Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 13, 2021

Mr. Chad Dingman, Administrator
Pines Rehab & Health Ctr
601 Red Village Road
Lyndonville, VT 05851-9068

Dear Mr. Dingman:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 21, 2021.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

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E 000	Initial Comments The Division of Licensing and Protection conducted an annual emergency preparedness survey on 4/21/21. The following regulatory violation was cited as a result:	E 000	E 024 1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility have the potential to be negatively affected by the alleged deficient practice. 3. Facility administration has reviewed and understands the requirement to develop and implement policies to address the use of volunteers in an emergency. 4. Emergency policies have been reviewed and a policy to address the use of volunteers in an emergency has been developed and shared with the leadership team. 5. The new policy will be reviewed and accepted at the facility QAA committee meeting. 6. Corrective action completed by 5/7/2021. E024 POC accepted 5/10/21 RTremblay RN / PMA	
E 024 SS=B	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/6/2021

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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E 024	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop and implement emergency preparedness policies and procedures that address the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Findings include: Per review of facility emergency preparedness policies on 4/21/21, there was no policy to address the use of volunteers in an emergency. On 4/21/21 at 11:18 AM, the Administrator confirmed that there was no policy to address volunteers in an emergency.	E 024	F 568 1. No residents were negatively affected related to the alleged deficient practice. 2. Residents residing in the facility with cash accounts have the potential to be affected by the alleged deficient practice. 3. The facility administrator and Business Office Manager have reviewed and understand the requirement to provide financial statements to residents quarterly and upon request. 4. Residents were provided with financial statements at the time of the survey. 5. Audits will be completed quarterly to ensure statements are provided as required. 6. Corrective action completed 4/23/2021 F568 POC accepted 5/10/21 RTremblay RN/PMC	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite recertification survey 4/19/21 - 4/21/21. The following regulatory violations were cited as a result:	F 000		
F 568 SS=B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be	F 568		

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F 568	Continued From page 2 available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure individual financial records are available to 27 of 27 applicable residents through quarterly statements and upon request. Findings include: During interview on 4/21/21, the Business Office Manager (BOM) stated that the facility does not provide quarterly statements for residents with cash accounts at the facility. On 04/20/21 at 03:13 PM, the BOM and the facility Administrator confirmed that 27 residents are not provided quarterly statements as required by regulation.	F 568	F 656 1. Resident #29 had no negative effect related to the alleged deficient practice. 2. Residents with care plan interventions for the care and treatment of catheters have the potential to be affected by the alleged deficient practice. 3. In-services have been completed for the procedure to document care plan implementation as it relates to medications and treatments ordered and process to follow when treatments or medications are not administered. 4. Twice weekly audits will be completed by the Director of Nurses or designee to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits. 6. Corrective action date 5/7/2021.	
F 656 SS=E	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	F 656		

F656 POC accepted 5/10/21
RTremblay RN / PMC

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F 656	Continued From page 3 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 upon interview and record review, the facility failed to ensure Care Plan interventions were implemented for 1 resident [Res. #29] of 2 residents with indwelling catheters regarding catheter care and treatment. Findings include: A review of Res. #29's medical record reveals the resident's diagnoses include Chronic Kidney Disease and End Stage Renal Disease, is on dialysis treatments 3 times a week, and has a Suprapubic catheter [A suprapubic catheter is a urinary drainage system inserted into the bladder via an incision through the anterior abdominal wall].	F 656		

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F 656	Continued From page 4 A review of Res. #29's Care Plan includes the resident identified as "requires the use of a Suprapubic Catheter secondary to retention due to Bladder Outlet Obstruction, history of Prostate Cancer and End Stage Renal Disease requiring dialysis". Care Plan interventions for the resident include: "Medications as ordered", "Irrigation per MD orders", and "Care/changing of urinary catheter per facility policy". 1. Review of Physician Medication orders for Res. #29 reveals an order for "Sevelamer [used to control high blood levels of phosphorus in people with chronic kidney disease who are on dialysis] - take one tablet three times daily with meals for End Stage Renal Disease." Per record review of Res. #29's Medication Administration Record [MAR] for December 2020, the resident was not administered doses three times daily as ordered on 12/3, 12/26, 12/28, & 12/30/20. Per review of Res. #29's Medication Administration Record [MAR] for January 2021, the MAR reveals that the medication was not administered three times daily as ordered on 1/8, 1/13, 1/20, & 1/30/21. Per review of Res. #29's Medication Administration Record [MAR] for February 2021, the MAR reveals that the medication was not administered three times daily as ordered on 2/5, 2/7, 2/10, 2/12, 2/24, 2/25, & 2/28/21. Per review of Res. #29's Medication Administration Record [MAR] for March 2021, the MAR reveals that the medication was not administered three times daily as ordered on 3/8, 3/13, 3/14, 3/17, 3/18, & 3/30/21.	F 656		

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F 656	Continued From page 5 Further record review reveals no documentation as to why the medication was not administered per the Care Plan intervention "Medications as ordered" on the above dates, or that the Physician was notified of the missed doses. 2. Review of Physician Orders for Res. #29 and the Treatment Administration Record [TAR] for January 2021 reveals an order to "Flush Supra Pubic Catheter every shift with 150 cc [cubic centimeters] of normal saline. Review of the TAR reveals dates left blank as the order not being completed on 15 of 31 days [1/4, 1/5, 1/6, 1/13, 1/14, 1/18, 1/19, 1/20, 1/24, 1/25, 1/27, 1/28, 1/29, 1/30, 1/31/21]. Review of Physician Orders for Res. #29 and the TAR for February 2021 reveals the order to "Flush Supra Pubic Catheter every shift with 150 cc [cubic centimeters] of normal saline" as not being fully completed three times a day as ordered on any of the 28 calendar days in February 2021, with the dates on the TAR left completely blank from 2/19 through the end of the month. Review of Physician Orders for Res. #29 and the TAR for March 2021 reveals the order to "Flush Supra Pubic Catheter every shift with 150 cc [cubic centimeters] of normal saline" as not being fully completed on 15 or 31 days: [3/1, 3/2, 3/3, 3/7, 3/8, 3/11, 3/12, 3/16, 3/18, 3/23, 3/24, 3/25, 3/26, 3/30, 3/31/21]. Review of Physician Orders for Res. #29 and the TAR for April 2021 reveals the order to "Flush Supra Pubic Catheter every shift with 150 cc [cubic centimeters] of normal saline" as not being fully completed on 8 or 21 days: [4/2, 4/3, 4/4,	F 656		

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F 656	Continued From page 6 4/5, 4/8, 4/9, 4/14, 4/19 [Survey dates are 4/19 - 4/21/21]. Further record review reveals no documentation as to why the Supra Pubic site was not flushed/irrigated as ordered per the Care Plan intervention "Irrigation per MD orders"on the above dates, or that the Physician was notified of the missed treatments. 3. Review of Physician Orders for Res. #29 includes an order to "Cleanse Supra pubic site with soap and water, cover with gauze twice a day". Review of the Treatment Administration Record [TAR] for December 2020 reveals that the Supra Pubic site was not documented as being done twice a day per Physician Orders on 11 of 31 days: [12/3, 12/11, 12/13, 12/14, 12/15, 12/19, 12/23, 12/26, 12/28, 12/30, 12/31/20] Review of the TAR for January 2021 reveals that the cleansing of the Supra Pubic site was not documented as being done twice a day per Physician Orders on 16 of 31 days: [1/4, 1/6, 1/7, 1/9, 1/11, 1/13, 1/14, 1/18, 1/19, 1/20, 1/24, 1/27, 1/28, 1/29, 1/30, 1/31] Review of the TAR for February 2021 reveals that the cleansing of the Supra Pubic site was not documented as being done twice a day per Physician on 21 of 28 days: [2/2, 2/4, 2/5, 2/6, 2/8, 2/10, 2/12, 2/14, 2/15, 2/16, 2/17, and 2/19 through the end of the month]. Review of the TAR for March 2021 reveals that the cleansing of the Supra Pubic site was not documented as being done twice a day per	F 656		

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F 656	Continued From page 7 Physician on 14 of 31 days: [3/1, 3/2, 3/3, 3/4, 3/6, 3/7, 3/12, 3/13, 3/16, 3/18, 3/19, 3/23, 3/25, 3/30]. 4. Review of Physician Orders for Res. #29 for January 2021, signed by the Physician on 1/5/21 include "Change Indwelling Supra Pubic Catheter every 4 weeks- Due [date is left blank]." Per review of the Treatment Administration Record [TAR] for Res. #29 for December 2020, the Supra Pubic Catheter is documented as being changed on 12/17/20, making the due date for the next change 1/17/21. Review of the TAR for January 2021 reveals an order to "Change Indwelling Supra Pubic Catheter every 4 weeks- Due 1/17/21. Review of the TAR records that area to initial the physician order as being completed on 1/17/21 is blank. Per record review of Nursing Notes and Nurse Practitioner Notes for January 2021, there is no documentation that the Supra Pubic Catheter was changed on that date as ordered. Review of the Treatment Administration Record [TAR] for February 2021 records the date to change the Supra Pubic Catheter as due on 2/17/21. Review of the TAR records that area to initial the physician order as being completed on 2/17/21 is blank. Per record review of Nursing Notes and Nurse Practitioner Notes for February 2021, there is no documentation that the Supra Pubic Catheter was changed on that date as ordered. Review of Physician Orders for Res. #29 for April 2021, signed by the Physician on 4/1/21 include ""Change Indwelling Supra Pubic Catheter every 4 weeks- Due 4/2/21." Review of the Treatment Administration Record	F 656		

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F 656	Continued From page 8 [TAR] for April 2021 reveals an order to "Change Indwelling Supra Pubic Catheter every 4 weeks-Due 4/2/21. Review of the TAR records that area to initial the physician order as being completed on 4/2/21 is blank. Per review of the TAR for Res. #29 for April 2021, the Supra Pubic Catheter is documented as being changed on 4/6/21. Nursing Progress Notes dated 4/6/21 record "Suprapubic catheter changed, as was due to be changed 4/2 but not done." An interview and record review were conducted with the Director of Nursing [DON] on 4/21/21 at 11:50 AM. The DON was able to demonstrate through Nurse Practitioner documentation that the Supra Pubic Catheter was changed sometime during January 2021. The DON confirmed that the Nurse Practitioner notes, electronically signed on 1/23/21, did not record the date the catheter was changed, and did not demonstrate that the catheter was changed on the due date of 1/17/21, 4 weeks after the last change as ordered by the Physician. The DON also confirmed there was no documentation that the Supra Pubic Catheter was changed at all during February 2021, and that per Physician Orders and Res. #29's Treatment record, the catheter was due to be changed on 4/2/21 but was not, with no documentation as to why the procedure was not completed or the Physician notified. The DON confirmed that interventions were not implemented per Res. #29's Care Plan regarding "Care/changing of urinary catheter per facility policy". An interview and record review were conducted with the Director of Nursing [DON] on 4/21/21 at 11:50 AM. The DON confirmed that interventions were not implemented per Res. #29's Care Plan regarding "Medications as ordered", "Irrigation	F 656		

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F 656	Continued From page 9 per MD orders", and "Care/changing of urinary catheter per facility policy".	F 656	F 690 1. Resident #29 had no negative effects related to the alleged deficient practice. 2. Residents requiring catheter care and treatment have the potential to be affected by the alleged deficient practice. 3. In-services have been completed for the procedure to document care and treatment of catheter care as ordered by the physician and procedure to follow if ordered medications or treatments are not administered. 4. Twice weekly audits will be completed by the Director of Nurses or designee to monitor effectiveness of the plan. 5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits. 6. Corrective action date 5/7/2021. F690 POC accepted 5/6/21 RTremblay RN / PMC	
F 690 SS=E	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 restore as much normal bowel function as	F 690		

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F 690	Continued From page 10 possible. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure 1 resident [Res. #29] of 2 residents with indwelling catheters received the appropriate care and services as ordered by the Physician regarding catheter care and treatment. Findings include: A review of Res. #29's medical record reveals the resident's diagnoses include Chronic Kidney Disease and End Stage Renal Disease and has a Suprapubic catheter [A suprapubic catheter is a urinary drainage system inserted into the bladder via an incision through the anterior abdominal wall]. Per review of "Suprapubic Catheter: A Quick Guide to Care of, Removal, and Changing" : [https://suprapubiccatheter.org/suprapubic-catheter-a-quick-guide-to-care-of-removal-and-changing/] "Without proper treatment of the device and the area in which it is inserted, the catheter may fail to perform properly, infection may occur, and serious illness can result ... It's important that procedures for suprapubic catheter care be followed and that care occurs in a timely manner. Care includes the daily changing of dressing ..." Review of Physician Orders for Res. #29 includes an order to "Cleanse Supra pubic site with soap and water, cover with gauze twice a day". Review of the Treatment Administration Record [TAR] for December 2020 reveals that the Supra Pubic site was not documented as being done twice a day per Physician Orders on 11 of 31 days:	F 690		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

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F 690	Continued From page 11 [12/3, 12/11, 12/13, 12/14, 12/15, 12/19, 12/23, 12/26, 12/28, 12/30, 12/31/20] Review of the TAR for January 2021 reveals that the cleansing of the Supra Pubic site was not documented as being done twice a day per Physician Orders on 16 of 31 days: [1/4, 1/6, 1/7, 1/9, 1/11, 1/13, 1/14, 1/18, 1/19, 1/20, 1/24, 1/27, 1/28, 1/29, 1/30, 1/31] Review of the TAR for February 2021 reveals that the cleansing of the Supra Pubic site was not documented as being done twice a day per Physician on 21 of 28 days: [2/2, 2/4, 2/5, 2/6, 2/8, 2/10, 2/12, 2/14, 2/15, 2/16, 2/17, and 2/19 through the end of the month]. Review of the TAR for March 2021 reveals that the cleansing of the Supra Pubic site was not documented as being done twice a day per Physician on 14 of 31 days: [3/1, 3/2, 3/3, 3/4, 3/6, 3/7, 3/12, 3/13, 3/16, 3/18, 3/19, 3/23, 3/25, 3/30]. Further record review reveals no documentation as to why the Supra Pubic site was not cleansed and a dressing applied as ordered on the above dates, or that the Physician was notified of the missed treatments. Review of Physician Orders for Res. #29 and the Treatment Administration Record [TAR] for January 2021 reveals an order to "Flush Supra Pubic Catheter every shift with 150 cc [cubic centimeters] of normal saline. Review of the TAR reveals dates left blank as the order not being completed on 15 of 31 days [1/4, 1/5, 1/6, 1/13, 1/14, 1/18, 1/19, 1/20, 1/24, 1/25, 1/27, 1/28, 1/29, 1/30, 1/31/21].	F 690		

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F 690	Continued From page 12 Review of Physician Orders for Res. #29 and the TAR for February 2021 reveals the order to "Flush Supra Pubic Catheter every shift with 150 cc [cubic centimeters] of normal saline" as not being fully completed three times a day as ordered on any of the 28 calendar days in February 2021, with the dates on the TAR left completely blank from 2/19 through the end of the month. Review of Physician Orders for Res. #29 and the TAR for March 2021 reveals the order to "Flush Supra Pubic Catheter every shift with 150 cc [cubic centimeters] of normal saline" as not being fully completed on 15 or 31 days: [3/1, 3/2, 3/3, 3/7, 3/8, 3/11, 3/12, 3/16, 3/18, 3/23, 3/24, 3/25, 3/26, 3/30, 3/31/21]. Review of Physician Orders for Res. #29 and the TAR for April 2021 reveals the order to "Flush Supra Pubic Catheter every shift with 150 cc [cubic centimeters] of normal saline" as not being fully completed on 8 or 21 days: [4/2, 4/3, 4/4, 4/5, 4/8, 4/9, 4/14, 4/19 [Survey dates are 4/19 - 4/21/21]. Further record review reveals no documentation as to why the Supra Pubic catheter was not flushed every shift as ordered on the above dates, or that the Physician was notified of the missed treatments. Review of Physician Orders for Res. #29 for January 2021, signed by the Physician on 1/5/21 include "Change Indwelling Supra Pubic Catheter every 4 weeks- Due [date is left blank]." Per review of the Treatment Administration Record [TAR] for Res. #29 for December 2020, the Supra Pubic Catheter is documented as being	F 690		

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F 690	Continued From page 13 changed on 12/17/20, making the due date for the next change 1/17/21. Review of the TAR for January 2021 reveals an order to "Change Indwelling Supra Pubic Catheter every 4 weeks- Due 1/17/21. Review of the TAR records that area to initial the physician order as being completed on 1/17/21 is blank. Per record review of Nursing Notes and Nurse Practitioner Notes for January 2021, there is no documentation that the Supra Pubic Catheter was changed on that date as ordered. Review of the Treatment Administration Record [TAR] for February 2021 records the date to change the Supra Pubic Catheter as due on 2/17/21. Review of the TAR records that area to initial the physician order as being completed on 2/17/21 is blank. Per record review of Nursing Notes and Nurse Practitioner Notes for February 2021, there is no documentation that the Supra Pubic Catheter was changed on that date as ordered. Review of Physician Orders for Res. #29 for April 2021, signed by the Physician on 4/1/21 include ""Change Indwelling Supra Pubic Catheter every 4 weeks- Due 4/2/21." Review of the Treatment Administration Record [TAR] for April 2021 reveals an order to "Change Indwelling Supra Pubic Catheter every 4 weeks- Due 4/2/21. Review of the TAR records that area to initial the physician order as being completed on 4/2/21 is blank. Per review of the TAR for Res. #29 for April 2021, the Supra Pubic Catheter is documented as being changed on 4/6/21. Nursing Progress Notes dated 4/6/21 record "Suprapubic catheter changed, as was due to be changed 4/2 but not done." An interview and record review were conducted with the Director of Nursing [DON] on 4/21/21 at 11:50 AM. The DON was able to demonstrate	F 690		

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F 690	Continued From page 14 through Nurse Practitioner documentation that the Supra Pubic Catheter was changed sometime during January 2021. The DON confirmed that the Nurse Practitioner notes, electronically signed on 1/23/21, did not record the date the catheter was changed, and did not demonstrate that the catheter was changed on the due date of 1/17/21, 4 weeks after the last change as ordered by the Physician. The DON also confirmed there was no documentation that the Supra Pubic Catheter was changed at all during February 2021, and that per Physician Orders and Res. #29's Treatment record, the catheter was due to be changed on 4/2/21 but was not, with no documentation as to why the procedure was not completed or the Physician notified. The DON also confirmed that Physician Orders for the resident's Suprapubic catheter related to dressing changes and flushing the catheter were not completed as ordered on multiple dates, with no documentation regarding why the care and treatment was not done, and no documentation that the Physician was notified regarding the missed treatments.	F 690		