STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING _____ B. WING _____	C 08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET LAKE WACCAMAW, NC 28450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The follow up has not been done due to hurricane florence. The NH sustained damage and as of 10/4/18 they are still working on repairs. BW	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to prevent physical abuse for 1 of 1 residents reviewed for abuse (Resident #1) during the provision of incontinence care a nursing assistant smacked Resident #1's hand. Findings included: Resident #1 was admitted to the facility on 06/29/18. Diagnoses included, in part, Alzheimer ' s disease. The Minimum Data Set (MDS) admission assessment dated 07/06/18 revealed the resident was severely cognitively impaired.	F 600	F Tag 600 Employee was suspended pending investigation immediately following incident and employment was terminated after the investigation was complete. Resident #1 was assessed to have no injuries. Family and MD were made aware of incident. Residents at risk of physical abuse related to behaviors were identified and care	9/21/18

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

Electronically Signed | 09/26/2018

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F 600	Continued From page 1 Resident #1 required extensive assistance from two staff members with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #1 had no impairments and was always incontinent of bowel and bladder. Resident #1 was noted to exhibit physical behaviors toward others such as hitting, kicking, pushing, scratching, and grabbing. A review of the care plan for Resident #1 initiated on 07/18/18 indicated Resident #1 had episodes of combative behavior during care such as hitting at staff and pushing staff away. Interventions included assess and anticipate resident's needs including food, thirst, toileting needs, comfort level and positioning, provide explanation to the resident regarding task that was being done before and while providing care, and when resident became combative, stop the task and try again in a few minutes; do not force. A review of a 24-hour report regarding the employee to resident abuse revealed the report was faxed to the State of North Carolina (NC) on 08/06/18 at 5:05 PM. A review of the 5-day investigation report regarding the employee to resident abuse revealed the report was faxed to the State of NC on 08/10/18 at 4:09 PM. The investigation stated Nursing Assistant (NA) #1 was assisting Resident #1 with incontinent care with the help of NA #2 and NA #3. The report stated NA #2 and NA #3 reported to the nurse on duty that NA #1 had slapped Resident #1 ' s right hand during incontinent care. A review of a statement written by NA #2 on 08/06/18 revealed NA #2 and NA #3 went into Resident #1 ' s room to do care with NA #1. The statement stated as the NAs were doing care, the	F 600	plans were updated as necessary to reflect appropriate interventions. A notice was put on time clock that by clocking in, all employees acknowledge Premier Living has ZERO TOLERANCE for any type of abuse towards our residents. Employees were inserviced on Physical Abuse and the legal consequences of such an act. Employees inserviced via Relias Training on Recognizing, Preventing, and Reporting Abuse. Education for new employees regarding Abuse and neglect was revised 9/1/18 and has been used at all General Orientations since that date. Daily "Huddles" are held by administrative nurses with direct care staff and in addition to reports of physical signs and symptoms, we are now inquiring about behaviors, what precipitates them, makes them better, worse, etc. Huddle sheets are brought to the clinical morning meeting and discussed with the interdisciplinary team M-F. Incident reports and weekly skin observations are reviewed daily in morning clinical meeting and any injuries of unknown origins are thoroughly investigated to rule out abuse. Audits are being performed during	

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F 600	Continued From page 2 next thing NA #2 knew was that NA #1 popped the resident on the right hand and said something to the resident about the patient had pinched her. NA #2 finished helping with care and reported her observation to the nurse. A review of a statement written by NA #3 on 08/06/18 revealed NA #1 stated Resident #1 pinched her, however, NA #3 did not see Resident #1 pinch NA #1. The next thing NA #3 saw was NA #1 pop the resident on the right hand and said "You done pinch me one time, and you are not going to do it again." NA #2 and NA #3 finished giving care and left the room. The incident was reported to the nurse. A review of a written statement by NA #1 on 08/06/18 revealed NA #1 asked NA #2 and NA #3 to help her change Resident #1. NA #1 stated Resident #1 gave me 3 busted lips and a bruise on my ribs a week ago which was still sore. NA #1 stated NA #3 was at the foot of the bed and NA #2 and herself were on the sides of the bed. NA #1 stated we turned the resident toward NA #2 and the resident swung. NA #1 started to clean the resident and got bowel movement on her hand from wiping her. When NA #2 guided her arm and turned her my way, the resident pinched me on my side and held it. NA #1 reported that her reflex was to pop or swat her hand away and stated "I barely hit her hand, my fingertips touched her." NA #1 did not want to grip the resident ' s hand because the resident puts her hand in her mouth and nose and she still had bowel movement on her gloved hand. NA #1 stated "That ' s all that happened." A review of NA #1 ' s personnel record revealed she had received abuse prevention training during orientation on 04/25/18. A course	F 600	care-giving regarding any combative/physically aggressive behaviors residents exhibit, what approaches care-givers utilize, frustration levels of staff as well as their receptiveness to coaching. Audits will be conducted weekly x 4 weeks and monthly x 3 months by administrative staff who are responsible to bring new care plan approaches to the morning clinical meeting M-F in order to continually update care plans with new approaches or techniques for residents who display combative behaviors during care. Audits will be reviewed at QAPI meeting for subsequent updates to current ongoing plan.	

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F 600	Continued From page 3	F 600		

completion history confirmed NA #1 completed the abuse and neglect in service via the computer on 04/25/18.

A review of the Social Worker ' s (SW) statement written on 08/09/18 revealed the SW was notified by the DON of the incident involving Resident #1 and NA #1 on 08/06/18. The note indicated the DON stated she was made aware on 08/06/18 at approximately 2:45 AM that NA #1 had made physical contact with Resident #1 on her hand. Nurse #1 asked NA #1 to clock out and leave the facility until an investigation was completed. The SW ' s statement reported the two witnesses (NA #2 and NA #3) that were in the room at the time of the incident were interviewed. The statement reported NA #2 stated they were providing incontinent care when Resident #1 started to push the staff away and pinched at NA #1. NA #2 stated NA #1 popped Resident #1 ' s hand as if you would pop a toddler to tell them no. NA #2 reported NA #1 said something to Resident #1, however, NA #2 stated she was so stunned NA #1 had just done that she didn ' t process what NA #1 said to the resident. NA #2 stated she thought to herself "did that just go down?" The statement reported both witnesses stated NA #1 did not move her arm back to hit Resident #1, but popped the top of her hand. NA #2 also stated Resident #1 had a surprised look on her face and did not try to pinch or push staff away during the remainder of her care. Both NA #2 and NA #3 stated they all left the room together after finishing care. NA #2 and NA #3 discussed the incident and decided NA #2 would tell the charge nurse. The statement reported Nurse #1 contacted the DON and NA #1 had been put on suspension. The SW ' s statement reported Resident #1 ' s hand had been reassessed for

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F 600	Continued From page 4	F 600		

any redness or bruising and there were no developing injuries. The statement revealed that after reviewing all the witnesses ' statements (NA #2 and NA #3) and speaking with the NAs, the DON and SW felt that this behavior by NA #1 was unacceptable and therefore would be terminating NA #1 ' s employment. The DON and SW called the employee and terminated her effective immediately.

An interview was conducted with NA #3 on 08/23/18 at 6:58 AM. NA #3 reported during the night of 08/06/18 she and NA #2 assisted NA #1 with doing incontinent care on Resident #1. NA #3 stated NA #2 wanted her to observe care with Resident #1 to see how to do care on an incontinent resident with physical behaviors. NA #3 stated she was at the foot of the bed observing NA #1 and NA #2. NA #1 was on the right side of the bed and NA #2 was on the left side of the bed near the wall. NA #3 stated they were attempting to put the brief on Resident #1 who was incontinent of urine only and NA #1 turned the resident toward NA #2. NA #3 stated she witnessed NA #1 smack Resident #1 ' s right hand and stated "you ' ve done pinched me once, you are not going to do that again." NA #3 stated the resident appeared to be stunned in her expression. NA #3 stated she did not see Resident #1 pinch NA #1. NA #3 reported the resident was cooperative through the remainder of the incontinent care and when they were done she left the room and discussed the incident with NA #2. NA #3 stated that NA #2 reported the incident to Nurse #1.

An interview was conducted with NA #2 on 08/23/18 at 7:10 AM. NA #2 stated the night of 08/06/18 she worked the night shift with Resident

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F 600	Continued From page 5	F 600		

#1 and was orienting NA #3. NA #2 stated she told NA #1 when she was ready to do care on Resident #1 to let her know because she wanted NA #3 to observe. NA #2 stated she was on the left of the resident and NA #1 was on the right side of the resident. NA #2 stated Resident #1 was known to be uncooperative and combative during care and we were informing the resident what we were going to do with her care. NA #2 stated sometimes we have to wait and come back a few minutes later if we are unable to redirect the resident. NA #2 stated she and NA #1 unfastened the brief and NA #1 attempted to turn the resident toward her to clean the resident. Resident #1 started to become combative and NA #2 noted she was incontinent of urine. NA #2 stated Resident #1 was known to become combative the moment staff attempted to turn her. Resident #1 began thrashing about and resisting care. NA #2 stated once Resident #1 was facing me while lying on her side, NA #1 tucked the brief under the resident and NA #2 then turned the resident back toward NA #1. NA #2 stated Resident #1 started hollering and fussing and swinging her arms around and she observed NA #1 pop Resident #1 ' s right hand. NA #2 stated she was shocked and thought to herself "Did this just go down?" NA #2 reported all she heard was NA #1 say something about pinching. NA #2 stated the resident had no redness or bruising on her hand and added, NA #1 did not move her arm back to hit the resident. NA #2 stated Resident #1 did not cry out or yell in pain. NA #2 stated when we were done, she and NA #3 left the room. NA #2 stated she spoke with NA #3 and told her that staff was not supposed to do that and it had to be reported to the nurse. NA #2 stated she told Nurse #1. NA #2 stated she was not aware of any injuries that were caused by

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F 600	Continued From page 6 Resident #1 on NA #1. An attempt to interview NA #1 was made via phone on 08/23/18 at 10:59 AM. The voice mail of NA #1 ' s phone was full and no message was able to be recorded. An interview with Nurse #1 was conducted on 08/23/18 at 3:03 PM via phone. Nurse #1 stated NA #2 reported to her what happened with NA #1 and Resident #1. Nurse #1 stated she followed the protocol and notified the DON and sent NA #1 home. Nurse #1 stated she checked on the resident and she had no redness, no swelling and no complaints of pain to her right hand. An interview was conducted with the DON on 08/23/18 at 3:24 PM. The DON reported she had NA #1 sent home and on suspension per the abuse protocol until the investigation was completed. The DON reported she called NA #1 and had her come to the facility to write a statement on 08/06/18. The DON stated after the investigation was completed, it was determined NA #1 should be terminated due to employee to resident abuse. The DON reported her expectation of all the staff was to adhere to the abuse policy and procedures and any staff member that did not follow the policy and was found guilty of any abuse would be terminated.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 602		9/21/18

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F 602	Continued From page 7 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident interview and staff interviews, the facility failed to prevent misappropriation of property by an employee which resulted in the theft a resident's bank card and credit card and withdrawal of monies from a resident's Automatic Teller Machine (ATM) bank card for 1 of 1 residents (Resident #2) reviewed for misappropriation of property. Findings included: Resident #2 was admitted to the facility on 05/23/18. The Minimum Data Set (MDS) 5-day assessment dated 05/30/18 revealed the resident was cognitively aware. There were no mood or behaviors indicated. A record review revealed a 24-hour report regarding the theft of Resident #2 ' s credit card and bank card was faxed to the State of North Carolina (NC) on 05/31/18 at 6:56 PM and a 5-day investigation report regarding the theft of Resident #2 ' s credit card and bank card was faxed to the State of NC on 06/06/18 4:03 PM. A review of a time lined statement written by the Social Worker (SW) from 05/31/18 through 06/16/18 was conducted. On 05/31/18, Resident #2 came to the SW's office and reported that he was missing 2 bank cards. The resident stated one card was a bank credit card and the other was an ATM card which Resident #2 ' s social security check was deposited into each month. The SW statement indicated Resident #2 ' s room	F 602	F Tag 602 Resident #2 had his money refunded. Local law enforcement agency was notified and investigation ensued. Based upon results of investigation, appropriate disciplinary action was taken after the investigation was complete and charges were filed. Resident #2 made decision to keep his wallet and cards in business office safe. Residents at risk of misappropriation of funds/theft due to keeping their funds in their rooms were identified. They were reminded of their rights to manage their own financial affairs by keeping their cards/money in their room or they were able to lock up their money and/or cards in the business office safe and were encouraged to do so. Care plans were updated. A notice was put on time clock that by clocking in, all employees acknowledge Premier Living has ZERO TOLERANCE for any type of abuse towards our residents, including misappropriation of property/funds. Employees were inserviced on	

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F 602	Continued From page 8 was searched and there were no cards to be found. The SW reported she called the bank for the credit card to report the card missing and was informed that the account had been closed in March, 2018, due to inactivity and to prevent fraud. The SW also reported she called the customer service number for the ATM card and was informed the card had been used at an ATM across the street from the facility. The customer service representative reported to the SW there was one attempt to withdraw $300.00 on 05/28/18 and it was unsuccessful due to insufficient funds. The customer service representative stated a second attempt was made to withdraw $200.00 on 05/28/18 at 11:54 AM and was successful. The statement reported that per Resident #2, the withdrawal from this ATM bank card was not authorized and he immediately cancelled the card with the customer service representative from the bank. The report stated Resident #2 and the SW filed a complaint with the dispute department with the ATM bank and contacted the local police department to file a report. The Chief of Police (COP) came to facility and met with Resident #2. The report indicated since the ATM was used to take money and a date and specific time was given by the customer service representative from the ATM bank, the COP would request the surveillance footage from the ATM that was used. The SW ' s time lined statement on 06/14/18 revealed the facility received the images of the ATM from the COP. The SW noted that after careful review of the images by herself, the Administrator and the COP, the most likely suspect was Nursing Assistant (NA) #4 who was employed at this facility. The report stated the COP would question the suspect (NA #4).	F 602	misappropriation of property/funds and the legal consequences of such an act. The Lake Waccamaw Chief of Police, Scott Hyatt, came and did two inservices for staff on 8/29/18 and 08/31/18. Staff who were unable to attend or are PRN were required to review the powerpoint presentation information and acknowledge same. 100% of all staff who have worked as of 9/21/18 have been inserviced. Education for new employees regarding Abuse and neglect was revised 9/1/18 and has been used at all General Orientations since that date. Residents will be reminded and encouraged in resident council meetings of their rights related to managing finances, however, they will also be reminded about alternatives that the facility can offer to assist with keeping their valuables safe. Social Services will track those residents who keep cards in their rooms and revisit those residents at risk for misappropriation of funds weekly x 4 weeks to check that their belongings have not been disturbed and to educate them that they may keep valuables in the safe in the business office if they so choose. They are also encouraged to immediately report anything lost or missing. Audits will continue quarterly with MDS schedule.	

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F 602	Continued From page 9 A review of the police report written by the COP on 06/14/18 revealed the images from the ATM were reviewed on 06/14/18. The police report stated after showing the surveillance photos to the Director of Nursing (DON) and the SW, the suspect was identified as NA #4. The report stated NA #4 was working at the facility on May 28th when the event in question occurred. NA #4 was scheduled to work that day and worked from 8:25 AM to 3:04 PM. The police report stated NA #4 admitted to taking Resident #2 ' s bank cards and withdrawing $200.00 from the resident ' s ATM bank account. Warrants were taken out for obtaining property by false pretense on NA #4. An interview was conducted with Resident #2 on 08/22/18 at 10:15 AM. Resident #2 reported that he had a credit card and a bank card in his wallet which he kept under his pillow. Resident #2 reported on 05/31/18 he noticed the bank card and the credit card were missing from his wallet. Resident #2 stated the last time he saw the cards in his wallet was on 05/28/18. Resident #2 reported on 05/31/18 he went to the SW to let her know they were missing. Resident #2 stated he did not give his cards to anyone nor did he authorize anyone to use his cards. Resident #2 reported the facility staff and the police identified who took the cards and withdrew money from his account and she was fired. Resident #2 stated he did not usually work NA #4 and he thought the NA was a housekeeper. An attempt to interview NA #4 via phone was made on 08/23/18 at 2:45 PM. The phone number that was provided was disconnected. An interview with the SW on 08/23/18 at 2:48 PM revealed Resident #2 came to her and told her	F 602	Data from the audits will be taken to QAPI meeting and discussed to evaluate need for continued / further changes that may be needed.	

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F 602	Continued From page 10	F 602		

his cards were missing on 05/31/18 and we identified that one of the cards was a credit card and the other card was an ATM bank card which he used to have his social security check deposited in each month. The SW reported she called the ATM bank with Resident #2 present and the customer service representative revealed there were two transactions on 05/28/18. One was for $300.00 but the transaction was not completed due to insufficient funds and the next one on the same day at 11:54 AM was for $200.00 which was completed. The customer service representative reported the address of the ATM machine and it was located across the street from the facility. The SW reported Resident #2 confirmed he did not authorize the use of the card and it was then determined it was stolen. The SW stated she called the local police department and made a formal report. The SW stated the COP went to the suspect ' s (NA #4) house and she admitted to taking the cards and withdrawing $200.00 from the ATM machine on 05/28/18. The SW indicated the COP arrested NA #4. The SW stated NA #4 was terminated due to misappropriation of resident ' s property. The SW reported that she did not actually speak to NA #4 because the phone numbers they had on file did not work. The SW reported she had no documentation to support in services were completed and no audits were done with additional residents after the incident occurred on 05/31/18. The SW stated looking back now she realized she should have done audits.

An interview was conducted with the DON on 08/24/18 at 10:00 AM. The DON confirmed NA #4 was terminated due to being found guilty of misappropriation of property. The DON confirmed NA #4 received abuse training upon

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F 602	Continued From page 11 orientation on 04/21/17. The DON stated her expectation of her staff was to adhere to the abuse policy and procedures which included misappropriation of property. An interview with the Administrator on 08/24/18 at 1:30 PM revealed her expectation was that the appropriate staff should have completed audits and in services after the incident occurred on 05/31/18 to ensure that education and monitoring was provided to the staff to help prevent any type abuse in the facility which included misappropriation of property.	F 602		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews and observation, the facility failed to obtain an order for an indwelling urinary catheter for 2 out of 3 residents (Resident #3 and Resident #5) observed for catheter care. Findings included: 1. Resident #3 was admitted to the facility on 05/17/18 with a readmission date of 08/02/18. Diagnoses included, in part, urinary tract infections, retention of urine, and benign prostate hypertrophy (BPH non-cancerous enlarged prostate).	F 658	F Tag 658 Orders were reviewed for Residents #3 and #5. Foley catheter orders with the words change in the description were discontinued and new orders reading only: Urinary catheter (size) for diagnosis of (diagnosis) were initiated for both residents. Any directions on how often to change were placed under additional directions in the order template. All current residents with catheters were audited and all orders were updated as above. All care plans were audited as well	9/21/18

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F 658	Continued From page 12 The Minimum Data Set (MDS) 5-day assessment dated 08/09/18 revealed Resident #3 was moderately cognitively aware and he required limited assistance with one staff assist with toileting. Resident #3 was coded as having an indwelling urinary catheter and was frequently incontinent of bowel. A review of the care plan for Resident #3 updated on 08/09/18 revealed the resident was at risk for complications related to the use of an indwelling catheter. A review of a hospital note written on 05/17/18 indicated Resident #3 had urinary retention and to continue urinary catheter for now and consider urology consult. A review of the physician's orders revealed there was no order to have urinary indwelling urinary catheter for Resident #3 on the 05/17/18 admission orders. A review of a progress note written on 07/26/18 revealed the resident was sent to the emergency room (ER) for an evaluation and was admitted to the hospital for congestive heart failure. A review of the physician's orders upon readmission on 08/02/18, revealed there was no order to have urinary indwelling urinary catheter for Resident #3. A review of the physician order written on 08/14/18 revealed an order to change urinary catheter as needed with 18 Fr.(French) / 6 milliliter (ml) balloon, change bag monthly and check to ensure privacy bag was in place each shift.	F 658	for accuracy and completeness.. Catheter order audit frequency increased from monthly to weekly. New order set created in Electronic Medical Record (EMR) for urinary Catheters that requires personalization of size and diagnosis. Administrative nurses continue to check new orders daily and correct/update any catheter orders incorrectly entered in EMR. All current residents have had their indwelling catheter orders updated using new templates. Audits for all residents who have a urinary catheter will be performed weekly by the DON or designee to ensure the orders are accurate, complete, and have a proper diagnosis x 3 months and results will be taken to the QAPI committee for further actions/recommendations.	

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An observation of Resident #3 on 08/22/18 at 4:00 PM revealed the resident had an indwelling urinary catheter.

An interview was conducted with Resident #3 on 08/22/18 at 4:00 PM. Resident #3 was alert and oriented and answering questions appropriately. Resident #3 confirmed that he had an indwelling urinary catheter due to an obstruction and that he was being followed by an urologist. Resident #3 could not recall when the catheter was inserted but it was before he was admitted to the facility.

An interview was conducted with Nurse #3 on 08/24/18 at 9:23 AM. Nurse #3 confirmed there was no physician orders written for Resident #3 to have an indwelling urinary catheter. Nurse #3 stated there were only orders on how to take care of the catheter. Nurse #3 stated he was originally admitted with the catheter in May, 2018 and he was being followed by the urologist. Nurse #3 stated at his last urology appointment the urologist suggested to keep the catheter in place due inability to void on his own.

An interview was conducted with Director of Nursing (DON) on 08/24/18 at 11:26 AM. The DON revealed there were no orders for the urinary catheter when the resident returned from the hospital on 08/02/18, but she confirmed he was readmitted with a urinary catheter and when he was sent to the urology appointment on 08/13/18. The DON reported it was her expectation that the nurses obtained catheter orders from the physician for any resident admitted with an indwelling urinary catheter.

2) Resident #5 was admitted to the facility on

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06/25/18. Diagnosis included, in part, urinary tract infections, acute kidney failure, prostate cancer, urinary retention and prostate hypertrophy (enlarged prostate).

The MDS 30-day assessment dated 07/23/18 revealed the resident was moderately cognitively aware. Resident #5 required limited assistance with one staff assist with toileting. Resident #5 was coded as having an indwelling urinary catheter and was always continent of bowel. Resident #5 was coded as having behaviors such as refusal of care.

A review of the care plan updated on 06/25/18 revealed the resident had a plan of care for an indwelling urinary catheter.

A review of the physician's orders revealed there was no order to have an indwelling urinary catheter for Resident #5 on 06/25/18.

An observation of Resident #5 was conducted on 08/23/18 at 9:00 AM. The resident was observed to have an indwelling urinary catheter. The resident refused to have catheter care completed.

An interview was conducted with Nurse #2 on 08/23/18 at 9:00 AM. Nurse #2 confirmed the resident had an indwelling urinary catheter but there was no actual physician order for the resident to have a urinary catheter.

An interview was conducted with the Director of Nursing (DON) on 08/24/18 at 11:26 AM. The DON confirmed there were no orders for the indwelling urinary catheters written in the physician orders for Resident #5. The DON reported Resident #5 was admitted with the

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F 658	Continued From page 15 catheter and was being followed by urology. The DON reported it was her expectation that the nurses obtained catheter orders from the physician for any resident admitted with an indwelling urinary catheter.	F 658		
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	F 690		9/21/18

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F 690	Continued From page 16 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to properly secure an indwelling urinary catheter on 1 of 3 residents observed for catheter care (Resident #3). Resident #3 was admitted to the facility on 05/17/18 with a readmission date of 08/02/18. Diagnoses included, in part, urinary tract infections, retention of urine, and BPH. The MDS dated 08/09/18 5-day assessment revealed Resident #3 was moderately cognitively aware and he required limited assistance with one staff assist with toileting. Resident #3 was coded as having an indwelling urinary catheter and was frequently incontinent of bowel. A review of the care plan for Resident #3 updated on 08/09/18 revealed the resident was at risk for complications related to the use of an indwelling catheter. An interview was conducted with Resident #3 on 08/22/18 at 4:00 PM. Resident #3 reported his catheter tubing was not secured to his leg and he could not recall the last time it was secured. An observation of catheter care was conducted with Nursing Assistant (NA) #6 on 08/22/18 at 4:20 PM. NA #6 provided privacy and informed Resident #3 of each step. While providing care, NA #6 noted the catheter tubing was not secured	F 690	Upon being notified that Resident # 3 did not have on a catheter stabilization device (CSD), one was retrieved and placed on the resident immediately by an Administrative RN. All other current residents who have catheters were audited to ensure properly applied CSD's. The Catheter monthly audit record was updated with additional column added to observe for CSD. Audit frequency increased from monthly to weekly. Nurses and CNA's have been inserviced on medical necessity of having CSD (or leg band) for each resident with a catheter. New orders have been created in the Electronic Health Record (EHR) for all residents with urinary catheters that include checking daily for presence of CSD and weekly removal and replacement and as needed of CSD. Care Plans have been reviewed to ensure appropriate interventions/actions have been included. Daily audits will be performed weekly by the DON or designee x's 3 months and results will be taken to the QAPI Committee for further actions/recommendations as necessary.	

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F 690	Continued From page 17	F 690		

to the resident ' s leg and questioned why it was not secured. NA #6 drained the catheter into a urinal and reconnected the bottom of catheter.

An interview was conducted with NA #6 on 08/22/18 at 4:45 PM. NA #6 reported the indwelling urinary catheter tubing should have been secured to the resident ' s leg. NA #6 reported when she was trained on the how to care for an indwelling urinary catheter she was instructed to make sure the catheter tubing was secured to the resident ' s leg to prevent it from pulling and causing damage to the resident ' s bladder. NA #6 did not know why the catheter tubing was not secured on Resident #3.

An observation of Resident #3 on 08/24/18 at 9:20 AM revealed the resident did not have the indwelling urinary catheter tubing secured to his leg.

An interview was conducted with Resident #3 on 08/24/18 at 9:20 AM. Resident #3 reported his indwelling urinary catheter tubing was not secured to his leg. The resident stated that no staff member had put one on since 08/22/18. Resident #3 stated he would not refuse to have the catheter secured nor would he remove it. Resident #3 stated he could not recall the last time the catheter tubing was secured to his leg.

An interview was conducted with Nurse #3 on 08/24/18 at 9:20 AM. Nurse #3 confirmed the resident had an indwelling urinary catheter and the protocol for urinary catheter care was to check the tubing (entry site), check the bag to be sure it was below the bladder, check for patency and ensure the catheter was draining, check for sediment, bloody or cloudy urine in the catheter

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F 690	Continued From page 18 bag and check to be sure the tubing was secured to the resident ' s leg. Nurse #3 stated the resident did not refuse care to his catheter or refuse the staff to secure the catheter to his leg. Nurse #3 reported when she did an assessment, she would check to be sure the catheter was in place and secured to the leg. Nurse #5 reported she had not assessed the catheter as of this time. An interview was conducted with the DON on 08/24/18 at 11:26 AM. The DON reported the staff were aware that the tubing for an indwelling urinary catheter was to be anchored to the resident at all times. The DON reported her expectation of the staff would be to ensure the catheter tubing was secured to the resident ' s leg as they were trained.	F 690		