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(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	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 4/23/19 through 4/25/19, was conducted 6/4/19 through 6/5/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. The census in this 176 certified bed facility was 136 at the time of the survey. The survey sample consisted of nine current Resident reviews (Residents #100 through #106 and Residents #108 through #109) and one closed record review (Resident #107).	{F 000}	E000: This Plan of Correction is submitted in accordance with established state and federal laws. Submission of this Plan of Correction is not an admission of a deficiency existing or that a deficiency was cited correctly, it constitutes written allegation of compliance for deficiencies cited.	
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	{F 656}	F- 656 1: Upon notification by the surveyor of the lack of implementation of care plans for oxygen administration for residents #101, #102, #103 settings of oxygen concentrators were set to the ordered settings, nursing supervisors observed oxygen concentrator settings and no further discrepancies were observed. 2: Current residents receiving oxygen therapy have potential to be affected by this practice. 3: Nurses and certified nursing assistants will be in-serviced on policy for oxygen administration and proper observation of oxygen concentrator flow setting as well as implementation of care plan interventions. Documentation in the electronic medical record will be implemented to record the flow meter settings for residents on oxygen every shift.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ramona J. Ringstaff | TITLE: Administrator | (X6) DATE: 6/13/2019

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{F 656}	Continued From page 1	{F 656}	4: The director of nursing or designee will audit oxygen equipment settings weekly, and address any discrepancies immediately, and report to the director of nursing to be addressed per policy. Audit findings will be discussed at the weekly risk management meeting. Any ongoing problems will be reported to the QA committee quarterly. 5: Completion date: 06/21/2019	

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 and clinical record review and facility document review, it was determined that facility staff failed to implement the comprehensive care plan for three of 10 residents in the survey sample, Residents # 101, # 102 and # 103.

1. The facility staff failed to implement Resident # 101's comprehensive care plan for the administration of oxygen.

2. The facility staff failed to implement Resident #102's comprehensive care plan for oxygen

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{F 656}	Continued From page 2	{F 656}		

administration.

3. The facility staff failed to implement Resident #103's comprehensive care plan for oxygen administration.

The findings include:

1. The facility staff failed to implement Resident # 101's comprehensive care plan for the administration of oxygen.

Resident # 101 was admitted to the facility on 07/14/2015 with a readmission of 03/24/2016 with diagnoses that included but were not limited to shortness of breath, atrial fibrillation (1), hypotension (2), and gastroesophageal reflux disease (3).

Resident # 101's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/25/19, coded Resident # 101 as scoring a 6 (six) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 6 (six) - being severely impaired of cognition for making daily decisions. Resident # 101 was coded as requiring extensive assistance of one staff member for activities of daily living and dependent of two staff members for bathing.

On 06/04/19 at 12:00 p.m., at 3:05 p.m., and on 06/05/19 at 7:20 a.m., observations of Resident # 101 revealed he was lying in bed receiving oxygen from an oxygen concentrator through a nasal cannula. Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate between two-and-a-half and three liters per minute.

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{F 656}	Continued From page 3	{F 656}		

The "Physician's Order Sheet" dated "06/04/2019" documented, "02 (oxygen) @ (at) 2L (two liters) via (by) n/c (nasal cannula) to maintain 02 above 90% check sat (saturation) q (every) shift. Order Date: 03/30/2018."

The comprehensive care plan for Resident # 101 with a target date of 08/29/2019 documented, "Focus. The resident has shortness of breath (SOB) at bedtime frequently. Date initiated: 03/03/2017." Under "Interventions/Tasks" it documented, "[sic] 2 @ [at] 2L via n/c to maintain O2 above 90% check sat Q shift."

On 04/05/19 at 7:30 a.m., an interview and observation was conducted with LPN (licensed practical nurse) # 1. When asked to describe the purpose of the comprehensive care plan, LPN # 1 stated, "For staff to be aware of their (resident's) plan of care, such as how they eat or drink, provide care. It gives you a picture of the resident." After review, Resident # 101's comprehensive care plan with a target date of 08/29/2019 for shortness of breath LPN # 1 was asked if the care plan was being implemented if the oxygen was not being administered at two liters per minute. LPN # 1 stated, "No."

The facility's policy "Comprehensive Person-Centered Care Planning" documented, "2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that include measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI)."

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On 06/05/19 at approximately 10:00 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(2) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.
2. The facility staff failed to implement Resident #102's comprehensive care plan for oxygen administration.

Resident #102 was admitted to the facility on 3/5/18. Resident #102's diagnoses included but were not limited to pneumonia, diabetes and muscle weakness. Resident #102's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/4/19, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #102 as requiring extensive assistance of one staff with bed mobility, toilet use and personal hygiene.

Review of Resident #102's clinical record

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revealed a physician's order dated 3/25/19 for oxygen at two liters. Resident #102's comprehensive care plan dated 5/9/18 documented, "The resident has oxygen therapy r/t (related to) shortness of breath...OXYGEN SETTINGS: 02 (oxygen) via NC (nasal cannula) @ 2LPM (liters per minute)..."

On 6/4/19 at 12:05 p.m., 3:22 p.m. and 6/5/19 at 7:48 a.m., Resident #102 was observed lying in bed receiving oxygen via a nasal cannula in the resident's nose. During each observation, the oxygen concentrator was set at a rate between one and a half and two liters as evidenced by the middle of the ball in the flow meter set between the one and a half and two-liter lines. These observations of the flow meters were conducted at eye level.

On 6/5/19 at 9:37 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked how nurses ensure oxygen is administered at the physician prescribed rate. LPN #2 stated, "Check the orders. The current ones in the computer." LPN #2 was asked where the ball in the oxygen concentrator flow meter should be positioned if a resident has a physician's order for two liters. LPN #2 stated, "You need to check it at eye level and right on the line." When asked what part of the ball should be right on the line, LPN #2 stated, "The middle." LPN #2 stated oxygen concentrators should be checked every two hours. LPN #2 stated that sometimes the concentrators get knocked when residents are transferred out of bed. LPN #2 was asked how nurses ensure they implement residents' care plans. LPN #2 stated, "We have access to it through (name of computer system). If need be we can pull it up and usually if there is

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a change, the care plan coordinator will send sticky notes to update us as well."

On 6/5/19 at 10:00 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The oxygen concentrator manufacturer's instructions documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter/minute) line prescribed."

The facility policy titled, "Comprehensive Person-Centered Care Planning" documented, "9. The resident will receive the services and/or items included in the plan of care..."

No further information was presented prior to exit.

3. The facility staff failed to implement Resident #103's comprehensive care plan for oxygen administration.

Resident #103 was admitted to the facility on 3/15/19. Resident #103's diagnoses included but were not limited to urinary tract infection, heart failure and shortness of breath. Resident #103's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/2/19, coded the resident as being cognitively intact. Section G coded Resident #103 as requiring extensive assistance of two or more staff with bed mobility and toilet use.

Review of Resident #103's clinical record revealed a physician's order dated 3/18/19 for

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oxygen at two liters. Resident #103's comprehensive care plan dated 3/21/19 documented, "OXYGEN SETTINGS: 02 (oxygen) via NC @ [at] 2LPM (liters per minute)..."

On 6/4/19 at 12:10 p.m. and 3:24 p.m., Resident #103 was observed lying in bed receiving oxygen via a nasal cannula in the resident's nose. The cannula was connected to an oxygen concentrator. During each observation, the oxygen concentrator was set at a rate between two and a half and three liters as evidenced by the middle of the ball in the flow meter set between the two and a half and three-liter lines. These observations of the flow meter were conducted at eye level.

On 6/5/19 at 9:37 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked how nurses ensure oxygen is administered at the physician prescribed rate. LPN #2 stated, "Check the orders. The current ones in the computer." LPN #2 was asked where the ball in the oxygen concentrator flow meter should be positioned if a resident has a physician's order for two liters. LPN #2 stated, "You need to check it at eye level and right on the line." When asked what part of the ball should be right on the line, LPN #2 stated, "The middle." LPN #2 stated oxygen concentrators should be checked every two hours. LPN #2 stated that sometimes the concentrators get knocked when residents are transferred out of bed. LPN #2 was asked how nurses ensure they implement residents' care plans. LPN #2 stated, "We have access to it through (name of computer system). If need be, we can pull it up and usually if there is a change, the care plan coordinator will send sticky notes to update us as well."

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{F 656}	Continued From page 8 On 6/5/19 at 10:00 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The oxygen concentrator manufacturer's instructions documented, "2. Check the flow meter to make sure that the flow meter ball is centered on the line next to the prescribed number of your flow rate." No further information was presented prior to exit.	{F 656}		
{F 695} SS=E	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, resident interview, staff interview and clinical record review and facility document review, it was determined that facility staff failed to provide respiratory care consistent with professional standards of practice, the comprehensive person-centered care plan for four of 10 residents in the survey sample, Residents # 100 and # 101, # 102, # 103. 1. The facility staff failed to store Resident #100's incentive spirometer (1) in a sanitary manner.	{F 695}	F-695 1: In this case upon notification by the surveyor of the oxygen observation the oxygen equipment for residents was adjusted to the proper setting, and the incentive spirometer was properly disposed of and nurse management checked all oxygen concentrators and reported no further incidence. 2: Current residents receiving respiratory therapy/treatments have a potential to be affected by this practice. 3: Clinical staff will be educated on policy and procedure for respiratory treatments and oxygen, with an emphasis on physician's orders, oxygen equipment settings, and proper infection control storage of personal respiratory equipment. Documentation in the electronic medical record will be implemented to record the flow meter settings for residents on oxygen every shift. Documentation will be put in place to record proper changing of respiratory storage equipment.	

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{F 695}	Continued From page 9	{F 695}	4: The director of nursing designee will audit oxygen/respiratory equipment weekly and report any discrepancies to the director of nursing to be addressed according to policy. Audit findings will be discussed at the weekly risk management meeting. Any ongoing problems will be reported to the QA committee quarterly.	

2. The facility staff failed to administer Resident # 101's oxygen according to the physician's orders.

3. The facility staff failed to administer oxygen to Resident #102 at the physician prescribed rate of two liters.

4. The facility staff failed to administer oxygen to Resident #103 at the physician prescribed rate of two liters.

The findings include:

1. The facility staff failed to store Resident #100's incentive spirometer (1) in a sanitary manner.

Resident # 100 was admitted to the facility on 12/22/2005 with a readmission of 08/23/2017 with diagnoses that included but were not limited to shortness of breath, chronic obstructive pulmonary disease (2), benign prostatic hyperplasia and angina (3).

Resident # 100's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 05/21/19, coded Resident # 100 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 100 was coded as requiring supervision with set-up for activities of daily living and dependent of one staff member for bathing.

On 06/04/19 at 11:53 a.m., 3:05 p.m., and at 7:20 a.m., an observation of Resident # 100's room revealed Resident # 100's incentive spirometer was uncovered sitting on a small folding table next to Resident # 100's bed.

5: Completion date: 06/21/2019

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The "Physician's Order" dated "5/15/19" documented, "Incentive spirometer."

The comprehensive care plan for Resident # 100 with a target date of 06/09/2019 documented, "Focus. The resident has altered respiratory status/difficulty breathing r/t (related to) COPD (chronic obstructive pulmonary disease), SOB (shortness of breath) and Hypoxemia. Date initiated: 08/24/2017." Under "Interventions/Tasks" it documented, "Encourage sustained deep breaths by: Using demonstration (emphasizing slow inhalation, holding and inspiration for a few seconds, and passive exhalation); Using incentive spirometer (place close for convenient resident use); Asking resident to yawn." Date initiated: 08/24/2017."

On 06/04/19 at 11:53 a.m., an interview was conducted with Resident # 100. When asked if he used the incentive spirometer Resident # 100 stated, "Yes."

On 04/05/19 at 7:30 a.m., an interview and observation was conducted with LPN (licensed practical nurse) # 1. When asked if a spirometer is respiratory equipment, LPN # 1 stated, "Yes." When asked how it should be stored when not in use LPN # 1 stated, "It should be bagged when not in use." LPN # 1 was asked to accompany this surveyor to Resident # 100's room. After observing the incentive spirometer on Resident # 100's bed side table LPN # 1 stated that the incentive spirometer should have been placed in a bag." LPN # 1 further stated that there was a bag for the spirometer in the drawer of the resident's bedside table. After searching through the bedside table LPN # 1 stated that there was

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not a bag for the spirometer and that she would immediately get one.

On 06/05/19 at approximately 10:00 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. By using the incentive spirometer, every 1 to 2 hours, or as instructed by your nurse or doctor, you can take an active role in your recovery and keep your lungs healthy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.

(2) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(3) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

2. The facility staff failed to administer Resident # 101's oxygen according to the physician's orders

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EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

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Resident # 101 was admitted to the facility on 07/14/2015 with a readmission of 03/24/2016 with diagnoses that included but were not limited to shortness of breath, atrial fibrillation (1), hypotension (2), and gastroesophageal reflux disease (3).

Resident # 101's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/25/19, coded Resident # 101 as scoring a 6 (six) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 6 (six) - being severely impaired of cognition for making daily decisions. Resident # 101 was coded as requiring extensive assistance of one staff member for activities of daily living and dependent of two staff members for bathing.

On 06/04/19 at 12:00 p.m., 3:05 p.m., and on 06/05/19 at 7:20 a.m., observations of Resident # 101 revealed he was lying in bed receiving oxygen from an oxygen concentrator through a nasal cannula. Observation of the flowmeter on the oxygen concentrator revealed the oxygen flow rate between two-and-a-half and three liters per minute.

The "Physician's Order Sheet" dated "06/04/2019" documented, "02 (oxygen) @ (at) 2L (two liters) via (by) n/c (nasal cannula) to maintain 02 above 90% check sat (saturation) q (every) shift. Order Date: 03/30/2018."

The comprehensive care plan for Resident # 101 with a target date of 08/29/2019 documented, "Focus. The resident has shortness of breath (SOB) at bedtime frequently. Date initiated: 03/03/2017." Under "Interventions/Tasks" it documented, "[sic] 2 @ 2L via n/c to maintain O2

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above 90% check sat Q shift."

On 04/05/19 at 7:30 a.m., an interview and observation was conducted with LPN (licensed practical nurse) # 1. When asked how an oxygen concentrator flowmeter was read, LPN # 1 stated, "The ball should be dead center on the line of what liter they're on." When asked what Resident # 101's oxygen flow rate should be LPN # 1 stated, 'It should be two liters per minute." LPN # 1 then stated she would check the physician's orders and accessed Resident # 101's HER (electronic health record). After reviewing the physician's orders for Resident # 101 on the computer LPN # 1 stated, "It should be two." After observing the flowmeter on the oxygen concentrator in Resident # 101's room LPN stated, "It's at two-and -a half." LPN # 1 then adjusted the flow rate to two liters.

The (Name of Oxygen Concentrator Manufacturer's Instructions) for Resident # 101's oxygen concentrator documented, "To properly read the flowmeter, locate the prescribe flowrate line on the flowmeter. 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 06/05/19 at approximately 10:00 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(2) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.
3. The facility staff failed to administer oxygen to Resident #102 at the physician prescribed rate of two liters.

Resident #102 was admitted to the facility on 3/5/18. Resident #102's diagnoses included but were not limited to pneumonia, diabetes and muscle weakness. Resident #102's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/4/19, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #102 as requiring extensive assistance of one staff with bed mobility, toilet use and personal hygiene.

Review of Resident #102's clinical record revealed a physician's order dated 3/25/19 for oxygen at two liters. Resident #102's comprehensive care plan dated 5/9/18 documented, "The resident has oxygen therapy r/t (related to) shortness of breath...OXYGEN SETTINGS: 02 (oxygen) via NC (nasal cannula) @ [at] 2LPM (liters per minute)..."

On 6/4/19 at 12:05 p.m., 3:22 p.m. and 6/5/19 at 7:48 a.m., Resident #102 was observed lying in bed receiving oxygen via a nasal cannula in the

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resident's nose. The nasal cannula was connected to an oxygen concentrator. During each observation, the oxygen concentrator was set at a rate between one and a half and two liters as evidenced by the middle of the ball in the flow meter set between the one and a half and two-liter lines. These observations of the flow meter were conducted at eye level.

On 6/5/19 at 9:37 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked how nurses ensure oxygen is administered at the physician prescribed rate. LPN #2 stated, "Check the orders. The current ones in the computer." LPN #2 was asked where the ball in the oxygen concentrator flow meter should be positioned if a resident has a physician's order for two liters. LPN #2 stated, "You need to check it at eye level and right on the line." When asked what part of the ball should be right on the line, LPN #2 stated, "The middle." LPN #2 stated oxygen concentrators should be checked every two hours. LPN #2 stated that sometimes the concentrators get knocked when residents are transferred out of bed.

On 6/5/19 at 10:00 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The oxygen concentrator manufacturer's instructions documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter/minute) line prescribed."

The facility policy regarding oxygen therapy documented, "All nursing/therapy staff are

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responsible for maintaining an adequate supply of oxygen to any resident requiring such."

No further information was presented prior to exit.

4. The facility staff failed to administer oxygen to Resident #103 at the physician prescribed rate of two liters.

Resident #103 was admitted to the facility on 3/15/19. Resident #103's diagnoses included but were not limited to urinary tract infection, heart failure and shortness of breath. Resident #103's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/2/19, coded the resident as being cognitively intact. Section G coded Resident #103 as requiring extensive assistance of two or more staff with bed mobility and toilet use.

Review of Resident #103's clinical record revealed a physician's order dated 3/18/19 for oxygen at two liters. Resident #103's comprehensive care plan dated 3/21/19 documented, "OXYGEN SETTINGS: 02 (oxygen) via NC @2LPM (liters per minute)..."

On 6/4/19 at 12:10 p.m. and 3:24 p.m., Resident #103 was observed lying in bed receiving oxygen via a nasal cannula in the resident's nose that was connected to any oxygen concentrator. During each observation, the oxygen concentrator was set at a rate between two and a half and three liters as evidenced by the middle of the ball in the flow meter set between the two and a half and three-liter lines. These observations of the flow meter were conducted at eye level.

On 6/5/19 at 9:37 a.m., an interview was

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{F 695}	Continued From page 17 conducted with LPN (licensed practical nurse) #2. LPN #2 was asked how nurses ensure oxygen is administered at the physician prescribed rate. LPN #2 stated, "Check the orders. The current ones in the computer." LPN #2 was asked where the ball in the oxygen concentrator flow meter should be positioned if a resident has a physician's order for two liters. LPN #2 stated, "You need to check it at eye level and right on the line." When asked what part of the ball should be right on the line, LPN #2 stated, "The middle." LPN #2 stated oxygen concentrators should be checked every two hours. LPN #2 stated that sometimes the concentrators get knocked when residents are transferred out of bed. On 6/5/19 at 10:00 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The oxygen concentrator manufacturer's instructions documented, "2. Check the flow meter to make sure that the flow meter ball is centered on the line next to the prescribed number of your flow rate." No further information was presented prior to exit.	{F 695}		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842	F-842 1: In this case upon notification by the surveyor of the inaccurate pain level documentation for residents #102 and #105 and the lack of non-pharmacological intervention documentation for resident #102 the nurses responsible were reminded of the importance of properly documenting pain levels and non-pharmacological interventions for pain management.	

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F 842	Continued From page 18 to do so §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or	F 842	2: Current residents receiving PRN pain medications have the potential to be affected by this practice. 3: Clinical staff will be educated on policy and procedure for accurate documentation of pain levels and non-pharmacological interventions. Documentation in the electronic medical record will be put in place to require documentation of non- pharmacological interventions for residents receiving PRN pain medications. 4: The director of nursing designee will audit PRN pain medication documentation weekly, and address any discrepancies immediately, and report them to the director of nursing. Audit findings will be discussed at the weekly risk management meeting. Any ongoing problems will be reported to the QA committee quarterly. 5: Completion date: 06/21/2019	

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(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of ten residents in the survey sample, Residents #102 and #105.

1. The facility staff failed to document non-pharmacological interventions that were provided to Resident #102 prior to as needed acetaminophen administration on 5/30/19 and failed to accurately document Resident #102's pain level on that same date.

2. The facility staff failed to document accurately Resident #105's pain level on 6/3/19.

The findings include:

1. The facility staff failed to document non-pharmacological interventions that were

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provided to Resident #102 prior to as needed acetaminophen (1) administration on 5/30/19 and failed to accurate document Resident #102's pain level on that same date.

Resident #102 was admitted to the facility on 3/5/18. Resident #102's diagnoses included but were not limited to pneumonia, diabetes and muscle weakness. Resident #102's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/4/19, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #102 as requiring extensive assistance of one staff with bed mobility, toilet use and personal hygiene.

Review of Resident #102's clinical record revealed a physician's order dated 1/13/19 for acetaminophen 325 mg (milligrams) - two tablets by mouth every six hours as needed for a pain level of one to five. Review of Resident #102's May 2019 MAR (medication administration record) revealed acetaminophen was administered to Resident #102 on 5/30/19 for a pain level of ten. Further review of Resident #102's clinical record (including 5/30/19 nurses' notes) failed to reveal documentation that non-pharmacological interventions were provided prior to the administration of as needed acetaminophen.

Resident #102's comprehensive care plan dated 3/5/18 documented, "Attempt non pharmacological interventions such as back rubs, distraction and hot/cold compresses for complaints of pain. Document attempted interventions..."

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On 6/5/19 at 10:20 a.m., a telephone interview was conducted with LPN (licensed practical nurse) #3 (the nurse who administered acetaminophen to Resident #102 on 5/30/19). LPN #3 stated she repositioned and applied washcloths to resident #102's forehead prior to administering acetaminophen to Resident #102 on 5/30/19. LPN #3 stated she was not sure if she documented these non-pharmacological interventions. When asked if she was supposed to document non-pharmacological interventions, LPN #3 stated she was supposed to document them in the nurses' notes. LPN #3 was also asked why she administered acetaminophen for a pain level of ten when the physician order documented to administer the medication for a pain level of one to five. LPN #3 stated she inaccurately documented the pain level and the resident's pain level was actually four or five.

On 6/5/19 at 10:00 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "POLICY FOR PAIN ASSESSMENTS" documented, "2. A numbered scale to describe pain will be used for the resident that can effectively articulate by verbal means; '0' being no pain and '10' being unbearable pain. In addition the resident will be asked the intensity, location, onset, duration, variation, and quality of the pain level experienced. This will be documented on the MAR."

No further information was presented prior to exit.

(1) Acetaminophen is used to relieve mild to moderate pain. This information was obtained

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from the website:
https://medlineplus.gov/druginfo/meds/a681004.html

2. The facility staff failed to document accurately Resident #105's pain level on 6/3/19.

Resident #105 was admitted to the facility on 5/19/19. Resident #105's diagnoses included but were not limited to right leg fracture, pain and chronic kidney disease. Resident #105's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/26/19, coded the resident as being cognitively intact. Section G coded Resident #105 as requiring extensive assistance of two or more staff with bed mobility and transfers.

Review of Resident #105's clinical record revealed a physician's order dated 6/2/19 for acetaminophen (1) 325 mg (milligrams) - two tablets by mouth every six hours as needed for a pain level of one to five. Further review of Resident #105's clinical record revealed a physician's order dated 6/2/19 for hydrocodone/acetaminophen (2) 10/325 mg- one tablet by mouth every four fours as needed for a pain level of five to ten. Review of Resident #105's June 2019 MAR (medication administration record) revealed hydrocodone/acetaminophen was administered to Resident #105 on 6/3/19 for a pain level of four. Resident #105's care plan dated 5/19/19 documented, "Administer pain medications as ordered. Document level of pain..."

On 6/5/19 at 9:37 a.m., an interview was conducted with LPN (licensed practical nurse) #2 (the nurse who administered

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hydrocodone/acetaminophen to Resident #105 on 6/3/19). LPN #2 was read the two above physician's orders and asked which medication should be administered for a pain level of four. LPN #2 stated, "The Tylenol (acetaminophen)." When asked why, LPN #2 stated, "Because the order specifies for the acetaminophen." LPN #2 was made aware that she administered hydrocodone/acetaminophen to Resident #105 for a documented pain level of four on 6/3/19. LPN #2 stated, "That must have been a data entry error." LPN #2 stated Resident #105 was in a lot of pain and tearing up when she administered hydrocodone/acetaminophen to the resident on 6/3/19.

On 6/5/19 at 10:00 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Acetaminophen is used to relieve mild to moderate pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html

(2) "Hydrocodone is a painkiller in the opioid family (related to morphine). Acetaminophen is an over-the-counter medicine used to treat pain and inflammation. They may be combined in one prescription medicine to treat pain." This information was obtained from the website: https://medlineplus.gov/ency/article/002670.htm