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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect 1 of 3 sampled resident's active diagnosis (Resident #1). Findings included: Resident #1 was admitted to the facility on 10/2/19 with the diagnoses of subarachnoid hemorrhage, dysphagia, respiratory failure, and pneumonia. The resident had a care plan dated 10/2/19 for receiving antibiotics secondary to aspiration pneumonia. Physician's order dated 10/2/19 revealed to give Augmentin (an antibiotic) via gastric tube to Resident #1 for pneumonia. The Medication Administration Record revealed the resident received Augmentin from 10/3/19 through 10/7/19. Resident #1's admission MDS dated 10/9/19 revealed Resident #1 was severely cognitively impaired. The resident's active diagnoses included gastroesophageal reflex disease, cerebrovascular accident, respiratory failure, traumatic subarachnoid hemorrhage without loss of consciousness, dysphagia, encephalopathy and vitamin D deficiency. The resident received	F 641	F641 Coding for resident number 1 could not be corrected since the resident had expired. An in-service/ clarification was completed on 11/1/19 with MDS nurses on coding according to the RAI Manual. All active diagnosis will be coded appropriately on admission and PRN. This in-service was conducted by the DON. All residents have the potential to be affected by the same issue. A 100% audit of all patients was completed to identify any active diagnosis that may not have been coded correctly. This occurred on 11/1/19 The interdisciplinary team, (IDT) (composed of the DON, ADON,MDS,RN Supervisor, Treatment Nurse, Dietary manager, Activities Director and Social Worker) were educated by the DON on 11/1/19 on accurate coding of MDS with active admission diagnosis. Measures put in place to ensure that this issue does not occur again are as follows. New admission orders and telephone orders will be reviewed in the clinical white board meeting 5 times per week by the IDT. Diagnosis will be reviewed in daily stand up meeting for appropriate active diagnosis for coding the MDS. The MDS nurses are responsible for coding the appropriate active diagnosis.	11/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Electronically Signed — 11/14/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	Continued From page 1 an antipsychotic and antibiotic medication. Pneumonia was not coded as an active diagnosis. The MDS nurse #1 was interviewed on 11/1/19 at 11:59 AM. She stated to code the resident's diagnoses section of the MDS, she would look at the hospital discharge summary and notes from the resident's chart for the 7 days look back period. The resident was admitted on 10/2/19 and the assessment reference date for the MDS was 10/9/19. She stated she could have coded pneumonia on the resident's MDS and she could do a modification of the MDS. The Director of Nursing was interviewed on 11/4/19 at 12:57 PM. She stated she would expect for any active diagnoses to be coded on the MDS.	F 641	Monitoring will occur by having residents reviewed in the weekly case management meeting for updates, corrections, and re-submissions as deemed appropriate. The DON will bring any trends to QAPI for review for the next 3 months or until substantial compliance is established by the committee.	
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	F 656		11/14/19

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F 656	Continued From page 2 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a care plan to address the resident's respiratory status for 1 of 3 residents reviewed for professional standards (Resident #1). Findings included: Resident #1 was admitted to the facility on 10/2/19 with the diagnoses of subarachnoid hemorrhage, respiratory failure, dysphagia, and pneumonia.	F 656	F656 The Care Plan for resident number 1 could not be corrected since the resident has expired. An in-service was conducted for the IDT by the DON concerning writing care plans and updating care plans on 11/1/19. Residents having the potential to be affected have had a 100% audit completed by the administrative nursing team to update any care plans for residents needing suctioning, O2 or	

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Resident #1's hospital discharge summary dated 10/2/19 revealed the resident had a diagnosis of respiratory failure and previously had a tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing).

Physician's orders for Resident #1 dated 10/2/19 through 10/31/19 revealed Ipratropium- albuterol 3 milliliters (ml) nebulizer (0.5-2.5 ml) (a respiratory medication) was ordered every 6 hours as needed for wheezing or shortness of breath.

Physician's orders for Resident #1 dated 10/3/19 revealed to suction oral cavity with "yankers" catheter as needed every hour for secretions.

The resident's Medication Administration Record (MAR) for 10/3/19 through 10/21/19 revealed to check the resident's oxygen saturation every shift and apply oxygen via nasal cannula at 2 liters for shortness of breath and for an oxygen saturation less than 93% (order date 10/3/19).

The resident had a care plan dated 10/2/19 for receiving antibiotics secondary to aspiration pneumonia. Interventions included to administer oxygen therapy as ordered, assess lung sounds daily and assess vital signs every shift. There were no care plans in place that addressed the resident's need for oral suctioning, respiratory breathing treatments or history of respiratory failure/tracheostomy.

Resident #1's admission Minimum Data Set (MDS) dated 10/9/19 revealed Resident #1 was severely cognitively impaired. The resident's active diagnosis included respiratory failure, dysphagia, and encephalopathy.

F 656

nebulizer treatments.
This was completed on 11/1/19
Measures put in place to ensure future compliance involved the corporate nurse consultant conducting a in-service for the MDS nurses and the Administrative nurse team on planning suctioning, oxygen and nebulizers. This occurred on 11/1/19.
During morning white board reviews by the IDT, orders will be reviewed for changes and or initiation of care plan to reflect the resident’s current disposition. The white board meetings occur 5 days per week.
Monitoring will be completed by having care plans reviewed or updated In the Patient At Risk,(PAR) composed of MDS nurses, Treatment Nurse, DON, ADON, SDC, Dietary Manager and Social Worker), committee meetings and standup meeting. The administrative nurses or the DON will report any trends or issues monthly to the QAPI meeting each month for 3 month or until substantial compliance is obtained as determined by the QA committee

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A nursing note dated 10/3/19 revealed the resident required oral suctioning once in the morning.

The MDS Nurse #1 was interviewed on 11/1/19 at 11:59 AM. She stated that care plans were created based on what triggered on the care area assessment (CAA). She stated she created the nursing section of the care plans for all residents. She explained that respiratory status was not typically care planned, unless the resident was on oxygen. She confirmed she was aware Resident #1 was getting oral suctioning. She stated she did not care plan the resident as receiving respiratory treatments because it appeared that he had not needed the medication according to the MAR. MDS Nurse #1 indicated moving forward she would create a care plan for any respiratory issues a resident had.

The Director of Nursing was interviewed on 11/14/19 at 12:57 PM. She stated she thought oral suctioning was a standard of care. She stated she went back (yesterday) and assessed the care plans for the entire building for residents with respiratory care needs. She stated she expected that staff would care plan any resident with respiratory care issues.

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		11/14/19

§ 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

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F 695	Continued From page 5 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 record review, observations, and staff and resident's guardian interviews, the facility failed to monitor a resident for the duration of his breathing treatment and failed to document the administration and response of a breathing treatment for 1 of 3 residents reviewed for professional standards (Resident #1). Findings included: The facility's procedure for administration of nebulizer treatments (no date) stated "remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer." Resident #1 was admitted to the facility on 10/2/19 with the diagnoses of subarachnoid hemorrhage, dysphagia, respiratory failure, and pneumonia. The resident had a care plan dated 10/2/19 for receiving antibiotics secondary to aspiration pneumonia. Interventions included to administer oxygen therapy as ordered, assess lung sounds daily and assess vital signs every shift. Resident's #1 admission Minimum Data Set dated 10/9/19 revealed Resident #1 was severely cognitively impaired. The resident did not have any moods present. The resident required supervision with bed mobility, transfers, locomotion on unit, toilet use and personal hygiene. The resident required total dependence	F 695	F695 Monitoring for resident number 1 cannot occur due to the patient being expired. On 11/1/19, a in-service and skills checkoff was completed with nurses the nurses involved with resident number 1's care, by the DON, ADON and SDC. Residents receiving respiratory care, (including tracheostomy care, oxygen use and nebulizer treatments, and lung sounds), could have the potential to be affected. A 100% audit was completed on 11/1/19 by the MDS nurse and nursing administration. Care Plans were updated and/or initiated for specific residents receiving respiratory care, nebulizer treatments and oxygen on 11/1/19 by the MDS nurse. An in-service was conducted with all licensed nurses on respiratory care, nebulized treatments, medication administration, documentation, assessment and evaluation of medication effectiveness on 11/1/19 and 11/4/19 by the SDC, ADON and DON. The procedures will be part of orientation of new hires and will be conducted at least yearly or PRN (which means as needed) as necessary. Systemic changes will have all new resident's orders and telephone orders reviewed in clinical rounds by nursing administration for respiratory orders and or changing orders. Orders will be	

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with eating. The resident was frequently incontinent of urine and of bowel. The resident had no shortness of breath and was not on oxygen therapy. The resident was not to have anything by mouth and was receiving tube feedings.

Physician's orders for Resident #1 dated 10/2/19 through 10/31/19 revealed Ipratropium- albuterol 3 milliliters (ml) nebulizer (0.5-2.5 ml) (a respiratory medication) was ordered every 6 hours as needed for wheezing or shortness of breath.

Physician's orders for Resident #1 dated 10/3/19 revealed to suction oral cavity with "yankers" catheter as needed every hour for secretions.

Resident #1's Medication Administration Record (MAR) from 10/3/19 through 10/21/19 revealed the "Iprat-albuterol nebulizer treatment as needed every 6 hours" was blank (indicting the resident did not receive the treatment).

Nursing notes were reviewed from 10/17/19 through 10/21/19, there were no nursing notes that revealed the resident received the Ipratropium- albuterol 3 milliliters nebulizer (0.5-2.5 ml) treatment. There was also no documentation in the medical record that the resident received a breathing nebulizer treatment or the resident's response to the breathing treatment.

The resident's guardian was interviewed on 11/5/19 at 12:15 PM. She stated the staff were not monitoring the resident's respiratory status. She stated she didn't think the resident was being suctioned when needed and had not received

Provider's Plan of Correction (F 695, continued):

updated by MDS, or the administrative nursing team/ designee.
Monitoring will occur by the administrative nurses weekly for four weeks then every 2 weeks for 4 weeks and then monthly until substantial compliance is achieved by the QAPI committee..
Trends will be taken to the QAPI meeting for review and or corrections monthly for substantial compliance for a period of 3 months by the DON.

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breathing nebulizer treatments. She stated she was given a copy of the resident's Medication Administration Record on a Friday after the resident was admitted to the facility (unknown date). She added the resident had received breathing treatments in the hospital prior to coming to the facility.

Nurse #1 (worked on 10/19/19 from 7:00 AM to 11:00 PM) was interviewed on 10/31/19 at 2:21 PM. She stated the resident had an old tracheostomy site that was healed. She stated they (the staff) would try to (orally) suction the resident as much as he would allow it. The resident would try and suction his tongue himself. The staff had to suction the "stuff" in the very back of his throat and tried to get him to cough it up. The resident drooled a lot and kept tissues with him to wipe his mouth. She stated she was getting ready to leave (on 10/19/19) and the night shift nurse was going to take over, but the resident needed a breathing treatment. The resident was drooling more and had "stuff" in the back of his throat. She stated she had suctioned the resident previously during her shift. She stated she placed the nebulizer breathing treatment on the resident (10/19/19) before she left, and the night shift nurse was to take it off. She stated the nebulizer breathing treatment should be ordered and documented on the MAR. She was unsure if the breathing treatment nebulizer order was scheduled or as needed.

Nurse #1 was interviewed again on 10/31/19 at 3:20 PM. She stated nurse #2 was coming on the night shift after she left the night of 10/19/19. She stated she placed the nebulizer treatment on the resident around 12:30 AM before she left. Nurse #2 stated that he would follow up. She stated

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Resident #1 was a little wheezy in the upper part of his chest. She stated she doesn't remember documenting the nebulizer breathing treatment on the MAR. She stated she didn't document it in the nursing notes because she wasn't the one to take it off the resident. She stated the other nurse (nurse #2) had already taken over for her around 11:00 PM and she gave the breathing nebulizer treatment as a favor to help the night shift nurse. (she verified the order for the breathing nebulizer treatment on the MAR was the medication she gave.)

Nurse #2 (cared for Resident #1 on 10/19/19 and 10/20/19 from 11:00 PM to 7:00 AM) was interviewed on 10/31/19 at 4:06 PM via phone. He stated the resident was sometimes oriented and other times he wasn't. He stated the resident had a continuous cough for about an hour or so overnight (10/20/19). He asked the resident if he had problems breathing. The resident really didn't give him an answer. He stated he gave the resident a breathing nebulizer treatment then (orally) suctioned him. He stated this all occurred early in shift before 2:00 AM. He stated he got up a lot of phlegm and mucus up when he suctioned the resident. The resident was not drooling a lot but was just coughing that night. That was the first time he heard the resident cough. He added that the resident had an order for oxygen therapy if his oxygen saturation level was less than 93%. He stated the resident's oxygen saturation level was never below that. He thought his oxygen saturation was "96% or so". He stated the resident stopped coughing after the breathing nebulizer treatment and (oral) suctioning. He stated he could not remember specifically if the previous nurse gave the breathing nebulizer treatment or if he gave the resident a breathing

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nebulizer treatment on 10/19/19. He stated the nebulizer breathing treatment should be documented on the MAR. He stated he may have taken the nebulizer treatment off the resident for the previous nurse but couldn't remember.

Nurse #3 (worked 10/20/19 from 3:00 PM to 11:00 PM) was interviewed on 11/1/19 at 4:20 PM. The resident was alert and oriented but needed a lot of things explained to him. She stated in the middle of her shift the resident was coughing a lot per the nursing assistant's report. She stated she set the resident up on the side of the bed and attempted to (orally) suction him during the coughing spell. This occurred between 6:00 PM and 7:00 PM (10/20/19). She stated she didn't get much up from suctioning the resident. The resident's coughing eased, and he stated he felt better. She passed it on (to the on-coming nurse) that the resident had a spell of trying to cough something up but couldn't. She stated she thought his vitals were taken. The sound from his lungs was deep. (She was unable to describe the sound). She stated she gave him a respiratory nebulizer treatment before suctioning the resident before dinner trays came out (10/20/19). She stated the resident's breathing nebulizer was stored on the dresser at the bed and the respiratory mask were stored in a bag at the resident's bedside. The resident had the breathing nebulizer medication stored on the medication cart. The breathing treatment nebulizer was documented on the MAR and there were special requirements to document when giving the treatment. She stated it wasn't on the MAR that she gave the nebulizer breathing treatment but there were requirements that should be documented when it's given. (She verified that the medication "Iprat-albuterol

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F 695	Continued From page 10 nebulizer treatment" on the MAR was the medication that she gave.) The Medical Director was interviewed on 11/1/19 at 11:11 AM via phone. The resident had a subarachnoid hemorrhage. He had been on and off the respiratory ventilator at the hospital. He was very cognitively impaired. He stated the nebulizer breathing treatment order was written to help moisturize and mobilize secretions and it was left up to the nurse to decide to use it. He didn't know of any concerns related to the breathing nebulizer treatment. The Director of Nursing was interviewed on 11/14/19 at 12:57 PM. She stated she didn't see the nebulizer breathing treatment documented in the notes or in the MAR so she thought it had not been used. She stated she did not think the resident needed the nebulizer. She added that many days they had computers issues, which may have been the cause of missing documentation. She stated she would expect that a respiratory assessment to be done pre and post breathing treatment, documented and signed off appropriately.	F 695		