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	345446	A. BUILDING _____ B. WING _____	09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHAB CENTER	95 LOCUST STREET CONNELLYS SPRINGS, NC 28612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair 21 resident doors with broken and splintered laminate and wood on 5 of 6 resident hallways (Resident room #102, #103, #201,#203, #204, #205, #207, #208, #210, #301, #304, #305, #308, #402, #403, #404, #409, #411, #603, #605 and #609 and failed to repair damaged wood and laminate on the edges of 4 of 4 sets of smoke prevention doors in the skilled nursing unit (100 hall, 200 Hall, 300 hall and 400 hall). The findings included: 1. a. Observations of Room #102 on 09/13/16 at 9:17 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/14/16 at 10:09 AM revealed the door of resident room #102 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/15/16 4:02 PM revealed the door of resident room #102 had broken and splintered laminate on the edges of the bottom half of the door. b. Observations of Room #103 on 09/13/16 at 9:18 AM revealed the door of the resident's room had broken and splintered laminate on the edges	F 253	* How corrective action will be completed for residents affected by F253 Resident's room doors & fire doors listed in the alleged deficient practice will be repaired to maintain safety and be esthetically pleasing. Doors listed will be repaired & or replaced upon arrival of materials ordered on 10/10/16. * Potential for other residents to be affected and corrective preventive action All residents have the potential to be affected by the listed alleged deficient practice. To ensure others are not affected Maintenance Director completed environmental rounds with audit and repair program initiated by 10/14/16 to assure continued safety of residents and esthetically pleasing environment. * Actions in place to ensure future deficient practice does not occur Environmental rounds to be completed by maintenance weekly X 6 weeks, monthly X 3 months, and ongoing randomly as appropriate. All staff to be re-educated by administrator or designee on reporting environmental hazards and or damages and completing appropriate work orders.	10/14/16

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

Electronically Signed | 10/10/2016

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F 253	Continued From page 1 of the bottom half of the door. Observations on 09/14/16 at 10:10 AM revealed the door of resident room #103 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/15/16 4:03 PM revealed the door of resident room #103 had broken and splintered laminate on the edges of the bottom half of the door. c. Observations of Room #201 on 09/13/16 at 9:19 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/14/16 at 10:11 AM revealed the door of resident room #201 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/15/16 4:04 PM revealed the door of resident room #201 had broken and splintered laminate on the edges of the bottom half of the door. d. Observations of Room #203 on 09/13/16 at 9:20 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/14/16 at 10:12 AM revealed the door of resident room #203 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/15/16 4:05 PM revealed the door of resident room #203 had broken and splintered laminate on the edges of the bottom half of the door. e. Observations of Room #204 on 09/13/16 at 9:21 AM revealed the door of the resident's room had broken and splintered laminate on the edges	F 253	* Plans to monitor to ensure correction achieved and maintained Administrator and or designee to complete weekly audits/rounds to ensure ongoing compliance with environment. Environmental upgrades/repairs to be completed based on audit findings and work orders as appropriate. Audit findings and repairs pending and completed to be reviewed in monthly QAPI meeting with revisions as necessary.	

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of the bottom half of the door.
Observations on 09/14/16 at 10:13 AM revealed the door of resident room #204 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:06 PM revealed the door of resident room #204 had broken and splintered laminate on the edges of the bottom half of the door.

f. Observations of Room #205 on 09/13/16 at 9:22 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:14 AM revealed the door of resident room #205 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:07 PM revealed the door of resident room #205 had broken and splintered laminate on the edges of the bottom half of the door.

g. Observations of Room #207 on 09/13/16 at 9:23 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:15 AM revealed the door of resident room #207 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:08 PM revealed the door of resident room #207 had broken and splintered laminate on the edges of the bottom half of the door.

h. Observations of Room #208 on 09/13/16 at 9:24 AM revealed the door of the resident's room had broken and splintered laminate on the edges

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of the bottom half of the door.
Observations on 09/14/16 at 10:16 AM revealed the door of resident room #208 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:09 PM revealed the door of resident room #208 had broken and splintered laminate on the edges of the bottom half of the door.

i. Observations of Room #210 on 09/13/16 at 9:25 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:17 AM revealed the door of resident room #210 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:10 PM revealed the door of resident room #210 had broken and splintered laminate on the edges of the bottom half of the door.

j. Observations of Room #301 on 09/13/16 at 9:27 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:19 AM revealed the door of resident room #301 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:12 PM revealed the door of resident room #301 had broken and splintered laminate on the edges of the bottom half of the door.

k. Observations of Room #304 on 09/13/16 at 9:28 AM revealed the door of the resident's room had broken and splintered laminate on the edges

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of the bottom half of the door.
Observations on 09/14/16 at 10:20 AM revealed the door of resident room #304 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:13 PM revealed the door of resident room #304 had broken and splintered laminate on the edges of the bottom half of the door.

l. Observations of Room #305 on 09/13/16 at 9:29 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:21 AM revealed the door of resident room #305 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:14 PM revealed the door of resident room #305 had broken and splintered laminate on the edges of the bottom half of the door.

m. Observations of Room #308 on 09/13/16 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:22 AM revealed the door of resident room #308 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:15 PM revealed the door of resident room #308 had broken and splintered laminate on the edges of the bottom half of the door.

n. Observations of Room #402 on 09/13/16 at 9:33 AM revealed the door of the resident's room had broken and splintered laminate on the edges

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of the bottom half of the door.
Observations on 09/14/16 at 10:25 AM revealed the door of resident room #402 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:25 PM revealed the door of resident room #402 had broken and splintered laminate on the edges of the bottom half of the door.

o. Observations of Room #403 on 09/13/16 at 9:34 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:26 AM revealed the door of resident room #403 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:27 PM revealed the door of resident room #403 had broken and splintered laminate on the edges of the bottom half of the door.

p. Observations of Room #404 on 09/13/16 at 9:35 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:27 AM revealed the door of resident room #404 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:29 PM revealed the door of resident room #404 had broken and splintered laminate on the edges of the bottom half of the door.

q. Observations of Room #409 on 09/13/16 at 9:36 AM revealed the door of the resident's room had broken and splintered laminate on the edges

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of the bottom half of the door.
Observations on 09/14/16 at 10:28 AM revealed the door of resident room #409 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:32 PM revealed the door of resident room #409 had broken and splintered laminate on the edges of the bottom half of the door.

r. Observations of Room #411 on 09/13/16 at 9:37 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:29 AM revealed the door of resident room #411 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:33 PM revealed the door of resident room #411 had broken and splintered laminate on the edges of the bottom half of the door.

s. Observations of Room #603 on 09/13/16 at 9:40 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:35 AM revealed the door of resident room #603 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:35 PM revealed the door of resident room #603 had broken and splintered laminate on the edges of the bottom half of the door.

t. Observations of Room #605 on 09/13/16 at 9:42 AM revealed the door of the resident's room had broken and splintered laminate on the edges

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of the bottom half of the door.
Observations on 09/14/16 at 10:37 AM revealed the door of resident room #605 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:36 PM revealed the door of resident room #605 had broken and splintered laminate on the edges of the bottom half of the door.

u. Observations of Room #609 on 09/13/16 at 9:43 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:43 AM revealed the door of resident room #609 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/15/16 4:43 PM revealed the door of resident room #609 had broken and splintered laminate on the edges of the bottom half of the door.

2 a. Observations on 09/13/16 at 9:50 AM of the smoke prevention doors on 100 hall revealed double doors with broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/14/16 at 10:45 AM of smoke prevention doors on 100 hall revealed a set of double doors with broken and splintered laminate on the edges of the bottom half of the doors.
Observations on 09/15/16 at 4:45 PM of smoke prevention doors on 100 hall revealed a set of double doors with broken and splintered laminate on the edges of the bottom half of the doors.

b. Observations on 09/13/16 at 9:51 AM of the smoke prevention doors on 200 hall revealed double doors with broken and splintered laminate

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on the edges of the bottom half of the door. Observations on 09/14/16 at 10:46 AM of smoke prevention doors on 200 hall revealed a set of double doors with broken and splintered laminate on the edges of the bottom half of the doors. Observations on 09/15/16 at 4:46 PM of smoke prevention doors on 200 hall revealed a set of double doors with broken and splintered laminate on the edges of the bottom half of the doors.

c. Observations on 09/13/16 at 9:52 AM of the smoke prevention doors on 300 hall on revealed double doors with broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/14/16 at 10:47 AM of smoke prevention doors on 300 hall revealed a set of double doors with broken and splintered laminate on the edges of the bottom half of the doors. Observations on 09/15/16 at 4:47 PM of smoke prevention doors on 300 hall revealed a set of double doors with broken and splintered laminate on the edges of the bottom half of the doors.

d. Observations on 09/13/16 at 9:53 AM of the smoke prevention doors on 400 hall revealed double doors with broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/14/16 at 10:48 AM of smoke prevention doors on 400 hall revealed double doors with broken and splintered laminate on the edges of the bottom half of the doors. Observations on 09/15/16 at 4:48 PM of smoke prevention doors on 400 hall revealed double doors with broken and splintered laminate on the edges of the bottom half of the doors.

During an interview and environmental tour on 09/16/16 at 12:09 PM with the Supervisor of Maintenance he explained they used a work order

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F 253	Continued From page 9 system for repairs. He stated any staff could fill out a work order in the computer system and staff reported to him any repairs that were needed as he made his routine rounds. He further stated he preferred and expected for staff to complete work orders in the computer system because then he could track and keep records of the repairs he completed. He confirmed the resident doors had broken and splintered laminate on the edges of the doors and he verified staff had not reported the damage to the doors and he had not noticed the damage to the doors. He stated he expected for staff to report damage to doors as they saw them and the doors needed to be sanded to remove splinters or rough edges and some doors with gouged out areas needed to be filled and smoothed. During an interview and environmental tour on 09/16/16 at 12:27 PM with the Administrator she confirmed resident doors had broken and splintered laminate and needed to be repaired and she was not aware the doors were so badly damaged. She stated it was her expectation when staff observed something that needed to be repaired, they should complete a work order for the Maintenance Supervisor. She explained they discussed maintenance concerns as part of the morning meetings every day and it was her expectation for staff to send maintenance concerns to the Maintenance Supervisor so they could be repaired and discussed. She stated the work order system was explained during orientation for all new employees and she expected for staff to follow the work order process.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		10/14/16

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F 272	Continued From page 10 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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F 272	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews the facility failed to complete the Care Area Assessment (CAA) that addressed underlying causes, contributing factors, and risk factors for 4 of 4 residents sampled for nutrition (Resident #39, Resident #7, Resident #162,and Resident #15). The findings included: 1. Resident #39 was admitted to the facility on 05/19/16 and discharged from the facility on 06/08/16 with diagnoses that included cancer, non-Alzheimer's dementia, depression, and epigastric pain. Review of the most recent comprehensive minimum data set (MDS) dated 05/26/16 revealed that Resident #39 was cognitively intact and required set up assistance with eating. Review of the Care Area Assessment (CAA) titled "Nutritional CAA" was blank except for under the Analysis of Findings it stated "See RD Note." The CAA did not specify any nutritional risk factors, contributing factors, or need for referrals. Interview with the MDS Coordinator on 09/15/16 at 11:47 AM revealed that the dietician completed most of the dietary section of the MDS and would be responsible for any nutritional CAA's that triggered. The MDS Coordinator stated that the dietician does not complete the CAA and that she goes into the CAA and typed "See RD Note" so that she could lock the MDS. The MDS coordinator stated that the dietician completed some type of other assessment but does not complete the CAA because that would be double documenting. The MDS nurse stated that when she completed CAA's that she triggered from the MDS that she summarized the findings, under	F 272	* How corrective action accomplished for affected resident (1) The CAAS for each resident listed in F272 corrected by 10/14/16 * Identify other residents with potential to be affected All other residents triggering for nutrition on a comprehensive MDS have the potential to be affected. All comprehensive assessments with ARD 9/19/16 or greater will have summary for triggered nutrition CAA per RAI guidelines * Measures to be put into place to prevent reoccurrence MDS Coordinators and interdisciplinary team completing sections of the MDS to be reeducated by the DON or designee by 10/14/16 on CAA completion and review for accuracy prior to MDS transmission. * How will plan be monitored to ensure compliance MDS CAA section to be monitored for accuracy and RAI compliance by DON &/or designee prior to transmission weekly x 4 weeks then monthly X 2 months. Audit findings to be reviewed at monthly QAPI meeting.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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lying causes and then determines from those findings whether or not to proceed to care plan. Interview with dietician on 09/15/16 at 2:28 PM revealed that she had completed the MDS for Resident #39 but did not complete the CAA. The dietician stated that she completed the nutritional assessment instead of completing the CAA.

2. Resident #7 was readmitted to the facility on 07/02/16 with diagnoses that included atrial fibrillation, heart failure, hypertension, urinary retention, and arthritis. Review of the most recent comprehensive minimum data set (MDS) dated 08/07/16 revealed that Resident #7 was cognitively intact and required set up assistance of one staff member for eating.

Review of the Care Area Assessment (CAA) dated 08/07/16 was blank except for under the Analysis of Findings it stated "SEE RD NOTE." The CAA did not specify any nutritional risk factors, contributing factors, or need for referrals. Interview with the MDS Coordinator on 09/15/16 at 11:47 AM revealed that the dietician completed most of the dietary section of the MDS and would be responsible for any nutritional CAA's that triggered. The MDS Coordinator stated that the dietician does not complete the CAA and that she goes into the CAA and types "See RD Note" so that she could lock the MDS. The MDS coordinator stated that the dietician completed some type of other assessment but does not complete the CAA because that would be double documenting. The MDS nurse stated that when she completed CAA's that she triggered from the MDS that she summarized the findings, under lying causes and then determines from those findings whether or not to proceed to care plan. Interview with dietician on 09/15/16 at 2:28 PM revealed that she had completed the MDS for Resident #39 but did not complete the CAA. The

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dietician stated that she completed the nutritional assessment instead of completing the CAA.

3. Resident #162 was admitted to the facility on 04/22/16 with diagnoses which included weakness, vitamin D deficiency and depression. A review of the most recent quarterly Minimum Data Set (MDS) dated 09/19/16 revealed Resident #162 has short term memory problems, no long term memory problems and was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #162 required supervision and set up for eating.

Review of the Care Area Assessment (CAA) titled "Nutritional CAA" was blank except for under the Analysis of Findings it stated "See RD Note." The CAA did not specify any nutritional risk factors, contributing factors, or need for referrals.

Interview with the MDS Coordinator on 09/15/16 at 11:47 AM revealed that the dietician completed most of the dietary section of the MDS and would be responsible for any nutritional CAA's that triggered. The MDS Coordinator stated that the dietician does not complete the CAA and that she goes into the CAA and typed "See RD Note" so that she could lock the MDS. The MDS coordinator stated that the dietician completed some type of other assessment but does not complete the CAA because that would be double documenting. The MDS nurse stated that when she completed CAA's that she triggered from the MDS that she summarized the findings, under lying causes and then determines from those findings whether or not to proceed to care plan.

Interview with dietician on 09/15/16 at 2:28 PM revealed she routinely completed the MDS for

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F 272	Continued From page 14 residents but did not complete the CAA. The dietician explained she completed the nutritional assessment instead of completing the CAA. 4. Resident #15 was admitted to the facility on 07/25/16 and discharged from the facility on 08/25/16 with diagnoses which included kidney disease, heart disease, anemia, weakness, vitamin D deficiency and depression. A review of an admission Minimum Data Set (MDS) dated 08/01/16 revealed Resident #15 was cognitively intact for daily decision making. The MDS also indicated Resident #15 was independent with set up help only for eating. Interview with the MDS Coordinator on 09/15/16 at 11:47 AM revealed that the dietician completed most of the dietary section of the MDS and would be responsible for any nutritional CAA's that triggered. The MDS Coordinator stated that the dietician does not complete the CAA and that she goes into the CAA and typed "See RD Note" so that she could lock the MDS. The MDS coordinator stated that the dietician completed some type of other assessment but does not complete the CAA because that would be double documenting. The MDS nurse stated that when she completed CAA's that she triggered from the MDS that she summarized the findings, under lying causes and then determines from those findings whether or not to proceed to care plan. Interview with dietician on 09/15/16 at 2:28 PM revealed she had completed the MDS for residents but did not complete the CAA. The dietician explained she completed the nutritional assessment instead of completing the CAA.	F 272		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		10/14/16

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F 314 SS=D	Continued From page 15 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident observation, and staff interviews the facility failed to assess a resident when signs of discomfort were exhibited as evidenced by moaning and facial grimaces in 1 of 3 residents with pressure ulcers (Resident #85). Findings Included: Resident #85 was admitted on 03/07/16. Diagnoses included dementia, diabetes, debility, failure to thrive, cancer, hypertension, atrial fibrillation, depression, hypothyroidism and an unstageable pressure ulcer on the right heel. A significant change Minimum Data Set (MDS) was completed on 09/05/16. The MDS indicated the resident had severe cognitive impairment. The resident needed extensive assistance with bed mobility, transfers, locomotion, dressing, toilet use and personal hygiene. The resident needed limited assistance with eating and was totally dependent for bathing. The resident was frequently incontinent of urine and always incontinent of bowel. The MDS indicated the resident received scheduled and PRN pain medication. The pain assessment interview	F 314	* How corrective action accomplished for affected resident Resident #85 no longer resides at facility * Identify other residents with potential to be affected All residents with pressure ulcers have the potential to be affected by this alleged deficient practice. DON or designee to observe for s/s of pain displayed by residents during dressing changes, with interventions implemented as indicated. * Measures to be put into place to prevent reoccurrence (1)DON or designee educated appropriate staff to assess residents for pain prior to and during dressing changes. (2) Changes to be made to the weekly wound report worksheet to include pain assessment and med administration as necessary. (3) DON or designee to complete	

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F 314	Continued From page 16 indicated the resident had frequent pain or hurting in the last 5 days. The resident had stage 2 pressure ulcer which worsened and formed eschar. The resident received pressure ulcer care, ointment and the application of a dressing to her right heel. The resident received hospice services and had a prognosis of a life expectancy of less than 6 months. According to the Care Area Assessment (CAA) summary, pain was addressed in the care plan. The pain CAA indicated that the family wanted resident to be kept comfortable. A review of the care plan indicated the resident had a pressure ulcer to the right heel with a goal of expressing or exhibiting consistent and tolerable pain relief and management. The intervention was to observe for expressed or signs/symptoms of pain (agitation, grimace, moans, etc.)--attempt repositioning, diversions, sensory stimulation strolls, etc. prior to drugs as possible. A physician's order was written on 09/01/16 for Morphine Sulfate Immediate Release (MSIR) 5 milligrams sublingually every 6 hours scheduled and every 2 hours as needed for pain/dyspnea. Observation on 09/14/16 at 9:15 AM of Nurse #3 changing the dressing on resident's right heel. Nurse #3 told the resident that she was going to change the dressing on the resident's foot. When Nurse #3 removed the old dressing, the resident began to exhibit signs of discomfort which included moaning and facial grimacing. Nurse #3 measured the wound, sprayed wound cleanser on the wound and rubbed the wound surface in a circular motion. The resident moaned louder when Nurse #3 rubbed the wound surface after spraying the wound with wound cleanser. Nurse #3 then applied ointment and a clean dressing. Nurse #3 did not stop at any time during the	F 314	education related to changes to the work sheet. * How will plan be monitored to ensure compliance (1) The DON or designee will observe dressing changes to residents with pressure ulcers weekly X 4, monthly X 3. (2)Audit/observation to be presented/discussed at monthly QAPI meetings X 1 year with revisions as necessary.	

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dressing change to assess the resident. After the dressing change, Nurse #2 asked Nurse #3, "Do I need to medicate her?" Nurse #3 replied, "Yes, I thought you already had."
An interview was conducted with Nurse #2 on 09/14/16 at 9:32 AM. When asked about the administration of pain medication and wound dressing changes, Nurse #2 stated, "Normally, I ask her (the resident) if she wanted pain medication prior to the dressing change but did not today." Nurse #2 stated that she (the resident) could have had her MSIR PRN dose.
An interview was conducted with Nurse #3 on 09/14/16 at 10:38 AM. When asked regarding stopping the dressing change if the resident is in pain Nurse #3 replied, "I usually do. I usually stop a minute then proceed." When Nurse #3 was asked if she usually checked to see if a pain medication was given prior to the dressing change Nurse #3 replied, "Normally I will ask the hall nurse if she has given the med but I did not do that this morning and that's on me. I usually ask the hall nurse then wait 20 minutes to one hour to change the dressing after pain medication is given."
An interview was conducted with Nurse #2 on 09/14/16 at 11:55 AM. Nurse #2 stated "pain medication is usually given 30-40 minutes prior to changing the dressing." Nurse #3 will check with Nurse #2 (the hall nurse) prior to changing the dressing and tell Nurse # 2 if the resident needs pain medication.
An interview was conducted with Nurse #3 on 09/15/16 at 11:22 AM. The Nurse #3 stated, "I knew she was declining and I should have thought about asking if she got her pain medication prior to the dressing change."
An interview was conducted with Nurse #3 on 09/15/16 at 3:10 PM. When asked what Nurse

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F 314	Continued From page 18 #3 should have done regarding an assessment of the resident yesterday when Nurse # 3 noticed the resident moaning during the dressing change Nurse #3 replied, "I would have covered the wound, and got medication for her. I would have repositioned her and waited for the medication to be effective." An interview was conducted with the intrim Director of Nursing (DOn) on 09/16/16 at 10:46 AM. When asked her expectations when a resident expressed pain during a dressing change. The intrim DON stated, "If a resident is expressing pain, the nurse should assess the resident to find out what hurts." The intrim DON further explained Nurse #2 and Nurse #3 communicate with each other through shift to shift report, 24 hour report sheet and verbal report.	F 314		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to administer oxygen at the physician ordered liters per minute for 1 of	F 328	* How corrective action accomplished for affected resident (1) Resident #50 assessed with notes	10/14/16

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F 328	Continued From page 19 1 residents receiving oxygen (Resident #50). The findings included: Resident #50 was admitted to the facility on 10/12/12 with diagnoses that included heart failure, hypertension, and depression. A review of the most recent quarterly minimum data set (MDS) dated 07/24/16 revealed that Resident #50 was moderately impaired for daily decision making and required extensive to total assistance of 2 staff members with activities of daily living (ADLs). The MDS also indicated that Resident #50 used oxygen and had no shortness of breath during the review period. Review of physician orders dated 09/01/16 through 09/30/16 and signed by the physician on 09/07/16 read in part Oxygen at 2 liters per minute via nasal cannula to keep oxygen saturation above 90%. Observation on 09/12/16 at 12:13 PM revealed Resident #50 in bed with head of bed elevated and was feeding herself lunch. Resident #50's oxygen was in her nose and the concentrator was on 1.5 liters per minute. Observation on 09/14/16 at 3:51 PM revealed Resident #50 was resting in bed with eyes closed and head of bed flat. Resident #50's oxygen was in her nose and the concentrator was on 1.5 liters per minute. Observation on 09/15/16 at 11:22 AM revealed Resident #50 was resting in bed with her eyes open her oxygen was laying on the side of her face. Resident #50's concentrator was on 1.5 liters per minute. Interview with Nurse #1 on 09/15/16 at 11:28 AM revealed that Resident #50 wore her oxygen all the time and verified that Resident #50's concentrator was on 1.5 liters a minute. Nurse #1 reviewed the physician order and confirmed that Resident #50's oxygen should have been on 2	F 328	to MD related to O2 saturation levels and any need for order changes. * Identify other residents with potential to be affected (1) All residents on O2 therapy have the potential to be affected by this alleged deficient practice. DON and or designee observed 100% of residents receiving O2 to assure correct rate of O2 was being administered. * Measures to be put into place to prevent reoccurrence (1) To further ensure ongoing compliance with O2 administration as ordered, a change in the process of verification and documentation of O2 orders was initiated. (2) DON or designee to educate nurses on process change of verifying correct O2 flow rate and documentation of O2 administration by 10/14/16. * How will plan be monitored to ensure compliance (1) At least 5% of residents receiving O2 will be observed by designated staff weekly X 14 weeks, monthly X 3 months and randomly thereafter as appropriate to assure ongoing compliance with verification and documentation of O2 administration. (2) DON or designated staff to present observation findings in monthly QAPI meetings X 1 year with revisions as necessary.	

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F 328	Continued From page 20 liters per minute. Nurse #1 stated that whoever completed treatments was responsible for checking the oxygen and making sure the correct liters per minute was set. Nurse #1 also stated that the hall nurses also check periodically throughout the day. Nurse #1 indicated that Resident #50's oxygen saturation level had been checked and was 97% but did not state the liters per minute had been checked. Nurse #1 stated that if the order was for 2 liters per minute then the concentrator should have been on 2 liters per minute and not 1.5 liters per minute. Interview with the intrim Director of Nursing (DON) on 09/16/16 at 1:17 PM revealed that she would expect that whoever had checked Resident #50's oxygen saturation level would have also checked the liters per minute because they are documenting that on the treatment sheet. The intrim DON further stated that she would expect that if the physician order stated 2 liters per minute that the concentrator would be on 2 liters per minute and not 1.5 liters per minute.	F 328		