66's potential for skin breakdown with interventions to educate the resident of causative factors and measures to prevent skin injury, identify and document potential factors and eliminate or resolve when possible.

A review of the medical record for Resident #66 revealed the last weekly skin assessment had been completed 7/19/2021 and no weekly skin assessments were in the medical record after that date.

The Unit Manager (UM) #1 was interviewed on 11/16/2021 at 11:38 AM. UM #1 reported the skin assessments were completed by the nurses and they would get a notification from the documentation system to complete the skin assessment. UM #1 reported he was not aware Resident #66 had no weekly skin assessments completed after 7/7/2021.

Nurse #1 was interviewed 11/17/2021 at 4:51 AM. Nurse #1 reported she had not completed a skin assessment on Resident #66. Nurse #1 explained when assessments were due for residents, the electronic system would notify the nurse.

An interview was conducted with Nurse #3 on 11/17/2021 at 7:45 PM. Nurse #3 reported the electronic documentation system would show an

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F 686	Continued From page 13 alert for a skin assessment when it was due, and if the alert didn ' t show, he did not complete a skin assessment. Nurse #3 reported he had not completed a skin assessment on Resident #66, and he thought day shift completed the assessment. UM #1 was interviewed on 11/18/2021 at 3:12 PM. UM #1 reported if a skin assessment was missed, the missed documentation prevented the system from populating a new notification for the next weekly skin assessment that was due. UM #1 stated once one skin assessment for Resident #66 was missed and the system did not populate the next due, staff nurses would not be aware a skin assessment was due. The MD was interviewed on 11/19/2021 at 9:31 AM. The MD reported the facility should complete a weekly skin assessment on all residents to monitor for changes. The DON was interviewed 11/19/2021 at 10:17 AM. The DON reported the skin assessments were not populating in the documentation system due to an electronic documentation issue and she had reached out to company to notify of the documentation errors. The DON reported she was not aware Resident #66 had not had a weekly skin assessment completed since 7/19/2021. The DON reported it was her expectation that skin assessments were completed weekly by the nurses.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		12/17/21

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F 688	Continued From page 14 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to apply a splinting device as recommended by occupation therapy (OT) and physician order for 1 of 6 residents (Resident #63) reviewed for range of motion. The findings included: Resident # 63 was admitted to the facility on 1/4/18 with a diagnosis that included hemiplegia affecting left nondominant side, muscle weakness, lack of coordination and contracture of the left hand, left elbow, left wrist and left hand. Review of Resident #63's care plan revised on 9/8/20 stated she had a limited physical mobility related to contractures. The goal stated Resident #63 would remain free of further complications related to immobility, contractures and thrombus formation. The intervention included provide gentle range of motion (ROM) as tolerated with	F 688	1. The facility failed to apply a splinting device as recommended by therapy and physician order for Resident #63. Physician order updated 12/16/21. 2. Nursing Leadership to include Director of Nursing, Assistant Director of Nursing, MDS Coordinator and Unit Managers conducted an audit of all current residents with splints to ensure they have appropriate intervention/orders/careplan in place. Any identified issues will be corrected and/or referred to therapy. Audit to be completed by 12/17/21 3. Director of Nursing and the Assistant Director of Nursing to educate all nursing	

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F 688	Continued From page 15 daily care and invite resident to activity program that encourage physical mobility. The care plan did not indicate interventions regarding donning (to put on), doffing (to take off) or parameters regarding the application of splinting. Review of OT evaluation and plan of treatment signed by the physician on 4/16/21 stated Resident #63 would tolerate passive range of motion (PROM) to left upper extremity (LUE), 2 x 10 reps each joint/plain with complaints of pain. The evaluation continued that Resident #63 would require the treatment in order to maintain her joint mobility and reduce risk of contractures. Review of function maintenance program dated 4/21/21 stated donning left resting hand splint daily x 1 at least 4 hours or as tolerated for Resident #63. Do not wear overnight. Review of OT discharge summary dated 4/28/21 stated discharge recommendations to included splint and brace program established. Left resting hand splint as tolerated with skin checks every 2 hours. Review of Resident #63's Nursing Assistant (NA) cardex/task sheet revealed it did not include parameters surrounding the application of a resting left-hand splint. Quarterly Minimum Data Set (MDS) assessment dated 10/15/21 revealed Resident #63 was cognitively intact. The MDS assessment further coded Resident #63 as requiring extensive assistance with activities of daily living and impaired range of motion in one upper extremity. Interview and observation of Resident #63 on	F 688	staff to include, Licensed Nurses, Certified Nursing Aids, and Contract nursing staff on applying splints per recommendations. Education will be added to New Hire Orientation. Education to be completed by 12/17/21. Director of Nursing or designee will audit 5 Residents with splints 3x per week x 4weeks then weekly x 8 weeks to ensure their splints are applied per physician order and careplan interventions. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Completion date is 12/17/2021	

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11/15/21 at 4:04pm revealed her to be in bed. She was observed to have her left hand in a fixed position with finger tips touching the palm of her left hand. Resident #63 revealed she was unable to open her hand voluntarily. She further stated she did have a splint for her hand, but staff had not put it on her in months.

Observation of Resident #63 on 11/16/21 at 8:45 am revealed her to be in bed. She had no splinting device to her left hand. The Resident stated her splint was on her clothing in her room. The splint was not observed to be on her clothing.

Observation of Resident #63 on 11/16/21 at 10:41 am revealed her to in bed with a crossword puzzle on her bedside table. The Resident did not have a splinting device to the left hand. Resident #63 stated she believed her splinting device was in her closet.

Interview with Nurse #1 on 11/16/21 at 10:46 am indicated Resident #63 had left side weakness. She indicted she did not believe Resident #63 had a contracture. Nurse #1 indicated the electronic medical record did not have a care plan for a contracture or splinting. She stated Nurses used a different version of the electronic medical record to obtain information regarding the resident's care planning. She further indicted she did not recall observing Resident #63 with a splinting device.

Interview with Nurse Aide (NA) #1 on 11/16/21 at 3:00 pm indicated physical therapy would communicate to NAs about a resident's splinting needs. He stated It would be in the electronic medical record to be charted. NA #1 stated with residents that required splinting the NAs would

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chart when they put the splinting device on and when they took the splinting device off a resident. NA #1 stated he had seen Resident #63 with a splinting device applied but it was not in her medical record as a task to complete. He further indicated he had not applied a splint on the resident.

Observation on 11/17/21 at 9:00 am revealed Resident #63 to not have a splint device to her left hand. Resident #63 stated she believed her splint was in her closet but was unsure where.

Interview with the Director of Rehabilitation on 11/17/21 at 9:20 am revealed nursing staff were educated on residents splinting requirements upon being discharged from therapy services with recommendations. The education took place on a functional maintenance program form for 1st, 2nd and 3rd shifts. She further indicated management was further educated on donning, doffing and checking a resident's skin integrity. Upon her review of the Resident #63 the Director of Rehabilitation revealed staff had signed an in-service for function maintenance program for Resident #63 on 4/21/21. She stated the functional maintenance program stated don left resting hand splint daily or at least 4 hours or as tolerated. It further stated that Resident #63 should not wear the splinting device overnight. The Director of Rehabilitation assessed Resident left hand contracture on 11/17/21 and identified the contracture had not worsened.

Interview with the MDS coordinator on 11/17/21 at 10:07 am revealed she became aware of care planning needs through management meetings. She would then update the care plan according to the resident's care needs with the information

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F 688	Continued From page 18 conveyed during the meeting to include the therapy department. The MDS Coordinator indicated she was not made aware of the splinting for Resident #63's hand contracture. She stated if she was aware, she would have care planned Resident #63's splint to include parameters for care and who would be responsible for its application. Had the care plan had interventions regarding the splint they would carry over to the cardex used by NAs. Observation with the Director of Rehabilitation on 11/17/21 10:31 am revealed Resident #63's splinting device to be in the back of her closet. Interview with the Director of Nursing (DON) on 11/19/21 at 11:12 am revealed staff should be applying splinting as recommended and ordered by Physical therapy. She was unaware Resident #63 had not been wearing her splint. Once a resident was discharged from therapy, the therapy department trained staff to donn and doff the device appropriately.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to	F 689	1. The facility failed to provide enteral feedings and pureed pleasure foods only	12/17/21

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F 689	Continued From page 19 provide enteral feedings and pureed pleasure foods only to 1 of 2 sampled residents assessed unsafe to consume fluids by mouth (Resident #131). Staff provided nectar thickened liquids to a resident with a physician order for nothing by mouth and a speech therapy recommendation for up to 4 ounces pureed pleasure foods and no liquids by mouth. Additionally, the facility failed to complete and document quarterly smoking assessments for 2 of 2 sampled residents reviewed for smoking (Resident #6 and Resident #78). These failures occurred for 3 of 4 sampled residents reviewed for supervision to prevent accidents (Residents #131, #6 and #78). Findings included: 1. Resident #131 was admitted to the facility on 3/16/21 and discharged to the hospital on 7/18/21. Resident #131 did not return to the facility. Diagnoses included gastrostomy status and oropharyngeal dysphasia following a cerebral infarction (stroke). A physician order dated 3/16/21 recorded her diet as "NPO" (Nothing by Mouth). A 3/22/21 admission Minimum Data Set, Care Area Assessment, and care plan, documented Resident #131 was totally dependent on staff for assistance with eating and that she received 51% or more of her total calories from an enteral feeding. The care plan interventions included speech therapy (ST) services for dysphagia, provide enteral feedings as ordered and maintain interventions to prevent aspiration. A ST discharge (DC) summary dated 5/24/21, documented ST services were provided 4/26/21 -	F 689	to Resident #131 who was assessed as unsafe to consume fluids by mouth and failed to complete and document quarterly smoking assessments for Resident #6 and #78. Resident #131 was discharged from the facility on 7/18/21. Resident #6 and #78 quarterly smoking assessment was completed on 11/15/21. 2. Nursing Leadership to include Director of Nursing, Assistant Director of Nursing, MDS Coordinator and Unit Managers and Director of Rehab conducted an audit of all current residents with enteral feedings to ensure they are receiving proper diet per Physician Orders. Any identified issues corrected. This audit was completed 12/16/21. Nursing Leadership to include Director of Nursing, Assistant Director of Nursing, MDS Coordinator and Unit Managers conducted an audit of all current smokers to ensure they have a current Smoking Assessment. Audit was completed on 12/13/21 no additional issues noted. 3. Director of Nursing and the Assistant Director of Nursing to educate nursing staff to include, Licensed Nurses, Certified Nursing Aids, and Contract nursing staff on ensuring proper diet is provided per physician orders. Director of Rehab to	

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F 689	Continued From page 20 5/24/21 with a long-term goal to improve swallow function and safety to consume the least restrictive diet. Comments included skilled intervention completed for dysphagia training with aspiration still occurring with nectar thick liquids (NTL) and thin liquids. The DC summary recorded DC recommendations for oral intake of solids with pleasure puree foods one time daily with 4 ounces tolerated safely and liquids recommended as NPO. Review of eating and fluid intake records for Resident #131 dated 5/24/21 - 7/8/21 recorded total fluids by day received by Resident #131 on the following dates: · 5/29/21 - 120 milliliters (ml) · 6/3/21 - 380 ml · 6/4/21 - 350 ml · 6/9/21 - 480 ml · 6/10/21 - 830 ml · 6/13/21 - 480 ml · 6/15/21 - 240 ml · 6/17/21 - 320 ml · 6/18/21 - 240 ml · 6/21/21 - 340 ml · 6/22/21 - 480 ml · 6/23/21 - 600 ml · 6/24/21 - 840 ml · 6/29/21 - 840 ml · 7/3/21 - 600 ml · 7/4/21 - 300 ml · 7/5/21 - 360 ml · 6/6/21 - 200 ml · 7/7/21 - 240 ml Staffing records provided by the Director of Nursing (DON) for review revealed Nurse Aide (NA) #3 provided nursing care to Resident #131	F 689	educate therapy staff on ensuring therapy recommendations are communicated to nursing department for proper assessment and care plan. Education will be added to New Hire Orientation. Education to be completed by 12/17/21. Director of Nursing and the Assistant Director of Nursing to educate all Licensed Nursing Staff to include contract staff on completing Quarterly Smoking Assessment and ensuring that they have the correct level of supervision based upon their current Smoking Assessment. Education will be added to New Hire Orientation. Education to be completed by 12/17/21. Director of Nursing or designee will audit residents with enteral feeds 3x week x 4 weeks then 1x week x 8 weeks to ensure they are receiving diet per physician orders. Director of Nursing or designee will audit current facility smokers 3x week x 4 weeks then 1x per week x 8 weeks to ensure that they are receiving the appropriate supervision based on their current Smoking Assessment.	

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F 689	Continued From page 21 on June 15, 17, 23, 24, and 29, 2021. Staffing records provided by the DON for review revealed NA #4 provided nursing care to Resident #131 on June 3, 4, 9, 15, 17, 23, 24, and 29, 2021. A telephone interview with NA #3 occurred on 11/18/21 at 6:06 PM. NA #3 stated that she worked for an agency at the facility from April 2021 - July 2021, Tuesdays - Thursdays on the 7 AM - 7 PM shift. NA #3 stated she worked with Resident #131 during this time and recalled the Resident received an enteral feeding, pureed pleasure foods, and drank thickened liquids by mouth. NA #3 stated she fed Resident #131 her dinner meals, which included thickened liquids, at times and documented any food/fluid intake Resident #131 received. NA #3 stated Resident #131 ate very little puree food but drank her fluids well. She stated Resident #131 could not feed herself and had to be fed by staff. NA #3 did not recall any concerns occurring which resulted from Resident #131 receiving thickened liquids by mouth. A telephone interview with NA #4 occurred on 11/18/21 at 6:18 PM. NA #4 stated that she worked with Resident #131 at various times during April 2021 - July 2021. NA #4 recalled that Resident #4 received pureed pleasure foods and thickened liquids per the request of the family. NA #4 remembered providing Resident #131 thickened liquids by mouth during this time but did not recall any concerns with swallowing during meals. A telephone interview with Nurse #4 occurred on 11/18/21 at 6:05 PM. Nurse #4 stated that she	F 689	4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Completion date is 12/17/2021	

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F 689	Continued From page 22	F 689		

worked for an agency at the facility during the months of May 2021 and July 2021. Nurse #4 recalled Resident #131 received enteral feedings and had a physician's order for NPO. Nurse #4 stated Resident #131 was not to receive fluids by mouth.

A telephone interview occurred with Nurse #5 on 11/18/21 at 6:37 PM. Nurse #5 stated that she worked with Resident #131 in June 2021 and July 2021. Nurse #5 recalled the family requested pleasure foods/fluids for Resident #131, but that the ST recommendation was for Resident #131 not to receive fluids by mouth.

An interview with the Rehab Director/Speech Therapist occurred on 11/17/21 at 3:45 PM. During the interview, she stated that Resident #131 was referred for ST services in April 2021 due to the family's request for re-evaluation of the Resident's swallowing. The interview revealed that during the ST evaluation, Resident #131 aspirated during a barium swallow study, and had previously failed a FEES (fiberoptic endoscopic assessment of swallowing) while in the hospital in March 2021. The Rehab Director stated that during the April 2021 ST evaluation, Resident #131 demonstrated the inability to support her upper body upright to safely swallow, consistently; during trials with applesauce, Resident #131 demonstrated mild delays with swallowing with up to 4 ounces, but inconsistency with swallowing thin and thickened liquids. The Rehab Director further stated that Resident #131 was DC from ST services on 5/24/21 with a recommendation for continued enteral feedings, pureed pleasure foods up to 4 ounces and NPO for liquids.

The DON was interviewed on 11/17/21 at 12:37

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PM and stated she started at the facility in May 2021 and at that time Resident #131 received enteral feedings only due to NPO status. The DON stated that Resident #131 had a physician's order for NPO and that she was not aware that Resident #131 received fluids by mouth. The DON further stated that, as a result of the survey the facility started reviewing physician orders to make sure nothing was missed and provided education to therapy staff to ensure orders and recommendations were communicated properly. The DON stated that when Resident #131 was DC from ST services on 5/24/21, ST recommendations were not communicated directly to nursing and that before Resident #131 received fluids by mouth, nursing should have requested clarification from therapy and obtained an appropriate physician order before providing Resident #131 with liquids by mouth while the Resident was on NPO status.

2. Resident #6 was admitted to the facility on 5/31/2019 with diagnoses to include lung disease and hypertension. The most recent quarterly Minimum Data Set (MDS) assessment dated 8/6/2021 assessed Resident #6 to be cognitively intact. The annual MDS dated 5/6/2021 assessed Resident #6 to use tobacco.

A smoking assessment dated 6/1/2019 was reviewed and the assessment determined that Resident #6 was safe to smoke with supervision.

The next smoking assessment dated 11/15/2021 determined that Resident #6 was safe to smoke with supervision.

There were no smoking assessments in the

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medical record between 6/1/2019 and 11/15/2021.

A care plan dated 8/20/2019 and revision date of 5/17/2020 addressed Resident #6's status as a safe smoker. The interventions included to instruct Resident #6 on smoking policies, notify the charge nurse if Resident #6 violated facility smoking policies and to observe skin and clothing for cigarette burns.

Nurse #1 was interviewed 11/17/2021 at 4:51 AM. Nurse #1 reported she had not completed a smoking assessment on Resident #6. Nurse #1 explained when assessments were due for residents, the electronic system would notify the nurse. Nurse #1 reported she had never completed a smoking assessment on night shift for any resident.

An interview was conducted with Nurse #3 on 11/17/2021 at 7:45 PM. Nurse #3 reported he had not completed a smoking assessment on Resident #6, and he thought day shift completed the assessment.

The MDS Nurse was interviewed on 11/18/2021 at 10:23 AM. The MDS nurse reported the assigned nurse was responsible for completing the quarterly smoking assessment and she did not know why Resident #6 did not have a smoking assessment completed between 6/1/2019 and 11/15/2021.

UM #1 was interviewed on 11/18/2021 at 3:12 PM. UM #1 reported if a smoking assessment was missed, the missed documentation prevented the system from populating a new notification for the next quarterly smoking

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assessment that was due. UM #1 stated once one smoking assessment for Resident #6 was missed and the system did not populate the next due, staff nurses would not be aware quarterly smoking assessment was due.

The facility physician (MD) was interviewed on 11/19/2021 at 9:31 AM. The MD reported the facility should complete a quarterly smoking assessment on all residents who smoked to monitor for changes.

The Director of Nursing (DON) was interviewed 11/19/2021 at 10:17 AM. The DON reported the smoking assessments were not populating in the documentation system due to an electronic documentation issue and she had reached out to company to notify of the documentation errors. The DON reported she was not aware Resident #6 had not had a quarterly smoking assessment completed between 6/1/2019 and 11/15/2021. The DON reported it was her expectation that smoking assessments were completed quarterly by nursing.

3. Resident #78 was admitted to the facility 5/21/2020 and readmitted 10/15/2021 with diagnoses to include osteomyelitis (bone infection), diabetes, and hypertension.

A smoking assessment dated 5/22/2020 indicated Resident #78 wanted to stop smoking with use of a nicotine patch.

A smoking assessment with the date 11/24/2020 indicated Resident #78 was an independent smoker and did not require supervision.

The annual MDS dated 4/10/2021 assessed

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Resident #78 to not use tobacco.

The most recent quarterly MDS assessment dated 10/22/2021 assessed Resident #78 to be cognitively intact.

A smoking assessment dated 11/15/2021 indicated Resident #78 required supervision during smoking.

A care plan dated 6/10/2020 and revised on 11/15/2021 assessed Resident #78 to be a supervised smoker. The interventions included to instruct Resident #6 on smoking policies, notify the charge nurse if Resident #6 violated facility smoking policies and to observe skin and clothing for cigarette burns.

Resident #78 was observed on 11/15/2021 at 3:21 PM in the smoking area. He reported the nurses kept his smoking materials and he would ask for the cigarettes and lighter, but he was able to come to the smoking area without supervision. Resident #78 reported he had been evaluated for smoking on this date 11/15/2021, but it had been months since he had a smoking evaluation.

Nurse #1 was interviewed 11/17/2021 at 4:51 AM. Nurse #1 reported she had not completed a smoking assessment on Resident #78. Nurse #1 explained when assessments were due for residents, the electronic system would notify the nurse. Nurse #1 reported she had never completed a smoking assessment on night shift for any resident.

An interview was conducted with Nurse #3 on 11/17/2021 at 7:45 PM. Nurse #3 reported he had not completed a smoking assessment on

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Resident #78, and he thought day shift completed the assessment.

The MDS Nurse was interviewed on 11/18/2021 at 10:23 AM. The MDS nurse reported the assigned nurse was responsible for completing the quarterly smoking assessment and she did not know why Resident #6 did not have a smoking assessment completed between 11/24/2020 and 11/15/2021. The MDS reported Resident #78 should have been coded as a smoker on the MDS and that was an error.

UM #1 was interviewed on 11/18/2021 at 3:12 PM. UM #1 reported if a smoking assessment was missed, the missed documentation prevented the system from populating a new notification for the next quarterly smoking assessment that was due. UM #1 stated once one smoking assessment for Resident #78 was missed and the system did not populate the next due, staff nurses would not be aware quarterly smoking assessment was due.

The facility physician (MD) was interviewed on 11/19/2021 at 9:31 AM. The MD reported the facility should complete a quarterly smoking assessment on all residents who smoked to monitor for changes.

The Director of Nursing (DON) was interviewed 11/19/2021 at 10:17 AM. The DON reported the smoking assessments were not populating in the documentation system due to an electronic documentation issue and she had reached out to company to notify of the documentation errors. The DON reported she was not aware Resident #78 had not had a quarterly smoking assessment completed between 11/24/2020 and 11/15/2021.

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F 689	Continued From page 28 The DON reported it was her expectation that smoking assessments were completed quarterly by nursing.	F 689		
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 (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	F 690		12/17/21

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F 690	Continued From page 29 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to change an indwelling urinary catheter every 30 days as ordered by the physician and failed to anchor the indwelling urinary catheter 1 of 2 residents reviewed for indwelling urinary catheters (Resident #66). Findings included: Resident #66 was admitted to the facility 6/9/2021 with diagnoses to include heart failure and retention of urine. The most recent quarterly Minimum Data Set (MDS) assessment dated 10/15/2021 documented Resident #66 was cognitively intact. The MDS documented Resident #66 had an indwelling urinary catheter and was always incontinent of bowels. Review of Resident #66's care plan dated 6/21/2021 addressed the indwelling urinary catheter which was needed due to urinary retention. The care plan goals included Resident #66 would remain free from catheter related trauma and have no signs or symptoms of urinary tract infection. Interventions for the care plan included to monitor for signs and symptoms of discomfort due to the indwelling urinary catheter and to monitor Resident #66 for signs and symptoms of urinary tract infection. A physician order dated 6/11/2021 ordered the indwelling urinary catheter to be changed every	F 690	1. The facility failed to change an indwelling urinary catheter every 30 days as ordered by the physician and failed to anchor the indwelling urinary catheter for Resident #66. Resident #66 Indwelling foley catheter was changed and anchored on 11/23/21. 2. Nursing Leadership to include Director of Nursing, Assistant Director of Nursing, MDS Coordinator and Unit Managers conducted an audit of all current residents with indwelling urinary catheter to ensure each had physician orders for when to change and orders for anchoring device with monitoring. Any identified issues corrected. Audit was completed on 12/16/21 and any issues identified were corrected. 3. Director of Nursing and the Assistant Director of Nursing to educate all nursing staff to include, Licensed Nurses, Certified Nursing Aids, and Contract nursing staff on proper placement of indwelling urinary catheter anchor/securement device. Education will be added to New Hire Orientation. Education to be completed by 12/17/21.	

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F 690	Continued From page 30 thirty days and as needed (PRN) on the 9th day of every month for infection prevention. A review of the medication administration record and treatment administration record (MAR/TAR) for 6/2021 to 11/2021 revealed no order to change the indwelling urinary catheter. The medical record and MAR/TAR were reviewed from 6/2021 to 11/2021 and there was no documentation that indicated the indwelling urinary catheter was changed every 30 days on the 9th day of the month. A physician order dated 11/3/2021 for phenazopyridine (a medication used to relieve dysuria) 100 mg three times per day. Phenazopyridine acts as an anesthetic in the bladder and can discolor the urine to a reddish-orange color. The medication may cause staining. Resident #66 was observed on 11/15/2021 at 12:13 PM. The indwelling urinary catheter was observed to hang off her right leg without an anchor. Resident #66 was interviewed at the time of the observation and she reported she could not remember the last time the indwelling urinary catheter had been changed. Resident #66 reported she was currently taking antibiotics for a urinary tract infection and she had multiple urinary tract infections over the past 5 months. Resident #66 reported the medication for dysuria helped to relieve her urinary pain, but it discolored her urine. Incontinence care and indwelling urinary catheter care was observed for Resident #66 on 11/17/2021 at 5:07 AM. The indwelling urinary	F 690	Director of Nursing and the Assistant Director of Nursing to educate all Licensed Nurses to include contract staff on changing Indwelling Urinary Catheters per physician orders. Education will be added to New Hire Orientation. Education to be completed by 12/17/21. Director of Nursing or designee will audit current residents with Indwelling Urinary Catheters 3x week x 4 weeks then 1x week x 8 weeks to ensure they have orders when to change, documentation of change, and that their device is properly secured. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Completion date is 12/17/2021	

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catheter was discolored a dark, rusty brown and the catheter was observed to hang off her right leg without an anchor. Resident #66 was incontinent of a small amount of liquid stool. This stool had not been absorbed into the incontinence brief and was noted to be on the skin of her buttocks. NA #2 provided catheter care to Resident #66 and then cleansed the stool off the skin off her buttocks.

Nursing assistant (NA) #2 was interviewed during the care. NA #2 reported Resident #66 had not had an anchor for the indwelling urinary catheter and she was not aware Resident #66 should have an anchor for the catheter.

Nurse #2 was interviewed on 11/17/2021 at 4:43 AM. Nurse #2 reported that indwelling urinary catheters were changed when the order appeared on the MAR/TAR with a notification it was time to change the catheter.

Nurse #1 was interviewed on 11/17/2021 at 5:21 AM. Nurse #1 reviewed the MAR/TAR and reported Resident #66 had no orders to change the catheter and there were no orders to apply an anchor. Nurse #1 reported indwelling urinary catheter change orders would show up on the MAR/TAR as a task that needed to be completed. Nurse #1 reported Resident #66 did not have an order to change the indwelling urinary catheter.

Nurse #3 was interviewed on 11/17/2021 at 7:45 PM. Nurse #3 reported he thought indwelling urinary catheters were to be changed every 30 days, but the physician would order for each resident. Nurse #3 reported he had never changed Resident #66's catheter. Nurse #3 reported the order to change the indwelling

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urinary catheter would show on the MAR/TAR. Nurse #3 reported when the order showed up in the MAR/TAR, the nurse knew it was time to change the indwelling urinary catheter. Nurse #3 reported he was not aware Resident #66's catheter was not anchored.

The NP was interviewed on 11/18/2021 at 10:37 AM. The NP reported she thought there should be orders for the indwelling urinary catheter to be changed every 30 days. The NP reported she had requested a consult with a urologist for catheter management for Resident #66.

The NP was interviewed again on 11/18/2021 at 11:09 AM and she clarified that current indwelling urinary protocols had changed, and it was no longer recommended to change the indwelling urinary catheter every 30 days. The NP reported she was not aware there was a physician order to change Resident #66's catheter every 30 days, or the indwelling urinary catheter had not been changed according to that order. The NP reported she was not aware Resident #66 did not have an anchor on the indwelling urinary catheter to promote drainage. The NP did not think more frequent indwelling urinary catheter changes, or an anchor would have prevented UTIs for Resident #66. The NP reported she had forgotten to enter the order for the urology consult after Resident #66's last UTI, but she would enter the order 11/18/2021.

The Director of Nursing (DON) was interviewed on 11/18/2021 at 12:08 PM. The DON reported she had entered the order to change the indwelling urinary catheter into the electronic documentation system on 6/11/2021 after she had reviewed Resident #66's chart and saw there

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was not an order to change the indwelling urinary catheter. The DON reported she was not aware the order was not populating on the MAR/TAR and the indwelling urinary catheter had not been changed for Resident #66. The DON reported she was not aware Resident #66 did not have an anchor for positioning the indwelling urinary catheter.

The facility physician (MD) was interviewed on 11/19/2021 at 9:31 AM. The MD reported the indwelling urinary catheter should be changed every 30 days, as well as positioned and anchored to promote adequate drainage. The MD reported he was not aware Resident #66's indwelling urinary catheter had not been changed every 30 days as ordered. The MD reported not changing the indwelling urinary catheter and the lack of anchor could have contributed to Resident #66's frequent UTIs. The MD reported the facility was able to manage the indwelling urinary catheter, but a urology consult would be needed to determine why Resident #66 had recurrent UTIs and if the indwelling urinary catheter could be discontinued.

The DON was interviewed again on 11/19/2021 at 10:17 AM. The DON reported she had incorrectly entered the order to change the indwelling urinary catheter for Resident #66 and this was why it had not populated on the MAR/TAR as a task that required completion. The DON reported the indwelling urinary catheter should have been changed according to the physician orders and an anchor should have been used to maintain positioning and drainage.