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	345575	A. BUILDING _____ B. WING _____	C 06/01/2018

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident, and physician interviews, the facility failed to monitor daily weights and to report weight gain as ordered for one of three residents reviewed for congestive heart failure, Resident #5. Findings included: Resident #5 was admitted to the facility on 05/01/18 with diagnoses which included, in part, anemia, congestive heart failure, hypertension, peripheral vascular disease, and diabetes mellitus. A review of the admission minimum data set (MDS) assessment dated 05/08/18 revealed Resident #5 was cognitively intact and exhibited no rejection of care behaviors. The admission MDS also indicated Resident #5 required extensive to total assistance with all activities of daily living except for eating, for which she required supervision only. Resident #5's nursing care plan initiated on 05/10/18 included a problem to address increased nutrition/hydration risk related to	F 684	F 684 1. Address how corrective action will be accomplished for those residents found to have been affected: 1a. Resident #5's weights were reviewed and MD was notified that resident #5 were not obtained as ordered. MD did not give any new orders upon notification. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: 2a. Current residents with weight orders have the potential to be affected by the deficient practice. Audit of current residents with weight orders for MD notification regarding variances have been audited and MD notified as warranted. 3. Address what measures will be put into place, or systematic changes to ensure that the deficient practice will not occur: 3a. Facility Director of Nursing and or	6/20/18

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

Electronically Signed | 06/19/2018

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F 684	Continued From page 1 edema, diuretic, diagnosis of congestive heart failure, and expected weight loss. The goal related to this focus was that Resident #5 would be free of significant weight changes every month. One of the interventions was to monitor weight per protocol. A review of the physician orders revealed an order dated 05/06/18 to take daily weights for 2 weeks, then weekly, and to report a weight gain of greater than 3 pounds in 24 hours, or a 7.5 pound weight gain in one week. The end date for the daily weights was 05/20/18. a) A review of the medication administration (MAR) record dated May 2018 revealed the following weights were documented per the physician's order for daily weights between 05/06/18 through 05/20/18: 05/09/18 - 248 pounds 05/14/18 - 242.6 pounds 05/15/18 - 242.8 pounds 05/16/18 - 241.8 pounds A review of Resident #5's chart revealed the following additional weight recorded which were not present on the May 2018 MAR: 05/07/18 - 242.6 pounds There were no daily weights recorded anywhere in Resident #5's chart for the following dates when were ordered for the period between 05/06/18 and 05/20/18: 05/08/18 05/10/18 (weight was refused) 05/12/18 (weight was refused) 05/13/18 05/17/18	F 684	designee(s) will in-service direct care staff on following MD orders regarding obtaining weights and MD notification of variances. Education will be provided to new employees during general orientation. 3b. Orders have been reviewed by DON/designee(s) for accuracy of CHF weight orders as specified per MD. MD was notified of any weights not obtained per MD orders of resident's that did not receive daily weights. 3c. DON/designee(s) to in-service direct care staff that weights will be given to Charge Nurse/Unit Manager for accuracy and increase. 3d. Weights will be monitored by Charge Nurse/Unit Manager for accuracy/increases and notify MD of any noted significant increases in weight for those residents with CHF diagnosis. 3e. Weights will be entered into PCC by Charge Nurse/Unit Manager and monitored by DON/designee(s) 4. Indicate how the facility plans to monitor it's performance to make sure that solutions are sustained: 4a. Facility DON/designee(s) will audit clinical records of residents with weight orders, including MD notification daily 5 times a week, then 5 times a week for 12 weeks. Results of the audit will be reviewed monthly for 3 months by the QAPI Committee. If discrepancies are noted, further action will be implemented. 5. Date of Compliance: 06/20/2018	

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F 684	Continued From page 2 05/18/18 05/19/18 05/20/18 In an interview on 05/30/18 at 3:00 PM with the nurse who recorded Resident #5's weight on 05/09/18 (Nurse #1), she stated that if the resident's weight was not recorded on the MAR, the nurse would have to look elsewhere in the record to determine whether there had been a weight gain to report to the physician. Nurse #1 also stated that if weights were not recorded anywhere in Resident #5's record, there would be no way to determine whether there had been a weight gain at all. She explained she had also been responsible for checking off on the May 2018 MAR that a weight had been taken on 05/06/18 and 05/07/18 and she did not know why she had not included the weight on the MAR with her initials or elsewhere in the record. In an interview on 05/30/18 at 3:20 PM with the nursing assistant (NA #1) who completed weights for Resident #5, she stated the nurse typically provided a list of residents who needed their weights taken. Then, she took the weights for those residents, record it on a piece of paper, and gave it to the nurse to record in the resident's record. NA #1 stated if Resident #5 was not included on the list of residents' weights to be taken, she would not have gotten her weight. Nurse #2, the nurse who was responsible for seeing that weights were assessed on 05/12/18, 05/13/18, and 05/14/18 was interviewed on 05/30/18 at 3:56 PM. Nurse #2 stated that NAs on her night shift (7:00 PM to 7:00 AM, or 11:00 PM to 7:00 AM) took weights starting at 6:00 AM in order to take weights before breakfast and that	F 684		

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she gave a list of weights to the NAs to complete. Nurse #2 stated the NAs typically provided the weights they had taken to her and she recorded them in the vital signs section of the chart and usually on the MAR. She was uncertain why Resident #5's weights were not recorded on the May 2018 MAR or anywhere else on her chart.

An interview was completed on 05/31/18 at 10:38 AM with Nurse #3, the nurse who checked that weights were completed on 05/10/18, 05/15/18, and on 05/16/18. Nurse #3 stated she provided a list of weights to her nursing assistants to complete and explained that she only included residents on the list who were being monitored due to congestive heart failure (CHF.) Nurse #3 stated if Resident #5's order did not specify that the weights were being completed for CHF monitoring, then she would not have included her name on the list of weights for the NA to take. She stated she did not think Resident #5 had CHF as a diagnosis.

In an interview with Resident #5's primary physician on 05/31/18 at 11:25 AM, he stated that weights were monitored in residents with congestive heart failure to assess the resident's fluid status and to anticipate a need for compensation or adjustment in a diuretic medication. The physician stated he would expect the weights to be taken daily as ordered for a resident with CHF in order to determine whether there had been a weight gain in a short period of time.

The Director of Nursing (DON) stated in an interview on 05/31/18 at 12:40 PM that she would expect for daily weights to be taken as ordered by the physician, especially in residents with CHF.

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She further stated this was the only way to monitor whether Resident #5 had a weight increase over a 24 hour period. The DON further stated she was aware that there had been some inconsistencies related to weight monitoring and documentation for residents and she was currently working with staff to resolve these inconsistencies.

b) Resident #5's weight was recorded in the vital sign section of her record as 242.6 pounds on 05/07/18. There was no weight recorded in the record for 05/08/18. On 05/09/18, Resident #5's weight was recorded as 248 pounds on the May 2018 MAR and in the vital signs section of the resident's record. This reflected a 5.4 pound weight increase between 05/07/18 and 05/09/18.

A review of the progress notes dated 05/09/18 and 05/10/18 revealed there was no indication that the physician was notified of the weight gain of 5.4 pounds.

In an interview with Nurse #1 on 05/30/18 at 3:00 PM, she stated she was the nurse who was responsible for Resident #5's weight monitoring on 05/09/18 and that the weight was measured at 248 pounds. Nurse #1 stated this was a weight gain over the previous weight of 242.6 pounds on 05/07/18. Nurse #5 indicated that this much of a weight gain should have been reported to the physician as ordered since it was an increase of 5.4 pounds. Nurse #5 did not recall notifying the physician, but stated that if there was that much weight gain over the previous weight, she might ask the NA to reweigh the resident.

Further review of the weights recorded in Resident #5's chart revealed there was no

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F 684	Continued From page 5 evidence of a retaken weight recorded for 05/09/18. In an interview with Resident #5's primary physician on 05/31/18 at 11:25 AM, he stated he would have expected the nurse to recognize the weight gain of 5.4 pounds between 05/07/18 and 05/09/18 and to notify him. He stated that a weight gain of 5.4 pounds in a resident with a diagnosis of CHF could have indicated a need for fluid compensation or medication adjustment. In an interview with the Director of Nursing (DON) on 05/31/18 at 12:40 AM, she stated she would have expected the nurse to notify the physician of Resident #5's 5.4 pound weight gain between 05/07/18 and 05/09/18.	F 684		
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, record review, and staff, resident, and physician interviews, the facility failed to maintain the portable supply of oxygen as needed and to maintain oxygen at the ordered flow rate for one of three residents reviewed with chronic pulmonary obstructive disease and congestive heart failure, Resident #5.	F 695	F 695 1. Address how corrective action will be accomplished for those found to have been affected by the deficient practice: 1a. Resident #5's oxygen was adjusted	6/20/18

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F 695	Continued From page 6 Findings included: Resident #5 was admitted to the facility with diagnoses which included, in part, anemia, chronic obstructive pulmonary disease (COPD) and congestive heart failure. Resident #5's nursing care plan initiated on 05/01/18 included a focus that Resident #5 was on oxygen therapy. The goal related to this focus was that Resident #5 would be free from signs and symptoms of hypoxia (oxygen deprivation). Some of the interventions included to achieve this goal were to administer oxygen as ordered, assess the pulse oximetry (oxygen saturation level), and to provide portable oxygen for ambulatory residents. A physician's order dated 05/01/18 was in place to administer oxygen at 1 liter per minute (LPM) via nasal cannula as needed. A review of the admission minimum data set (MDS) assessment dated 05/08/18 revealed Resident #5 was cognitively intact and exhibited no rejection of care behaviors. The admission MDS also indicated Resident #5 required extensive to total assistance with all activities of daily living except for eating, for which she required supervision only. a) A progress note dated 05/21/18 at 6:59 PM revealed that the nurse was made aware by the nursing assistant (NA) that Resident #5 was having trouble breathing while eating dinner at the dining table. The progress note further indicated that on assessment, Resident #5's oxygen saturation level was 89% and that her oxygen tank was empty. The same note further indicated	F 695	to the correct level per MD orders which is 1Liter/Min via nasal cannula and verification that portable oxygen tank has enough oxygen flow to complete activity. 1b. 100% of residents receiving oxygen had orders reviewed, verified, and validated correct flow in progress. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: 2a. DON in-serviced clinical staff on checking any residents that is on oxygen to view settings at eye level to ensure resident is receiving the appropriate ordered amount of oxygen. 2b. 100% of licensed nursing were re-educated by DON on following MD orders regarding oxygen delivery to include view of settings at eye level to ensure resident is receiving appropriate oxygen flow with concentrator and/or oxygen tanks when resident are going to any activity outside of room. 3. Address what measures will/were put in place , or systemic changes made to ensure that the deficient practice will not occur: 3a. The facility DON and or designee(s) to in-service all licensed nurses on ensuring if resident has an order for oxygen, that the oxygen amount is checked at eye level, and that any	

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that the oxygen tank was replaced and Resident #5's oxygen level increased to 95% and that her breathing returned to normal with respirations at 20 respirations per minute. The note was signed by Nurse #4.

In an interview with Resident #5 during an observation on 05/30/18 at 10:35 AM, she stated she wore her oxygen at all times because she felt as though she could not breathe comfortably without it. Resident #5 stated one day recently she had run out of oxygen in her portable tank while she was eating dinner and she was unable to catch her breath and she became anxious. She also stated the nurse came and replaced her oxygen tank after the nursing assistant (NA) notified her of her shortness of breath. Resident #5 stated and after oxygen tank was replaced she started to feel better and breathe more easily. At the time of the interview, Resident #5's oxygen was in place via a nasal cannula at 2 LPM from the oxygen concentrator in her room.

Nurse #4 stated in a phone interview on 05/30/18 at 4:32 PM that she was the nurse who responded to the NA's report that Resident #5 was having difficulty breathing. Nurse #4 explained she was not assigned to care for Resident #5 on 05/21/18 when her episode of short ness of breath occurred, but the nurse who was assigned to care for Resident #5 was not available, so she went immediately to the dining room to assess her condition. She stated her assessment revealed Resident #5 had an oxygen saturation level of 89% and she was taking deep breaths to take in more air. Nurse #4 stated check the oxygen level indicator on her portable tank and it showed the oxygen tank was empty, so she got another oxygen tank and replaced it.

portable oxygen tanks utilized by the resident is checked for correct level/amount as ordered by the MD.

3b. All oxygen orders will go on the Medication Administration Record (MAR), oxygen saturation levels will be maintained/documented on the MAR every shift,with the changing and maintenance of equipment for oxygen on the Treatment Administration Record (TAR).

3c. Resident's with an order for oxygen have been reviewed and placed on the correct administration record per the DON.

4. Indicate how the facility plans to monitor its performance to make the solutions are sustained:

4a. Facility DON and or designee(s) will review resident's medical record and maintain those resident's MD orders for oxygen daily times 2 weeks during morning rounds and the clinical meeting to ensure that the oxygen is being administered per MD orders as warranted for 12 weeks beginning on 6/11/2018. Results of the audit will be reviewed monthly for 3 months by the QAPI committee. If discrepancies are noted, further action will be implemented.

5. Date of Compliance 6/20/2018

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She added that Resident #5 started to breathe normally a few minutes after the new oxygen tank was replaced and her oxygen saturation rate improved to 98%. Nurse #4 further indicated that whenever a resident who received oxygen needed to attend out of room dining or activities, a nurse needed transfer the oxygen tubing from the oxygen concentrator in the room and connect it to a portable oxygen tank which had an adequate supply of oxygen for the out of room activity. She stated she did not know which nurse had connected Resident #5's oxygen to the portable oxygen tank that day before she went to eat in the dining room, and she could not recall which NA had reported Resident #5's episode of shortness of breath to her.

In an interview with Resident #5's physician on 05/31/18 at 11:25 AM, he stated that he expected for the nursing staff to monitor the portable oxygen tank and to replace it before the oxygen supply is depleted. He further stated the shortness of breath episode could have been prevented if her oxygen supply had not run out.

The Director of Nursing (DON) stated in an interview on 05/31/18 at 12:50 PM that nurses were ultimately responsible for making sure that portable oxygen tanks had adequate oxygen levels for the out of room activities. The DON further stated that she expected for the nurse who had connected Resident #5's oxygen tubing to the portable oxygen tank to have checked the oxygen tank level to prevent it from running out. The DON stated that the shortness of breath episode on 05/21/18 might have been avoided if the portable oxygen tank had adequate oxygen.

In a phone interview on 06/01/18 at 4:40 PM with

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the nurse who was assigned to care for Resident #5, Nurse #1, she stated she was not aware that Resident #5's portable oxygen tank was running out on 05/21/18 and she was not aware of Resident #5's episode of shortness of breath. Nurse #1 stated another nurse must have assisted with getting the portable oxygen tank hooked up for Resident #5 to go to the dining room. She added that NAs were not allowed to touch the oxygen tanks, so only nurses were responsible for changing the oxygen source from the oxygen concentrator in her room to the portable oxygen tank and for adjusting the oxygen flow rate.

b) The physician's order dated 05/01/18 indicated Resident #5 was to receive oxygen via a nasal cannula at a flow rate of 1 liter per minute (LPM).

A review of the May 2018 medication administration record (MAR) revealed the order for the oxygen via nasal cannula at 1 LPM was not present.

A review of the May 2018 treatment administration record (TAR) revealed the physician's order for oxygen via nasal cannula at 1 LPM dated 05/01/18 was present. There were no initials or notes present to indicate any oxygen was provided per the order on any day from 05/01/18 to 05/31/18.

A nursing progress note dated 05/21/18 at 11:03 PM revealed that Resident #5's oxygen was flowing at 2 LPM and that she had no shortness of breath.

Another nursing progress note dated 05/26/18

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indicated that Resident #5's oxygen was in place flowing at 2 LPM and she had no shortness of breath.

In an observation on 05/30/18 at 10:35 AM, Resident #5 was lying in bed with the head of the bed elevated, and her oxygen was in place via a nasal cannula. The flow rate on the oxygen concentrator was set at 2.5 liters per minute (LPM.) Resident #5 did not appear to be in any respiratory distress.

In an observation of Resident #5 on 05/30/18 at 2:55 PM, she was sitting up in a high back wheelchair and her oxygen was in place via nasal cannula at 3 LPM. Resident #5 stated during the interview that she was feeling very tired and did not feel like completing her exercises in therapy that day.

In an observation of Resident #5 on 05/31/18 at 9:00 AM, she was sitting up in her wheelchair while Nurse #5 administered her medication. Resident #5 had a mask over her nose and mouth and Nurse #5 stated at the time she was administering a nebulizer treatment for her.

An observation of Resident #5 in her room on 05/31/18 at 9:20 AM, her oxygen via nasal cannula was in place, running at 2 LPM. Resident #5 stated in an interview at that time that she was not feeling as though she had any shortness of breath.
On 05/31/18 at 9:25 AM, an interview was conducted with Nurse #5, who had administered Resident #5's medications at 9:00 AM. Nurse #5 stated she was not certain what Resident #5's oxygen flow rate order was, but thought it was 2 LPM.

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In an observation with Nurse #5 at the medication cart computer on 05/31/18 at 9:26 AM, she noted there was no oxygen flow rate order present on the May 2018 MAR for Resident #5. Nurse #5 then checked the May 2018 TAR and noted that the oxygen order dated 05/01/18 indicated the flow rate was 1 LPM via nasal cannula. There were no initials present to indicate any oxygen via nasal cannula had been administered. Nurse #5 stated she would check Resident #5's oxygen flow rate in her room. Upon observation of the oxygen concentrator in Resident #5's room with Nurse #5 on 05/31/18 at 9:30 AM, she saw that the oxygen flow rate was set on 2 LPM. Nurse #5 reset the flow rate to 1 LPM at that time. Nurse #5 did not offer a reason why the oxygen administration was not signed off on the May 2018 TAR during the month of May.

In an interview with Resident #5's physician on 05/31/18 at 11:25 AM, he stated that he would expect the nursing staff to maintain the oxygen flow rate at the ordered level of 1 LPM. The physician also stated the nurses should have been monitoring the oxygen flow rate, and if Resident #5 was requiring a higher flow rate than was ordered to prevent shortness of breath, they should notify the physician so that an evaluation could take place to determine her oxygen needs.

The Director of Nursing (DON) was interviewed on 05/31/18 at 12:40 PM. The DON stated she expected for nurses to provide Resident #5's oxygen via nasal cannula at the flow rate of 1 LPM as needed and for the record to indicate when it was provided. She stated became aware of the administration of oxygen at a flow rate higher than ordered rate for Resident #5 that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	**9600 NO 5 SCHOOL ROAD ASH, NC 28420**

(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 695	Continued From page 12 morning. The DON stated that when she learned of the flow rate error, she went to Resident #5's oxygen regulator and placed red tape on the ordered of 1 LPM level as a reminder to the nurses where to keep the flow rate. She added she had been not aware of any increased oxygen needs for Resident #5. The DON explained that some nurses entered the physician's oxygen orders onto the MAR, and other nurses entered the orders onto the TAR, so depending on which nurse processed the order, it could be found in either place. For Resident #5, it was located on the TAR; however, an order to check her oxygen saturation levels was placed on the MAR. The DON indicated she felt that oxygen was a medication and that she and the administrative staff were trying to determine consistent place where the oxygen order should be placed in order to help prevent oxygen administration errors.	F 695		