STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495359	A. BUILDING _____ B. WING _____	06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAB	120 DOGWOOD LANE ORANGE, VA 22960

(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 6/22/2021 through 6/24/2021. 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 6/22/2021 through 6/24/2021. 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 164 certified bed facility was 135 at the time of the survey. The survey sample consisted of 40 current Resident reviews and 5 closed record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. 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 the facility staff failed to ensure one of 45 sampled residents, (Resident #106), was assessed for self-administration of medications. A bottle of Refresh Tears was observed on Resident #106's nightstand and Resident #106 stated she uses them all the time. The clinical record failed to evidence a physicians order and assessment for	F 554	1.Resident #106 had a physician order placed on 6/23/21 for refresh tears. Resident #106 had a self-administration form completed on 6/23/21. Resident #106 had care plan updated on 6/23/21 to show eye drops and self-administration. 2. The other residents of the facility have the potential to be affected.	7/28/21

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

Electronically Signed | 07/07/2021

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F 554	Continued From page 1 Resident #106 to self administer the eye drops. The finding include: Resident #106 was admitted to the facility on 11/12/2018 with diagnoses that included but were not limited to: diabetes, anxiety (state of mild to severe apprehension) (1), and macular degeneration (A disease destroys your sharp, central vision). (2) The most recent MDS (minimum data set) assessment, an assessment, with an assessment reference date of 5/20/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. Resident #106 was coded as independent for all of her activities of daily living except bathing in which she required limited assistance of one staff member. On 6/22/2021 at 10:41 a.m., observation of Resident #106's room revealed the resident in her recliner, and a bottle of Refresh Tears (moisturizing eye drops) on the bedside table. When asked if she uses the drops, Resident #106 stated she uses them all the time. She stated she was going to the eye doctor later today. On 6/23/2021 at 10:15 a.m., a second observation of the resident's room, again, the resident was in her recliner and the Refresh Tears sitting on the nightstand. Review of the physician orders failed to evidence an order for the Refresh Tears. Review of the comprehensive care plan failed to evidence documentation related to the eye drops.	F 554	3. Facility Nursing staff were re-educated on 7/3/21 on obtaining a physician order for any medications including over the counter medications, self-administration process, and care planning. A letter with communication to families, residents, and staff was issued on 7/1/21 to educate families, residents, and staff that residents receiving medications including eye gtts and other over-the-counter medications must be given to the nurse to follow the process of self-administration of medications, if appropriate. 4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3 months related to: obtaining a physician order for any medications including over the counter medications, self-administration process and care planning. This information will be forwarded to QAPI for review. Completion date: 07/28/2021	

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An interview was conducted with LPN (licensed practical nurse) #6 on 6/23/2021 at 11:02 a.m. When asked if a resident can self-administer medications, LPN #6 stated not all medications but eye drops or creams they can. She further stated that they have to be stored in a locked box in their room. When asked if there is any type of assessment completed before this is done, LPN #6 stated yes. When asked if there should be a physician order for a resident to self-administer a medication, LPN #6 stated yes. When asked where the assessment is documented, LPN #6 stated she would have to check. LPN #6 returned and stated the unit manager and the physician have to do an assessment for the self-administration of medications. LPN #6 stated it would be in the assessment section in the computer record.

An interview was conducted with RN (registered nurse) #5 on 6/23/2021 at 11:22 a.m. When asked if a resident is allowed to self-administer medications, RN #5 stated, yes, if they have been assessed and there is a physician order and we have to watch them perform it, if it's okay, then they can do it. When asked about the location in the clinical record for the self-administration of mediations, RN #5 stated it would be in the documents tab under forms and templates.

A review of the clinical record failed to evidence an assessment for the self-administration of the Refresh Tears. There was a "Self-Administration Of Medication" assessment form completed for the use of a cream for pain management but there was no assessment form for the use of the Refresh Tears.

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F 554	Continued From page 3	F 554		

At 12:35 p.m., LPN #6 was accompanied to Resident #106's room. When asked if she saw anything unusual on the nightstand, LPN #6 stated she [Resident #106] had Refresh Tear eye drops. Resident #106 stated she does have a lock box for her cream. She said she could keep them [Refresh Tear eye drops] there. Resident #106 stated her daughter bought them per the instructions of her eye doctor. LPN #6 went to the computer and stated there was no physician order for the eye drops and there was no assessment for the self-administration of the eye drops.

The facility policy, "Self Administration of Medications by Patients/Residents" documented in part, "Policy Statement: Each patient/resident who desires to self-administer medications is permitted to do so if the healthcare center's Licensed Nurse and physician have determined that the practice would be safe for the patient/resident and other patients/residents of the healthcare center. Medication self-administration also applies to family members who wish to administer medication...Procedure:...2. If the patient /resident or family member desires to self-administer medications, an assessment is conducted by the Licensed Nurse to assess the individual's cognitive, physical, and visual ability to carry out this responsibility. In addition, the resident or family member should in conjunction with the facility nurse, utilize the Electronic Medical Record Observation tool, Medication Self - Administration Observation to complete the administration of medication. 3. If the Licensed nurse determined the patient/resident or family member to be capable of self-administration of medications, the attending physician must write

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F 554	Continued From page 4 an order to that effect that includes the specific mediations based on of the Self-Administration Medication Observation. 4. If the patient/resident or family member demonstrates the ability to safely, self-administer mediations, a further assessment of the safety of bedside medication storage is conducted. 5. Bedside Storage of Medications is permitted only when it does not present a risk to confused patients/residents who wander in to the rooms of, or room with patients/residents who self-administer." ASM (administrative staff member) #1, the director of nursing, RN (registered nurse) #2, the director of compliance, and RN #4, the assistant director of nursing, were made aware of the above concern on 6/23/2021 at 4:48 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 554		
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	F 655		7/28/21

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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.
(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.

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F 655	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to develop a baseline care plan for one of 45 residents in the survey sample, Resident #480. The facility failed to develop a baseline care plan to address and include Resident # 480's use of a CPAP (continuous positive airway pressure) machine. The findings include: During the facility tour on 6/22/21 at 11:30 AM, observation revealed a CPAP machine sitting on Resident #480's bedside nightstand with the nasal prongs uncovered. On 6/22/21 at 3:30 PM, a second observation revealed the CPAP machine on Resident #480's bedside nightstand with the nasal prongs uncovered. Resident #480 was admitted to the facility on 6/17/21. Resident #480's diagnoses included but were not limited to: obstructive sleep apnea [OSA] (transient periods of apnea during sleep) (2), ESRD [end stage renal disease] (inability of the kidneys to excrete waste and maintain electrolyte balance) (3) and fracture of the right eye orbit (a break in the bony cavity housing right eye) (4). Resident #480's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/17/21, coded the resident as scoring 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: had not been coded. MDS Section H-Bowel and	F 655	1.Resident #480 had his baseline care plan updated on 6/23/21 to add a continuous positive airway pressure device. 2. The other residents of the facility that use respiratory devices have the potential to be affected. 3. Facility Nursing staff were re-educated on 7/3/21 to the updated form to ensure adding respiratory devices including a CPAP to the nursing admission assessment and the baseline care plan. 4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3 months related to: ensuring the form is being utilized for adding respiratory devices including a CPAP are noted on the nursing admission assessment and the baseline care plan. This information will be forwarded to QAPI for review. Completion date: 07/28/2021	

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Bladder had not been coded. MDS Section O-Special Treatments / Procedures had not been coded.

A review of Resident #480's baseline care plan dated 6/17/21 failed to evidence documentation addressing for Resident #480's use a CPAP (1). The baseline care plan, documented in part, "Special Treatments/Procedures: CPAP & CPAP equipment. Cleaning/maintenance per facility protocol. Liters per minute___." Check boxes by each of these, all the boxes on Resident #480's baseline care plan were unchecked.

A review of the physician orders dated 6/17/21, failed to evidence a CPAP order.

Review of the physician's history and physical dated 6/18/21, documented in part, "Assessment and Plans: OSA [obstructive sleep apnea] on CPAP.

Review of the nursing admission assessment dated 6/17/21, failed to evidence documentation of OSA [obstructive sleep apnea] or the use of a CPAP machine.

An interview was conducted on 6/22/21 at 1:55 PM with Resident #480, regarding the CPAP machine. Resident #480 stated, "I use it every night." When asked if the CPAP nasal prongs were covered, Resident #480 stated, "No, it's never covered. It fell on the floor once and I wiped it off before I used it again. I believe it should be covered when I'm in this building."

An interview was conducted on 6/23/21 at 2:15 PM with LPN (licensed practical nurse) #5. When asked the purpose of the baseline care plan, LPN

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#5 stated, "The purpose of the care plan is to develop the plan for the resident and to meet their needs on admission." When asked if treatments such as CPAP should be included on the baseline care plan, LPN #5 stated, "Yes they should be included as that is part of their treatment."

An interview was conducted on 6/23/21 at 3:00 PM with RN (registered nurse) #3, the clinical reimbursement director. When asked who develops the baseline care plan, RN #3 stated, "The IDT [interdisciplinary team] develops the baseline care plan. The purpose of the care plan is to provide care specific to a resident based on the physician's orders and needs. I do not see CPAP on the care plan- it would usually be under Sleep Apnea. If there is not an order for it, then nursing is responsible for getting the order and putting it on the care plan."

On 6/23/21 at 3:30 PM, RN #3 brought in a copy of the nursing progress noted dated and timed 6/23/21 3:12 PM which documented in part, "Informed of CPAP machine in room. Resident reports CPAP was dropped off by wife a few days ago; he couldn't remember which day. He states he uses this at night for his sleep apnea. It was observed on his bedside table. Unit manager aware and following up." RN #3 also provided a revised baseline care plan for review, which documented in part, "Special Treatments/Procedures: CPAP & CPAP equipment. Cleaning/maintenance per facility protocol. Liters per minute___." Check boxes by each of these, box checked and dated 6/23/21. "Other condition: Sleep Apnea, Intervention: CPAP per order", dated 6/23/21. A copy of the physician's order dated 6/23/21, documented in part, "CPAP settings of 7.0 centimeters of water.

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Resident at night for OSA. Monitor on 3-11 and 11-7 shift. Ensure CPAP has distilled water in chamber at bedtime. CPAP face mask to be changed every 6 months by 3-11 shift in July and January. Wipe mask with CPAP wipes, allow 2 minutes to dry on clean surface and apply mask."

An interview was conducted on 6/23/21 at 4:00 PM with ASM (administrative staff member) #1, the director of nursing. When asked the purpose of the baseline care plan, ASM #1 stated, "It is the individualized plan of care for the resident to meet their needs." ASM #1 stated, "The IDT (interdisciplinary team) initiates it [baseline care plan], but nursing is responsible for revisions."

ASM #1, the director of nursing, RN #1, the director of compliance and RN #4, the assistant director of nursing, were made aware of the above concern on 6/23/21 at 4:45 PM.

The facility's "Policy and Procedure for Comprehensive Person-Centered Care Planning" dated 3/2018, documents in part, "A baseline care plan is developed within 48 hours of admission to include minimum healthcare information to properly care for the resident."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 141.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 531.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and

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F 655	Continued From page 10 Chapman, page 498. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 416.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required 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	F 656		7/28/21

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F 656	Continued From page 11 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, clinical record reviews and facility document reviews it was determined that the facility staff failed to implement the comprehensive care plan for two of 45 residents in the survey sample, Residents #70 and #115. The facility staff failed to implement the comprehensive care plan to administer oxygen per the physician order for Resident #70 and Resident #115. The findings include: 1. Resident #70 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (COPD) (1), acute respiratory failure (2) and sleep apnea (3). Resident #70's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 5/11/2021, coded Resident #70 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Section O coded	F 656	1.Residents #70 and #115 had their oxygen adjusted to the correct flow rate to match physician orders and care plan on 6/24/21. 2. The other residents of the facility that use oxygen have the potential to be affected. 3. Facility Nursing staff will be re-educated on 7/3/21 on ensuring that residents that require oxygen will have a command hook placed on their concentrator where the oxygen bag is to be placed. Residents receiving oxygen, per physician orders, will receive the amount ordered and the care plan will match to follow physician orders. 4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3 months related to: ensuring that residents that require oxygen will have a command hook placed on their concentrator where the oxygen bag is to be placed. Residents receiving oxygen, per physician orders, will receive	

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F 656	Continued From page 12 Resident #70 as receiving oxygen while a resident at the facility. On 6/22/21 at approximately 12:42 p.m., an interview was conducted of Resident #70 in their room. Resident #70 was observed in bed wearing an oxygen nasal cannula with a humidifier bottle dated 6/16/21 attached to an oxygen concentrator. The oxygen flow rate set on the concentrator was observed set at 2.5 lpm (liters per minute). Resident #70 stated that they wore the oxygen all the time. When asked if he ever adjusted the oxygen rate, Resident #70 stated that the nurses set the oxygen rate and he did not adjust the settings. Additional observations of Resident #70 on 6/22/21 at approximately 4:15 p.m. and 6/23/21 at approximately 11:45 a.m. revealed the oxygen flow rate set at 2.5 lpm. The comprehensive care plan for Resident #70 dated 12/31/2020 documented in part, "[Resident #70] is at risk for impaired gas exchange R/T (related to) COPD, Pulmonary HTN (hypertension) (4), allergies and OSA (obstructive sleep apnea)...." Under "Intervention" it documented in part, "Administer oxygen per MD (medical doctor) orders, See eTAR (electronic treatment administration record). Start Date: 12/31/2020..." The physician order's for Resident #70 documented in part, "Order Date: 5/10/21...Resident to wear oxygen @ [at] 3L/min (liters per minute) via NC (nasal cannula) continuously for SOB (shortness of breath)/COPD- Check flowmeter and O2 SATs (saturations) Q (every) shift..."	F 656	the amount of oxygen ordered and the care plan will match to follow physician orders. This information will be forwarded to QAPI for review. Completion date: 07/28/2021 12 VAC 5-371-250 (G) Cross reference to F656	

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On 6/23/2021 at approximately 1:10 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the purpose of the care plan was to help everyone understand what care was to be provided to the resident. LPN #2 stated that the nursing staff used the care plans.

On 6/23/2021 at approximately 1:20 p.m., LPN #2 observed Resident #70's oxygen concentrator. LPN #2 stated that the oxygen was set at 2.5 lpm and they did not know how it had gotten set that way because it was supposed to be set at 3 lpm. LPN #2 stated that the oxygen being set at 2.5 lpm was not following the plan of care.

On 6/23/2021 at approximately 3:34 p.m., an interview was conducted with RN (registered nurse) #3, the clinical reimbursement director. RN #3 stated that they were not following the care plan if they were not administering the oxygen at the prescribed rate.

The facility policy "Policy and Procedure for Comprehensive Person-Centered Care Planning" dated 3/2018 documented in part, "...The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychological needs identified throughout the comprehensive Resident Assessment Instrument (RAI) process..."

On 6/23/21 at approximately 4:45 p.m., ASM #1, the director of nursing, RN #1, the director of compliance and RN #4, the assistant director of nursing were notified of the findings. No further

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information was provided prior to exit.

References:

1. 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.

2. Respiratory failure: 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.

3. 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.

4. Pulmonary hypertension (PH) is high blood pressure in the arteries to your lungs. It is a serious condition. If you have it, the blood vessels that carry blood from your heart to your lungs become hard and narrow. Your heart has to work harder to pump the blood through. Over time, your heart weakens and cannot do its job and you can develop heart failure. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=pulmonary+hypertension&_ga=2.195097636.96184153.1624557775-1838772440.1562936034

2. The facility staff failed to implement the

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comprehensive care plan to administer oxygen per the physician order for Resident #115.

Resident #115 was admitted to the facility with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (2) and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria)(3).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/24/2021, coded Resident #115 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. Resident #115 was coded as requiring limited assistance of one staff member for most of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, Resident #115 was coded as using oxygen while in the facility.

The comprehensive care plan dated 8/25/2020 documented in part, "Care Plan - (Resident #115) has impaired gas exchange r/t (related to) COPD, Shortness of breath. She has hx (history) of wheezing. She is on continuous oxygen. She has a cough." The "Interventions" documented in part, "Administer oxygen per MD (medical doctor) orders."

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On 6/22/2021 at 10:45 a.m. observation revealed Resident #115 sitting in her recliner with oxygen on via a nasal cannula connected to an oxygen concentrator that was running. Further observation revealed the oxygen flow meter was set at 2.5 LPM (liters per minute). A second observation on 6/22/2021 at 3:39 p.m. revealed, the oxygen flow rated was set at 2.5 LPM.

On 6/23/2021 at 9:30 a.m., observation of Resident #115 revealed oxygen was in use by the resident and the flow meter flow rate on the oxygen concentrator was set at 2.5 LPM. When asked if she adjusts the oxygen flow rate, Resident #115 stated she had it at home and knows how to adjust it but the staff here has told her not to touch it so she doesn't.

The physician order dated 8/19/2020 documented, "Resident to wear oxygen @ (at) 2 L/MIN (liters per minute) continuously for SOB (shortness of breath)/COPD) check flowmeter and O2 (oxygen) sats (saturations) Q (every) shift."

The eTAR (electronic treatment administration record) documented, "Resident to wear oxygen @ 2 L/MIN continuously for SOB/COPD check flowmeter and O2 sats Q shift." The eTAR documented the use of oxygen on all three shifts for 6/22/2021 and 6/23/2021. It also documented a "2" under each shift for the liter flow rate.

An interview was conducted with RN (registered nurse) #3 on 6/23/2021 at 3:30 p.m. When asked the purpose of the comprehensive care plan, RN #3 stated it mostly is to present the picture of the resident and what their person centered life and

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F 656	Continued From page 17 what the needs, desire and their preferences. It contains things other staff members need to provide care to them. When asked what it means if the comprehensive care plan includes an intervention to administer oxygen per the physician and the oxygen was not observed set at the physician prescribed rate, RN #3 stated that's not following the care plan but also not following the physician orders. ASM (administrative staff member) #1, the director of nursing, RN (registered nurse) #2, the director of compliance, and RN #4, the assistant director of nursing, were made aware of the above concern on 6/23/2021 at 4:48 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	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	F 658		7/28/21

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F 658	Continued From page 18 by: Based on staff interview and facility document review, it was determined the facility staff failed to follow professional standards of practice in obtaining physician orders for one of 45 residents in the survey sample, Resident #480. The facility failed to follow professional standards of practice in obtaining physician orders for CPAP (continuous positive airway pressure) (1) use for Resident #480. The findings include: During the facility tour on 6/22/21 at 11:30 AM, observation revealed a CPAP machine sitting on Resident #480's bedside nightstand with the nasal prongs uncovered. On 6/22/21 at 3:30 PM, a second observation revealed the CPAP machine on Resident #480's bedside nightstand with the nasal prongs uncovered. Resident #480 was admitted to the facility on 6/17/21. Resident #480's diagnoses included but were not limited to: obstructive sleep apnea [OSA] (transient periods of apnea during sleep) (2), ESRD [end stage renal disease] (inability of the kidneys to excrete waste and maintain electrolyte balance) (3) and fracture of the right eye orbit (a break in the bony cavity housing right eye) (4). Resident #480's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/17/21, coded the resident as scoring 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively	F 658	1.Resident # 480 had a physician order placed on 6/23/21 for his continuous positive airway pressure device. 2. The other residents of the facility that receive md orders including continuous positive airway pressure devices have the potential to be affected. 3. Facility Nursing staff will be re-educated on 7/3/21 obtaining orders for residents who require them including continuous positive pressure devices. A letter with communication to families, residents, and staff was issued on 7/1/21 to educate families, residents, and staff that residents receiving respiratory services, including continuous positive airway pressure, the equipment must be given to the nurse. 4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3 months related to: obtaining orders for residents who require them including continuous positive pressure devices. This information will be forwarded to QAPI for review. Completion date: 07/28/2021 12 VAC 5-371-200 (B)(1)(ii) cross reference to F658	

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impaired. MDS Section G- Functional Status: had not been coded. MDS Section H-Bowel and Bladder had not been coded. MDS Section O-Special Treatments / Procedures had not been coded.

A review of Resident #480's baseline care plan dated 6/17/21 failed to evidence documentation addressing for Resident #480's use a CPAP (1). The baseline care plan, documented in part, "Special Treatments/Procedures: CPAP & CPAP equipment. Cleaning/maintenance per facility protocol. Liters per minute___." Check boxes by each of these, all the boxes on Resident #480's baseline care plan were unchecked.

A review of the physician orders dated 6/17/21, failed to evidence a CPAP order.

Review of the physician's history and physical dated 6/18/21, documented in part, "Assessment and Plans: OSA [obstructive sleep apnea] on CPAP.

Review of the nursing admission assessment dated 6/17/21, failed to evidence documentation of OSA [obstructive sleep apnea] or the use of a CPAP machine.

An interview was conducted on 6/22/21 at 1:55 PM with Resident #480, regarding the CPAP machine. Resident #480 stated, "I use it every night." When asked if the CPAP nasal prongs were covered, Resident #480 stated, "No, it's never covered. It fell on the floor once and I wiped it off before I used it again. I believe it should be covered when I'm in this building."

An interview was conducted on 6/23/21 at 2:15

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PM with LPN (licensed practical nurse) #5. When asked who is responsible for obtaining physician orders, LPN #5 stated, "Nursing is responsible for obtaining orders from the physician." When asked if treatments such as CPAP should have a physician order, LPN #5 stated, "Yes, there should be an order."

An interview was conducted on 6/23/21 at 3:00 PM with RN (registered nurse) #3, the clinical reimbursement director regarding physician orders for the use of a CPAP machine. RN #3 stated, "If there is not an order for it [CPAP], then nursing is responsible for getting the order and putting it on the care plan."

On 6/23/21 at 3:30 PM, RN #3 brought in a copy of the nursing progress noted dated and timed 6/23/21 3:12 PM which documented in part, "Informed of CPAP machine in room. Resident reports CPAP was dropped off by wife a few days ago; he couldn't remember which day. He states he uses this at night for his sleep apnea. It was observed on his bedside table. Unit manager aware and following up." RN #3 also provided a revised baseline care plan for review, which documented in part, "Special Treatments/Procedures: CPAP & CPAP equipment. Cleaning/maintenance per facility protocol. Liters per minute___." Check boxes by each of these, box checked and dated 6/23/21. "Other condition: Sleep Apnea, Intervention: CPAP per order", dated 6/23/21. A copy of the physician's order dated 6/23/21, documented in part, "CPAP settings of 7.0 centimeters of water. Resident at night for OSA. Monitor on 3-11 and 11-7 shift. Ensure CPAP has distilled water in chamber at bedtime. CPAP face mask to be changed every 6 months by 3-11 shift in July and

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January. Wipe mask with CPAP wipes, allow 2 minutes to dry on clean surface and apply mask."

An interview was conducted on 6/23/21 at 4:00 PM with ASM (administrative staff member) #1, the director of nursing. When asked the purpose of the physician orders, ASM #1 stated, "Orders are to take care of the resident needs and for medications and treatments, oxygen and CPAP orders." When asked who is responsible to obtain/clarify physician orders, ASM #1 stated, "Any nurse is to get physician orders. They can be obtained in the evening or weekend, we have on call physicians. We need a process if the family brings in a device to make sure we have an order."

ASM #1, the director of nursing, RN #1, the director of compliance and RN #4, the assistant director of nursing, were made aware of the above concern on 6/23/21 at 4:45 PM.

The facility's policy on "Physician Orders" dated 9/13/17, documents in part, "A physician order must include in the following information: Quantity or duration (length) of therapy, diagnosis or condition for which prescribed, resident name."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 141.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 531.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and

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F 658	Continued From page 22 Chapman, page 498. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 416.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review and staff interview, it was determined that facility staff failed to provide supervision and ensure an environment free of accident hazards for one of 45 residents in the survey sample, Resident # 108. The facility staff failed to provide supervision to prevent Resident # 108 from exiting the facility in his wheelchair unattended through an emergency exit door. Staff interview revealed the emergency exit door lock and alarm were not functioning at the time of Resident #108's elopement. The findings include: Resident # 108 was admitted to the facility with diagnoses that included but were not limited to: above the knee left leg amputation, dementia with behavioral disturbances [1], and muscle weakness.	F 689	1.Resident #108 remains with supervision and in an environment that is free of accidents and hazards. 2. The other residents of the facility that require supervision have the potential to be affected. 3. Facility Nursing staff were re-educated on 7/3/21 to the updated form documenting on new admissions every shift for 72 hours including residents who are exit-seeking. Placing residents who are exit-seeking on increased supervision and document findings. Alarmed exterior doors will be tested frequently to ensure the alarm is functioning properly. 4. To ensure compliance, audits will be conducted by Director of	7/28/21

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F 689	Continued From page 23 Resident # 108's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/20/2021, coded Resident # 108 as scoring a 1 [one] on the brief interview for mental status (BIMS) of a score of 0 - 15, one - being severely impaired of cognition for making daily decisions. Resident # 108 was coded as requiring extensive assistance of one staff member for activities of daily living. Section "P0200 Alarms" coded Resident # 108 as "E. Wander / elopement alarm. Used daily." The baseline care plan for Resident # 108 dated 08/21/2020 documented in part, "Initial Goals: Cognition: Elopement risk." The facility's "Admission Data Collection Tool" for Resident # 108 dated 08/21/2020 documented in part, "Does resident have any history of wandering or elopement? Yes." The nurse's note for Resident # 108 dated 08/21/2020 at 9:39 p.m., documented in part, "...Has been exit seeking since admission, when redirected from outside doors he likes to use the F word." The nurse's note for Resident # 108 dated 08/23/2020 at 11:26 a.m. documented, "Resident was observed in wheel chair under shaded tree near [Name of County Health Department] off facility grounds around 1000 [10:00 a.m.] by staff. He was brought back to facility and released to the care of the nurse. Resident was assessed for injuries. None observed. Vital signs 97.2 [temperature] 124 [pulse], 18 [respiration], 91/67 [91 over 67 - blood pressure], 92% [pulse oximetry]. Nurse manager, NP [nurse practitioner - [Name of Nurse Practitioner], DON [director of	F 689	Nursing/Maintenance (or Designee) every week x 4 weeks, then monthly x 3 months related to: documenting on new admissions every shift for 72 hours including those who are exit-seeking placing these residents on increased supervision and document findings; auditing of the recording of alarm testing process to ensure completion. This information will be forwarded to QAPI for review. Completion date: 07/28/2021 12 VAC 5-371-220 (A) and (B) and (D) cross reference to F689	

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nursing] and administrator notified. Guardian [Name of Guardian] notified of elopement and spoke with resident encouraging him to stay inside facility. When asked why he left he stated he was trying to get where he was going. While interviewed he states he was not harmed, he felt safe, and was just leaving. Resident has been placed on Q [every] 15 minute checks. Signed by: [Name of Licensed Practical Nurse # 8."

Further review of the facility's nurse's notes for Resident # 108 failed to evidence any notes for 08/22/2020.

The facility's "24 HOUR REPORT / CHANGE OF CONDITION REPORT" dated 08/21/2020 documented in part, "Resident: [Name of Resident # 108]. REMARKS (3-11) [3:00 p.m. to 11:00 p.m. shift]: Exit seeks."

The facility's "24 HOUR REPORT / CHANGE OF CONDITION REPORT" dated 08/22/2020 documented in part, "Resident: [Name of Resident # 108]. REMARKS (11-7) [11:00 p.m. to 7:00 a.m. shift]: Exit seeking."

The facility's "24 HOUR REPORT / CHANGE OF CONDITION REPORT" dated 08/23/2020 documented in part, "Resident: [Name of Resident # 108]. REMARKS (11-7) [11:00 p.m. to 7:00 a.m. shift]: Exit seeking. REMARKS (7-3) Left facility."

The FRI [Facility Reported Incident] for Resident # 108 dated 08/23/2020 documented, "Incident Date: 8/23/2020. Injuries: No. Resident Elopement. Staff noted resident in wheelchair down by lower parking lot area. Staff approached resident and brought resident back to nurse's

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station. Full body assessment completed by staff - no injuries."

The facility's "INCIDENT INVESTIGATION" regarding Resident # 108 dated 8/23/2020 documented in part, "Resident seen on [abbreviation for name of unit] lower end camera down by laundry room around 9:48 am [a.m.]. Resident seen on [abbreviation for name of unit] camera facing toward dumpster around 9:52 am. Resident seen going down hill [Sic.] towards lower back parking lot where 2 [two] aides seen resident in w/c [wheelchair]. Resident was brought back up to [name of unit abbreviation] nurse's station by aides. Event was less than 10 minutes."

The facility's "Completed Work Orders" summary revealed that the facility's exit door alarms and magnetic locks were checked and in working order on 08/17/2020. Under "Tasks" it documented, "Check Magnetic Locks." Under "Description" it documented, "Check each door that has a magnetic locking device to be sure the device works properly. Check to be sure the magnetic lock releases and alarms if you push on it for 15 seconds."

On 06/23/2021 at 8:40 a.m., an interview was conducted with OSM [other staff member] # 2, director of maintenance. When asked to explain the 'malfunction' of the emergency exit door on the [name of unit] on 08/23/2020, OSM # 2 stated that something in the key pad failed and didn't allow the 15 minute delay where the magnetic lock is engaged, keeping the door closed unless the push bar is held in for 15 seconds. After that, the magnetic lock releases and the door opens. OSM # 2 also stated that the audible alarm did

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not alarm either. When asked if the exit doors in the facility are checked or inspected on a regular basis, OSM # 2 stated that weekly preventative maintenance is conducted on every exit door in the facility. When asked what they check or look for in the inspection, OSM # 2 stated that they make sure the 15 minute delay is working, it alarms, the door is locking during that time and operating the way it should be. When asked if they were aware of the elopement of a resident on 08/23/2020, OSM # 2 stated that he was notified after the incident that the door was not working and that he changed out the entire key pad.

On 06/23/2021 at 9:09 a.m., an interview was conducted with RN [registered nurse] # 1 regarding Resident # 108's elopement on 08/23/2020. RN # 1 stated that they were the unit manager at the time on the [name of unit] unit and was on-call that day. RN # 1 stated, "I was called in when the incident happened." When asked to describe the procedure they follow when a newly admitted resident demonstrates exit seeking behaviors, RN #1 stated that staff closely monitor the resident. When asked to describe 'closely monitoring' RN # 1 stated that they would keep the resident in sight and if they are attempting to leave we would give them a wander guard. When asked if they were aware if Resident # 108 had exit seeking behaviors, RN # 1 stated no.

On 06/23/2021 at 9:09 a.m., an interview was conducted with CNA [certified nursing assistant] # 1 regarding Resident # 108's elopement on 08/23/2020. After reviewing their witness statement CNA # 1 stated that they recalled Resident # 108 and the incident. CNA # 1 stated,

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"I was in the dayroom at the end of the hall of the EM [east main] unit [directly above name of unit] looking out the window toward the back of the building and saw CNA # 2 pushing a person in a wheelchair up the driveway next to the employee parking lot. I went out to help [CNA # 2] and they told me he [Resident #108] was a resident from the facility. We took him to the nurse on [name of unit]. I didn't know or work with him."

On 06/23/2021 at approximately 2:00 p.m., an interview was conducted with LPN [licensed practical nurse] # 8 regarding Resident # 108's elopement on 08/23/2020. When asked to describe the procedure staff follow when a newly admitted resident demonstrates exit seeking behaviors, LPN #8 stated, "It takes time for a resident to settle down or orient to a new environment so we watch them, maybe put them on 15 minute checks." When asked how the staff are informed that a resident has exit seeking behaviors, LPN # 8 stated, "By word of mouth and/or the 24 hour report." LPN # 8 was then asked to provide evidence that Resident # 108 was being monitored from the time of their admission.

No further information was provided by LPN # 8 during the days of the survey.

On 06/23/2021 at approximately 4:02 p.m., a telephone interview was conducted with LPN [licensed practical nurse] # 7 regarding Resident # 108's elopement on 08/23/2020. LPN # 7 stated that they were working on the [name of unit] on 08 23/2020, when Resident # 108 eloped and stated they worked PRN [as needed]. LPN # 7 stated, "I was passing meds [medication] when the CNAs brought him in, I wasn't aware he left

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the building." When asked to describe the procedure staff follow when a newly admitted resident demonstrates exit seeking behaviors LPN #7 stated, "Usually put them on 15 minute checks." LPN # 7 further stated that they could not recall Resident # 108 demonstrating exit seeking behaviors and didn't remember it being on the 24 hour report.

On 06/23/2021 at 3:26 p.m., an interview was conducted with ASM [administrative staff member] # 1, director of nursing, regarding Resident # 108's elopement on 08/23/2020. When asked to describe the procedure staff follows when a newly admitted resident demonstrates exit seeking behaviors, ASM #1 stated, "We monitor them closely, not one-to-one but line-of-sight." When asked to describe line-of-sight ASM # 1 stated, "Walking up and down the hall putting eyes on them." ASM # 1 further stated, "At the time [when Resident # 108 was admitted] the [name of unit], the unit was the COVID observation unit, where residents who came in from the outside were placed for 14 day observation. The unit was closed off, at the one end we had a plastic wall up with the zipper door and the only other door out of the building was the emergency exit at the other end of the hallway." ASM # 1 stated that they assumed that Resident # 108 could not get off the unit because of the plastic barrier with the zipper door and the emergency exit at the other end that was alarmed but had no idea that the alarm was not working. When asked if they could provide evidence that Resident # 108 was being monitored for elopement on 08/21/2020, 08/22/2020 and on 08/23/2020 prior to the elopement ASM # 1 stated no.

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On 06/23/2021 at 4:17 p.m., an interview was conducted with CNA # 2 regarding Resident # 108's elopement on 08/23/2020. After reviewing their witness statement CNA # 2 stated that they recalled Resident # 108 and the incident. CNA # 2 stated, "I was going out for lunch and saw a resident out toward [Name of Health Department] in the grassy area. I took him back to the unit. Another CNA came and helped me take him back." When asked if they knew the resident, CNA # 2 stated, "I saw his name band and knew he was from the facility." When asked if they worked on the [name of unit] they stated, "Not at that time."

On 06/23/2021 at 5:07 p.m., a telephone interview was conducted with CNA # 3 regarding Resident # 108's elopement on 08/23/2020. CNA # 3 stated that they were working on the [name of unit] that day and recalled Resident # 108 but didn't recall them having exit seeking behaviors. When asked about the elopement CNA # 3 stated, "I wasn't aware of it, I was in another resident's room providing care. When asked how there are informed of a resident having exit seeking behaviors, CNA # 3 stated that the charge nurse would inform them during report. When asked to describe the procedure staff follows when a newly admitted resident demonstrates exit seeking behaviors, CNA #3 stated, "Do checks every 15 minutes."

On 06/24/2021 at 8:30 a.m., an interview was conducted with CNA # 4 regarding Resident # 108's elopement on 08/23/2020. When asked how they know a resident has exit seeking behaviors, CNA # 4 stated, "From the way they act, they will say they want to leave and/or they try to leave the building." When asked how they are

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informed that a resident has exit seeking behaviors, CNA # 4 stated, "In report, by another CNA at shift change or the charge nurse will tell us." When asked if they were assigned to Resident # 108 on 08/23/2020, CNA # 4 stated that they could not remember. When asked if they were aware that Resident # 108 had exit seeking behaviors, CNA # 4 stated, "We were all aware, he was adamant about leaving. His room was across from the nurse's station. He was in his door way when I was leaving to take my lunch. We were supposed to keep an eye on him."

The facility's policy "Elopement or Missing Resident" it documented in part, "If a staff member observes a nursing facility resident attempting to leave the facility: Attempt to prevent the resident from leaving the property while remaining with the resident; Attempt to notify other staff to assist as needed in a courteous manner, remain with resident while other staff member notifies charge nurse; When resident is returned to unit, notify MD [medical doctor], RP [responsible party] of exit seeking; If a resident does not have a Roam Alert, obtain order from MD; Resident should have increased monitoring

On 6/23/21 at 4:59 p.m., ASM [administrative staff member] #1, director of nursing, was made aware of the above concern.

No further information was presented prior to exit.

References:
[1] Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety

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F 689	Continued From page 31 psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, clinical record reviews and facility document reviews it was determined that the facility staff failed to provide respiratory care, consistent with professional standards of practice, and the comprehensive person-centered plan of care for three of 45 residents in the survey sample, Residents #70, #480 and #115. The facility staff failed to administer oxygen to Resident #70 and Resident #115 at the flow rate prescribed by the physician and failed to ensure a physician's order for Resident #480's use of a CPAP machine and failed to ensure the CPAP was stored in a sanitary manner when not in use.	F 695	1.Residents #70, and #115 had their oxygen corrected to match the physician order and care plan. Resident #480 had an order placed on 6/23/21 for his continuous positive airway pressure device to be placed and cleaned. The device was cleaned on 6/23/21 and placed in a bag. Resident #480 was seen by the Nurse Practitioner on 6/28/21 with continuous positive airway pressure device listed in progress notes and lungs clear to auscultation. 2. The other residents of the facility that	7/28/21

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F 695	Continued From page 32 The findings include: 1. The facility policy "Oxygen Administration" dated "January 2016" documented in part, "...This facility provides guidelines for safe oxygen administration per physician orders..." Resident #70 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (COPD) (1), acute respiratory failure (2) and sleep apnea (3). Resident #70's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 5/11/2021, coded Resident #70 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Section O documented Resident #70 receiving oxygen while a resident at the facility. On 6/22/21 at approximately 12:42 p.m., an interview was conducted with Resident #70 in their room. Resident #70 was observed in bed wearing an oxygen nasal cannula with a humidifier bottle dated 6/16/21 attached to an oxygen concentrator. The oxygen flow rate set on the concentrator was observed set at 2.5 lpm (liters per minute). Resident #70 stated they wore the oxygen all the time. When asked if he ever adjusted the oxygen rate, Resident #70 stated that the nurses set the oxygen rate and he did not adjust the settings. Additional observations of Resident #70 on 6/22/21 at approximately 4:15 p.m. and 6/23/21 at approximately 11:45 a.m. revealed the oxygen	F 695	require respiratory device, including oxygen and continuous positive airway pressure devices, have the potential to be affected. 3. Facility Nursing staff were re-educated on 7/3/21 to administer oxygen as ordered per physician orders and care plan and have oxygen bag on the command strip placed on concentrator to avoid any disturbances with dial flow meter. Staff educated on obtaining orders as required, including for a continuous positive airway pressure device, completing the baseline care plan on admission with checking all boxes including the Liters Per Minute box appropriately including the special treatment procedures to include continuous positive airway pressure device, completing the nursing admission assessment to show devices, including a continuous positive airway pressure device, and cleaning continuous positive airway devices, as ordered. 4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3 months related to: administering oxygen as ordered per physician orders and care plan and hanging oxygen bag on the command strip placed on concentrator to avoid any disturbances with dial flow meter. Staff educated on obtaining orders as required including for a continuous positive airway pressure device, completing the baseline	

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F 695	Continued From page 33 flow rate set at 2.5 lpm. The physician order's for Resident #70 documented in part, "Order Date: 5/10/21...Resident to wear oxygen @ [at] 3L/min (liters per minute) via NC (nasal cannula) continuously for SOB (shortness of breath)/COPD- Check flowmeter and O2 SATs (saturations) Q (every) shift..." The comprehensive care plan for Resident #70 dated 12/31/2020 documented in part, "[Resident #70] is at risk for impaired gas exchange R/T (related to) COPD, Pulmonary HTN (hypertension) (4), allergies and OSA (obstructive sleep apnea)...." Under "Intervention" it documented in part, "Administer oxygen per MD (medical doctor) orders, See eTAR (electronic treatment administration record). Start Date: 12/31/2020..." The eTAR dated June 2021 for Resident #70 documented oxygen at 3L/min continuously with flowmeter and O2 saturation checks each day at 6:00 a.m., 2:00 p.m. and 10:00 p.m. On 6/23/2021 at approximately 1:10 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the oxygen was set by centering the silver ball inside of the flow meter on the line beside the number of the liter that was prescribed. LPN #2 stated that oxygen was checked for the correct flow rate and set up at least once a shift. On 6/23/2021 at approximately 1:20 p.m., LPN #2 observed Resident #70's oxygen concentrator. LPN #2 stated that the oxygen was set at 2.5 lpm and they did not know how it had gotten set that	F 695	care plan on admission with checking all boxes including the Liters Per Minute box appropriately including the special treatment procedures to include continuous positive airway pressure device, completing the nursing admission assessment to show devices including a continuous positive airway pressure device and cleaning continuous positive airway devices as ordered. This information will be forwarded to QAPI for review. Completion date: 07/28/2021 12 VAC 5-371-220 cross reference to F695	

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way because it was supposed to be set at 3 lpm. LPN #2 adjusted the flow rate of Resident #70's oxygen to 3 lpm.

The manufacturer's instructions for use for the oxygen concentrator in Resident #70's room provided by the facility documented in part, "...2. Check the flow meter to make sure that the flow meter ball is centered on the line next to the prescribed number of your flow rate. Caution- It is very important to follow your oxygen prescription. Do not increase or decrease the flow of oxygen- consult your physician..."

On 6/23/21 at approximately 4:45 p.m., ASM #1, the director of nursing, RN #1, the director of compliance and RN #4, the assistant director of nursing were notified of the findings. No further information was provided prior to exit.

References:

1. 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.

2. Respiratory failure: 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.

3. 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

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website: https://medlineplus.gov/sleepapnea.html.

4. Pulmonary hypertension: (PH) is high blood pressure in the arteries to your lungs. It is a serious condition. If you have it, the blood vessels that carry blood from your heart to your lungs become hard and narrow. Your heart has to work harder to pump the blood through. Over time, your heart weakens and cannot do its job and you can develop heart failure. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=pulmonary+hypertension&_ga=2.195097636.96184153.1624557775-1838772440.1562936034

2. During the facility tour on 6/22/21 at 11:30 AM, observation revealed a CPAP machine sitting on Resident #480's bedside nightstand with the nasal prongs uncovered. On 6/22/21 at 3:30 PM, a second observation revealed the CPAP machine on Resident #480's bedside nightstand with the nasal prongs uncovered.

Resident #480 was admitted to the facility on 6/17/21. Resident #480's diagnoses included but were not limited to: obstructive sleep apnea [OSA] (transient periods of apnea during sleep) (2), ESRD [end stage renal disease] (inability of the kidneys to excrete waste and maintain electrolyte balance) (3) and fracture of the right eye orbit (a break in the bony cavity housing right eye) (4).

Resident #480's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/17/21, coded the resident as scoring 12 out of 15 on the

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BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: had not been coded. MDS Section H-Bowel and Bladder had not been coded. MDS Section O-Special Treatments / Procedures had not been coded.

A review of Resident #480's baseline care plan dated 6/17/21 failed to evidence documentation addressing the care and use of a CPAP. The baseline care plan, documented in part, "Special Treatments/Procedures: CPAP & CPAP equipment. Cleaning/maintenance per facility protocol. Liters per minute___." Check boxes by each of these, all the boxes on Resident #480's baseline care plan were unchecked.

A review of the physician orders dated 6/17/21, failed to evidence CPAP order.

A review of the physician's history and physical dated 6/18/21, documented in part, "Assessment and Plans: OSA on CPAP.

A review of the nursing admission assessment dated 6/17/21 failed to evidence documentation of OSA or CPAP machine.

An interview was conducted on 6/22/21 at 1:55 PM with Resident #480. When asked how often he uses the CPAP machine, Resident #480 stated, "I use it every night." When asked if the CPAP nasal prongs were covered, Resident #480 stated, "No, it's never covered. It fell on the floor once and I wiped it off before I used it again. I believe it should be covered when I'm in this building."

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Observation on 6/23/21 at 9:30 AM, of Resident #480's CPAP machine, revealed the CPAP was now covered with disposable, plastic grocery bag.

An interview was conducted on 6/23/21 at 1:15 PM with Resident #480. When asked the frequency of using CPAP, Resident #480 stated, "I use it every night." When asked about the plastic grocery bag covering the CPAP nasal prongs, Resident #480 stated, "After we talked yesterday, I decided to put them in the plastic bag to help keep them clean."

An interview was conducted on 6/23/21 at 2:15 PM with LPN (licensed practical nurse) #5. When asked how CPAP nasal prongs are maintained, LPN #5 stated, "They are covered with a plastic bag." When asked if treatments such as CPAP should have a physician order, LPN #5 stated, "Yes, there should be an order."

An interview was conducted on 6/23/21 at 3:00 PM with RN (registered nurse) #3, the clinical reimbursement director. RN #3 stated, "I do not see CPAP on the care plan- it would usually be under Sleep Apnea. If there is not an order for it, then nursing is responsible for getting the order and putting it on the care plan."

On 6/23/21 at 3:30 PM, RN #3 brought in a copy of the nursing progress noted dated and timed 6/23/21 3:12 PM which documented in part, "Informed of CPAP machine in room. Resident reports CPAP was dropped off by wife a few days ago; he couldn't remember which day. He states he uses this at night for his sleep apnea. It was observed on his bedside table. Unit manager aware and following up." RN #3 also provided a revised baseline care plan for review, which

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documented in part, "Special Treatments/Procedures: CPAP & CPAP equipment. Cleaning/maintenance per facility protocol. Liters per minute___." Check boxes by each of these, box checked and dated 6/23/21. "Other condition: Sleep Apnea, Intervention: CPAP per order", dated 6/23/21. A copy of the physician's order dated 6/23/21, documented in part, "CPAP settings of 7.0 centimeters of water. Resident at night for OSA. Monitor on 3-11 and 11-7 shift. Ensure CPAP has distilled water in chamber at bedtime. CPAP face mask to be changed every 6 months by 3-11 shift in July and January. Wipe mask with CPAP wipes, allow 2 minutes to dry on clean surface and apply mask."

An interview was conducted on 6/23/21 at 4:00 PM with ASM (administrative staff member) #1, the director of nursing. When asked the purpose of the physician orders, ASM #1 stated, "Orders are to take care of the resident needs and for medications and treatments, oxygen and CPAP orders." When asked who is responsible to obtain/clarify physician orders, ASM #1 stated, "Any nurse is to get physician orders. They can be obtained in the evening or weekend, we have on call physicians. We need a process if the family brings in a device to make sure we have an order."

ASM #1, the director of nursing, RN #1, the director of compliance and RN #4, the assistant director of nursing, were made aware of the above concern on 6/23/21 at 4:45 PM.

The facility's policy on "Policy and Procedure for Cleaning of BiPAP and CPAP Machines" dated 5/2018, documents in part, "Clean with CPAP mask/nasal pillow with CPAP wipes before use".

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The facility's policy on "Tubing for Oxygen, CPAP and BiPAP devices and Nebulizer Tubing Set-Up" dated 6/2016, documents in part, "Infection Control: When not in use, place tubing in drawstring bags".

The facility's policy on "Physician Orders" dated 9/13/17, documents in part, "A physician order must include in the following information: Quantity or duration (length) of therapy, diagnosis or condition for which prescribed, resident name."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 141.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 531.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 498.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 416.
3. Resident #115 was admitted to the facility with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (2) and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and

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resulting in decreased heart output and frequently clot formation in the atria)(3).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/24/2021, coded Resident #115 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. Resident #115 was coded as requiring limited assistance of one staff member for most of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while in the facility.

On 6/22/2021 at 10:45 a.m. observation revealed Resident #115 sitting in her recliner with oxygen on via a nasal cannula connected to an oxygen concentrator that was running. Further observation revealed the oxygen flow meter was set at 2.5 LPM (liters per minute). A second observation on 6/22/2021 at 3:39 p.m. revealed, the oxygen flow rated was set at 2.5 LPM.

On 6/23/2021 at 9:30 a.m., observation of Resident #115 revealed oxygen was in use by the resident and the flow meter flow rate on the oxygen concentrator was set at 2.5 LPM. When asked if she adjusts the oxygen flow rate, Resident #115 stated she had it at home and knows how to adjust it but the staff here has told her not to touch it so she doesn't.

The physician order dated 8/19/2020 documented, "Resident to wear oxygen @ (at) 2 L/MIN (liters per minute) continuously for SOB (shortness of breath)/COPD) check flowmeter and O2 (oxygen) sats (saturations) Q (every)

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shift."

The eTAR (electronic treatment administration record) documented, "Resident to wear oxygen @ 2 L/MIN continuously for SOB/COPD check flowmeter and O2 sats Q shift." The eTAR documented the use of oxygen on all three shifts for 6/22/2021 and 6/23/2021. It also documented a "2" under each shift for the liter flow rate.

The comprehensive care plan dated 8/25/2020 documented in part, "Care Plan - (Resident #115) has impaired gas exchange r/t (related to) COPD, Shortness of breath. She has hx (history) of wheezing. She is on continuous oxygen. She has a cough." The "Interventions" documented in part, "Administer oxygen per MD (medical doctor) orders."

On 6/23/2021 at 12:43 p.m. LPN (licensed practical nurse) # 6 was accompanied to Resident #115's room. LPN #6 was asked the flow rate setting of Resident #115's oxygen. LPN #6 observed the flow meter on Resident #115's oxygen concentrator and stated it was at 2.5 LPM. LPN #6 was then observed changing Resident #115's oxygen flow rate to 2LPM and stated, "The order is for 2 LPM". When asked how to read the oxygen concentrator, LPN #6 stated that the line of the prescribed rate goes through the center of the ball. When asked how often a nurse is to check the rate of the oxygen, LPN #6 stated a nurse should check it at least every shift.

ASM (administrative staff member) #1, the director of nursing, RN (registered nurse) #2, the director of compliance, and RN #4, the assistant director of nursing, were made aware of the

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F 695	Continued From page 42 above concern on 6/23/2021 at 4:48 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 695		
F 698 SS=E	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 staff interview and facility document review, it was determined the facility staff failed to provide dialysis services, consistent with professional standards of practice, and the comprehensive person-centered care plan, for three of 45 residents in the survey sample, Resident #480, Resident #56 and Resident #22. The facility failed to evidence ongoing collaboration and communication with the dialysis treatment center on 6/18/21 and 6/23/21 for Resident #480.	F 698	1.Residents #480 was visited by the Nurse Practitioner on 6/28/21 with no adjustment related to dialysis, #56 was seen by the primary care physician on 6/25/21 with no adjustments related to dialysis, resident # 22 was seen by the NP on 6/25/21 with no adjustments related to dialysis. Dialysis was contacted and in-serviced by the Director of Education on 6/23/21, to inform them of a form called the Resident Condition Summary that would be sent with residents and	7/28/21

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F 698	Continued From page 43 2. The facility staff failed to ensure ongoing collaboration and communication with the dialysis center regarding Resident #56's care in May 2021 and June 2021. 3. The facility staff failed to ensure ongoing collaboration communication with the dialysis center regarding Resident #22's care in May 2021 and June 2021. The findings include: 1. The facility's policy on "Dialysis: Coordination of Hemodialysis Services" dated 11/2016, documents in part, "Residents requiring an outside ESRD facility will have services coordinated by the facility to include care planning, nursing, medications, nutritional, social services, activities and physician services. There will be communication between the facility and the ESRD facility regarding the resident. Procedure: A communication form will be initiated by the facility for any resident going to an ESRD facility for hemodialysis. This form will be kept in a binder that is sent with the resident for treatments. Nursing will collect information regarding the resident to send to the ESRD facility with the resident-information recommended but not limited to: resident information face sheet, copy of current physician orders, copy of care plan, blank progress note, blank hemodialysis communication form, changes in the resident's condition, any new labs. Nursing will send the resident information with the resident to the designated appointment at the ESRD facility. Nursing will give a brief summary of the resident's physical, mental and emotional condition, oral intake, activity tolerance and	F 698	expected to be returned with a signature. 2. The other residents of the facility that require dialysis have the potential to be affected. 3. Facility Nursing staff were re-educated on 7/3/21 communication and collaboration of residents receiving dialysis and maintain a person-centered care plan by sending a form with current information called the Resident Condition Summary form that should be printed and placed in the resident□s dialysis book to be signed by a dialysis employee. When the book is returned to facility, the nurse should view and follow-up on recommendations with MD/NP as listed. The information will be placed in the resident□s medical record. 4. To ensure compliance, audits will be conducted by Director of Nursing (or Designee) every week x 4 weeks, then monthly x 3 months related to: Review dialysis residents to ensure that communication and collaboration of residents receiving dialysis and maintain a person-centered care plan by sending a form with current information called the Resident Condition Summary form that should be printed and placed in the resident□s dialysis book to be signed by a dialysis employee. When the book is returned to facility, the nurse should view and follow-up on recommendations with Md/NP as listed. The information will be placed in the resident□s medical record.	

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F 698	Continued From page 44 change in physician orders since the last appointment." Resident #480 was admitted to the facility on 6/17/21. Resident #480's diagnoses included but were not limited to: obstructive sleep apnea [OSA] (transient periods of apnea during sleep) (1), ESRD [end stage renal disease] (inability of the kidneys to excrete waste and maintain electrolyte balance) (2) and fracture of the right eye orbit (a break in the bony cavity housing right eye) (3). Resident #480's most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/17/21, coded the resident as scoring 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: had not been coded. MDS Section H-Bowel and Bladder had not been coded. MDS Section O-Special Treatments / Procedures had not been coded. A review of Resident #480's baseline care plan dated 6/18/21 documents in part, "Other conditions: ESRD: dialysis. Intervention: dialysis three times a week. Administer meds as ordered. Treatments per physician order see TAR (treatment administration record). Assess upon return from dialysis per physician orders. Monitor fistula to right upper extremity, dressing to fistula per physician orders." A review of the physician orders dated 6/17/21, documented in part, "Send to dialysis treatment center for additional treatment, dialysis at 7:30	F 698	This information will be forwarded to QAPI for review. Completion date: 07/28/2021	

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AM-wife will transport. Monitor fistula to right upper extremity. Check for bruit and thrill every shift, Assess resident upon return from dialysis. Dressing to fistula to be changed at dialysis on dialysis days."

An activities progress note dated 6/19/21 at 12:05 PM, documented in part, "He goes out to dialysis 3 times a week, wife transports."

A review of the dialysis center's date of service communication with the facility, lists dates of service as 6/18/21, 6/21/21 and 6/23/21.

An interview was conducted on 6/22/21 at 1:55 PM with Resident #480. When asked if he has dialysis, Resident #480 stated, "Yes, I go Monday, Wednesday and Friday". When asked if he takes papers from the facility to the dialysis center, Resident #480 stated, "I'm not sure. If I do, they are in that orange bag. You can look in there." Observation inside the 'orange bag' referenced cy Resident #480 failed to evidence a dialysis communication book or papers from the facility other than papers dated 6/21/21 from the dialysis center.

An interview was conducted on 6/22/21 at 2:05 PM with LPN (licensed practical nurse) # 3, regarding what communication is sent with a resident to dialysis. LPN #3 stated, "If we had sent communication to the dialysis center it would be in this notebook we set up." Review of the binder referenced by LPN #3, failed to evidence a resident name and all pages in the binder were blank without any name. LPN #3 stated, "I do not see any paperwork, so none was sent. I guess we have not set this up for him yet." LPN #3 stated, "He [Resident #480] goes on Monday,

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Wednesday and Friday. Let's see if the paperwork is in his room" LPN #3 was accompanied to Resident #480's room. LPN #3 found the paperwork from the dialysis center dated 6/21/21 in the orange bag. LPN #3 stated, "This paperwork needs to be in the binder so we know their communication back to us."

An interview was conducted on 6/23/21 at 1:45 PM with ASM (administrative staff member) #1, the director of nursing. When asked about the facility's process to communicate with the dialysis facility, ASM #1 stated, "We don't communicate with the dialysis facility unless there is a change. That is what the dialysis facility wants. I will bring you the policy."

An interview was conducted on 6/23/21 at 1:15 PM with Resident #480. When asked if he had taken any paperwork from the facility to the dialysis center, Resident #480 stated, "If I did, it would be in the orange bag and you can look in there." A White binder with resident name found inside the orange bag. The pages inside the white binder were blank including the form from the 6/23/21 dialysis.

The facility's "Dialysis Communication Form" dated 1/18/17 is divided into two portions: top portion to be completed by skilled nursing facility, bottom portion for completion by dialysis center. Skilled nursing facility includes: resident name, date, changes since last visit: physical, mental, emotional (checkbox for none); physical order changes: (checkbox for order none; new labs: (checkbox of none) and checkbox for see attached; signature of nurse.

An interview was conducted on 6/23/21 at 2:39

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PM with LPN #2. When asked the facility process for ongoing communication with dialysis center, LPN #2 stated, "I can double check. We usually do phone calls. There should be a section in the dialysis documentation book that we can relay information and they send information back to us. LPN #2 verified that the Dialysis Communication Form is the correct form. LPN #2 stated, "We would write a nurses note in the back of the book about the resident." When asked if staff would document phone calls with the dialysis center, LPN #2 stated, "Yes, I would document it." LPN #2 stated, "If anything changed such as meds [medications], status, hospital, nutrition; because it can impact them [residents']. The vital signs are not communicated every time, weights with increase or decrease, fistula bruit or thrill. If there were no change from baseline, I would write that in the book. We do communicate every day of dialysis." When asked how you would communicate a resident's fluid restriction, LPN #2 stated, "I would let them know intake. We would send a copy of the advance directive."

ASM #1, the director of nursing, RN #1, the director of compliance and RN #4, the assistant director of nursing, were made aware of the above concern on 6/23/21 at 4:45 PM.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 531.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and

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Chapman, page 498.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 416.

2. The facility staff failed to ensure communication regarding Resident #56's care with the dialysis center in May 2021 and June 2021.

Resident #56 was admitted to the facility on 4/28/21. Resident #56's diagnoses included but were not limited to end stage kidney disease, heart failure and diabetes. Resident #56's significant change in status minimum data set assessment with an assessment reference date of 5/3/21, coded the resident as being cognitively intact. Section O coded Resident #56 as having received dialysis.

Resident #56's comprehensive care plan dated 4/28/21 documented, "WILL CONTINUE TO PARTICIPATE IN HEMODIALYSIS (1) 3X (times) WEEKLY WITHOUT CRISIS WITH AID OF DIALYSIS STAFF, FACILITY STAFF AND MD (medical doctor) THRU NEXT REVIEW. COMMUNICATE CHANGES IN HIS CONDITION, FUNCTION OR BEHAVIOR TO DIALYSIS CENTER VIA NOTEBOOK OR PHONE CALL. REPORT ABNORMAL LABS TO DIALYSIS CENTER..."

Review of Resident #56's clinical record revealed a physician's order dated 4/29/21 for dialysis every Tuesday, Thursday and Saturday.

Further review of Resident #56's clinical record (including May 2021 and June 2021 nurses' notes) failed to reveal evidence that the facility

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staff provided ongoing communication regarding Resident #56 to the dialysis center staff. Resident #56's dialysis communication book contained blank dialysis communication forms that contained sections for the facility staff to document physical, mental and emotional changes since the last visit, physician order changes and new labs. The communication book also contained information from the dialysis center staff but no communication from the facility staff to the dialysis center staff.

On 6/23/21 at 2:39 p.m., an interview was conducted with LPN (licensed practical nurse) #2, regarding the facility process for providing ongoing communication to the dialysis center staff. LPN #2 stated it had been "a bit" since she cared for a resident who received dialysis. LPN #2 stated she usually provided verbal communication to dialysis center staff via phone because it was quicker and she would document these phone calls. LPN #2 stated she would also write nurses' notes and place them in the communication book that was sent to the dialysis center. LPN #2 stated information such as medical status changes, medication changes, hospitalizations, nutritional changes, vital sign changes, weight changes and fluid intake (for resident on fluid restrictions) should be communicated from the facility staff to the dialysis center staff. LPN #2 stated she would also send the dialysis center a note documenting no changes if the resident was at his or her baseline.

Review of Resident #56's physician's orders revealed a physician's order dated 5/24/21 for a fluid restriction but the clinical record or the communication book revealed no communication from the facility staff to the dialysis center staff

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regarding the resident's fluid intake during May 2021 or June 2021. Also, review of nurses' notes revealed the following:
-5/8/21- Resident #56 presented with a large, swollen, hard area on the inner left thigh.
-5/26/21- A change in Resident #56's insulin.
-5/28/21- Resident #56 presented with a significant weight gain.
Further review of Resident #56's clinical record and the communication book revealed no evidence of communication from the facility staff to the dialysis center staff regarding the above changes.

On 6/23/21 at 4:59 p.m., ASM (administrative staff member) #1 (the director of nursing) was made aware of the above concern.

Reference:
(1) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was taken from the website https://medlineplus.gov/dialysis.html.
3. The facility staff failed to ensure communication regarding Resident #22's care with the dialysis center in May 2021 and June 2021.

Resident # 22 was admitted to the facility with

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diagnoses included but were not limited to end stage kidney disease [1], heart failure and diabetes.

Resident # 22's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/01/2021, coded Resident # 22 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 22 was coded as requiring supervision of one staff member for activities of daily living. Section "O Special Treatments, Procedures and Programs" coded Resident # 22 for "Dialysis" while a resident.

The POS [physician's order sheet] for Resident # 22 documented, "Dialysis T-TH-SAT [Tuesday-Thursday-Saturday] at 1200 [12:00 p.m.] [Name of Dialysis Center]. Order Date: 06/10/2020. Start Date: 06/10/2020."

The comprehensive care plan for Resident #22 dated 06/10/2020, documented in part, "WILL CONTINUE TO PARTICIPATE IN HEMODIALYSIS [2] 3X (three times) WEEKLY WITHOUT CRISIS WITH AID OF DIALYSIS STAFF, FACILITY STAFF AND MD (medical doctor) THRU NEXT REVIEW." Under "Intervention" COMMUNICATE CHANGES IN [Resident #22's] CONDITION, FUNCTION OR BEHAVIOR TO DIALYSIS CENTER VIA [by] NOTEBOOK OR PHONE CALL. REPORT ABNORMAL LABS [laboratory tests] TO DIALYSIS CENTER."

Review of facility's nurse's notes dated 05/01/2021 through 06/22/2021, Resident # 22's failed to evidence documentation that the facility

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staff provided ongoing communication regarding Resident # 22 to the dialysis center staff. Further review of the nurse's notes documented, "5/26/2021 [at] 3:50 PM [p.m.] New order: Apply skin prep/foam dressing to right planter foot callus for skin irritation" and "6/16/2021. 1:53 PM RNP [restorative nursing program] review with input from RNP staff; {Resident # 22] is participating; has had some soreness in BLE [bilateral lower extremity] with ambulation; monitoring ..."

Review of Resident #22's dialysis communication book failed to evidence documentation from the facility staff to the dialysis center staff regarding the above changes. Further review of Resident #22's dialysis communication book revealed it contained blank dialysis communication forms that contained sections for the facility staff to document physical, mental and emotional changes since the last visit, physical order changes and new labs. The communication book also contained information from the dialysis center staff but no communication from the facility staff to the dialysis center staff.

On 06/23/20 21 at 2:39 p.m., an interview was conducted with LPN (licensed practical nurse) #2, regarding the facility process for providing ongoing communication to the dialysis center staff. LPN #2 stated it had been "a bit" since she cared for a resident who received dialysis. LPN #2 stated she usually provided verbal communication to dialysis center staff via phone because it was quicker and she would document these phone calls. LPN #2 stated she would also write nurses' notes and place them in the communication book that was sent to the dialysis center. LPN #2 stated information such as

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medical status changes, medication changes, hospitalizations, nutritional changes, vital sign changes, weight changes and fluid intake (for resident on fluid restrictions) should be communicated from the facility staff to the dialysis center staff. LPN #2 stated she would also send the dialysis center a note documenting no changes if the resident was at his or her baseline.

On 6/23/21 at 4:59 p.m., ASM [administrative staff member] #1, director of nursing, was made aware of the above concern.

No further information was presented prior to exit.

References:
[1] The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

[2] 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/000707.htm.