

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/27/2017
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	
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F 309 SS=G	<p>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l)</p> <p>483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.</p> <p>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, including but not limited to the following:</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:</p>	F 309		11/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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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 309	<p>Continued From page 1</p> <p>Based on record review and staff interviews the facility failed to respond to a residents nonverbal signs of pain while providing incontinent care for 1 of 3 residents sampled for well-being (Resident #69). Resident #69 was discharged to the hospital on 10/10/17 and diagnosed with a chronic nonunion displaced right femoral neck fracture.</p> <p>The finding included:</p> <p>Resident #69 was most recently readmitted to the facility on 10/25/17. His diagnoses included hemiplegia/hemiparesis, sepsis, pressure ulcer of the sacrum, retention of urine, pneumonia and others. Review of Resident #69's medical revealed that he had been present in the facility from 09/20/17 to 10/10/17 and again from 10/12/17 to 10/17/17.</p> <p>Resident #69 was discharged back to the hospital on 10/26/17.</p> <p>Review of the most recent quarterly minimum data set (MDS) dated 07/31/17 revealed that Resident #69 was rarely/never understood and had no speech. Resident #69 was also severely cognitively impaired for daily decision making and required total assistance of 2 staff members for bed mobility. The MDS further indicated that Resident #69 had no non-verbal indicators of pain during the reference period.</p> <p>Review of Situation Background Assessment and Recommendation (SBAR) dated 10/10/17 indicated that at 4:25 PM a Nursing Assistant (NA) reported to the nurse that Resident #69 "did not look right" and was making "facial expression and was tearful when turned and repositioned."</p>	F 309	Past noncompliance: no plan of correction required.		

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F 309	<p>Continued From page 2</p> <p>Resident #69 was assessed by the nurse and the unit manager. Upon assessment Resident #69 was observed with abnormal posture and abnormal positioning. When right leg was moved Resident #69 was observed grimacing and noted to have labored breathing and a single tear was noted to his face. Resident #69 was reassessed around 5:45 PM and no facial grimacing, no labored breathing, and no crying was noted. No further signs of pain were noted and he was resting comfortably in bed. Family and Nurse Practitioner (NP) made aware.</p> <p>Review of a physician order dated 10/10/17 read, x-ray bilateral hips related to pain and abnormal positioning one time only.</p> <p>Review of a radiology report dated 10/10/17 read, acute displaced right femoral neck fracture.</p> <p>Review of a physician order dated 10/10/17 read, send to emergency room (ER) for acute femur fracture.</p> <p>Review of a radiology report from the hospital dated 10/11/17 read, likely chronic nonunion displaced right femoral neck fracture.</p> <p>Review of an Orthopedic consultation dated 10/16/17 read in part, Resident #69 has an old femoral neck fracture. No orthopedic intervention needed.</p> <p>Interviews were conducted with NA #1 on 10/26/17 at 5:05 PM and again on 10/27/17 at 2:37 PM. NA #1 indicated that on 10/10/17 the Wound Nurse (WN) had stated that they had just finished wound care on Resident #69 and he needed incontinent care. NA #1 stated she</p>	F 309			

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F 309	<p>Continued From page 3</p> <p>entered Resident #69's room and he was resting in bed and she started to provide incontinent care to Resident #69 he began making "facial expressions and became very tense and scrunched his face and was moaning and frowning. NA #1 stated that the facial expression got much worse while she was providing the incontinent care but she was right in the middle of care and she had to finish the care. NA #1 stated that immediately after she finished the care Resident #69 was "finally able to relax from the pain" and she alerted Nurse #2. NA #1 stated that she checked on Resident #69 during the rest of her shift but did not have to provide any care to him.</p> <p>An interview was conducted with the WN on 10/27/17 at 9:12 AM. The WN stated that on 10/10/17 she and the wound doctor had been in to provide wound care to Resident #69. She added that the wound care was uneventful and Resident #69 tolerated the treatment well with no signs or symptoms of pain or discomfort and indicated they had been in the room for approximately 10 to 15 minutes. She added that while performing wound care to Resident #69's sacrum they noted some feces that needed to be cleaned up and so when they had finished wound care and exited the room she had told NA #1 that Resident #69 needed incontinent care.</p> <p>An interview was conducted with the Director of Nursing (DON) on 10/27/17 at 11:23 AM. The DON stated that NA #1 was providing care to Resident #69 had noticed that he did not look right and she went and asked Nurse #2 to come and check on him. She added that after Nurse #2 had assessed him she wanted Nurse #1 to come and take a look at Resident #69. After both</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>nurses had assessed Resident #69 they agreed that the NP on call needed to be made aware. The NP ordered x-ray and those were obtained and came back with a fracture and Resident #69 was sent to the ER for evaluation. The DON stated that she was at the facility working and was notified of the situation and at the end of NA#1's shift she was interviewed and she then left the facility. The DON stated she needed to conduct further interviews to validate what was going on. The DON stated she would expect that if Resident #69 was displaying signs and symptoms of pain that they stop what they were doing and notify the nurse.</p> <p>An interview was conducted with Nurse #2 on 10/27/17 at 12:51 PM. Nurse #1 stated that she was working on 2nd shift on 10/10/17 when NA #1 reported that Resident #69 "did not look right and was making facial expressions." Nurse #2 stated she went to Resident #69's room to assess him and when she pulled back the covers "he did not look right laying in the bed" he did not appear to be in any pain at that time but I ran to get Nurse #1 who was the supervisor. When Nurse #1 and I reassessed Resident #69 we agreed that we needed to contact the NP that was on call. Nurse #1 stated that she called the NP and got an order to X-ray both hips and when the X-ray technician came Resident #69 was resting comfortably in bed and did not appear to be any pain.</p> <p>An interview was conducted with Nurse #1 on 10/27/17 at 2:05 PM. Nurse #1 stated she was the supervisor on 10/10/17 when Nurse #2 had asked me to come to Resident #69's room and assess him. Nurse #1 stated that when she entered Resident #69's room NA #1 stated "there is something wrong with him" and stated "he is</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>not normally positioned like this." Nurse #1 stated she did not manipulate Resident #69 at all and due to the statements made by NA #1 and Nurse #2's previous assessment she went and called the NP. Nurse #1 stated that at the time she saw Resident #69 he was resting in bed and did not appear to be in any pain, there was no frowning, moaning, or crying that she noted.</p> <p>An interview was conducted with the NP on 10/27/17 at 1:49 PM. The NP stated that she had received a call from the facility on 10/10/17 and was made aware that Resident #69 "looked differently" and they wanted to get X-ray and that was what we did. The NP stated that when the facility called her they did not indicate that Resident #69 was in any pain and if they had she stated she would have went ahead and sent him to the ER for evaluation.</p> <p>The facility provided credible evidence of the corrective measure implemented after the incident. The measures included:</p> <ul style="list-style-type: none"> - Disciplinary action for NA #1 and education how to determine non-verbal signs of pain or discomfort that if noted during care to stop and report it to the nurse. <p>The following was completed after the alleged deficient practice was identified:</p> <ul style="list-style-type: none"> - Audits of all Residents who were non-verbal were completed on 10/12/17 by the Director of Nursing and Nurse Managers. - Pain assessments were completed for all residents by the Director of Nursing and Nurse Managers on 10/12/17. - Pain Observation orders obtained and entered into the electronic medical record by the Director of Nursing and Nurse Managers on 	F 309			

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F 309	<p>Continued From page 6 10/12/17.</p> <ul style="list-style-type: none"> - Resident with Pressure Ulcers were also assessed for pain and new orders obtained as needed by the Director of Nursing and Nurse Managers on 10/12/17. <p>On 10/12/17 education was provided to all licenses nurses on pain management and provided them pain management symptom handouts.</p> <p>On 10/12/17 all staff was educated on Abuse and Neglect.</p> <p>On 10/12/17 the therapy staff was educated on reporting pain to nurses using the Stop and Watch tool.</p> <p>On 10/12/17 all licenses nurses, NAs, and therapy staff were educated on the non-verbal signs of pain in residents.</p> <p>Monitoring:</p> <ul style="list-style-type: none"> - The Social Worker (SW) will complete the abuse and neglect monitoring for 5 residents weekly for 4 weeks for 1 month. - Nurse Managers to monitor 5 non-verbal residents for pain weekly for 4 weeks then weekly for 1 month. - All the finding will be presented Quality Assurance Performance Improvement (QAPI) for 3 months. <p>During the investigation validation of the corrective measures through interviews with staff, observations and record review indicated the facility had implemented measures to identify non- verbal signs of pain and how to respond.</p>	F 309			

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F 000	INITIAL COMMENTS On October 27, 2017, The Division of Health Service Regulation, Nursing Home Licensure and Certification completed a revisit and complaint investigation. The facility remains out of compliance.	F 000		
{F 314} SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, and hospital wound nurse interviews the facility failed to identify pressure from oxygen tubing and implement pressure relieving interventions upon readmission to a resident's left ear for 1 of 3 residents sampled for pressure ulcers (Resident #69). The findings included:	{F 314}	1. Resident #69 was readmitted to the facility on 10/25/17. Nursing Admission Data Collection on readmission indicated that Resident #69 had 2 Stage 4 pressure ulcers, 1 to heel and 1 to sacrum, no areas identified behind resident's ears. The Data Collection did note that resident #69 required oxygen via nasal cannula. The admitting nurse continued the	11/19/17

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{F 314}	<p>Continued From page 1</p> <p>Resident #69 was most recently readmitted to the facility on 10/25/17. His diagnoses included hemiplegia/hemiparesis, sepsis, pressure ulcer of the sacrum, retention of urine, pneumonia and others. Review of Resident #69's medical record revealed that he had been present in the facility from 09/20/17 to 10/10/17 and again from 10/12/17 to 10/17/17. Resident #69 was discharged back to the hospital on 10/26/17.</p> <p>Review of the most recent quarterly minimum data set (MDS) dated 07/31/17 revealed that Resident #69 was severely cognitively impaired for daily decision making and required total assistance of 2 staff members for bed mobility. The MDS further indicated that Resident #69 had 3 Stage 3 pressure ulcers and 1 Unstageable pressure ulcer. No use of oxygen was required during this reference period.</p> <p>Review of Resident #69's medical record revealed that he had a Stage 3 pressure ulcer to his left ear that was resolved on 09/26/17. The area was related to pressure caused from oxygen tubing.</p> <p>Review of Nursing Admission Data Collection dated 10/25/17 on readmission to the facility indicated that Resident #69 had 2 Stage 4 pressure ulcers, 1 to the left heel and 1 to the sacrum. The data collection tool also indicated that Resident #69 required oxygen via nasal cannula. The form was signed by Nurse #1.</p> <p>An interview was conducted with Nurse #1 on 10/26/17 at 1:53 PM. Nurse #1 stated she was the 2nd shift supervisor and was working on 10/25/17 and had readmitted Resident #69 when</p>	{F 314}	<p>preventive measure put in place by the hospital which included the comfort soft plus cannulas. On 10/26/17 an assessment was completed with the surveyor, a red scaly area was noted near the resident's hairline behind resident #69 left ear.</p> <p>2. Residents who use oxygen tubing have the potential to be affected by the alleged deficient practice; therefore an audit was completed on residents with oxygen by Administrative Nurses (DON, ADON, UM, Wound Nurse) on 10/26/2017 with no areas identified. The oxygen tubing was replaced with comfort soft plus cannulas or tubing with foam ear protectors for residents that require oxygen as a preventative measure to alleviate pressure behind the ears.</p> <p>3. Nursing staff will be educated by the Administrative Nurses (DON/ADON/UM/Wound Nurse/Area SDC) on the use of comfort soft plus cannulas or tubing with foam ear protectors for residents requiring oxygen via nasal cannula. Licensed Nurses will be educated on initiating preventative measures on resident with oxygen via nasal cannula upon admission/readmission. Education will be completed by 11/19/17. Resident's requiring use of oxygen will be audited weekly x 12 weeks, to ensure preventive measure in place.</p> <p>4. Nurse Management (DON, ADON,</p>		

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{F 314}	<p>Continued From page 2</p> <p>he returned from the hospital. Nurse #1 stated she had completed the numerous assessments that were required on readmission including the skin assessment. She added that she visualized his skin from head to toe and had to remove the bandages from his sacrum and left heel to see the pressure areas that were there. Nurse #1 stated she had looked behind Resident #69's ear and did not see any areas of concern.</p> <p>Review of a Braden Scale for predicting Pressure Sore Risk dated 10/25/17 indicated Resident #69's score was 11 which indicated he was high risk for developing of pressure sores. The assessment was signed by Nurse #1.</p> <p>An observation of wound care was made on 10/26/17 at 11:51 AM with the facility Wound Nurse (WN), Nurse #3 and Nurse #4. The WN proceeded to treat the left heel and sacrum as ordered and indicated she was finished. Before leaving Resident #69's room the WN, Nurse #3, and Nurse #4 were asked to visualize the area behind Resident #69's left ear. Nurse #3 proceeded to remove the oxygen tubing and observe the left ear which revealed a small area of redness with an indented center. The indented center was a light shade of white and there was brown crusty substances that covered the red and indented area noted.</p> <p>An interview was conducted with Nursing Assistant (NA) #1 on 10/26/17 at 2:09 PM. NA #1 stated that she routinely provided care to Resident #69 on 1st shift. She stated that provided him with a full bed bath and shaved him on a routine basis. NA #1 added that she provided routine incontinent care and turn and repositioned him every 1 to 2 hours. NA #1 stated</p>	{F 314}	<p>UM, Wound Nurse) or designee will audit residents with use of oxygen tubing weekly x 12 weeks to ensure oxygen tubing with foam ear protectors or comfort soft plus cannulas are in use to prevent skin breakdown.</p> <p>Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by the DON monthly x 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further audits are needed to obtain compliance.</p> <p>Date of Compliance: 11/19/17</p>		

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{F 314}	<p>Continued From page 3</p> <p>that she would observe Resident #69 frequently throughout the day to make sure his oxygen was in place but did not remove it. She added that she would just lift the tubing to wash his face and behind his ears but other than that she did not remove the oxygen tubing. NA #1 stated she was not aware of any skin breakdown that Resident #69 had behind his left ear.</p> <p>An interview was conducted with the WN on 10/26/17 at 4:26 PM. The WN stated the nurse who admitted or readmitted a resident to the facility was responsible for completing the initial skin assessment and then she would verify the assessment the following day. The WN stated that the area appeared red and scaly to her and that due to the pressure of the oxygen tubing she would classify the area as pressure in origin. The WN further stated that due to the scaly nature of the area and the fact that she could not visualize the wound bed she would classify the wound as an Unstageable or Deep Tissue Injury (DTI). The WN stated that if the resident had a history of pressure ulcers from the oxygen tubing they would just pad the tubing to relieve the pressure. The WN confirmed that Resident #69's oxygen tubing was not padded. The WN stated that she had completed the paperwork and initiated treatment to the area and she would reach out to the wound doctor.</p> <p>A follow up interview was conducted with the WN on 10/26/17 at 4:55 PM. The WN stated she had contacted the Wound doctor via phone and he, without visualizing the wound, stated it was a Stage 1 pressure ulcer.</p> <p>An interview was conducted with the hospital WN (HWN) on 10/27/17 at 8:18 AM. The HWN</p>	{F 314}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/27/2017
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 314}	<p>Continued From page 4</p> <p>indicated that she was very familiar with Resident #69 and immediately when she was aware that Resident #69 was in the hospital she would go to his room and replace his oxygen tubing with a soft silicone tubing that alleviated the pressure from behind the ears. The HWN stated that because she could not back stage a wound (identify previous healing of wound) the area to Resident #69 ' s left ear would always be healing Stage 4 wound. The HWN stated that she had visualized the wound to Resident #69 ' s left ear prior to his discharge from the hospital on 10/25/17 and the wound remained slightly opened and red and would still be classified a healing stage 4 pressure ulcer. The HWN stated that the pressure was coming from the oxygen tubing and that once alleviated those wounds tend to heal very quickly. She further stated it would be up to the facility how to treat those areas, either by padding the oxygen tubing or placing a dressing over the wound.</p> <p>An interview was conducted with the Director of Nursing (DON) on 10/27/17 at 11:23 AM. The DON stated that the facility had processes in place for identification of wounds and those processes were in place with Resident #69. She stated that after the initial skin assessment was completed then the WN would validate the assessment and we had not had the time to do that because Resident #69 once again returned to the hospital. The DON stated that the WN would have discovered the wound and initiated treatment had she had the time to complete the validation of the admission assessment. The DON stated that Resident #69's left ear had a wound that was resolved on 09/26/17 and that the left ear area was a "new wound to the facility."</p>	{F 314}			

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{F 314}	Continued From page 5 In a follow up interview with Nurse #1 on 10/27/17 at 2:05 PM. Nurse #1 stated that when Resident #69 was readmitted to the facility on 10/25/17 she knew he was on a specialty bed and already had positioning wedges in place. She added that if he had not had those items then it would have been her responsibility to get those for him. Nurse #1 added that she was not aware that Resident #69 had a history of pressure ulcers behind his ears from the oxygen tubing and if she had known then she would have repositioned the cannula and would expect the staff to routinely reposition the cannula on his face to relieve the pressure. She stated actually the staff would be doing it very frequently since Resident #69 was so sick and the staff were in his room much more frequently than in other rooms. Nurse #1 stated that she would have been responsible for initiating preventative measures that were needed on readmission.	{F 314}			
{F 520} SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	{F 520}		11/19/17	

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{F 520}	Continued From page 6 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July 2017. This was for one recited deficiency that was originally cited in July 2017 on a recertification and complaint survey and again in September 2017 on a follow up survey and subsequently recited in October 2017 on a follow up survey and complaint investigation. The deficiency was in the area of pressure ulcers. They continued failure of the facility during three	{F 520}	1. Facility Administrator conducted a Quality Assurance and Improvement Committee on 11/01/2017 to discuss the survey citation from exit on 10/27/2017. 2. Residents who use oxygen tubing have the potential to be affected by the alleged deficient practice; therefore an audit was completed on residents with oxygen by Administrative Nurses (DON, ADON, UM, Wound Nurse) on 10/26/2017 with no areas identified. The oxygen tubing was replaced with either comfort		

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{F 520}	<p>Continued From page 7</p> <p>federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.</p> <p>The findings included:</p> <p>This tag is cross referenced to F-314:</p> <p>Based on observations, record reviews, staff, and hospital wound nurse interviews the facility failed to identify pressure from oxygen tubing and implement pressure relieving interventions upon readmission to a resident's left ear for 1 of 3 residents sampled for pressure ulcers (Resident #69).</p> <p>During the recertification survey dated 07/14/17 the facility was cited for failure to assess and provide treatment to prevent development of pressure ulcer for one of four sampled residents (Resident #69). The resident was readmitted on 06/15/17 to the facility with a reddened area on left heel. The area on the left heel was not reassessed until 06/25/17 at which time the left heel area was black in color.</p> <p>During the follow up survey dated 09/08/17 the facility was cited for failure to prevent a Stage 2 pressure ulcer from worsening to a Stage 3 pressure ulcer (Resident #57) and to ensure the correct treatment order was transcribed and implemented for a resident with a pressure ulcer (Resident #69) for 2 of 4 residents sampled for pressure ulcers.</p> <p>An interview was conducted with the Administrator on 10/26/17 at 3:08 PM. The Administrator stated that he had been at the facility for 2 weeks and been debriefed on the</p>	{F 520}	<p>soft plus cannulas or tubing with foam ear protectors for residents that require oxygen as a preventative measure to alleviate pressure behind the ears.</p> <p>3. The QIO has been contacted and will set up additional education for the facility related to the Quality Assurance process.</p> <p>4. The Interdisciplinary Team including the Medical Director will meet weekly x 4 weeks then monthly x 2 months to conduct the facility's Quality Assurance and Performance Improvement. A member of the Divisional team to include the DDCS or the DDO to attend the weekly meeting by person or phone weekly x 4 weeks then monthly x 2 months.</p> <p>Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by the DON weekly x 4 weeks then monthly x 2 months at which time the committee will evaluate the effectiveness of the interventions and determine if further audits is needed to obtain compliance.</p> <p>Date of Compliance: 11/19/17</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 520}	Continued From page 8 current plan of correction and felt systems were in place to correct the deficient practice. He added that he met with the departments weekly to review the audits tools for compliance and felt the facility was in good standing and had made a lot of progress.	{F 520}		