STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495279	A. BUILDING _____ B. WING _____	C 05/19/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/17/21 through 05/19/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/17/2021 through 05/19/2021. One complaint [VA00051491-unsubstantiated with no deficiencies] were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 180 bed certified facility was 166 at the time of the survey. The survey sample consisted of 33 current resident reviews and six closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		6/8/21

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

Electronically Signed | 06/01/2021

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to promote resident's dignity for three of 33 current residents in the survey sample, Resident's # 26, #141 and #108. The facility staff were observed standing while feeding Resident #26 and Resident #141. The facility staff failed to provide privacy for Resident # 108's catheter collection bag [1]. The findings include:	F 550	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s	

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F 550	Continued From page 2 1. Facility staff stood next to Resident # 26 while they fed them their lunch and breakfast. Resident # 26 was admitted to the facility with diagnoses that included but were not limited to: swallowing difficulties, muscle weakness and high blood pressure. Resident # 26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/03/2021, coded Resident # 26 as scoring a 7 [seven] on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being moderately impaired of cognition for making daily decisions. Resident # 26 was coded as requiring extensive assistance of one staff member for eating. On 05/17/2021 at 12:45 p.m., an observation was conducted of Resident # 26 being assisted with their lunch by a CNA [certified nursing assistant] # 2. The observation revealed Resident # 26 was lying in the bed with head of the bed raised and the CNA # 2 was standing next to the bed, the over-the-bed-table next to the bed with their lunch tray on the over-the-bed-table feeding Resident # 26. Further observation revealed the privacy curtain was open and the CNA # 2 could be seen feeding Resident # 26 from the hallway. On 05/17/2021 at 12:45 p.m., an observation was conducted of Resident # 26 being assisted with their breakfast by a CNA # 1. The observation revealed Resident # 26 was lying in the bed with head of the bed raised and CNA # 1 was standing next to the bed, the over-the-bed-table next to the bed with their lunch tray on the over-the-bed-table feeding Resident # 26.	F 550	allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 cross reference to 12VAC5-371-150A 1. Resident # 26 and #141 have been stable with no signs of status indignation from the staff standing up to assist feed them on 5/17/2021. The staff involved will receive a 1-1 remediation on standard protocol during patient feeding assistance. Also, the catheter collection receptacle for Resident #108 was placed in a privacy bag on 5/18/2021. 1-1 in-service with the affected staff that worked with Resident #108 on 5/17/21 & 5/18/2021 will be conducted by the Staff Development Coordinator (SDC) on maintaining privacy for catheter bag use by patients. 2. Unit Managers will audit all current patients using catheter to ascertain that they are placed in a privacy bag accordingly. Also, the UMs will observe feeding assistance during the different daily meals to assure that patients dignity are maintained in the process consistently. Any anomaly noted will be corrected immediately as applicable. Result of the audit will also be used to provide an individualized in-service to the affected nursing staff. 3. SDC in coordination with the Unit Managers will in-service the nursing staff on the following topics: a) Maintaining patient dignity during assist feeding b) Maintaining patient privacy in the use of a catheter	

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F 550	Continued From page 3 On 05/18/2021 at 1:45 p.m., an interview was conducted with CNA # 1. When asked if it was dignified to stand and feed a resident CNA # 1 stated, "It's ok. That's how I was trained." On 05/18/21 at 1:54 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, unit manager, regarding a CNA's position when feeding a resident. LPN # 4 stated, "They [CNA's] are not trained to stand and feed the resident. They should have been sitting down and the curtain should be pulled." When informed of the observations above LPN # 4 stated, "They should have gotten a chair and brought it into the room." When asked if it was dignified to feed a resident while standing LPN # 4 stated no. The facility's document entitled "Resident Rights" documented in part, "12. To be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs." On 05/18/2021 at approximately 4:40 p.m., ASM # 1, administrator and ASM # 2, director of nursing, and ASM # 3, nurse consultant, were made aware of the above findings. No further information was provided prior to exit. 2. Facility staff stood next to Resident # 141 while they fed them their lunch and breakfast. Resident # 141 was admitted to the facility with diagnoses that included but were not limited to: Alzheimer's disease and high blood pressure. Resident # 141's most recent MDS (minimum	F 550	4. DON/ADON/UMs will audit active assist feeding and catheter bags weekly x1 month and monthly x3 months to assure that patient dignity and privacy are maintained consistently. Any noted deficient practice will be rectified immediately as appropriate. Findings will also be forwarded to the QAPI Committee for additional review and recommendation where applicable. 5. Date of compliance: 6/8/2021.	

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data set), a quarterly assessment with an ARD (assessment reference date) of 04/29/2021, coded Resident # 141 as scoring a 3 [three] on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severly impaired of cognition for making daily decisions. Resident # 141 was coded as requiring extensive assistance of one staff member for eating.

On 05/17/2021 at 12:45 p.m., an observation was conducted of Resident # 80 being assisted with their lunch by a CNA [certified nursing assistant] # 2. The observation revealed Resident # 80 was in bed with the head of the bed raised and a CNA # 2 was standing next to the bed, the over-the-bed-table in front of the CNA #2 with Resident # 80's lunch tray on the over-the-bed-table feeding Resident # 80

On 05/18/21 at 8:47 a.m., an observation was conducted of Resident # 80 being assisted with their breakfast by a CNA #3. The observation revealed Resident # 80 was in bed with the head of the bed raised and a CNA #3 was standing next to the bed, the over-the-bed-table in front of the CNA #3 with Resident # 80's breakfast tray on the over-the-bed-table feeding Resident # 80.

On 05/18/2021 at 1:45 p.m., an interview was conducted with CNA # 1. When asked if it was dignified to stand and feed a resident CNA # 1 stated, "It's ok. That's how I was trained."

On 05/18/21 at 1:54 p.m., an interview was conducted with LPN [licensed practical nurse] # 4, unit manager, regarding a CNA's position when feeding a resident. LPN # 4 stated, "They [CNA's] are not trained to stand and feed the resident. They should have been sitting down and

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the curtain should be pulled." When informed of the observations above LPN # 4 stated, "They should have gotten a chair and brought it into the room." When asked if it was dignified to feed a resident while standing LPN # 4 stated no.

On 05/18/2021 at approximately 4:40 p.m., ASM # 1, administrator and ASM # 2, director of nursing, and ASM # 3, nurse consultant, were made aware of the above findings.

No further information was provided prior to exit.

3. The facility staff failed to provide privacy for Resident # 108's catheter collection bag [1].

Resident # 108 was admitted to the facility with diagnoses that included but were not limited to: retention of urine, muscle weakness and high blood pressure..

Resident # 108's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/19/2021, coded Resident # 108 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 - being moderately impaired of cognition for making daily decisions. Resident # 108 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

On 05/17/2021 at 12:40 p.m., an observation of Resident #108 revealed they were lying in bed. Observation of the bed revealed a catheter collection bag and its contents hanging from the lower frame of the bed, could be seen from the hallway.

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On 05/17/21 at 4:26 p.m., an observation of Resident #108 revealed they were lying in bed. Observation of the bed revealed a catheter collection bag and its contents hanging from the lower frame of the bed, could be seen from the hallway.

On 05/18/21 at 2:40 p.m., an observation of Resident #108 revealed they were lying in bed. Observation of the bed revealed a catheter collection bag and its contents hanging from the lower frame of the bed, could be seen from the hallway.

On 05/18/2021 at approximately 2:42 p.m., an interview was conducted with Resident # 108 regarding the catheter collection bag and its contents being visible from the hallway. Resident # 108 stated, "It doesn't make me feel good, I know what it for but other people don't. I don't like that it can be seen."

On 05/18/2021 at approximately 2:45 p.m., an observation of Resident # 108's catheter collection bag was conducted with LPN [licensed practical nurse] #4, unit manager, from the hallway. Upon observing the catheter collection bag and its contents LPN # 4 stated, "It should be in a privacy bag so it can't be seen."

The POS [physician's order sheet] dated May 2021 for Resident # 108 documented in part, "Foley care q [every] shift. Start Date: 5/5/2021."

The comprehensive care plan for Resident # 108 dated 01/16/2021 documented in part, "Need: FOLEY: [Resident # 108] has Foley Catheter [2] r/t [related to] urinary retention. Created on: 05/05/2021." Under "Interventions" it

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F 550	Continued From page 7 documented in part, "Monitor for s/s [signs and symptoms] of discomfort on urination and frequency. Created on: 05/05/2021." The facility's policy "Urinary/Catheter Care" documented in part, "18. Hang bag below level of the bladder and place privacy bag over the drainage bag." On 05/18/2021 at approximately 4:40 p.m., ASM # 1, administrator and ASM # 2, director of nursing, and ASM # 3, nurse consultant, were made aware of the above findings. No further information was provided prior to exit. References: [1] Urine drainage bags collect urine. Your bag will attach to a catheter (tube) that is inside your bladder. You may have a catheter and urine drainage bag because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000142.htm. [2] A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		6/8/21

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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 section.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 9 Based on observation, resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to implement the comprehensive care plan for the use of TED hose for one of 33 residents in the survey sample, Resident #42. The findings include: Resident #42 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (COPD) (2) and diabetes (3). Resident #42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/10/2021 coded Resident #42 as scoring an eight on the staff assessment for mental status (BIMS) of a score of 0 - 15, 8- being moderately impaired for making daily decisions On 5/17/2021 at approximately 1:10 p.m., an observation was conducted of Resident #42 in their room. Resident #42 was observed lying in bed. Resident #42 was observed not wearing TED (1) hose and was observed wearing red anti-slip socks on their feet. An additional observation on 5/17/2021 at approximately 3:55 p.m. revealed the findings above. An interview was conducted at this time. When asked if they wore TED hose during the day, Resident #42 stated they did not know. The comprehensive care plan dated 7/28/2017, documented in part, "ADL: (activities of daily living) [Resident #42] has an ADL self-care performance deficit r/t (related to) intellectual disability, (4), impaired mobility... Created on:	F 656	F656 1. Resident # 42□s Tedhose was placed on him on 5/18/2021 as ordered by the physician and care planned. Resident #42 continue to stable at baseline with no presentation of acute onset of edema to low extremities consequent to the occasional non-adherence to the MD order for Tedhose observed on 5/17/21 and partially on 5/18/2021. 2. Unit Managers will audit all current patients with active Tedhose orders to ascertain that they have been placed on the patients as directed by the physician. Any deficient practice noted will be corrected immediately as appropriate. Result of the audit will also be used to provide an individualized in-service to the affected nursing staff. 3. SDC in coordination with the Unit Managers will in-service the nursing staff on the following topics: a) Following the physician□s order b) Maintaining and managing the Tedhose 4. DON/ADON/UMs will audit current patients with active Tedhose orders weekly x1 month and monthly x3 months to assure that they are been followed accordingly. Any noted deficient practice will be rectified as applicable. Findings will also be forwarded to the QAPI Committee for additional review and recommendation where applicable. 5. Date of compliance: 6/8/2021.	

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07/28/2017, Revision on: 09/06/2018." Under "Interventions" it documented in part, "TED Hose as ordered. Created on: 02/19/2021..."

The physician orders for Resident #42 documented in part, "Ted hose: to be applied in the AM (morning) and removed in the PM (evening) one time a day for edema and remove per schedule. Order Date: 12/28/20."

The eTAR (electronic treatment administration record) for Resident #42 documented in part, "Ted hose: to be applied in the AM and removed in the PM one time a day for edema (swelling) and remove per schedule. Order Date 12/28/2020. Remove 0859 (8:59 a.m.) Apply 0900 (9:00 a.m.)." The eTAR documented Resident #42 wearing the TED hose each day 5/1/2021 through the present.

On 5/18/2021 at approximately 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that TED hose were applied and removed as ordered by the physician. LPN #4 stated that the nursing staff cared for the TED hose by washing them and replacing them when needed with new hose.

On 5/18/2021 at approximately 2:10 p.m., LPN #4 was accompanied to Resident #42's room. LPN #4 examined Resident #42's legs and stated that the TED hose were not in place and Resident #42 only had on the red gripper socks. LPN #4 checked Resident #42's closet drawers and stated that there were no TED hose in the drawer. LPN #4 stated that they would ask LPN #3 to obtain TED hose for Resident #42.

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On 5/19/2021 at approximately 8:05 a.m., an interview was conducted with LPN #4. LPN #4 stated that the care plan documented different categories of patient care related to the specific patient. LPN #4 stated that the care plan served as a pathway to the residents care. LPN #4 stated that they were not following the care plan for Resident #42 if not applying the TED hose as ordered. LPN #4 stated that they should document refusals and when Resident #42 was not wearing the TED hose as ordered.

On 5/18/2021 at approximately 5:00 p.m., a request was made by written list to ASM (administrative staff member) #1, the administrator for the facility policy on implementing the care plan.

The facility policy, "Resident Assessment & Care Planning" dated 11/01/19 documented 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 patient..."

On 5/19/2021 at approximately 8:00 a.m., ASM #1 stated that the facility used Potter & Perry as their nursing standard of practice.

According to Potter, Patricia A., & Perry, Anne Griffin. (2005). Fundamentals of nursing. 6th Edition, St. Louis, MO: Mosby, Inc. Page 327, "A nursing care plan is a guide for clinical care. It also serves as a document that communicates a client's nursing care to all members of the health

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F 656	Continued From page 12	F 656		

care team. It is made available to the team as a ready reference for nursing care interventions."

On 5/18/2021 at approximately 4:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the nurse consultant were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. TED (thromboembolic disease) hose: Compression stockings to improve blood flow in your legs. Compression stockings gently squeeze your legs to move blood up your legs. This helps prevent leg swelling and, to a lesser extent, blood clots. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000597.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. Diabetes mellitus: A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

4. Intellectual disability: Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and

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F 656	Continued From page 13 routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to follow professional standards of practice for one of nine residents in the medication administration observation, Resident #30. The facility staff failed to follow medication administration standards of practice during the administration of a Dulera Aerosol inhaler to Resident #30 on 5/17/2021. The findings include: Resident #30 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (COPD) (2) and dementia (3). Resident #30's most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of	F 658	F658 1. Resident #30 remain stable with no negative effect from the staff failure to follow standard of practice in the administration of Dulera inhaler on 5/17/2021. Individualized in-service will be provided to the affected nurse on standard protocol to administer Dulera inhaler. 2. Unit Managers will audit all current patients with active orders for inhaler use (such as Dulera) to ascertain that standard of practice are maintained consistently by the nursing in their administration to the patients. Any anomaly identified will be corrected immediately as applicable. Result of the audit will also be used to provide an individualized in-service to any affected nursing staff identified by the audit.	6/8/21

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F 658	Continued From page 14 3/1/2021 coded Resident #30 as scoring an 11 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 11- being moderately impaired for making daily decisions. On 5/17/2021 at approximately 4:49 p.m., an observation of medication administration for Resident #30 was conducted with LPN (licensed practical nurse) #2. LPN #2 prepared medications to administer to Resident #30 including removing a Dulera inhaler from the manufacturer's box it was stored in. The Dulera inhaler was observed without a cap over the mouthpiece. LPN #2 stated that the cap was missing. LPN #2 was observed administering the Dulera inhaler to Resident #30. LPN #2 failed to wipe off the mouthpiece before or after the administration of the dosages. LPN #2 waited approximately 12 seconds between administration of the first puff and administration of the second puff. LPN #2 failed to utilize or offer the ordered spacer with the inhaler to Resident #30. LPN #2 failed to have Resident #30 rinse their mouth after administration of the inhaler. On 5/17/2021 at approximately 4:56 p.m., an interview was conducted with LPN #2. LPN #2 stated that they had forgotten to have Resident #30 rinse their mouth after their inhaler. LPN #2 stated that the mouthpiece cap for Resident #30's inhaler was missing and they did not know where it was. LPN #2 stated that they were unsure what the process was when the cap was missing as this was not their normal medication cart or hallway. LPN #2 stated that the cap was on the inhaler to keep it clean. On 5/18/2021 at approximately 8:15 a.m., an	F 658	3. SDC will in-service the nurses on the following topics: a) Standard of practicing in administering inhaler, such as Dulera 4. DON/ADON/UMs will audit 10% of all current patients on active inhaler therapies, such as Dulera weekly x1 month, and monthly x3 months to ascertain that standard of practice in their administration are followed consistently. Any noted deficient practice will be rectified immediately as appropriate. Findings will also be forwarded to the QAPI Committee for additional review and recommendation where applicable. 5. Date of compliance: 6/8/2021.	

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F 658	Continued From page 15	F 658		

interview was conducted with LPN #3. LPN #3 stated that Resident #30 had an ordered Dulera inhaler. LPN #3 stated that they waited 2-3 minutes between puffs to ensure that the medication was getting into the lungs and giving it time to work. LPN #3 stated that after the second puff they had Resident #30 rinse their mouth with water and spit the water out. LPN #3 stated that the purpose of the water was to rinse off any residual medication in their mouth and throat. LPN #3 stated that rinsing the mouth after the inhaler was a standard of practice with this medication. LPN #3 stated that they cleaned off the mouthpiece with a tissue before and after administration. LPN #3 stated that Resident #30 was supposed to use a spacer with their Dulera inhaler but they did not like to use it and refused it frequently. LPN #3 stated that the spacer should be offered with each administration and documented if Resident #30 refused to utilize it with their inhaler. LPN #3 stated that the purpose of the spacer was to hold the medication inside longer allowing the resident time to breathe the medication in if they were unable to breathe in when the puff came out.

Review of the "Order Summary Report" dated "May 19, 2021" documented in part, "Dulera Aerosol 100-5 MCG/ACT 2 (two) puff inhale orally two times a day related to chronic obstructive pulmonary disease, unspecified. Rinse mouth with water after use. Do not swallow. Order Date: 06/17/2020."

The "Medication Administration Record" dated "5/1/2021-5/31/2021" documented Resident #30 receiving the Dulera inhaler as documented above each day at 9:00 a.m. and 5:00 p.m. It further documented, "Spacer/Aero-Holding

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Chambers (4) Device 2 (two) puff inhale orally two times a day related to WHEEZING. Order Date: 11/05/2019." The medication administration record documented Resident #30 using the spacer/Aero-holding chamber each day at 9:00 a.m. and 5:00 p.m.

The comprehensive care plan for Resident #30 dated 6/14/19 documented in part, "[Resident #30] has episodes of shortness of breath r/t (related to) COPD. Created on: 06/14/2019; Revision on: 10/17/2019..." Under "Interventions" it documented, "Administer medications and/or treatments as ordered..."

On 5/18/2021 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy on medication administration related to inhalers and for the manufacturer's instructions for use for the Dulera inhaler.

The facility policy "General Dose Preparation and Medication Administration" dated "12/01/07" documented in part, "...During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: ...Provide the resident with any necessary instructions (e.g., using an inhaler); Follow manufacturer medication administration guidelines..." The policy further documented, "...After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: ...Clean any reusable equipment or supplies..."

The drug information document from [Name of

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Pharmacy] for the Dulera inhaler provided by the facility documented in part, "...Shake the inhaler well before each use. Remove the cap. Inhale this medication by mouth as directed by your doctor, usually twice daily (in the morning and evening). Always replace the cap properly after using the inhaler. If your prescribed dose is 2 puffs, wait at least one minute between them...Gargle and rinse your mouth with water after each use of this medication to help prevent dryness, irritation, and yeast infections (thrush) in the mouth and throat. Do not swallow the rinse water..."

On 5/19/2021 at approximately 8:00 a.m., ASM #1 stated that the facility used Potter & Perry as their nursing standard of practice.

The facility provided document, "Using Metered-Dose Inhalers" from Clinical Nursing Skills & Techniques, 8th Edition, Potter & Perry, pgs. 521- 523" documented in part, "... Instruct patient to tilt head back slightly and inhale slowly and deeply through mouth for 3 to 5 seconds while depressing canister fully. Have patient hold breath for about 10 seconds. Instruct patient to wait 20 to 30 seconds between inhalations (if same medication)...About 2 minutes after last dose, instruct patient to rinse mouth with warm water and spit water out..."

On 5/18/2021 at approximately 4:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the nurse consultant were made aware of the findings.

No further information was presented prior to exit.

References:

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F 658	Continued From page 18 1. Dulera inhaler DULERA is a prescription medicine used to control symptoms of asthma and prevent symptoms such as wheezing in people 5 years of age and older. This information was obtained from the website: https://www.dulera.com/using-dulera-inhaler/ 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. Dementia A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 4. Spacer/Aero-Holding Chambers Device Spacers (also called holding chambers) work with your metered dose inhaler (MDI) to deliver inhaled medication more easily and effectively, and can reduce side effects. Spacers hold the "puff" of medicine between you and the MDI, so that you can inhale it slowly and more completely. As a result, more of the medicine gets into your airways. This information was obtained from the following website: https://medlineplus.gov/ency/presentations/100203_1.htm	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		6/8/21

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F 684	Continued From page 19 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to follow the physician's order for the use of TED hose for one of 33 residents in the survey sample, Resident #42. The findings include: Resident #42 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (COPD) (2) and diabetes (3). Resident #42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/10/2021 coded Resident #42 as scoring an eight on the staff assessment for mental status (BIMS) of a score of 0 - 15, 8- being moderately impaired for making daily decisions On 5/17/2021 at approximately 1:10 p.m., an observation was conducted of Resident #42 in their room. Resident #42 was observed lying in bed. Resident #42 was observed wearing red anti-slip socks on their feet and their legs were observed to be bare.	F 684	F684 1. Resident # 42□s Tedhose was placed on him on 5/18/2021 as ordered by the physician. Resident #42 continue to stable at baseline with no presentation of acute onset of edema to low extremities consequent to the occasional non-adherence to the MD order for Tedhose observed on 5/17/21 and partially on 5/18/2021. 2. Unit Managers will audit all current patients with active Tedhose order to ascertain that the physician□s orders on them are been followed consistently. Any deficient practice noted will be corrected immediately as appropriate. Result of the audit will also be used to provide an individualized in-service to the affected nursing staff. 3. SDC in coordination with the Unit Managers will in-service the nursing staff on the following topics: a) Following the physician□s order b) Maintaining and managing the Tedhose 4. DON/ADON/UMs will audit current patients with active Tedhose orders weekly x1 month and monthly x3 months	

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F 684	Continued From page 20 An additional observation on 5/17/2021 at approximately 3:55 p.m. revealed the findings above. An interview was conducted at this time. When asked if they wore TED hose during the day, Resident #42 stated they did not know. The physician orders for Resident #42 documented in part, "Ted hose: to be applied in the AM (morning) and removed in the PM (evening) one time a day for edema and remove per schedule. Order Date: 12/28/20." The eTAR (electronic treatment administration record) for Resident #42 documented in part, "Ted hose: to be applied in the AM and removed in the PM one time a day for edema (swelling) and remove per schedule. Order Date 12/28/2020. Remove 0859 (8:59 a.m.) Apply 0900 (9:00 a.m.)." The eTAR documented Resident #42 wearing the TED hose each day 5/1/2021 through the present. The progress notes for Resident #42 documented in part, "12/27/2021 12:47 (12:47 p.m.) ...New orders per [Name of nurse practitioner] for ted hose for both legs to be put on in the morning and removed in the PM (evening) every day and night for shift for edema..." The comprehensive care plan dated 7/28/2017 documented in part, "ADL: (activities of daily living) [Resident #42] has an ADL self-care performance deficit r/t (related to) intellectual disability, (4), impaired mobility... Created on: 07/28/2017, Revision on: 09/06/2018." Under "Interventions" it documented in part, "TED Hose as ordered. Created on: 02/19/2021..."	F 684	to assure that they are been followed accordingly. Any noted deficient practice will be rectified as applicable. Findings will also be forwarded to the QAPI Committee for additional review and recommendation where applicable. 5. Date of compliance: 6/8/2021.	

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On 5/18/2021 at approximately 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that TED hose were applied and removed as ordered by the physician. LPN #4 stated that the nursing staff cared for the TED hose by washing them and replacing them when needed with new hose.

On 5/18/2021 at approximately 2:10 p.m., LPN #4 observed Resident #42 in their room. LPN #4 examined Resident #42's legs and stated that the TED hose were not in place and Resident #42 only had on the red gripper socks. LPN #4 checked Resident #42's closet drawers and stated that there were no TED hose in the drawer. LPN #4 stated that they would ask LPN #3 to obtain TED hose for Resident #42.

On 5/18/2021 at approximately 5:00 p.m., a request was made by written list to ASM (administrative staff member) #1, the administrator for the facility policy on following the physician orders.

The facility policy "Physician's Orders" dated 3/24/20 failed to evidence guidance for following the physician's orders.

On 5/19/2021 at approximately 8:00 a.m., ASM #1 stated that the facility used Potter & Perry as their nursing standard of practice.

According to Fundamentals of Nursing, 6th edition, Perry and Potter 2005, page 1451-1453, "Elastic stockings (sometimes called thromboembolic device hose) (TED) also aid in maintaining external pressure on the muscles of the lower extremities and thus may promote

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venous return....The skill of applying TED hose can be performed by assistive personnel. The nurse is responsible for assessing circulation to the lower extremities....Record date and time of stocking application and stocking length and size in nurse's notes....Record condition of skin and circulatory assessment."

On 5/18/2021 at approximately 4:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the nurse consultant were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. TED (thromboembolic disease) hose
Compression stockings to improve blood flow in your legs. Compression stockings gently squeeze your legs to move blood up your legs. This helps prevent leg swelling and, to a lesser extent, blood clots. This information was obtained from the website:
https://medlineplus.gov/ency/patientinstructions/000597.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. Diabetes mellitus
A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/

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F 684	Continued From page 23 001214.htm. 4. Intellectual disability Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		6/8/21

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F 690	Continued From page 24 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services for a catheter bag for one of 33 residents in the survey sample, Resident #142. Multiple observations of Resident #142 revealed the attached leg bag above the level of the nephrostomy (1) site it was connected to. The findings include: Resident #142 was admitted to the facility with diagnoses that include but were not limited to acute pyelonephritis (2), acute cystitis (3) and hydronephrosis (4). Resident #142's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/12/2021 coded Resident #142 as scoring a six on the staff assessment for mental status (BIMS) of a score of 0 - 15, 6- being severely impaired for making daily decisions. Section G coded Resident #142 as totally dependent of one person for toilet use and	F 690	F690 1. Resident #142 nephrostomy bag was adjusted below the bladder level on 5/17/2021 and thereafter but was constantly pulled upwards with every move made by the patient because of the shortness of the connecting tube (which is a specialized tube not available at the Center). Routine follow-up with the patient and the repositioning of the nephrostomy bag to below the bladder level initiated until seen by the nephrologist, at which point the Center has requested a longer tubing replacement. Resident #142 remain stable at baseline with no presentation of acute onset of infection or complication relating to the placement of the nephrostomy bag. 2. Unit Managers will audit current patients with nephrostomy catheter bag to ascertain that they are being always placed at below the bladder level. Any anomaly noted will be corrected immediately as applicable. Result of the	

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F 690	Continued From page 25 requiring extensive assistance from one person for bed mobility and personal hygiene. Section H coded Resident #142 being always incontinent of bowel and bladder. Observation was made of Resident #142 on 5/17/2021 at 12:51 p.m. lying in bed. A urine collection leg bag was observed freely hanging and draped over the bar of the assist rail attached to the left side of Resident #142's bed near the window. The assist rail was observed in the up position. Resident #142's head of bed was observed elevated approximately 45 degrees and the urine collection leg bag was observed to be level with Resident #142's middle upper arm. A second observation was made on 5/17/2021 at 3:51 p.m. of Resident #142 in bed with a urine collection leg bag observed freely hanging over the bar of the assist rail on the upper portion of the bed. The assist rail was observed in the up position. Resident #142's head of bed was observed elevated approximately 45 degrees, the urine collection bag was observed to be level with Resident #142's elbow. On 5/18/2021 at 8:24 a.m., an observation was made of Resident #142 in bed with a urine collection leg bag observed lying on the mattress in the bed beside their pillow. Resident #142's head of bed was observed elevated approximately 45 degrees, the urine collection leg bag was observed to be level with Resident #142's left shoulder. The comprehensive care plan for Resident #142 dated 5/7/2021 documented in part, "Nephrostotomy [sic]: [Resident #142] has a nephrostomy tube d/t (due to) urosepsis (5) and	F 690	audit will also be used to provide an individualized in-service to the affected nursing staff. 3. SDC in coordination with the Unit Managers will in-service the nursing staff on the following topics: a) Maintaining and managing nephrostomy bag 4. DON/ADON/UMs will audit all current patients with active nephrostomy catheter bag weekly x1 month and monthly x3 months to assure that they are maintained at below the bladder level consistently. Any noted deficient practice will be rectified immediately as appropriate. Findings will also be forwarded to the QAPI Committee for additional review and recommendation where applicable. 5. Date of compliance: 6/8/2021.	

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obstructive uropathy (6). Created on 05/07/2021. Revision on: 05/18/2021." Under "Interventions" it documented in part, "...Nephrostomy tube, as ordered. Created on: 05/07/2021."

The physician orders for Resident #142 documented in part,
- "Attach bag to nephrostomy site as needed for if pt (patient) experiences fever, chills, pain, or other s/s (signs, symptoms) of infec (infection). Order Date: 05/07/2021."
- "Change Nephrostomy bag every day shift every 14 day(s) for prophylactic. Order Date: 05/07/2021."
- "Monitor Nephrostomy output every day and night shift for monitor. Order Date: 05/07/2021."
- "Monitor nephrostomy tube site for s/s (signs, symptoms) of infection. every day and night shift for monitor. Order Date: 05/07/2021."
- "Nephrostomy site: Empty Bag First. Remove old dressing. Clean around catheter using soap and water. Apply folded 4x4 (gauze pad) on each side of percufix (drainage loop catheter) and under tube, placed unfolded 4x4 on top and cover dressing with tap every day(s) for site care. Order Date: 05/07/2021."

The eTAR (electronic treatment administration record) documented the treatment to Resident #142's Nephrostomy as ordered above.

The progress notes for Resident #142 documented in part,
- "5/6/2021 18:21 (6:21 p.m.) ...Re-admit from [Name of Hospital]...Nephrostomy tube in place on left Iliac crest (arching bones on each side of pelvis) (rear) draining with some blood at this time..."
- "5/12/2021 14:23 (2:23 p.m.) ...Residents

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nephrostomy drainage bag noted to be bright red blood. Nephrostomy tube is newly placed. Residents vitals all WNL (within normal limits), afebrile (without fever) and resident denies pain/discomfort. NP (nurse practitioner) [Name of nurse practitioner] made aware, state could be normal since tube is newly placed, and gave orders to have CBC BMP (complete blood count, basic metabolic panel, laboratory tests) drawn in AM (morning). RP (responsible party) [Name of RP] made aware."

On 5/18/2021 at approximately 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that catheter bags had privacy covers on them and were hooked on the bed. LPN #4 stated that catheter bags were kept off of the floor and maintained below the bladder to promote gravity to drain the urine.

On 5/18/2021 at approximately 2:15 p.m., LPN #4 was accompanied to Resident #142's room. LPN #4 examined Resident #142's urine collection bag attached to the nephrostomy site. The urine collection bag was observed hanging freely off the side of the bed mattress. LPN #4 stated that the urine collection bag was positioned appropriately at that current time but the bag was hanging freely off the mattress and should be anchored so it would not pull on the nephrostomy site. LPN #4 stated that having the urine collection bag hanging over the bar of the assist rail on the upper portion of the bed or on the mattress beside the pillow were not appropriate because they could potentially create a backflow of urine back into the nephrostomy site. LPN #4 stated that they would educate staff on the appropriate placement of the urine collection bag.

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On 5/18/2021 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for care of catheter bags.

The facility provided policy, "Suprapubic Catheter (7) Reinsertion" dated 11/1/19 documented in part, "...Hang bag below level of the bladder and place privacy bag over the drainage bag..."

On 5/19/2021 at approximately 8:00 a.m., ASM #1 stated that the facility followed Potter & Perry as their nursing standard of practice.

According to Fundamentals of Nursing, 8th Edition, Potter & Perry, pg. 1047 documented, "...Care must be taken not to pull on tubing, especially in a nephrostomy, since it can be pulled out, causing tissue and organ damage and infection. Most nephrostomies are sutured into the kidney..."

On 5/18/2021 at approximately 4:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the nurse consultant were made aware of the above concern.

No further information was provided prior to exit.

References:

1. Nephrostomy
A percutaneous nephrostomy is the placement of a small, flexible rubber tube (catheter) through your skin into your kidney to drain your urine. It is inserted through your back or flank. This information was obtained from the website:

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https://medlineplus.gov/ency/article/007375.htm

2. Acute pyelonephritis
Kidney infection is a type of urinary tract infection (UTI) that commonly begins in your bladder and moves upstream to one or both of your kidneys. In rare cases, kidney infections can lead to serious health problems, but quick treatment prevents most complications. This information was obtained from the website: https://www.niddk.nih.gov/health-information/urologic-diseases/kidney-infection-pyelonephritis

3. Acute cystitis
Acute cystitis is an infection of the bladder or lower urinary tract. Acute means that the infection begins suddenly. This information was obtained from the website: https://medlineplus.gov/ency/article/000526.htm

4. Hydronephrosis is the swelling of a kidney due to a build-up of urine. It happens when urine cannot drain out from the kidney to the bladder from a blockage or obstruction. Hydronephrosis can occur in one or both kidneys. This information was obtained from the website: https://www.kidney.org/atoz/content/hydronephrosis

5. Urosepsis: Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. A bacterial infection anywhere in the body may set off the response that leads to sepsis. Common places where an infection might start include the:
· Bloodstream

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F 690	Continued From page 30 · Bones (common in children) · Bowel (usually seen with peritonitis) · Kidneys (upper urinary tract infection, pyelonephritis or urosepsis) · Lining of the brain (meningitis) · Liver or gallbladder · Lungs (bacterial pneumonia) · Skin (cellulitis) This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm 6. Obstructive uropathy Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm 7. Suprapubic catheter "A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem." This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000145.htm.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		6/8/21

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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, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to consistent with professional standards of practice, the comprehensive person-centered care plan for two of 33 residents in the survey sample, Residents #38 and #42.

1. The facility staff failed to maintain an Ambu bag [1] at Resident # 38's bed side according to physician's orders.

2. The facility staff failed to store a nebulizer (1) in a sanitary manner for Resident #42.

The findings include:

1. Resident # 38 was admitted to the facility with diagnoses that include but not limited to: traumatic brain injury with loss of consciousness [2], respiratory failure [3] and tracheostomy [4].

Resident # 38's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/10/2021, coded Resident # 38 as scoring a 3 [three] on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 38 for "Tracheostomy care" while a resident.

On 05/17/21 at 4:20 p.m., an observation of

F695
1. Resident #38 ambu-bag was placed in her room on 5/17/2021 as ordered by the physician. Staff had interpreted the order to meant having the ambu-bag at the bedside only at night. Staff continue to maintain the ambu-bag at the bedside continuously since 5/17/2021. The need for the use of the ambu-bag has not arisen prior, intra, and post survey of 5/17/2021. Resident #42 nebulizer mask and tubing was placed in a holding bag on 5/18/2021 and has been maintained there when not in use. Resident # 42 remain stable at baseline and has not demonstrated any signs of infection since the survey.
2. Unit Managers will audit all current trach patients or patients with ambu-bag orders at the bedside and those on active nebulizer therapy to ascertain that the ambu-bag are being kept at the bedside as ordered by the physician and nebulizer tubing/masks are placed in holding bags when not in use. Any noted non-compliance to the physician□s order for ambu-bag, and the failure of the staff to appropriately store nebulizer tubing/mask will be corrected immediately as applicable.
3. SDC, in coordination with the Unit Managers will in-service the nursing staff on the following topics:
a) Following physician order on

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F 695	Continued From page 32 Resident # 38's room failed to evidence an ambu bag. On 05/18/21 at 8:01 a.m., an observation of Resident # 38's room failed to evidence an ambu bag. The physician's order dated 04/01/2021 for Resident # 38 documented, "Ambu-bag and trach collar to be kept at bedside. Every night shift related to ENCOUNTER FOR ATTENTION TO TRACHEOSTOMY. " The eTAR [electronic treatment administration record] for Resident # 38 dated May 2021 documented the physician's order above. Further review of the eTAR revealed check marks on 05/17/2021 and 05/18/2021 on the night shift. The comprehensive care plan for Resident # 38 with a revision date of 08/19/2018 documented in part, "Need: TRACHEOSTOMY: [Resident # 38] has a tracheostomy r/t [related to] injury TBI [traumatic brain injury]. Created on: 08/10/2017. Revision on: 08/19/2018." Under "Interventions" it documented in part, "Trach [tracheostomy] care as ordered/tolerated. Created on: 122/08/2019." On 05/18/21 at 1:49 p.m., an observation of Resident # 38's room was conducted with LPN [licensed practical nurse] # 2. When asked to locate the ambu bag for Resident # 38, LPN # 2 opened the bedside table, looked inside and stated that it wasn't in the room. After reviewing the physician's orders for Resident # 38 in the electronic health record, LPN # 2 stated that there was an order for the ambu bag to be at the resident's bed side. When asked why the ambu bag was needed at Resident # 38's bed side,	F 695	ambu-bag b) Managing and storing nebulize tubing/mask at the bedside 4. DON/ADON/UMs will audit all current patients with active ambu-bag order at bedside weekly x1 month and monthly x3 months to assure that the nursing staff are following the physician□s order consistently across all shifts. Any noted deficient practice will be rectified immediately as appropriate. Findings will also be forwarded to the QAPI Committee for additional review and recommendation where applicable. 5. Date of compliance: 6/8/2021.	

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LPN # 4 stated, "To ensure they have an open airway at all times in-case something goes wrong. If the order says at bed side it should be there."

On 05/19/2021 at 8:30 a.m., an interview was conducted with LPN # 4, unit manager. When asked to explain the physician's order for Resident # 38's ambu bag as documented above, LPN # 4 stated, "It [The ambu bag] has to be available an since she [Resident # 38] is a full code we have to have it available at bedside. We also have one on the crash cart." When asked to describe the crash cart LPN # 4 stated that it contained supplies for residents who may code and it is stored in the medication room. When asked how often the ambu bag needed to be kept at Resident # 38's bedside LPN # 4 stated, "All the time." When asked to clarify the portion of the physician's order that documented, "Every night shift", LPN # 4 stated, "The night shift checks to ensure that it [ambu bag] is in the resident's room and it is check off on the eTAR [electronic treatment administration record]."

On 05/18/2021 at approximately 4:40 p.m., ASM # 1, administrator and ASM # 2, director of nursing, and ASM # 3, nurse consultant, were made aware of the above findings.

No further information was provided prior to exit.

References:

[1] A self-refilling bag-valve-mask unit with a 1 - 1.5 liter capacity, used for artificial respiration which, while suboptimal for the non-intubated patient, is effective for ventilating and oxygenating intubated patients, allowing both spontaneous and artificial respiration. This information was

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obtained from the website: https://medical-dictionary.thefreedictionary.com/Ambu+bag

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

[3] When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

[4] A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm.
2. The facility staff failed to store a nebulizer (1) in a sanitary manner for Resident #42.

Resident #42 was admitted to the facility with diagnoses that included but were not limited to

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chronic obstructive pulmonary disease (COPD) (2) and diabetes (3). Resident #42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/10/2021 coded Resident #42 as scoring an eight on the staff assessment for mental status (BIMS) of a score of 0 - 15, 8- being moderately impaired for making daily decisions.

On 5/17/2021 at approximately 1:10 p.m., an observation was conducted of Resident #42 in their room. Resident #42 was observed lying in bed. A nebulizer machine was observed on Resident #42's bedside table. A mask attached to a nebulizer deliver device was observed uncovered lying on the front of the nebulizer machine. When asked if they received medication through the nebulizer mask, Resident #42 nodded yes.

Additional observations on 5/17/2021 at 3:55 p.m., 5/18/2021 at 8:44 a.m. revealed the same findings as above.

The physician orders for Resident #42 documented in part, "DuoNeb Solution 0.5-2.5 MG (milligram) / 3ML (milliliter) (Ipratropium-Albuterol) 3 ml inhale orally every 4 (four) hours related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED, Order Date: 11/2/2018."

The eMAR (electronic medication administration record) for Resident #42 documented in part, "DuoNeb Solution 0.5-2.5 MG (milligram) / 3ML (milliliter) (Ipratropium-Albuterol) 3 ml inhale orally every 4 (four) hours related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED, Order Date: 11/2/2018." The

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eMAR documented Resident #42 receiving the medication every four hours each day 5/1/2021 through the present.

The comprehensive care plan dated 7/28/2017 documented in part, "CARE NEEDS: [Resident #42] has nursing care needs r/t (related to) ... COPD...Created on: 07/28/2017. Revision on: 02/11/2021." Under "Interventions" it documented in part, "Administer medications and/or treatments as ordered. Created on: 07/28/2017..."

On 5/18/2021 at approximately 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that nebulizers were changed every Monday, Wednesday and Friday by the night shift and as needed. LPN #4 stated that nebulizers were wiped out after each use and stored in oxygen bags when not in use. LPN #4 stated that they had oxygen bags with the date the nebulizer was changed and the resident's room number on them to store the nebulizer in when not in use. LPN #4 stated that the purpose of the bag was to keep them clean.

On 5/18/2021 at approximately 2:10 p.m., LPN #4 was accompanied to Resident #42's room. LPN #4 observed the nebulizer mask lying on Resident #42's bedside table uncovered. LPN #4 stated that the nebulizer and mask should not be lying on the table and that she would replace it with a nebulizer stored in an oxygen storage bag when not in use. LPN #4 stated that they would ask LPN #3 to replace the nebulizer.

On 5/18/2021 at approximately 5:00 p.m., a request was made by written list to ASM

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(administrative staff member) #1, the administrator for the facility policy nebulizer mask storage.

The facility policy "Respiratory/Oxygen Equipment" dated 11/01/19 documented in part, "...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 5/19/2021 at approximately 8:00 a.m., ASM #1 stated that the facility used Potter & Perry as their nursing standard of practice.

According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 780, Box 33-2 "Sites for and causes of nosocomial infections....Respiratory Tract - Contaminated respiratory therapy equipment".

On 5/18/2021 at approximately 4:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the nurse consultant were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Nebulizer - "a device used to aerosolize medications for delivery to patients." Taken from Encyclopedia & Dictionary of Medicine, Nursing & Allied Health -Seventh Edition, Miller-Keane, page 1182

2. Chronic obstructive pulmonary disease (COPD)
Disease that makes it difficult to breath that can

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F 695	Continued From page 38 lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 3. Diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 695		
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, staff interview, and facility document review, it was determined that the facility staff failed to dispose of trash in a sanitary manner in one of three rolling linen carts positioned outside the kitchen door. The rolling linen cart was open to air, and contained standing water and several bags of trash. One of the bags contained soiled linens which were covered in green mold like appearing substance. The findings include: On 5/17/21 at 11:26 a.m., observation was made of the area just outside the kitchen entrance. Three rolling carts stood against the exterior wall of the facility. One of the carts, open to air, contained standing water and multiple clear bags of trash. One of the trash bags contained soiled linens; a green mold like substance was visible growing on the bagged linens.	F 814	F814 cross reference to 12VAC5-371-370 1. Carts with garbage by the dumpster on 5/17/2021 were removed and placed in the dumpster on the same day they were noted by the surveyor. The carts were been decommissioned to transport linen on the Unit. No other garbage has been left unattended since the state survey of 5/17/2021. 2. Maintenance Director/Housekeeping Director will audit all dumpsters on the premise to ascertain that there is no uncovered garbage on any of the sites. Any deficient practice noted will be corrected immediately as applicable. 3. Maintenance Director/Housekeeping Manager will conduct an in-service with all the two departments staff on the following: a) Managing and maintaining the	6/8/21

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F 814	Continued From page 39 On 5/17/21 at 11:32 a.m., OSM (other staff member) #2, maintenance director, also observed the trash in the rolling cart. OSM #2 stated, "This is definitely not suitable." He stated all facility trash should be placed in the dumpster, which is covered. OSM #2 stated, "These are linen carts, used to transport linen." He stated the carts should never have been placed on the facility's exterior. He confirmed that mold was growing in the bag with the soiled linens. On 5/18/21 at 4:38 p.m., ASM (administrative staff member) #1, the administrator, #2, the director of nursing, and #3, the nurse consultant, were informed of these concerns. A review of the facility policy, "Equipment/Grounds Inspection," revealed, in part: "Inspect dumpsters, walkways, parking lots, courtyards, grounds, signs (for damage) and other areas to verify they are clean and clear of debris and safety hazards." No further information was provided prior to exit.	F 814	dumpster area. 4. Maintenance Director/Housekeeping Director will audit all the dumpster sites on the facility□s premise weekly x1 month and monthly x3 months to assure that they are free of exposed garbage consistently. Any noted deficient practice will be corrected immediately as appropriate. Findings will also be forwarded to the QAPI Committee for additional review and recommendation where applicable. 5. Date of compliance: 6/8/2021.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 919	F919	6/8/21

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F 919	Continued From page 40 interview and facility document review, it was determined that the facility staff failed to maintain a functional call system for two of 33 residents in the survey sample, Resident #46 and Resident #66. Resident #46 and Resident #66 shared a room with a broken call bell and had no alternate means to call staff when the call bell was not working. The findings include: Resident #46 was admitted to the facility with diagnoses that included but were not limited to chronic kidney disease (1) and diabetes (2). Resident #46's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/11/2021, coded Resident #46 as scoring a 10 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 10- being moderately impaired for making daily decisions. Section G coded Resident #46 as requiring extensive assistance of two or more persons for bed mobility and transfers and extensive assistance from one person for toilet use and personal hygiene. Resident #66 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (3) and diabetes. Resident #66's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/2021, coded Resident #66 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Section G coded Resident #66 as requiring extensive assistance of two or more persons for transfers and extensive assistance from one person for bed mobility, toilet	F 919	1. Residents #46 and #66 were given handbell as an interim remedy to call for help until their call bells were replaced on 5/18/2021. Residents #46 and #66 did not report staff failure in addressing their needs during the period call for help system was down in their room. 2. Maintenance and Nursing management to audit all call light systems in the room and further review the protocol for reporting and getting work orders for repairs completed to ascertain that none of the call bell is defected and that work orders are addressed on a timely basis. Any identified deficiencies will be corrected as applicable and appropriate immediately. 3. Maintenance/Nursing staff will be in-serviced on the following: a) Managing work order for repairs b) Managing patients with defected call bell system 4. Maintenance Director/UMs will audit 10% of every Unit□s call bells weekly x1 month and monthly x3 months to assure that they are maintained in a functional working condition. Any noted deficient practice will be rectified immediately as appropriate. Findings will also be forwarded to the QAPI Committee for additional review and recommendation where applicable. 5. Date of compliance: 6/8/2021.	

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use and personal hygiene.

On 5/17/2021 an observation was made of the hallway outside of Resident #46 and Resident #66's shared room. The call light on the outside of the room was observed lit with a steady light.

Additional observations on 5/17/2021 at 1:38 p.m., 2:10 p.m., 3:57 p.m., 4:59 p.m. and 5/18/2021 at 8:44 a.m. revealed the same findings as above.

On 5/17/2021 at 11:35 a.m., an interview was conducted with Resident #46. Resident #46 was observed in bed with their call bell within reach. Resident #46 stated that they knew that Resident #66's call bell was broken but they thought that theirs worked. Resident #46 proceeded to press their call bell which did not light up on the wall panel in the room. The steady light outside of the room remained lit. No staff responded during the interview with both residents in the room.

On 5/17/2021 at 11:45 a.m., an interview was conducted with Resident #66. Resident #66 was observed in bed. Resident #66 stated that staff had informed them the night before, 5/16/2021 that their call bell was not working. Resident #66 stated that maintenance had come in the room to check the call bell earlier on 5/17/2021 and were working on it but it was still not working. When asked how they called staff if they needed assistance, Resident #66 stated, "I just wait for them to come in, and hope that they come to check on me."

No alternate means of calling staff for assistance were observed in Resident #46 and Resident #66's shared room on 5/17/2021 at 11:35 a.m.,

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11:45 a.m., 1:38 p.m., 2:10 p.m., and 3:57 p.m.

Observations of the call bells in the facility during the survey dates revealed all other call bells to be functioning.

On 5/18/2021 at 8:44 a.m., an observation of Resident #46 revealed them in bed with a hand bell on the bed beside them. When asked about the hand bell, Resident #46 stated, "They gave it to me last night after you were in here."

On 5/18/2021 at 8:46 a.m., an observation of Resident #66 revealed them in bed with a hand bell on the over-bed table. When asked about the hand bell, Resident #66 stated, "The nurse brought it in last night around dinner time."

On 5/18/2021 at approximately 8:55 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. LPN #4 stated that the call light in Resident #46 and Resident #66's shared room was broken. LPN #4 stated that they had given them the hand bells on 5/17/2021 but did not remember the time. LPN #4 stated that they worked until approximately 5:00 p.m. on 5/17/2021. LPN #4 stated that they had put in a work order for maintenance to fix the call bell and spoken to the maintenance director who told them that they were fixing it. LPN #4 stated that when call bells were broken they put in a work order and also made sure that the resident has something to alert the staff. LPN #4 stated that they let the staff know that the residents have the hand bells so they are alert to listen for the ringing.

On 5/18/2021 at approximately 4:07 p.m., an interview was conducted with OSM (other staff

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member) #2, the maintenance director. OSM #2 stated that they had a computer system which showed the work orders for repairs put in by the staff. OSM #2 stated that there was a priority system for repairs and call bells were a high priority. OSM #2 stated that LPN #4 had verbally informed them of the call bell issue that morning and they had looked at it that morning and were able to reset the light. OSM #2 stated that when they cleared the light they did not provide an alternate means to call the nursing staff because they thought they had fixed the problem. OSM #2 stated that they realized the light was still broken and they were able to replace the call button and cord which was causing the problem that afternoon to fix the problem. OSM #2 stated that the nursing staff had hand bells to provide the residents when the call bells were broken, the receptionist at the entrance had hand bells and they had hand bells also.

The "Work Order" dated 5/17/2021 at 11:29 a.m. documented in part, "Call bell will not turn off. Room/Area [Resident #46 and Resident #66's shared room number]..."

On 5/18/2021 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy regarding call bell repairs.

On 5/19/2021 at approximately 8:00 a.m., ASM #1 stated that they did not have a policy specific to call bell repairs.

On 5/19/2021 at approximately 8:59 a.m., ASM #1 provided the policy "Timely Completion of Repairs" dated 2/1/2021. The policy failed to evidence documentation of providing an alternate

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means of call bell when call bells are broken.

On 5/18/2021 at approximately 4:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the nurse consultant were notified of the concern.

No further information was presented prior to exit.

References:

1. Chronic kidney disease
Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html.

2. Diabetes mellitus
A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

3. 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.