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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 02-05-24 through 02-08-24. The facility was found in compliance with the requirment CFR 483.73, Emergency Preparedness Event ID #73OY11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted on 02/05/24 through 02/08/24. Event ID #BOUF11. The following intake was invesitgated: NC00210148. One (1) of 1 allegation did not result in deficiency. | F 000 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, resident, staff, and Nurse Practitioner interviews the facility failed to administer oxygen at the prescribed rate of liters for 1 of 2 residents reviewed for respiratory care (Resident #92).<br><br>The findings included:<br><br>Resident #92 was admitted to the facility on 01/05/24 with diagnoses that included chronic obstructive pulmonary disease, congestive heart | F 695 | The facility failed to ensure resident #92 oxygen concentrator setting matched the physician□s order. The resident had oxygen set at 4LPM, while the order stated 3LPM.<br><br>On 2/7/24 the nurse for resident #92 verified the order for 3LPM and immediately ensured the concentrator was set accordingly. Nurse obtained oxygen saturation rate for resident #92 | 2/12/24 |

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

Electronically Signed | 02/28/2024

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| F 695 | Continued From page 1<br>failure, and history of pulmonary embolism.<br><br>A physician order dated 01/07/24 read, oxygen at 3 liters via nasal canula for respiratory failure.<br><br>A comprehensive Minimum Data Set (MDS) assessment dated 01/11/24 revealed that Resident #92 was severely cognitively impaired, had shortness of breath when lying flat and wore oxygen and a non-invasive mechanical ventilator during the assessment reference period.<br><br>An observation and interview were conducted with Resident #92 on 02/05/24 at 10:56 AM. Resident #92 was resting in bed with oxygen in place via nasal canula at 4 liters per minute. He stated that he wore his oxygen all the time since being at the facility and also wore his continuous positive airway pressure (CPAP) at night when he was sleeping.<br><br>An observation of Resident #92 was made on 02/06/24 at 8:36 AM. Resident #92 was in bed with the head of his bed elevated and was eating breakfast. He had oxygen in place via nasal canula at 4 liters per minute.<br><br>An observation and interview were conducted with Resident #92 on 02/07/24 at 3:01 PM. Resident #92 stated the staff had just assisted him back to bed and he was noted to have no oxygen in place. Resident #92 was asked if he needed his oxygen and he stated "I ain't thought nothing about it" and reached for the cannula and put the canula back in his nose. The oxygen concentrator sitting next to his bed was set to deliver 4 liters of oxygen. Resident #92 was asked how much oxygen he required, and he stated, "not much." | F 695 | which was 99%. Resident #92 still resides in the facility and has had no negative outcomes.<br><br>On 2/7/24 the director of nursing or designee completed 100% audit of all residents currently on oxygen to ensure concentrator settings matched the written order. Any issues identified were corrected.<br><br>On 2/7/24 the Director of Nursing or designee completed education with all licensed nurses on checking the oxygen concentrator setting to ensure it matches the physician□s order. Any nurse not educated on 2/7/24 will receive education prior to working a shift. All new hired licensed nurses will receive this same education as part of orientation.<br><br>To ensure compliance beginning 2/11/24 the director of nursing or designee will review 10 residents on oxygen per week x 12 weeks to ensure oxygen settings match the physician order.<br><br>Findings will be brought to QAPI committee for review as needed. | |

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| F 695 | Continued From page 2 | F 695 | | |

Nurse #1 was interviewed on 02/07/24 at 3:05 PM and stated that Resident #92 required 2 liters of oxygen via nasal cannula and stated, "to be honest I have not looked at his oxygen concentrator today." He stated that night shift nurses were responsible for changing out the oxygen tubing, humidifiers, and nebulizer sets weekly. Nurse #1 further stated that the Nurse Aides (NA) were not able to adjust the oxygen rate that would be the responsibility of the nurse. Nurse #1 was asked to verify the physician order for Resident #92's oxygen and when he did, he stated Resident #92was actually supposed to be on 3 liters of oxygen via nasal cannula. Nurse #1 was asked to visual Resident #92's oxygen rate during the interview and confirmed that it was on 4 liters per minute and adjusted it to the correct dose of 3 liters. Nurse #1 also placed a pulse oximeter on Resident #92's finger and it indicated his oxygen saturation level was 95%.

The Director of Nursing (DON) was interviewed on 02/07/24 at 3:58 PM and stated oxygen tubing was changed every Sunday night by the nursing staff. She further explained that the nursing staff changed the oxygen tubing, cleaned the filters, and humidifiers as needed and then signed off on it in the medical record. The DON stated the hall nurse should be ensuring that the residents were receiving the correct dose of oxygen, in addition oxygen rate was apart of the guardian angel rounds that the management staff conducted every morning. The facility also had a list of devices that included oxygen and reviewed it weekly to ensure the correct amount of oxygen was being delivered.

The Nurse Practitioner (NP) was interviewed on

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| F 695 | Continued From page 3<br>02/07/24 at 11:56 AM who stated when she first met Resident #92, he had lots of generalized edema and she knew she had to get that fluid off of him due to his history of heart failure. The NP stated they used diuretics to pull the extra fluid off of Resident #92 to the amount of about 40 pounds. She stated that initially Resident #92 was non complaint and combative and was not aware of what was going on but since his admission he had really improved a great deal and was very alert and oriented. She added Resident #92 was very compliant with care at this time and with his oxygen. The NP stated that Resident #92's oxygen setting of 4 liters instead of 3 liters did not appear to have any ill effect on him with his pulse oximeter level of 95%. | F 695 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and | F 867 | | 2/26/24 |

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| F 867 | Continued From page 4 | F 867 | | |

information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness

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| F 867 | Continued From page 5 | F 867 | | |

of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's

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| F 867 | Continued From page 6<br>governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place for Infection Control (F880) following the complaint survey conducted on 01/07/22, and for Respiratory Care (F695) following a recertification and complaint survey on 08/25/22. The two deficiencies were recited during the recertification and complaint survey on 02/08/24. The repeat deficiencies during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program.<br><br>The findings included:<br><br>This tag is cross referred to:<br><br>F880 D: Based on observation, record review, and staff interviews, the facility failed to implement their policy for Personal Protective Equipment (PPE) when Nurse Aide (NA) #1 failed to clean her hands and don personal protective equipment as directed before entering 1 of 3 | F 867 | The facility failed to maintain an effective Quality Assurance Performance Improvement (QAPI) program due to receiving citation F695 during annual survey on 8/22/22 and F880 during infection control survey on 1/5/2022. These citations were received again during annual survey 2/5/24.<br><br>On 2/7/24 resident #92 oxygen concentrator was immediately changed to 3L as per physician□s order. Resident # 92 still resides in the facility and has had no negative outcomes as a result of the deficient practice.<br><br>On 2/6/24 the staff member was immediately educated by the director of nursing on proper hand hygiene and personal protective equipment(PPE). Resident #1 still resides in the facility and has had no negative outcomes as a result of deficient practice. | |

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| F 867 | Continued From page 7<br>residents' room on transmission-based precautions (Resident #1).<br><br>During the complaint investigation of 01/07/22 the facility failed to follow the CDC guidance regarding appropriate Personal Protective Equipment (PPE) for counties of high county transmission rates when 1 of 2 wound care personnel failed to wear eye protection while performing wound care for 1 of 3 residents who required wound care, 3 of 6 Nurse Aides (NA) provided care to 4 of 4 residents without wearing eye protection, 1 of 6 NAs delivered meal trays to 4 of 4 residents without wearing eye protection, and 1 of 4 nurses failed to don eye protection when entering a resident room on enhanced droplet isolation. These practices had the potential to affect all residents who received care from the facility staff. These failures occurred during a COVID-19 pandemic.<br><br>F695: Based on observations, record review, resident and staff interview the facility failed to administer oxygen at the prescribed rate of liters for 1 of 2 residents reviewed for respiratory care (Resident #92).<br><br>During the recertification and complaint survey on 08/25/22 the facility failed to secure an oxygen tank that was stored upright on the floor in a resident room for 1 of 2 residents reviewed for respiratory therapy.<br><br>The Administrator and the Director of Nursing (DON) were interviewed on 02/08/24 at 12:22 PM. The Administrator stated that the Quality Assurance (QA) committee met monthly and included Administration, all department heads, Pharmacy, and their Medical Director. She stated | F 867 | All residents have the ability to be affected by this deficient practice. The findings of personal protective equipment and oxygen will be reviewed weekly by the Quality Assurance Performance Improvement committee to ensure compliance with the implemented measures.<br><br>To prevent this from reoccurring on 2/23/24 the Regional Director of Clinical Services educated the administrator on the federal regulation of Quality Assurance Performance Improvement. The administrator then educated all interdisciplinary team members on the federal regulation of Quality Assurance Performance Improvement on 2/23/24. All new interdisciplinary team members will receive this same education prior to completion of orientation.<br><br>Beginning 2/26/24 a Quality Assurance Performance Improvement meeting form will be completed weekly to show compliance for the plan of correction for F695 and F880 for 12 weeks.<br><br>The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement committee for further review and recommendations.<br><br>Administrator is responsible for compliance. | |

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| F 867 | Continued From page 8<br>occasionally they invited a direct care staff member for front line staff input. Additionally, they had two top performance improvement plans in place for falls and reducing hospital readmission. The Administrator stated the QA committee members were very committed to quality improvement and their meetings were very active, effective, and efficient. Additionally, they reviewed all serious incidents and grievances and they tracked and trended all that information for improved resident safety. | F 867 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and | F 880 | | 2/27/24 |

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| F 880 | Continued From page 9 | F 880 | | |

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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| F 880 | Continued From page 10<br>IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interviews, the facility failed to implement their policy for Personal Protective Equipment (PPE) when Nurse Aide (NA) #1 failed to perform hand hygiene and don personal protective equipment as directed before entering 1 of 3 residents' room on transmission-based precautions (Resident #1).<br><br>The findings included:<br><br>Review of the facility's "Transmission Based Precaution Policy" dated 01/2024 read in part, Contact Precautions: intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment. Contact precautions also apply where the presence of excessive wound drainage, urine, or fecal incontinence, or other discharges from the body suggest an increased potential for environmental contamination and risk of transmission. Personal Protective Equipment recommended: Gloves: whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident. Gowns: whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the resident.<br><br>According to the facility protocol document titled "Hand Hygiene/Handwashing Policy" revised Oct 2019, hand hygiene should be performed before and after contact with residents, after removing gloves, and should be performed after contact with inanimate objects including medical | F 880 | The facility failed to ensure staff perform hand hygiene and use proper personal protection equipment (PPE) when entering a resident□s room on transmission based precautions.<br><br>On 2/6/24 the staff member was immediately educated on proper hand hygiene and personal protective equipment when entering a resident□s room on transmission based precautions by the director of nursing. Resident #1 still resides in the facility and has had no negative outcomes.<br><br>All residents have the potential to be affected by the deficient practice. On 2/6/24 an audit was completed by the director of nursing or designee to ensure all residents on transmission based precautions had the appropriate signage and personal protective equipment supplies accessible to staff.<br><br>Beginning on 2/9/24 staff were educated on proper hand hygiene and personal protective equipment for transmission based precautions use by the administrator or designee. Staff not educated will not be permitted to work until education is completed. All new staff will receive the same education as part of orientation.<br><br>Beginning 2/25/24 the director of nursing or designee will audit hand hygiene and | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 880 | Continued From page 11<br>equipment in the immediate vicinity of the resident.<br><br>A continuous observation was made on 02/06/24 at 8:39 AM to 8:45 AM. Resident #1's call light was noted to come on at 8:39 AM and signage on door that stated "Contact Precautions everyone must: clean their hands, including before entering and when leaving the room, put on gloves before room entry, discard before room exit, put on gown before room entry, and discard gown before room exit. There was also a container of PPE sitting directly outside of Resident #1's door that was well stocked with gowns and gloves. At 8:41 AM Nurse Aide (NA) #1 knocked on the door and entered Resident #1's room and proceeded to her bedside without cleaning her hands or applying gloves or gown. NA #1 was observed to touch Resident #1's bedrail and call light which were in close proximity to the resident and then was observed to go to the closet and obtain a towel and washcloth then returned to Resident #1's bedside where she placed the towel and washcloth on Resident #1's bed. NA #1 then exited the room and was observed using hand sanitizer that was on the wall across from Resident #1's room.<br><br>NA #1 was interviewed on 02/06/24 at 8:42 AM. NA #1 stated Resident #1 was on "contact precautions for something in her urine, so if I am doing something with her urine then I would put on PPE." NA #1 further stated she did not think she had to apply PPE unless she had contact with Resident #1's urine and the resident wanted some towels for when she got up later in the morning.<br><br>The Director of Nursing (DON) was interviewed | F 880 | the use of personal protective equipment for 5 residents on transmission based precautions per week x 12 weeks.<br><br>Findings will be brought to the QAPI committee for review as needed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345511 | A. BUILDING _____ B. WING _____ | C 02/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 880 | Continued From page 12<br>on 02/06/24 at 9:50 AM who stated she also served as the facility's Infection Preventionist. The DON explained that Resident #1 was on contact precautions for extended spectrum beta lactamases (ESBL) which was a type of infection and staff were expected to follow the directions of the signage on the door. She explained the sign directed them to clean their hands before they enter the room, apply gown, and gloves before they enter the room, and remove gown and gloves before exiting the room and clean hands when they leave the room. The DON explained the importance of staff applying PPE "anytime they go into the room or cross the threshold" to prevent the spread of infection or risk of contamination.<br><br>The Administrator was interviewed on 02/08/24 at 9:13 AM and explained they had done a great deal of training on infection control and the importance of applying PPE during their town hall (staff meeting) and even had a demonstration of the correct way to don and doff PPE in the last few months. | F 880 | | |