STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495279	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULPEPER HEALTH & REHABILITATION CENTER	602 MADISON ROAD CULPEPER, VA 22701

(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 Emergency Preparedness survey was conducted 09/18/18 through 09/20/18. The facility was in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/18/18 through 9/20/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 bed certified bed facility was 151 at the time of the survey. The survey sample consisted of 37 current Resident record reviews (Residents #115, 238, 98, 78, 49, 76, 96, 23, 114, 32, 35, 338, 90, 111, 133, 1, 128, 91, 16, 94, 438, 31, 129, 120, 95, 3, 53, 46, 29, 81, 2, 134, 239, 41, 132, 103, and 538) and five closed record reviews (Residents #488, 136, 140, 445, and 288).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		10/10/18

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

Electronically Signed | 10/04/2018

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to serve food in a manner to promote resident dignity for one of 31 residents in the observation of the main dining room, Resident # 114. The facility staff failed to serve food to Resident # 114 in a manner to promote dignity during the	F 550	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility	

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F 550	Continued From page 2 lunch meal in the main dining room. The findings include: Resident # 114 was admitted to the facility on 06/24/2015 with diagnoses that included but were not limited to: Alzheimer's disease (1), depressive disorder (2), hypertension (3) and atherosclerotic heart disease (4). Resident # 114's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/04/18, coded Resident # 114 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 114 was coded as being independent for activities of daily living with set up assistance only. On 09/18/18 at 11:57 a.m., an observation was conducted in the main dining room of the facility. On 09/18/18 at 12:30 p.m., an observation of a dining room table in the main dining room revealed four residents seated at one of the tables, three of the four residents were served lunch and eating. The fourth resident at the table, Resident # 114, was sitting at the table with a beverage without a meal. Resident # 114 was positioned at the table with her back to the wall and was able to look across the table out into the dining room. The facility staff were observed serving the next two tables, to the left of Resident # 114 and the table across from Resident # 114. Staff were observed walking by Resident # 114's table, in front of her, with plated meals for other residents at the other tables, while Resident #114 waited without her meal.	F 550	has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 1. Resident #114 has received food service timely in a dignified manner since 9/18/2018 noted anomaly. The staff who served in the dining room on 9/18/2018 were given remediation session on dignified food service during meals in all the dining rooms. 2. The Dietary Manager completed a two days audit of dignified meal services to residents in the three dining areas. No resident was found to have received an undignified meal service □ all residents served on a table within the same time frame. 3. Dietary Manager/Dietitian to provide an in-service to all CNAs and Dietary Techs. on the following topics: a) What constitute a dignified resident meal service b) Managing meal service and time in the dining room c) Policy ad procedure on meal service in the dining room d) Customer service during meal service 4. Administrator, Dietary Manager and Dietitian to complete meal service audit weekly x1 month and monthly x3 months to ascertain that residents are served timely and in a dignified manner. Any noncompliance to the above-stated	

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F 550	Continued From page 3 On 09/18/18 at12:30 p.m., the facility staff were observed serving the next two table, walking by resident while she waits meals for other residents without her meal. Table across from resident and to the left On 09/18/18 at 12:36 p.m. Resident # 114 was observed to stopping a staff member (CNA (certified nursing assistant) # 3, walking by her table and asked for her meal. CNA # 3 was observed responding, "Okay" and walked by. Continued observation of the dining room failed to evidence the staff member, CNA # 3 coming back to follow up with Resident # 114. On 09/18/18 at 12:41 p.m., Resident # 114 was observed stopping another staff member, CNA # 5, who was walking by her table and asking for her meal. CNA #5 was observed responding, "I'll look into it" and walked by. Further observation during the course of the dining room observation failed to evidence the staff member coming back to Resident # 114 and following up. Observation of the other three residents who were dining with Resident # 114 revealed they were more than half way through their meal." On 09/18/18 at12:44 p.m., Resident # 114 was served her lunch. On 09/18/18 at 12:46 p.m., an interview was conducted with Resident # 114, regarding having to wait for her meal while everyone else at the table was eating. Resident # 114 stated, "They're not paying attention to what they are doing." On 09/18/18 at 1:57 p.m., an interview was conducted with CNA (certified nursing assistant) #	F 550	standard will be rectified immediately and further forwarded to the QAPI committee for review and recommendation.	

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F 550	Continued From page 4	F 550		

3. When asked to describe the process for distributing meals in the dining room, CNA # 3 stated, "Keep cleanliness by keeping hands clean and sanitized, serve everyone at a table then move to the next table, honor the resident's choices in terms of food seating." When asked if she was working in the dining room, earlier during lunch and if she spoke with Resident # 114, CNA # 3 stated, "Yes." When asked if Resident # 114 asked about her meal, CNA # 3 stated, "Yes." When asked what her response to Resident # 144 was, CNA # 3 stated, "I said okay." When asked if she followed up with Resident # 114, CNA # 3 stated, "I should have gotten her order and should have followed up with the resident to let her know where her meal was."

On 09/18/18 at 2:08 p.m., an interview was conducted with CNA # 5. When asked to describe the process for distributing meals in the dining room, CNA # 5 stated, "Serve one table at a time, and make sure that table has all their food before going to the next table." When asked if she was working in the dining room, earlier during lunch and if she spoke with Resident # 114, CNA # 5 stated, "Yes." When asked if Resident # 114 asked about her meal, CNA # 5 stated, "I told her he I would look in to it. I asked my coworkers and told the kitchen that the resident was upset and then I waited for the kitchen to bring the meal out." When asked if she followed up with Resident # 114, CNA # 5 stated, "No." When asked why is it important to serve everyone at the table before swerving the next table, CNA # 5 stated, "So no one feels left out."

On 09/18/18 at 2:16 p.m., an interview was conducted with OSM (other staff member) # 5, dietary manager. When asked to describe the

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F 550	Continued From page 5	F 550		

process for distributing meals in the dining room, OSM # 5 stated, "CNAs will get the resident's orders, pass drinks, start soup and salad pass, give tickets to the kitchen, the kitchen fills the orders, plates the food and brings the trays to dining room. CNAs pass meals table by table." OSM # 5 stated, "The main meals should be served one table at a time." When informed of the observations regarding Resident # 114, OSM # stated, "That is not the correct practice. The standard is that everyone at the table is served together."

The facility's "Resident Handbook" documented, "RESIDENT RIGHTS: 12. To be treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs."

On 09/19/18 at approximately 5:10 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger,

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F 550	Continued From page 6 or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) A disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium, and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the flow of oxygen-rich blood to your body. This information was obtained from the website: https://medlineplus.gov/atherosclerosis.html.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a call bell was within reach for use for one of 42 residents in the survey sample, Resident #29. The facility staff failed to ensure the call bell was within Resident #29's reach while she was seated	F 558	F558 1. Resident #29□s call bell was placed within reach on 9/18/2018 mid of 3-11 shift and has remained reachable to her at all times when in room 2. DON/ADON/Unit Managers completed a 100% call bell reachability audit on 9/19/2018 and noted no	10/10/18

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F 558	Continued From page 7 in her wheelchair next to her bed. The findings include: Resident #29 was admitted to the facility on 12/8/14, with a readmission on 7/15/15 with diagnoses that included but were not limited to: Multiple Sclerosis [A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. (1)], high blood pressure, pseudobulbar affect [A group of progressive neurological disorders that destroy motor neurons, the cells that control essential voluntary muscle activity such as speaking, walking, breathing, and swallowing. (2)], depression and history of stroke. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/10/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance for moving in the bed, dressing, toileting, and personal hygiene. The resident was coded as having limitation in range of motion in one upper extremity and both lower extremities. Observation was made of the Resident #29 on 9/18/18 at 11:12 a.m. during the initial	F 558	unreachable call bells to current residents. Remediation session on monitoring call bell reachability by residents provided by Unit Managers to all CNAs during huddles of the days following 9/19/2018. 3. Staff Development Coordinator (SDC)/Designee to complete re-education with the CNAs on the following topics relating to call bell reachability by resident a) Positioning of call bell for resident reach b) Auditing of call bell before and after ADL care to ensure reachability by residents c) Routine rounding of call bell during shift to ensure functionality and reachability by the residents 4. DON/ADON/Unit Managers will complete an audit on call bell reachability by residents weekly x1 month and monthly x3 months to assure no deficient practice. Any noted call bell unreachability by residents will be corrected immediately and forwarded to QAPI committee for further review and recommendation.	

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F 558	Continued From page 8	F 558		

observations. The resident was sitting in her wheelchair on the right side of her bed. The call bell was observed on the floor on the left side of the bed. The resident's room was observed again at 12:33 p.m. The call bell remained on the floor on the left side of the bed. On 9/18/18 at 4:31 p.m., the call bell was observed on the floor on the left side of the bed. The resident was on the right side of the bed, working on her bills, writing checks. When asked how she calls staff for assistance, Resident #29 stated she goes out in the hallway and grabs them. When asked if she has to do that frequently, Resident #29 stated it happens frequently."

An interview was conducted with CNA (certified nursing assistant) # 9, on 9/19/18 at 4:43 p.m. When asked where a resident call bell should be located, CNA #9 stated, "Within the resident's reach." When informed of the observations above of Resident #29's call bell on the floor out of reach, CNA #9 stated, "It shouldn't be there (on the floor), it should be pinned to the resident."

An interview was conducted with LPN (licensed practical nurse) #3 on 9/19/18 at 4:45 p.m. When asked where resident call bells should be located, LPN #3 stated, "Within the reach of the patient." When informed of the above observation of Resident #29's call bell on the floor, LPN #3 stated, "It (call bell) should not be there." When asked where a call bell should be located for a resident seated in a wheel chair positioned next to their bed, LPN #3 stated, "It should be pinned on the bed next to where the resident is."

The administrator and director of nursing were made aware of the above concern on 9/19/18 at 5:10 p.m.

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F 558	Continued From page 9 The policy presented by the facility on 9/20/18 at approximately 12:30 p.m. documented, "Shift Responsibilities for CNA - 4. promptly respond to call lights and notify the licensed nurse of any pertinent patient findings." A second policy titled, "Patient Admitted" documented in part, "6. b. Communication system: call light at bedside and bathroom." No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/multiplesclerosis.html. (2) This information was obtained from the following website: https://rarediseases.info.nih.gov/diseases/12012/pseudobulbar-affect,	F 558		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made	F 577		10/10/18

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F 577	Continued From page 10 respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on group interview, observation, staff interview and facility document review it was determined the facility staff failed to post, in a place readily accessible to residents and family, the results of previous surveys. The facility staff failed to ensure posting of the complete survey results, with the plan of corrections, and failed to ensure the results were readily available, accessible to residents and family and failed to ensure posting that the past three survey results were available upon request. The findings include: On 09/19/18 at approximately 10:10 a.m., a group interview was conducted with four alert and oriented residents. When asked about the availability of past surveys results, the residents replied they did not know where the survey results were located. When asked if they knew the past survey, results were available at the front desk, the residents responded that they were unaware. On 09/19/18 at approximately 10:56 a.m., observation was made of a framed sign that documented "Survey Results Locations,	F 577	F577 1. Previous year survey results with corresponding plan of corrections was updated in the survey binder at the front desk on 9/19/2018. The signage was also reframed to expose all writings for residents visibility and readability. 2. The survey results signage for residents accessibility to review/read were also posted in common areas in the Facility during the week following the survey. Patient access and reading of the survey results to be discussed in the next residents council meeting as way of further re-enforcing to the residents the information on the posted signage on the topic. 3. Vice President of Operation/Designee to provide re-education to the Administrator on survey results accessibility by the residents, families, and responsible parties at all time. 4. Administrator to audit survey binder at front desk/signage readability/visibility weekly x1 month and monthly x3 months to ensure completeness and accessibility by the residents at all times.	

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Attention: Patients and Families, Please find the results of our most recent survey. If you have any questions or concerns please contact the Administrator." Observation of the receptionist's desk in the facility's lobby revealed a black three ring binder. The cover of the black binder documented, "Survey Results." The three ring binder contained survey results without the plan of correction from the annual survey ending on 08/09/17. Further observation of the contents of the book failed to evidence three years of survey results and plan of corrections.

On 09/19/18 at approximately 11:01 a.m., observation was made of common spaces. The whole building was observed, including all nurses' stations and resident accessible areas; however, no signs were posted in spaces frequented by residents informing them that survey results were available for review at the receptionist desk.

On 09/19/18 at approximately 12:43 p.m., observation was made of Survey Results sign after removing the sign from the frame. It was observed that the sign documented, "Survey results from the past three years are available upon request". This portion of the sign was obscured due to the picture frame matting.

On 09/19/18 at approximately 2:05 p.m., an observation was made of the survey results book with ASM (administrative staff member) #1, the administrator. ASM #1 was asked if there was a completed survey with a plan of correction in the survey book, ASM #1 replied, "It must have been put in the wrong binder." ASM #1 acknowledged that the plan of correction for the annual survey ending on 08/09/17 was not included in the binder.

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F 577	Continued From page 12 On 09/19/18 at approximately 2:03 p.m., a second interview was conducted with ASM #1, the administrator, regarding who is responsible for posting survey results. ASM #1 replied, "I generally post them and the receptionist keeps them at her desk." When asked how residents are informed of previous survey results, ASM #1 replied, "Results for the last survey are kept at the front desk." When asked how many years are supposed to be available, ASM #1 responded, "We keep the last year at the front desk and have three years available upon request." When asked if this was posted, ASM #1 responded "Yes, at the front (desk) for residents and family to see." When asked if the plans of correction are supposed to be included, ASM #1 responded, "Yes, we post them once finished." ASM #1 was made aware of the above concerns and observation of the posting for the survey results for the past three years at this time. The facility resident "Business Contract" documented, "I have been informed as to the location of the HRC's (Health and Rehabilitation Center) most recently conducted survey as well as any actions that have been taken by the HRC to correct any deficiencies." On 09/19/17 at 5:05 p.m. ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 577		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-	F 622		10/10/18

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F 622	Continued From page 13 §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger	F 622		

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that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;

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F 622	Continued From page 15 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure that all required documentation was provided to the receiving provider for a facility initiated transfer for one of 42 residents in the survey sample, Resident #23. The facility staff failed to evidence the required documentation was sent with Resident #23 upon a facility-initiated transfer to the hospital on 9/12/18. The findings include: Resident #23 was admitted to the facility on 3/27/18 and readmitted on 9/17/18 with diagnoses that included but were not limited to: left hip dislocation, acute kidney failure, high blood pressure, muscle weakness, and hypothyroidism. Resident #23's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 4/3/18. Resident #23 was coded as severely impaired of cognitive function scoring 05 of out 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #23's clinical record revealed he had was transferred to the hospital on 9/12/18. The following nursing note was written: "The signs and symptoms of the change of condition: Pain (uncontrolled) This (sic) started on 09/12/18	F 622	F622 1. Resident #23 was readmitted to the Facility on 9/17/2018 and has not been transferred to the ER/Hospital since his return. All residents transferred to the hospital since 9/24/2018 were audited and found to have been sent with appropriate documentation, including the eInteract transfer Form and comprehensive care plan goals. 2. DON/ADON/Unit Managers will complete an audit of all patient transfer to the hospital in the last 30 days since 8/17/2018 to ascertain that they were sent with necessary documentation (including eInteract transfer Form and comprehensive care plan goals). Any noted anomaly will be used to provide nurses with remediation session on resident transfer on the hospital. 3. Staff Development Coordinator/Unit Managers to provide staff re-education on patient transfer to the hospital on the following topics: a) Resident transfer process b) Accessing and generating the eInteract Transfer Form and Comprehensive care plan goals for patient transfer to the hospital c) MFA policy and procedures on resident transfer to the ER/Hospital 4. DON/ADON/Unit Managers to audit	

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F 622	Continued From page 16 during the morning...Recommendations: Reported to (Name of nurse practitioner (NP)). Date and time of notification: 09/12/18 12:00 PM. Recommendation of Primary Clinician (s): xray (sic) (1) ultrum (sic) (2) 50 mg (milligrams) po (by mouth) q (every) 6 hrs (hours) prn (as needed) pain. Testing: X-ray. Interventions: New of Change Medications. Name of family/healthcare agent notified: (Name of RP (responsible party))." The next nursing note dated 9/12/18 documented the following: "Transferred to ER (emergency room) via stretcher for eval (evaluation) and tx (treatment). (Name of NP [nurse practitioner]) aware. (Name of responsible party) rp aware." Further review of the clinical record revealed Resident #23 was admitted to the hospital with diagnoses of a UTI (urinary tract infection) and left hip dislocation. Resident #23 arrived back to the facility on 9/17/18. Further review of the clinical record failed to evidence that the required documentation; contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, All special instructions or precautions for ongoing care, as appropriate and comprehensive care plan goals were sent/ provided to the hospital, upon transfer of the resident. [* See below- per staff interview, this information would be documented on a hospital transfer sheet that was missing from Resident #23's clinical record]. On 9/19/18 at 12:00 p.m., Resident #23's hospital transfer sheet for his transfer on 9/12/18 was requested by administration.	F 622	all patient transfer to the ER/Hospital daily x2 weeks, weekly x1 month, and monthly x3 months to ensure that necessary documentation were sent with the every transferred patient. Any anomaly will rectified as appropriate and then forwarded to the QAPI committee for further review and recommendation	

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On 9/19/18 at 1:59 p.m., ASM (administrative staff member) #5, the nurse consultant, stated that he could not find a hospital transfer sheet for Resident #23.

On 9/20/18 at 8:46 a.m., an interview was conducted with LPN (licensed practical nurse) #9, the LPN on Resident #23's unit. When asked about the process staff follows when a resident is sent to the hospital for an acute change in condition, LPN #9 stated if the resident is having an acute change in condition and the NP (nurse practitioner) was in the building, he would have the NP do an assessment. LPN #9 stated if the NP were unavailable, he would have the nursing supervisor do an assessment. LPN #9 stated that he would notify the NP/MD (medical doctor) if it was determined that the resident needed to go to the hospital. LPN #9 stated he would print off the following documents to be sent with the resident to the receiving hospital at the time of transfer; the resident's medication list, face sheet, transfer form, and advanced directives. LPN #9 stated that the transfer form should list all contact information (RP, MD), advanced directives, special instructions etc. LPN #9 stated that he would also send any pertinent laboratory tests. When asked if the comprehensive care plan goals or the comprehensive care plan was sent with the resident at the time of transfer, LPN #9 stated, "I don't think you would send the care plan." LPN #9 was asked if he could find Resident #23 transfer sheet for his transfer to the hospital on 9/12/18.

On 9/20/18 at 10:15 a.m., ASM (administrative staff member) #1, and ASM #5 were made aware of the above concerns. ASM #1 stated he thought

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F 622	Continued From page 18 the RP (responsible party), initiated Resident #23's transfer. ASM #1 was asked to provide any documentation evidencing this. On 9/20/18 at 1:39 p.m., ASM #2, the DON (Director of Nursing) stated that she could not find documented evidence that the responsible party initiated Resident #23's hospital transfer and a hospital transfer sheet for this transfer to the hospital could not be located and provided. The facility policy titled, "Nursing Documentation, Patient Transfer Form," documented in part, the following: "A patient transfer form must be sent with the patient when transporting to a hospital or acute care setting. This process will provide a format of all pertinent information regarding the patient's medical status when the patient requires additional hospital care and treatment." (1) Medical x-rays are used to generate images of tissues and structures inside the body. This information was obtained from The National Institutes of Health. https://www.nibib.nih.gov/science-education/science-topics/x-rays. (2) Ultram, also known as Tramadol, is an analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		10/10/18

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representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

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F 623	Continued From page 20 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 21 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that facility staff failed to ensure the resident or the responsible party (RP) and the ombudsman were provided written notice of a facility initiated transfer to the hospital for five of 42 residents in the survey sample, Resident #111, Resident #53, Resident #41, Resident #23 and Resident #31. 1. The facility staff failed to provide written notification to the resident and responsible party (RP) of a facility initiated transfer to the hospital on 06/30/18 for Resident # 111. 2. The facility staff failed to provide written notification to Resident/Responsible Representative of a transfer to the hospital on 7/11/18, for Resident #53. 3. The facility staff failed to provide written notification to Resident/Responsible Representative of a transfer to the hospital on 7/6/18, for Resident #41. 4. The facility staff failed to evidence written notification to Resident #23 or the responsible	F 623	F623 1. Resident #111, #53, #41, #23, and #31 are all current residents at the Facility post transfer on 6/30/2018, 7/11/2018, 7/6/2018, 9/12/2018, and 6/30/2018 respectively. All responsible parties/patients of residents transferred to the hospital since 9/20/2018 have been notified in writing accordingly. 2. Discharge Planning and Admission to audit all transfers in the last 30 days (starting from 8/16/2018) to assess RPs/patients notification of residents transfer to the hospital. Any anomaly noted will be used to streamline the process for consistency moving forward 3. Administrator to provide in-service to the Discharge Planning and Admission staff on the notification of responsible party/patient with every resident transfer to the hospital on the following topics: a) Interdisciplinary approach to patient transfer management, including written notification to RPs/patient b) Policy and procedures on the management of patient transfer to the	

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F 623	Continued From page 22 party for a facility-initiated transfer to the hospital on 9/12/18. 5. The facility staff failed to evidence written notification to Resident #31 or the responsible party for a facility-initiated transfer to the hospital on 6/30/18. The findings include: 1. The facility staff failed to provide written notification to the resident and responsible party (RP) of a facility initiated transfer to the hospital on 06/30/18 for Resident # 111. Resident # 111 was admitted to the facility on 07/20/2015 with a readmission 08/19/2018 with diagnoses that included but were not limited to: respiratory failure (1), chronic obstructive pulmonary disease (2), hypertension (3) and heart failure (4). Resident # 111's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/19/18, coded Resident # 111 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. The "Nurse's Note" for Resident # 111 dated, "6/31/2018 at 18:35 (6:35 p.m.," documented, "Resident was admitted to (Name of Hospital) with dx (diagnosis) of PNA (pneumonia) and Hypoxia (5) ." Review of Resident # 11's EHR (electronic health record) failed to evidence documentation that Resident # 111 and Resident # 111's responsible	F 623	hospital, including RP/Resident written notification of the transfer c) Possible content in the written notification to the responsible party/affect resident 4. Administrator to audit the completion of written notification on resident transfer to the hospital weekly x1 month and monthly x3 months to ensure compliance. Any anomaly in the process identified will be rectified immediately as appropriate.	

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party (RP) were provided written notification the facility initiated transfer to the hospital on 06/30/18 for Resident # 111.

On 09/19/18 at 4:20 p.m., an interview was conducted with LPN (licensed practical nurse) # 4 regarding written notification of the facility initiated transfer on 6/30/18, to Resident # 111 and Resident # 111's responsible party. LPN # 4 stated, "We call the responsible party." When asked if they provide written notification, LPN # 4 stated, "No."

On 09/19/18 at 5:10 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Condition when not enough oxygen passess from your lungs into your blood. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022885/

(2) COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. This information was obtained from the website: https://www.nhlbi.nih.gov/health-topics/copd

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

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(4) Heart failure is a serious but common condition. In heart failure, the heart cannot pump enough blood to meet the body's needs. Heart failure develops over time as the pumping action of the heart gets weaker, or if it gets more difficult to adequately fill the heart with blood between heartbeats. It can affect either the right, the left, or both sides of the heart. Heart failure does not mean that the heart has stopped working or is about to stop working. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(5) Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.

2. The facility staff failed to provide written notification to Resident/Responsible Representative of a transfer to the hospital on 7/11/18, for Resident #53.

Resident #53 was admitted to the facility on 4/22/14, with a most recent readmission of 7/11/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1) (chronic lung disease that makes it hard to breath), urinary tract infection, cerebral infarction (2) (a stroke), and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/30/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment for daily decision making.

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The nurse's note dated 7/11/18 at 2:43 p.m., documented in part, "The signs/symptoms of the change of condition are: Altered mental status (3) (Confusion, disorientation, and inability to make decisions). This started on 7/11/18 during the afternoon ...Reported to [nurse practitioner's name] ...Recommendation of Primary Clinician(s): send to Hospital for fluids and ABX (antibiotics)."

The nurse practitioner's note dated 7/11/18 at 2:56 p.m., documented in part, "AMS (altered mental status) accompanied by tachycardia (4) (a fast heart rate) - due to possible UTI (urinary tract infection) and dehydration ...Transfer to the hospital for further evaluation. Family notified by charge nurse. Son in agreement."

Review of the clinical record failed to evidence documentation that Resident # 53 and Resident # 53's responsible party (RP) were provided written notification the facility initiated transfer to the hospital on 7/11/18 for Resident # 53.

On 9/19/18 at 4:21 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to the resident or the residents' representatives.

On 09/20/18 at 8:43 a.m., an interview was conducted with LPN #9, a charge nurse. LPN #9 also stated that notification to a resident's responsible representative is verbal, either in person or via a telephone call. When asked if the information is provided in writing to the resident or

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the resident's responsible representative, LPN #9 stated, "No."

ASM (administrative staff member) #1, the administrator, and ASM #5, nurse consultant, were made aware of the above findings on 9/20/18 at 11:05 a.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000091.htm

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ischemicstroke.html

3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm

4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/arrhythmia.html

3. The facility staff failed to provide written notification to Resident/Responsible Representative of a transfer to the hospital on 7/6/18, for Resident #41.

Resident #41 was admitted to the facility on 2/29/16, with a most recent readmission of 7/13/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1) (chronic lung disease that makes it hard to breath), pneumonia, difficulty swallowing, hypertension, diabetes, dementia, and heart

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disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/20/18, coded the resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment for daily decision making.

The nurse's note dated 7/6/18 at 11:39 a.m. documented in part, "The signs/symptoms of the change of condition are: Fever [sic] Respiratory infection. This started on 7/6/18 during the night ...Reported to [nurse practitioner's name] ...Recommendation of Primary Clinician(s): send to ER (emergency room) for eval (evaluation) and Tx (treatment)."

The nurse practitioner's note dated 7/6/18 at 11:50 a.m., documented in part, "Tachycardia (2) (a fast heart rate), hypoxemia (3) (not getting enough oxygen to the blood when breathing), abnormal lung sounds, AMS (altered mental status) (4) (Confusion, disorientation, and inability to make decisions) - Transfer to the hospital. Case discussed with [name], primary NP (nurse practitioner."

Review of the clinical record failed to evidence documentation that Resident # 41 and Resident # 41's responsible party (RP) were provided written notification the facility initiated transfer to the hospital on 7/06/18 for Resident # 41.

On 9/19/18 at 4:21 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she calls residents' representatives when residents are transferred to

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the hospital but she does not provide written notification of the transfers to the resident or the residents' representatives.

On 09/20/18 at 8:43 a.m., an interview was conducted with LPN #9, a charge nurse. LPN #9 also stated that notification to a resident's responsible representative is verbal, either in person or via a telephone call. When asked if the information is provided in writing to the resident or the resident's responsible representative, LPN #9 stated, "No."

ASM (administrative staff member) #1, the administrator, and ASM #5, nurse consultant, were made aware of the above findings on 9/20/18 at 11:05 a.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000091.htm

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/arrhythmia.html

3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/breathingproblems.html

4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm
4. The facility staff failed to evidence written notification to Resident #23 or the responsible party for a facility-initiated transfer to the hospital on 9/12/18.

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Resident #23 was admitted to the facility on 3/27/18 and readmitted on 9/17/18 with diagnoses that included but were not limited to left hip dislocation, acute kidney failure, high blood pressure, muscle weakness, and hypothyroidism. Resident #23's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 4/3/18. Resident #23 was coded as being severely impaired in cognitive function scoring 05 of out 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #23's clinical record revealed that he had been transferred to the hospital on 9/12/18.

A nursing note dated 9/12/18 documented the following: "Transferred to ER (emergency room) via stretcher for eval (evaluation) and tx (treatment). (Name of NP) aware. (Name of RP) rp aware."

Further review of the clinical record revealed that Resident #23 was admitted to the hospital with diagnoses of a UTI (urinary tract infection) and left hip dislocation. Resident #23 arrived back to the facility on 9/17/18.

There was no evidence that the facility provided written notification to the responsible party documenting the reason for transfer.

On 9/20/18 at 8:46 a.m., an interview was conducted with LPN (licensed practical nurse) #9, the LPN on Resident #23's unit. When asked the process when a resident is sent to the hospital for an acute change in condition, LPN #9 stated that

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if the resident is having an acute change in condition and the NP (nurse practitioner) was in the building, he would have the NP do an assessment. LPN #9 stated if the NP were unavailable, he would have the nursing supervisor do an assessment. LPN #9 stated that he would notify the NP/MD (medical doctor) if it was determined that the resident needed to go to the hospital. LPN #9 stated he would also notify the RP (responsible party) by phone if they were not present at the time of transfer. When asked if nursing staff provide written notification to the RP documenting the reason for transfer, LPN #9 stated nursing staff did not provide written notification to the RP.

09/20/18 09:13 AM, an interview was conducted with OSM (other staff member) #3 the social worker. OSM #3 stated that she did not provide written notification to the responsible party regarding hospital transfers. OSM #3 stated that typically nursing notifies the RP regarding hospital transfers and that notification was usually done verbally.

On 9/20/18 at 10:15 a.m., ASM (administrative staff member) #1, and ASM #5 were made aware of the above concerns. ASM #1 stated he thought Resident #23's transfer was initiated by the RP (responsible party). ASM #1 was asked to provide this evidence.

On 9/20/18 at 1:39 p.m., ASM #2, the DON (Director of Nursing) stated that she could not find documented evidence that the responsible party initiated his hospital transfer.

A policy could not be provided regarding the above concerns.

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No further information could be provided prior to exit.

(1) Medical x-rays are used to generate images of tissues and structures inside the body. This information was obtained from The National Institutes of Health. https://www.nibib.nih.gov/science-education/science-topics/x-rays.

(2) Ultram, also known as Tramadol, is an analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197

5. Resident #31 was admitted to the facility on 7/15/17 and readmitted on 7/3/18 with diagnoses that included but not limited to: pneumonia, dementia, peripheral vascular disease (1), irregular heartbeat and elevated cholesterol.

The most recent MDS (minimum data set), an annual assessment, with ARD (assessment reference date) of 7/10/18 coded the resident as being severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's note dated 6/30/18 at 10:40 p.m. documented, "Change of Condition Evaluation. Please see the assessment for full details. The signs/symptoms of the change of condition are: Shortness of breath. Other change in condition are: Shortness of breath. Other change in condition....Recommendations: Reported to (name of nurse practitioner)...Recommendation of Primary Clinician(s)..Interventions: Other Sent the

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resident to te (sic) ER."

Further review of the clinical record failed to evidence documentation regarding the resident's representative receiving written notification of the transfer to the hospital.

An interview was conducted on 9/19/18 at 04:16 p.m. with LPN (licensed practical nurse) #3, the unit manager. When asked how resident's responsible representative was notified, LPN #3 stated, "By telephone or if the patient is their own representative we tell them. When asked if the resident representative received anything in writing about the transfer, LPN #3 stated, "No ma'am."

On 9/19/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the nurse consultant were made aware of the findings.

Review of the facility's policy titled, "Patient Transfer Form" did not evidence documentation of the requirement to provide written notification to the resident's representative of the transfer.

No further information was provided prior to exit.

1. Peripheral vascular disease -- Peripheral artery disease (P.A.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood. This information was obtained from: https://www.nhlbi.nih.gov/health-topics/peripheral-artery-disease

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F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written bed hold notification for a transfer to the hospital for five of 42 residents in the survey sample, Resident #111, Resident #53, Resident	F 625	F625 1. Resident #111, #53, #41, #128, and #31 are all current residents at the Facility post transfer on 6/30/2018, 7/11/2018, 7/6/2018, 6/30/2018, and 6/30/2018 respectively. Written bed hold policy	10/10/18

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F 625	Continued From page 34 #41, Resident #128, and Resident #31. 1. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a facility initiated transfer to the hospital on 06/30/18 for Resident # 111. 2. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 7/11/18 for Resident #53. 3. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 7/6/18 for Resident #41. 4. The facility staff failed to provide Resident #128 and/or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 6/30/18. 5. The facility staff failed to provide Resident #31 and/or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 6/30/18. The findings include: 1. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a facility initiated transfer to the hospital on 06/30/18 for Resident # 111.	F 625	notification have been provided to all residents/responsible parties for patients transferred to the hospital since 9/20/2018 accordingly. 2. Admission to audit all transfers to the hospital in the last 30 days (starting from 8/16/2018) to assess RPs/patients written notification on bed hold policy. Any anomaly noted will be used to streamline the process for consistency moving forward 3. Administrator/Designee to provide in-service on bed hold provision for transferred patient to the hospital on the following topics: a) MFA policy and procedure on bed hold for transferred patient to the hospital b) Facility process in the implementation MFA policy and procedure on bed hold 4. Administrator to audit the completion of written notification on bed hold for patients transferred to the hospital weekly x1 month and monthly x3 months to ensure compliance. Any anomaly in the process identified will be rectified immediately as appropriate and then forwarded to the QAPI committee for further review and recommendation	

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Resident # 111 was admitted to the facility on 07/20/2015 with a readmission 08/19/2018 with diagnoses that included but were not limited to: respiratory failure (1), chronic obstructive pulmonary disease (2), hypertension (3) and heart failure (4).

Resident # 111's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/19/18, coded Resident # 111 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 111 was coded as requiring extensive assistance of one staff member for activities of daily living.

The "Nurse's Note" for Resident # 111 dated, "6/31/2018 at 18:35 (6:35 p.m.," documented, "Resident was admitted to (Name of Hospital) with dx (diagnosis) of PNA (pneumonia) and Hypoxia (5) ."

Review of Resident # 11's EHR (electronic health record) failed to evidence documentation Resident # 111 and Resident # 111's responsible party (RP) were provided written notification of the bed hold policy upon Resident #111's transfer to the hospital on 06/30/18.

On 09/20/18 at 10:55 a.m., an interview was conducted with OSM (other staff member) # 1, admissions coordinator. OSM #1 was asked to describe the procedure regarding bed holds when a resident has a facility-initiated transfer to the hospital. OSM # 1 stated, "I call the resident, responsible party of the emergency contact and ask if they want to hold the bed, if they do they

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are required to come in and complete the paperwork." When asked if she sends the bed hold form with the resident at the time of transfer OSM # 1 stated, "No."

On 09/19/18 at 5:10 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Condition when not enough oxygen passess from your lungs into your blood. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022885/

(2) COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. This information was obtained from the website: https://www.nhlbi.nih.gov/health-topics/copd

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(4) Heart failure is a serious but common condition. In heart failure, the heart cannot pump enough blood to meet the body's needs. Heart failure develops over time as the pumping action of the heart gets weaker, or if it gets more difficult to adequately fill the heart with blood between heartbeats. It can affect either the right, the left, or both sides of the heart. Heart failure does not

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mean that the heart has stopped working or is about to stop working. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(5) Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.
2. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 7/11/18 for Resident #53.

Resident #53 was admitted to the facility on 4/22/14, with a most recent readmission of 7/11/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1) (chronic lung disease that makes it hard to breath), urinary tract infection, cerebral infarction (2) (a stroke), and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/30/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment for daily decision making.

The nurse practitioner's note dated 7/11/18 at 2:56 p.m., documented in part, "AMS (altered mental status) accompanied by tachycardia (4) (a fast heart rate) - due to possible UTI (urinary tract infection) and dehydration ...Transfer to the hospital for further evaluation."

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Further review of the clinical record failed to evidence documentation Resident #53 and Resident # 53's responsible party (RP) were provided written notification of the bed hold policy upon Resident #53's transfer to the hospital on 07/11/18.

On 9/20/18 at 9:50 a.m., an interview was conducted with OSM (other staff member) #1, admissions coordinator. OSM #1 stated she provides verbal bed hold information to the resident or the residents' representatives when residents are transferred to the hospital but she does not provide written notification of the bed hold policy upon transfer.

ASM (administrative staff member) #1, the administrator, and ASM #5, nurse consultant, were made aware of the above findings on 9/20/18 at 11:05 a.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000091.htm

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ischemicstroke.html

3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm

4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/arrhythmia.html

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3. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 7/6/18 for Resident #41.

Resident #41 was admitted to the facility on 2/29/16, with a most recent readmission of 7/13/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1) (chronic lung disease that makes it hard to breath), pneumonia, difficulty swallowing, hypertension, diabetes, dementia, and heart disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/20/18, coded the resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment for daily decision making.

The nurse's note dated 7/6/18 at 11:39 a.m. documented in part, "The signs/symptoms of the change of condition are: Fever [sic] Respiratory infection. This started on 7/6/18 during the night ...Reported to [nurse practitioner's name] ...Recommendation of Primary Clinician(s): send to ER (emergency room) for eval (evaluation) and Tx (treatment)."

The nurse practitioner's note dated 7/6/18 at 11:50 a.m., documented in part, "Tachycardia (2) (a fast heart rate), hypoxemia (3) (not getting enough oxygen to the blood when breathing), abnormal lung sounds, AMS (altered mental

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status) (4) (Confusion, disorientation, and inability to make decisions) - Transfer to the hospital."

Further review of the clinical record failed to evidence documentation Resident #41 and Resident # 41's responsible party (RP) were provided written notification of the bed hold policy upon Resident #41's transfer to the hospital on 07/06/18.

On 9/20/18 at 9:50 a.m., an interview was conducted with OSM (other staff member) #1, admissions coordinator. OSM #1 stated she provides verbal bed hold information to the resident or the residents' representatives when residents are transferred to the hospital but she does not provide written notification of the bed hold policy upon transfer.

ASM (administrative staff member) #1, the administrator, and ASM #5, nurse consultant, were made aware of the above findings on 9/20/18 at 11:05 a.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000091.htm

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/arrhythmia.html

3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/breathingproblems.html

4) This information was obtained from the

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National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm 4. The facility staff failed to provide Resident #128 and/or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 6/30/18.

Resident #128 was admitted to the facility on 9/5/17. Resident #128's diagnoses included but were not limited to paralysis of all four limbs, difficulty swallowing, and sleep apnea. Resident #128's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/28/18, coded the resident as being cognitively intact.

Review of Resident #128's clinical record revealed nurses' notes dated 6/30/18 that documented Resident #128 was discharged to the hospital on 6/30/18 due to a fever. Further review of Resident #128's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #128 and/or the resident's representative.

On 9/19/18 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the admissions department is responsible for providing the bed hold policy and nurses do not participate in that process.

On 9/19/18 at 3:15 p.m., an interview was conducted with OSM (other staff member) #1 (the admissions coordinator). OSM #1 was asked to provide evidence that written notice of the bed hold policy was provided to Resident #128 and/or the resident's representative when the resident

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was discharged to the hospital on 6/30/18. OSM #1 stated she called and spoke with Resident #128's representative and he declined a bed hold but she could not provide evidence that written notice was provided.

On 9/19/18 at 5:58 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was provided prior to exit.

5. The facility staff failed to provide Resident #31 and/or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 6/30/18.

Resident #31 was admitted to the facility on 7/15/17 and readmitted on 7/3/18 with diagnoses that included but not limited to: pneumonia, dementia, peripheral vascular disease (1), irregular heartbeat and elevated cholesterol.

The most recent MDS (minimum data set), an annual assessment, with ARD (assessment reference date) of 7/10/18 coded the resident as being severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's note dated 6/30/18 at 10:40 p.m. documented, "Change of Condition Evaluation. Please see the assessment for full details. The signs/symptoms of the change of condition are: Shortness of breath. Other change in condition are: Shortness of breath. Other change in condition....Recommendations:

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Reported to (name of nurse practitioner)...Recommendation of Primary Clinician(s)..Interventions: Other Sent the resident to te (sic) ER."

Further review of the clinical record failed to evidence documentation regarding the resident's representative receiving written notification of the bed hold policy.

An interview was conducted on 9/19/18 at 3:15 p.m. with OSM (other staff member) #1, the admissions coordinator. When asked who gave the resident's representative the bed hold, OSM #1 stated that she did. When asked the process she followed, OSM #1 stated, "I call them and they say they don't want to do a bed hold they would have to come in and sign the paper and most of them don't." When asked if this was documented, OSM #1, "No."

On 9/19/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the nurse consultant were made aware of the findings.

Review of the facility's policy titled, "Bed Reserve" documented, "POLICY: The Health & Rehabilitation Center charges the prevailing room rate for any bed reservation arrangement whenever a patient is not in the Health & Rehabilitation Center for the day or when reserving a bed for in-house transfer. PROCEDURE: 3. Hospitalization/Observation - Medicare and Medicaid programs do not pay to hold beds in the Health & Rehabilitation Center when a patient is hospitalized overnight. Consequently, whenever any patient (regardless of payer source) is transferred from the Health &

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F 625	Continued From page 44 Rehabilitation Center and is admitted for overnight hospitalization/observation (defined as being absent from the Health & Rehabilitation Center for more than 24 hours), the patient and or the responsible representative (or hospital) must pay to hold the bed if the patient wishes to ensure that he/she can return to the bed he/she has been occupying....To make this arrangement the patient and/or responsible representative must (1) promptly complete and sign a formal "Voluntary Bed Retention Agreement" and (2) provide private payment to the Health & Rehabilitation Center for the requested days." No further information was provided prior to exit. 1. Peripheral vascular disease -- Peripheral artery disease (P.A.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood. This information was obtained from: https://www.nhlbi.nih.gov/health-topics/peripheral-artery-disease	F 625		
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	F 656		10/10/18

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F 656	Continued From page 45 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for three of 42 residents in the survey sample, Residents #338, #49, and #111.	F 656	F656 1. Resident #338 discharged on 9/18/2018. Residents' #49 and #111 oxygen therapies were calibrated to the exact dosages as per their respective physician orders and care plans. None was noted with respiratory distress	

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F 656	Continued From page 46 1. The facility staff failed to implement Resident #338's care plan for pain management. 2. The facility staff failed to implement/follow Resident # 49's comprehensive care plan for the administration of oxygen. 3. The facility staff failed to follow Resident # 111's comprehensive care plan for the administration of oxygen. The findings include: 1. The facility staff failed to implement Resident #338's care plan for pain management. Resident #338 was admitted to the facility on 9/13/18. Resident #338's diagnoses included but were not limited to diabetes, high blood pressure and strain of muscle(s) and tendon(s). Resident #338's admission MDS (minimum data set) assessment was not complete. An admission assessment dated 9/13/18 documented Resident #338 was alert and oriented to person, place, time and situation. The assessment further documented Resident #338 reported rare pain over the last five days. Resident #338's comprehensive care plan dated 9/13/18, documented, "PAIN: (Name of Resident #338) has acute pain r/t (related to) Right Rotator Cuff Sprain...Administer analgesia per order..." Review of Resident #338's clinical record revealed a physician's order dated 9/13/18 for Lyrica (1) 75 mg (milligrams) by mouth three times a day related to strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder. Review of Resident #338's September 2018 MAR	F 656	MD/RP of the respective patients will be notified accordingly 2. DON/ADON/Unit Managers to audit the dosage calibration of oxygen therapy for all current patients on oxygen supplement to ascertain correct administration of the MD order. Also, all patients on Lyrica will be reviewed to ensure that there was no delayed in the administration of their medication. Any missed dose noted will be made known to the MD/RP and then follow MD instruction accordingly 3. SDC/Designee will complete an in-service on the following topics a) Managing oxygen therapy through the utilization of resident care plan and physician order. b) Calibrating oxygen therapy dosage on an oxygen concentrator or portable tank c) Managing new order for Lyrica for prompt delivery and administration d) Managing new admissions with Lyrica order 4. DON/ADON/Unit Managers will audit 10% of all oxygen therapies and Lyrica orders weekly x1 month and monthly x3 months to ascertain accurate administration of the oxygen and timely administration of the Lyrica as ordered by the MD. Any anomaly noted will be rectified accordingly and then forwarded to the QAPI committee for further review and recommendation	

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(medication administration record), September 2018 nurses' notes and a Lyrica controlled medication utilization record revealed the resident was not administered Lyrica until 9/18/18 (note-nurses' notes documented the physician was notified).

Further review of Resident #338's Lyrica controlled medication utilization record revealed the medication was received by the facility staff on 9/18/18.

On 9/18/18 at 4:33 p.m., an interview was conducted Resident #338. Resident #338 stated she was supposed to get Lyrica three times a day. Resident #338 stated she thought she was getting Lyrica now but she was not previously getting the medication at the facility.

On 9/19/18 at 3:06 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (Resident #338's unit manager). LPN #3 was asked why Resident #338 did not receive Lyrica per physician's order. LPN #3 stated Resident #338 arrived to the facility at approximately 10:40 p.m., on Thursday (9/13/18) and a written prescription was not received. LPN #3 stated the facility staff eventually obtained a written prescription but the prescription did not document a quantity so that correction had to be made.

On 9/19/18 at 4:15 p.m., an interview was conducted with LPN #4. LPN #4 was asked the purpose of the care plan. LPN #4 stated, "We use it to provide care directly for that patient. If you go in you can see they are customized for each person." When asked how nurses ensure they follow residents' care plans, LPN #4 stated, "They are supposed to be going to their care plan

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daily to check and if there is any new change in condition they are supposed to update the care plan."

On 9/19/18 at 5:58 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Resident Assessment & Care Planning" documented, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient."

No further information was provided prior to exit.

(1) Lyrica is used to treat pain from damaged nerves. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605045.html
2. The facility staff failed to implement/ follow Resident # 49's comprehensive care plan for the administration of oxygen.

Resident # 49 was admitted to the facility on 08/09/2017 with a readmission 10/05/2018 with diagnoses that included but were not limited to: traumatic brain injury (1), tracheostomy (2), hypertension (3) and subdural hemorrhage (4).

Resident # 49's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 07/25/18, coded

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Resident # 49 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired cognitively intact for making daily decisions. Resident # 49 was coded as being totally dependent of two staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 49 was coded for "C. Oxygen therapy."

On 09/18/18 at 11:40 a.m., an observation of Resident # 49 revealed she was lying in bed receiving oxygen by the tracheostomy. Observation of the oxygen flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half and five liters per minute.

On 09/18/18 at 2:28 p.m., an observation of Resident # 49 revealed she was lying in bed receiving oxygen by the tracheostomy. Observation of the oxygen flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half and five liters per minute.

On 09/19/18 at 8:01 at a.m., an observation of Resident # 49 revealed she was lying in bed receiving oxygen by the tracheostomy. Observation of the oxygen flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half and five liters per minute.

On 09/19/18 at 11:35 a.m., an observation of Resident # 49 revealed she was lying in bed receiving oxygen by the tracheostomy. Observation of the oxygen flow meter on the

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oxygen concentrator revealed the oxygen flow rate was set between four and a half and five liters per minute.

The POS (physician's order sheet) for Resident # 49 dated "September 2018"documented, "Oxygen Therapy - Oxygen 28% (percent) at 5 (five) liters per minute via (by) tracheostomy every shift for oxygen. Order Date: 07/31/2018. Start Date: 07/31/2018."

The comprehensive care plan for Resident # 49 with a revision of 06/14/2018 documented, "Focus. The resident has a tracheostomy r/t (related to) injury (TBI) [traumatic brain injury]." Under "Interventions" it documented, "OXYGEN administered as ordered. Created on 08/10/2017."

On 09/19/18 at 4:20 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the purpose of the care plan, LPN # 4 stated, "To provide care directly to the resident. The care plans are customized to the resident and are a guide for resident care." LPN # 4 further stated, "Nursing should check the care plan each day to make sure orders are being followed and if there are any new interventions." LPN #4 was informed of the observations of Resident #49's oxygen not set at the physician ordered rate. When asked if Resident # 49's care plan for oxygen was being implmented according to the physician's order, LPN # 4 stated, "The care plan was not followed."

On 09/19/18 at 5:10 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

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No further information was provided prior to exit.

Reference:
(1) Happens when a bump, blow, jolt, or other head injury causes damage to the brain. Symptoms of a TBI may not appear until days or weeks following the injury. A concussion is the mildest type. It can cause a headache or neck pain, nausea, ringing in the ears, dizziness, and tiredness. People with a moderate or severe TBI may have those, plus other symptoms: A headache that gets worse or does not go away, Repeated vomiting or nausea, Convulsions or seizures, Inability to awaken from sleep, Slurred speech, Weakness or numbness in the arms and legs, Dilated eye pupils. This information was obtained from the website: https://medlineplus.gov/traumaticbraininjury.html

(2) A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube.. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm.

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(4) A bleeding in the area between the brain and the thin tissues that cover the brain. This area is called the subarachnoid space. This information was obtained from the website: https://medlineplus.gov/ency/article/000701.htm.

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3. The facility staff failed to follow Resident # 111's comprehensive care plan for the administration of oxygen.

Resident # 111 was admitted to the facility on 07/20/2015 with a readmission 08/19/2018 with diagnoses that included but were not limited to: respiratory failure (1), chronic obstructive pulmonary disease (2), hypertension (3) and heart failure (4).

Resident # 111's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/19/18, coded Resident # 111 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 111 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 49 was coded for "C. Oxygen therapy."

On 09/18/18 at 11:50 a.m. an observation of Resident # 11 revealed she was sitting on the edge of the bed receiving oxygen by nasal cannula. Observation of the flow rate on the oxygen concentrator revealed the oxygen was being delivered at a flow rate of between two and a half and three liters per minute.

On 09/19/18 at 11:30 a.m. an observation of Resident # 11 revealed she was sitting in her w/c in her room receiving oxygen by nasal cannula. Observation of the flow rate on the oxygen concentrator revealed the oxygen was being

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delivered at a flow rate of between two and a half and three liters per minute.

On 09/19/18 at 1:18 p.m. an observation of Resident # 11 revealed she was sitting in her w/c in her room receiving oxygen by nasal cannula. Observation of the flow rate on the oxygen concentrator revealed the oxygen was being delivered at a flow rate of between two and a half and three liters per minute.

The POS (physician's order sheet) for Resident # 111 dated "September 2018"documented,
- "Oxygen at 3 (three) liters (liters per minute) every shift for Hypoxia (5) Order Status: Discontinued. Order Date: 09/19/2018. Start Date: 09/19/2018."
- "Oxygen at 3 (three) liters (liters per minute) PRN (as needed) for Hypoxia. Order Status: Active. Order Date: 09/19/2018. Start Date: 09/19/2018."

The comprehensive care plan for Resident # 111 with a revision of 09/02/2018 documented, "Focus. RESPIRATORY THERAPY: (Resident # 111) has altered respiratory status/difficulty breathing r/t pulmonary fibrosis and COPD (chronic obstructive pulmonary disease). Under "Interventions" it documented, "O2 (oxygen) as ordered/tolerated. Created on 09/02/2018."

On 09/19/18 at 4:20 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the purpose of the care plan LPN # 4 stated, "To provide care directly to the resident. The care plans are customized to the resident and are a guide for resident care." LPN # 4 further stated, "Nursing should check the care plan each day to make

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sure orders are being followed and if there are any new interventions." When informed of the observations above of Resident #111's oxygen not set at the physician ordered rate and asked if Resident # 111"s care plan was being implemented according to the physician's order, LPN # 4 stated, "The care plan was not followed."

On 09/19/18 at 5:10 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:
(1) Condition when not enough oxygen passess from your lungs into your blood. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022885/

(2) COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. This information was obtained from the website: https://www.nhlbi.nih.gov/health-topics/copd

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(4) Heart failure is a serious but common condition. In heart failure, the heart cannot pump enough blood to meet the body's needs. Heart failure develops over time as the pumping action of the heart gets weaker, or if it gets more difficult

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F 656	Continued From page 55 to adequately fill the heart with blood between heartbeats. It can affect either the right, the left, or both sides of the heart. Heart failure does not mean that the heart has stopped working or is about to stop working. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. (5) Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		10/10/18

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F 657	Continued From page 56 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and review of facility documentation it was determined the facility staff failed to review and revise the comprehensive care plan for two of 42 sampled residents, Resident #98 and Resident #91. 1. The facility staff failed to revise Resident #98's comprehensive care plan after she obtained a skin tear on 9/10/18. 2. The facility staff failed to revise the comprehensive care plan following a resident-to-resident sexual altercation for Resident #91. The findings include: 1. Resident #98 was admitted to the facility on 5/21/18 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), major depressive disorder, heart failure, and anxiety disorder. Resident #98's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference date) of 8/28/18. Resident #98 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview of Mental Status) exam. Resident #98 was coded as requiring extensive assistance from two plus persons with bed	F 657	F657 1. Resident #98 care plan was reviewed on 9/19/2018 to reflect patient skin tear to right lower leg. Resident #91 care plan was reviewed on 9/21/2018 to reflect patient-to-patient sexual altercation involving her that occurred on 12/15/2017. 2. DON/ADON/Unit Mangers will review all current patients with skin tear to ascertain its reflection on their current comprehensive care plans. Also, the medical records current residents will be reviewed to determine any occurrence of altercation since 12/15/2018 and its reflection in their respect care plan. Any identified missing care plan review/update noted will be rectified accordingly as appropriate. 3. SDC/Designee to in-service the charge nurses on care plan initiation, revision/updating, and utilization. 4. DON/ADON/Unit Managers to audit skin tear care and behavior care planning weekly x4 weeks and monthly x3 months to ascertain the updating of care plan to reflect resident□ change of condition. Any identified deficient practice will be rectified accordingly.	

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mobility, transfers, toileting, and total dependence on one staff member with bathing.

Review of Resident #98's incident report dated 9/10/18, documented the following: "Incident Description: skin tear noted on anterior right shin consistent with hitting on wheelchair leg adapter. Immediate action taken: cleansed with ns (normal saline) and applied Primapore (dressing)."

Review of Resident #98's September 2018 POS (physician order summary) revealed the following active order: "Right lower leg wound care every evening shift. Cleanse with NSS (normal saline solution). Apply primapore."

Review of Resident #98's September 2018 TAR (treatment administration record) revealed that Resident #98 was receiving treatments for her right leg skin tear until 9/19/18 (the second day of survey).

Review of Resident #98's comprehensive care plan dated 5/22/18 and revised 8/31/18 failed to evidence her skin tear to her right lower leg.

On 9/19/18 at 4:13 p.m., an interview was conducted with LPN (licensed practical nurse) #4, Resident #98's nurse, regarding the process staff follows when a resident obtains a skin tear. LPN #4 stated that if the resident did not know where the skin tear came from, she would investigate and ask staff that had the resident that day. LPN #4 stated that she would create an incident report, notify the RP (responsible party) and MD (medical doctor) and the MD would give an order to treat the skin tear. LPN #4 stated that she would also update the resident's care plan to reflect the skin tear and treatment order. When

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asked the purpose of the care plan, LPN #4 stated that the purpose of the care plan was to provide care directly to that patient. LPN #4 stated that each care plan was customized depending on the resident's needs. LPN #4 stated that a resident's care plan would address care areas such as falls, nutrition, diseases the resident may have, ADL (activities of daily living) etc. LPN #4 stated that the floor nurses were responsible for updating the care plan with any new changes. When asked if she would expect to see Resident #98's skin tear on the care plan, LPN #4 stated that she would. LPN #4 wasn't sure if Resident #98 had an active skin tear. LPN #4 confirmed that there was no evidence that the care plan had been updated after Resident #98 obtained the skin tear.

On 9/19/18 at 10:15 a.m., ASM (administrative staff member) #1, the administrator, and ASM #5 the nurse consultant were made aware of the above findings.

The facility policy titled, "Care Planning, "documents in part the following: "Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient

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and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

No further information was presented prior to exit.
2. The facility staff failed to revise the comprehensive care plan following a resident-to-resident sexual altercation for Resident #91.

Resident #91 was admitted to the facility on 8/30/17 with diagnoses that included but were not limited to: seizures, difficulty walking, depression and dementia.

The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 8/21/18 coded the resident as having a ten out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively. The resident was coded as requiring supervision from staff for activities of daily living.

Review of the facility reported incident dated 12/15/17 documented, "Allegation that male resident inappropriately touched female resident. Residents separated, investigation pending. On 12/15/17 at approximately 9:00 pm., (Name of male resident) was alleged to have inappropriately touched (Resident #91) while she was in her room sleeping... .In light of the above investigative outcome of the incident, based on the reviewing of available information and the interviewing of the staff present/patients involved, the Facility was able to substantiate that (name of male resident) inappropriately touched (Resident #91)...."

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Review of the 12/15/17 nurse's note documented, "resident [Resident 91] reports unwanted contact and inappropriate comments from another resident. skin assessment completed no injury-bruising or redness noted. resident denies any pain or discomfort. education provided to resident regarding residents rights and option. supervisor notified. rp (responsible party) notified.

Review of the social services note dated 12/19/17 social services documented, "This author spoke to resident [Resident 91] re: incident with male resident. I explained steps in our process with follow up. Patient said she feels safe in this facility. DCP (director of clinical practice) to continue to support as needed."

Review of the nurse's note dated 12/19/17 documented, "Writer spoke to resident to follow-up in-regards to incident with male resident. Discussed follow-up steps in place. Resident reported she was ok at this time and did not feel in danger. Resident reported she planned to refrain from engaging in conversation with male resident when in dining room as previously they would sit together for meals and she would be switching tables. Resident was lying in bed watching television with no complaints. will continue to support as appropriate."

Review of the nurse reactionary's note dated 12/19/18 documented, "Spoke to pt (patient) regarding weekend incident in which pt was inappropriately touched by a male resident. Pt states she is "still rattled" by the situation but is feeling well otherwise. Pt endorses sleeping well and appetitive is unchanged. Pt denies increased anxiety. Pt has no other complaints and

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verbalizes satisfaction that the resident has been moved off of her unit."

Review of the resident's care plan initiated on 9/12/17 and revised on 8/18/18 did not evidence documentation regarding the 12/15/17 resident-to-resident sexual altercation.

An interview was conducted on 9/19/18 at 2:25 p.m. with LPN (licensed practical nurse) #5, the unit manager where the resident resides. When asked why residents had care plans, LPN #5 stated, "To follow how their progress is going. To make sure that all their needs are being met. When asked who used the care plan, LPN #5 stated, "Everyone, nurses, management, all therapies, administration, everyone." When asked when a care plan would be reviewed and revised, LPN #5 stated, "At any point that there's a change in medication, diet change, health status change, or if they complete something on their care plan." When asked if she was aware of the incident with Resident #91 and the male resident, LPN #5 stated, "Yes. I wasn't aware of that exact situation. I make sure that my patient feels safe and if he's coming over to the room I would notify administration." When asked if she expected to see the incident and interventions on the care plan, LPN #5 stated, "Yes." When asked to review the care plan, LPN #5 stated there was nothing on the care plan regarding the incident. When asked who updated the care plans, LPN #5 stated, "Usually at the care plan meeting is when they revise it, the unit manager attends those meetings and she updates it." When asked who would have updated the resident's care plan, LPN #5 stated, "I'm just not sure who would update it."

An interview was conducted on 9/19/18 at

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approximately 3:00 p.m., with OSM (other staff member) #3, the social worker. When asked what part of the care plan she completed, OSM #3 stated, "We see what psychotropic meds (medications) they are on, make sure they don't have any behaviors, anxiety or distress." When asked who updated the care plan for a resident-to-resident sexual incident, OSM #3 stated, "We typically will interview each resident separately. We update the care plan to monitor and to see if there's a pattern." When asked to review Resident #91's care plan, OSM #3 stated there was no update regarding the 12/15/17 incident.

On 9/19/18 at 5:00 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the nurse consultant were made aware of the findings.

An interview was conducted on 9/20/18 at 9:00 a.m. with ASM #3, the assistant director of nursing. When asked why residents had care plans, ASM #3 stated, "So that anyone who logs into their chart knows how to care for them." When asked who used the care plan, ASM #3 stated, "The nurses, management uses them, MDS uses them." When asked when the care plan would be revised, ASM #3 stated, "At any change in orders, change in condition, treatment changes." When asked who updated the care plans, ASM #3 stated, "Nursing leadership and the other departments at the table." When asked if the care plan would be revised when there was a resident-to-resident altercation, ASM #3 stated, "Yes." ASM #3 was made aware of the findings at that time.

Review of the facility's policy titled, "Care

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F 657	Continued From page 63 Planning" documented, "POLICY: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health -related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. PROCEDURE: Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment." No further information was obtained prior to exit.	F 657		
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 staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow professional standards of practice for one of 42 residents in the survey sample, Resident #238. The facility staff failed to clarify Resident #238's two different as needed orders for Tylenol (1) prescribed by the physician to determine when to administer the amount of Tylenol ordered based on pain assessment parameters. The findings include:	F 658	F658 1. Resident #238 Tylenol orders were clarify with MD and readjusted on 10/04/2018 to only one order of the Extra Strength Tylenol 500mg □ Give 2 tablets every 6 hours as need for pain. Extra Strength Tylenol 500mg □ Give 1 tablet by mouth every 6 hours as needed for pain was discontinued on same date above. 2. DON/ADON/Unit Managers to audit all current Tylenol orders for pain to ascertain that resident(s) with two Tylenol orders have parameter to direct the	10/10/18

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F 658	Continued From page 64 Resident #238 was admitted to the facility on 8/31/18 with diagnoses that included but were not limited to MRSA (1) in his wounds, paraplegia, neurogenic bladder, and chronic pain. Resident #238's most recent MDS (minimum data set) was 14 day scheduled assessment with an ARD (assessment reference date) of 9/14/18. Resident #238 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #238 was coded as requiring extensive assistance from two or more staff members with bed mobility, locomotion, dressing, and personal hygiene, and total dependence on staff with bathing. Review of Resident #238's September 2018 POS (physician order summary) revealed two different orders for prn (as needed) Tylenol as follows: "Tylenol Extra Strength 500 mg (milligrams) -Give 1 tablet by mouth every 6 hours as needed for pain. Tylenol Extra Strength 500 mg -Give 2 tablets by mouth every 6 hours as needed for pain." These orders were initiated on 9/13/18. Review of Resident #238's September 2018 MAR (medication administration record) revealed that Resident #238 had not received prn (as needed) Tylenol that month. On 9/20/18 at 8:49 a.m., an interview was conducted with LPN (licensed practical nurse) #9, the nurse on Resident #238's unit. When asked about the process staff follows if a resident has two different orders for PRN (as needed) Tylenol, LPN #9 stated that if the resident was alert and oriented, he would ask the resident if they needed one or two pills. LPN #9 stated that he would also	F 658	nurses of the quantity to administer at a given time. Any noted two Tylenol orders (related to pain) for a patient will be clarified with the MD and adjusted accordingly. 3. SDC/Designee will complete an in-service with the nurses on the following topics: a) Getting and transcribing two Tylenol orders for a patient b) Receiving and transcribing two orders of the same medication for pain 4. DON/ADON/Unit Managers will complete an audit of all Tylenol orders for pain weekly x1 month and monthly x3 months to assure that duplicate orders with different doses have parameter to direct administration. Any anomaly noted will be rectified immediately as per MD order and forwarded to the QAPI committee for further review and recommendation.	

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ask the resident their pain rating on a scale from 1-10 (10 being the worst possible pain). When asked what he would consider enough pain to give two Tylenol as opposed to one, LPN #9 stated he would give two pills for a pain level of 8 or greater. When asked if all nurses would give two Tylenol for a pain level of 8 or greater, LPN #9 stated that he wasn't sure how many pills other nurses would give based on their pain assessment. LPN #9 stated that the order probably should be clarified.

On 9/20/18 at 10:15 a.m., ASM (administrative staff member) #1, the administrator and ASM #5, the nurse consultant were made aware of the above concerns. ASM #5 stated that it was a nursing standard of practice for nurses to decide how many pain medications to administer based on their pain assessment and based on how many pills the resident requests. A request was made at this time for this professional standard.

On 9/20/18 at 10:38 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows when a resident had to different Tylenol orders, to determine how many pills to give, LPN #1 stated that the amount of pills given would depend on their pain rating. LPN #1 stated that if a resident had a pain level from 1-5, she would administer one pill and if a resident had a pain level greater than 5, she would administer 2 pills. LPN #1 stated that she would also ask the resident how many pills they wanted. When asked if all nurses knew to administer one pill for a pain level of 1-5 and two pills for a pain level of greater than 5, LPN #1 stated, "I think so." LPN #1 stated that they usually have orders with pain parameters on them directing nurses on how many pills to give

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when. LPN #1 stated that she didn't think the order had to be clarified but that it would help if the order addressed parameters. LPN #1 stated, "Just so we know what to give for sure."

On 9/20/18 at approximately 1:00 p.m., further interview was conducted with ASM #5. ASM #5 pulled a professional standard from Lippincott that showed nurses how to do a pain assessment based on the pain scale from 1-10. This reference did not evidence that nurses were able to decide how many pain medications to give if the order did not specify a pain parameter.

The facility policy titled, "Pain Management Assessments," did not address the above concerns.

No further information was presented prior to exit.

According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

(1) MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection (pronounced "staff infection") that is resistant to several common antibiotics. This

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F 658	Continued From page 67 information was obtained from the This information was obtained from The National Insitutes of Health. https://medlineplus.gov/mrsa.html (2) Tylenol- Treats minor aches and pains and also reduces fever. This information was obtained from The National Insitutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services to promote healing and prevent infection of a pressure ulcer for one of 42 residents in the survey sample, Resident #2. The facility staff failed to administer a physician prescribed treatment in a manner to promote	F 686	F686 1. Resident #2 wound was assessed by the wound doctor on 9/26/2018 and noted to have no acute onset of infection. LPN #4 was in-service on 9/19/2018 on wound care/treatment, including the observance of standard precaution during wound treatment. 2. DON/ADON/Unit Managers will	10/10/18

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F 686	Continued From page 68 healing and prevent the infection of a pressure ulcer for Resident #2. During wound care LPN (licensed practical nurse) #4 was observed wipe over Resident #2's pressure sore with the same gauze, from top to bottom repeatedly. The findings include: Resident #2 was admitted to the facility on 9/10/18 with diagnoses that included but were not limited to: achondroplasia [an inherited disorder in which a defect in cartilage and bone formation results in a form of dwarfism characterized by short limbs on a normal trunk. (1)], anxiety disorder, and pressure ulcer on the right buttock. There was no MDS (minimum data set) assessment, completed since admission on 9/10/18. The "Admission Assessment" dated, 9/10/18 documented the resident was alert and oriented to person, place time and situation. The assessment documented that her cognition was intact. Resident #2 was documented as requiring extensive assistance of one staff member for most of her activities of daily living. The form documented, "Pressure ulcer*/ left lower lumbar, measures 3 cm (centimeters) L (length) X (by) 3.5 cm W (width) x 1.5 depth. Resident was seen at wound clinic reported Santyl ** in use." *Pressure ulcers are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. (2) ** "Santyl Enzyme topical debridement. Use-Promotes debridement of necrotic tissue in	F 686	complete treatment observation with all the nurses to ascertain their adherence to standard infection precaution during wound care. Any nurse noted with deficient practice will receive an individualized in-service from the SDC/Designee on wound care/treatment 3. SDC/Designee to complete an in-service on standard infection precaution during wound care/treatment with all nurses. 4. DON/ADON/Unit Managers/SDC will complete a routine treatment observation with 10% of nurses weekly x1 month and monthly x3 months to ascertain adherence to standard infection precaution during wound care/treatment. Any deficient practice will be remediated immediately and forwarded to the QAPI committee for further review and recommendation.	

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dermal ulcers..." (3)

The "Skin/Wound Note" dated, 9/10/18 at 11:10 a.m. documented in part, "Pt (patient) admitted into facility this shift with a stage 2 pressure wound to left lower back. Treatment in place. Wound MD (medical doctor) to eval. (evaluate)."

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence-associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). (4)

The "Wound Doctor Note" dated, 9/12/18, documented in part, "Length - 2.5 cm x Width - 2.6 x depth - 0. unstageable lower back, 80% slough/nonviable [dead tissue, usually cream or yellow in color. (5)], tissue type."

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

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Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (4)

The "Skin/Wound Note" dated, 9/16/18 at 6:37 p.m. documented in part, "Pt seen by (name of wound doctor). Clarification made, wound is noted to lower left back and is not a stage 2 pressure, wound is unstageable at this time r/t (related to) slough."

The "Wound Doctor Notes" dated, 9/19/18 documented in part, "Length - 2.5 cm x width - 3 cm x depth 0.7 cm. unstageable lower back, 80% (percent) granular and 20% slough."

The comprehensive care plan dated, 9/13/18, documented in part, "Focus: Skin (Resident #2) has actual skin impairment and is at risk for skin impairment r/t (related/to) impaired mobility and incontinence." The "Interventions" documented in part, "Keep skin clean and dry. Moisture barrier cream as needed for protection of skin. Peri-care with incontinence episodes. Pressure reduction mattress."

During an interview on 9/18/18 at 12:34 p.m., with Resident #2, the resident stated she went home in April with a small area on her back. Resident #2 stated it got worse while she was home and she started going to a wound clinic. She stated now the wound doctor comes here to see her.

Observation was made on 9/19/18 at 2:58 p.m. of LPN (licensed practical nurse) #4 performing the wound care for Resident #2. LPN #4 was observed taking a gauze pad, soaked with normal saline and wiping the wound three times from top to bottom, using the same gauze pad. She

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repeated this process with two additional gauze pads, wiping the wound three time from top to bottom with the same gauze pads. The wound doctor (administrative staff member - ASM #4) proceeded to debride the wound and LPN #4 then applied the treatment.

An interview was conducted with LPN #4 on 9/19/18 at 3:59 p.m. The observation of her cleaning the wound was reviewed with LPN #4. When asked if she was taught to clean the wound with the same gauze and to repeat cleaning the wound over the same area with the same gauze, LPN #4 stated, "(Name of wound doctor) instructed me to take multiple gauze and vigorously clean the wound three times and then after that gets soiled then three more times." When asked what she was taught in nursing school, LPN #4 stated, "I was taught to wash my hands and change my gloves between dirty and clean." When asked if she was taught to clean a wound from the inside out, LPN #4 stated, "I was following (Name of wound doctor)'s instructions."

An interview was conducted with ASM #4, the wound doctor, on 9/19/18 at 4:13 p.m. When asked if he had trained the staff at this facility how to clean a wound, ASM #4 stated, "I haven't don't any in-services here." When asked how to clean a wound, ASM #4 stated, "It should be cleaned from the center out. Just like scrubbing for a surgical procedure, you start from the center, coming out in a circular motion and then discard your gauze." When asked if it is acceptable to wipe over the wound with the same gauze, from top to bottom repeatedly, ASM #4 stated, "No."

The facility policy, "General Wound Care/Dressing Changes" documented in part,

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"Procedure: 5. Licensed nurses will follow recognized standards of practice regarding dressing change(s) including date and initials on dressing."

"For an open wound, such as a pressure ulcer, gently wipe in concentric circles, again starting directly over the wound and moving outward. Us a separate gauze pad each time the wound is cleaned. Discard the gauze pad for each wiping motion; repeat the procedure until you've cleaned the entire wound. Dry the wound with 4" X 4" gauze pads, using the same procedure as for cleaning. Discard the used gauze pads in the plastic bag." (6)

ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concern on 9/19/18 at 5:10 p.m.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 7.
(2) This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000147.htm.
(3) Lexi-Comp's Drug Reference Handbooks: Drug Information Handbook for Nursing: 8th Edition 2007 pg. 301.
(4) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/
(5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC13

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F 686	Continued From page 73 60405/ (6) Fundamentals of Nursing Made Incredibly Easy, Lippincott, Williams & Wilkins, 2007, page 428.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to provide respiratory care and services for three of 42 residents in the survey sample, Resident # 49, # 111 and # 98. 1. The facility staff failed to administer Resident # 49's oxygen according to the physician's orders. 2. The facility staff failed to administer Resident # 111's oxygen according to the physician's orders. 3. The facility staff applied contaminated oxygen tubing to Resident #98. The findings include: 1. The facility staff failed to administer Resident # 49's oxygen according to the physician's orders.	F 695	F695 1. Residents□ #49 and #111 oxygen therapies were calibrated to the exact dosages as per their respective physician□s orders on the same date of the surveyors□ observation. Resident #98 oxygen tubing was replaced on 9/19/2018 with an uncontaminated one. 2. DON/ADON/Unit Managers will audit all current oxygen orders administration to ascertain that the oxygen concentrators/tanks are calibrated at exact dosage as per physician orders. Also, the oxygen tubing will be audited by the same to assure that they are applied in congruence with standard infection control precaution. 3. SDC/Designee will complete re-education on the following with the nurses:	10/10/18

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F 695	Continued From page 74 Resident # 49 was admitted to the facility on 08/09/2017 with a readmission 10/05/2018 with diagnoses that included but were not limited to: traumatic brain injury (1), tracheostomy (2), hypertension (3) and subdural hemorrhage (4). Resident # 49's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 07/25/18, coded Resident # 49 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired cognitively intact for making daily decisions. Resident # 49 was coded as being totally dependent of two staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 49 was coded for "C. Oxygen therapy." On 09/18/18 at 11:40 a.m., an observation of Resident # 49 revealed she was lying in bed receiving oxygen by the tracheostomy. Observation of the oxygen flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half and five liters per minute. On 09/18/18 at 2:28 p.m., an observation of Resident # 49 revealed she was lying in bed receiving oxygen by the tracheostomy. Observation of the oxygen flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half and five liters per minute. On 09/19/18 at 8:01 at a.m., an observation of Resident # 49 revealed she was lying in bed	F 695	a) Calibrating oxygen concentrators and tank b) Standard infection control precaution in oxygen therapy management 4. DON/ADON/Unit Managers to complete a 10% audit of current oxygen therapies weekly x1 month and monthly x3 months to ascertain accurate calibration of oxygen concentrators/tank as per MD orders and maintenance of standard infection control precaution in oxygen therapy administration. Any anomaly will be rectified accordingly and then forwarded to the QAPI committee for further review and recommendation	

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receiving oxygen by the tracheostomy. Observation of the oxygen flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half and five liters per minute.

On 09/19/18 at 11:35 a.m., an observation of Resident # 49 revealed she was lying in bed receiving oxygen by the tracheostomy. Observation of the oxygen flow meter on the oxygen concentrator revealed the oxygen flow rate was set between four and a half and five liters per minute.

The POS (physician's order sheet) for Resident # 49 dated "September 2018"documented, "Oxygen Therapy - Oxygen 28% (percent) at 5 (five) liters per minute via (by) tracheostomy every shift for oxygen. Order Date: 07/31/2018. Start Date: 07/31/2018."

The comprehensive care plan for Resident # 49 with a revision of 06/14/2018 documented, "Focus. The resident has a tracheostomy r/t (related to) injury (TBI) [traumatic brain injury]." Under "Interventions" it documented, "OXYGEN administered as ordered. Created on 08/10/2017."

On 09/19/18 at 1:20 p.m., an interview was conducted with LPN (licensed practical nurse) #10. When asked to describe the procedure for reading the oxygen flow rate on an oxygen concentrator, LPN # 10 stated, "The liter line should pass through the middle of the ball." When asked how often resident's oxygen flow rate is checked, LPN # 10 stated, "It's checked every hour. When asked what the oxygen flow rate was for Resident # 49. LPN # 10 looked up

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the physician's order for Resident # 49 and stated, "It's five liters per minute." LPN # 10 was asked to read the oxygen flow rate on Resident # 49's oxygen concentrator. LPN stated it's between four and a half and five liters."

On 09/20/18 at 8:50 a.m., an interview was conducted with ASM # 2 (administrative staff member) # 2, director of nursing regarding Resident # 49's oxygen flow rate. ASM # 2 stated, "I spoke with the pulmonologist yesterday and they stated the oxygen concentrator should be set at five liters per minute because it provides oxygen concentration of 28% (twenty-eight percent)."

The (Name of the Manufacturer's Oxygen Concentrator Instructions) documented, "For prescriptions of 5 LPM (five liters per minute), be sure the ball is centered on the 5 liter line. The ball should not touch the red line."

The facility's policy "Respiratory Care" documented, "POLICY: Licensed nurses will administer and maintain respiratory equipment, oxygen administration and oxygen equipment per physician's orders and in Accordance with standards of practice."

On 09/19/18 at 5:10 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:
(1) Happens when a bump, blow, jolt, or other head injury causes damage to the brain.

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Symptoms of a TBI may not appear until days or weeks following the injury. A concussion is the mildest type. It can cause a headache or neck pain, nausea, ringing in the ears, dizziness, and tiredness. People with a moderate or severe TBI may have those, plus other symptoms: A headache that gets worse or does not go away, Repeated vomiting or nausea, Convulsions or seizures, Inability to awaken from sleep, Slurred speech, Weakness or numbness in the arms and legs, Dilated eye pupils. This information was obtained from the website: https://medlineplus.gov/traumaticbraininjury.html

(2) A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm.

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(4) A bleeding in the area between the brain and the thin tissues that cover the brain. This area is called the subarachnoid space. This information was obtained from the website: https://medlineplus.gov/ency/article/000701.htm.

2. The facility staff failed to administer Resident # 111's oxygen according to the physician's orders.

Resident # 111 was admitted to the facility on 07/20/2015 with a readmission 08/19/2018 with

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diagnoses that included but were not limited to: respiratory failure (1), chronic obstructive pulmonary disease (2), hypertension (3) and heart failure (4).

Resident # 111's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/19/18, coded Resident # 111 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 111 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 49 was coded for "C. Oxygen therapy."

On 09/18/18 at 11:50 a.m., an observation of Resident # 11 revealed she was sitting on the edge of the bed receiving oxygen by nasal cannula. Observation of the flow rate on the oxygen concentrator revealed the oxygen was being delivered at a flow rate of between two and a half and three liters per minute.

On 09/19/18 at 11:30 a.m., an observation of Resident # 11 revealed she was sitting in her w/c in her room receiving oxygen by nasal cannula. Observation of the flow rate on the oxygen concentrator revealed the oxygen was being delivered at a flow rate of between two and a half and three liters per minute.

On 09/19/18 at 1:18 p.m., an observation of Resident # 11 revealed she was sitting in her w/c in her room receiving oxygen by nasal cannula. Observation of the flow rate on the oxygen

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concentrator revealed the oxygen was being delivered at a flow rate of between two and a half and three liters per minute.

The POS (physician's order sheet) for Resident # 111 dated "September 2018"documented,
- "Oxygen at 3 (three) liters (liters per minute) every shift for Hypoxia (5) Order Status: Discontinued. Order Date: 09/19/2018. Start Date: 09/19/2018."
- "Oxygen at 3 (three) liters (liters per minute) PRN (as needed) for Hypoxia. Order Status: Active. Order Date: 09/19/2018. Start Date: 09/19/2018."

The comprehensive care plan for Resident # 111 with a revision of 09/02/2018 documented, "Focus. RESPIRATORY THERAPY: (Resident # 111) has altered respiratory status/difficulty breathing r/t pulmonary fibrosis and COPD (chronic obstructive pulmonary disease). Under "Interventions" it documented, "O2 (oxygen) as ordered/tolerated. Created on 09/02/2018."

On 09/19/18 at 1:20 p.m., an interview was conducted with LPN (licensed practical nurse) #10. When asked to describe the procedure for reading the oxygen flow rate on an oxygen concentrator LPN # 10 stated, "The liter line should pass through the middle of the ball." When asked how often resident's oxygen flow rate is checked, LPN # 10 stated, "It's checked every hour. When asked what the oxygen flow rate was for Resident # 111. LPN # 10 looked up the physician's order for Resident # 111 stated, '"It's three liters per minute." LPN # 10 was asked to read the oxygen flow rate on Resident # 111's oxygen concentrator. LPN stated it's between two and a half and three liters."

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The (Name of the Manufacturer's Oxygen Concentrator Instructions) documented, "NOTE: To properly read the flow meter located the prescribed flow rate line on the flow meter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed."

On 09/19/18 at 5:10 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:
(1) Condition when not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022885/

(2) COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. This information was obtained from the website: https://www.nhlbi.nih.gov/health-topics/copd

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(4) Heart failure is a serious but common condition. In heart failure, the heart cannot pump enough blood to meet the body's needs. Heart failure develops over time as the pumping action

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of the heart gets weaker, or if it gets more difficult to adequately fill the heart with blood between heartbeats. It can affect either the right, the left, or both sides of the heart. Heart failure does not mean that the heart has stopped working or is about to stop working. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(5) Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.
3. The facility staff applied contaminated oxygen tubing to Resident #98.

Resident #98 was admitted to the facility on 5/21/18 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), major depressive disorder, heart failure, and anxiety disorder. Resident #98's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference date) of 8/28/18. Resident #98 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview of Mental Status) exam. Resident #98 was coded as requiring extensive assistance from two plus persons with bed mobility, transfers, toileting, and total dependence on one staff member with bathing. Section O (Special treatments, procedures, and programs) coded Resident #98 as receiving oxygen therapy.

Review of Resident #98's September 2018 POS (physician order summary) documented the following order: "Oxygen at 2 liters per minute via

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nasal cannula."

On 9/18/18 at 2:11 p.m., an observation was made of Resident #98. She was sitting up in her wheelchair. Her oxygen tubing, nasal cannula included, was lying on the floor. Her oxygen tubing was dated 9/17/18. Her oxygen was set at 2 liters. Resident #98 stated that she didn't need her oxygen all the time and would take it off herself.

On 9/18/18 at 4:15 p.m., an observation was made of Resident #98. Her oxygen tubing dated 9/17/18, remained on the floor.

On 9/19/18 at 9:02 a.m. and at 1:40 p.m., observations were made of Resident #98. She was sleeping in bed with her oxygen on and in place at 2 liters. Her tubing was dated 9/17/18, and was the same tubing that had been on the floor the day prior.

On 9/19/18 at 2:56 p.m., an interview was conducted with RN (registered nurse) #2, the nurse on that unit. When asked about the process followed if she were to see oxygen tubing on the floor, RN #2 stated that she would throw the tubing away and get another one. RN #2 stated that she would not place the tubing back on the resident because it was contaminated by the floor and this was an infection control issue. RN #2 stated that Resident #98 could not reach her tubing or concentrator from her bed. RN #2 stated that she was not Resident #98's nurse that day.

On 9/19/18 at 2:59 p.m., Resident #98 continued to lay in bed with her oxygen tubing in place dated 9/17/18. When asked if she could reach her

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F 695	Continued From page 83 oxygen concentrator and tubing from her bed, Resident #98 stated that she could not. Resident #98 stated that the staff put her oxygen on. On 9/19/18 at 4:13 p.m., an interview was conducted with LPN (licensed practical nurse) #4, Resident #98's nurse. When asked about the process followed if she were to see oxygen tubing, including the nasal cannula on the floor, LPN #4 stated that she would immediately throw the tubing away and get a new one. When asked why she would throw the tubing away, LPN #4 stated that the tubing was contaminated by the floor. LPN #4 could not recall Resident #98's tubing on the floor. When asked if Resident #98 could reach her oxygen tubing or nasal cannula from her bed, LPN #4 stated, "She probably can't." On 9/19/18 at 10:15 a.m., ASM (administrative staff member) #1, the administrator, and ASM #5 the nurse consultant were made aware of the above findings. The facility policy titled, "Respiratory Care" did not address the above concerns. A policy could be provided regarding infection control with respiratory equipment. No further information was presented prior to exit.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		10/10/18

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F 697	Continued From page 84 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement a complete pain management program for one of 42 residents in the survey sample, Resident #338. Resident #338 was admitted to the facility on 9/13/18. The facility staff failed to administer the resident's pain medication Lyrica (1) until 9/18/18. The findings include: Resident #338 was admitted to the facility on 9/13/18. Resident #338's diagnoses included but were not limited to diabetes, high blood pressure and strain of muscle(s) and tendon(s). Resident #338's admission MDS (minimum data set) assessment was not complete. An admission assessment dated 9/13/18 documented Resident #338 was alert and oriented to person, place, time and situation. The assessment further documented Resident #338 reported rare pain over the last five days. Review of Resident #338's clinical record revealed a physician's order dated 9/13/18 for Lyrica 75 mg (milligrams) by mouth three times a day related to strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder. Review of Resident #338's September 2018 MAR (medication administration record), September 2018 nurses' notes and a Lyrica controlled medication utilization record revealed the resident was not administered Lyrica until 9/18/18 (note-nurses' notes documented the physician was notified).	F 697	F697 1. Resident #338 discharged on 9/18/2018. 2. DON/ADON/Unit Managers will review the MAR of all current patients on Lyrica to ensure that there was no delayed in the administration of their medication. Any missed dose noted will be made known to the MD/RP and then follow MD instruction accordingly 3. SDC/Designee will complete an in-service on the following topics e) Managing new order for Lyrica for prompt delivery and administration f) Managing new admissions with Lyrica order 4. DON/ADON/Unit Managers will audit 10% of all oxygen therapies and Lyrica orders weekly x1 month and monthly x3 months to ascertain the adherence of standard precaution with oxygen therapy and timely administration of new Lyrica order by the MD. Any anomaly noted will be rectified accordingly and then forwarded to the QAPI committee for further review and recommendation	

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Further review of Resident #338's September 2018 MAR revealed the resident was administered as needed oxycodone (2) 10 mg per physician's order on 9/15/18 for a pain level of eight, 9/16/18 for a pain level of seven, and 9/17/18 for a pain level of seven. The MAR further documented Resident #338 was administered as needed tramadol (3) 50 mg per physician's order on 9/14/18 for a pain level of eight, again on 9/14/18 for a pain level of seven and on 9/15/18 for a pain level of five.

Further review of Resident #338's Lyrica controlled medication utilization record revealed the medication was received by the facility staff on 9/18/18.

The facility STAT (immediate) box (a box containing various medications that can be utilized for all residents) list revealed Lyrica was not contained in the STAT box.

Resident #338's care plan dated 9/13/18 documented, "PAIN: (Name of Resident #338) has acute pain r/t (related to) Right Rotator Cuff Sprain...Administer analgesia per order..."

On 9/18/18 at 4:33 p.m., an interview was conducted Resident #338. Resident #338 stated she was supposed to get Lyrica three times a day. Resident #338 stated she thought she was getting Lyrica now but she was not previously getting the medication at the facility.

On 9/19/18 at 2:31 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (a nurse responsible for administering Lyrica to Resident #338 on 9/16/18). LPN #1 was asked

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the process for ensuring medications are available for administration. LPN #1 stated if the medication is not a narcotic then nurses can see if the medication is in the STAT box or nurses can call the pharmacy and have the medication sent STAT (immediately). LPN #1 stated if the medication is a narcotic, then nurses need to get a script (written prescription) from the doctor, fax the script to the pharmacy then fill out a request to remove the medication from the STAT box or have the medication sent STAT from the pharmacy. LPN #1 was asked why Lyrica was not administered to Resident #338 per physician's order. LPN #1 stated the resident's Lyrica was not in the facility on 9/16/18 so she had the nurse practitioner sign and fax a script to the pharmacy that day.

On 9/19/18 at 2:48 p.m., an interview was conducted with LPN #2 (a nurse responsible for administering Lyrica to Resident #338 on 9/17/18). LPN #2 was asked about the process staff follows for ensuring medications are acquired for newly admitted residents. LPN #2 stated all admission orders are reviewed by the nurse practitioner and entered into the computer system that sends the orders to the pharmacy. LPN #2 stated if a medication requires a written prescription then she immediately requests a script from the nurse practitioner and faxes the script to the pharmacy. LPN #2 was asked why Lyrica was not administered to Resident #338 per physician's order. LPN #2 stated she was off during the weekend (9/15/18 and 9/16/18) and returned to work on Monday (9/17/18). LPN #2 stated on that day, the pharmacy called and stated there was no quantity documented on the Lyrica script and the medication could not be sent until a quantity was clarified. LPN #2 stated she

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addressed this and the medication was then sent.

On 9/19/18 at 3:06 p.m., an interview was conducted with LPN #3 (Resident #338's unit manager). LPN #3 was asked why Resident #338 did not receive Lyrica per physician's order. LPN #3 stated Resident #338 arrived to the facility at approximately 10:40 p.m., on Thursday (9/13/18) and a written prescription was not received. LPN #3 stated the facility staff eventually obtained a written prescription but the prescription did not document a quantity so that correction had to be made.

On 9/19/18 at 5:58 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Pain Management" documented, "3. Administration of pain medication and effectiveness will be documented..."

No further information was provided prior to exit.

(1) Lyrica is used to treat pain from damaged nerves. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605045.html

(2) Oxycodone is a narcotic medication used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html

(3) Tramadol is used to relieve pain. This

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F 697	Continued From page 88 information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		10/10/18

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F 755	Continued From page 89 by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide pharmacy services for one of 42 residents in the survey sample, Resident #338. Resident #338 was admitted to the facility on 9/13/18. The facility staff failed to acquire the resident's medication Lyrica (1) until 9/18/18. The findings include: Resident #338 was admitted to the facility on 9/13/18. Resident #338's diagnoses included but were not limited to diabetes, high blood pressure and strain of muscle(s) and tendon(s). Resident #338's admission MDS (minimum data set) assessment was not complete. An admission assessment dated 9/13/18 documented Resident #338 was alert and oriented to person, place, time and situation. The assessment further documented Resident #338 reported rare pain over the last five days. Review of Resident #338's clinical record revealed a physician's order dated 9/13/18 for Lyrica 75 mg (milligrams) by mouth three times a day related to strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder. Review of Resident #338's September 2018 MAR (medication administration record), September 2018 nurses' notes and a Lyrica controlled medication utilization record revealed the resident was not administered Lyrica until 9/18/18 (note-nurses' notes documented the physician was notified). Further review of Resident #338's Lyrica	F 755	F755 1. Resident #338 discharged on 9/18/2018. 2. DON/Administrator to meet with the Medical Director and pharmacy representative to identify narcotic medication (particularly Lyrica) delivery limitations and the resources available to remedy the problem, so as to avoid delay in the delivery of ordered medication by the pharmacy in the future. 3. SDC/Designee to complete an in-service with nurses on managing new Lyrica orders with the pharmacy for timely delivery and administration 4. DON/Designee to audit new Lyrica medication (and other narcotic medications) delivery time weekly x1 month and monthly x3 months to assure that they are delivered and administered timely. Any anomaly will be addressed accordingly.	

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controlled medication utilization record revealed the medication was received by the facility staff on 9/18/18.

The facility STAT box (a box containing various medications that can be utilized for all residents) list revealed Lyrica was not contained in the STAT box.

Resident #338's care plan dated 9/13/18 documented, "PAIN: (Name of Resident #338) has acute pain r/t (related to) Right Rotator Cuff Sprain...Administer analgesia per order..."

On 9/18/18 at 4:33 p.m., an interview was conducted Resident #338. Resident #338 stated she was supposed to get Lyrica three times a day. Resident #338 stated she thought she was getting Lyrica now but she was not previously getting the medication at the facility.

On 9/19/18 at 2:31 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (a nurse responsible for administering Lyrica to Resident #338 on 9/16/18). LPN #1 was asked about the process followed for ensuring medications are available for administration. LPN #1 stated if the medication is not a narcotic then nurses can see if the medication is in the STAT box or nurses can call the pharmacy and have the medication sent STAT (immediately). LPN #1 stated if the medication is a narcotic, then nurses need to get a script (written prescription) from the doctor, fax the script to the pharmacy then fill out a request to remove the medication from the STAT box or have the medication sent STAT from the pharmacy. LPN #1 was asked why Lyrica was not administered to Resident #338 per physician's order. LPN #1 stated the resident's

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Lyrica was not in the facility on 9/16/18 so she had the nurse practitioner sign and fax a script to the pharmacy that day.

On 9/19/18 at 2:48 p.m., an interview was conducted with LPN #2 (a nurse responsible for administering Lyrica to Resident #338 on 9/17/18). LPN #2 was asked about the process followed for ensuring medications are acquired for newly admitted residents. LPN #2 stated all admission orders are reviewed by the nurse practitioner and entered into the computer system that sends the orders to the pharmacy. LPN #2 stated if a medication requires a written prescription then she immediately requests a script from the nurse practitioner and faxes the script to the pharmacy. LPN #2 was asked why Lyrica was not administered to Resident #338 per physician's order. LPN #2 stated she was off during the weekend (9/15/18 and 9/16/18) and returned to work on Monday (9/17/18). LPN #2 stated on that day, the pharmacy called and stated there was no quantity documented on the Lyrica script and the medication could not be sent until a quantity was clarified. LPN #2 stated she addressed this and the medication was then sent.

On 9/19/18 at 3:06 p.m., an interview was conducted with LPN #3 (Resident #338's unit manager). LPN #3 was asked why Resident #338 did not receive Lyrica per physician's order. LPN #3 stated Resident #338 arrived to the facility at approximately 10:40 p.m., on Thursday (9/13/18) and a written prescription was not received. LPN #3 stated the facility staff eventually obtained a written prescription but the prescription did not document a quantity so that correction had to be made.

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On 9/19/18 at 5:58 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "1.0 Providing Pharmacy Products and Services" documented, "Procedure: 1. Pharmacy will provide Facility with the Facility-Specific Information Sheet set forth in (the 'Facility-Specific Information'), which details how Facility staff can contact Pharmacy twenty-four (24) hours a day, seven (7) day (sic) a week. 2. During the normal business hours set forth in the Facility-Specific Information Sheet, Facility staff may contact Pharmacy by phone or fax at the phone/fax numbers provided in the Facility-Specific Information Sheet, or by mail or hand delivery, as specified by Applicable Law. 3. After the normal business hours set forth in the Facility-Specific Information Sheet, Facility staff should contact Pharmacy by dialing the telephone number provided in the Facility-Specific Information Sheet to page the on-call pharmacist. 4. If orders for medications are received from Physician/Prescriber when Pharmacy is closed, Facility staff should take the following steps: 4.1 Remind Physician/Prescriber that Pharmacy is closed and that a delay in medication therapy can be prevented by using a medication that is included in Facility's Emergency Medication Supply as permitted by state regulation. 4.2 If a medication cannot be substituted, ask Physician/Prescriber if the medication therapy can be initiated the next morning. If it is possible to initiate the medication therapy the next morning, Facility staff should document the conversation with the prescriber and include the start time in the order. 4.3 If a medication is considered essential and cannot be substituted or

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F 755	Continued From page 93 delayed, contact the emergency number provided by Pharmacy. The emergency number should either page the on-call pharmacist or contact an answering service. Orders should be received directly from a Facility nurse or a licensed Physician/Prescriber, and cannot be faxed, emailed or provided to answering service personnel..." No further information was provided prior to exit. (1) Lyrica is used to treat pain from damaged nerves. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605045.html	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		10/10/18

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F 812	Continued From page 94 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to serve food in a sanitary manner in the facility kitchen and in one of three dining rooms, the assistive dining room. 1. The facility staff failed to properly wear hair restraints while in the facility kitchen on 9/19/18. 2. The facility staff failed to serve bread in a sanitary manner to a resident in the assistive dining room during the 9/18/18 lunch dining observation. The findings include: 1. On 9/19/18 at 4:30 p.m., observation of the facility kitchen was conducted. Temperatures of dinner and tray line was conducted with OSM (other staff member) # 5, the dietary manager. OSM #5's hair net was not covering her entire head. The bottom part of her hair was exposed. Her hair net was not worn properly for the entire tray line while she was serving food. The tray line lasted until approximately 6:15 p.m. On 9/20/18 at 9:09 a.m., an interview was conducted with OSM #5. When asked how air restraints should be worn in the kitchen, OSM #5 stated that the goal was to have the hairnet cover all hair and to make sure they are pulled down. OSM #5 stated that she has a mirror at the sink so staff can check to see if their hair net was still in place. When asked the purpose of the hair net, OSM #5 stated that the purpose of the hair net was to prevent hair from falling into the food.	F 812	F812 1. The affected CNA was in-serviced immediately by the Dietary Director for sanitary food handling in the dining room with returned demonstration by the same. The affected dietary staff member□s hairnet was immediately replaced to cover her entire hair. 2. Sanitary food handling by CNAs was reviewed in all three dining areas in the facility. No deficient practice was noted from the exercise. Hairnets audit of all dietary and axillary staff was completed with none of the staff observed in deficient practice. 3. Re-education of all staff involved directly or indirectly in food services at the facility will be completed on the following topics by the Dietary Director and Registered Dietitian: a) Proper sanitary food handling techniques and services b) Proper hairnet donning 4. Dietary Director and Registered Dietitian will complete a daily audit of all meal services x1 week, then weekly x1 month, and monthly x3 months to ascertain sanitary handling of foods and proper hairnet donning are maintained. Any deficient practice observed will be immediately rectified and then forwarded to QAPI committee for further review and recommendation.	

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When OSM #5 was informed about the above observations, OSM #5 stated that generally they try to keep pulling them down. OSM #5 stated that the hairnets rise up with movement. OSM #5 stated that it was so chaotic in the kitchen on 9/19/18 that she forgot to pull down her hair net.

On 9/20/18 at 10:15 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the nurse consultant were made aware of the above concerns. ASM #1 stated that the hairnets rise up with movement while the staff are working.

Facility policy titled, "Dining Services Policies and Procedures" documents in part, the following: "Dining Services employees shall practice optimal hygiene and shall dress appropriately based on the Center dress code to promote the professional appearance, ensure the safety of dining services personnel, and minimize contamination of food and risks of food-borne illness...All persons in the food preparation and food storage areas shall wear hair restraints such as hair coverings, hair nets, or beard guards where necessary, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-use articles."

No further information was presented prior to exit.

2. The facility staff failed to serve bread in a sanitary manner to a resident in the assistive dining room during the 9/18/18 lunch dining observation.

A dining observation was conducted on 9/18/18 at 12:21 p.m. in the assistive dining room. CNA #3 was observed moving a chair from one table to

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F 812	Continued From page 96 another. CNA #3 then picked up a resident's roll with her bare hand and buttered it. CNA #3 then gave the roll to the resident. An interview was conducted on 9/20/18 at 8:15 a.m. with CNA #3. When asked when it was appropriate for staff to touch a resident's food with their bare hands, CNA #3 stated, "It isn't". When asked why, CNA #3 stated, "Cross contamination." When the observation above was shared, CNA #3, I should have not done that." On 9/19/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the nurse consultant were made aware of the findings. An interview was conducted on 9/20/18 at 9:41 a.m. with LPN (licensed practical nurse) #7, the unit manager. When asked when it was appropriate for staff to touch a resident's food with their bare hands, LPN #7 stated, "Never, that's cross contamination, an infection control issue." No further information was provided prior to exit.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		10/10/18

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program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 98 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services in a manner to prevent the spread of infection for two of 42 residents in the survey sample, Resident #2 and Resident #98. 1. The facility staff failed to clean a wound in a manner to prevent infection for Resident #2. 2. The facility staff failed to follow infection control practices and applied Resident #98's oxygen after the tubing had been sitting on the floor. The findings include: 1. There was no MDS (minimum data set) assessment, completed since admission on 9/10/18. The "Admission Assessment" dated, 9/10/18 documented the resident was alert and oriented to person, place time and situation. The	F 880	F880 1. Resident #2 wound was assessed by the wound doctor on 9/26/2018 and noted to have no acute onset of infection. LPN #4 was in-service on 9/19/2018 on wound care/treatment, including the observance of standard precaution during wound treatment. Resident #98 oxygen tubing was replaced on 9/19/2018 with an uncontaminated one. Resident #98 was assessed to have no signs and symptoms of acute infection. 2. DON/ADON/Unit Managers will complete treatment observation with all the nurses to ascertain their adherence to standard infection precaution during wound care. Also, applied oxygen tubing will be audited to assure that they are not contaminated and are in congruence with the MFA policy and procedures on standard infection control precaution for	

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F 880	Continued From page 99 assessment documented that her cognition was intact. Resident #2 was documented as requiring extensive assistance of one staff member for most of her activities of daily living. The form documented, "Pressure ulcer*/ left lower lumbar, measures 3 cm (centimeters) L (length) X (by) 3.5 cm W (width) x 1.5 depth. Resident was seen at wound clinic reported Santyl ** in use." *Pressure ulcers are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. (2) ** "Santyl Enzyme topical debridement. Use-Promotes debridement of necrotic tissue in dermal ulcers..." (3) The "Skin/Wound Note" dated, 9/10/18 at 11:10 a.m. documented in part, "Pt (patient) admitted into facility this shift with a stage 2 pressure wound to left lower back. Treatment in place. Wound MD (medical doctor) to eval. (evaluate)." Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including	F 880	oxygen therapy administration. 3. SDC/Designee will complete an in-service on standard infection control precaution during wound care/treatment and oxygen therapy administration with all nurses 4. DON/ADON/Unit Managers will audit 10% of all oxygen therapies and wound care/treatment weekly x1 month and monthly x3 months to ascertain the adherence to standard precaution during wound care/treatment and/or oxygen therapy. Any deficient practice observed will be immediately rectified and then forwarded to QAPI committee for further review and recommendation.	

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incontinence-associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). (4)

The "Wound Doctor Note" dated, 9/12/18, documented in part, "Length - 2.5 cm x Width - 2.6 x depth - 0. unstageable lower back, 80% slough/nonviable [dead tissue, usually cream or yellow in color. (5)], tissue type."

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (4)

The "Skin/Wound Note" dated, 9/16/18 at 6:37 p.m. documented in part, "Pt seen by (name of wound doctor). Clarification made, wound is noted to lower left back and is not a stage 2 pressure, wound is unstageable at this time r/t (related to) slough."

The "Wound Doctor Notes" dated, 9/19/18 documented in part, "Length - 2.5 cm x width - 3 cm x depth 0.7 cm. unstageable lower back, 80% (percent) granular and 20% slough."

The comprehensive care plan dated, 9/13/18, documented in part, "Focus: Skin (Resident #2) has actual skin impairment and is at risk for skin impairment r/t (related/to) impaired mobility and incontinence." The "Interventions" documented in

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part, "Keep skin clean and dry. Moisture barrier cream as needed for protection of skin. Peri-care with incontinence episodes. Pressure reduction mattress."

During an interview on 9/18/18 at 12:34 p.m., with Resident #2, the resident stated she went home in April with a small area on her back. Resident #2 stated it got worse while she was home and she started going to a wound clinic. She stated now the wound doctor comes here to see her.

Observation was made on 9/19/18 at 2:58 p.m. of LPN (licensed practical nurse) #4 performing the wound care for Resident #2. LPN #4 was observed taking a gauze pad, soaked with normal saline and wiping the wound three times from top to bottom, using the same gauze pad. She repeated this process with two additional gauze pads, wiping the wound three time from top to bottom with the same gauze pads. The wound doctor (administrative staff member - ASM #4) proceeded to debride the wound and LPN #4 then applied the treatment.

An interview was conducted with LPN #4 on 9/19/18 at 3:59 p.m. The observation of her cleaning the wound was reviewed with LPN #4. When asked if she was taught to clean the wound with the same gauze and to repeat cleaning the wound over the same area with the same gauze, LPN #4 stated, "(Name of wound doctor) instructed me to take multiple gauze and vigorously clean the wound three times and then after that gets soiled then three more times." When asked what she was taught in nursing school, LPN #4 stated, "I was taught to wash my hands and change my gloves between dirty and clean." When asked if she was taught to clean a

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wound from the inside out, LPN #4 stated, "I was following (Name of wound doctor)'s instructions."

An interview was conducted with ASM #4, the wound doctor, on 9/19/18 at 4:13 p.m. When asked if he had trained the staff at this facility how to clean a wound, ASM #4 stated, "I haven't don't any in-services here." When asked how to clean a wound, ASM #4 stated, "It should be cleaned from the center out. Just like scrubbing for a surgical procedure, you start from the center, coming out in a circular motion and then discard your gauze." When asked if it is acceptable to wipe over the wound with the same gauze, from top to bottom repeatedly, ASM #4 stated, "No."

The facility policy, "General Wound Care/Dressing Changes" documented in part, "Procedure: 5. Licensed nurses will follow recognized standards of practice regarding dressing change(s) including date and initials on dressing."

"For an open wound, such as a pressure ulcer, gently wipe in concentric circles, again starting directly over the wound and moving outward. Us a separate gauze pad each time the wound is cleaned. Discard the gauze pad for each wiping motion; repeat the procedure until you've cleaned the entire wound. Dry the wound with 4" X 4" gauze pads, using the same procedure as for cleaning. Discard the used gauze pads in the plastic bag." (6)

ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concern on 9/19/18 at 5:10 p.m.

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 7.
(2) This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000147.htm.
(3) Lexi-Comp's Drug Reference Handbooks: Drug Information Handbook for Nursing: 8th Edition 2007 pg. 301.
(4) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/
(5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/
(6) Fundamentals of Nursing Made Incredibly Easy, Lippincott, Williams & Wilkins, 2007, page 428.

2. For Resident #98, facility staff failed to follow infection control practices and applied her oxygen after the tubing had been sitting on the floor.

Resident #98 was admitted to the facility on 5/21/18 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), major depressive disorder, heart failure, and anxiety disorder. Resident #98's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference date) of 8/28/18. Resident #98 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview of Mental Status) exam. Resident #98 was coded as requiring extensive

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assistance from two plus persons with bed mobility, transfers, toileting, and total dependence on one staff member with bathing. Section O (Special treatments, procedures, and programs) coded Resident #98 as receiving oxygen therapy.

Review of Resident #98's September 2018 POS (physician order summary) documented the following order: "Oxygen at 2 liters per minute via nasal cannula."

On 9/18/18 at 2:11 p.m., an observation was made of Resident #98. She was sitting up in her wheelchair. Her oxygen tubing, nasal cannula included, was lying on the floor. Her oxygen tubing was dated 9/17/18. Her oxygen was set at 2 liters. Resident #98 stated that she didn't need her oxygen all the time and would take it off herself.

On 9/18/18 at 4:15 p.m., an observation was made of Resident #98. Her oxygen tubing dated 9/17/18, remained on the floor.

On 9/19/18 at 9:02 a.m. and at 1:40 p.m., observations were made of Resident #98. She was sleeping in bed with her oxygen on and in place at 2 liters. Her tubing was dated 9/17/18, and was the same tubing that had been on the floor the day prior.

On 9/19/18 at 2:56 p.m., an interview was conducted with RN (registered nurse) #2, the nurse on that unit. When asked about the process followed if she were to see oxygen tubing on the floor, RN #2 stated that she would throw the tubing away and get another one. RN #2 stated that she would not place the tubing back on the resident because it was contaminated by

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the floor and this was an infection control issue. RN #2 stated that Resident #98 could not reach her tubing or concentrator from her bed. RN #2 stated that she was not Resident #98's nurse that day.

On 9/19/18 at 2:59 p.m., Resident #98 continued to lay in bed with her oxygen tubing in place dated 9/17/18. When asked if she could reach her oxygen concentrator and tubing from her bed, Resident #98 stated that she could not. Resident #98 stated that the staff put her oxygen on.

On 9/19/18 at 4:13 p.m., an interview was conducted with LPN (licensed practical nurse) #4, Resident #98's nurse. When asked about the process followed if she were to see oxygen tubing, including the nasal cannula on the floor, LPN #4 stated that she would immediately throw the tubing away and get a new one. When asked why she would throw the tubing away, LPN #4 stated that the tubing was contaminated by the floor. LPN #4 could not recall Resident #98's tubing on the floor. When asked if Resident #98 could reach her oxygen tubing or nasal cannula from her bed, LPN #4 stated, "She probably can't."

On 9/19/18 at 10:15 a.m., ASM (administrative staff member) #1, the administrator, and ASM #5 the nurse consultant were made aware of the above findings.

The facility policy titled, "Respiratory Care" did not address the above concerns. A policy could be provided regarding infection control with respiratory equipment. No further information was presented prior to exit.