STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345196	A. BUILDING: _____ B. WING _____	9/1/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VISTA HEALTH PARK	106 MOUNTAIN VISTA HEALTH PARK ROAD DENTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 657	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to revise a care plan interventions for 1 of 2 sampled residents (Resident #28) reviewed for transmission-based precautions. The findings included: Resident #28 was originally admitted 12/2/2021 and re-admitted to the facility on 7/7/22 with diagnoses that included respiratory failure, congestive heart failure and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment dated 7/14/22 indicated Resident #28's cognition was moderately impaired and she was not being isolated or quarantine for an active infection. Review of Resident #28's care plan dated 7/26/22 revealed a problem that read resident was incontinent of bladder and required total assistance with incontinence care. The goal was for the resident to be free of urinary infection. There was no intervention for Multidrug resistant organism (MDRO) or Extended Spectrum Beta-Lactamase (ESBL). A review of Resident #28's medical record from 7/7/22 through 8/30/22 revealed no physician order for Transmission based precautions (TBP) or MDRO. Further review of the resident's laboratory results revealed no urine culture in the medical record documenting ESBL. An observation on 8/30/22 at 8:53 AM of Resident #28's room revealed a sign posted on the outside wall of her door which read enhanced barrier precautions. A personal protective equipment (PPE) container was hung

The above isolated deficiencies pose no actual harm to the residents

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over the resident's door which contained gowns and gloves.

An interview with Nurse #1 on 8/30/22 at 10:57AM revealed Resident #28 was on TBP due to her having MDRO with ESBL in her urine. The nurse added that full PPE was to be donned by staff only with incontinence care and bed baths.

Resident #28's incontinence care was observed on 8/31/22 at 10:11AM. Nurse Assistant (NA) #1 and NA #2 had on a mask and eye protection when entering room and donned gown and gloves prior to care.

During an interview with NA #1 and NA #2 during care explained Resident #28 had a bacteria in her urine that required them to wear full PPE with incontinence care and bathing.

An interview with MDS Coordinator #1 on 8/31/22 at 9:50AM revealed she was made aware of changes that required care planning in morning meetings, through copies of new physician orders and updates in care plan meetings. After reviewing the care plan for Resident #28 the MDS nurse added the MDRO and ESBL were not care planned because she did not find a lab on the medical record. She further added that MDS reviewed the labs on the medical record and would update the care plan. However, the lab was not in the medical record, and it was missed with care plan update.

During an interview with the Director of Nursing (DON) on 8/31/22 at 10:00AM revealed the facility determined who was on TBP through orders, labs and followed infection control criteria. The DON added they did not write orders for TBP, but the staff were educated constantly. The DON revealed Resident #28 had a urine culture dated 4/12/22 which indicated positive ESBL in the urine and this was why she remained on TBP. The DON stated she expected the MDS coordinator to have care planned the MDRO and ESBL for Resident #28.

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	345196	A. BUILDING _____ B. WING _____	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VISTA HEALTH PARK	106 MOUNTAIN VISTA HEALTH PARK ROAD DENTON, NC 27239

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 8/29/22 through 9/1/22. The facility was found in complinace with requirement CFR 483.73 Emergency Prepardness. Event ID#2OH011.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted on 8/29/22 through 9/1/22 Event ID# 2OH011.	F 000		
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 observations, record review, staff interviews, Medical Director interview and oxygen vendor interview the facility failed to administer oxygen (02) as ordered by the physician for 1 of 2 residents reviewed for oxygen (Resident #46). The findings included: Resident #46 was admitted to the facility on 2/17/22 with diagnoses that included dementia, chronic obstructive pulmonary disease, asthma, and dependence on supplemental 02, right hemiplegia and hemiparesis	F 695	1. Corrective action for those residents found affected by the deficient practice. On 8/30/2022 at between the time of 4:25PM until 4:34PM Resident #46 oxygen setting was corrected to 6L/min due to the regulator not having a 5 L/min setting and oxygen tank was replaced by the Director of Nursing. Respiratory assessment of Resident #46 was completed by Director of Nursing with no noted distress. Director of Nursing notified Resident #46's physician of the L/min settings not administered per order.	9/26/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/21/2022

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Most recent quarterly Minimum Data Set (MDS) dated 8/12/22 revealed the resident had cognitive impairment, used supplemental 02 and had a one sided impairment on the upper and lower extremities.

Physician orders for Resident #46 included:

-Incruse Ellipta 62.5 micrograms/actuation powder for inhalation, 1 puff daily for wheezing and
shortness of breath dated 7/18/22

-02 at 5 liters per minute (l/min) via nasal cannula continuously for dependence on supplemental 02
dated 8/10/22

Resident #46's Care plan updated on 8/9/22 revealed Resident #46 had impaired respiratory status and required supplemental 02. The goal was Resident #46 would be free of respiratory infection and would have adequate 02 exchange. The interventions included monitor 02 sat every shift, 02 at 5L/min continuously to maintain 02 sat (measurement of the level of oxygen in the blood) above 89%, administer medication (incruse ellipta) as ordered.

An observation was made of Resident #46 on 8/30/22 at 8:28 AM, the resident was lying in his bed with his nasal cannula in place in his nares. The nasal cannula tubing was connected to the 02 concentrator and the 02 concentrator was set at 6L/min. The resident did not appear to be in any distress.

On 8/30/22 at 3:42 PM Resident #46 was

As well as the tank required replacement with noted desaturation without distress. Physician then gave new orders for Oxygen at 6L/min and oxygen saturation protocol. Director of Nursing checked and corrected setting for both Oxygen tank and concentrator for Resident #46. Completed 8/30/2022

2. Identification of other residents having the potential to be affected by the same deficient practice.
The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator will complete an audit of all residents that receive oxygen. Completed 8/30/2022- Findings noted that all residents receiving oxygen were at the correct L/min.

3. Measures to be placed to ensure deficient practice will not reoccur
The Nursing staff will receive education from the Director of Nursing and/or Staff Development Coordinator related to Oxygen Administration per facility policy and procedure, facility competency assessment of Oxygen Administration, Operating Instructions for WALK-O2-Bout Airgas E tanks and E tank life per L/min by 9/19/2022. New Nursing staff will receive education from the Staff Development Coordinator/Director of Nursing related to Oxygen Administration per facility policy and procedure, facility Competency Assessment of Oxygen Administration, Operating Instructions for WALK-O2-Bout Airgas E tanks and E tank life per L/min as part of the orientation

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observed in the dining room near the window. His nasal cannula was in place in the resident's nares and connected to the portable 02 tank. The resident's portable 02 tank was set on 8L/min and the 02-gauge needle was in the red, which indicated it was empty. The resident was in no respiratory distress.

During an interview with Nurse Aide (NA) #3 on 8/30/22 at 4:07 PM revealed nurses were responsible for adjusting the residents 02 to the correct rate. NA's could apply the resident's nasal cannula and turn on the 02 concentrator or apply nasal cannula from the portable 02 tank to the resident, but the nurse was responsible for turning on the 02 tank. NA #3 demonstrated how she turned on the 02 concentrator. When turned on it was at 6L/min. She stated she did not think it was right and would notify the nurse.

An interview was conducted on 8/30/22 at 4:20 PM with the Director of Nursing (DON). She stated Resident #46's 02 order in the electronic medical record (EMR) was 5L/min continuously.

On 8/30/22 at 4:25 PM until 4:34 PM a continuous observation was conducted by this surveyor and the DON of Resident #46. During the observation an interview was conducted with the DON. Resident #46 was observed self-propelling in his wheelchair (WC) exiting from the activity room. The resident's 02 tank was held in a fabric sleeve attached to the back of his WC. The DON observed and indicated the dial on the 02 tank was set at 8L/min and adjusted the 02. When she was done, this surveyor asked that she view the 02 gauge. The 02 gauge was observed in the red, which indicated the tank was empty. The DON removed the nasal cannula tubing from the

process. Completed 9/19/2022

4. The Director of Nursing will monitor its performance to make sure the solutions are sustained by: Each week, the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will complete weekly audits for 4 weeks and then monthly for 2 months to ensure that residents receiving oxygen administration are receiving the correct L/min as prescribed in the Resident's Physicians Orders via method of delivery (i.e., Concentrator or Portable E tank). The results of these audits will be submitted to the QAPI Committee monthly for 3 months. The Quality Assurance Committee will reevaluate the need for further monitoring after 3 months. The Administrator will review the audits to determine the need for further evaluation.

5. Date when corrective action will be completed:
September 26, 2022

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02 tank, there was no sound of air escaping the 02 tank observed when the tubing was removed. The DON removed the 02 tank from the sleeve and stated she would get another 02 tank. Resident #46 was in no distress and continued to propel himself across the hall to the dining room. At 4:28 PM the DON returned with an 02 tank and placed it in the sleeve on the back of the resident's WC. This surveyor asked the DON if she had a pulse oximeter to check the resident's 02 sat. It took the DON approximately one minute to retrieve the pulse oximeter and at 4:29 PM the pulse oximeter was applied and the residents 02 sat was 74%. Resident #46 was in no respiratory distress; his breathing was normal, and his color was good. When asked if he felt ok, he nodded yes. At 4:30 PM the nasal cannula tubing was attached to the 02 tank by the DON. At 4:33 PM the Resident #46's 02 sat was 86% and at 4:34 PM the 02 sat was 92%. Resident #46 did not show any signs of distress at any time during the observation.

During an interview and observation on 8/30/22 at 4:46 PM Nurse #2 explained, resident's that used 02 had their 02 sats measured every shift by either the nurse aide or nurse. If the 02 sat was below 90% it should be reported to the nurse. She further explained Resident #46 used 02 at 5L/min and she had not checked Resident #46's 02sat or tank yet because he was not in his room. She stated the resident was mobile in his WC and she would have to find him to check his 02 sat. Nurse #2 revealed she received report from Nurse #1 and Nurse #1 had changed resident #46's 02 tank and checked his 02 sat sometime before her shift ended. Nurse #2 stated she was not aware that the resident's 02 tank was set on 8L/min or that the in room concentrator was set

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on 6L/min. An observation was made with Nurse #2 of the 02 concentrator. Nurse #2 indicated the concentrator was set too high and she had adjusted it back to 5L/per min. She stated she did not know how that happened.

An interview was conducted on 8/30/22 at 5:05 PM with the DON, who indicated she was not aware that Resident #46's 02 concentrator was set at 6L/min. She indicated nurses were responsible for ensuring their residents were receiving 02 at the ordered rate.

During an interview on 8/31/22 at 11:00 AM Nurse #1 revealed she cared for Resident #46 during dayshift on 8/30/22. She further revealed the resident wore 5L/min and that she changed his 02 tank and turned the tank on 5L/min around 12:30 PM on 8/30/22.

On 8/31/22 at 1:43 PM an interview was conducted with the oxygen vendor that supplies 02 tanks for the facility. The vendor revealed the facility used E sized tanks. An E sized tank that was completely full and had 02 running at 5L/min would be empty in 2 hours (hr) and 16 minutes (min). He further revealed if the E sized tank was completely full and had 02 running at 8L/min the tank would be empty in 1hr 25min.

During an interview on 8/31/22 at 1:14 PM The Medical Director revealed he was familiar with Resident #46 and his need for 02 use. He indicated if the resident's 02 sats were lower than 88% he expected the staff to ensure the resident was wearing the 02 or encourage the resident to wear the 02 then recheck the 02 sat. If the 02 sat remained low, he expected to be notified. He further indicated he expected the nursing staff to

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use the ordered dose of 02. If there was a concern that the resident needed a change in the 02 dose, staff should call for a new order. The Medical Director stated he was aware of the events that took place with Resident #46 on 8/30/22 and did not believe the that it had any significant adverse effects on the resident.