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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/25/2020 through 2/27/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard inspection was conducted 02/25/2020 through 02/27/2020. 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 109 at the time of the survey. The survey sample consisted of 42 current Resident reviews and 7 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to ensure one of 49 sampled residents, (Resident #275) needs for the use of a call bell were accommodated. The facility staff	F 558	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited	3/16/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/12/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	Continued From page 1 failed to place Resident #275's call bell within reach during observations on 2/25/2020 and 2/26/2020. The findings include: Resident #275 was admitted to the facility on 2/23/2020 with diagnoses including, but not limited to pneumonia and difficulty swallowing. He had not been a resident of the facility long enough for an MDS (minimum data set) assessment to be completed. On the admission nursing assessment dated 2/23/20, he was documented as being oriented only to person. He was documented as moving all of his extremities well. On the following dates and times, Resident #275's call bell was observed looped around the left grab bar and hanging down near the floor, out of the resident's reach: 2/25/20 20 at 2:21 p.m. and 2/26/2020 at 8:36 a.m. On 2/26/20 at 8:36 a.m., Resident #275 was sitting up in bed. The call bell was hanging down on left side of bed, out of the resident's reach, as described above. Resident #275 stated, "I need to use the call bell. I can't reach it." A review of Resident #275's care plan dated 2/23/2020 revealed, in part: "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed." On 2/27/2020 at 9:40 a.m., LPN (licensed practical nurse) #4 was interviewed. When asked if a resident who is capable of using a call bell should have it within reach, LPN #4 stated it should. When asked if she is familiar with	F 558	in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F558 cross reference to 12 VAC 5-371-220 1. Resident #275 call bell was ensured to be within reach since 2/26/2020. Management follow-up on the patient continue to assure that his call bell is always within reach when in his room. 2. ADON/Unit Managers/Designee will audit all current patients□ rooms to ensure that their call bells are always within their reach when in bed/chair. Any patient found in their bed/chair without call bell in reach will have it immediately accessible to them and assigned staff identified for remediation. 3. SDC/Designee to provide an in-service to the staff on the following topics: a) Call bell management and response 4. Director of Nursing (DON)/ADON/Designee to complete 10% audit of all occupied rooms weekly x4 weeks and monthly x3 months to ascertain that call bells are within the reach of patients. Any deficient finding will be immediately rectified and forwarded to the QAPI Committee for further review	

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F 558	Continued From page 2 Resident #275, LPN #4 stated: "I have cared for him a few days that he has been here." When asked where his call bell should be located, LPN #4 stated his call bell should be clipped to his gown so that it is accessible if he needs it. When asked who is responsible for making sure a resident's call bell is within reach, LPN #4 stated, "All of us; the whole team." On 2/27/2020 at 9:56 a.m., CNA (certified nursing assistant) #4 was interviewed, regarding where residents call bells should be located. CNA #4 stated that it should always be located within the resident's reach. When asked if she takes care of Resident #275, CNA #4 stated she usually takes care of him when she works the night shift. She stated she puts the call bell close to Resident #275's body so that he can use it to call staff. CNA #4 stated she remembers the resident using the call bell to call staff on multiple occasions since he was admitted. On 2/27/2020 at 11:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and ASM #4, the assistant director of nursing, were informed of these concerns. A policy regarding call bell placement was requested. At this time, ASM #2 stated the facility does not have a policy related to call bell placement. No further information was provided prior to exit.	F 558	and recommendation. 5. Date of compliance: 03/16/2020	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		3/16/20

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F 600	Continued From page 3 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review, and review of a Facility Reported Incident (FRI), it was determined that the facility staff failed to ensure that one of 49 residents, Resident #7, was free from sexual abuse and coercion by another resident. The facility staff failed to ensure that Resident #7 was free from inappropriate touching and coercion by Resident #21 on 11/26/19. The findings include: Resident #7 was admitted to the facility on 2/28/18; diagnoses include but are not limited to dementia with behaviors, high blood pressure, psychosis, anxiety disorder, schizoaffective disorder, depression, and diabetes. The annual MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 11/4/19 coded the resident as being severely impaired in ability to make daily life decisions. Resident #21 was admitted to the facility on	F 600	F600 cross reference to 12 VAC 5-371-110 & 12 VAC 5-371-140 1. Resident #7 inappropriate touching by Resident #21 was FRI□ed on 11/26/2019 and has not experienced such an incident since then. Resident #21 was also moved to another Unit and did not exhibit such a posture towards others until discharged on 02/19/2020. 2. Administrator/Discharge Planning/Designee will interview all patients with frequency of interaction with resident #21 to ascertain that there has not been any incident of sexual impropriety against them from her until her discharged on 02/19/2020. Any impropriety credence of an FRI will be immediately reported as per MFA policy and procedure and the state regulation on abuse. 3. The Administrator/Discharge Planning/Designee will in-service all staff on the following:	

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F 600	Continued From page 4 7/14/19; diagnoses include but are not limited to diabetes, depression, hernia, chronic obstructive pulmonary disease, peripheral vascular disease, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/22/19 coded the resident as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers and toileting, limited assistance for hygiene and dressing; and supervision for eating. A review of a FRI dated 11/26/19 documented, "Resident (#21) unzipped the pants of (Resident #7) and was attempting to put her hands inside his pants. Residents were immediately separated." A review of the witness statements and FRI investigation revealed the following: CNA #1 (Certified Nursing Assistant) statement documented, "(Resident #21) was touching (Resident #7) so I approached her with (CNA #3 and CNA #2) and she (Resident #21) cursed at me and told me to walk away / tried throwing her glass at me then proceeded to unzip (Resident #7) pants and pulled at him to go to his room so she could follow. She stood up and started walking to his room. (Resident #7) tried to stand up multiple times but (Resident #21) kept pulling his arm." CNA #2 statement documented, "I was in the dining room not at the site of incident but in the same vicinity.... (Resident #21) abusive language (cursing at CNA #1). (Resident #21) touching (Resident #7) inappropriately in his private areas (on top of clothing). I am unsure whether consent	F 600	a) Types of abuse b) Preventing abuse c) Reporting requirements of an abuse 4. Administrator/Discharge Planning will attend residents□ council meetings monthly x3 months to check whether there have been any unreported abuse related incidents from the patients. Any incident emanating from the meeting will be reviewed and reported accordingly, if assessed to be an FRI□ed incident. The unreported FRI related incident(s) will also be forwarded to the QAPI Committee for further review and recommendation as applicable. 5. Date of compliance: 03/16/2020	

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was given."

RN #2 (Registered Nurse) statement documented, "Unit manager (RN #2) and (OSM #2 - Other Staff Member) discharge planner, interviewed (Resident #21) regarding situation. Asked patient if there was an incident that she remembers that happened during lunch. Patient stated "No, I don't think so but I can't remember." She then stated "Someone was arguing at the same table" and stated, "Man at the end of the table, I was playing with his belly and arm - it was my husband - he's a son of a bitch." Patient heavily confused."

A review of the investigation report documented, "(Resident #7) interviewed by DON/UM (Director of Nursing and Unit Manager - ASM #2 (Administrative Staff Member, (the Director of Nursing) and RN [registered nurse] #2) and states he doesn't remember..."

The final report of the incident, dated 11/26/19, documented, "...it has been determined that there was an inappropriate interaction between the two residents but that no sexual abuse/assault occurred."

A review of Resident #7's clinical record revealed the following:

A nurse's note dated 11/27/19 that documented, "Pt (patient) was involved in an attempt of inappropriate touching by another pt on 11/26/19. Staff intervened and advancing pt was moved away from him. Pt was assessed with no noted distress. The pt that attempted advancement was transferred to another unit. MD/RP (Medical Doctor/Responsible Party) notified. Care plan for

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behavior reviewed at this time and interventions deemed appropriate in addition to the above. Staff will continue to monitor the safety of the patient."

The comprehensive care plan For Resident #7, dated 3/1/18, documented one for "Behaviors - (Resident #7) has adverse behavioral symptoms such as hx (history) protruding on other pt's (patient's) privacy (walking into pt rooms unannounced), and wandering with exit-seeking r/t (related to) Dementia." The interventions documented were as follows: "Distract resident by offering pleasant diversions, structured activities, food, conversation, television shows based on his preferences." This intervention was dated 4/2/19. "Monitor location. Notify the nurse of wandering behavior and attempted diversional interventions." This intervention was dated 4/2/19. "Monitor/document/report any adverse behavioral symptoms." This intervention was dated 11/3/19. "Wander Alert: Wander guard to alert staff of patient leaving the building." This intervention was dated 4/2/19. "Wander guard to alert staff of patient exit seeking behavior." This intervention was dated 5/15/19.

Review of Resident #21's clinical record revealed the following:

A nurse's note dated 11/27/19 that documented, "Pt was noted to be inappropriately touching another pt in dining room d/t (due to) misidentification of pt's husband on 11/26/19 at 1300 (1:00 pm). Staff immediately separated pt's; assessed both pts, notified MD/RP, Psych (psychiatric) consult ordered, completed FRI on the incident, and moved her to another unit.

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Current care plan on behavior has been reviewed at this time and is deemed appropriate in addition to the above interventions."

An order dated 11/26/19 for geriatric psych [psychiatric] consult. Further review of the clinical record failed to reveal documentation evidencing a psych consult.

The comprehensive care plan for Resident #21, dated 9/16/19, documented, "Behaviors: (Resident #21) exhibits adverse behavioral symptoms as evidenced by frequently positioning herself on floor, removing sheets off of bed and wrapping them around her body, taking O2 (oxygen) NC (nasal cannula) off, rejection of care, misidentification of other pt's (patients) as her husband, and inappropriately touching other pt's." The interventions documented were as follows: "If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident." This intervention was dated 9/16/19. "Minimize potential for the resident's disruptive behaviors by offering tasks which divert attention such as watching television or listening to music." This intervention was dated 9/16/19. "Monitor/doc (document)/report and adverse behavioral sx's (symptoms)." This intervention was dated 11/26/19. "Praise any indication of the resident's progress/improvement in behavior." This intervention was dated 9/16/19. "Staff to provide opportunity for positive interaction, attention. Stop and talk with her as passing by." This intervention was dated 11/27/19.

On 2/26/20 at 1:26 PM. an interview was conducted with RN #2, (Unit Manager, now

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F 600	Continued From page 8 Minimum Data Set), regarding the incident. RN #2 stated, "My CNA had come to me and said that she saw (Resident #21) mess with (Resident #7) private area in the dining room. The CNA said she helped (Resident #21) back to her room, and then came and notified me." RN #2 stated, "I don't remember much after that. I know we put (Resident #21) on a different unit. She is pleasantly confused most of the time. (Resident #21) said that was her husband. The touching was inappropriate touching, from what the CNA told me, I didn't witness it myself. She said it was inappropriate and that (Resident #21) had touched his private areas." When asked if a resident, touches another resident in a private area is that considered any type of abuse, RN #2 stated, "It is if it is unwarranted." When asked if Resident #7 can consent to sexual contact, RN #2 stated, "I think he could consent." When asked about being able to consent to sexual activity with a low cognitive status reflected by a BIMS (Brief Interview for Mental Status) of 5 (five), RN #2 stated, "I don't not know if someone with a BIMS of 5 can consent. I just learned what the BIMS is. He has dementia." When asked if someone with dementia can consent to sexual contact, RN #2 stated, "I think it is a case by case basis." When asked if there is a process that has to be followed to determine if someone who wants to have sexual contact can consent, RN #2 stated, "If there is anything it would be in policy. I don't know if there is one." On 2/26/20 at 1:42 PM, an interview was conducted with OSM #2, discharge planner. OSM #2 stated that she was present for the interview with Resident #21. She stated that she asked	F 600		

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Resident #21 if anything unusual happened at lunch and Resident #21 said she could not remember. OSM #2 stated she then asked Resident #21 if anything unusual happened with a man, and Resident #21 stated she couldn't remember, and then started talking about Resident #7 being her husband and she was messing with his belly. OSM #2 stated that after that she wrote her official statement and handed it to the DON (ASM #2). She stated she was in the DON's office when both families were called to notify them and she called the non-emergent police. She stated that she was not involved in the investigation any further than that.

CNA #1, CNA #2 and CNA #3, who were present at the time of the incident, whose written statements are documented above, were no longer at the facility or were working on an as-needed status and were in school and unavailable for interview.

A review of the facility policy, "Abuse/Neglect/Misappropriation/Crime" documented, "Policy: There is zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the (facility). Procedure: 1. Patients of the Center have the legal right to be free from verbal, sexual, mental and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician....In determining Abuse, Neglect and Misappropriation of property the following definitions will apply:...3) Sexual Abuse: (1) Sexual harassment, inappropriate touching. (2)

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F 600	Continued From page 10 Sexual coercion. (3) Sexual assault or allowing a patient to be sexually abused by another. (4) Inciting any of the above...." On 2/27/20 at 10:27 AM, ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided.	F 600		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655		3/16/20

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(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to implement the baseline care plan for one of 49 residents in the survey sample, Resident #275. The facility staff failed to implement Resident #275's care plan to place the call bell within reach. During observations conducted on 2/25/2020 and 2/26/2020, Resident #275's call bell was looped around the left grab bar and hanging down near the floor, out of the resident's reach.

The findings include:

Resident #275 was admitted to the facility on 2/23/2020 with diagnoses including, but not limited to pneumonia and difficulty swallowing. He had not been a resident of the facility long enough for an MDS (minimum data set) to be completed. On the admission nursing assessment dated 2/23/20, he was documented as being oriented

F 655

F 655 cross reference to 12VAC 5-371-250

1. Resident #275 call bell was ensured to be within reach since 2/26/2020. Management follow-up on the patient continue to assure that his call bell is always within reach when in his room as per his care plan.
2. ADON/Unit Managers/Designee will audit all current patients rooms to ensure that their call bells are always within their reach when in bed/chair as per their respective care plans. Any patient found in their bed/chair without call bell in reach will have it immediately accessible to them and assigned staff identified for remediation.
3. Staff Development Coordinator will in-service the staff on the following:
a) Implementing patient care plan for

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F 655	Continued From page 12	F 655		

only to person. He was documented as moving all of his extremities well.

A review of Resident #275's care plan dated 2/23/2020 revealed, in part: "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed."

On the following dates and times, Resident #275's call bell was observed looped around the left grab bar and hanging down near the floor, out of the resident's reach: 2/25/20 20 at 2:21 p.m. and 2/26/2020 at 8:36 a.m.

On 2/26/20 at 8:36 a.m., Resident #275 was sitting up in bed. The call bell was hanging down on left side of bed, out of the resident's reach, as described above. Resident #275 stated: "I need to use the call bell. I can't reach it."

On 2/27/2020 at 9:40 a.m., LPN (licensed practical nurse) #4 was interviewed. When asked if a resident who is capable of using a call bell should have it within reach, LPN #4 stated it should. When asked if she is familiar with Resident #275, LPN #4 stated: "I have cared for him a few days that he has been here." When asked where his call bell should be located, LPN #4 stated his call bell should be clipped to his gown so that it is accessible if he needs it. When asked who is responsible for making sure a resident's call bell is within reach, LPN #4 stated, "All of us; the whole team." When asked the purpose of a care plan, LPN #4 stated, "So we know how to take care of a resident." When asked who is responsible for making sure care plans are implemented, she stated that all facility staff members are responsible.

Provider's Plan of Correction (F 655, continued):

service provision, including that of the call bell

4. DON/UMs will audit 10% of all current patients weekly x4 weeks and monthly x3 months to assure that their call bell management is in conformity with their respective care plans. The outcome of the audit will be used to conduct continuing education on call bell management and then forwarded to the QAPI committee for further review and guidance.
5. Date of compliance: 03/16/2020

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F 655	Continued From page 13 On 2/27/2020 at 9:56 a.m., CNA (certified nursing assistant) #4 was interviewed, regarding where residents call bells should be located. CNA #4 stated that it should always be located within the resident's reach. When asked if she takes care of Resident #275, CNA #4 stated she usually takes care of him when she works the night shift. She stated she puts the call bell close to Resident #275's body so that he can use it to call staff. CNA #4 stated she remembers the resident using the call bell to call staff on multiple occasions since he was admitted. When asked if she is aware of what a resident's care plan documents, CNA #4 stated the nurses assign CNAs relevant parts of the care plan. She stated she cannot see the entire care plan for any resident. On 2/27/2020 at 11:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and ASM #4, the assistant director of nursing, were informed of these concerns. A review of the facility policy "Care Planning" revealed, in part: "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the resident." No further information was provided prior to exit.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		3/16/20

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F 656	Continued From page 14 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights 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	F 656		

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F 656	Continued From page 15 section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined that the facility staff failed to implement the comprehensive care plan for one of 49 residents in the survey sample, Residents # 72. The staff failed to implement Resident #72's comprehensive care plan to administer oxygen as ordered by the physician. The findings include: Resident # 72 was admitted to the facility with diagnoses that included but were not limited to: multiple sclerosis [1] and high blood pressure. Resident # 72's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/18/2020, coded Resident # 72 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. In Section O "Special Treatment, Procedures and Programs", coded Resident # 72 was coded as receiving oxygen. The comprehensive care plan for Resident # 72 with a revision date of 10/15/2019 documented in part, "Focus. Oxygen Therapy: [Resident # 72] has oxygen therapy r/t [related to] ineffective gas exchange. Revision on: 10/15/2019." Under "Interventions" it documented, "Oxygen Setting: O2 [oxygen] via nasal cannula as ordered. Revision on: 10/15/2019." On 02/25/20 at 3:25 p.m., an observation of Resident # 72 revealed the resident lying in bed awake, receiving oxygen by nasal cannula	F 656	F656 1. Resident #72 oxygen flow rate was adjusted to 2L/minute as per physician�s order and has continue to be maintained at the ordered rate. 2. DON/UMs will audit the oxygen concentrator of all current patients with oxygen supplementation to ascertain that the ordered rate is accurately administered in accordance with their comprehensive care plan. Any noted inaccurate rate administration will be rectified and assigned nurse identified for on the spot documented in-service. 3. SDC/UMs will re-educate the nurses on the following topics: a) Setting the oxygen flow rate on a concentrator. b) Implementing patient comprehensive care plan 4. DON/UMs to perform 10% audit of current residents on oxygen weekly x1 month and monthly x3 months to ascertain that they are receiving accurate ordered oxygen therapy. Any noted inaccurate administration will be rectified, and continuing education provided to affected identified assigned patient. The issue will also be forwarded to the QAPI Committee for further review and recommendation 5. Date of compliance: 03/16/2020	

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F 656	Continued From page 16	F 656		

connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed the three-liter line passed through the middle of the flow meter ball indicating an oxygen flow rate of three liters per minute.

On 02/26/20 at 10:13 a.m., an observation of Resident # 72 revealed the resident lying in bed awake receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed the three-liter line passed through the middle of the flow meter ball indicating an oxygen flow rate of three liters per minute.

The POS [physician's order sheet] for Resident # 221 dated February 2020 documented in part, "Oxygen 2L [two liters] VIA [by] NC [nasal cannula] continuous shift. Order Date: 12/04/2019. Start Date: 12/04/2019."

The eTAR [electronic treatment administration record] for Resident # 72 dated February 2020 documented the above physician order for oxygen. Further review of the eTAR revealed that Resident # 72 received oxygen at two liters per minute on 02/25/20 and 02/26/20.

On 02/26/2020 at approximately 1:25 p.m., an observation of Resident # 72's flow meter on their oxygen concentrator and interview was conducted with LPN [licensed practical nurse] # 3. When asked how to read the flow meter on the oxygen concentrator, LPN # 3 stated that the liter line should pass through the middle of the ball inside the flow meter. After observing the

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F 656	Continued From page 17 flow meter on Resident # 72's oxygen concentrator, LPN # 3 stated that it was set at three liters per minute. LPN #3 was asked what the physician prescribed oxygen flow rate was for Resident # 72. LPN # 3 reviewed the physician's order and then stated that it should have been at two liters per minute. When asked to describe the purpose of a resident's comprehensive care plan, LPN # 3 stated that it was a treatment plan for the patient. After reviewing Resident # 72's comprehensive care plan for oxygen therapy, LPN # 3 was asked if the care plan was being implemented for the administration of oxygen at two liters per minute. LPN # 3 stated no. On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures, and Lippincott as their standard of practice. The facility's policy "Resident Assessment & Care Planning" documented in part, "Policy: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental and psychosocial well-being of the patient."." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for	F 656		

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F 656	Continued From page 18 achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77. On 02/26/2020 at 4:45 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nursing consultants were made aware of the above findings. No further information was provided prior to exit. References: [1] A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.	F 656		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		3/16/20

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F 692	Continued From page 19 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to provide care and services to maintain hydration status for one of 49 residents in the survey sample, Resident #275. The facility staff failed to offer fluids to or place fluids within Resident #275's reach during observations on 2/25/2020 and 2/26/2020. The findings include: Resident #275 was admitted to the facility on 2/23/2020; diagnoses include, but are not limited to pneumonia and difficulty swallowing. He had not been a resident of the facility long enough for an MDS (minimum data set) assessment to be completed. On the admission nursing assessment dated 2/23/20, he was documented as being oriented only to person. He was documented as moving all of his extremities well. The admission assessment contained no documentation of his needing assistance while eating/drinking. On 2/25/2020 at 2:21 p.m., Resident #275 was observed sitting up slightly in his bed. His lips and	F 692	F692 cross reference to 12 VAC 5-371-220 & 12 VAC 5-371-340 1. Resident #275 nectar thick liquid continue to be offered to him since 02/26/2020. The patient has also been assessed to have the capacity to call and to self-hydrate □ the nectar thick liquid has, therefore, been made easily accessible to him. 2. DON/Dietitian/UMs will audit all current patients with ordered altered fluids (thickened liquids) to ascertain that they are always within the reach of the patient and/or offered by staff for at least every 2 hours as tolerated by the affected patient. 3. SDC/Dietitian will in-service the nursing staff on the following: a) Managing altered fluids (thickened liquids) for patient hydration 4. DON/Dietitian will complete 10% of current patient on altered fluids weekly x1 month and monthly x3 months to ascertain that they are being hydrated adequately as tolerated. Any inadequate hydration of patient noted will be rectified	

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F 692	Continued From page 20 mouth appeared dry. No fluids were observed within the resident's reach. A cooler with nectar thick water and juice was observed beside his bed, but was positioned out of the resident's reach. On 2/26/2020 at 10:37 a.m. and 2:02 p.m., Resident #275 was observed sitting up in bed. No fluids were observed within reach. Resident #275 was observed for the next two hours. During that time, two nurses and two CNAs (certified nursing assistants) went into the resident's room; none of these staff members offered the resident fluids or placed any fluids within his reach. A cooler with nectar thick water and juice was observed beside his bed, but was positioned out of the resident's reach. On 2/27/2020 at 8:36 a.m., Resident # 275 was observed sitting up in bed. The surveyor observed the resident using his right arm to drink fluids from a cup on his over bed table. A review of Resident #275's care plan dated 2/23/2020 revealed no information related to his hydration status. A review of the OT (occupational therapy) evaluation dated 2/24/2020 revealed, in part: "Range of Motion: UE (upper extremity) ROM (range of motion): RUE (right upper extremity) ROM = WFL (within functional limitations)." A review of the short-term goals within this assessment revealed no goals related to eating/feeding. On 2/27/2020 at 8:40 a.m., OSM (other staff member) #8, the registered dietician, was interviewed. When asked for an approximation of	F 692	accordingly, including that of an additional remedial session with assigned staff to the affected patient. The result will also be forwarded to the QAPI committee for review/recommendation. 5. Date of compliance: 03/16/2020	

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how much fluid a resident needs to take in to maintain good hydration status, OSM #8 stated, "Of course, every resident is different, but I would say usually between 1600 milliliters and 2 liters a day." When asked if a resident usually takes in that amount of fluid just from mealtime fluid intake, OSM #8 stated the fluids, should be supplemented during the day because the meal trays do not contain enough fluids.

On 2/27/2020 at 9:40 a.m., LPN (licensed practical nurse) #4 was interviewed. When asked if a resident receives all the fluids, he or she needs at meal times, LPN #4 stated, "No. They need to have fluids all through the day." She stated the nursing staff offers fluids "all the time." She stated the CNAs (certified nursing assistants) pass out ice water at designated times. She stated that each time a staff member goes in a room; they should be making sure the resident has fluids accessible to them. When asked specifically about Resident #275, LPN #4 stated the resident has not been at the facility but a few days. For this reason, it is even more important for the staff to monitor him frequently and to make sure he has fluids within reach.

On 2/27/2020 at 9:56 a.m., an interview was conducted with CNA #4, regarding resident hydration. When asked if a resident needs to drink fluids at other times other than meal times to maintain hydration status, CNA #4 stated, "Yes, the residents need to be offered fluids all the time." CNA #4 stated, "We pass fluids like water during the day." She stated she takes fluids to residents whenever they ask for it, and if they are not able to ask, she offers fluids whenever she goes in the resident's room.

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F 692	Continued From page 22 On 2/27/2020 at 10:16 a.m., OSM (other staff member) #9, the speech therapist, was interviewed. When asked about her focus for therapy for Resident #275, she stated she is working on upper extremity strength, and on the resident's ability to swallow. OSM #9 stated the resident is at risk for aspiration if he drinks thin liquids. When asked if the resident was safe to have nectar-thick fluids within reach, and to consume these fluids without staff supervision, OSM #9 stated, "He is safe to have fluids within reach if they are nectar thick." On 2/27/2020 at 11:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and ASM #4, the assistant director of nursing, were informed of these concerns. A review of the facility policy "Hydration" revealed, in part: "Patients will be appropriately hydrated by offering a variety of fluids and encouraging ongoing fluid intake throughout the day...The staff will encourage patients to consume all fluids on meal trays and also in-between meal supplements/nourishments/snacks...CNAs will be expected to offer fluids periodically each shift." No further information was provided prior to exit.	F 692		
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	F 695		3/16/20

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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, facility document review and clinical record review, it was determined facility staff failed to provide respiratory services consistent with professional standards of practice, and the comprehensive person-centered care plan, for six of 49 residents in the survey sample, Residents #322, #321, #118, #221, #47 and #72. The nebulizer masks for Residents #322, #321, Resident #118 and Resident #47 were observed uncovered on top of the residents' nebulizer machines or over the bed tables; and the incentive spirometer for Resident #321 and 221, were observed uncovered on the resident night stand and over bed table. Resident #72 was observed receiving oxygen at 3 LPM (liter per minute) instead of the 2 LPM ordered by the physician.

The findings include:

1. Resident #322 was admitted to the facility on 2/14/2020, with diagnoses that included but were not limited to chronic obstructive pulmonary disease (2), atrial fibrillation (3) and legal blindness. Resident #322's most recent MDS (minimum data set), was not due at the time of the survey. The facility's nursing admission assessment dated 2/14/2020 coded Resident #322 as being oriented times four, "Oriented to person, place, time and situation."

On 2/25/20 at 2:05 p.m., and on 2/25/20 at 4:30 p.m. observations were made of Resident #322's

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1. Residents #322, #321, #118, #221, and #47□s nebulizer masks and tubes were returned to the Center□s designated holding bags on 2/25/2020 and have ever since been maintained. The incentive spirometer for Residents #321 and #221 were placed in Center designated holding bag when not in use. Resident #72 oxygen flow rate was adjusted to 2L/minute as per physician□s order and has continue to be maintained at the ordered rate. Medication error protocol will be initiated. No side effect experienced by the patient. An in-service on the calibration of oxygen rate on concentrator was provided to the assigned nurse(s) to the patient on 2/25/2020 and 2/26/2020. Residents #221 and #118 discharged on 3/6/2020 and 3/4/2020 respectively.

2. DON/ADON/UMs to audit all current patients on ordered nebulizer and incentive spirometer therapies to assure that the nebulizer masks and incentive spirometers are placed in Center□s designated holding bags when not in use. An audit of all current patients on oxygen therapy will be completed to ascertain that their ordered oxygen supplementation flow rate is accurately calibrated on the oxygen concentrator. Any unused nebulizer mask and incentive spirometer

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F 695	Continued From page 24 room. Resident #322 was not in the room at the time. A nebulizer unit was observed located on top of the resident's nightstand to the left side of the bed. An uncovered mask was observed attached to the nebulizer machine and was lying on top of the nebulizer machine. On 2/26/20 at 8:10 a.m., an interview was conducted with Resident #322. During the interview an additional observation of the nebulizer unit on top of the nightstand to the left of the bed revealed the uncovered nebulizer mask was lying on top of the nebulizer machine as documented in the observations above. When asked about the nebulizer and mask, Resident #322 stated that she received the nebulizer as needed for shortness of breath due to COPD (chronic obstructive pulmonary disease). Resident #322 stated that she had used the nebulizer a couple of times since admission when she got short of breath after therapy. When asked how the facility staff maintains the nebulizer and mask, Resident #322 stated that she was not sure because she was legally blind and had a hard time seeing things. The physicians "Order Summary Report" dated "Feb (February) 26, 2020" for Resident #322 documented in part, "Ipratropium-Albuterol (4) Solution 0.5-2.5 MG (milligram)/3 (three) ML (milliliter), 3 ml inhale orally every 4 (four) hours as needed for wheezing related to chronic obstructive pulmonary disease, unspecified, Order Date: 02/14/2020, Start Date: 02/14/2020." The comprehensive care plan for Resident #322 documented in part, "Nursing Care Needs: [Name of Resident #322] has nursing care needs r/t	F 695	not bagged will be immediately returned to designated holding bag. Any inaccurate oxygen calibrated flow rate noted will be rectified immediately. The outcome of the above audit will also be used to complete a targeted in-service with nurses assigned to affected patients. 3. SDC/Designee will provide in-service to the nursing staff on the following topics: a) Maintaining sanitary condition of nebulizer mask and incentive spirometer b) Calibrating ordered oxygen rate on the oxygen concentrator. 4. DON/UMs will audit 10% of all current patients with ordered oxygen, nebulizer, and incentive spirometer therapies weekly x4 weeks and monthly x3 months to assure that unused masks/incentive spirometer are place designated holding bags and oxygen rate are calibrated on the concentrator as ordered. Any anomaly noted will be rectified accordingly as appropriate and then forwarded to the QAPI Committee for further review and recommendation. 5. Date of compliance: 03/16/2020	

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F 695	Continued From page 25 (related to) GI (gastrointestinal) bleed secondary to rectal ulcer (5), pneumonia (6), hypertension (7), hyperlipidemia (8), COPD ... Created on 02/14/2020, Revision on 02/25/2020." Under "Interventions" it documented in part, "Administer medications as ordered and monitor for effectiveness/side effect. Created on 02/14/2020." The "Medication Administration Record" for Resident #322, dated "2/1/2020-2/29/2020" documented Resident #322 receiving "Ipratropium-Albuterol Solution" on 2/18/2020 at 5:21 a.m. On 2/26/20 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows for residents with as needed nebulizer medication orders, LPN #1 stated that nebulizer machines are kept in the rooms of the residents. LPN #1 stated that the masks and tubing for the nebulizers are changed three times a week on Mondays, Wednesdays and Fridays. When asked about the process staff follows storing nebulizers after administration of treatments and when not in use, LPN #1 stated the medication is administered to the resident and afterwards the nebulizer is rinsed out and allowed to air dry. LPN #1 stated that after the nebulizer is dried it is placed in a bag for storage. When asked how long the nebulizer is allowed to dry before being placed in the bag, LPN #1 stated that the nebulizer is air dried for at least ten to fifteen minutes and then placed back in the bag for storage until needed. When asked why the nebulizer mask is stored in a bag, LPN #1 stated it is for infection control purposes because it goes on the residents face. When asked if a nebulizer	F 695		

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F 695	Continued From page 26 is considered a respiratory treatment, LPN #1 stated, "Yes." When asked about the nebulizer mask observed in Resident #322's room and advised of the above observations on 2/25/20 at 2:05 p.m. and 4:30 p.m. and on 2/26/20 at 8:30 a.m., LPN #1 stated that she had discarded the mask this morning during her room rounds around 9:00 a.m. LPN #1 stated that the mask was uncovered and that it was not stored according to the practice of the facility so she had discarded it. On 2/26/20 at approximately 11:00 a.m., a request was made by written list to ASM (administrative staff member) #2, the director of nursing for the facility policy on nebulizer therapy. The facility policy "Respiratory/Oxygen Equipment, Effective Date 11/01/19" documented in part, "Medicated Nebulizer Treatment ...5. Rinse out nebulizer reservoir with tap water, dry, and place in a plastic bag when not in use. Nebulizers and bags must be changed every Monday, Wednesday, and Friday and dated." On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures, and Lippincott as their standard of practice. According to The Lippincott Manual of Nursing Practice 10th Edition, 2014, page 236, Procedure Guidelines 10-11 documented in part, "Follow-up phase 1. Record medication used and description of secretions. 2. Disassemble and clean nebulizer after each use. Keep this equipment in the patient's room. The equipment is changed according to facility policy. Each patient has own breathing circuit (nebulizer,	F 695		

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tubing and mouthpiece). Through proper cleaning, sterilization, and storage of equipment, organisms can be prevented from entering the lungs."

On 2/26/20 at approximately 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Nebulizer- A nebulizer is a small machine that turns liquid medicine into a mist. You sit with the machine and breathe in through a connected mouthpiece. This information was obtained from the website: https: https://medlineplus.gov/ency/patientinstructions/000006.htm.

2. Chronic obstructive pulmonary disease (COPD) is a 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. Atrial fibrillation is 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.

4. Albuterol and Ipratropium oral inhalation. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and

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opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html

5. Rectal ulcer solitary rectal ulcer syndrome is an uncommon condition that can affect both men and women, and is associated with long-standing constipation and prolonged straining during bowel movement. In this condition, an area in the rectum (typically in the form of a single ulcer) leads to passing blood and mucus from the rectum. This information was obtained from the website: https://www.asge.org/home/for-patients/patient-information/understanding-minor-rectal-bleeding

6. Pneumonia is an infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.

7. Hypertension is high blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

8. Hyperlipidemia is the medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

2. Resident #321 was admitted to the facility on 2/13/2020, with diagnoses that included but were not limited to cervical disc disorder (3),

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pneumonia (4) and hypertension (5). Resident #321's most recent MDS (minimum data set), was not due at the time of the survey. The facility's nursing admission assessment dated 2/13/2020 coded Resident #321 as being oriented times three, "Oriented to person, place, and situation."

On 2/25/20 at 2:35 p.m., an interview was conducted with Resident #321. During the interview, observation of Resident #321's room revealed a nebulizer unit located on top of the nightstand to the left side of the bed near the window and an uncovered incentive spirometer. An uncovered mask was observed attached to the nebulizer machine and was lying on top of the nebulizer machine. When asked about the nebulizer and mask, Resident #321 stated that he received the nebulizer on a regular basis since his admission to the facility. When asked about the incentive spirometer on the nightstand Resident #321 stated that he received it while in the hospital and still uses it at least once a day. When asked if he required assistance when using the nebulizer and incentive spirometer, Resident #321 stated that the staff assists him with both because of his neck collar that he is required to wear and limited mobility. When asked how the facility staff maintains the incentive spirometer, nebulizer and mask, Resident #321 stated that he does not really pay attention to it, that the staff takes care of them. When asked if he has ever seen the staff put the nebulizer or the incentive spirometer in a bag when not being used, Resident #321 stated that he did not remember.

An additional observation made on 2/25/20 at 4:35 p.m. and 2/26/20 at 8:45 a.m. revealed the same findings above for the nebulizer, nebulizer

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F 695	Continued From page 30 mask and incentive spirometer. The physicians "Order Summary Report" dated "Feb (February) 26, 2020" for Resident #321 documented in part, "Albuterol Sulfate (6) Nebulization Solution (2.5 MG (milligram)/3 (three) ML (milliliter), 0.083% 3 (three) ml inhale orally via (by way of) nebulizer two times a day for shortness of breath, Order Date: 02/13/2020, Start Date: 02/14/2020." The physician order summary report for Resident #321 failed to evidence documentation for the use of the incentive spirometer. The comprehensive care plan for Resident #321 documented in part, "Nursing Care Needs: [Name of Resident #321] has nursing care needs r/t (related to) HTN (hypertension), BPH (benign prostatic hypertrophy) (7), dysphagia (8), hypoxemia (9) ... Created on 02/13/2020, Revision on 02/24/2020." Under "Interventions", it documented in part, "Administer medications/treatment as ordered. Created on 02/13/2020." The "Medication Administration Record" for Resident #321, dated "2/1/2020-2/29/2020" documented Resident #321 receiving "Albuterol Sulfate Nebulization Solution" at 9:00 a.m. and 5:00 p.m. each day from 2/14/20 through 2/26/20. The "Rehab [rehabilitation] Progress Note" from the transferring hospital dated 2/12/2020 at 11:43 a.m. included in Resident #321's electronic medical record documented in part, "Impression and Plan/Medical Assessment: Rehab Plan: ...Transient hypoxia (10)/abnormal chest x-ray- appreciate input and recommendations from [Name of Physician]."	F 695		

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F 695	Continued From page 31 Included in Resident #321's electronic medical record, a "Progress Note-Physician" from the transferring hospital dated 2/12/2020 at 3:01 p.m. was observed electronically signed by the physician whose recommendations were requested in the rehab progress note documented above. The progress note documented in part, "Impression and Plan, 1. Abnormal CXR (chest x-ray), L. (left) sided infiltrates, 2. Cough. Recommendations: 1. Agree with empiric Levaquin (antibiotic) to complete a seven day course, 2. BID (two times a day) and PRN (as needed) nebs (nebulizers), 3. Follow up CXR pending, 4. Incentive spirometry." On 2/26/20 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows for residents with as needed nebulizer medication orders, LPN #1 stated that nebulizer machines are kept in the rooms of the residents. LPN #1 stated that the masks and tubing for the nebulizers are changed three times a week on Mondays, Wednesdays and Fridays. When asked about the process staff follows storing nebulizers after administration of treatments and when not in use, LPN #1 stated the medication is administered to the resident and afterwards the nebulizer is rinsed out and allowed to air dry. LPN #1 stated that after the nebulizer is dried it is placed in a bag for storage. When asked how long the nebulizer is allowed to dry before being placed in the bag, LPN #1 stated that the nebulizer is air dried for at least ten to fifteen minutes and then placed back in the bag for storage until needed. When asked why the nebulizer mask is stored in a bag, LPN #1 stated it is for infection control purposes because it goes	F 695		

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on the residents face. When asked if a nebulizer is considered a respiratory treatment, LPN #1 stated, "Yes." When asked if residents who use incentive spirometers should have an order, LPN #1 stated that they should. When asked about the process staff follows for residents who have, an incentive spirometer brought in from the hospital that they use, LPN #1 stated that the physician is called to determine if an order is needed for the resident to continue using it. LPN #1 observed Resident #321's nebulizer unit with the uncovered mask on top of the unit located on top of the nightstand to the left side of the bed near the window and the uncovered incentive spirometer. LPN #1 checked the area and stated that there was no bag for the mask or the incentive spirometer to be stored. LPN #1 stated that the incentive spirometer was available for use at the bedside for Resident #321 and there should be a physician order for its use.

On 2/26/20 at approximately 11:00 a.m., a request was made by written list to ASM (administrative staff member) #2, the director of nursing for the facility policy on nebulizer therapy and incentive spirometry.

On 2/26/20 at approximately 12:00 p.m., ASM #2 provided the policy "Respiratory/Oxygen Equipment, Effective Date 11/01/19" which failed to evidence guidance on incentive spirometry.

The facility policy "Respiratory/Oxygen Equipment, Effective Date 11/01/19" documented in part, "Medicated Nebulizer Treatment ...5. Rinse out nebulizer reservoir with tap water, dry, and place in a plastic bag when not in use. Nebulizers and bags must be changed every Monday, Wednesday, and Friday and dated."

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On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures, and Lippincott as their standard of practice.

According to The Lippincott Manual of Nursing Practice 10th Edition, 2014, page 236, Procedure Guidelines 10-11 documented in part, "Follow-up phase 1. Record medication used and description of secretions. 2. Disassemble and clean nebulizer after each use. Keep this equipment in the patient's room. The equipment is changed according to facility policy. Each patient has own breathing circuit (nebulizer, tubing and mouthpiece). Through proper cleaning, sterilization, and storage of equipment, organisms can be prevented from entering the lungs."

According to Lippincott's Nursing Procedures (sixth Edition) 2013, "Wash the mouthpiece in warm water and dry it. Avoid immersing the spirometer itself in water because water enhances bacterial growth and impairs the internal filter's effectiveness in preventing inhalation of extraneous material. Place the mouthpiece in a plastic storage bag between exercises, and label it and the spirometer, if applicable, with the patient's name to avoid inadvertent use by another patient. Keep the incentive spirometer within the patient's reach."

According to Lippincott Nursing Procedures, Seventh edition, page 383 documented, "Direct supervision of incentive spirometry use isn't necessary after the patient is able to demonstrate proper technique. However, periodic reassessment is necessary to make sure the

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patient complies with proper technique." Page 384 documented in part "Documentation ...Document the flow or volume levels, date and time of the procedure, type of spirometer, and number of breaths taken. Also record the patient's condition before and after the procedure, tolerance for the procedure, and the results of the pre procedure and post procedure auscultation."

On 2/27/20 at approximately 11:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4, the assistant director of nursing were made aware of the findings.

On 2/27/20 at approximately 11:20 a.m., ASM #3 stated that upon admission the discharge summary is reviewed as well as all information sent from the hospital. ASM #3 stated that if the resident has an incentive spirometer that is still being used then the resident is educated to graduate away from using it and it is put away or it is sent home. ASM #3 reviewed the "Progress Note-Physician" from the transferring hospital dated 2/12/2020 for Resident #321, which documented recommendations for incentive spirometer use as documented above and stated that it would be included in the admission review of records.

No further information was provided prior to exit.

Reference:

1. Nebulizer- a nebulizer is a small machine that turns liquid medicine into a mist. You sit with the machine and breathe in through a connected mouthpiece. This information was obtained from

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F 695	Continued From page 35 the website: https: https://medlineplus.gov/ency/patientinstructions/000006.htm. 2. Incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm. 3. Cervical disc disorder Your backbone, or spine, is made up of 26 bone discs called vertebrae. The vertebrae protect your spinal cord and allow you to stand and bend. A number of problems can change the structure of the spine or damage the vertebrae and surrounding tissue. They include Infections, Injuries, Tumors, Conditions, such as ankylosing spondylitis and scoliosis. Bone changes that come with age, such as spinal stenosis and herniated disks, Spinal diseases often cause pain when bone changes put pressure on the spinal cord or nerves. They can also limit movement. Treatments differ by disease, but sometimes they include back braces and surgery. This information was obtained from the website: https://medlineplus.gov/spineinjuriesanddisorders.html 4. Pneumonia is an infection in one or both of the lungs. This information was obtained from the website: https://medlineplus.gov/pneumonia.html. 5. Hypertension is high blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 695		

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6. Albuterol is in a class of medications called bronchodilators. It works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a607004.html

7. Benign prostatic hyperplasia is an enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

8. Dysphagia is a swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

9. Hypoxemia is low concentrations of oxygen in the blood. This information was obtained from the website: https://ghr.nlm.nih.gov/condition/surfactant-dysfunction.

10. Hypoxia is a deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.

3. Resident #118 was admitted to the facility on 1/30/2020, with diagnoses that included but were not limited to hypertension (2), chronic kidney disease (3) and atherosclerotic heart disease (4). Resident #118's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/5/2020, coded Resident #118, as scoring a 0 (zero) on the staff

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assessment for mental status (BIMS) of a score of 0 - 15, 0- being severely impaired for making daily decisions.

On 2/25/20 at 2:25 p.m., on 2/25/20 at 4:45 p.m. and 2/26/20 at 8:50 a.m., observations of Resident #118's room revealed a nebulizer unit was observed located on top of the nightstand to the right side of the bed. An uncovered nebulizer mask was attached to the nebulizer machine and was propped on top of the machine. A plastic bag was observed hanging underneath the nebulizer machine on the nightstand dated "2/5/20."

The physicians "Order Summary Report" dated "Feb (February) 26, 2020" for Resident #118 documented in part, "Ipratropium-Albuterol (5) Solution 0.5-2.5 MG (milligram)/3 (three) ML (milliliter), 3 ml inhale orally via (by way of) nebulizer three times a day related to other asthma (6) Order Date: 02/11/2020, Start Date: 02/12/2020."

The comprehensive care plan for Resident #118 documented in part, "Nursing Care Needs: [Name of Resident #118] has nursing care needs r/t (related to) hypertension, chronic kidney disease, hyponatremia (6), right eye blindness, asthma (7), ... Created on 01/30/2020, Revision on 02/11/2020." Under "Interventions", it documented in part, "Administer medications and treatment per order. Created on 01/30/2020."

The "Medication Administration Record" for Resident #118, dated "2/1/2020-2/29/2020" documented Resident #118 receiving "Ipratropium-Albuterol Solution" four times a day from 2/1/2020 through 2/11/2020 and three times

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F 695	Continued From page 38 a day from 2/12/20 through 2/26/20. On 2/26/20 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows for residents with as needed nebulizer medication orders, LPN #1 stated that nebulizer machines are kept in the rooms of the residents. LPN #1 stated that the masks and tubing for the nebulizers are changed three times a week on Mondays, Wednesdays and Fridays. When asked about the process staff follows storing nebulizers after administration of treatments and when not in use, LPN #1 stated the medication is administered to the resident and afterwards the nebulizer is rinsed out and allowed to air dry. LPN #1 stated that after the nebulizer is dried it is placed in a bag for storage. When asked how long the nebulizer is allowed to dry before being placed in the bag, LPN #1 stated that the nebulizer is air dried for at least ten to fifteen minutes and then placed back in the bag for storage until needed. When asked why the nebulizer mask is stored in a bag, LPN #1 stated it is for infection control purposes because it goes on the residents face. When asked if a nebulizer is considered a respiratory treatment, LPN #1 stated, "Yes." LPN #1 observed the nebulizer unit with the uncovered mask on top of the unit located on top of the nightstand to the right side of the bed. LPN #1 viewed the nebulizer and the mask and stated that it was not in a bag. On 2/26/20 at approximately 11:00 a.m., a request was made by written list to ASM (administrative staff member) #2, the director of nursing for the facility policy on nebulizer therapy. The facility policy "Respiratory/Oxygen	F 695		

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Equipment, Effective Date 11/01/19" documented in part, "Medicated Nebulizer Treatment ...5. Rinse out nebulizer reservoir with tap water, dry, and place in a plastic bag when not in use. Nebulizers and bags must be changed every Monday, Wednesday, and Friday and dated."

On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures, and Lippincott as their standard of practice.

On 2/26/20 at approximately 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Nebulizer is a small machine that turns liquid medicine into a mist. You sit with the machine and breathe in through a connected mouthpiece. Medicine goes into your lungs as you take slow, deep breaths for 10 to 15 minutes. It is easy and pleasant to breathe the medicine into your lungs this way. This information was obtained from the website: https: https://medlineplus.gov/ency/patientinstructions/000006.htm.

2. Hypertension is high blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

3. Chronic kidney disease -Kidneys are damaged

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and can't filter blood, as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html.

4. Atherosclerosis: A disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium, and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the flow of oxygen-rich blood to your body. This information was obtained from the website: https://medlineplus.gov/atherosclerosis.html.

5. Albuterol and Ipratropium oral inhalation- Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html

6. Hyponatremia - Low sodium (salt) level. This information was obtained from the website: https://medlineplus.gov/ency/article/000394.htm.

7. Asthma is a disease that causes the airways of the lungs to swell and narrow. It leads to wheezing, shortness of breath, chest tightness, and coughing. This information was obtained from the website: https://medlineplus.gov/ency/article/000141.htm.

4. Resident # 221 was admitted to the facility with diagnoses that included but were not limited to: obstructive sleep apnea [1] and high blood

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pressure. Resident # 221's MDS (minimum data set), assessment was not due at the time of the survey. The facility's nursing "Admission Assessment" for Resident # 221 documented in part, "2. Orientation: a. Person, b. Place, c. Time (day, month, year), d. Situation."

On 02/25/20 at 11:57 a.m., 02/25/20 at 2:00 p.m. and 02/26/20 at 10:03 a.m., an observations of Resident # 221's room revealed an incentive spirometer on the over-the-bed table uncovered.

On 02/27/20 at 11:25 a.m., an interview was conducted with Resident #221. When asked if they used the incentive spirometer Resident 221 stated that they used it a couple of times a day.

The POS [physician's order sheet] for Resident # 221 dated February 2020 documented in part, "Incentive Spirometer Q 1 H PRN [every hour as needed] when awake. Order Date: 02/22/2020."

The comprehensive care plan for Resident # 221 dated 02/20/2020 documented in part, "Focus. Altered Respiratory Status: [Resident # 221] has altered respiratory status, difficulty breathing r/t [related to] Sleep Apnea. Created on: 02/20/2020." Under "Interventions" it documented, "Administer medications/puffers as ordered. Monitor for effectiveness and side effects. Created on: 02/20/2020."

On 02/26/2020 at 1:25 p.m., an observation of Resident # 221's incentive spirometer sitting on their bedside table uncovered and interview was conducted with LPN [licensed practical nurse] # 3. When asked if an incentive spirometer was considered respiratory equipment, LPN # 3 stated yes. When asked how staff store an incentive

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spirometer when not in use, LPN # 3 stated, "It should be placed in a bag and dated." After observing the spirometer sitting on the bedside table uncovered, LPN # 3 stated that it should be placed in a bag.

On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures, and Lippincott as their standard of practice.

On 02/26/2020 at 4:45 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nursing consultants were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.

5. Resident # 47 was admitted to the facility with diagnoses that included but were not limited to: pneumonia, respiratory failure and chronic obstructive pulmonary disease [1]. Resident # 47's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/19/2019, coded Resident # 47 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. In Section O "Special Treatment, Procedures and Programs", coded Resident # 47 was coded as

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receiving oxygen therapy.

On 02/25/20 at 12:03 p.m., 02/25/20 at 3:45 p.m., and 02/26/20 at 10:08 a.m., observations of Resident # 47's nebulizer mask revealed it was on the bedside table uncovered.

The POS [physician's order sheet] for Resident # 47 dated February 2020 documented in part, "Nebulizer tubing setup change M-W-F [Monday-Wednesday-Friday] 11-7 [11:00 p.m. - 7:00 a.m.] shift every night shift for Protocol. Order Date: 09/03/2019. Start Date: 09/03/2019."

The comprehensive care plan for Resident # 47 dated 09/13/2019 documented in part, "Focus. Oxygen Therapy: [Resident # 47] has oxygen therapy r/t [related to] COPD [chronic obstructive pulmonary disease]. Patient has sob [shortness of breath] when lying flat and with exertion. Created on: 09/13/2019." Under "Interventions" it documented, "Give medications as ordered by physician. Created on: 09/13/2019."

On 02/26/2020 at approximately 1:25 p.m., an observation of Resident # 47's nebulizer mask sitting on their bedside table uncovered and interview was conducted with LPN [licensed practical nurse] # 3. When asked if a nebulizer mask was considered respiratory equipment, LPN # 3 stated yes. When asked how a nebulizer mask should be stored when not in use, LPN # 3 stated, "It should be placed in a bag and dated." After observing the nebulizer mask on the bedside table uncovered LPN # 3 stated that it [Resident #47's nebulizer mask] should be placed in a bag.

On 2/25/2020 at approximately 11:30 a.m., ASM

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#2, the director of nursing stated that the facility staff uses their policies, procedures, and Lippincott as their standard of practice.

On 02/26/2020 at 4:45 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nursing consultants were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] 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.

6. Resident # 72 was admitted to the facility with diagnoses that included but were not limited to: multiple sclerosis [1] and high blood pressure.

Resident # 72's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/18/2020, coded Resident # 72 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. In Section O "Special Treatment, Procedures and Programs", coded Resident # 72 was coded as receiving oxygen.

On 02/25/20 at 3:25 p.m., and 02/26/20 at 10:13 a.m., Resident # 72 was observed lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed the three-liter line passed through the middle of the flow meter ball

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F 695	Continued From page 45 indicating an oxygen flow rate of three liters per minute. The POS [physician's order sheet] for Resident # 221 dated February 2020 documented in part, "Oxygen 2L [two liters] VIA [by] NC [nasal cannula] continuous shift. Order Date: 12/04/2019. Start Date: 12/04/2019." The eTAR [electronic treatment administration record] for Resident # 72 dated February 2020 documented the same order as above. Further review of the eTAR revealed that Resident # 72 received oxygen at two liters per minute on 02/25/20 and 02/26/20. The comprehensive care plan for Resident # 72 with a revision date of 10/15/2019 documented in part, "Focus. Oxygen Therapy: [Resident # 72] has oxygen therapy r/t [related to] ineffective gas exchange. Revision on: 10/15/2019." Under "Interventions" it documented, "Oxygen Setting: O2 [oxygen] via nasal cannula as ordered. Revision on: 10/15/2019." On 02/26/2020 at approximately 1:25 p.m., an observation of Resident # 72's flow meter on their oxygen concentrator and interview was conducted with LPN [licensed practical nurse] # 3. When asked how a flow meter on the oxygen concentrator is read, LPN # 3 stated that the liter line should pass through the middle of the ball inside the flow meter. After observing the flow meter on Resident # 72's oxygen concentrator, LPN # 3 stated that it was set at three liters per minute. When asked what the physician prescribed oxygen flow rate was for Resident #72, LPN # 3 looked up the physician's order and stated that it should have been at two liters per	F 695		

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minute. LPN # 3 immediately readjusted the oxygen flow rate on Resident # 72's oxygen concentrator.

On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures, and Lippincott as their standard of practice.

The facility's policy "Respiratory Care" documented in part, "Oxygen Therapy via Nasal Cannula, Simple Mask, Venturi Mask and Oximizer. 3. Set appropriate flow rate and place oxygen delivery device on the patient."

The [Name of Manufacturer's] instructions for Resident # 72's oxygen concentrator documented in part, "Chapter 2: Operating Instructions. 5. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line making the specific flow rate."

On 02/26/2020 at 4:45 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nursing consultants were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website:

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F 695	Continued From page 47 https://medlineplus.gov/multiplesclerosis.html.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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 observation, staff interview, facility document review and clinical record review, it was determined facility staff failed to provide a complete dialysis (1) communication plan for one of 49 residents in the survey sample, Resident #113. The facility staff failed to ensure the dialysis communication book fro Resident #113 was completed to ensure ongoing communication with the dialyisis center. The finding include: Resident #113 was admitted to the facility on 5/3/2019 with a readmission on 1/28/20, with diagnoses that included but were not limited to chronic obstructive pulmonary disease (2), atrial fibrillation (3), and dependence on renal (kidney) dialysis. Resident #113's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/3/2020, coded Resident #113 as scoring a 1 (one) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 1- being severely impaired for making daily decisions. Section O of the assessment documented Resident #113 receiving dialysis.	F 698	F698 1. Resident #113 dialysis communication book was fully completed on 2/28/2020 dialysis appointment date and has ever since been completed on her dialysis day. 2. ADON/UMs will audit all current patients on dialysis to ascertain that their communication book is fully completed with every visit to a dialysis Center. Any identified inadequacy will be rectified, and result used to provide targeted remediation to affected staff. 3. SDC to provide in-service to all charge nurses on the following topics: a) Maintaining the dialysis communication book b) Managing dialysis patient 4. DON/UMs to perform a 100% audit of the communication books for all current dialysis patients weekly x1 month and monthly x3 months to assure that they are being fully completed consistently without missing appointment days. Any identified deficient practice noted will be rectified accordingly and as appropriate and then	3/16/20

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F 698	Continued From page 48 The physicians "Order Summary Report" dated "Feb (February) 27, 2020" for Resident #113 documented in part, "Hemodialysis: Patient goes for dialysis at [Name, location and phone number of Dialysis Center]. Mondays, Wednesdays and Fridays. Every day shift every Mon, (Monday) Wed, (Wednesday) Fri (Friday). Order Date: 02/17/2020; Start Date: 02/19/2020." The comprehensive care plan for Resident #113 documented, "Hemodialysis- [Name of Resident #113] requires hemodialysis r/t (related to) renal failure. [Name, location and phone number of Dialysis Center]. Weekly Schedule: Mondays, Wednesdays and Fridays. Created on: 06/01/2019, Revision on: 02/17/2020." On 2/27/20 at approximately 9:00 a.m., LPN (licensed practical nurse) #1 provided a white binder kept at the unit nurse's station labeled with Resident #113's name and room number and stated that it was the dialysis communication book that was sent with Resident #113 each time the resident was transported to dialysis. Review of the binder labeled "[Name and Room number of Resident #113] Dialysis Transfer Book" included Resident #113's admission record (a paper documenting resident information including but not limited to name, address, admission date, payer information, contacts, diagnosis), the current physician order summary, and 11 pages titled "Dialysis Communication Form." Review of the pages titled "Dialysis Communication Form" revealed "Section A: Pre-Dialysis (to be completed by Health & (and) Rehab Center); Section B: Dialysis (to be completed by Dialysis Center); Section C: Post- Dialysis (to be	F 698	forwarded to the QAPI committee for further review/recommendation. 5. Date of compliance: 03/16/2020	

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completed by Health & Rehab Center)." Section A documented the following information to be communicated to the dialysis center pre-dialysis:
- "Meal provided to take to dialysis: yes/no
- Medication required before dialysis: yes/no, Name of med(s) (medications):
- Has resident had a change in condition before going to dialysis: yes/no, Describe:
- Medication to be given during dialysis: yes/no, Name of med(s):
- Signature:"

Further review of the pages revealed Section A and Section C completed by the facility on one of 11 pages on 2/1/2020, ten pages failed to evidence documentation of communication to the dialysis center from the facility. Ten pages were observed to be blank in Sections A. Nine pages were observed to be blank in Sections C.

On 2/27/20 at 9:15 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked the process for communication with dialysis for residents who require offsite treatments LPN #1 stated that the dialysis book is utilized. LPN #1 stated that the dialysis book is sent with the resident to dialysis at each treatment for the facility to communicate information with the dialysis center and for the center to communicate information back to them. LPN #1 stated that if there is a significant change in the resident's condition a phone call is made to speak directly to the center and the dialysis center calls them as well. LPN #1 stated that they do not call the dialysis center prior to every appointment for Resident #113, that the communication book is utilized. LPN #1 reviewed the white binder labeled "[Name and Room number of Resident #113] Dialysis Transfer Book" and agreed that the pages titled "Dialysis

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Communication Form" failed to evidence documentation of communication from the facility to the dialysis center on 10 of 11 pages. LPN #1 stated that it appeared to be completed at times and other times it was not being done. LPN #1 stated that Sections A and Sections C of the communication form are the responsibility of the facility staff and should have been completed for each dialysis treatment Resident #113 received.

On 2/27/20 at approximately 11:00 a.m., a request was made by written list to ASM (administrative staff member) #2, the director of nursing for the facility policy on dialysis.

The facility policy "Hemodialysis, Effective Date 11/01/19" documented in part, "7. The Dialysis Communication Form will be initiated prior to sending patient for dialysis ..."

On 2/27/20 at approximately 11:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4, the assistant director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Hemodialysis
Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0

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F 698	Continued From page 51 00707.htm.\ 2. Chronic obstructive pulmonary disease (COPD) 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. Atrial fibrillation 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.	F 698		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to obtain a psychiatric per a physician's order after a resident to resident incident for one of 49 residents in the survey sample, Resident #21. Resident #21 was the aggressor in a resident-to-resident incident of	F 740	F740 1. Resident #21 was discharged on 02/19/2019. Resident #21 initial and last psychiatry evaluation was on 2/14/2020 by Center□s psychiatrist. No changes to her care resulted from the evaluation.	3/16/20

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F 740	Continued From page 52 inappropriate touching of another resident, Resident #7 on 11/26/19. The physician ordered a psychiatric consult for Resident #21, and the facility staff failed to obtain the consult as ordered. The findings include: Resident #21 was admitted to the facility on 7/14/19 with the diagnoses of but not limited to diabetes, depression, hernia, chronic obstructive pulmonary disease, peripheral vascular disease, and high blood pressure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/22/19 coded the resident as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers and toileting, limited assistance for hygiene and dressing; and supervision for eating. Resident #7 was admitted to the facility on 2/28/18 with the diagnoses of but not limited to dementia with behaviors, high blood pressure, psychosis, anxiety disorder, schizoaffective disorder, depression, and diabetes. The annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/4/19 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as limited assistance for bathing, hygiene, toileting, dressing, and transfers; and supervision for ambulation and eating. A review of a FRI dated 11/26/19 documented, "Resident (#21) unzipped the pants of (Resident #7) and was attempting to put her hands inside his pants. Residents were immediately	F 740	2. DON/UMs to review all current patients with incidents requiring psych consult to ascertain that they were completed as ordered by the physician. Anyone noted incomplete will be initiated as a stat order for the psychiatrist to see. 3. SDC/Designee will use the review result in Step 2 above to conduct an in-service with the nurses on the following: a) Managing psychiatry consults. 4. DON/UMs to audit 10% of all patients with psychiatry consult weekly x1 month and monthly x3 months to ascertain that they were completed as ordered. Anyone found not to have been completed will be initiated as a stat order for the psychiatrist. Findings will also be forwarded to the QAPI Committee for additional review and recommendation where applicable. 5. Date of compliance: 3/16/2020	

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separated."

A review of the witness statements and FRI investigation revealed the following:

CNA #1 (Certified Nursing Assistant) statement documented, "(Resident #21) was touching (Resident #7) so I approached her with (CNA #3 and CNA #2) and she (Resident #21) cursed at me and told me to walk away / tried throwing her glass at me then proceeded to unzip (Resident #7) pants and pulled at him to go to his room so she could follow. She stood up and started walking to his room. (Resident #7) tried to stand up multiple times but (Resident #21) kept pulling his arm."

CNA #2 statement documented, "I was in the dining room not at the site of incident but in the same vicinity....(Resident #21) abusive language (cursing at CNA #1). (Resident #21) touching (Resident #7) inappropriately in his private areas (on top of clothing). I am unsure whether consent was given."

RN #2 (Registered Nurse) statement documented, "Unit manager (RN #2) and (OSM #2 - Other Staff Member) discharge planner, interviewed (Resident #21) regarding situation. Asked patient if there was an incident that she remembers that happened during lunch. Patient stated "No, I don't think so but I can't remember." She then stated "Someone was arguing at the same table" and stated, "Man at the end of the table, I was playing with his belly and arm - it was my husband - he's a son of a bitch." Patient heavily confused."

A review of the investigation report documented,

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"(Resident #7) interviewed by DON/UM (Director of Nursing and Unit Manager - ASM #2 (Administrative Staff Member, (the Director of Nursing) and RN #2) and states he doesn't remember..."

The final report of the incident, dated 11/26/19, documented, "...it has been determined that there was an inappropriate interaction between the two residents but that no sexual abuse/assault occurred."

A review of the clinical record for Resident #21 revealed a nurse's note dated 11/27/19 that documented, "Pt was noted to be inappropriately touching another pt in dining room d/t (due to) misidentification of pt's husband on 11/26/19 at 1300 (1:00 pm). Staff immediately separated pt's; assessed both pts, notified MD/RP, Psych (psychiatric) consult ordered, completed FRI on the incident, and moved her to another unit. Current care plan on behavior has been reviewed at this time and is deemed appropriate in addition to the above interventions."

A physician's order dated 11/26/19, documented geriatric psych [psychiatric] consult. Further review of the clinical record failed to reveal documentation evidencing a psych consult was completed.

The "Geriatric Psychiatry initial Evaluation" dated 2/14/2020, documented, "Asked to evaluate Review Mood + (plus) Medications." Further review of the consult failed to reveal any documentation regarding the 11/26/19 incident.

On 2/27/20 at 8:47 AM, an interview was

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F 740	Continued From page 55 conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. ASM #2 stated that the February psych eval is the first one that was done; that none was done after the incident as ordered. She stated she was not sure why it wasn't done. She stated she reached out to the psychiatric physician and that he stated that he see's everyone that is on the list provided to him. ASM #2 stated that she put the resident on the list but does not have the list any longer to evidence that. She stated that it could be the resident was out of the facility at the time of the visit and it should have been followed up on. ASM #2 stated that at this point she would say it got missed. On 2/27/20 at 10:21 AM, ASM #2 stated that there wasn't a policy on providing psych services as ordered. The policy provided, "Report of Consultation" documented, "Policy: The physician may order a consultation with another physician or health care provider. Procedure: 1. Review the Report of Consultation of Physician Progress Notes if applicable. 2. Report findings to attending physician. 3. Implement orders as indicated." On 2/27/20 at 10:27 AM, ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided.	F 740		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		3/16/20

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F 812	Continued From page 56 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to serve food in a sanitary manner on one of four nursing units, the 400 unit. The facility staff failed to handle plates without putting thumbs on the food contact, surface area of the plate and the facility staff failed to cover facial hair during tray line service. The findings include: On 2/25/20 at 11:50 AM, the dining observation was made on the 400-unit dining room. OSM #3 (Other Staff Member) a dining associate, was in the unit dining room small kitchen area, plating food from the steam table for the residents. She was noted to be wearing gloves but was handling serving spoon handles, meal tickets, the surface of the steam table, and other items. She was observed handling plates with her thumb on top side of the rim, which was part of the food contact, surface area, with the same gloves on	F 812	F812 cross reference to 12 VAC 5-371-140; 12 VAC 5-371-180; & 12 VAC 5-371-340 1. The dining services employee observed touching the rim of the plate with a gloved thumb was given 1:1 coaching on 2/26/20. Also, the dining services staff observed with partially uncovered facial hairs was given 1-1 remediation on 2/26/2020. 2. All meal services will be observed to ensure that staff are handling dishes with gloved hands but without touching other surfaces prior to handling individual dishware that would contain food. Dining Services Manager (DSM) will purchase beard guards that are large enough to cover mustache, beard and sides of face that may contain facial hairs. These will be made available to all facility staff upon entering kitchen area. All dining services	

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F 812	Continued From page 57 that she, had worn while touching multiple other items. OSM #3 was also observed picking up rolls with her hand and placing them on the plates, wearing the same gloves, and not using tongs. On 2/26/20 at 8:55 AM, an interview was conducted with OSM #3. OSM #3 stated that the thumb should not be on the top of the plate's food surface area, and that she should pick the rolls up with tongs and not her hand. OSM #3 stated, "I usually grab them with my gloves but I should use tongs." A review of the facility policy, "Glove and Utensil Use" documented, "Tongs may be used instead of gloves to avoid direct hand contact with food during meal service to portion meats, bread, garnishes, baked potatoes, etc." The policy did not include any criteria for handling plates without touching the food contact, surface area. On 2/26/20 at 12:05 PM, during observation of tray line temperatures for the small kitchen of the 400 dining room area, OSM #4, the Dietary Manager, was assisting with the service by preparing bowls of chicken noodle soup from the soup pot. He was observed with a hairnet on his head and beard. However, the hairnet on his beard only covered the front visible portion of the beard and not the back portion under the chin or the sideburns. In addition, he had a mustache, which was not covered. On 2/27/20, at 8:25 AM in an interview with OSM #4, he stated that it should be covering all his facial hair. He stated normally it is but he does pull it down when he is talking to a resident and he had forgotten to put it back into place before	F 812	staff were in-serviced regarding standard precautions while serving on 2/26/20. 3. SDC/Dietitian/Designee will complete the following in-service to all dining staff: a. Standard precautions during meal services: such as handling dishware and covering of facial hairs 4. Dietitian/Dining Services Manager/Designee will audit meal services weekly x1 month and monthly x3 months to ascertain that standard precautions are followed during meal services. Any deficient practice noted will be rectified accordingly and then forwarded to the QAPI committee for further review and recommendation. 5. Date of compliance: 03/16/2020	

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F 812	Continued From page 58 preparing the bowls of chicken noodle soup. A review of the facility policy, "Personal Hygiene and Dress Code" documented, "All persons in the food preparation and food storage areas shall wear hair restraints such as hair coverings, hair nets, or beard guards where necessary, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-use articles. Hats may be worn over top of a hair net." On 2/27/20 at 10:27 AM, ASM #1 (Administrative Staff Member, the Administrator) was made aware of the findings. No further information was provided.	F 812		
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain the dumpster in a sanitary manner to prevent pests. During the kitchen observation on 2/25/2020, the dumpster was observed with multiple overturned boxes of trash and multiple trash bags lying on the ground outside the confines of the dumpster. The findings include: On 2/25/2020 at 11:30 a.m., OSM (other staff member) #4, the dietary manager, accompanied the surveyor on an observation of the facility	F 814	F814 1. The multiple overturned boxes of trash and trash bags on the ground outside of the dumpster were cleaned and placed in the dumpster on 2/25/2020. There has been no siting of trash on ground by the dumpster ever since. Also, there has been no siting of pest within facility and its premises. 2. The House Keeping Manager/Maintenance Director will audit all the premises of the Center to ascertain that the ground is free of trash and	3/16/20

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F 814	Continued From page 59 dumpster. There were several pieces of paper trash on the ground around and in front of the dumpster. On the backside of the dumpster, there were multiple overturned boxes of trash and multiple trash bags lying on the ground outside the confines of the dumpster. The trash had a sour smell. OSM #4 was asked if the trash behind the dumpster should be there. OSM #4 stated, "Of course not. All these materials should be in the dumpster, not behind it." He stated when the dumpster is especially full, trash spills out behind the dumpster onto the ground when the compactor company personnel transfers the garbage to their vehicle. OSM #4 stated the trash compactor company comes to the facility "typically every day." When asked if the company had come to the facility that day (2/25/2020), he stated it had not. When asked if that meant the trash visible behind the dumpster had been there since the day before, OSM #4 stated, "I guess so. I'm going to have one of my folks jump on this." When asked who is responsible for following up after the trash compactor company has come to the facility, OSM #4 stated, "Maintenance." On 2/27/2020 at 8:03 a.m., OSM #7, the maintenance director was interviewed. When asked his responsibilities for the dumpster, he stated he does a daily walk around, and that it is everyone's responsibility to make sure the dumpster area is clean. He stated this includes housekeeping, maintenance, dietary, and nursing. He stated he is aware that when the trash compacting company comes, "lots of times they drop stuff." He stated the walk around occur after the trash compacting company has come for the day. He stated the facility does not have a policy on maintaining the dumpster.	F 814	garbage. Any siting of trash/garbage will be immediately cleaned, and result reported to the daily stand-up meeting for interdepartmental intervention. 3. House Keeping Manager/Maintenance Director/Designee will complete in-service with all the Center staff on the following topics: a. Reporting garbage/trash siting within the Center and its premises b. Maintenance of dumpster area in a sanitary condition 4. House Keeping/Maintenance Director to audit the dumpster area weekly x1 month and monthly x3 months to assure that there are no trash and/or garbage on the ground. Any continuing deficient practice will be rectified immediately and then forwarded to the QAPI Committee for further review and recommendation. 5. Date of compliance: 03/16/2020.	

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F 814	Continued From page 60 On 2/27/2020 at 11:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and ASM #4, the assistant director of nursing, were informed of these concerns. A review of a document that provides instructions for the facility from the maintenance software company revealed, in part: "Check area around dumpsters for cleanliness and security." No further information was provided prior to exit.	F 814		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		3/16/20

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F 880	Continued From page 61 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 62 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined, that the facility staff failed to implement infection control procedures to prevent infection for five of 49 residents in the survey sample, Residents #322, #321, #118, #221 and #47. The facility staff failed to implement infection control procedures for the storage of nebulizer masks when not in use for Residents #322, #321, Resident #118 and Resident #47 and failed to implement infection control procedures for the storage of Resident #321 and 221's incentive spirometers when not in use. The findings include: 1. Resident #322 was admitted to the facility on 2/14/2020, with diagnoses that included but were not limited to chronic obstructive pulmonary disease (2), atrial fibrillation (3) and legal blindness. Resident #322's most recent MDS (minimum data set), was not due at the time of the survey. The facility's nursing admission assessment dated 2/14/2020 coded Resident #322 as being oriented times four, "Oriented to person, place, time and situation." On 2/25/20 at 2:05 p.m., and on 2/25/20 at 4:30 p.m., observations of Resident #322's room revealed a nebulizer unit was observed to be located on top of the nightstand to the left side of the bed. An uncovered mask was observed to be attached to the nebulizer machine and lying on	F 880	F880 1. Residents #322, #321, #118, #221, and #47□s nebulizer masks and tubes were returned to the Center□s designated storage bags on 2/25/2020 and have ever since been maintained. The incentive spirometer for Residents #321 and #221 were placed in Center designated storage bag when not in use. Residents #221 and #118 discharged on 3/6/2020 and 3/4/2020 respectively. 2. DON/ADON/UMs to audit all current patients on ordered nebulizer and incentive spirometer therapies to assure that all necessary standard precautions are maintained. Any unused nebulizer mask and incentive spirometer not bagged will be cleanse as ordered and immediately returned to designated storage bag. The outcome of the above audit will also be used to complete a targeted in-service with nurses assigned to affected patients. 3. SDC/Designee will provide in-service to the nursing staff on the following topics: c) Maintaining sanitary condition of nebulizer mask and incentive spirometer d) Maintaining standard precaution in the management of nebulizer/incentive spirometer therapies. 4. DON/UMs will audit 10% of all current patients with ordered nebulizer and incentive spirometer therapies weekly x4 weeks and monthly x3 months to assure	

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F 880	Continued From page 63 top of the nebulizer machine. On 2/26/20 at 8:10 a.m., an interview was conducted with Resident #322. An additional observation of the nebulizer unit on top of the nightstand to the left of the bed revealed the uncovered mask lying on top of the nebulizer machine as observed above. When asked about the nebulizer and mask, Resident #322 stated that she received the nebulizer as needed for shortness of breath due to COPD (chronic obstructive pulmonary disease). Resident #322 stated that she had used the nebulizer a couple of times since admission when she got short of breath after therapy. When asked how the facility staff maintains the nebulizer and mask, Resident #322 stated that she was not sure because she was legally blind and had a hard time seeing things. The physicians "Order Summary Report" dated "Feb (February) 26, 2020" for Resident #322 documented in part, "Ipratropium-Albuterol (4) Solution 0.5-2.5 MG (milligram)/3 (three) ML (milliliter), 3 ml inhale orally every 4 (four) hours as needed for wheezing related to chronic obstructive pulmonary disease, unspecified, Order Date: 02/14/2020, Start Date: 02/14/2020." The comprehensive care plan for Resident #322 documented in part, "Nursing Care Needs: [Name of Resident #322] has nursing care needs r/t (related to) GI (gastrointestinal) bleed secondary to rectal ulcer (5), pneumonia (6), hypertension (7), hyperlipidemia (8), COPD ... Created on 02/14/2020, Revision on 02/25/2020." Under "Interventions" it documented in part, "Administer medications as ordered and monitor for effectiveness/side effect. Created on	F 880	that standard precautions are maintained in their administration. Any deficient practice noted will be rectified accordingly and then forwarded to the QAPI Committee for further review and recommendation. 5. Date of compliance: 03/16/2020	

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F 880	Continued From page 64 02/14/2020." The "Medication Administration Record" for Resident #322, dated "2/1/2020-2/29/2020" documented Resident #322 receiving "Ipratropium-Albuterol Solution" on 2/18/2020 at 5:21 a.m. On 2/26/20 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows for the storage of the nebulizer after administration of medications, LPN #1 stated that the medication is administered to the resident and afterwards the nebulizer is rinsed out and allowed to air dry. LPN #1 stated that after the nebulizer is dried it is placed in a bag for storage. LPN #1 stated that the nebulizer is air dried for at least ten to fifteen minutes and then placed back in the bag for storage until needed. When asked why the nebulizer mask is stored in a bag, LPN #1 stated it is for infection control purposes because it goes on the residents face. When asked if a nebulizer is considered a respiratory treatment, LPN #1 stated, "Yes." When asked about the nebulizer mask observed in Resident #322's room during the above observations on 2/25/20 at 2:05 p.m. and 4:30 p.m. and on 2/26/20 at 8:30 a.m., LPN #1 stated that she had discarded the mask this morning during her room rounds around 9:00 a.m. LPN #1 agreed that the mask was uncovered and that it was not stored according to the practice of the facility so she had discarded it. On 2/26/20 at approximately 11:00 a.m., a request was made by written list to ASM (administrative staff member) #2, the director of nursing for the facility policy on nebulizer therapy.	F 880		

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F 880	Continued From page 65 The facility policy "Respiratory/Oxygen Equipment, Effective Date 11/01/19" documented in part, "Medicated Nebulizer Treatment ...5. Rinse out nebulizer reservoir with tap water, dry, and place in a plastic bag when not in use. Nebulizers and bags must be changed every Monday, Wednesday, and Friday and dated." On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures and Lippincott as their standard of practice. According to The Lippincott Manual of Nursing Practice 10th Edition, 2014, page 236, Procedure Guidelines 10-11 documented in part, "Follow-up phase 1. Record medication used and description of secretions. 2. Disassemble and clean nebulizer after each use. Keep this equipment in the patient's room. The equipment is changed according to facility policy. Each patient has own breathing circuit (nebulizer, tubing and mouthpiece). Through proper cleaning, sterilization, and storage of equipment, organisms can be prevented from entering the lungs." On 2/26/20 at approximately 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant were made aware of the findings. No further information was provided prior to exit. Reference: 1. Nebulizer is a small machine that turns liquid medicine into a mist. This information was	F 880		

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F 880	Continued From page 66 obtained from the website: https: https://medlineplus.gov/ency/patientinstructions/000006.htm. 2. Chronic obstructive pulmonary disease (COPD) is a 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. Atrial fibrillation is 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. 4. Albuterol and Ipratropium oral inhalation are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html 5. Rectal ulcer- In this condition, an area in the rectum (typically in the form of a single ulcer) leads to passing blood and mucus from the rectum. This information was obtained from the website: https://www.asge.org/home/for-patients/patient-information/understanding-minor-rectal-bleeding 6. Pneumonia is an infection in one or both of the lungs. This information was obtained from the website: https://medlineplus.gov/pneumonia.html. 7. Hypertension is high blood pressure. This information was obtained from the website:	F 880		

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

8. Hyperlipidemia- Cholesterol is a fat (also called a lipid) that your body needs to work properly. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

2. Resident #321 was admitted to the facility on 2/13/2020, with diagnoses that included but were not limited to cervical disc disorder (3), pneumonia (4) and hypertension (5).

Resident #321's most recent MDS (minimum data set), was not due at the time of the survey. The facility's nursing admission assessment dated 2/13/2020 coded Resident #321 as being oriented times three, "Oriented to person, place, and situation."

On 2/25/20 at 2:35 p.m., an interview was conducted with Resident #321. Observation of Resident #321's room revealed a nebulizer unit was observed located on top of the nightstand to the left side of the bed near the window and an uncovered incentive spirometer. An uncovered mask was observed attached to the nebulizer machine and lying on top of the nebulizer machine. When asked about the nebulizer and mask, Resident #321 stated that he received the nebulizer on a regular basis since his admission to the facility. When asked about the incentive spirometer on the nightstand, Resident #321 stated that he received it while in the hospital and still uses it at least once a day. When asked if he required assistance when using the nebulizer and

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F 880	Continued From page 68 incentive spirometer, Resident #321 stated that the staff assists him with both because of his neck collar that he is required to wear and limited mobility. When asked how the facility staff maintains the incentive spirometer, nebulizer and mask, Resident #321 stated that he does not really pay attention to it, that the staff takes care of them. When asked if he has ever seem the staff put the nebulizer or the incentive spirometer in a bag when not being used, Resident #321 stated that he did not remember. An additional observation made on 2/25/20 at 4:35 p.m. and 2/26/20 at 8:45 a.m. revealed the findings above. The physicians "Order Summary Report" dated "Feb (February) 26, 2020" for Resident #321 documented in part, "Albuterol Sulfate (6) Nebulization Solution (2.5 MG (milligram)/3 (three) ML (milliliter)), 0.083% 3 (three) ml inhale orally via (by way of) nebulizer two times a day for shortness of breath, Order Date: 02/13/2020, Start Date: 02/14/2020." The physician order summary report for Resident #321 failed to evidence documentation for the use of the incentive spirometer. The comprehensive care plan for Resident #321 documented in part, "Nursing Care Needs: [Name of Resident #321] has nursing care needs r/t (related to) HTN (hypertension), BPH (benign prostatic hypertrophy) (7), dysphagia (8), hypoxemia (9) ... Created on 02/13/2020, Revision on 02/24/2020." Under "Interventions", it documented in part, "Administer medications/treatment as ordered. Created on 02/13/2020."	F 880		

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F 880	Continued From page 69 The "Medication Administration Record" for Resident #321, dated "2/1/2020-2/29/2020" documented Resident #321 receiving "Albuterol Sulfate Nebulization Solution" at 9:00 a.m. and 5:00 p.m. each day from 2/14/20 through 2/26/20. The "Rehab [rehabilitation] Progress Note" from the transferring hospital dated 2/12/2020 at 11:43 a.m. included in Resident #321's electronic medical record documented in part, "Impression and Plan/Medical Assessment: Rehab Plan: ...Transient hypoxia (10)/abnormal chest x-ray- appreciate input and recommendations from [Name of Physician]." Included in Resident #321's electronic medical record, a "Progress Note-Physician" from the transferring hospital dated 2/12/2020 at 3:01 p.m. was observed to be electronically signed by the physician whose recommendations were requested in the rehab progress note documented above. The progress note documented in part, "Impression and Plan, 1. Abnormal CXR (chest x-ray), L. (left) sided infiltrates, 2. Cough. Recommendations: 1. Agree with empiric Levaquin (antibiotic) to complete a seven day course, 2. BID (two times a day) and PRN (as needed) nebs (nebulizers), 3. Follow up CXR pending, 4. Incentive spirometry." On 2/26/20 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows for residents with ordered nebulizer medications, LPN #1 stated that nebulizer machines are kept in the rooms of the residents. LPN #1 stated that the masks and tubing for the nebulizers are changed three times a week on Mondays, Wednesdays and Fridays. When asked about	F 880		

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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 880	Continued From page 70 the process staff follows for the storage of the nebulizer after administration of medications, LPN #1 stated that the medication is administered to the resident and afterwards the nebulizer is rinsed out and allowed to air dry. LPN #1 stated that after the nebulizer is dried it is placed in a bag for storage. LPN #1 stated that the nebulizer is air dried for at least ten to fifteen minutes and then placed back in the bag for storage until needed. When asked why the nebulizer mask is stored in a bag, LPN #1 stated it is for infection control purposes because it goes on the residents face. When asked if a nebulizer is considered a respiratory treatment, LPN #1 stated, "Yes." When asked about the purpose of an incentive spirometer, LPN #1 stated that it is used to improve deep breathing. When asked if an incentive spirometer is considered a respiratory treatment, LPN #1 stated, "Yes". LPN #1 observed the nebulizer unit with the uncovered mask on top of the unit located on top of the nightstand to the left side of the bed near the window and the uncovered incentive spirometer. LPN #1 checked the area and stated that there was no bag for the mask or the incentive spirometer to be stored. LPN #1 stated that the incentive spirometer was available for use at the bedside for Resident #321. On 2/26/20 at approximately 11:00 a.m., a request was made by written list to ASM (administrative staff member) #2, the director of nursing for the facility policy on nebulizer therapy and incentive spirometry. On 2/26/20 at approximately 12:00 p.m., ASM #2 provided the policy "Respiratory/Oxygen Equipment, Effective Date 11/01/19" which failed to evidence guidance on incentive spirometry.	F 880		

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F 880	Continued From page 71 The facility policy "Respiratory/Oxygen Equipment, Effective Date 11/01/19" documented in part, "Medicated Nebulizer Treatment ...5. Rinse out nebulizer reservoir with tap water, dry, and place in a plastic bag when not in use. Nebulizers and bags must be changed every Monday, Wednesday, and Friday and dated." On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures and Lippincott as their standard of practice. According to The Lippincott Manual of Nursing Practice 10th Edition, 2014, page 236, Procedure Guidelines 10-11 documented in part, "Follow-up phase 1. Record medication used and description of secretions. 2. Disassemble and clean nebulizer after each use. Keep this equipment in the patient's room. The equipment is changed according to facility policy. Each patient has own breathing circuit (nebulizer, tubing and mouthpiece). Through proper cleaning, sterilization, and storage of equipment, organisms can be prevented from entering the lungs." According to Lippincott's Nursing Procedures (6th Edition) 2013, it documented, "Wash the mouthpiece in warm water and dry it. Avoid immersing the spirometer itself in water because water enhances bacterial growth and impairs the internal filter's effectiveness in preventing inhalation of extraneous material. Place the mouthpiece in a plastic storage bag between exercises, and label it and the spirometer, if applicable, with the patient's name to avoid inadvertent use by another patient. Keep the	F 880		

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F 880	Continued From page 72	F 880		

incentive spirometer within the patient's reach."

On 2/27/20 at approximately 11:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4, the assistant director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Nebulizer is a small machine that turns liquid medicine into a mist. This information was obtained from the website: https: https://medlineplus.gov/ency/patientinstructions/000006.htm.

2. Incentive spirometer a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.

3. Cervical disc disorder -Spinal diseases often cause pain when bone changes put pressure on the spinal cord or nerves. They can also limit movement. Treatments differ by disease, but sometimes they include back braces and surgery. This information was obtained from the website: https://medlineplus.gov/spineinjuriesanddisorders.html

4. Pneumonia is an infection in one or both of the lungs. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.

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F 880	Continued From page 73	F 880		

5. Hypertension is high blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

6. Albuterol is in a class of medications called bronchodilators. It works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a607004.html

7. Benign prostatic hyperplasia is an enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

8. Dysphagia is a swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

9. Hypoxemia is low concentrations of oxygen in the blood. This information was obtained from the website: https://ghr.nlm.nih.gov/condition/surfactant-dysfunction.

10. Hypoxia is deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.

3. Resident #118 was admitted to the facility on 1/30/2020, with diagnoses that included but were

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F 880	Continued From page 74 not limited to hypertension (2), chronic kidney disease (3) and atherosclerotic heart disease (4). Resident #118's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/5/2020, coded Resident #118, as scoring a 0 (zero) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 0- being severely impaired for making daily decisions. On 2/25/20 at 2:25 p.m., an observation was made of Resident #118's room revealed a nebulizer unit located on top of the nightstand to the right side of the bed. An uncovered mask was observed attached to the nebulizer machine, propped on top of the machine. A plastic bag was observed hanging underneath the nebulizer machine on the nightstand dated "2/5/20." Additional observations of Resident #118's room on 2/25/20 at 4:45 p.m. and 2/26/20 at 8:50 a.m. revealed the findings above. The physicians "Order Summary Report" dated "Feb (February) 26, 2020" for Resident #118 documented in part, "Ipratropium-Albuterol (5) Solution 0.5-2.5 MG (milligram)/3 (three) ML (milliliter), 3 ml inhale orally via (by way of) nebulizer three times a day related to other asthma (6) Order Date: 02/11/2020, Start Date: 02/12/2020." The comprehensive care plan for Resident #118 documented in part, "Nursing Care Needs: [Name of Resident #118] has nursing care needs r/t (related to) hypertension, chronic kidney disease, hyponatremia (6), right eye blindness, asthma (7), ... Created on 01/30/2020, Revision on	F 880		

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F 880	Continued From page 75 02/11/2020." Under "Interventions", it documented in part, "Administer medications and treatment per order. Created on 01/30/2020." The "Medication Administration Record" for Resident #118, dated "2/1/2020-2/29/2020" documented Resident #118 receiving "Ipratropium-Albuterol Solution" four times a day from 2/1/2020 through 2/11/2020 and three times a day from 2/12/20 through 2/26/20. On 2/26/20 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows for residents with ordered nebulizer medications, LPN #1 stated that nebulizer machines are kept in the rooms of the residents. LPN #1 stated that the masks and tubing for the nebulizers are changed three times a week on Mondays, Wednesdays and Fridays. When asked about the process staff follows for the storage of the nebulizer after administration of medications, LPN #1 stated that the medication is administered to the resident and afterwards the nebulizer is rinsed out and allowed to air dry. LPN #1 stated that after the nebulizer is dried it is placed in a bag for storage. LPN #1 stated that the nebulizer is air dried for at least ten to fifteen minutes and then placed back in the bag for storage until needed. When asked why the nebulizer mask is stored in a bag, LPN #1 stated it is for infection control purposes because it goes on the residents face. When asked if a nebulizer is considered a respiratory treatment, LPN #1 stated, "Yes." LPN #1 observed the nebulizer unit with the uncovered mask on top of the unit located on top of the nightstand to the right side of the bed. LPN #1 viewed the nebulizer and the mask and stated that it was not in a bag.	F 880		

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On 2/26/20 at approximately 11:00 a.m., a request was made by written list to ASM (administrative staff member) #2, the director of nursing for the facility policy on nebulizer therapy.

The facility policy "Respiratory/Oxygen Equipment, Effective Date 11/01/19" documented in part, "Medicated Nebulizer Treatment ...5. Rinse out nebulizer reservoir with tap water, dry, and place in a plastic bag when not in use. Nebulizers and bags must be changed every Monday, Wednesday, and Friday and dated."

On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures and Lippincott as their standard of practice.

According to The Lippincott Manual of Nursing Practice 10th Edition, 2014, page 236, Procedure Guidelines 10-11 documented in part, "Follow-up phase 1. Record medication used and description of secretions. 2. Disassemble and clean nebulizer after each use. Keep this equipment in the patient's room. The equipment is changed according to facility policy. Each patient has own breathing circuit (nebulizer, tubing and mouthpiece). Through proper cleaning, sterilization, and storage of equipment, organisms can be prevented from entering the lungs."

On 2/26/20 at approximately 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant were made aware of the findings.

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No further information was provided prior to exit.

Reference:

1. Nebulizer is a small machine that turns liquid medicine into a mist. You sit with the machine and breathe in through a connected mouthpiece. This information was obtained from the website: https: https://medlineplus.gov/ency/patientinstructions/000006.htm.

2. Hypertension is high blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

3. Chronic kidney disease: Kidneys are damaged and cannot filter blood, as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html.

4. Atherosclerosis is a disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium, and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the flow of oxygen-rich blood to your body. This information was obtained from the website: https://medlineplus.gov/atherosclerosis.html.

5. Albuterol and Ipratropium oral inhalation are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.h

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6. Hyponatremia is low sodium (salt) level. This information was obtained from the website: https://medlineplus.gov/ency/article/000394.htm.

7. Asthma is a disease that causes the airways of the lungs to swell and narrow. It leads to wheezing, shortness of breath, chest tightness, and coughing. This information was obtained from the website: https://medlineplus.gov/ency/article/000141.htm.
4. The facility staff failed to implement infection control procedures for the storage of Resident # 221's incentive spirometer.

Resident # 221 was admitted to the facility with diagnoses that included but were not limited to: obstructive sleep apnea [1] and high blood pressure. Resident # 221's MDS (minimum data set), was not due at the time of the survey. The facility's nursing "Admission Assessment" for Resident # 221 documented in part, "2. Orientation: a. Person, b. Place, c. Time (day, month, year), d. Situation."

On 02/25/20 at 11:57 a.m., 02/25/20 at 2:00 p.m., and on 02/26/20 at 10:03 a.m., an observation of Resident # 221's room revealed an incentive spirometer on the over-the-bed table uncovered.

On 02/27/20 at 11:25 a.m., an interview was conducted with Resident #221. When asked if they used the incentive spirometer Resident 221 stated that they used it a couple of times a day.

The POS [physician's order sheet] for Resident # 221 dated February 2020 documented in part, "Incentive Spirometer Q 1 H PRN [every hour as

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F 880	Continued From page 79 needed] when awake. Order Date: 02/22/2020." The comprehensive care plan for Resident # 221 dated 02/20/2020 documented in part, "Focus. Altered Respiratory Status: [Resident # 221] has altered respiratory status, difficulty breathing r/t [related to] Sleep Apnea. Created on: 02/20/2020." Under "Interventions" it documented, "Administer medications/puffers as ordered. Monitor for effectiveness and side effects. Created on: 02/20/2020." On 02/26/2020 at 1:25 p.m., an observation of Resident # 221's incentive spirometer sitting on their bedside table uncovered and interview was conducted with LPN [licensed practical nurse] # 3. When asked if an incentive spirometer was considered respiratory equipment, LPN # 3 stated yes. When asked how an incentive spirometer should be stored when not in use, LPN # 3 stated, "It should be placed in a bag and dated." After observing the spirometer sitting on the bedside table uncovered, LPN # 3 stated that it should be placed in a bag. When asked why it was important to store the incentive spirometer in a bag, LPN # 3 stated to prevent infection. On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures and Lippincott as their standard of practice. "Wash the mouthpiece in warm water and dry it. Avoid immersing the spirometer itself in water because water enhances bacterial growth and impairs the internal filter's effectiveness in preventing inhalation of extraneous material. Place the mouthpiece in a plastic storage bag between exercises, and label it and the	F 880		

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spirometer, if applicable, with the patient's name to avoid inadvertent use by another patient. Keep the incentive spirometer within the patient's reach." Lippincott's Nursing Procedures (6th Edition) 2013.

On 02/26/2020 at 4:45 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nursing consultants were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.

5. Resident # 47 was admitted to the facility with diagnoses that included but were not limited to: pneumonia, respiratory failure and chronic obstructive pulmonary disease [1].

Resident # 47's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/19/2019, coded Resident # 47 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. In Section O "Special Treatment, Procedures and Programs", coded Resident # 47 was coded as receiving oxygen therapy.

On 02/25/20 at 12:03 p.m., 02/25/20 at 3:45 p.m., and 02/26/20 at 10:08 a.m., observations of

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F 880	Continued From page 81 Resident # 47's nebulizer mask revealed it was on the bedside table uncovered. The POS [physician's order sheet] for Resident # 47 dated February 2020 documented in part, "Nebulizer tubing setup change M-W-F [Monday-Wednesday-Friday] 11-7 [11:00 p.m. - 7:00 a.m.] shift every night shift for Protocol. Order Date: 09/03/2019. Start Date: 09/03/2019." The comprehensive care plan for Resident # 47 dated 09/13/2019 documented in part, "Focus. Oxygen Therapy: [Resident # 47] has oxygen therapy r/t [related to] COPD [chronic obstructive pulmonary disease]. Patient has sob [shortness of breath] when lying flat and with exertion. Created on: 09/13/2019." Under "Interventions" it documented, "Give medications as ordered by physician. Created on: 09/13/2019." On 02/26/2020 at approximately 1:25 p.m., an observation of Resident # 47's nebulizer mask sitting on their bedside table uncovered and interview was conducted with LPN [licensed practical nurse] # 3. When asked if a nebulizer mask was considered respiratory equipment, LPN # 3 stated yes. When asked how a nebulizer mask should be stored when not in use, LPN # 3 stated, "It should be placed in a bag and dated." After observing the nebulizer mask on the bedside table uncovered LPN # 3 agreed that it should be placed in a bag. When asked why it was important to store the nebulizer mask in a bag, LPN # 3 stated to prevent infection. On 2/25/2020 at approximately 11:30 a.m., ASM #2, the director of nursing stated that the facility staff uses their policies, procedures, and Lippincott as their standard of practice.	F 880		

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F 880	Continued From page 82 On 02/26/2020 at 4:45 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nursing consultants were made aware of the above findings. No further information was provided prior to exit. References: [1] 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.	F 880		