STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey on 3/29/18 Event ID SGT211.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		4/25/18

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

Electronically Signed | 04/20/2018

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide privacy cover for the urinary catheter drainage bag for 1 of 3 sampled resident with an indwelling catheter (Resident #5). The findings included: Resident #5 was admitted on 2/26/16. The diagnoses included urinary retention, diabetes and seizure disorder. The most recent Minimum Data Set (MDS) dated 10/10/17, revealed Resident #5 was cognitively impaired and was incontinent at all times of bladder and coded as incontinent bladder. During an observation 03/26/18 10:02 AM, Resident #5 was lying in bed near door with bed in lowest position. The drainage bag and tubing were lying on the floor under the bed without a privacy cover at the same level as the urinary bladder and could be seen from the hall. During an observation on 3/27/18 at 9:37 AM, Resident #5 was lying in bed at lowest position and the drainage bag and tubing were lying on the floor under the bed without a privacy cover at the same level as the urinary bladder. Resident #5 did not have a leg strap in place.	F 550	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Process that lead to the Deficiency: Resident #5 was admitted to the facility on 2/26/2016 with urinary retention among the diagnoses. On 3/26/ 2018 and 3/27/2018, resident was observed lying in bed and the drainage/catheter bag on the floor without a privacy cover. Resident #5 still resides in the facility. Root Cause Analysis: Failure to supervise and ensure the catheter/drainage bag has a privacy cover at all times. Lack of education for licensed nurses and certified nursing aides on resident rights as relates to dignity by not providing a privacy cover.	

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F 550	Continued From page 2 During an interview on 3/27/18, at 9:40 AM, Nurse #7 confirmed Resident #5 ' s catheter was located under the bed, without a leg strap and without a privacy cover. Nurse #7 stated staff should ensure the privacy cover was in place. During an interview on 3/28/18 at 10:12 AM, NA# 8 indicated that the expectation would be to check to make sure the leg strap was in place and provide a privacy cover. During an interview on 3/28/18 at 10:20 AM, the Director of Nursing indicated the expectation was for staff to check all residents with catheter to ensure the privacy cover was in place. During an interview on 3/28/18 at 2:01 PM, the Administrator stated the expectation was for staff to ensure the privacy cover were provided.	F 550	Process for implementing the acceptable plan of correction for specific deficiency. On 3/27/2018, resident #5 was immediately provided a privacy cover for the catheter/drainage bag to ensure his resident right was restored and maintained. All other residents with drainage/catheter bags were reviewed on 3/27/2018 by the Director of Health Services and the Nurse Managers to ensure privacy covers were in place. Nurse Managers and charges nurses will observe and document the presence of a privacy cover for all catheters/drainage bags daily using the catheter checklist tool initiated on 4/2/2018. All licensed nurses and all certified nursing aides are responsible for ensuring that all catheter/drainage bags have a privacy cover at all times. Education/in-service for all licensed nurses and all certified nursing aides on resident rights to ensure catheter/drainage bags have a privacy cover was initiated by the Director of Health Services on 3/27/2018 and will completed by 4/25/2018. Licensed nurses and certified nursing aides who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses and certified nursing aides will be educated on resident rights to ensure catheter/drainage bags have a privacy cover during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services.	

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F 550	Continued From page 3	F 550	Monitoring procedure to ensure that the plan of correction is effective. The Director of Health Services and the Administrator educated all licensed nurses and all certified nursing aides. The Administrator and the Director of Health Services will ensure all new hired licensed nurses and certified nursing aides are educated during orientation. Nurse Managers and charge nurses will observe and document the presence of a privacy bag for all catheters/drainage bags on a daily using the catheter checklist tool. The Administrator and the Director of Health Services will ensure the facility has extra privacy bags for use whenever needed. All new admissions with catheter/drainage bag will be provided with a privacy bag upon admission by the admitting nurse. The catheter checklist tool will be utilized by Nurse Managers and charge nurses daily and reviewed weekly by the Director of Health Services for 4 weeks and, monthly for 3 months until compliance is maintained. The Administrator will review the catheter checklist tool weekly for 4 weeks and then monthly for 3 months and report any findings of non-compliance to the QAA committee for recommendations as needed and then quarterly thereafter until compliance has been maintained for 3 quarters. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for	

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F 550	Continued From page 4	F 550	implementing the acceptable plan of correction. Date of Compliance: 4/25/2018	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the required Significant Change in Status Assessment (SCSA) following admission to hospice care for 1 of 1 residents (Resident # 153) reviewed for hospice. The findings included: Resident #153 was admitted to the facility on 2/07/18 with diagnoses that included failure to thrive, metabolic encephalopathy, cervical cancer, depression and Dysphagia. Review of physician's order dated 3/03/18 revealed Resident # 153 admitted to hospice.	F 637	Process that lead to the Deficiency: Resident #153 was admitted to the facility on 2/7/2018 with diagnoses that included cervical cancer and failure to thrive among others. Resident was later admitted to hospice on 3/03/2018. Resident #153 expired on 4/9/2018 and is no longer in the facility. A Significant Change in Status Assessment (SCSA) was not completed within 14 days of admission to hospice care as required. Root Cause Analysis: Lack of training for MDS nurses on the requirement to complete the investigation and assessment for a Significant Change in Status for hospice residents within 14	4/25/18

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F 637	Continued From page 5 Review of hospice documentation indicated Resident #153 was admitted to hospice care on 3/03/18. Review of the electronic assessments in progress for Resident #153 revealed a Significant Change in Status Assessment (SCSA) dated 3/15/18 that was not complete. Resident # 153's SCSA had not been completed within 14 days of admission to hospice care (by 3/16/18). During an interview on 03/28/18 at 4:10 PM, the MDS coordinator indicated she thought she had 14 days from the day of significant change to start the MDS and an additional 14 days after to complete the investigation and assessment. During an interview on 03/29/18 at 4:45 PM, the Administrator indicated the facility was short staffed related to MDS coordinators and had recently hired a new MDS coordinator. He indicated he was aware that the MDS assessments for some of the residents were incomplete.	F 637	days of admission to hospice has been identified as the root cause. Process for implementing the acceptable plan of correction for specific deficiency. The Significant Change in Status Assessment (SCSA) for resident #153 was completed on 3/29/2018 by the MDS nurse following admission to hospice. All residents with a Significant Change in Status and/or admitted to hospice in the last 30 days were reviewed on 3/29/2018 and ensured the SCSA were completed as required. The Administrator, the Director of Health Services and, the MDS Consultant initiated education for MDS nurses on completing Significant Change of Status Assessments within 14 days of any resident being admitted to hospice care based on RAI guidelines. Newly hired MDS personnel will be educated on completing Significant Change of Status Assessments within 14 days of residents being admitted to hospice based on RAI guidelines during new hire orientation by the Administrator and/or the Director of Health Services. Upon a resident□s admission to hospice services, the Administrator and the Director of Health Services will ensure that MDS nurses set the ARD and the SCSA completed within 14 days. An updated MDS 3.0 Manual has been ordered for MDS nurses to use and latest updates will be sent automatically when available. Monitoring procedure to ensure that the plan of correction is effective. Residents admitted to hospice will be	

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F 637	Continued From page 6	F 637	reviewed weekly by the Administrator and the Director of Health Services to ensure the SCSA is completed within 14 days of admission in accordance with the RAI guidelines. The review by the Administrator and the Director of Health Services will be done weekly for 4 weeks and bi-weekly for 2 months until compliance is maintained and then quarterly thereafter until compliance has been maintained for 3 quarters. The Administrator will report any findings of non-compliance to the QAA/QAPI committee for recommendations as needed. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 4/25/2018	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the	F 638	Process that lead to the Deficiency: Resident # 10 and resident #359 were admitted on 5/25/2016 and 9/1/2017	4/25/18

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F 638	Continued From page 7 previous MDS assessment for 2 of 6 residents (Resident #10 and Resident # 359) reviewed. The findings included: 1. Review of Resident # 359's comprehensive admission assessment dated 9/8/17 revealed resident was admitted to the facility on 9/1/17 with diagnoses that included but not limited to: hypertension, diabetes mellitus type II, transient cerebral ischemic attack and cerebrovascular accident . During a review of the resident's most recent quarterly MDS assessment dated 1/05/18 revealed the assessment was in progress and not completed. Further review of the assessment revealed Section Z for signature of persons completing the assessment and Registered Nurse assessment coordinator verifying assessment as complete was noted to be blank and no date entry noted. During an interview with MDS Coordinator #1 on 03/28/18 02:02 PM, the MDS Coordinator stated she had recently joined the facility and was aware the facility was behind in some of the assessments and some quarterly assessments were incomplete for some residents. During an interview with the Administrator on 03/29/18 at 04:45 PM, the Administrator stated it was his expectation that the all MDS assessments would be completed as required. He further stated that the facility was short staffed related to MDS coordinators and had recently hired a new MDS coordinator. He indicated that he was aware that the MDS assessments for some of the residents were incomplete.	F 638	respectively. Record review and interviews revealed the facility□s failure to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the previous MDS assessment. Root Cause Analysis: The loss of key personnel in the MDS department was the root cause of this deficiency. The unexpected loss of one MDS nurse without backup led to some quarterly MDS assessments being late. Process for implementing the acceptable plan of correction for specific deficiency. A new MDS Director was hired in February 2018 and has been actively working on helping the facility catch up on any late quarterly MDS assessments. The quarterly MDS assessment for resident #10 and resident #359 were completed on 4/17/2018 and 4/4/2018 respectively. On 3/30/2018, the MDS Director and the MDS Coordinator together with the Administrator and the Director of Health Services reviewed the late and current quarterly MDS assessments. The MDS Director and the MDS Coordinator reviewed the calendar with priority given to late quarterly assessments. The Interdisciplinary Team (IDT) was provided with the assessments calendar to ensure each discipline completes their part in the quarterly MDS assessment. On 3/30/2018, the Administrator and the Director of Health Services initiated education for the IDT (including MDS nurses, the Social Worker, the Director of Recreational Services and, the Dietary Manager) on the	

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F 638	Continued From page 8 2. A review of Resident #10's most recent Minimum Data Set (MDS) was dated 10/30/17. The assessment revealed the resident was re-admitted to the facility on 6/15/17 with diagnoses that included but not limited to: hypertension, cerebral infraction, anxiety disorder and depression. Review of the resident's quarterly MDS assessment dated 1/30/18 revealed the assessment was in progress and not completed. Another quarterly MDS assessment dated 2/26/18 had been opened for Resident #10 and it was also incomplete. During an interview with MDS Coordinator #1 on 03/28/18 02:02 PM, the MDS Coordinator stated she had recently joined the facility and was aware the facility was behind in some of the assessment and some quarterly assessments were incomplete for some residents. During an interview with the Administrator on 03/29/18 at 04:45 PM, the Administrator stated it was his expectation that the all MDS assessments would be completed as required. He further stated that the facility was short staffed related to MDS coordinators and had recently hired a new MDS coordinator. He indicated that he was aware that the MDS assessments for some of the residents were incomplete.	F 638	requirement of completing quarterly MDS assessments within 92 days of the previous assessment as required. Education was completed on 4/4/2018. Any new hires to join the IDT will be educated on the requirement of completing quarterly MDS assessments within 92 days of the previous assessment by the Administrator and/or the Director of Health Services during new hire orientation based on RAI guidelines. Any late quarterly assessments will be completed by 4/25/2018. In event of loss of key personnel in the MDS department, the Administrator will seek help from the Area Vice President to ensure quarterly MDS assessments are completed within 92 days of the previous assessment as required. Monitoring procedure to ensure that the plan of correction is effective. The Administrator and the Director of Health Services will review the due quarterly assessments 5 days a week for 4 weeks then weekly for 2 months and then quarterly thereafter until compliance has been maintained for 3 quarters. The quarterly assessments due will be reviewed during daily standup meeting for 4 weeks and then weekly for 2 months and then quarterly thereafter until compliance has been maintained for 3 quarters. by the IDT to ensure compliance is maintained. The Administrator will report any findings of non-compliance to the QAA/QAPI committee quarterly for recommendations as needed.	

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F 638	Continued From page 9	F 638	Title of Person Responsible for Implementing the Acceptable plan of Correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 4/25/2018	
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	F 656		4/25/18

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F 656	Continued From page 10 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete and update the care plan following admission to hospice care for 1 of 1 residents (Resident # 153) reviewed for hospice. The findings included: Resident #153 was admitted to the facility on 2/07/18 with diagnoses that included failure to thrive, metabolic encephalopathy, cervical cancer, depression and dysphagia. Review of physician's order dated 3/03/18 revealed Resident # 153 admitted to hospice. Review of hospice documentation indicated Resident #153 was admitted to hospice care on 3/03/18. Review of Resident # 153's care plan dated 2/7/18 revealed the care plan was not updated to	F 656	Process that lead to the Deficiency: Resident #153 was admitted to the facility on 2/7/2018 with diagnoses that included cervical cancer and failure to thrive among others. Resident was later admitted to hospice on 3/03/2018. Resident #153 expired on 4/9/2018 and is no longer in the facility. The facility failed to complete and update the care plan following resident□s admission to hospice. Root Cause Analysis: Lack of training for MDS nurses on completing and updating care plans to reflect a Significant Change in Status for hospice residents after admission to hospice care services has been identified as the root cause. Process for implementing the acceptable plan of correction for specific deficiency.	

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F 656	Continued From page 11 reflect hospice care. During an interview on 03/28/18 at 4:10 PM, the MDS coordinator indicated she thought she had 14 days from the day of significant change to start the MDS and an additional 14 days after to complete the investigation and assessment. She also indicated that resident's care plan would be updated only after MDS has been completed. During an interview on 03/29/18 at 4:45 PM, the Administrator stated it was his expectation that the all MDS assessments and care plans were completed as required. He further stated that the facility was short staffed related to MDS coordinators and had recently hired a new MDS coordinator. He indicated that he was aware that the MDS assessments for some of the residents were incomplete.	F 656	The Significant Change in Status Assessment (SCSA) for resident #153 was completed on 3/29/2018 following admission to hospice. The resident□s care plan was updated and completed on 3/29/2018 to reflect hospice care. All residents with a Significant Change in Status and/or admitted to hospice in the last 30 days were reviewed by the nursing team on 3/29/2018 and all care plans updated as needed. Care plans for hospice residents will be updated upon admission to hospice care. The Interdisciplinary Team (IDT) including MDS nurses will be responsible for updating the care plans upon admission of any resident to hospice care services. Education for the Interdisciplinary Team including the Social Worker, Dietary Manager, the Director of Recreational Activities, MDS nurses and Unit Managers on updating care plans was initiated by the Administrator and the Director of Health Services on 3/29/2018 and completed on 4/6/2018. Any new hires to join the IDT will be educated by the Administrator and/or the Director of Health Services on the requirement update care plans as and when needed. Monitoring procedure to ensure that the plan of correction is effective. The Administrator and the Director of Health Services will review all resident with a Significant Change of Status during clinical meetings and/or stand-up meetings and ensure that care plans are completed and updated as needed by the IDT. The review will be conducted daily for	

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F 656	Continued From page 12	F 656	2 weeks, then weekly for 2 weeks, and then monthly for 2 months until compliance is maintained and then quarterly thereafter until compliance has been maintained for 3 quarters. Any areas on non-compliance will be reported by the Administrator and/or the Director of Health Services to the QAA Committee quarterly for recommendations as needed. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 4/25/2018	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, staff and physician interviews, the facility failed to administer continuous oxygen therapy on the rate as ordered by physician, for 2 of 4 sampled resident (Residents # 104 and 309). Findings included:	F 658	Process that lead to the Deficiency: Resident #104 and resident #309 were admitted to the facility on 9/2/2015 and 3/31/2016 respectively. Based on record review, resident, staff and physician interviews, the facility failed to administer continuous oxygen therapy on the rate as	4/25/18

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F 658	Continued From page 13 1. Resident #104 admitted on 7/26/17. Review of the Annual Minimum Data Set assessment, dated 2/7/18, revealed resident ' s intact cognition. Her diagnoses included heart failure, diabetes mellitus, hypertension (high blood pressure) and asthma. Record review revealed the physician ' s order, dated 9/1/17, for Resident #104, to receive oxygen therapy via nasal cannula on the rate of 2 L (Liter) per minute for any status of SAT (amount of oxygen in blood) 90% (percent) or less. Review of Resident 104 ' s Medication Administration Record for 3/26/18 - 3/28/18 revealed that it was marked as completed for oxygen therapy with the rate of two L per minute and SAT between 96 and 98% for all shifts. On 3/26/18 at 8:30 AM, during the observation/interview, Resident #104 was in her room. The resident had nasal cannula attached to her nose, connected to the oxygen concentrator, which showed 3.5 L/minute of oxygen rate. The resident indicated that she "supposed to receive oxygen on the rate of 2 L/minute". On 3/28/18 at 12:30 PM, during the observation of Resident #104 together with Nurse #1, unit coordinator, the oxygen concentrator was set up for 3.5 L/minute, attached to the resident ' s nasal cannula. The nurse adjusted the oxygen rate to 2 L/minute during the observation. On 3/28/18 at 12:32 PM, during an interview, Nurse #1 indicated that Resident #104 had an order for 2 L/minute oxygen therapy. The nurse added that the resident adjusted the oxygen rate	F 658	ordered by the physician. Root Cause Analysis: Licensed charge nurses and Unit Manager/supervisors failed to supervise, monitor and, administer oxygen therapy at the rate as ordered by the physician. There was also lack of follow-through and communication for licensed nurses to supervise, monitor and, administer oxygen therapy on rate as ordered by the physician. Process for implementing the acceptable plan of correction for specific deficiency. The Unit Manager ensured that both oxygen concentrators were adjusted to 2LPM of oxygen therapy on 3/28/2018 as ordered by the physician. Both residents continue to receive oxygen therapy as ordered by the physician. Resident #309 has been observed to adjust her oxygen level by herself on the oxygen concentrator. Resident #309 has been informed of the risks of adjusting oxygen up and her care plan has been updated to reflect non-compliance regarding adjusting oxygen level on the oxygen equipment (concentrator and oxygen tank). All residents with oxygen therapy orders were reviewed by the Director of Health Services and Unit Managers on 3/28/2018 and oxygen therapy was being administered continuously on the rate as ordered by the physician. The Administrator and the Director of Health Services initiated education on 3/28/2018 for all licensed nurses on	

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F 658	Continued From page 14 on oxygen concentrator at times. The staff reminded her do not All nurses on the floor were responsible to monitor the correct rate of oxygen therapy for residents. On 3/28/18 at 1:30 PM, during an interview, the Director of Nursing expected the staff to follow the physician ' s order in oxygen therapy. All the nurses on the floor were responsible to monitor the correct rate of oxygen therapy for residents during the shift. On 3/28/18 at 1:50 PM, during an interview, the Physician Assistant indicated that her expectation the staff to follow physician ' s orders: check the SAT and make sure the rate of oxygen provided, according to the order. In the case of decrease in SAT, the staff should notify the physician. 2. Resident #309 admitted on 9/12/17. Review of the Quarterly Minimum Data Set assessment, dated 12/6/17, revealed resident ' s intact cognition. Her diagnoses included heart failure, anemia, hypertension (high blood pressure) and asthma. Record review revealed the physician ' s order, dated 3/1/18, for Resident #309, to receive oxygen therapy via nasal cannula on the rate of 2 L per minute for any status of SAT 90% or less. Review of Resident 309 ' s Medication Administration Record for 3/26/18 - 3/28/18 revealed that it was marked as completed for oxygen therapy with the rate of two L per minute and SAT between 94 and 98% for all shifts. On 3/26/18 at 9:30 AM, during the observation/interview, Resident #309 was in bed.	F 658	administering/following oxygen therapy orders on the rate as ordered by the physician. The education will be completed by 4/25/2018. Licensed nurses who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses will be educated on administering/following oxygen therapy orders on the rate as ordered by the physician during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Monitoring procedure to ensure that the plan of correction is effective. The Administrator and the Director of Health Services will ensure all licensed nurse are educated on administering/following oxygen therapy continuously on rate as ordered by the physician. Any licensed nurse not educated will not be allowed to work until the education has been completed. An oxygen therapy observation tool to was initiated on 4/2/2018 to be utilized by licensed nurses to match the oxygen therapy orders with the actual settings on the oxygen equipment (Oxygen concentrator or Oxygen tank) being used. The tool will be used daily for 3 months until compliance is maintained and then quarterly thereafter until compliance has been maintained for 3 quarters. The Director of Health Services will review the tool weekly for 3 months and report to the Administrator on any findings. The Administrator will review the findings and report any areas of non-compliance to the	

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F 658	Continued From page 15 She had nasal cannula attached to her nose, connected to the oxygen concentrator near the bed, which showed 4 L/minute of oxygen rate. The resident indicated that she "supposed to receive oxygen on the rate of 2 L/minute". On 3/26/18 - 3/27/18, during the multiple observations, the oxygen concentrator showed 4 L/minute of oxygen rate at all time. On 3/28/18 at 12:30 PM, during the observation of Resident #309 together with Nurse #1, the oxygen concentrator was set up for 4 L/minute, attached to the resident ' s nasal cannula. The nurse adjusted the oxygen rate to 2 L/minute during the observation. On 3/28/18 at 12:32 PM, during an interview, Nurse #1 indicated that Resident #309 had an order for 2 L/minute oxygen therapy. All nurses on the floor were responsible to monitor the correct rate of oxygen therapy for residents. On 3/28/18 at 1:30 PM, during an interview, the Director of Nursing expected the staff to follow the physician ' s order in oxygen therapy. All the nurses on the floor were responsible to monitor the correct rate of oxygen therapy for residents during the shift. On 3/28/18 at 1:50 PM, during an interview, the Physician Assistant indicated that her expectation the staff to follow physician ' s orders: check the SAT and make sure the rate of oxygen provided, according to the order. In the case of decrease in SAT, the staff should notify the physician.	F 658	QAA committee quarterly for 3 quarters for recommendations as needed. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 4/25/2018	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		4/25/18

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F 690	Continued From page 16 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interviews and record review, the facility failed to secure	F 690	Process that lead to the Deficiency: The facility failed to secure catheter and	

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F 690	Continued From page 17 catheter and keep the drainage bag below the bladder for 3 of 3 sampled resident with a catheter (Resident #5, #133 and #261). The findings included: 1. Resident #5 was admitted on 2/26/16. The diagnoses included urinary retention, diabetes and seizure disorder. The most recent Minimum Data Set (MDS) dated 10/10/17, revealed he was incontinent at all times of bladder and coded as incontinent bladder. Review of physician's order dated 7/22/16 revealed the catheter site and securement of the catheter should be monitored daily for proper placement. Review of the care plan dated 2/27/18, identified the problem as resident required a catheter related to urinary retention. The goal included resident would remain free of UTI. The approaches included to check catheter every shift for patency, proper position of tubing and bag, report catheter leakage to charge nurse and report complaints of pain/discomfort from catheter. During an observation 03/26/18 10:02 AM, Resident #5 was lying in bed near door with bed in lowest position. The drainage bag and tubing were lying on the floor under the bed. Resident #5's leg strap was not in place. During an observation on 3/27/18 at 9:37 AM, Resident #5 was lying in bed at lowest position and the drainage bag and tubing were lying on the floor under the bed. Resident #5's leg strap was not in place. Resident #5 did not have a leg	F 690	keep the drainage bag below the bladder for resident #5, #133 and, #261. For all three residents, the catheter bags were not secured in place and the bags were on the floor. Resident #261 discharged from the facility on 4/4/2018 while resident #5 and resident #133 still reside in the facility. Root Cause Analysis: Lack of supervision to ensure the catheter is secure and drainage bag is kept below the bladder. There was also lack of education for licensed nurses and certified nursing aides on securing the catheter and keeping the drainage bag below the bladder. Process for implementing the acceptable plan of correction for specific deficiency. On 3/28/2018, the Director of Health Services together with Unit Managers secured the catheter and kept the drainage bag below the bladder for resident #5, resident #133 and resident #261. All other residents with catheter and drainage bag were reviewed on 3/28/2018 by the Director of Health Services and the Nurse Managers to ensure the catheter was secure and drainage bag below the bladder. Nurse Managers and charges nurses will utilize the catheter checklist tool to document the catheter is secure and drainage bag is below the bladder on a daily basis. All licensed nurses and certified nursing aides are responsible for ensuring that all	

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F 690	Continued From page 18 strap in place. During an interview on 3/27/18, at 9:40 AM, Nurse #7 confirmed Resident #5's catheter was located under the bed, without a leg strap and not secured. Nurse #7 stated staff should ensure the leg strap was in place, provide a privacy cover and secure the catheter properly below bladder level. During an interview on 3/28/18 at 10:12 AM, Nurse Aide (NA) # 8 indicated that the expectation would be to check to make sure the leg strap was in place, provide a privacy cover and secure the catheter in proper position. She further stated she had not noticed it earlier in the shift. During an interview on 3/28/18 at 10:20 AM, the Director of Nursing indicated the expectation was for staff to check all residents with catheter to ensure they were properly secured with catheter strap, privacy bag and below bladder level. During an interview on 3/28/18 at 2:01 PM, the Administrator stated the expectation was for staff to ensure the privacy bag were provided to all residents with catheter, the leg straps should be in place and catheter should be below bladder level. 2. Resident # 133 was readmitted on 12/14/17. The diagnoses included flaccid neuropathic bladder, diabetes mellitus Type II and chronic kidney disease (stage II). The most recent Minimum Data Set (MDS) dated 12/14/17, revealed resident was cognitively intact and coded for indwelling catheter. Review of the physician order dated 12/14/17	F 690	catheter s secure and drainage bag is below the bladder. Education/in-service for all licensed nurses and certified nursing aides on securing the catheter and keeping the drainage bag below the bladder was initiated by the Director of Health Services on 3/28/2018 and will completed by 4/25/2018. Licensed nurses and certified nursing aides who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses and certified nursing aides will be educated on securing the catheter and keeping the drainage bag below the bladder during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Monitoring procedure to ensure that the plan of correction is effective. The Director of Health Services and the Administrator educated all licensed nurses and all certified nursing aides. The Administrator and the Director of Health Services will ensure all new hired licensed nurses and certified nursing aides are educated during orientation. Nurse Managers and charge nurses Nurse Managers and charges nurses will utilize the catheter checklist tool to document the catheter is secure and drainage bag is below the bladder on a daily basis. The catheter checklist tool will be utilized by Nurse Managers and charge nurses daily and reviewed weekly by the Director of Health Services for 4 weeks and, monthly for 3 months until compliance is	

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F 690	Continued From page 19 revealed catheter care every shift and monitor leg strap every shift. Review of the care plan updated on 3/26/18, identified the problem as resident required indwelling catheter related to benign prostatic hyperplasia (BPH) neurogenic. The goal included resident would remain free of urinary tract infection (UTI) and injury with indwelling catheter. The interventions included to change of catheter as ordered, position urine collection bag below the bladder, Observe for need to empty bag and empty as needed, observe signs and symptoms of UTI such as abdominal pain, fever, discoloration and foul smell of urine. During an observation on 03/27/18 at 8:00 AM, Resident #133 was lying in bed. The drainage bag and tubing were lying on the floor beside the bed. Resident # 133's leg strap was not in place. On 3/27/18 at 10:15 AM, during the catheter care observation for Resident # 133, provided by the Nurse Aide (NA) # 6, the Foley catheter tubing was clean, dry, secured to the right leg, went down to the urinary drainage bag, located on the floor near bed. The NA # 6 provided the catheter care, attached the drainage bag to the right side of bed frame. She did not check the location or condition of the urinary drainage bag and left it on the floor. On 3/27/18 at 10:20 AM during an interview, NA # 6 indicated that resident had Foley catheter. She stated the nurses were responsible for urinary catheter changes and drainage bag changes. She also indicated the resident went outside the facility to change the catheter. She also indicated the nurse aides were responsible to empty the	F 690	maintained and then quarterly thereafter until compliance has been maintained for 3 quarters. The Administrator will review the catheter checklist tool weekly for 4 weeks and then monthly for 3 months and then quarterly thereafter until compliance has been maintained for 3 quarters and report any findings of non-compliance to the QAA committee for recommendations as needed. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 4/25/2018	

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F 690	Continued From page 20	F 690		

urinary drainage bag every shift and as needed. She confirmed that the drainage bag cannot be on the floor and needed to be attached to the bed frame.

On 3/29/18 at 10:00 AM during an interview, Nurse #1 indicated NA were responsible to provide catheter care and usually done during bathing and incontinent care. Drainage bag was checked every shift by nurses and the resident's catheter change was done outside the facility. She indicated that nurses monitor the catheter care after the NA have completed care every shift and check for leg straps and dignity bags. She further indicated an in-service was done for NA's when a new patient was admitted on the floor.

On 03/29/18 at 2:49 PM during an interview, the administrator indicated that it was his expectation that the urinary catheter was changed appropriately, catheter bag placed below the bladder, hung and not on the floor and covered with a dignity bag. He indicated that he was made aware of this issue by staff and PPI has started.

3. Resident #261 was admitted on 3/16/18 with diagnoses in part of neurogenic bladder with suprapubic catheter. The most recent minimum data set (MDS) dated 3/21/18 revealed she was cognitively intact with a suprapubic catheter.

An observation of the catheter bag on 3/26/18 12:00PM revealed the catheter bag laying on the floor.

During an observation on 03/27/18 at 9:47 AM revealed the catheter bag was laying on the floor full of urine without a privacy cover.

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F 690	Continued From page 21 On 03/27/18 at 9:50AM Nursing Assistant #4 entered the room and indicated that the bag should not be on the floor and needed a cover. An interview on 3/28/18 at 4:14 pm, Nursing Assistant #5 indicated that the catheter bag should be hung from the bed off of the floor and covered.	F 690		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification survey in April 2017 and subsequently recited in March 2018 on the current recertification and complaint survey. The recited deficiencies were in the areas of provide services to meet professional standards, develop a comprehensive care plan and Quality Assurance Planning and Implementation (QAPI)/ (QAA) improvement activities. These deficiencies were recited in the current recertification survey. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality	F 867	Process that lead to the Deficiency: Facility□s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions put in place following recertification survey in April 2017. This is cross referenced with citations F 656 and F 658. Root Cause Analysis: The Quality Assurance Committee did not maintain implemented procedures and monitor their interventions that were put in place after recertification survey. The QAA Committee failed to identify that complete and update the care plan following resident□s admission to hospice	4/25/18

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F 867	Continued From page 22 Assurance (QA) Program. The findings included: These tag were cross referenced to: F 658 - Services Provided Meet Professional Standards Based on record reviews, resident, staff and physician interviews the facility failed to administer continuous oxygen therapy on the rate ordered by physician, for 2 of 4 sampled residents (Residents # 104 and 309). During the previous survey on 4/07/17, the facility had failed to transcribe physician consult orders for 1 of 1 residents (Resident #163). F 656 - Develop Comprehensive Care Plan Based on record review and staff interview, the facility failed to complete and update the care plan following admission to hospice care for 1 of 1 residents (Resident #153) reviewed for hospice. During the previous recertification survey of 4/07/17 the facility had failed to provide a comprehensive care plan for 3 of 4 sampled residents who required splints (#55, # 92, and #160) and 1 of 3 sampled residents with a pressure ulcer (#92) and failed to update care plans with measurable goals and individualized approaches. (#55, # 92) During the previous recertification survey on 4/07/17, the facility was cited for QAA Committee failure to maintain implemented procedures and monitor interventions the committee put into place on April of 2016. This was for one deficiency which was originally cited on April 1,	F 867	care services as well as failure to administer continuous oxygen therapy on the rate as ordered by the physician. Process for implementing the acceptable plan of correction for specific deficiency. The Administrator and the Director of Health Services initiated re-education on 4/2/2018 on the QAPI process for all staff on the QAA/QAPI Committee with emphasis on identifying areas that may lead to deficiency practice. Education will be completed by 4/24/2018. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on ensuring that any areas on non-compliance are addressed to prevent further deficient practices related to failure to complete and update Care Plans and administering oxygen therapy on rate as ordered by the physician. At least a member of the regional team that includes senior nurse consultant, clinical reimbursement consultant or area vice president will attend QAPI meetings for 3 quarters. Monitoring procedure to ensure that the plan of correction is effective. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on areas that have led to repeated citations and/or deficiencies. This will ensure that the facility is identified areas on non-compliance and are addressed to prevent further deficient practices related to completing and updating Care Plans and administering oxygen therapy on rate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 23 2016, on a recertification survey. The deficiency was in the area of food procurement, storage and sanitary conditions. During an interview on 3/29/18 at 4:59 PM, the Administrator indicated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits and monitors that plan and 4) discusses the outcome. The Administrator indicated QAA was a work in progress. He stated that the facility was focusing on certain areas, but had not looked into the basic problems related to citations found in the current survey.	F 867	as ordered by the physician. At least a member of the regional team that includes the senior nurse consultant, clinical reimbursement consultant or area vice president will attend QAPI meetings for the next 3 months and then quarterly for 3 quarters to ensure that any areas leading to deficiency practice identified during clinical and compliance rounds are acted upon by the facility according to the QAPI process. The administrator will report to the Quality Assurance and Performance Improvement Committee any areas of non-compliance monthly for 3 months and then quarterly for 3 quarters for recommendations as needed. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 4/25/2018	