STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 02/23/2018

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation. Event ID WBHG11. On 03/12/18 the State Agency provided the facility with an amended 2567 report because a revision was made to the information in tag F-695. Event ID# WBHG11.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578		3/23/18

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

Electronically Signed | 03/15/2018

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F 578	Continued From page 1 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to have advanced directives in place for 3 of 22 residents (Resident #57, 51, and 62). The findings included: Review of a facility policy, Living Wills/Agents for Health Care Decisions, effective 2/1/15, recorded in part: A. "A copy of the Center's policies governing the implementation of self-determination of rights is presented upon admission by the Admission's Office and the Notification Acknowledgement Form verifying all communication regarding advance directives is to be placed in the medical record at the time of admission." B. "Upon admission a licensed nurse must immediately review the advanced medical directive documents provided. If the Living Will specifies or declares the withholding of CPR or specifies that they do not want to be resuscitated, a licensed nurse must immediately notify the	F 578	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F578: The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to have advanced directives in place for 3 of 22 residents. (resident #57, #51, and #62) F578: The procedure for implementing the acceptable plan of correction for the	

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F 578	Continued From page 2 attending physician and secure a valid Do Not Resuscitate (DNR) order." 1. Resident #57 was admitted on 1/05/18 and planned to be discharged on 2/22/18 to the community. Diagnoses included diverticulosis of the intestine, gastritis, atrial fibrillation, hypertension, and diabetes. An admission Minimum Data set, dated 1/12/18 had documentation of Resident #57 being assessed to have intact cognition. An observation on 2/22/18 at 11:30am revealed Nurse #3 had ran out of the room for Resident #57 and appeared to be concerned. She was overheard reporting to Nurse #1 that Resident #57 had an altered mental status and her color had changed. Nurse #1 ran into the room for Resident #57 and Nurse #3 ran down the hall with portable oxygen towards the same room. Nurse #1 came out of the room and stated Resident #57 did not look good and was not able to be aroused. During a brief interview on 2/22/18 at 11:34am with Nurse #1, she indicated that assistance was needed from Unit Manager #1 or Director of Nursing (DON) due to a change in status for Resident #57. During a brief interview with the DON on 2/22/18 at 11:36am, it was reported to the DON that help was needed as requested by the nursing staff for Resident #57 due to an emergent change in condition.	F 578	specific deficiency cited: Resident # 57, #51, and #62 had advanced directives corrected immediately and golden rod was initiated on 2/23/18. All other current residents had advanced directives audited for compliance on 2/23/18 by Regional Nurse Consultant and Staff Development Nurse. All licensed nurses will be in-serviced by Staff Development nurse or RN Unit Managers or Director of Nursing on Policy number 301 Living Wills/Agents for health Care Decisions: Upon admission a licensed nurse must immediately review the advanced medical directive documents provided. If the Living Will specifies or declares the withholding of CPR or specifies that they do not want to be resuscitated, a licensed nurse must immediately notify the attending physician and secure a valid Do Not Resuscitate (DNR) order. If a valid DNR order is received, a licensed nurse must enter the order in the electronic record. All new nurses will receive education by Staff Development nurse on: Policy number 301 Living Wills/Agents for health Care Decisions: Upon admission a licensed nurse must immediately review the advanced medical directive documents provided. If the Living Will specifies or declares the withholding of CPR or specifies that they do not want to be resuscitated, a licensed nurse must immediately notify the attending physician and secure a valid Do Not Resuscitate (DNR) order. If a valid DNR order is received, a licensed nurse must enter the order in the electronic record during	

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F 578	Continued From page 3 An interview with the DON on 2/22/18 at 12:00pm revealed staff administered oxygen and vital signs indicated a fluctuating heart rate. The DON stated Resident #57 was able to awake on her own without resuscitation and 911 had been called to send her out for further examination at the Emergency Department with possible atrial fibrillation. The DON stated Resident #57 was a DNR and should have a Goldenrod (A legal form communicating the patient's wishes for DNR code status). She revealed her expectation was for nurses to determine the code status by looking at the electronic orders, care profile, and possible scanned documents. During the interview the DON retrieved Resident #57's electronic records and revealed the care profile under special recommendations listed the resident as a DNR. There was no order for code status and no scanned documents of advanced directives or a Goldenrod. She indicated Goldenrods are kept in a notebook at the nurses' station. An observation at the nurses' station on 2/22/18 at 12:30pm revealed no Goldenrod was filed in the DNR notebook for Resident #57. An interview on 2/22/18 at 12:30pm with Unit Manager #1 revealed she did not think Resident #57 was a DNR because there was no order written. She stated the floor staff were to treat her as a Full Code. During the interview the Unit Manager #1 stated the DNR listed in the care profile under special recommendations must have been a mistake. She stated the code status field was left blank and DNR was entered under special recommendations without an order. An interview on 2/22/18 at 12:40pm with Nurse #1 revealed she printed out all paper work related to	F 578	orientation. F578: The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected/and or in compliance with the regulatory requirements: Director of Nursing or Admission nurse or medical records coordinator and/ or Unit Managers will conduct audits on all new admissions/re-admissions for completion of Policy number 301 Upon admission a licensed nurse must immediately review the advanced medical directive documents provided. If the Living Will specifies or declares the withholding of CPR or specifies that they do not want to be resuscitated, a licensed nurse must immediately notify the attending physician and secure a valid Do Not Resuscitate (DNR) order. If a valid DNR order is received, a licensed nurse must enter the order in the electronic record daily Monday through Friday X 2 weeks, weekly X 2 weeks, Biweekly X 2, and monthly X 1. Results of all audits will be reviewed at Quarterly Quality Assurance meeting X 1 for further problem resolution. F578: The Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing	

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Resident #57 for the transfer earlier in the day to the hospital and there was no Goldenrod or DNR order.

An interview on 2/22/18 at 3:20pm with the DON revealed her expectation was for the admitting nurse to write an order determining code status at admission. She stated if no order was written then residents would be treated as a Full Code.

An interview on 2/22/18 at 3:30pm with the Administrator revealed he expected all residents to have advanced directives in place in the electronic health record at admission.

2. Review of a facility policy, Advance Medical Directives, effective 7/26/16, recorded in part, "Advance Directive declaration provided or initiated at the time of admission, or initiated at any point during the patient's course of stay will be placed in the medical record."

Resident #51 was re-admitted to the facility on 12/29/17 and discharged to the community on 2/22/18.

Diagnoses included vascular dementia, Parkinson's disease, cerebral vascular disease, diabetes mellitus type 2, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, and heart disease, among others.

An admission Minimum Data Set, dated 1/5/18 assessed Resident #51 with impaired cognition and severely impaired decision-making skills.

Review of the electronic medical record for Resident #51 revealed there was no documentation regarding the resident's decision

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of medical code status or an advanced directive.

During an interview on 02/22/18 at 11:14 AM with the Director of Nursing (DON) and review of the electronic medical record for Resident #51, the DON stated Resident #51's closed medical record from a previous admission included a discontinued physician's order for a full code medical status. The DON stated that the facility should have verified with the Resident/family the code status during the most recent admission and obtained a physician's order. The DON stated that the resident's code status or documentation of advance directives should be obtained during the admission process and a physician's order should be written.

Review of the Admission Assessment/Screening, dated 12/29/17, revealed Nurse #2 completed the new admission assessment for Resident #51. An interview with Nurse #2 on 02/23/18 at 6:22 PM revealed she could not recall completing the admission assessment for Resident #51, but her typical practice was to review hospital records, interview the resident/family to determine the code status and to notify the physician of the resident's code status so that a physician's order could be written.

3. Resident #62 was admitted to the facility on 12/22/17. Diagnoses included scoliosis, diabetes mellitus type 2, hyperlipidemia, and cerebral infarction with hemiplegia, among others.

A significant change Minimum Data Set, dated 1/15/18 assessed Resident #62 with impaired cognition and moderately impaired decision-making skills.

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F 578	Continued From page 6 Review of the electronic medical record for Resident #62 revealed there was no documentation regarding the resident's decision of medical code status or an advanced directive. During an interview on 02/22/18 at 11:14 AM with the Director of Nursing (DON) and review of the electronic medical record for Resident #62, the DON stated that the facility should have verified with the Resident/family the code status at the time of admission and obtained a physician's order. The DON stated that the resident's code status or documentation of advance directives should be obtained during the admission process and a physician's order should be written. The DON stated that the nurse who completed the Admission Assessment/Screening, dated 12/21/17 for Resident #62 was no longer employeed and unavailable for interview.	F 578		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 636		3/23/18

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F 636	Continued From page 7 (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility	F 636		

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F 636	Continued From page 8 following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to an indwelling catheter, cognition, mood and falls for 3 of 22 sampled residents (Residents #33, #51 and #76). The findings included: 1. Resident #33 was admitted to the facility on 09/01/16 with diagnoses which included spinal cord injury with a neurogenic bladder. Admission orders included direction to flush Resident #33's suprapubic catheter twice daily and as needed. Review of a physician's order dated 12/06/16 revealed Resident #33 requested flushes to be conducted between 7:00 AM and 9:00 AM. The physician directed an urologist to change Resident #33's suprapubic catheter on a monthly basis. Review of Resident 33's annual Minimum Data Set (MDS) dated 08/14/17 revealed an assessment of intact cognition. The MDS indicated Resident #33 used an indwelling urinary catheter and required extensive assistance with toilet use. The MDS triggered the Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA). Review of Resident #33's Urinary Incontinence and Indwelling Catheter CAA dated 08/22/17	F 636	1. F636 The plan of correcting the specific deficiency. Process that lead to the deficiency cited: Facility failed to conduct a comprehensive assessment, to identify and analyze how condition affected function and quality of life related to an indwelling catheter, cognition, mood and falls for 3 of 22 sampled residents (Residents #33, #51, and #76). MDSC inadvertently did not include documentation of findings with a description of the problem, contributing factors and risk factor related to the indwelling catheter and supporting decision to proceed to care plan. MDSC inadvertently did not complete the Cognition (BIMS) and Mood (PHQ-9) interviews correctly for resident #51 and #76. The employee who conducted the interviews and completed the MDS is no longer employed by employer. MDSC inadvertently did not complete the resident□s #76 Admission MDS 11/22/17 Question J1700. Fall History on Admission/Entry or Reentry correctly. 2. F636 The Procedure for implementing the acceptable pan of correction for the specific deficiency cited: All current residents□ most recent comprehensive MDS were reviewed to determine if the triggered Urinary	

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F 636	Continued From page 9 revealed no documentation of findings with a description of the problem, contributing factors and risk factor related to the indwelling catheter. The CAA listed Resident #33 received incontinence care. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Interview with Resident #33 on 02/20/18 at 7:51 AM revealed staff flushed the suprapubic catheter. Resident #33 reported he refused the flushes when the nurse could not flush the catheter at 8:00 AM. Observation during the interview revealed Resident # 33's suprapubic catheter drained clear, yellow urine to gravity. Interview with Nurse #5 on 02/22/18 at 8:11 AM revealed Resident #33 received catheter care. Nurse #5 reported Resident #33 frequently refused flushes in the morning but always received flushes at bedtime. Interview with the MDS Coordinator on 02/22/18 at 11:50 AM revealed the facility's former MDS Coordinator conducted and documented Resident #33's Urinary Incontinence and Indwelling Catheter CAA. The MDS Coordinator reported Resident #33's Urinary Incontinence and Indwelling Catheter CAA did not contain a documented comprehensive assessment. Interview with the Director of Nursing on 02/22/18 at 11:55 AM revealed she expected staff to document a comprehensive assessment with an analysis of findings. 2. Resident #51 was admited to the facility on 12/29/17. Diagnoses included vascular dementia, Parkinson's disease, cerebrovascular disease, diabetes mellitus type 2, major depressive	F 636	Incontinence CAA included documentation of findings with a description of the problem, causes, and contributing factors and risk factors related to an indwelling catheter. All current residents most recent MDS were reviewed to determine if the resident interview for both Cognition and Mood were coded correctly. All current residents most recent completed comprehensive MDS was correctly coded for Question J7100 Fall History on Admission/Entry or Reentry comprehensive MDS with to determine if Question J1700. Fall History on Admission/Entry or Reentry was correctly answered. On March 15, 2018, the MDSC Consultant provided education to the MDSC completion of the analyze of the finding section in the Urinary Incontinence CAA included documentation of findings with a description of the problem, causes, and contributing factors and risk factors related to and indwelling catheter; on completing the resident interview for both Cognition (BIMS) and Mood (PHQ-9) interviews and coding the MDS for Sections C and D correctly per the RAI Manual; on completing Question J1700 Fall History on Admission/Entry or Reentry correctly per the RAI Manual 3. F636 The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited	

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F 636	Continued From page 10 disorder, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, and heart disease, among others. Review of the admission Minimum Data Set (MDS) dated 1/5/18 revealed Section C, Cognitive Patterns, 0400 Recall, was not assessed. Additionally, Section D, Mood, D0200, Resident Mood Interview was incomplete. During an interview on 02/23/18 at 01:03 PM with the MDS Coordinator and the Data Analysis Verification Specialist (DAVS) (via phone), the MDS Coordinator stated that when she attempted to complete the Cognitive Patterns/Mood sections of the MDS, Resident #51 did not answer the first question and so she proceeded to the staff assessment sections. The DAVS stated that Resident #51 should have been asked 4 of the questions in each section and if the Resident did not answer, or provided nonsensical responses, then the staff assessment sections should have been completed. An interview with the Director of Nursing occurred on 02/23/18 at 05:34 PM and revealed that she expected the MDS Coordinator to follow the Resident Assessment Instrument Manual when completing the MDS. 3. Resident #76 was admitted to the facility on 11/15/17 and discharged on 12/4/17 with home health services of physical therapy and nursing. Diagnoses included osteoarthritis, pain in the right knee, and anterior soft tissue impingement. Review of the admission Minimum Data Set (MDS) dated 11/22/17 revealed Section C, Cognitive Patterns, Brief Interview for Mental Status (BIMS), was not assessed. Section D,	F 636	remains corrected and/or in compliance with the regulatory requirements: The MDS Consultant or designee will audit 5 residents comprehensive MDS who have an indwelling catheter to ensure their Urinary Incontinence CAA included documentation of findings with a description of the problem, causes, and contributing factors and risk factors. This will be accomplished 1 time a week for 1 month, twice a month for 1 month and Monthly for one month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS. The Audits will be presented during the Quality Assurance meeting X 1 for further problem resolution. The MDS Consultant or designee will audit 5 residents MDS for accurate completion of the resident interview sections for both Cognition (BIMS) and Mood (PHQ-9) interviews on their MDS. This will be accomplished 1 time a week for 1 month, twice a month for 1 month and Monthly for one month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS. The Audits will be presented during the Quality Assurance meeting X 1 for further problem resolution. The MDS Consultant or designee will audit 5 residents comprehensive MDS for accurate completion of Question J1700 Fall History on Admission/Entry or Reentry. This will be accomplished 1 time	

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F 636	Continued From page 11 Mood (PHQ-9), 0200, 0300 Resident Mood Interview, was not assessed. Additionally, Section J, Health Conditions, J1700, Fall History on Admission, was checked as unable to determine. During an interview on 2/23/18 at 12:38pm with the MDS Coordinator and the Data Analysis Verification Specialist (DAVS) via telephone, the MDS Coordinator stated the resident had been unavailable on the day she attempted the admission assessment due to the resident having therapy services or other activity. The MDS Coordinator stated she had been trained to attempt 2 to 3 times on the day of the assessment, otherwise to go directly to the staff interview to complete the assessment. The DAVS stated he expected the interview for Resident # 76 to be coordinated with the resident's schedule during the 7 day look back period in regards to Section C and Section J. He explained Section D, Mood, should have been coordinated with the resident anytime during the day before and day of the scheduled admissions assessment. The DAVS indicated the only time the MDS coordinator should have advanced to the staff interview was if the resident was unwilling to participate or answered 4 nonsensical responses in the sections for Cognitive Patterns and Mood. An interview with the Director of Nursing on 2/23/18 at 5:34pm revealed her expectation was for the MDS Coordinator to follow the Resident Assessment Instrument Manual when completing the MDS.	F 636	a week for 1 month, twice a month for 1 month and Monthly for one month. The Audits will be presented during the Quality Assurance meeting X 1 for further problem resolution. 4. F636 The Title of the person responsible for implementing the acceptable plan of correction: Data Analysis Verification Specialist	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		3/23/18

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F 641	Continued From page 12 §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 code the Minimum Data Set (MDS) assessment accurately in the area of Discharge Status for 1 of 3 sampled residents who were reviewed for discharge planning (Resident #76). The findings included: Resident #76 was admitted to the facility on 11/15/17 and discharged on 12/4/17 with home health services of physical therapy and nursing. Diagnoses included osteoarthritis, pain in the right knee, and anterior soft tissue impingement. A discharge MDS assessment dated 12/4/18 documented Resident #76 was discharged to an acute hospital. A record review of a progress note dated 12/4/17 written by the discharge planner revealed Resident #76 had been scheduled for discharge to home on 12/4/18 per the resident's request due to day 21 of therapy and insurance ending for coverage. The note read a hospital bed had been ordered and home care had been arranged for nursing, physical therapy, and occupational therapy services. An interview was conducted with the MDS Coordinator on 2/23/17 at 11:36am and revealed she had coded in error Resident #76 had discharged to the hospital and had in fact	F 641	1. F 641 The plan for correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility failed to code the MDS assessment accurate in the areas of discharge status of 1 of 3 samples who were reviewed for discharge planning. The resident was discharged to home. The MDSC inadvertently coded Question A2100 Discharge Status incorrectly on resident #76 DC MDS as discharge to the hospital. 03/14/18, the MDSC modified resident #76□s 12/4/17 Discharge (DCRNA) MDS to code Question A2100 Discharge Status to Community and not to Acute Hospital. 2. F641 The procedure for implementing the acceptable plan of correction for the specific deficiency cited: MDS Coordinator and/or MDSC Consultant will conduct an audit of all discharged residents discharged as Discharged Return Not Anticipated within the last 30 days to ensure Question A2100 Discharge Status was correctly coded. March 15, 2018 MDSC Consultant provided education to the MDSC regarding the RAI Rules for coding	

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F 641	Continued From page 13 discharged home. The MDS Coordinator indicated she may have made the error due to a hospital record that had been scanned in to the electronic records on the day of Resident #76's discharge, 12/4/18. She revealed the scanned hospital record was actually from the original hospital stay prior to her entry to the facility. An interview on 2/23/18 at 5:34pm was conducted with the Director of Nursing. She stated the expectation was for the MDS Coordinator to follow the Resident Assessment Instrument Manual when completing the MDS.	F 641	Question A2100 Discharge Status. 3. F 641The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The MDS Consultant will audit 5 discharged residents□ Discharge Return Not Anticipated MDS to ensure Question A2100 Discharge Status was coded correctly. This will be accomplished 1 time a week for 1 month, twice a month for 1 month and Monthly for one month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS. The Audits will be presented during the Quality Assurance meeting X 1 for further problem resolution. 4. F 641 The Title of the person responsible for implementing the acceptable plan of correction: Data Analysis Verification Specialist	
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 reviews, and staff	F 695	F695: The plan of correcting the specific	3/23/18

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F 695	Continued From page 14 interviews, the facility failed to administer oxygen at 3 liters per minute as prescribed by the physician to 1 of 3 residents sampled for oxygen therapy (Resident #45). Findings included: Resident #45 was readmitted to the facility on 8/16/17 with diagnoses that included acute and chronic respiratory failure with hypoxia, diastolic heart failure and encounter for attention to tracheostomy. A review of the electronic treatment administration dated 2/19/18 through 2/23/18 read in part, Oxygen at 3 liters per minute via trach collar every shift. Each shift was electronically signed by the staff indicating that Resident # 45 was receiving 3 liters of oxygen via trach collar during each shift. A review of the electronic treatment administration dated 2/19/18 through 2/23/18 read in part, Oxygen saturation to be maintained between 96-100% every shift related to acute and chronic respiratory failure with hypoxia and encounter for attention to tracheostomy. The summary of oxygen saturation for Resident #45 revealed the oxygen level was above 96% with each check that was performed. A review of the annual Minimum Data Set (MDS) dated 2/15/18 had documentation indicating Resident #45 was cognitively intact and received oxygen therapy, suctioning, and tracheostomy care. A review of the care plan revised on 6/1/17 revealed Resident # 45 had a tracheostomy	F 695	deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to administer oxygen at 3 liters per minute as prescribed by the physician to 1 of 3 residents. (#45) F695: The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The director of nursing obtained an order from Beth Scism NP to maintain resident #45 oxygen level between 96 □ 100 % via trach collar 2/23/18. The order was initiated immediately and the resident pulse oxygen level was at 97% via trach collar 02/23/2018. All current patients with orders for Oxygen as of 3/05/2018 were audited to verify correct administering of oxygen as prescribed by the physician. All licensed nurses will be in-service on administering oxygen as prescribed by the physician by Staff Development nurse. F695: The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected/and or in compliance with the regulatory requirements: Director of Nursing or Unit Managers or House Supervisor will conduct audits of all patients with oxygen orders to validate oxygen administered as prescribed by the physician daily Monday through Friday X 2 weeks, Biweekly X 2 weeks and monthly X 1. All new licensed nurses will received education on administering oxygen as	

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F 695	Continued From page 15 related to impaired breathing mechanics. Interventions in place included oxygen settings via trach collar to be set at 2 liters per minute. Review of an order dated 9/20/17 read Oxygen Therapy- Oxygen at 3 liters per minute via trach collar every shift. An observation on 2/20/18 at 6:58am revealed Resident #45 was awake reading the Bible in bed. She was receiving oxygen therapy via trach collar at 2 liters per minute using a concentrator at the bedside. Resident # 45 was in no distress. An observation on 2/20/18 at 11:11am revealed Resident # 45 was resting in bed positioned upright with the television on. She was receiving oxygen therapy via trach collar at 2 liters per minute using a concentrator at the bedside. Resident # 45 was in no distress. An observation on 2/22/18 at 9:41am revealed Resident # 45 was sleeping in bed upright. She was receiving oxygen therapy via trach collar at 2 liters per minute using a concentrator at the bedside. Resident # 45 was in no distress. An observation on 2/23/18 at 10:21am revealed Resident # 45 awake in bed reading. She was receiving oxygen therapy via trach collar at 2 liters per minute using a concentrator at the bedside. Resident # 45 was in no distress. During an interview on 2/23/18 at 4:55pm, Nurse #2 stated she had worked in the facility for approximately one year and was the full-time nurse for the resident during second shift. She stated Resident # 45 should receive oxygen via trach collar at 2 liters per minute. Nurse # 2	F 695	prescribed by the physician by Staff Development nurse during orientation. Results of all audits will be reviewed at Quarterly Quality Assurance meeting to review for further problem resolution. F695: The Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing	

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F 695	Continued From page 16	F 695		

reviewed the order for Resident # 45 and indicated she had made a mistake and the order had read the resident was to receive oxygen therapy at 3 liters per minute. She revealed she had over-looked the order and Resident # 45 had no reports of shortness of breath with oxygen saturation rates ranging between 96-100%.

An interview with the Unit Manager # 1 on 2/23/18 at 5:00pm revealed she thought the concentrator did not need to be set on 3 liters since she had a trach regulator that controlled the oxygen Resident # 45 received. During the interview the Unit Manager #1 increased the oxygen setting to 2.5 liters per minute on the concentrator and stated she needed to get clarification from the Director of Nursing (DON).

An interview with Unit Manager #2 on 2/23/18 at 5:05pm revealed she had remembered the Medic team telling staff that the green trach regulator controlled the oxygen and not the concentrator itself. She believed room air was combined to achieve the full 3 liters.

During an interview with the Director of Nursing on 2/23/18 at 5:10pm, the DON could not verify if the concentrator should be set at 3 liters when the order read oxygen was to be received via trach collar. The packaging for the green regulator was written in a foreign language and she did not have any other documentation. She stated that all nursing staff had been trained by Respiratory Therapy in the past 6 months. The DON called the Respiratory Therapist assigned to the facility.

A review of an in-service dated 10/23/17 revealed Respiratory taught tracheostomy care, suctioning,

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F 695	Continued From page 17 emergent situations, and high flow nebulizer treatments. The DON, Unit Manager #1, and Nurse #2 were not listed as present for the in-service. An interview with the Respiratory Therapist on 2/23/18 at 5:29pm revealed he had given the facility an order set with 2 orders to be written when receiving residents needing oxygen therapy via trach. He stated if the physician order read to give oxygen at 3 liters per minute then the concentrator should be set on 3 liters and to follow the physician order according to concentration. He stated the regulator was just a percentage of oxygen the resident received.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		3/23/18

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F 761	Continued From page 18 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, Pharmacy Consultant interview, and policy review, the facility failed to label and/or date opened medications for 3 or 4 medication carts (100A, 200B, and 200A), failed to discard an expired insulin vial for 1 of 4 medication carts (100A), and failed to secure and label unidentified loose pills for 2 of 4 medication carts (100A, 200A). The findings included: A review of the facility's policy, Storage and Expiration of Medications, Biologicals, Syringes and Needles, revised on 10/31/16, recorded in part, "facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." 1. A. An observation on 2/21/18 at 10:30am revealed Hall 100 medication cart A had 3 bottles of eye drops opened without an open date, 6 multi-dose insulin vials opened and undated, and 8 multi-dose insulin pens opened and undated. An interview with Nurse #4 on 2/21/18 at 3:07pm revealed the Staff Development Coordinator had audited the 100A medication cart a few months previous and a Pharmacy Tech used to audit carts monthly until a change 6 months ago and that job no longer existed. Nurse #4 stated now the 3rd shift nurse was supposed to audit the	F 761	F 761 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility failed to label/and or date opened medications for 3 of 4 medication carts (100A, 200B, and 200A), failed to discard an expired insulin vial for 1 of 4 medication carts (100A), and failed to secure and label unidentified loose pills for 2 or 4 medication carts (100A, 200A). F 761 The Procedure for implementing the acceptable plan of correction for the specific deficiency cited: Drugs and biologicals in each medication cart will be audited and any expired items, unlabeled or not dated items, or loose pills items will be removed and disposed of per facility policy. Nurses will be in-serviced on Pharmacy Policy 5.3 Storage and Expiration of Medications, biologicals that have an expired date on the label, are stored separate from other medications until destroyed or returned to the pharmacy or supplier (5 Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medication. Facility staff	

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F 761	Continued From page 19 carts at night but 3rd shift had been covered by an agency nurse until a full-time nurse could be hired. She stated all medications that had been opened should have been labeled with an open date. B. An observation on 2/22/18 at 10:14am revealed Hall 200 medication cart B had an UTI Stat medication bottle opened and undated. An interview with Nurse #1 on 2/22/18 at 10:14am responsible for the 200B medication cart revealed she had meant to discard the bottle and the last time she used it was a month ago. She stated keeping her medication cart clean and organized had been hard to keep up. She stated all medications opened should have an open date. C. An observation on 2/22/18 at 10:19am of Hall 200 medication cart B revealed 1 insulin pen opened and undated. An interview with Nurse #3 on 2/22/18 at 10:19am responsible for the 200A medication cart revealed she was considered a floater and worked on all of the medication carts. She stated all nurses were responsible for checking medication carts for undated medications and were usually checked every shift. She added the administrative staff also made random audits. 2. An observation on 2/21/18 at 10:30am revealed Hall 100 medication cart A had 1 expired vial of insulin. An interview with Nurse #4 on 2/21/18 at 3:07pm revealed the vial of insulin had expired on 1/8/18 and was past the 28 day storage date recommended by pharmacy. She stated the vial	F 761	should record the date opened on the medication container when the medication has a shortened expiration date once opened, (10 Facility should ensure that medications and biologicals for each resident are stored in the containers in which they were originally received, 17 Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis. F 761 The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected/and or in compliance with the regulatory requirements: Director of Nursing, RN Unit manager, or House Supervisor will conduct audit of drugs and biologicals on each medication cart weekly X 4 weeks, Bi Weekly X 2 weeks and monthly X Results of audits will be reviewed at Weekly Quality Assurance Risk meeting for further problem resolution if needed. All new hire licensed nurses will be educated in general orientation on storage and expiration of drugs and biologicals. Results of all audits will be reviewed at Quarterly Quality Assurance meeting X 1 for further problem resolution if needed. F 761 The Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing	

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F 761	Continued From page 20	F 761		

had been over-looked. She explained the Staff Development Coordinator had audited the 100A medication cart a few months previous and a Pharmacy Tech used to audit carts monthly until a change 6 months ago and that job no longer existed. Nurse #4 stated now the 3rd shift nurse was supposed to audit the carts at night but 3rd shift had been covered by an agency nurse until a full-time nurse could be hired.

3. A. An observation on 2/22/18 at 10:19am revealed Hall 200 medication cart A had 4 unidentified loose pills and 4 unidentified half loose pills in the second drawer.

An interview on 2/22/18 at 10:19am with Nurse #3 indicated that every nurse was responsible for the medication cart and carts were usually checked every shift. Nurse #3 stated administrative staff also checked medication carts for loose pills. She believed the medication packaging had a thin area for the nurse to puncture and it could easily happen without the nurse knowing.

B. An observation on 2/22/18 at 11:51am revealed Hall 100 medication cart B had 6 loose pills in the second drawer.

An interview with on 2/22/18 at 11:51am with Nurse #4 revealed there was no set schedule for cleaning the medication carts and agency staff often covered her cart on second and third shifts. She indicated agency staff had been assigned the medication cart temporarily until a full time nurse was hired and had gone through the training program. Nurse #4 stated she often came in to the facility on Saturdays to clean and organize her medication cart.

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F 761	Continued From page 21 An interview on 2/22/18 at 12:25pm with the Director of Nursing (DON) revealed it was her expectation for all nurses to check the medication cart every shift, the Unit Manager to check weekly, and random audits to be conducted by management and administrative staff for opened and undated medications, expired medication and loose pills. An interview on 2/22/18 at 12:26pm with the Nurse Consultant revealed there had been a change in the contract from the pharmacy providing services and a pharmacy tech was no longer a role for auditing medication carts. An interview on 2/22/18 at 3:13pm with the Pharmacy Consultant via the telephone revealed he performed a 10% audit on each visit to the facility looking for expired medications, opened and unlabeled medications, and loose pills. He stated he made visits twice a month and usually checked 1 medication cart and 1 medication room. He explained he would send a quality assurance summary report of findings to the DON via email and a verbal report to the DON or Charge Nurse. The Pharmacy Consultant indicated he expected staff to label medication when opened and if not labeled he would assume the open date to be the dispensed date. An interview on 2/22/18 at 3:33pm with the Administrator revealed he expected administrative and nursing staff to monitor the medication carts as often as necessary to look for expired medications, opened and undated medications, and loose pills.	F 761		