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	49A043	A. BUILDING _____ B. WING _____	04/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare Focused initial survey was conducted 4/11/17 through 4/12/17. This was intended to be the facility's starting survey to begin the reasonable assurance period following termination. The survey found the facility to be out of compliance with the 42 CFR Part 483 Federal Long Term Care requirements. Corrections are required.

The census in this 196 certified bed facility was 68 at the time of the survey. The survey sample consisted of 9 current record reviews (Residents #1 through #9).

F 328 SS=D 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS

(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

F 328

F 328 SS-D Special Needs

A. What actions will be accomplished for those residents found to have been affected by this practice?

1. Resident #5 receives oxygen per physician order

B. How the facility will identify other residents having the potential to be affected by the same deficient practice?

2. Residents that have physician orders for oxygen (has) have had a quality review completed by director of Clinical Services/designee to ensure oxygen is being administered per physician order. Follow up based on findings.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/27/17

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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(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed for one (Resident #5) of 9 residents in the survey sample, to administer oxygen per physician's

C. What measures will be put in to place or what systemic changes made to ensure that the deficient practice will not recur?
1. The Director of Nursing or designee to(in-service)re-educate licensed nurses regarding following physician orders for oxygen administration also on checking concentrator settings for physician ordered liter flow and accurate documentation of oxygen administration on TAR..

D. How the facility plans to monitor its performance to make sure that solutions are sustained?
1. The Director of Clinical Services (DCS) or designee to complete a quality review 5 times a week for 4 weeks. Then 3 times a week for 4 weeks new physician orders for oxygen administration, to ensure oxygen administration/liter flow settings is per physician orders.. Follow up based on findings.. Quality Review schedule modified based on findings.

The Director of Nursing or designee to report Quality Review findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. Performance Improvement Plan developed and modified based on findings

E. Date of Compliance:
1. 5/3/2017

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order.

Resident #5 was observed with oxygen in use at 2 liters per minute (lpm), however the physician's order was for 3 lpm.

The findings included:

Resident #5 was admitted to the facility on 12/30/16 with the diagnoses of, but not limited to, COPD (chronic obstructive pulmonary disease), obesity, and sleep apnea.

The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 3/8/17. The MDS coded Resident #5 with no cognitive impairment; was dependent on staff for transfers, toileting and bathing; required extensive assistance from staff for bed mobility, locomotion on and off the unit and personal hygiene; and required supervision for eating. The MDS included oxygen therapy use.

On 4/12/17 at 8:30 a.m. Resident #5 was observed lying in bed, head elevated, alert and talking with the Director of Nursing (Admin-B). Resident #5 had oxygen with humidification in use via nasal cannula. The oxygen concentrator was set on 2 lpm. When asked how her breathing was today, Resident #5 stated "good."

On 4/12/17 at 10:40 a.m. Resident #5's clinical record was reviewed. The review revealed signed physician orders which included: "12/30/16: OXYGEN VIA NASAL CANNULA AT 3L/MIN CONTINUOUSLY-DX: COPD."

The Treatment Administration Record (TAR) for

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March and April 2017 was reviewed and included the oxygen per above physician's order. The hours listed on the TAR for oxygen use where the nurses would initial for use were 7a-7p and 7p-7a.

Resident #5's care plan included a focus of "The resident has an ineffective breathing pattern r/t (related to) COPD," and interventions which included "Oxygen as ordered" with a "Date Initiated: 01/09/2017."

On 4/12/17 at 11:15 a.m. surveyor asked Admin-B and Licensed Practical Nurse-A (LPN-A) to come to Resident #5's room and showed them that Resident #5's oxygen concentrator was set at 2 lpm. The staff members were informed the oxygen was set on 2 liters on both observations yet the physician's order was for 3 lpm. Surveyor asked Resident #5 what her oxygen is normally set on and the resident replied "It should be on 3 liters but sometimes they put it on 2, I don't know why." Admin-B changed the oxygen concentrator to 3 lpm and told LPN-A to take Resident #5's vitals. A copy of physician orders, TAR's and oxygen policy was requested.

On 4/12/17 at 11:20 a.m. LPN-A was observed in Resident #5's room with a blood pressure cuff around the resident's lower arm. LPN-A stated Resident #5's oxygen saturation (result) was 100%.

On 4/12/17 at 11:40 a.m. the Administrator (Admin-A) and Admin-B entered the conference room where the survey team was working. Admin-B explained she changed the rate this morning when she was making rounds. She stated it (the oxygen) was on 3 liters and she

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changed it to 2. She stated she thought the order was for 2 liters.

Facility policy and procedure titled "Oxygen Therapy" was reviewed and included:

"...PROCEDURE:
1. Review physician's order...
9. Start O2 flowrate at the prescribed liter flow or appropriate flow for administration device..."

On 4/12/17 at 1:55 p.m. the Administrator (Admin-A) explained upon admission Resident #5 had a hospice order for 2-4 liters per minute. Surveyor reviewed current physician's order with Admin-A and explained the order was initiated 12/30/16 for 3 liters per minute. Admin-A presented a new physician's order for 2 liters per minute obtained after observation. No further information was provided by the facility staff.

F 514 SS=B 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

(i) Medical records.
(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

F 328

F 514

F-514 483.75 (l) (1) Clinical Records

A. What actions will be accomplished for those residents found to have been affected by this practice?

1. Resident #5 is administered oxygen per physician order. Resident medical record was updated in nurse's note to reflect the changes.

B. How the facility will identify other residents having the potential to be affected by the same deficient practice.

1. **Residents with physician orders for oxygen have been reviewed using a quality review for receiving oxygen per physician order** The documentation regarding oxygen administration of residents with physician orders has been reviewed. Follow up based on findings.

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(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for one (Resident #5) of 9 residents in the survey sample, to accurately document oxygen administration.

For Resident #5, the facility nursing staff initialed the March and April 2017 Treatment Administration Record (TAR) that oxygen was administered at 3 liters per minute (lpm) however, on 9 occasions the nurses documented in the progress notes that 2 lpm was in use.

The findings included:

Resident #5 was admitted to the facility on 12/30/16 with the diagnoses of, but not limited to, COPD (chronic obstructive pulmonary disease), obesity, and sleep apnea.

C. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
The Director of Nursing or designee to in(-service) re-educate licensed nurses on accurate documentation of oxygen administration, verifying the physician orders, and the concentrator settings to ensure accuracy and documenting on the TAR. New physician orders reviewed in Morning Clinical Meeting.

D. How the facility plans to monitor its performance to make sure that solutions are sustained?
1. The Director of Clinical Services or designee to Quality Review 5 times a week for 4 weeks then 3 times(a) weekly for 4 weeks. Oxygen administration documentation on Treatment Administration Record (TAR) for liter flow being documented per physician order for those residents with physician orders for oxygen. Follow up based on findings.
The Director of Nursing or designee to quality review residents receiving oxygen 5 times (a) weekly for 4 weeks. Then 3 times a week for 4 weeks on residents receiving oxygen.. Quality Review schedule modified based on findings
The Director of Nursing or designee will report their findings to the Quality Assurance and Performance Improvement (QAPI) Committee. Quality Monitoring/Review findings reviewed and Performance Improvement Plan modified as indicated.

E. Date of Compliance:
1. 5/3/2017

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The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 3/8/17. The MDS coded Resident #5 with no cognitive impairment; was dependent on staff for transfers, toileting and bathing; required extensive assistance from staff for bed mobility, locomotion on and off the unit and personal hygiene; and required supervision for eating. The MDS included oxygen therapy use.

On 4/12/17 at 8:30 a.m. Resident #5 was observed lying in bed, head elevated, alert and talking with the Director of Nursing (Admin-B). Resident #5 had oxygen with humidification in use via nasal cannula. The oxygen concentrator was set on 2 lpm. When asked how her breathing was today, Resident #5 stated "good."

On 4/12/17 at 10:40 a.m. Resident #5's clinical record was reviewed. The review revealed signed physician orders which included: "12/30/16: OXYGEN VIA NASAL CANNULA AT 3L/MIN CONTINUOUSLY-DX: COPD."

The Treatment Administration Record (TAR) for March and April 2017 was reviewed and included the oxygen per above physician's order. The hours listed on the TAR for oxygen use where the nurses would initial for use were 7a-7p and 7p-7a. Although the TAR was initialed by the nursing staff that oxygen at 3 lpm was administered, the "INTERDISCIPLINARY PROGRESS NOTES" read, on the following dates, that 2 liters per minute was in use:

4/1/17 at 6:30 p.m., 3/31/17 at 12 p.m., 3/30/17 at 1:30 p.m., 3/25/17 at 5:40 a.m., 3/24/17 at 4:46

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a.m., 3/23/17 at 12 a.m., 3/22/17 at 1:15 a.m., 3/21/17 at 3:25 p.m. and 3/20/17 at 1:30 p.m.

Resident #5's care plan included a focus of "The resident has an ineffective breathing pattern r/t (related to) COPD," and interventions which included "Oxygen as ordered" with a "Date Initiated: 01/09/2017."

On 4/12/17 at 11:15 a.m. surveyor asked Admin-B and Licensed Practical Nurse-A (LPN-A) to come to Resident #5's room and showed them that Resident #5's oxygen concentrator was set at 2 lpm. The staff members were informed the oxygen was set on 2 liters on both observations yet the physician's order was for 3 lpm. Surveyor asked Resident #5 what her oxygen is normally set on and the resident replied "It should be on 3 liters but sometimes they put it on 2, I don't know why." Admin-B changed the oxygen concentrator to 3 lpm and told LPN-A to take Resident #5's vitals. A copy of physician orders, TAR's and oxygen policy was requested.

Facility policy and procedure titled "Oxygen Therapy" was reviewed and included:

"...Documentation shall include:
...3. Liter flow...

"...PROCEDURE:
1. Review physician's order...
9. Start O2 flowrate at the prescribed liter flow or appropriate flow for administration device...
16. Document initiation of therapy in the resident's chart.."

On 4/12/17 at 2:00 p.m. at the end of day meeting, the Administrator, Assistant

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Administrator, Director of Nursing, Assistant Director of Nursing and Corporate Registered Nurse (Admin-C) were informed of the oxygen liters charting discrepancies.

On 4/12/17 at 2:20 p.m. the Corporate Nurse (Admin-C) stated and showed surveyors education sheets dated 3/20/17 regarding documentation. Admin-C stated she identified the documentation discrepancies during audits which revealed to her "sometimes they (nurses) documented 2 liters, sometime 3 liters." Surveyor stated to Admin-C that some of the inaccurate documentation occurred even after the training was done. The facility staff did not present any further information.