STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495131	A. BUILDING _____ B. WING _____	C 08/24/2018

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NHC HEALTHCARE,BRISTOL	245 NORTH STREET BRISTOL, VA 24201

(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 08/21/18 through 08/24/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	This Plan of Correction is submitted as required under State and Federal Law. The submission of this plan does not constitute an admission on the part of NHC HealthCare, Bristol as to the accuracy of the Surveyors' findings nor the conclusions drawn therefrom. The facility's submission of the Plan of Correction does not constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard and Complaint survey was conducted 08/21/18 through 08/24/18. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 107 at the time of the survey. The final survey sample consisted of 19 current resident reviews and 4 closed record reviews.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580	F-580 (E) – Notify of Changes 1. Corrective Actions Accomplished For The Residents Found To Have Been Affected By The Allegedly Deficient Practice. Resident #43 had no negative outcome as a result of this deficiency. The identified nurses responsible for not notifying the physician of blood sugars greater than 400 were in-serviced on the proper policy and procedure for insulin administration and facility's sliding scale protocol. Completed by: 9/13/18 2. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken. All diabetic residents with orders for the sliding scale protocol have the potential to be affected by the same deficient practice. All current residents on 9/12/18 with the sliding scale protocol were reviewed by the DON, ADON, and Resident Care Coordinators to identify incidents that the sliding scale protocol was not followed according to the facility policy. One other resident was identified with no adverse affects. Physician was notified 9/1/18. Licensed Nurses involved will be re-educated on proper policy and procedure for insulin administration and facility's sliding scale protocol. Completed: 9/13/18.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 9/13/18

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

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F 580	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the Physician of blood sugars greater than 400, for	F 580	Continued from previous page. 3. The Measures we Have Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Not Recur. All Licensed Nurses will be re-educated on the facility policy for safe medication administration, including the proper procedure for the facility's sliding scale protocol and physician notification. Any Partner unavailable or on leave will be in-serviced prior to their next shift worked. To be completed by: 10/11/18 4. The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur. Beginning 9/17/18, the DON or designee will perform a monthly QA study x 3 months of all patient blood sugars over 400 to ensure the proper policy and procedure for insulin administration and facility's sliding scale protocol have been followed. Results will be reported to the QA committee. The Center's Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director and Health Information Director and meets monthly. Additional in-services and/or monitoring will be determined as necessary by the Quality Assurance Committee. To be completed by: 10/11/18	

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F 580	Continued From page 2 one of 23 Residents, Resident #43. Per Clinical Record Review Resident #43 was admitted to the facility on 01/23/18. Diagnosis included, but were not limited to: Chronic, Pain, Diabetes Mellitus, Aftercare following explanation of shoulder joint prosthesis, Altered Mental Status, History of Falling, Orthostatic Hypotension, and Muscle Weakness (Generalized). Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/12/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The Residents CCP (comprehensive care plan) included the problem area; Diabetes related to the diagnosis DM (diabetes mellitus). Interventions included, but were not limited to: Administer Insulin as ordered, Rotate sites, Finger sticks as ordered, Observe for signs/symptoms of increased/decreased BS (blood sugar). Resident #43's current POS (physician order summary) included orders for sliding scale insulin before meals and at bedtime If greater than 400 recheck in 2 hours and call MD. Humalog Kwik pen insulin for a BS of 0-150 0 units, 151-200 2 units, 201-250 4 units, 251-300 6 units, 301-350 8 units, 351-400 10 units 401 or greater then 10units *MD call A review of Resident #43 EMARs (electronic medication administration records) for 08/2018 revealed that on 08/12 at 8:00p.m. the Residents BS reading was 509, 08/13 at	F 580	This page intentionally left blank.	

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F 580	Continued From page 3 4:30 p.m. the Residents BS reading was 433, 08/14 at 4:30 p.m. the Residents BS reading was 415, and 08/15 the Residents BS reading was 496. There was no documentation to indicate that the MD had been notified. 08/23/18 09:22 a.m. the record review revealed no Nursing notes or Physician notes were found to indicate the Physician was notified per order. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 580	This section intentionally left blank.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for 1 of 24 Residents in the sample survey, Resident #73. The Findings Included: For Resident #73 the facility staff failed to code/capture the use of oxygen on a 14-Day Medicare Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 8/5/18. Resident #73 was an 85-year-old female who was admitted on 7/21/18. Admitting diagnoses included, but were not limited to: fractured femur,	F 641	F-641 (D) – Accuracy of Assessments 1. Corrective Actions Accomplished For The Residents Found To Have Been Affected By The Allegedly Deficient Practice. Resident #73 had no negative out come as a result of this deficiency. The identified inaccurate Minimum Date Set (MDS) assessment of 8/5/18 for Resident #73 was updated and corrected. Completed on: 8/24/18 2. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken. All residents have the potential to be affected by the same deficient practice. All residents that have physician orders for oxygen had Section O of the MDS assessment reviewed for accuracy on 9/13/18. Two other residents were identified and their MDS assessments were corrected. Completed on: 9/13/18. 3. The Measures we Have Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Not Recur. MDS Department will be re-educated to review nurses' notes prior to completing assessments to ensure assessments are accurate and reflect services provided. To be completed by: 9/25/18	

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F 641	Continued From page 4 history of falling, chronic obstructive pulmonary disease, Alzheimer's, hypertension and dementia with behaviors. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 14-Day MDS assessment with an Assessment Reference Date (ARD) of 8/5/18. The facility staff coded that Resident #73 had short and long-term memory impairment and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #73 required extensive assistance (3/3) with ADL's. In Section O. Special Treatments and Programs, the facility staff did not code that Resident #73 was receiving oxygen. On August 24, 2018 at 11:15 a.m., the surveyor reviewed Resident #73's clinical record. Review of the clinical record produced Skilled Nurse's Notes" dated 8/3/18 and 8/5/18 that documented that Resident #73 was receiving oxygen. On August 24, 2018 at 11:20 a.m., the surveyor notified two Registered Nurse's (RN's), who were the MDS Nurse's, that Resident #73's MDS with the ARD of 8/5/18 was incorrect. The surveyor reviewed the 14-Day Medicare MDS with the ARD of 8/5/18 with two RN's (MDS Nurse's). The surveyor pointed out that Section O. Special Treatments did not code/capture Resident #73's oxygen use. The surveyor reviewed Resident #73's clinical record with the two MDS Nurse's. The surveyor and two MDS Nurse's reviewed the Skilled Nurse's Notes that documented that Resident #73 received oxygen on 8/3/18 and 8/5/18.	F 641	Continued from previous page. F-641 4. The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur. Beginning 9/17/18, the Regional Consultant or designee will perform a monthly QA study x 2 months of all patients receiving respiratory services to ensure Section O of the MDS assessments are accurate for the services provided. Results will be reported to the QA committee. The Center's Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director and Health Information Director and meets monthly. Additional in-services and/or monitoring will be determined as necessary by the Quality Assurance Committee. To be completed by: 10/11/18	

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F 641	Continued From page 5 On August 24, 2018 at 11:45 a.m., the surveyor notified the Administrator (ADM), Director of Nursing (DON) and Assistant Director of Nursing (ADON) that Resident #73's MDS with the ARD of 8/5/18 was incorrect. The surveyor notified the Administrative Team (AT) that the facility staff had not coded/captured Resident #73's use of oxygen in Section O. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure and complete and accurate MDS assessment for Resident #73. The facility staff failed to code/capture the use of oxygen on a 14-Day MDS assessment with the ARD of 8/5/18.	F 641	This section intentionally left blank.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676	F-676 (D) – Activities of Daily Living 1. Corrective Actions Accomplished For The Residents Found To Have Been Affected By The Allegedly Deficient Practice. Resident #34 had no negative outcome as a result of this deficiency. Resident #34 received oral care as requested on 8/22/18. Nurse Aide was re-educated on proper oral care by the Supervisor. Completed on: 8/22/18 The ADL documentation for Resident #34 that was in error on 8/22/18 was corrected by a late entry nurses note. Completed 9/13/18. 2. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken. All residents have the potential to be affected by the same deficient practice. Beginning 9/17/18, DON and Nurse Supervisors will interview and/or do mouth care observations of patients to ensure mouth care is being completed appropriately. 3. The Measures we Have Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Not Recur. All Nurse Aides will be re-educated by DON or designee on the facility policy and expectation of providing the necessary care and services for residents regarding oral care. Any Partner unavailable or on leave will be in-serviced prior to their next shift worked. To be completed by: 10/11/18	

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F 676	Continued From page 6 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide oral care to 1 of 23 residents (Resident #34). The findings included: The facility staff failed to provide oral care to Resident #34 on 8/22/18. The clinical record of Resident #34 was reviewed 8/21/18 through 8/24/18. Resident #34 was admitted to the facility 11/20/15 with diagnoses that included but not limited to respiratory failure, dependence on supplemental oxygen, hypertensive chronic kidney disease, stage 3, long term use of aspirin, major depressive disorder, gastro-esophageal reflux disease, constipation, pulmonary hypertension, and dysphagia.	F 676	Continued from previous page. F 676 4. The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur. Beginning 9/17/18, the DON or designee will perform a monthly QA study x 3 months consisting of patient interviews regarding staff assistance with providing necessary oral care. Results will be reported monthly to the QA committee. The Center's Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director and Health Information Director and meets monthly. Additional in-services and/or monitoring will be determined as necessary by the Quality Assurance Committee. To be completed by: 10/11/18	

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F 676	Continued From page 7 Resident #34's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/5/18 coded the resident with a BIMS (brief interview for mental status) Summary Score of 14 out of a possible 15. Section G Functional Status coded the resident needed extensive assistance of 2 plus persons for personal hygiene (combing hair, brushing teeth, shaving, applying make-up, washing/drying face and hands). Bathing required extensive assistance of one person. Resident #34's current comprehensive care plan updated 7/16/18 included the care area for ADL (activities of daily living) related to impaired vision, generalized muscle weakness. Interventions: Assist with ADL/meals per patient need and preferences. The surveyor interviewed Resident #34 on 8/22/18 at 2:21 p.m. During the interview, the surveyor asked the resident how often she received a shower. The resident stated she got showers two times a week. The surveyor then asked how often she brushed her teeth and Resident #34 stated "My teeth are brushed on my bath days-two times a week." The surveyor was seated beside the resident in a chair. Resident #34 was lying in bed. The surveyor was close enough to the resident to smell her breath, which was not pleasant. The surveyor asked Resident #34 if she had brushed her teeth today and she stated "No." The surveyor informed the unit manager registered nurse #1 on 8/22/18 at 2:31 p.m. and asked her to come with the surveyor to observe the resident. The resident told both the surveyor and the unit manager that she only gets her teeth brushed on bath days. The unit manager	F 676	This page intentionally left blank.	

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F 676	Continued From page 8 registered nurse #1 stated she would address the issue with the staff. The surveyor and the unit manager registered nurse #1 reviewed the "Results List" for Resident #34. The question "Was oral care completed? The box was marked yes for 8/22/18 at 11:07 a.m. The surveyor informed the assistant director of nursing of the above concern on 8/23/18 at 9:18 a.m. and requested the August 2018 ADL (activities of daily living) sheets. On the ADL sheet for 8/22/18 at 11:07 a.m., the certified nursing assistant had charted oral care was provided which it had not been. The ADON stated the unit manager was in-servicing the CNAs and the ADON expected the certified nursing assistants to provide oral care. The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the regional nurse consultant of the above concern during the end of the day meeting on 8/23/18 at 4:01 p.m. No further information was provided prior to the exit conference on 8/24/18.	F 676	This section intentionally left blank.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684	F-684 (D) – Quality of Care 1. Corrective Actions Accomplished For The Residents Found To Have Been Affected By The Allegedly Deficient Practice. When identified, staff replaced the oxygen tank for Resident #73 on 8/21/18. The identified nurses responsible for not following physician orders when the patient was asleep will be re-educated by Resident Care Coordinators on the proper policy and procedure for medication and treatment administration on or before 9/25/18.	

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F 684	Continued From page 9 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to follow physician orders for 2 of 24 Residents in the sample survey, Resident #73 and Resident #393. The Findings Included: 1. For Resident #73 the facility staff failed to administer oxygen at 4 liters per minute and failed to administer physician ordered Divalproex and Ipratropium-Albuterol. Resident #73 was an 85-year-old female who was admitted on 7/21/18. Admitting diagnoses included, but were not limited to: fractured femur, history of falling, chronic obstructive pulmonary disease, Alzheimer's, hypertension and dementia with behaviors. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 14-Day MDS assessment with an Assessment Reference Date (ARD) of 8/5/18. The facility staff coded that Resident #73 had short and long-term memory impairment and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #73 required extensive assistance (3/3) with ADL's. On August 21, 2018 at 6:07 p.m., the surveyor observed Resident #73 sitting in a reclining Geri-chair in the dining room. Resident #73 had a nasal cannula in her nose and an oxygen tank	F 684	Continued from previous page. F-684 2. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken. All residents have the potential to be affected by the deficient practice. All residents oxygen tanks were checked on 8/21/18. No other residents were affected. All in-house residents on 9/11/18 were reviewed for any pain medications not given when the patient was asleep. No other residents were identified. 3. The Measures we Have Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Not Recur. All nursing staff will be re-educated by the DON or designee on the importance of checking oxygen tank levels routinely and to replace as needed. To be completed by 10/11/18. All licensed nursing staff will be re-educated by the DON or designee on the facility expectation and proper procedure for the following physician orders. Any Partner unavailable or on leave will be in-serviced prior to their next shift worked. To be completed by: 10/11/18 4. The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur. Beginning 9/17/18, the DON or designee will perform a monthly QA study x 2 months to ensure oxygen tanks are not empty and that residents with respiratory related orders are being followed as ordered by the Physician. Results will be reported monthly to the QA committee. The Center's Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director and Health Information Director and meets monthly. Additional in-services and/or monitoring will be determined as necessary by the Quality Assurance Committee. To be completed by: 10/11/18	

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F 684	Continued From page 10 on the back of her wheelchair. The dial for oxygen in the tank was in the red, reflecting that the oxygen tank was low on oxygen. The surveyor asked Resident #73 remove her nasal cannula for the surveyor to determine if oxygen was being delivered. Resident #73 removed the nasal cannula from her nose and the surveyor held her hand in front of the nasal cannula and did not feel any oxygen coming from the tank. The surveyor alerted the Unit Manager (UM), who was a Registered Nurse (RN), that Resident #73 was not getting any oxygen. The UM (RN) went to get a tank of oxygen and a Certified Nursing Assistant (C.N.A.) came and obtained Resident #73's oxygen saturation (O2 Sat). Resident #73's O2 Sat was 83%. On August 21, 2018 at 6:25 p.m., the surveyor observed Resident #73 in the day room. A C.N.A. was setting up Resident #73's supper tray. The surveyor asked the C.N.A. if Resident #73's O2 sat had been repeated. The C.N.A. replied that Resident #73's O2 sat had been repeated and was 89%. On August 22, 2018 at 1:05 p.m., the surveyor reviewed Resident #73's clinical record. Review of the clinical record produced signed physician orders dated 7/21/18. Signed physician orders included, but where not limited to: "Ipratropium-albuterol 0.5mg-3mg (2.5 mg base)/3 Ml Neb (nebulizer) (IPRATROPIUM BROMIDE/ALBUTEROL SULFATE) 1 ampul (ampule) nebulization every 6 hours 30 day supply no refill. Divalproex 125 mg sprinkle capsule (DIVALPROEX SODIUM) 2 capsule, sprinkle by mouth every 8 hours. OXYGEN [TAR] (Treatment Administration Record) As Needed every shift As Needed SHORTNESS OF	F 684	This page intentionally left blank.	

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F 684	Continued From page 11 BREATH **4 L (liters) NC (nasal cannula) *** as needed as tolerated." (sic) Continued review of the clinical record revealed Resident #73's August 2018 Medication Administration Records (MAR's). The August 2018 MAR's documented that Resident #73's Divalproex 125 mg was not given on 8/2/18 at 2 a.m. The facility staff documented that Resident #73 was a sleep. Further review of the August 2018 MAR's documented that the Ipratropium-Albuterol was not administered on August 5, 2018 at 4 a.m. The facility staff documented that Resident #73 was asleep. The surveyor observed the physician orders once again and did not observe a physician ordered to hold/not give the medications if Resident #73 was sleeping. On August 22, 2018 at 2:48 p.m., the surveyor notified a Licensed Practical Nurse (LPN) that Resident #73's Depakote was not given on 8/2/18 at 2 a.m., and that the Ipratropium-Albuterol was not given on 8/05/18 at 4 a.m. The surveyor notified the LPN that the facility staff had documented that the medication was not given as Resident #73 was sleeping. The surveyor reviewed Resident #73's clinical record with the LPN. The surveyor pointed out that the physician orders did not give an order to hold/not administer the medications. The surveyor then reviewed the August 2018 MAR's with the LPN. The surveyor informed the LPN that the physician had not given an order to hold the medications. The LPN stated, "I see that now."	F 684	This page intentionally left blank.	

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F 684	Continued From page 12 On August 23, 2018 at 3:53 p.m., the surveyor notified the Administrator (ADM), Director of Nursing (DON), Assistant Director of Nursing (ADON) and Assistant Regional Manager (ARM) that the facility staff had not followed physician orders for Resident #73. The surveyor notified the Administrative Team (AT) that the facility staff had not administered Resident #73's oxygen as ordered by the physician. The surveyor also notified the AT that the facility staff had held/not administered the physician ordered Divalproex and Ipratropium-Albuterol. The surveyor notified the AT that the facility staff documented that Resident #73 was asleep. The surveyor notified the AT that the facility staff did not have orders to hold/not administer the medications. No additional information was provided prior to exiting the facility as to why the facility staff failed to follow physician orders for the administration of oxygen and medications for Resident #73. 2. For Resident #393 the facility staff failed to administer the Residents hypertensive medication Lisinopril as ordered by the Physician. The order was for one time per day and the facility failed to administer medication on 08/12/18 at 8:00 A.M. The record review revealed that Resident #393 had been admitted to the facility 08/06/18. Diagnosis included, but were not limited to, Aftercare following joint replacement surgery, Presence of Right artificial knee joint, Long term (current) anticoagulants, Muscle weakness (generalized), Essential (primary) hypertension, and Type 2 diabetes mellitus without complications. Resident's admission MDS (minimum data set) assessment unavailable due to the Resident	F 684	This page intentionally left blank.	

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F 684	Continued From page 13 being a new admission. Resident #393 current POS (physician order summary) included orders for Lisinopril 10mg tablet (LISINOPRIL) 1 tablet by mouth 1 time per day DX (diagnosis): HYPERTENSION with an order date 08/06/18. A review of Resident #393 EMARs (electronic medication administration records) for 08/2018 revealed that Lisinopril was not administered on 08/12/18 at 8:00 A.M. The EMAR was coded with an "X" on 08/12/18 at 8:00 A.M. The "X" indicating medication not given due to "Special Requirement Parameters". Per Clinical Record Review no Nursing notes or Physician's orders were noted to hold medication. Per random review of the Residents blood pressures, last completed blood pressure was performed prior to scheduled Lisinopril administration on 08/11/2018 at 9:37pm results of blood pressure were documented as 100/56 sitting. There were no HOLD orders for Lisinopril that require Lisinopril to be held for certain parameters. No Vital signs were obtained on the morning of August 12th and the medication was scheduled to be given at 8:00am. 08/23/18 12:50 PM Surveyor spoke to ADON (assistant director of nursing) to obtain records and report concerns. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684	This section intentionally left blank. F - 695 Continued on next page	
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		

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F 695 SS=E	Continued From page 14 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, clinical record review and facility document review it was determined that the facility staff failed to store respiratory equipment in a clean and sanitary manner for 6 of 24 Residents in the sample survey, Resident #73, Resident #19, Resident #29, Resident #32, Resident #34 and Resident #68. The Findings Included: 1. For Resident #73 the facility staff failed to store a nasal cannula and a nebulizer in a clean and sanitary manner. Resident #73 was an 85 year old female who was admitted on 7/21/18. Admitting diagnoses included, but were not limited to: fractured femur, history of falling, chronic obstructive pulmonary disease, Alzheimer's, hypertension and dementia with behaviors. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 14-Day MDS assessment with an Assessment Reference Date (ARD) of 8/5/18. The facility staff coded that Resident #73 had short and long-term	F 695	F-695 - Continued from previous page. F-695 (E) – Respiratory/Tracheostomy Care and Suctioning 1. Corrective Actions Accomplished For The Residents Found To Have Been Affected By The Allegedly Deficient Practice. Resident #73: O2 tubing was replaced and nebulizer mask cleaned and bagged on 8/21/18. Resident #19: Nebulizer mask was cleaned and bagged on 8/21/18. Resident #29, #32, #34, and #68 had their concentrators filters replaced on 8/21/18 2. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken. All residents receiving respiratory services have the potential to be affected by the same deficient practice. All patient O2 concentrator filters were cleaned and/or replaced on 8/21/18. All residents using O2 tanks were checked and replaced if necessary on 8/21/18. All residents with nebulizer masks were reviewed to ensure they were properly stored on 8/21/18. 3. The Measures we Have Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Not Recur. All nursing staff will be re-educated by the DON or designee on the facility expectation and proper procedure for storing and maintaining respiratory equipment. Any Partner unavailable or on leave will be in-serviced prior to their next shift worked. To be completed by: 10/11/18. Nursing staff will receive one on one re-education for any further incidents identified. Beginning 9/17/18, Central Supply staff or designee will clean and/or replace oxygen concentrator filters weekly. 4. The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur. Beginning 9/17/18, the DON or designee will perform a monthly QA study x 3 months consisting of weekly audits of respiratory equipment being stored properly and equipment filters clean to identify further incidents. Results will be reported monthly to the QA committee. The Center's Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director and Health Information Director and meets monthly. Additional in-services and/or monitoring will be determined as necessary by the Quality Assurance Committee. To be completed by: 10/11/18	

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F 695	Continued From page 15 memory impairment and was severely impaired (3) with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #73 required extensive assistance (3/3) with ADL's. In Section O. Special Treatments and Programs, the facility staff did not code that Resident #73 was receiving oxygen. On August 21, 2018 at 1:47 p.m. the survey made an initial tour of the unit that Resident #73 resided on. The surveyor observed Resident #73's room and observed Resident #73 bed lines were pulled down. The surveyor observed an oxygen nasal cannula lying on top of the sheet and in direct contact with the sheet. The surveyor also observed a nebulizer on top of the bedside table. The nebulizer was not covered and was indirect contact with the top of the bedside table. On August 21, 2018 at 3:30 p.m., the surveyor observed Resident #73's room. The surveyor observed that the nasal cannula was still lying on the bed linens and that the nebulizer was still lying on the bedside table and in direct contact with the table. On August 22, 2018 at 1:05 p.m., the surveyor reviewed Resident #73's clinical record. Review of the clinical record produced signed physician orders dated 7/21/18. Signed physician orders included, but where not limited to: "Oxygen [TAR] (Treatment Administration Record) As Needed every shift As Needed SHORTNESS OF BREATH **4 L (liters) via NC (Nasal Cannula) ***As needed as tolerated. Dx (diagnoses) ADMIT," (sic) On August 21, 2018 at 6:14 p.m., the surveyor	F 695	This page intentionally left blank.	

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F 695	Continued From page 16 notified the Unit Manager (UM), who was a Registered Nurse (RN), that Resident #73's oxygen cannula and nebulizer were not stored in a clean and sanitary manner. The surveyor notified the RN (UM) that Resident #73's nasal cannula was lying on top of the bed linens and the nebulizer was lying on the bedside table. The surveyor asked the RN (UM) if the nasal cannula and nebulizer were supposed to be kept in plastic bags when not in use and the RN (UM) stated, "Yes.). The surveyor requested the facility policy and procedure for storage of oxygen equipment when not in use. August 23, 2018 at 11:40 a.m., the surveyor notified the Assistant Director of Nursing (ADON) that Resident #73's oxygen nasal cannula and nebulizer were not being stored in a clean and sanitary manner when not in use. The surveyor requested the facility policy and procedure for storage of oxygen equipment when not in use. On August 23, 2018 at 3:53 p.m., the surveyor notified the Administrator (ADM), Director of Nursing (DON), ADON and Assistant Regional Manager (ARM) that Resident #73's oxygen was not stored in a clean and sanitary manner. The surveyor notified the Administrative Team (AT) that Resident #73's nasal cannula and nebulizer equipment was lying out and on top of bed linens and tabletop. On August 24, 2018 at 9:50 a.m., the ADON hand delivered the facility policy and procedure titled, "Respiratory Therapy Equipment." The policy and procedure read in part ..."3. Respiratory equipment (i.e., nasal cannula, aerosols, etc.) at bedside will be covered with a plastic bag when not in use."	F 695	This page intentionally left blank.	

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

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F 695	Continued From page 17 No additional information was provided prior to exiting the facility as to why the facility staff failed to stored oxygen equipment in a clean and sanitary manner for Resident #73. 2. The facility staff failed to ensure the oxygen filter on Resident #32's oxygen (O2) concentrator was clean. The clinical record of Resident #32 was reviewed 8/21/18 through 8/24/18. Resident #32 was admitted to the facility 7/14/17 with diagnoses that included but not limited to diastolic heart failure, atherosclerotic heart disease, atrial fibrillation, hyperlipidemia, chronic obstructive pulmonary disease (COPD), fall history, weakness, hypothyroidism, edema, and dementia without behavioral disturbances. Resident #32's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/2/18 assessed the resident with a BIMS (brief interview for mental status) Summary Score of 15 out of a possible 15. Section O Treatments, Procedures and Programs was coded for oxygen therapy. Resident #32's current comprehensive care plan identified the care area/problem of impaired respiratory function updated 1/16/18. Interventions: Oxygen 3 l/m (liters per minute) via nasal cannula as tolerated per order. Resident #32's physician order summary dated 8/1/-8/22/18 read "Oxygen every shift**3 LPM (liters per minute) via NC (nasal cannula) as tol (tolerated) Dx: (diagnosis) COPD." The surveyor observed Resident #32 during the	F 695	This page intentionally left blank.	

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F 695	Continued From page 18 initial tour on 8/21/18 around 1:54 p.m. Resident #32 was in bed. Next to the bed, was an oxygen concentrator with the setting on 3 Liters. The O2 tubing was dated 8/19/18; however, the oxygen filter had a white debris on the charcoal colored filter. The surveyor showed the unit manager registered nurse #1 the filter. She stated the air filter needed to be cleaned, took it out, washed it with soap and water and replaced it. The surveyor requested the facility policy on cleaning the air filters on the oxygen concentrators. The unit manager R.N. #1 called the assistant director of nursing (ADON) on 8/21/18 at 4:05 p.m. for the facility policy on care of oxygen concentrators. The unit manager registered nurse #1 stated the filters need to be cleaned when the tubing is changed. The surveyor reviewed the facility policy titled "Supplemental Oxygen" on 8/22/18. The policy read in part "Infection Control: 2. Check and clean concentrator filter weekly. Clean with warm water and mild soap, pat dry with paper towel." The surveyor informed the administrator, the director of nursing, the assistant director of nursing and the regional nurse of the above concern during the end of the day meeting on 8/23/18 at 4:01 p.m. No further information was provided prior to the exit conference on 8/24/18. 3. The facility staff failed to ensure Resident #34's oxygen concentrator filter was clean.	F 695	This page intentionally left blank.	

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F 695	Continued From page 19 The clinical record of Resident #34 was reviewed 8/21/18 through 8/24/18. Resident #34 was admitted to the facility 11/20/15 with diagnoses that included but not limited to respiratory failure, dependence on supplemental oxygen, hypertensive chronic kidney disease, stage 3, long term use of aspirin, major depressive disorder, gastro-esophageal reflux disease, constipation, pulmonary hypertension, and dysphagia. Resident #34's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/5/18 coded the resident with a BIMS (brief interview for mental status) Summary Score of 14 out of a possible 15. Resident #34's current comprehensive care plan updated 4/18/18 included the care area of respiratory related to Dx (diagnosis) of CHF (congestive heart failure), Respiratory Failure, Pulmonary fibrosis, and interstitial pulmonary disease. Interventions: Oxygen: 2 LPM (liters per minute) BNC (by nasal cannula) as patient tolerates per order." The 8/1/18 through 8/22/18 physician order summary included orders for Oxygen at 2 LPM as patient tolerates for shortness of breath. The surveyor observed Resident #34 during the initial tour on 8/21/18 around 1:54 p.m. Resident #34 was in bed. Next to the bed, was an oxygen concentrator with the setting on 2 liters. The O2 tubing was dated 8/19/18; however, the oxygen filter had a white debris on the charcoal colored filter. The surveyor showed the unit manager registered nurse #1 the filter. She stated the air filter needed to be cleaned, took it out, washed it	F 695	This page intentionally left blank.	

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F 695	Continued From page 20 with soap and water and replaced it. The surveyor requested the facility policy on cleaning the air filters on the oxygen concentrators. The unit manager R.N. #1 called the assistant director of nursing (ADON) on 8/21/18 at 4:05 p.m. for the facility policy on care of oxygen concentrators. The unit manager registered nurse #1 stated the filters need to be cleaned when the tubing is changed. The surveyor reviewed the facility policy titled "Supplemental Oxygen" on 8/22/18. The policy read in part "Infection Control: 2. Check and clean concentrator filter weekly. Clean with warm water and mild soap, pat dry with paper towel." The surveyor informed the administrator, the director of nursing, the assistant director of nursing and the regional nurse of the above concern during the end of the day meeting on 8/23/18 at 4:01 p.m. No further information was provided prior to the exit conference on 8/24/18. 4. The facility staff failed to ensure the filter on Resident #29's oxygen concentrator was clean. The surveyor reviewed the clinical record of Resident #29 8/21/18 through 8/24/18. Resident #29 was admitted to the facility 10/27/2011 with diagnoses that included but not limited to intervertebral disc degeneration, lumbar region, type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), hypokalemia, hypothyroidism, Vitamin B deficiency, major	F 695	This page intentionally left blank.	

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F 695	Continued From page 21 depressive disorder, and anxiety. Resident #29's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/2/18 assessed the resident with a BIMS (brief interview for mental status) as 15 out of a possible 15. Resident #29's current comprehensive care plan identified the care area/problem of impaired respiratory function related to dx (diagnosis) of heart failure, COPD, and sleep apnea. Interventions: Oxygen: 2 LPM (liters per minute) as patient tolerates (updated 1/9/18). Resident #29's current physician orders for 8/1/18 through 8/22/18 read in part "Oxygen as needed every shift as needed shortness of breath 2 L (liters) nasal cannula as patient tolerates, to maintain O2 sat (saturation) above 90%." During the initial tour on 8/21/18 beginning at 1:54 p.m., Resident #29 was observed sitting in her wheelchair. Her oxygen concentrator was not in use currently. Resident #29 stated she usually needed the oxygen at bedtime. With Resident #29's permission, the oxygen concentrator's filter was checked. The filter had an accumulation of white debris on the charcoal colored filter. The surveyor informed the unit manager registered nurse #1 on 8/21/18. The unit manager registered nurse #1 observed the filter and stated "I'll take care of that." The surveyor requested the facility policy on cleaning the air filters on the oxygen concentrators. The unit manager R.N. #1 called the assistant director of nursing (ADON) on 8/21/18 at 4:05 p.m. for the facility policy on care	F 695	This page intentionally left blank.	

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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
F 695	Continued From page 22 of oxygen concentrators. The unit manager registered nurse #1 stated the filters need to be cleaned when the tubing is changed. The surveyor reviewed the facility policy titled "Supplemental Oxygen" on 8/22/18. The policy read in part "Infection Control: 2. Check and clean concentrator filter weekly. Clean with warm water and mild soap, pat dry with paper towel." The surveyor informed the administrator, the director of nursing, the assistant director of nursing and the regional nurse of the above concern during the end of the day meeting on 8/23/18 at 4:01 p.m. No further information was provided prior to the exit conference on 8/24/18. 5. The facility staff failed to ensure the filter on Resident #68's oxygen concentrator was clean. The clinical record of Resident #68 was reviewed 8/21/18 through 8/24/18. Resident #68 was admitted to the facility 5/1/18 with diagnoses that included but not limited to hypertensive heart disease with heart failure, atrial fibrillation, muscle weakness, chronic obstructive pulmonary disease (COPD), type 2 diabetic neuropathy, and long term use of aspirin. Resident #68's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 8/1/18 assessed the resident with a BIMS (brief interview for mental status) Summary Score of 15 out of 15. Oxygen therapy was coded in Section O Special Treatments, Procedures and	F 695	This page intentionally left blank.	

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	495131	A. BUILDING _____ B. WING _____	C 08/24/2018

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F 695	Continued From page 23 Programs. Resident #68's current comprehensive care plan was updated 5/21/18 for the care area of impaired respiratory function. Interventions: 4 L (liters) NC (nasal cannula). The physician order summary for 8/1/18 through 8/22/18 included an order for oxygen every shift 4 L per NC as patient tolerates. During the initial tour on 8/21/18 beginning at 1:54 p.m., Resident #68 was observed in bed. The reading on the oxygen concentrator was positioned on 4 liters. With Resident #68's permission, the oxygen concentrator's filter was checked. The filter had an accumulation of white debris on the charcoal colored filter. The surveyor informed the unit manager registered nurse #1 on 8/21/18 at 4:10 p.m. The unit manager registered nurse #1 observed the filter and stated the filter should be cleaned when the tubing is changed every Sunday. The surveyor requested the facility policy on cleaning the air filters on the oxygen concentrators. The unit manager R.N. #1 called the assistant director of nursing (ADON) on 8/21/18 for the facility policy on care of oxygen concentrators. The unit manager registered nurse #1 stated the filters need to be cleaned when the tubing is changed. The surveyor reviewed the facility policy titled "Supplemental Oxygen" on 8/22/18. The policy read in part "Infection Control: 2. Check and clean concentrator filter weekly. Clean with warm	F 695	This page intentionally left blank.	

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F 695	Continued From page 24 water and mild soap, pat dry with paper towel." The surveyor informed the administrator, the director of nursing, the assistant director of nursing and the regional nurse of the above concern during the end of the day meeting on 8/23/18 at 4:01 p.m. No further information was provided prior to the exit conference on 8/24/18. 6. The facility staff failed to ensure the nebulizer facemask of Resident #19 was stored in a plastic bag. The clinical record of Resident #19 was reviewed 8/21/18 through 8/24/18. Resident #19 was admitted to the facility 7/21/17 with diagnoses that included but not limited to peripheral vascular disease, atherosclerosis of left leg with ulceration, chronic embolism and thrombosis of left popliteal vein, long-term use of anticoagulants, muscle weakness, pain in left foot, and chronic kidney disease stage 4. Resident #19's 14 (fourteen) day MDS (minimum data set) with ARD (assessment reference date) of 8/6/18 assessed the resident with a BIMS (brief interview for mental status) of 15 out of 15 in Section C Cognitive Patterns. Resident #19's current comprehensive care plan was updated 7/5/18 for the care area of impaired respiratory function. Interventions: Administer medications per order: ipratropium albuterol, Lasix. Resident #19's physician order summary was reviewed and included an order for	F 695	This page intentionally left blank.	

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F 695	Continued From page 25 Ipratropium-albuterol 0.5 mg (milligrams)-3 mg (2.5 mg base)/3 ml (milliliter) Neb (nebulizer) solution 1 ampul nebulization every 6 hours-start date 6/15/18. The surveyor observed Resident #19 during the initial tour on 8/21/18 at 1:54 p.m. Resident #19 was sitting in a wheelchair and reading a book. A nebulizer machine was observed on the nightstand behind her. The nebulizer facemask was sitting in the machine but was not in a plastic bag. The surveyor interviewed Resident #19 on 8/21/18 at 3:30 p.m. and asked if the mask was stored in a plastic bag. Resident #19 stated she had no bags in any of the drawers and had not seen staff put the mask in a plastic bag. The surveyor showed the unit manager registered nurse #1 the nebulizer facemask on 8/21/18 at 3:47 p.m. and asked if the facemask needed to be in a plastic bag. She stated facemask are to be in a bag when not in use. The surveyor requested the facility policy on the storage of nebulizer equipment when not in use by the resident. The surveyor reviewed the facility policy titled "Infection Control Manual Respiratory". The policy read in part "3. Respiratory equipment (i.e., nasal cannula, aerosols, etc.) at bedside will be covered with a plastic bag when not in use." The surveyor informed the administrator, the director of nursing, the assistant director of nursing and the regional registered nurse of the above issue during the end of the day meeting on 8/23/18 at 4:01 p.m.	F 695	This page intentionally left blank.	

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F 695	Continued From page 26 No further information was provided prior to the exit conference on 8/24/18.	F 695	F-697 (E) – Pain Management 1. Corrective Actions Accomplished For The Residents Found To Have Been Affected By The Allegedly Deficient Practice.	
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. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders in regards to pain management for one of 23 Residents, Resident #43. The findings included: Per Clinical Record Review Resident #43 was admitted to the facility on 01/23/18. Diagnosis included, but were not limited to, Chronic, Pain, Diabetes Mellitus, Aftercare following explanation of shoulder joint prosthesis, Altered Mental Status, History of Falling, Orthostatic Hypotension, and Muscle Weakness (Generalized). Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/12/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The Residents CCP (comprehensive care plan) included the problem area; Comfort/Pain related	F 697	The identified licensed nurses responsible for not following physician orders when Resident # 43 was asleep will be re-educated by 9/25/18 on the proper policy and procedure for medication and treatment administration. There was no adverse affect to Resident #43. 2. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken. All residents receiving medications have the potential to be affected. All in-house residents on 9/11/18 were reviewed for any pain medications not given when the patient was asleep. No other residents were identified. 3. The Measures we Have Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Not Recur. All licensed nursing staff will be re-educated by the DON or designee on the facility expectation and proper procedure for medication administration and physician notification. Any Partner unavailable or on leave will be in-serviced prior to their next shift worked. To be completed by: 10/11/18. 4. The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur. Beginning 9/17/18, the DON or designee will perform a monthly QA study x 3 months consisting of weekly reviews of all medications not given to identify any deficient practices. Results will be reported monthly to the QA committee. The Center's Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director and Health Information Director and meets monthly. Additional in-services and/or monitoring will be determined as necessary by the Quality Assurance Committee. To be completed by: 10/11/18	

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F 697	Continued From page 27 to the diagnosis Fracture, Chronic Pain Syndrome, Fibromyalgia and Restless Legs Syndrome. Interventions included, but were not limited to, Administer medications as ordered and assess for effectiveness, Administer Norco, Tylenol, butalbital/acetaminophen-caffeine, and Neurontin per order, and Assess for pain. Resident #43 current POS (physician order summary) included order for Hydrocodone-Acetaminophen 10mg-325mg tablet (HYDROCODONE BIT/ ACETAMINOPHEN) 1 tablet by mouth every 6 hours #120 DX (diagnosis): CHRONIC PAIN with an order date of 01/24/18. A review of Resident #43 EMARs (electronic medication administration records) for 08/2018 revealed that Hydrocodone was not administered on 8/10, 8/11, 8/15, or 8/16 at 2:00am. The EMAR was coded with an "X" on 8/10, 8/11, 8/15, and 8/16 at 2:00am. The "X" indicating the Resident was asleep. Per Clinical Record Review no Nursing notes or Physician's orders were noted to hold medication. 08/23/18 09:45 AM Surveyor spoke to ADON (assistant director of nursing) to obtain records and report concerns. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 697	This section intentionally left blank.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F 757	F-757 (D) – Drug Regimen is Free from Unnecessary Drugs. Continued on next page.	

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F 757	Continued From page 28 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 23 residents (Resident #35) was free of an unnecessary medication. The findings included: The facility staff failed to follow the diabetic protocol for management of Resident #35's sliding scale insulin. The clinical record of Resident #35 was reviewed 8/21/18 through 8/24/18. Resident #35 was admitted to the facility 12/1/2016 with diagnoses that included but not limited to dementia with behavioral disturbances, weakness,	F 757	F-757 (D) – Drug Regimen is Free from Unnecessary Drugs. 1. Corrective Actions Accomplished For The Residents Found To Have Been Affected By The Allegedly Deficient Practice. Resident #35 did not have any negative outcome from the deficient practice identified. The Nurse responsible for not notifying the physician of blood sugars greater than 400 were in-serviced on 8/24/2018 on the proper policy and procedure for insulin administration and facility's sliding scale protocol. 2. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Taken. All diabetic residents with orders for the sliding scale protocol have the potential to be affected by the same deficient practice. All current residents on 9/12/18 with the sliding scale protocol were reviewed by the DON, ADON, and Resident Care Coordinators to identify incidents that the sliding scale protocol was not followed according to the facility policy. One other resident was identified with no adverse affects. Physician was notified 9/1/18. Licensed Nurses involved will be re-educated on proper policy and procedure for insulin administration and facility's sliding scale protocol. Completed: 9/13/18. 3. The Measures we Have Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Not Recur. All Licensed Nurses will be re-educated on the facility policy for safe medication administration, including the proper procedure for the facility's sliding scale protocol and physician notification. Any Partner unavailable or on leave will be in-serviced prior to their next shift worked. Nursing staff will receive one on one re-education for any further incidents identified. To be completed by: 10/11/18. 4. The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur. Beginning 9/17/18, DON or designee will perform a monthly QA study x 3 months of all patient blood sugars over 400 to ensure the proper policy and procedure for insulin administration, facility's sliding scale protocol and physician notification have been followed. Results will be reported monthly to the QA committee. The Center's Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director and Health Information Director and meets monthly. Additional in-services and/or monitoring will be determined as necessary by the Quality Assurance Committee. To be completed by: 10/11/18	

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F 757	Continued From page 29 hypertension, type 2 diabetes mellitus, long-term use of insulin, dorsalgia, dysphagia, and muscle weakness. Resident #35's 5 day MDS (minimum data set) with an ARD (assessment reference date) of 6/11/18 assessed the resident to have short-term memory problems, long-term memory problems, and severely impaired cognitive skills for daily decision-making. Resident #35's current comprehensive care plan was updated 2/20/18 for the care area of diabetes. Interventions: Observe for signs/symptoms of increased/decreased blood sugar. The 6/1/18 through 6/30/18 physician's order sheet was reviewed. Resident #35's orders included: Humalog 100 unit/ml (milliliter) Sub-Q (Insulin Lispro) Units per sliding scale subq (subcutaneous) before meals and at bedtime: If greater than 400 recheck in 2 hours and call MD (medical doctor) Blood Glucose Check Site Location 0-150=0 units 151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units 401 or greater than 10 units * MD call Dx (diagnosis): Diabetes Mellitus The surveyor reviewed the June 2018 electronic medication administration record (eMAR). The blood sugar result on 6/5/18 at 11:00 a.m. was recorded as 410. Based on the sliding scale protocol, Resident #35 should have had his blood	F 757	This page intentionally left blank.	

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F 757	Continued From page 30 sugar rechecked in 2 hours after he received the 10 units of sliding scale Humalog. The surveyor informed the unit manager registered nurse #1 on 8/23/18 at 2:00 p.m. of the surveyor's inability to locate the results of the blood sugar that should have been rechecked around 1:00 p.m. on 6/5/18. The unit manager registered nurse #1 reviewed the eMARs and the progress notes but was unable to locate the results. The surveyor interviewed the family nurse practitioner on 8/23/18 at 2:48 p.m. The nurse practitioner stated she could see in her computer all of Resident #35's blood glucose results but stated she didn't have one recorded for 6/5/18 around 1:00 p.m. The unit manager registered nurse #1 stated Resident #35's blood sugar was obtained but the nurse did not document what the results were or document that she had informed the physician. As part of my defense, his blood sugar had dropped from 410 at 11:00 a.m. to in the 200's at 4:30 p.m. The surveyor informed the administrator, the director of nursing, the assistant director of nursing and the regional registered nurse of the above concern in the end of the day meeting on 8/23/18 at 4:01 p.m. No further information was provided prior to the exit conference on 8/24/18.	F 757	This section intentionally left blank.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842	F-842 (D) – Resident Records-Identifiable Information. Continued on next page.	

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

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F 842	Continued From page 31 §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 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.	F 842	F-842 (D) – Resident Records- Identifiable Information. 1. Corrective Actions Accomplished For The Residents Found To Have Been Affected By The Allegedly Deficient Practice. Resident #43 medication review was completed timely on 2/7/18 but not scanned into the electronic medical record. It was scanned into the record on 8/24/18. Resident #34 received oral care as requested on 8/22/18. Nurse Aide was re-educated on proper oral care by the Supervisor. Completed on: 8/22/18 The ADL documentation for Resident #34 that was in error on 8/22/18 was corrected by a late entry nurses note. Completed 9/13/18. 2. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken. All residents have the potential to be affected by the same deficient practice. All current residents on 9/13/18 were reviewed to ensure that medication reviews were completed and in the medical record. No other residents were identified. Beginning 9/17/18, DON and Nurse Supervisors will interview and/or do mouth care observations of patients to ensure mouth care is being completed appropriately. 3. The Measures we Have Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Not Recur. Beginning 9/17/18, the Pharmacy Consultant will begin scanning medication reviews into the medical record weekly to ensure all medication reviews are on the medical record timely. All Nurse Aides will be re-educated by DON or designee on the facility policy and expectation of providing the necessary care and services for residents regarding oral care. Any Partner unavailable or on leave will be in-serviced prior to their next shift worked. To be completed by: 10/11/18 4. The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur. Beginning 9/17/18, DON or designee will perform a monthly QA study x 3 consisting of monthly reviews of Medication Regimen Reviews to ensure all have been recorded in chart appropriately. Results will be reported monthly to the QA committee. The Center's Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director and Health Information Director and meets monthly. Additional in-services and/or monitoring will be determined as necessary by the Quality Assurance Committee. To be completed by: 10/11/18	

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F 842	Continued From page 32 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(l)(4) Medical records must be retained for- (i) The period of time required by State law; or (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 and clinical record review the facility failed to keep an accurate clinical record for two of 23 Residents, Resident #43 and Resident #34. The findings included: 1. For Resident #43 the facility failed to sustain an accurate clinical record regarding monthly Medication Regimen Reviews. Per Clinical Record Review Resident #43 was	F 842	This page intentionally left blank.	

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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
F 842	Continued From page 33 admitted to the facility on 01/23/18. Diagnosis included, but were not limited to, Chronic, Pain, Diabetes Mellitus, Aftercare following explanation of shoulder joint prosthesis, Altered Mental Status, History of Falling, Orthostatic Hypotension, and Muscle Weakness (Generalized). Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/12/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The clinical record did not include a Medication Regimen Review for February 2018. 08/23/18 10:04 AM DON (director of nursing) notified of discrepancy with Medication Regimen Reviews, record reviewed with DON at this time 08/23/18 10:16 AM DON showed pharmacy reviews in clinical record and provided copies to surveyor. Per documents provided and CRR (clinical record review), no Medication Regimen Review was performed in February 08/23/18 04:03 PM Administrative staff were notified of missing Medication Regimen Review in a meeting with survey team. 08/24/18 07:45 AM DON provided documentation that Medication Regimen Review was completed on Resident #43 on February 7, 2018. Medication Regimen Review for February was not added to the Clinical Record upon completion of review for the month of February. 08/24/18 12:00 PM Administrative staff notified survey team that February Medication Regimen	F 842	This page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495131	A. BUILDING _____ B. WING _____	C 08/24/2018

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F 842	Continued From page 34 Review was added to the clinical record on this day 08/24/18 during exit meeting with survey team. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility staff failed to ensure the clinical record of Resident #34 was accurate. The facility documented oral care was provided on 8/22/18 at 11:07 a.m. Oral care had not been provided to Resident #34 on 8/22/18 at 11:07 a.m. The clinical record of Resident #34 was reviewed 8/21/18 through 8/24/18. Resident #34 was admitted to the facility 11/20/15 with diagnoses that included but not limited to respiratory failure, dependence on supplemental oxygen, hypertensive chronic kidney disease, stage 3, long term use of aspirin, major depressive disorder, gastro-esophageal reflux disease, constipation, pulmonary hypertension, and dysphagia. Resident #34's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/5/18 coded the resident with a BIMS (brief interview for mental status) Summary Score of 14 out of a possible 15. Section G Functional Status coded the resident needed extensive assistance of 2 plus persons for personal hygiene (combing hair, brushing teeth, shaving, applying make-up, washing/drying face and hands). Bathing required extensive assistance of one person. Resident #34's current comprehensive care plan updated 7/16/18 included the care area for ADL (activities of daily living) related to impaired vision, generalized muscle weakness.	F 842	This page intentionally left blank.	

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F 842	Continued From page 35 Interventions: Assist with ADL/meals per patient need and preferences. The surveyor interviewed Resident #34 on 8/22/18 at 2:21 p.m. During the interview, the surveyor asked the resident how often she received a shower. The resident stated she got showers two times a week. The surveyor then asked how often she brushed her teeth and Resident #34 stated "My teeth are brushed on my bath days-two times a week." The surveyor was seated beside the resident in a chair. Resident #34 was lying in bed. The surveyor was close enough to the resident to smell her breath, which was not pleasant. The surveyor asked Resident #34 if she had brushed her teeth today and she stated "No." The surveyor informed the unit manager registered nurse #1 on 8/22/18 at 2:31 p.m. and asked her to come with the surveyor to observe the resident. The resident told both the surveyor and the unit manager that she only gets her teeth brushed on bath days. The unit manager registered nurse #1 stated she would address the issue with the staff. The surveyor and the unit manager registered nurse #1 reviewed the "Results List" for Resident #34. The question "Was oral care completed? The box was marked yes for 8/22/18 at 11:07 a.m. The surveyor informed the assistant director of nursing of the above concern on 8/23/18 at 9:18 a.m. and requested the August 2018 ADL (activities of daily living) sheets. On the ADL sheet for 8/22/18 at 11:07 a.m., the certified nursing assistant had charted oral care was	F 842	This page intentionally left blank.	

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F 842	Continued From page 36 provided which it had not been. The ADON stated the unit manager was in-servicing the CNAs and the ADON expected the certified nursing assistants to provide oral care and document correctly. The surveyor informed the administrator, the director of nursing, the assistant director of nursing, and the regional nurse consultant of the above concern during the end of the day meeting on 8/23/18 at 4:01 p.m. The surveyor reviewed the facility policy on documentation on 8/24/1. The document titled "Professional Standards of Documentation" read in part "Observations, events, assessments/evaluations, treatments, services, and patient responses are accurately recorded and authenticated with appropriate signatures." No further information was provided prior to the exit conference on 8/24/18.	F 842	This page intentionally left blank.	