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	345393	A. BUILDING _____ B. WING _____	C 02/28/2019

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PISGAH MANOR HEALTH CARE CENTER	104 HOLCOMBE COVE ROAD CANDLER, NC 28715

(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 survey was conducted on 02/25/19 through 02/28/19. The facility was found in compliance for the requiredment CFR 483.73, Emergency Preparedness. Event ID 1GLP11.	E 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 review and staff interviews the facility failed to accurately assess 1 of 5 sampled residents reviewed for unnecessary medication utilizing the Minimum Data Set (MDS) to reflect active diagnosis and medication received (Resident #20). Findings included: Resident #20 was admitted to the facility on 06/20/17. A review of the physician's orders from 12/01/18 to 12/31/18 that were signed by the physician indicated Resident #20 had diagnosis of anxiety and was receiving medication to treat anxiety and had no order for Resident #20 to receive an antibiotic. A review of the medication administration record (MAR) from 12/01/18 to 12/31/18 indicated per staff documentation on the MAR that Resident #20 received Lorazepam (antianxiety medication) 0.5 milligrams (mg) 1 tablet by mouth in the	F 641	F000 Disclaimer Pisgah Manor Health Care Center submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote	3/21/19

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

Electronically Signed | 03/22/2019

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 correction is requisite to continued program participation.

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F 641	Continued From page 1 morning for anxiety and did not receive an antibiotic from 12/01/18 to 12/31/18. A review of a care plan dated 12/14/18 to 12/21/18 indicated Resident #20 had a problem of receiving antianxiety medication and interventions were implemented to address the problem. A review of Resident 20's quarterly Minimum Data Set (MDS) assessment dated 12/21/18 indicated Resident #20 had been coded under Section I Active Diagnoses as not having a diagnoses of anxiety disorder and was coded under Section N Medications Received as receiving an antibiotic times 7 days. On 02/26/19 at 5:47 PM an interview was conducted with MDS Coordinator who stated he coded Section I Active Diagnoses and Section N Medications Received on Resident #20's quarterly MDS dated 12/21/18. The MDS Coordinator stated Resident #20 had a diagnosis of anxiety disorder and should have been coded as having an anxiety disorder and stated Resident #20 had not received an antibiotic during the look back period from 12/15/18 to 12/21/18 and should not have been coded as having received an antibiotic during the look back period. The MDS Coordinator stated he would need to submit a modification to Resident #20's quarterly MDS dated 12/21/17 to reflect active diagnoses of anxiety disorder and reflect Resident #20 did not receive an antibiotic during the 7 day look back period. On 02/26/19 at 6:05 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Resident	F 641	action by any third party against the Provider. Any changes to Provider policy or procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. F641 Resident #20. Resident Minimum Data Set (MDS) assessment (Quarterly) with Assessment Reference Date (ARD) 12/21/2018) was modified with a Corrective Attestation Date of 2/26/2019. The assessment was submitted to the state QIES system on 2/26/2019 and was accepted on 2/26/2019. Submission ID: 16336323. All current residents with Quarterly Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 3/15/2019 through 3/21/2019, an audit was completed by the MDS Nurse Consultant to review the most recent Minimum Data Set (MDS) in the last 6 months. This audit ensured that all residents with an active diagnosis of Anxiety Disorder were coded accurately in Section I5700 (Anxiety Disorder) and to ensure that Section N0410F (Medication Received: Days Antibiotic) was coded accurately. Out of the 108 current residents, 0 residents did not have their quarterly assessments coded accurately for Section I5700 and 0 residents did not have their quarterly assessments coded accurately for Section N0410F. The audit showed that these two	

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F 641	Continued From page 2 #20's quarterly MDS assessment dated 12/21/18 would have been accurately coded under Section I Active Diagnoses to reflect active diagnoses of anxiety disorder and under Section N Medications Received as not receiving an antibiotic during the 7 day look back period. The DON stated her expectation was that the quarterly MDS assessment dated 12/21/18 would be modified and submitted to accurately reflect active diagnoses of anxiety disorder and indicate Resident #20 did not receive antibiotic during the 7 day look back period. On 02/26/19 at 6:15 PM an interview was conducted with the Administrator who stated her expectation was that the quarterly MDS assessment dated 12/21/18 would have been accurately coded to reflect active diagnoses of anxiety disorder and reflect Resident #20 did not receive antibiotic medication during the look back period. The Administrator stated her expectation was the quarterly MDS assessment 12/21/18 would be modified and submitted to accurately reflect active diagnosis of anxiety disorder and reflect Resident #20 had not received antibiotic during the look back period.	F 641	areas were correct for all residents reviewed. On 3/18/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused included: The facility must ensure that each assessment accurately reflects the resident's status. Section I: Active Diagnosis. The facility must ensure to code physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look back period (except for Item I2300 UTI, which does not use the active 7day look back period. The facility must ensure to review the documentation in the medical record to identify the resident's medical conditions to include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered. Section N: Medications. The facility must ensure to record the number of days, during the last 7days (or since admission/entry or reentry if less than 7days) that a resident received antibiotic medication. Review	

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F 641	Continued From page 3	F 641	documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room). This in service was completed by 3/18/2019. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments that is Comprehensive/ Quarterly / PPS Mini Data Set (Assessments) per week to ensure that Section I5700 (Anxiety Disorder) and Section N0410F (Medication Received: Days Antibiotic) was coded accurately. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the monthly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and	

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F 641	Continued From page 4	F 641	ongoing auditing program reviewed at the monthly QA Committee meeting. Administrator, Director of Nursing, MDS Coordinator, Assistant Director of Nursing, Staff Development Coordinator and other members of the interdisciplinary team, attend the monthly QA meeting.	
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 §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)-	F 656		3/21/19

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F 656	Continued From page 5 (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 record review and staff interviews the facility failed to implement the care plan for 1 of 2 residents reviewed for catheter care (Resident #96) and failed to develop a comprehensive care plan for 1 of 3 residents reviewed for activities of daily living (Resident #98). The findings included: 1. Resident #96 was admitted to the facility on 01/22/19 with diagnoses which included neurogenic bladder. The admission 5-day Minimum Data Set (MDS) dated 01/29/19 revealed Resident #96 had some cognitive impairment and required extensive assistance with bed mobility, toileting and hygiene. The MDS further revealed Resident #96 had an indwelling catheter. Review of the Care Area Assessment from the admission 5-day MDS revealed Resident #96 had an indwelling catheter due to neuromuscular dysfunction of her bladder (when the bladder is unable to completely empty out urine).	F 656	F656 Resident #96's care plan was reviewed and updated on 3/18/2019 to ensure that it was accurate for catheter care and activities of daily living. Resident #98's care plan was reviewed and updated on 3/18/2019 to ensure that it was accurate catheter care and activities of daily living. All current residents with requiring catheter care and activities of daily living have the potential to be affected by the alleged practice. On 3/15/2019 through 3/20/2019, an audit was completed by the Minimum Data Set (MDS) Nurse Consultant and MDS Coordinators, to ensure that a care plan was implemented for current residents requiring catheter care and activities of daily living. All current residents who require catheter care and activities of daily living have updated care plans. This was completed on 3/20/2019. On 3/18/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team	

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F 656	Continued From page 6 Review of the Care Plan dated 01/23/19 revealed the following intervention: "Position catheter bag and tubing below the level of the bladder and away from entrance room door." During an interview with Resident #96 on 02/26/19 at 8:56AM she stated that she currently had a bladder infection and was unsure what they were doing with her catheter. An observation of her catheter bag revealed it was seen with a privacy bag over it, hanging on the bed frame with the catheter tubing and bag off the floor with clear, yellow urine draining from the tubing into the catheter bag. During an observation of incontinence care on 02/27/19 at 12:06PM, Nursing Assistant (NA) #4 was observed to remove the catheter bag from the bed frame of Resident #96 and lay it on top of the mattress where Resident #96 was laying down. NA #5 and NA #4 proceeded to provide incontinence care to Resident #96 while the catheter bag remained on the mattress with yellow urine visibly present in the tubing. NA #5 and NA #4 completed catheter care for Resident #96 and NA #4 was observed placing the catheter bag on the bed frame at 12:15PM. At this time, the question was asked to both NA's why the catheter was put on the bed during incontinence care and NA #5 replied it was to prevent the catheter tubing from pulling when Resident #96 was rolled side to side for her incontinence care. During an interview with NA #4 on 02/27/19 at 12:30PM, NA #4 stated she had been trained that the catheter bag was not supposed to go above the bladder, but she must have forgotten. During an interview with the Director of Nursing	F 656	member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on the following areas: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident's exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident's representative's on the residents goals for admission and desired outcomes, the resident's preference and potential for future discharge, and discharge plans. A comprehensive person centered care plan must be implemented for all residents requiring catheter care and must be developed for all resident's receiving activities of daily living that identifies the type of care needed for activities of daily living. This in service was completed by 3/18/2019. Any MDS	

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F 656	Continued From page 7 on 02/27/19 she stated her expectations were for the NAs to follow Resident #96's care plan by keeping the resident's catheter bag and tubing below the level of his bladder. 2. Resident #98 was admitted to the facility on 08/24/2017. Her diagnoses included Alzheimer's dementia and non-Alzheimer's dementia. A review of the quarterly Minimum Data Set (MDS) dated 02/11/2019 revealed that Resident #98 was oriented to self and required extensive assistance for activities of daily living (ADL) with bed mobility, transfers, toileting, dressing, hygiene, bathing, and locomotion on/off the unit. Resident #98 was able to eat with limited assistance from one person. A review of Resident #98's care plans revealed no care plan was initiated for assistance with ADL. An interview with Nursing Assistant (NA) #1 on 02/26/2019 at 03:32 PM revealed the kiosk (wall computer for providing resident care information to NAs) gives a summary of what care the resident requires. NA #1 explained the kiosk details basic needs for all the residents pertaining to ADL and any special requirements. An interview with the MDS Coordinator on 02/26/2019 at 05:25 PM revealed if the MDS does not trigger ADL in the Care Area Assessment section then he would not develop a care plan. An interview with NA #2 on 02/27/2019 at 07:50 AM revealed Resident #98 required extensive assistance of 2 people for most of her ADL.	F 656	nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will observe five residents requiring catheter care to ensure that care plan is implemented and will review five residents electronic medical record to ensure that a comprehensive care plan is developed for activities of daily living. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. The Director of Nursing will present reports to the monthly QA Committee and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Committee meeting. Administrator, Director of Nursing, MDS Coordinator, Assistant Director of Nursing, Staff Development Coordinator and other members of the interdisciplinary team, attend the monthly QA meeting.	

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F 656	Continued From page 8 An interview with the Director of Nursing on 02/27/2019 at 10:38 AM revealed her expectation was that all residents should have an ADL care plan. An interview with the Administrator on 02/27/2019 at 11:19 AM revealed her expectation was that all the residents should have a care plan that identifies the type of care needed and how much staff is required to perform ADL.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to respond to a call light timely to provide medicine for 1 of 3 residents reviewed for providing care to maintain well-being (Resident #22). The findings included: Resident #22 was admitted to the facility on 12/29/16. The annual Minimum Data Set (MDS) dated 12/27/18 revealed Resident #22 was cognitively intact. The MDS also indicated Resident #22 was totally dependent for all	F 684	On 2/25/19, the facility nurse and nurse aide responded to (Resident #22) the request for assistance and met the needs for ADL care. On 2/25/19, the Administrator completed 100% audit of call light wait times for all residents. The findings of the audit were that all lights were answered in compliance with the facility's policy. No additional concerns were identified. On 2/25/19 the facility Assistant Director of Nursing and Staff Development Coordinator began educating facility staff	3/21/19

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F 684	Continued From page 9 activities of daily living. Record review of the physician progress note dated for 02/20/19 revealed Resident #22 was seen by the physician for an acute cough and fever. The physician ordered an as needed cough suppressant. During an interview with Resident #22 on 02/25/19 at 1:54PM, she stated she had to wait a very long time after using her call light. Resident #22 was observed to have a flat pad call light that was attached to her shirt. During an observation on 02/26/19 at 4:40PM, the call light notification system was on in the hallway for the room of Resident #22. Resident #22 stated she had activated her call light 30 minutes before and was still waiting on someone to assist her. The call light was observed attached to Resident #22's shirt. Resident #22 further stated she wanted a cough suppressant and was observed coughing twice during the interview. On 02/26/19 at 5:17PM, Nursing Assistant (NA) #3 was observed to enter the room of Resident #22 at which time Resident #22 told NA #3 she needed some cough medication. During an interview with NA #3 on 02/26/19 at 5:59PM, NA #3 stated she had not been scheduled to work today but had been called in and arrived at 4:50PM. NA #3 further stated that no resident should have to wait more than 5 minutes for their call light to be answered. NA #3 also stated that Resident #22 requested cough medication and she had informed the nurse when she left the room of Resident #22.	F 684	on importance of answering call bells timely to ensure that the quality of care principles are provided to facility residents. This was completed on 3/20/19 with 85 staff members. On 3/18/19 the Administrator will begin a QA audit of timely answering call bells timely to ensure that the quality of care principles are provided to facility residents by using the QA tool for Call bells. Administrator will audit five residents randomly throughout the building weekly and then monthly as listed below. This audit will be completed weekly x4 then monthly x 3. QA Reports will be presented in the weekly QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. Administrator, Director of Nursing, MDS Coordinator, Assistant Director of Nursing, Staff Development Coordinator and other members of the interdisciplinary team, attend the monthly QA meeting.	

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F 684	Continued From page 10	F 684		

During an interview with Nurse #3 on 02/26/19 at 6:09PM, Nurse #3 stated he answered call lights all the time. Nurse #3 further stated no resident should have to wait more than 5 minutes to have their call light answered.

During an interview with the Assistant Director of Nursing (ADON) on 02/26/19 at 6:25PM, the ADON stated that 15-20 minutes was a reasonable time for NA's to answer call lights, but they should not go over 30 minutes.

A review of the facility's call bell response time report revealed Resident #22 had a response time of one hour, eight minutes and six seconds on 02/26/19 between 4:00PM and 6:00PM.

During an interview with Nurse #3 on 02/26/19 at 6:51PM, Nurse #3 verified that NA #3 had let him know that Resident #22 had requested cough medicine, and this had been administered to her at 6:22PM.

During an interview with Resident #22 on 02/27/19 at 4:20PM, she stated she tried to be patient with the staff because she knew they have other residents to attend to, but she does become frustrated having to wait so long for help. Resident #22 also stated this happens several times each month when she needs care since she is unable to do anything for herself. Resident #22 specifically referred to using her call bell to request something to drink, being put to bed at night and in this instance, requesting medication.

During an interview with the Director of Nursing (DON) on 02/27/19 at 4:52PM, she stated was for all staff to answer call lights. The DON also stated that staff should at least go in the room,

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	345393	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PISGAH MANOR HEALTH CARE CENTER	104 HOLCOMBE COVE ROAD CANDLER, NC 28715

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F 684	Continued From page 11 answer the light and address the issue as soon as they can get to it. The DON further stated response time to call lights was very important.	F 684		
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		3/21/19

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F 690	Continued From page 12 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 maintain a urinary catheter below the level of the bladder for 1 of 2 residents review for catheter care (Resident #96). The findings included: Resident #96 was admitted to the facility on 01/22/19 with diagnoses which included neurogenic bladder. The admission 5-day Minimum Data Set (MDS) dated 01/29/19 revealed Resident #96 had some cognitive impairment and required extensive assistance with bed mobility, toileting and hygiene. The MDS further revealed Resident #96 had an indwelling catheter. Review of the Care Area Assessment from the admission 5-day MDS revealed Resident #96 had an indwelling catheter due to neuromuscular dysfunction of her bladder (when the bladder is unable to completely empty out urine). Review of the Care Plan dated 01/23/19 revealed the following intervention: "Position catheter bag and tubing below the level of the bladder and away from entrance room door." Review of physician progress notes dated 2/21/19 revealed a diagnosis of gross hematuria (blood in the urine) and Resident #96 began an antibiotic for a urinary tract infection on 02/22/19. During an interview with Resident #96 on 02/26/19 at 8:56AM she stated that she currently	F 690	F690 On 2/27/19, the Assistant Director of Nursing and Staff Development Coordinator assessed resident #96's catheter function, catheter tubing placement, and resident general condition, and no concerns were noted. On 2/27/19, the Assistant Director of Nursing and Staff Development Coordinator assessed 100% of other residents with indwelling catheters. There were five residents with indwelling catheters at this time and no concerns were identified. On 3/13/19, the Staff Development Coordinator and Assistant Director of Nursing began in-servicing facility nursing assistants on catheter care, peri-care, which included training on maintaining a catheter bag below the level of the bladder when providing personal care. Assistants were also in-serviced in a meeting 3/20/19. This has been completed with 26 assistants as of 3/20/19. In-serving will continue to ensure all that assistants have been trained. Nurses were also provided additional education on catheter care, peri-care, which included training on maintaining a catheter bag below the level of the bladder when providing personal care on 3-13-19 in the monthly meeting. On 3/13/19, the Assistant Director of Nursing and Staff Development Coordinator will begin a QA audit of	

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F 690	Continued From page 13 had a bladder infection and was unsure what they were doing with her catheter. An observation of her catheter bag revealed it was seen with a privacy bag over it, hanging on the bed frame with the catheter tubing and bag off the floor with clear, yellow urine draining from the tubing into the catheter bag. During an observation of incontinence care on 02/27/19 at 12:06PM, Nursing Assistant (NA) #4 was observed to remove the catheter from the bed frame of Resident #96 and lay it on top of the mattress where Resident #96 was laying down. NA #5 and NA #4 proceeded to provide incontinence care to Resident #96 while the catheter bag remained on the mattress with yellow urine visibly present in the tubing. NA #5 and NA #4 completed catheter care for Resident #96 and NA #4 was observed placing the catheter bag on the bed frame at 12:15PM. At this time, the question was asked to both NA's why the catheter was put on the bed during care and NA #5 replied it was to prevent the catheter tubing from pulling when Resident #96 was rolled side to side for incontinence care. During an interview with NA #4 on 02/27/19 at 12:30PM, NA #4 stated she had been trained that the catheter bag was not supposed to go above the bladder, but she must have forgotten. During an interview with the Staff Development Coordinator (SDC) on 02/27/19 at 2:16PM, she stated she goes over peri care and catheter care with the NAs during orientation. The SDC further stated that she did not review the need to keep the urinary catheter bag below the level of the bladder because this was something they would have been trained to do while getting their	F 690	observations of facility nurse aides providing catheter care to ensure that the a resident in the facility with an indwelling catheter receives appropriate treatment and services to prevent urinary tract infections and to maintain the catheter. This audit will be observing one assistant and one resident weekly x4 then monthly x 3. QA Reports will be presented in the monthly QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. Administrator, Director of Nursing, MDS Coordinator, Assistant Director of Nursing, Staff Development Coordinator and other members of the interdisciplinary team, attend the monthly QA meeting.	

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F 690	Continued From page 14 certification to be an NA. During an interview with the Director of Nursing (DON) on 02/27/19 at 1:50PM she stated her expectations were for the NAs to not place the urinary catheter bag at the level of the bladder. The DON also stated that the NAs should be providing the care that the residents need according to proper protocol so that they do not cause any type or problem or infection. The DON further stated that ongoing staff training should be done so that the NAs know the expectations of providing urinary catheter care.	F 690		