STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING ______ B. WING ______	R-C 03/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	**5939 REDDMAN ROAD** **CHARLOTTE, NC 28212**

(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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		4/18/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/06/2018

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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§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to notify the resident's primary physician after the resident was not connected to a non-invasive mechanical ventilator to provide oxygen as ordered by the physician and was found deceased for 1 of 3 residents sampled for respiratory services (Resident #1).

Findings included:

Resident #1 was readmitted to the facility on 12/19/15 with diagnoses which included: respiratory failure, heart failure, hypertension, diabetes and chronic obstructive pulmonary disease. Resident #1 expired at the facility on 03/06/18.

A review of the most recent quarterly Minimum Data Set (MDS) dated 01/02/18 revealed Resident #1 had mild cognitive impairment for daily decision making and required limited to extensive assistance from staff with activities of daily living. The MDS further revealed Resident #1 required oxygen and suctioning and had a tracheostomy but ventilator was not checked on the MDS.

"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law."

F580 Notify of Changes
1. At 10:47pm on 3/6/18, Nurse #1 and Nurse #2 responded to resident #1's room following report of change of condition from NA#1. Resident #1was noted to be unresponsive. Nurse #2 exited resident #1's room to obtain the crash cart. At 10:55pm Nurse #1 checked resident's advanced directives and noted resident #1 was a DNR. At 11:00pm Nurse #1 and Nurse #2 assessed resident #1's vital signs and Vital signs were absent. At 11:03pm the Director of Nursing was notified of resident #1's death. On 3/6/18 Nurse #1 did not notify Resident #1's primary physician. The Nurse Practitioner was made aware on 3/7/18 and the

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F 580	Continued From page 2 A review of a physician order dated 07/17/17 indicated non-invasive mechanical ventilator at bedtime. A review of a Treatment Administration Record (TAR) dated 03/01/18 through 03/31/18 indicated Respiratory Therapy (RT)/Nursing to place Resident #1 on non-invasive mechanical ventilator at bedtime and the time for application was 9:00 PM. A review of a RT note dated 03/07/18 at 10:06 AM signed by RT #1 revealed Nurse #1 informed RT #1 that Resident #1 had passed away in the night. The note indicated RT #1 asked Nurse #1 what happened and Nurse #1 stated Nursing Assistants (NAs) put Resident #1 to bed around 10:15 PM and they returned to Resident #1's room again at 10:55 PM and found Resident #1 deceased. The note further indicated RT #1 asked Nurse #1 if Resident #1 was placed on tracheostomy collar with oxygen or was he placed on his nocturnal non-invasive mechanical ventilator as ordered. The note revealed Nurse #1 stated she had not gotten there yet due to her medication pass so she was unsure if he was on his tracheostomy collar or his non-invasive mechanical ventilator. The note further revealed RT #1 checked the non-invasive mechanical ventilator event log which indicated the non-invasive mechanical ventilator was powered on at 10:51 PM and stopped at 10:57 PM. During an interview on 03/08/18 at 3:06 PM, Nurse #1 confirmed she worked second shift on 03/06/18 and was assigned to provide care to Resident #1. She explained at approximately 10:55 PM on 03/06/18 NA #1 and NA #3 reported to her Resident #1 was in bed and his tongue was	F 580	Primary physician was made aware of incident by the Director of Nursing 3/9/18. 2. Residents with a change of condition resulting in death have the potential to be affected. The Nurse Managers conducted an audit of residents who have expired in the facility during the last 30 days to ensure notification was made to the Primary Physician following the resident's death. This audit was completed by 4/18/18. Any opportunities were corrected by the Nurse Managers by 4/18/18 3. The Areas Staff Development Manager and Nurse Manager re-educated licensed nurses regarding the facility's policy for Notification of Changes to include: Notification to MD for Change in Condition and Death. This education was completed by 4/18/18. 4. The Director of Nursing and Nurse Managers will review the 24 hour report to identify resident with changes in condition 3 times per week for 12 weeks and ensure proper notification was made to the Physician for residents with changes. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) team by the Administrator for 3 months, at which time, the QAPI Committee will evaluate the effectiveness of the interventions to determine if additional auditing is necessary to maintain compliance. Date of Compliance: 4/18/18	

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F 580	Continued From page 3	F 580		

hanging out. Nurse #1 stated she ran to Resident #1's room and he was unresponsive and she told the NAs to get the crash cart. Nurse #1 stated when she entered Resident #1's room he did not have his oxygen on and she could not recall if it was accessible to him. She explained she hooked up his non-invasive mechanical ventilator and turned it on and then left the room to check to see if Resident #1 had a Do Not Resuscitate (DNR) order. She further explained when she was sure he had a DNR order in place she returned to Resident #1's room and turned the ventilator off. Nurse #1 stated she and Nurse #2 pronounced Resident #1 deceased at 11:00 PM and then she called palliative care and told them Resident #1 had expired. She confirmed she did not call the resident's primary physician or the on-call physician service because if a resident received palliative care she thought she was supposed to call them.

A review of a change in condition document titled Situation, Background, Assessment, and Recommendation (SBAR) dated 03/09/18 indicated on 03/06/18 at 10:55 PM Resident #1 was found without signs of life. The document revealed Resident #1 was assessed for vital signs and none were present and Resident #1 had a DNR order. The document further revealed the Director of Nursing (DON) and family were notified of Resident #1's death.

During an interview on 03/09/18 at 12:08 PM, the DON explained Nurse #1 had called her on 03/06/18 after she found Resident #1 was not breathing and told her Resident #1 had expired. She stated Nurse #1 told her she had called palliative care but did not say she had called Resident #1's primary physician.

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During an interview on 03/12/18 at 11:41 AM, the current Medical Director stated he was new in the facility and today was only his third time in the facility. He stated there was physician coverage available 24 hours a day and after hours nursing staff were expected to call the on-call service for a resident's change in condition or if they had expired. He stated if a resident received palliative care services the nurse should still call the resident's primary physician or the on-call service to notify them.

During a follow up interview on 03/13/18 at 10:52 AM, the DON stated it was her expectation when a resident had a change in condition or a respiratory event, they should call the resident's primary physician to report it. She further stated if a resident received palliative care services, the nurse should call them but the nurse should also call the resident's primary physician and should document in nurse's notes they had called both of them.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Resident Records - Identifiable Information

Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345243	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 3/13/2018

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 842

Continued From Page 1

(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and current Medical Director interviews the facility failed to maintain an accurate medical record by not documenting that a resident expired for 1 of 3 residents sampled for accurate medical records (Resident #1).

The findings included:

Resident #1 was readmitted to the facility on 12/19/15 with diagnoses that included: respiratory failure, heart failure, hypertension, diabetes mellitus, and chronic obstructive pulmonary disease.

Review of a Situation, Background, Assessment, and Recommendation (SBAR) dated 03/09/18 indicated that on 03/06/18 at 10:55 AM Resident #1 was found without signs of life. Resident #1 was assessed for vital signs and none were present. The Director of Nursing (DON) and family were notified of Resident #1 ' s death. The SBAR was not a part of Resident #1 ' s medical record.

Review of Resident #1 ' s medical record on 03/08/18 at 10:00 AM revealed no documentation of Resident ' s passing or the events leading up to his death.

An interview was conducted with Nurse #1 on 03/08/18 at 3:06 PM. Nurse #1 confirmed that she was working with Resident #1 on 03/06/18 on 2nd shift. Nurse #1 stated that she pronounced Resident #1 dead at 11:00 PM but had failed to document the event in the medical record because she ran out of time at the end of her shift.

An interview was conducted with the current Medical Director (CMD) on 03/12/18 at 11:41 AM. The CMD director stated the he expected Nurse #1 to document in the medical record exactly what happened and the details that lead up Resident #1 passing away which included the notification of the family and Medical Director.

An interview was conducted with the Director of Nursing (DON) on 03/13/18 at 10:52 AM. The DON stated that they had been conducting audits of medical records to check for accuracy and had not identified any issues. She confirmed that Nurse #1 did not document the event in the medical record and stated "we have been stressing the importance of documenting everything." The DON added that the facility was going through a cultural change and has had some challenges and getting the staff to document was one of them. She added that a lot of times the staff would wait until the end of their shift to document and then they would simply run out of time because they had other places to be. She added that she has instructed the staff that when something occurred to stop as soon as possible and document the event so we were not left wandering what took place. The DON again stated that she expected Nurse #1 to document the events of Resident #1 in the medical record.

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F 000	INITIAL COMMENTS A complaint survey was conducted from 03/08/2018 through 03/13/2018. Immediate Jeopardy was identified at: CFR 483.12 at tag F-600 at a scope and severity of (J). CFR 481.21 at tag F-656 at a scope and severity of (J). CFR 481.25 at tag F-695 at a scope and severity of (J). CFR 483.70 at tag F-835 at a scope and severity of (K). Tags F-600 and F-695 constituted Substandard Quality of Care. Immediate Jeopardy began on 03/06/2018 and was removed on 03/13/2018. A partial extended survey was conducted in conjunction with the complaint survey. The survey team left the facility on 03/10/18 and returned to the facility on 03/12/18 to continue conducting the partial extended survey and the survey concluded on 03/13/18. Event ID #M8KD11.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		

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

Electronically Signed

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§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on record review, staff, Respiratory Therapist, former Medical Director, Pulmonologist and current Medical Director interviews, the facility neglected to connect a resident to a non-invasive mechanical ventilator to provide oxygen as ordered by the physician for 1 of 3 residents sampled for respiratory services (Resident #1). When Resident #1 was found by staff without the physician ordered non-invasive mechanical ventilator he was deceased. The facility also neglected to perform incontinent care for a dependent resident for 1 of 3 residents sampled for activities of daily living (Resident #6).

Immediate Jeopardy began on 03/06/18 when Resident #1's oxygen was removed before transferring him to bed by Nurse Aide (NA) #1 and #3 and they told Nurse #1 he was ready to be connected to his non-invasive mechanical ventilator. Nurse #1 was passing her night time medications and neglected to stop passing her medications to connect Resident #1 to his non-invasive mechanical ventilator and approximately 45 minutes later NA #1 and NA #3 discovered Resident #1 was not breathing and alerted Nurse #1. Nurse #1 realized she had neglected to place Resident #1 on his non-invasive mechanical ventilator and entered his room and turned the device on. She then exited Resident #1's room to find out his code status and after she confirmed he had a Do Not Resuscitate (DNR) order she re-entered Resident

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#1's room and turned off the non-invasive mechanical ventilator and pronounced Resident #1 deceased. Immediate jeopardy was removed on 03/13/18 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff education and ensure monitoring systems put into place are effective for applying respiratory devices as ordered.

The facility was cited at F600 for example #2 at a scope and severity level of D.

Findings included:

1. Resident #1 was readmitted to the facility on 12/19/15 with diagnoses that included: respiratory failure, heart failure, hypertension, diabetes and chronic obstructive pulmonary disease. Resident #1 expired at the facility on 03/06/18.

A review of a care plan initiated 01/05/16 and revised on 01/07/18 revealed in part, Resident #1 had a tracheostomy (trach) related to a respiratory illness and the goals were Resident #1 would have clear and equal breath sounds bilaterally and would have no signs or symptoms of infection by the review date. The interventions indicated to provide oxygen via trach collar and suction as needed (initiated 01/05/16) and Resident #1 was to be placed on a non-invasive mechanical ventilator at night as ordered (initiated on 03/24/16).

A review of a physician order sheet dated 07/17/17 indicated non-invasive mechanical

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ventilator at bedtime.

A review of the most recent quarterly Minimum Data Set (MDS) dated 01/02/18 revealed Resident #1 had mild cognitive impairment for daily decision making and required limited to extensive assistance from staff with activities of daily living. The MDS further revealed no behaviors or rejection of care and Resident #1 required oxygen and suctioning and had a tracheostomy during the assessment reference period but ventilator use was not indicated on the MDS.

A review of a Treatment Administration Record (TAR) dated 03/01/18 through 03/31/18 indicated RT/Nursing to place Resident #1 on non-invasive mechanical ventilator at bedtime and the time for application was 9:00 PM.

A review of a Respiratory Therapy (RT) note dated 03/07/18 at 10:06 AM signed by RT #1 revealed Nurse #1 informed RT #1 that Resident #1 had passed away in the night. The note indicated RT #1 asked Nurse #1 what happened and Nurse #1 stated Nursing Assistants (NAs) put Resident #1 to bed around 10:15 PM and they returned to Resident #1's room again at 10:55 PM and found Resident #1 deceased. The note further indicated RT #1 asked Nurse #1 if Resident #1 was placed on tracheostomy collar with oxygen bled in or was he placed on his nocturnal non-invasive mechanical ventilator as ordered. The note revealed Nurse #1 stated she had not gotten there yet due to her medication pass so she was unsure if he was on his tracheostomy collar or his non-invasive mechanical ventilator. The note further revealed RT #1 checked the non-invasive mechanical

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ventilator event log which indicated the non-invasive mechanical ventilator was powered on at 10:51 PM and stopped at 10:57 PM. The note indicated there was no as needed (PRN) RT on shift at the time of the event.

During an interview on 03/08/18 at 12:52 PM, RT #1 confirmed Resident #1 had chronic respiratory failure and was ventilator dependent at night. He stated Resident #1 was cognitively alert and would sporadically take himself off the ventilator but he was not able to put himself on the ventilator. RT #1 explained he arrived to work on 03/07/18 at 5:20 AM and generally Resident #1 was up in his wheelchair waiting for the RT to get him a new tank of oxygen but on this day he was not. RT #1 stated he questioned Nurse #1 where Resident #1 was and Nurse #1 stated he was deceased. He explained Resident #1 was very stable and had not been sick, had no increased oxygen needs and was only suctioned maybe 1-2 times a day. RT #1 stated he questioned Nurse #1 what happened and she explained at approximately 10:15 PM on 03/06/18 Resident #1 requested to go to bed so the NAs put him to bed and they went back to check on him at 10:55 PM and he was deceased. RT #1 further stated he asked Nurse #1 if Resident #1 had been on his non-invasive mechanical ventilator or his tracheostomy collar and she stated he was not on the non-invasive mechanical ventilator because she was still passing medications and had not had time to hook him up yet. He explained he checked the non-invasive mechanical ventilator log inside the monitor on the ventilator and discovered that the ventilator had been turned on and off within just a few minutes. RT #1 stated there was no RT in the building that night and Nurse #1 should have stopped her medication

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pass and connected Resident #1 to his non-invasive mechanical ventilator as ordered. RT #1 stated the nurses had been trained to place residents on the non-invasive mechanical ventilator in the absence of an RT.

During an interview on 03/09/18 at 3:43 PM, NA #1 stated she routinely provided care for Resident #1 and confirmed she provided care for him on 03/06/18 on second shift. NA #1 explained at 9:50 PM NA #3 assisted her with placing Resident #1 in bed. She stated after Resident #1 was placed in bed and care was provided, she handed Resident #1 his call bell, urinal, and oxygen tubing. She further stated Resident #1 was able to put on his oxygen and she handed him the tubing but was not sure if he placed it on himself or not. NA #1 explained she and NA #3 left Resident #1's room and returned 35-45 minutes later when Resident #1's call light was on. She stated when she and NA #3 entered Resident #1's room she noticed he was not breathing but could not recall if he had on his oxygen or not. She explained NA #3 called Nurse #1 to the room and Nurse #1 confirmed Resident #1 was not breathing and had a Do Not Resuscitate (DNR) order and NA #1 stated she left the room.

During an interview on 03/08/18 at 3:27 PM, NA #3 confirmed she provided care for Resident #1 on 03/06/18 on second shift. NA #3 explained at approximately 9:50 PM to 10:00 PM she and NA #1 placed Resident #1 in bed and she had removed his oxygen to put him to bed but could not recall if she had replaced it or not. NA #3 stated after she had put Resident #1 to bed she told Nurse #1 he was in the bed and was ready for her to hook him up to his machine. She further stated approximately 30-45 minutes later

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Resident #1's call light was on and she and NA #1 entered his room to see what he needed and Resident #1 had grabbed the hand rail with his hand and had turned himself so that his legs were off the side of the bed. She stated NA #1 put his legs back in the bed and as they turned to leave the room they noticed that his chest was not rising or falling so they ran to get Nurse #1. She explained Nurse #1 came into the room and checked his vital signs and Resident #1 appeared to take a deep breath at one point when Nurse #1 was in the room. NA #3 stated she was not sure if Resident #1 had been hooked up to his ventilator because Nurse #1 was responsible for that.

During an interview on 03/08/18 at 3:06 PM, Nurse #1 confirmed she provided care to Resident #1 on 03/06/18 on second shift. Nurse #1 explained Resident #1 had been his usual self on 03/06/18 and had been up in a wheelchair and had his oxygen in place at 2-3 liters through a tracheostomy collar. She stated at approximately 10:55 PM on 03/06/18 NA #1 and NA #3 told her Resident #1 was in bed and his tongue was hanging out. Nurse #1 explained she ran to Resident #1's room and he was unresponsive and she directed the NAs to get the crash cart. Nurse #1 stated when she entered Resident #1's room he did not have his oxygen on and could not recall if it was accessible to him and she hooked up his non-invasive mechanical ventilator and turned it on and then left the room to check to see if Resident #1 had a DNR order. She explained when she was sure he had a DNR order in place she returned to Resident #1's room and turned the ventilator off. She further explained she had not had time to place him on his non-invasive mechanical ventilator because she was passing medications. Nurse #1 stated she had not had

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time to provide tracheostomy care and that was generally when she would have put him on the non-invasive mechanical ventilator. She further stated Resident #1 had alarms on his ventilator but because she had not hooked him up yet they were not on. Nurse #1 stated she and Nurse #2 pronounced Resident #1 deceased at 11:00 PM.

During an interview on 03/08/18 at 5:06 PM, Nurse #2 stated she worked on second shift on 03/06/18 and late in the evening a NA called Nurse #1 to Resident #1's room. She explained she went with Nurse #1 to Resident #1's room and when she entered Resident #1's room he was lying in bed and seemed to have no life in him. She further stated she could not recall if he had his oxygen in place or if he was hooked to the non-invasive mechanical ventilator but she left the room to grab a pulse oximeter. She explained when she returned to Resident #1's room, Nurse #1 had placed Resident #1 on the non-invasive mechanical ventilator and checked for a pulse but could not find a pulse. She stated Nurse #1 left the room to check Resident #1's chart and then returned to the room and confirmed he had a DNR order and Nurse #1 turned the ventilator off. She further stated they both listened for lung sounds for 3-5 minutes but there were none and Resident #1 was pronounced deceased.

During an interview on 03/08/18 at 4:41 PM, the former Medical Director (FMD) stated she had been Resident #1's physician until approximately 02/28/18 and had never seen Resident #1 without his oxygen. She explained she did not have to see him very often because he was stable with a tracheostomy and non-invasive mechanical ventilator. She explained at night Resident #1

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F 600	Continued From page 8 required the extra support of the non-invasive mechanical ventilator which to her knowledge was a traditional ventilator. The FMD stated if Resident #1 did not have his oxygen on or his ventilator connected that could have contributed to his death along with his heart disease, lung disease, and hypertension. The FMD further stated she would expect for Resident #1 to have his oxygen in place and for him to be hooked to his non-invasive mechanical ventilator as ordered. During an interview on 03/09/18 at 2:51 PM, the Pulmonologist stated Resident #1 was very stable and very independent but had chronic respiratory failure with a permanent tracheostomy and he was dependent on a nocturnal (at night) non-invasive mechanical ventilator. The Pulmonologist explained Resident #1 required the non-invasive mechanical ventilator as back up ventilation at night and anyone who required the non-invasive mechanical ventilator was ventilator dependent. He stated Resident #1 was dependent on the non-invasive mechanical ventilator at night to support his ventilations (breathing). During an interview on 03/12/18 at 11:41 AM, the current Medical Director (CMD) stated this was only his third time in the facility but he recalled he met with Resident #1 while he was sitting up in his wheelchair on a previous visit. The CMD stated he was not familiar with the noninvasive mechanical ventilators used in the facility and he left the management of those devices up to the Pulmonologist who visited the facility on a weekly basis. The CMD stated it was his expectation for staff to follow the physician orders and they should have placed Resident #1 on his	F 600		

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non-invasive mechanical ventilator as ordered. He further stated it was his expectation for staff to communicate any issues to himself or the Pulmonologist.

During an interview on 03/09/18 at 12:07 PM, the Director of Nursing (DON) stated Resident #1 required the use of non-invasive life support and it was usually placed on him when he went to bed to assist him with breathing. The DON explained Nurse #1 had contacted her on the evening of 03/06/18 and reported Resident #1 had passed away and she gave Nurse #1 directions as to what she needed to do. The DON stated that Nurse #1 did not communicate with her at that time all the facts in regards to Resident #1's death. The DON further stated it was her expectation for Nurse #1 to apply Resident #1's non-invasive mechanical ventilator as ordered by the physician.

Review of Resident #1's Certificate of Death dated 03/12/18 revealed the immediate cause of death was respiratory failure.

Credible Allegation of Compliance

F600 Neglect

1. The Resident identified to be affected by the alleged deficient practice.

At 9:30pm on 3/6/18 Nurse #1 administered medication to resident #1. Resident #1 experienced no distress or change in his baseline condition. Resident #1 swallowed his medication and drink without problems. At 9:50pm Nurse Aide #1 and Nurse Aide #3 assisted resident #1

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in preparing for bed. Nurse Aide #1 and Nurse Aide #3 transferred resident #1 via sit to stand lift from the chair to the bed. NA #1 placed resident #1's call light and urinal within reach. NA#1 and NA #3 exited room. At 10:45pm NA#1 exited another resident's room and noted resident #1's call light was on. NA #1 noted that resident #1 had his right leg off of the bed and the call bell in his hand. NA #1 went around the bed to address the call light. Resident #1's tongue was protruding from his mouth. NA #1 stated resident's color was gray. NA #1 went to the door of resident #1's room and yelled for help. NA #3 ran to the nurses' station to get help. At 10:47pm Nurse #1 and Nurse #2 responded to resident #1's room. Nurse #1 placed resident #1 on the respiratory assistive device. Resident #1 noted to be unresponsive. Nurse #2 exited resident #1's room to obtain the crash cart. At 10:55pm Nurse #1 checked resident's advanced directives and noted resident #1 was a DNR. At 11:00pm Nurse #1 and Nurse #2 assessed resident #1's vital signs and Vital signs were absent. At 11:03pm the Director of Nursing was notified of resident #1's death
A 24 hour report was sent to the NC Health Care Registry, NCDHHS by the Administrator on 3/10/18 reporting this event. The police were notified by the Administrator on 3/10/18. The NC Board of Nursing was notified via email on 3/10/18 by the Director of Nursing.

" A Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 3/9/18 and it was determined that the Nurse #1 did not apply oxygen via trach collar and Astral ventilation was not initiated for Resident #1 immediately after the NA # 1 assisted Resident to bed. There was no Respiratory Therapist (RT) on duty to assist Nurse #1 with completion of respiratory related

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tasks which led to Nurse #1 failing to follow the physician orders to apply the Astral ventilation system. The IDT determined this event was the result of a lack of RT staffing on 2nd shift.

Further Root Cause Analysis was conducted regarding the admission of residents with tracheostomies requiring ventilation assistance. Education was conducted with the Administrator, Director of Nursing, Respiratory therapist and facility Sales Representative by the Division Team regarding admission requirements for residents with tracheostomies on 6/16/17. This education required that no residents with tracheostomies, requiring ventilation would be admitted to the facility thereafter. Since 6/16/17, 4 residents exceeding this criteria, have been admitted in error and 1 resident received physician's order to add ventilation assistance due to a decline in status while remaining in the facility

2. Residents with the potential to be affected by the alleged deficient practice.

" Residents with tracheostomies requiring ventilation assistance have the potential to be affected by the alleged deficient practice.
" On 3/9/18 an audit was completed by the Director of Nursing and Nurse Managers, of residents with tracheostomies requiring ventilation assistance to ensure oxygen and Astral/Trilogy devices were applied according to the physician's orders.
" On 3/9/18 Residents #8, #9, #10 and #11 were identified with tracheostomies utilizing respiratory equipment that requiring ventilation assistance was transferred to hospital setting.

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F 600	Continued From page 12 3. Systemic Measures " The Director of Nursing and Nurse Managers re-educated licensed nurses and nurse aides on Abuse and Neglect Prevention beginning on 3/10/18. Beginning 3/10/18 No staff will be allowed to work until the training is complete. This education also included ensuring staff awareness that failure to provide respiratory equipment and services such as tracheostomy care and oxygen administration as ordered by the physician, can constitute resident neglect. The NHA and DON will have a no tolerance approach to any deviation from the policy. " On 3/10/18 the District Director of Clinical Services provided education to the Interdisciplinary Team (IDT) regarding the facility's admission capabilities with a focus on resident requiring respiratory assistance. This education includes the following: -Specific types of respiratory referrals and levels of respiratory support required -Admission criteria regarding referrals with tracheostomies which includes the District Director of Clinical Services approval prior to offering placement. -No ventilation assistance will be provided via Astral/Trilogy or other devices " On 3/9/18 Respiratory Therapist/Nurse Managers re-educated licensed nurses using the facility's policy for Respiratory/Tracheostomy Care to include suctioning, applying t-collar, and completing a respiratory assessment. " On 3/9/18 the Nurse Managers re-educated the Nurse Aides on reporting observations of residents with tracheostomies requiring oxygen administration to include notification of the nurse when oxygen is not applied as required. " No licensed nurses or nurse aides will work	F 600		

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F 600	Continued From page 13 before receiving education after 3/9/18. " New hires (licensed nurses and nurse aides) will be educated by the Nurse Manager on the facility's policy for Respiratory/Tracheostomy Care during the orientation process. " All licensed nurses and nurse aides will be educated annually, by the Nurse Manager, for continued proficiency in respiratory/tracheostomy care utilizing the facility's policy for Respiratory/Tracheostomy Care. " The Director of Nursing or Nurse Managers will review new admissions daily during the clinical meeting to validate physician ordered respiratory equipment is available and applied according to the physician's orders. " The Director of Nursing or Nurse Managers will audit 10 residents requiring respiratory equipment weekly for 12 weeks to ensure respiratory equipment applied according to the physician's orders. " The Director of Nursing will report the results of this morning during the weekly QAPI meeting and the committee will make recommendations as needed. " The facility will no longer admit residents with tracheostomies that require the use of the Trilogy, Astral or other systems that provide ventilation assistance. All referrals with tracheostomies will be reviewed by the District Director of Clinical Services (DDCS) and placement will be offered for only those approved by the DDCS. 4. The facility Administrator is responsible for implementing this acceptable plan of correction. Date of Compliance: 3/12/18 Immediate jeopardy was removed on 03/13/18 at 2:20 PM when nursing staff interviews revealed	F 600		

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they had received education on the application of respiratory devices, use of respiratory equipment and suctioning of residents. The interviews also confirmed staff had received training regarding how to properly care for tracheostomies and to provide care according to physician's orders. The staff interviews also revealed that residents who required use of non-invasive mechanical ventilators had been discharged from the facility.

2. Resident #6 readmitted to the facility on 04/08/16 with diagnoses that included gastro esophageal reflux disease, history of ileus, and chronic obstructive pulmonary disease.

Review of the most recent comprehensive Minimum Data Set (MDS) dated 01/08/18 revealed that Resident #6 was cognitively impaired and required extensive assistance of 1 staff member with toileting. The MDS further revealed that Resident #6 was frequently incontinent of bowel. No behaviors or rejection of care was noted during the assessment reference period.

A continuous observation was made of Resident #6 on 03/08/18 from 10:09 AM to 10:31 AM. Resident #6 was observed to be resting in bed with a gown on that was pulled up exposing his lower abdomen and legs. There was fecal odor noted immediately upon entering Resident #6's room. There was a large pile of light brown colored soft non formed stool laying between Resident #6's legs that extended from the brief to mid-thigh region. There was also light brown colored soft non formed stool laying on Resident #6's abdomen just above the brief. To the left side of Resident #6's bed was a large pool of yellow liquid on the floor. Resident #6 indicated that he

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had defecated and urinated on himself and wanted a cup of coffee. Numerous staff members were noted to pass by Resident #6's room during the observation. During the continuous observation the facility's Social Worker (SW) knocked on Resident #6's door and entered the room and was observed to cover Resident #6's lower extremities with a blanket and exit the room. Nursing Assistant (NA) #2 was observed to enter Resident #6's room and turn around and exited the room. She returned a few minutes later with a bag of linen supplies, she entered Resident #6's room delivered the linen supplies and exited the room. Resident #6's roommate entered the room and noted the puddle of fluid on the floor and asked the housekeeper to mop it up.

An interview was conducted with NA #2 on 03/08/18 at 10:32 AM. NA #2 confirmed that she was caring for Resident #6 and was very familiar with him and his needs. NA #2 indicated she was going to start an incontinent round at the other end of the hall and work her way towards Resident #6 and would be providing care to him in approximately 20 to 30 minutes.

An observation of Resident #6 was made on 03/08/18 at 10:53 AM. Resident #6 was resting in bed with a blanket that covered his lower extremities. There was a strong fecal odor now detected out in the hall directly in front of Resident #6's room. Light brown colored soft non-formed stool was observed to be lying on his lower abdomen just above the brief and the pile of light brown colored non-formed stool continued to ooze down between his legs nearly reaching his knee that was exposed from under the blanket.

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F 600	Continued From page 16 An observation was made of NA #2 entering Resident #6's room on 03/08/18 at 11:19 AM to provide incontinent care. The fecal odor was now heavily prevalent in the hallway and in Resident #6's room. Upon entering Resident #6's room NA # 2 stated "he had a huge blow out." NA #2 was observed to provide incontinent care to Resident #6 and to remove the linen from his bed that was heavily soiled with light brown colored fecal matter. No skin breakdown was noted to Resident #6's buttock areas, they were slightly red but the skin was intact. Under the sheet the mattress had a large ring that was darker in color indicating the blue mattress was wet. Again Resident #6 indicated that he had defecated and urinated all over himself. NA #2 was observed to dress Resident #6 and place him in his wheelchair. A follow up interview was conducted with NA #2 on 03/08/18 at 11:21 AM. NA #2 explained that she was working the whole hall by herself and was running behind. She stated that generally Resident #6 was up and dressed when she arrived to work but today he was not. NA #2 stated that she had provided incontinent care to him at around 8:00 AM prior to his breakfast tray arriving and she was just now getting back to him. NA #2 stated that when she delivered linen supplies to his room earlier she had not noted the fecal odor and only when she arrived to provide care to Resident #6 did she detect the fecal odor. An interview was conducted with the Unit Manager (UM) on 03/09/18 at 10:23 AM. The UM stated she had been in her current role since December 2017. The UM explained that generally she had 4 to 5 NAs on her unit each day and yesterday was the same. She indicated that the	F 600		

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unit was fully staffed on 03/08/18 and that NA #2 did not have the entire hall by herself. The UM explained that the 2 nurses on the unit and herself made rounds sporadically throughout the day looking for things that needed to be done like incontinent care. She added that some residents were able to alert the staff that they were incontinent and needed to be clean up but some residents including Resident #6 were routinely checked and changed. The UM stated that it was unacceptable that Resident #6 laid in bed that soiled for that long and that care should have been provided much sooner.

An interview was conducted with the Charge Nurse (CN) on 03/12/18 at 12:38 PM. The CN stated that she was responsible for overseeing the NAs on the unit where Resident #6 resided. The CN stated that she rounded daily on the unit and looked for things like beds being made, call lights being answered, linens were clean, full trash cans, and making sure staff was offering fluids to the residents. The CN stated that on 03/08/18 to her knowledge the unit was fully staffed and NA #2 was not working the unit by herself. She added that it was unacceptable to her that NA #2 neglected to provide incontinent care and Resident #6 laid soiled for that long. She added she was not aware that the situation had occurred and would immediately address the issue with the staff including NA #2.

An interview was conducted with the SW on 03/12/18 at 12:55 PM. The SW recalled entering Resident #6's room on 03/08/18 and covering his legs with a blanket. The SW stated she did not see that he was soiled and did not smell the fecal odor. She stated if she would have seen it or smelled she would have immediately went and

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F 600	Continued From page 18 got the NAs to clean him up. She stated "I just noticed he was uncovered and I threw the blanket over his legs" and exited his room. An interview was conducted with the Director of Nursing (DON) on 03/13/18 at 10:52 AM. The DON stated that she expected NA #2 to provide care as soon as possible and to never leave any resident heavily soiled for as long as Resident #6 was left soiled. She indicated that was unacceptable for Resident #6 to lay soiled for over an hour.	F 600		
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the	F 608		

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F 608	Continued From page 19 suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to identify neglect and follow policy and procedure to notify the state agency and report to law enforcement the suspicion of a crime when a resident was not connected to a non-invasive mechanical ventilator or provide oxygen as ordered by the physician and was found deceased for 1 of 3 residents sampled for respiratory services (Resident #1). Findings included: A review of a facility document titled Abuse and Neglect Prohibition with a revised date of August 2017 indicated in part Facility supervisors will immediately investigate and correct reported or identified situations in which abuse or neglect is at risk of occurring. A section labeled Reporting and Response indicated in part the facility will report all allegations of abuse and neglect to the Administrator, State Survey Agency and law enforcement officials. Resident #1 was readmitted to the facility on 12/19/15 with diagnoses that included: respiratory failure, heart failure, hypertension, diabetes and chronic obstructive pulmonary disease. Resident #1 expired at the facility on 03/06/18. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/02/18 revealed	F 608		

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Resident #1 had mild cognitive impairment for daily decision making and required limited to extensive assistance from staff with activities of daily living. The MDS further revealed Resident #1 required oxygen and suctioning and had a tracheostomy but ventilator was not checked.

A review of a physician order dated 07/17/17 indicated non-invasive mechanical ventilator at bedtime.

A review of a Respiratory Therapy (RT) note dated 03/07/18 at 10:06 AM signed by RT #1 revealed Nurse #1 informed RT #1 that Resident #1 had passed away in the night. The note indicated RT #1 asked Nurse #1 what happened and Nurse #1 stated Nurse Aides (NAs) put Resident #1 to bed around 10:15 PM and they returned to Resident #1's room again at 10:55 PM and found Resident #1 deceased. The note further indicated RT #1 asked Nurse #1 if Resident #1 was placed on tracheostomy collar with oxygen bled in or was he placed on his nocturnal non-invasive mechanical ventilator as ordered. The note revealed Nurse #1 stated she had not gotten there yet due to her medication pass so she was unsure if he was on his tracheostomy collar or his non-invasive mechanical ventilator. The note further revealed RT #1 checked the non-invasive mechanical ventilator event log which indicated the non-invasive mechanical ventilator was powered on at 10:51 PM and stopped at 10:57 PM.

During an interview on 03/08/18 at 12:52 PM, RT #1 confirmed Resident #1 had chronic respiratory failure and was ventilator dependent at night. RT #1 explained he arrived to work on 03/07/18 at 5:20 AM and generally Resident #1 was up in his

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F 608	Continued From page 21 wheelchair waiting for the RT to get him a new tank of oxygen but on this day he was not. RT #1 stated he questioned Nurse #1 where Resident #1 was and Nurse #1 stated he was deceased. He explained Resident #1 was very stable and had not been sick, had no increased oxygen needs and was only suctioned maybe 1-2 times a day. RT #1 stated he questioned Nurse #1 what happened and she explained at approximately 10:15 PM on 03/06/18 Resident #1 requested to go to bed so the NAs put him to bed and they went back to check on him at 10:55 PM and he was deceased. RT #1 further stated he asked Nurse #1 if Resident #1 had been on his non-invasive mechanical ventilator or his tracheostomy collar and she stated he was not on the non-invasive mechanical ventilator because she was still passing medications and had not had time to hook him up yet. He explained he checked the non-invasive mechanical ventilator log inside the monitor on the ventilator and discovered that the ventilator had been turned on and off within just a few minutes. RT #1 stated there was no RT in the building that night and Nurse #1 should have stopped her medication pass and connected Resident #1 to his non-invasive mechanical ventilator as ordered. During an interview on 03/08/18 at 3:06 PM, Nurse #1 explained Resident #1 had been his usual self on 03/06/18 and had been up in a wheelchair and had his oxygen in place at 2-3 liters through a tracheostomy collar. She stated at approximately 10:55 PM on 03/06/18 NA #1 and NA #3 told her Resident #1 was in bed and his tongue was hanging out. Nurse #1 explained she ran to Resident #1's room and he was unresponsive and she directed the NAs to get the crash cart. Nurse #1 stated when she entered	F 608		

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Resident #1's room he did not have his oxygen on and could not recall if it was accessible to him and she hooked up his non-invasive mechanical ventilator and turned it on and then left the room to check to see if Resident #1 had a Do Not Resuscitate (DNR) order. She explained when she was sure he had a DNR order in place she returned to Resident #1's room and turned the ventilator off. She further explained she had not had time to place him on his non-invasive mechanical ventilator because she was passing medications. Nurse #1 stated she had not had time to provide tracheostomy care and that was generally when she would have put him on the non-invasive mechanical ventilator. She further stated Resident #1 had alarms on his ventilator but because she had not hooked him up yet they were not on. Nurse #1 stated she and Nurse #2 pronounced Resident #1 deceased at 11:00 PM.

During an interview on 03/09/18 at 12:07 PM, the Director of Nursing (DON) stated Nurse #1 had contacted her on the evening of 03/06/18 and reported Resident #1 had passed away and she gave Nurse #1 directions as to what she needed to do. The DON stated that Nurse #1 did not communicate with her at that time all the facts in regards to Resident #1's death.

During an interview on 03/10/18 at 2:02 PM, the new Administrator confirmed there were no reports submitted to the State Agency since the last recertification survey in August 2017.

During a follow up interview on 03/13/18 at 10:52 AM, the Director of Nursing explained she did not start an investigation or file reports to the state agency or notify law enforcement because Nurse #1 had told her Resident #1 had just passed

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F 608	Continued From page 23 away. She stated she was not made aware of what had happened until the surveyors asked questions regarding the RT note on 03/06/18 at 10:06 AM. She explained after she realized what had happened she filed the 24 hour report with the State Agency and notified law enforcement on 03/10/18. She stated it had been a reality check to everyone and Nurses sometimes forgot about the severity of things. She stated they were are going to have be more aggressive with investigation when incidents involved a death of a resident and they would file the reports and stay on top of it. During a follow up interview on 03/13/18 at 11:03 AM, the new Administrator stated it was her usual practice to file reports to the stage agency according to policy and within the required time periods and she would notify law enforcement anytime there was reasonable suspicion of a crime.	F 608		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and former Medical Director and Pulmonologist interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect the use of a ventilator for 4 of 4 sampled residents who received respiratory services and required non-invasive mechanical ventilators at night to assist with breathing (Resident #1, #9, #10 and #11).	F 641		

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Findings included:

1. Resident #1 was readmitted to the facility on 12/19/15 with diagnoses which included respiratory failure, heart failure, hypertension, diabetes and chronic obstructive pulmonary disease.

A review of the most recent quarterly Minimum Data Set (MDS) dated 01/02/18 revealed Resident #1 had mild cognitive impairment for daily decision making and required limited to extensive assistance from staff with activities of daily living. The MDS further revealed Resident #1 required oxygen and suctioning and had a tracheostomy during the assessment reference period but ventilator was not checked on the MDS.

A review of a physician's orders dated 07/17/17 indicated non-invasive mechanical ventilator at bedtime.

During an interview on 03/08/18 at 12:52 PM, Respiratory Therapist (RT) #1 stated Resident #1 had chronic respiratory failure and was ventilator dependent at night.

During an interview on 03/08/18 at 4:41 PM, the former Medical Director (FMD) stated she had been Resident #1's physician until approximately 02/28/18 and Resident #1 had a tracheostomy which required the use of oxygen. She explained at night Resident #1 also required the extra support of the non-invasive mechanical ventilator which to her knowledge was a traditional ventilator.

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During an interview on 03/09/18 at 2:51 PM, the Pulmonologist stated Resident #1 was very stable and independent but had chronic respiratory failure with a permanent tracheostomy and he was dependent on a nocturnal (at night) non-invasive mechanical ventilator. The pulmonologist explained Resident #1 required the non-invasive mechanical ventilator as back up ventilation at night and anyone who required the non-invasive mechanical ventilator was ventilator dependent.

During an interview on 03/09/18 at 6:06 PM the former Administrator stated they did not use ventilators in the facility.

During an interview on 03/12/18 at 11:23 AM, the MDS Coordinator explained she had been coming to the facility a couple of days a week to assist a Resident Care Management Director (RCMD) with MDS but he had recently left the facility. She further explained she was hired full time approximately 3 weeks ago and at the present time she was the only MDS staff member at the facility. She stated she did not code ventilators on residents MDS at the facility because she had been told by the RCMD they did not use ventilators at the facility. She explained she had questioned the RCMD about the machines and was told the facility did not use ventilators according to respiratory therapy. She stated she then talked with RT #1 about the machines but was told at that time the non-invasive mechanical ventilators were used as continuous positive airway pressure (C-pap) or the Bi-level positive airway pressure (Bi-pap) machines. She stated based on what she was told by RT #1 she coded the non-invasive mechanical ventilators as C-pap/Bipap on the

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resident's MDS and verified ventilator was not coded on the MDS for Resident #1. She stated it was her expectation for the MDS to be complete and accurate.

During an interview on 03/13/18 at 10:52 AM, the current Administrator explained she had been called by corporate staff to come to the facility on 03/09/18. She stated she was just learning about the non-invasive mechanical ventilators the facility had used but it was her expectation for the resident's MDS to be coded accurately. She further stated after review of RT notes which indicated ventilator settings the resident's MDS should be coded for ventilator.

2. Resident #9 was readmitted to the facility on 12/05/17 with diagnoses which included acute and chronic respiratory failure with hypercapnia (excessive carbon dioxide in the bloodstream).

A review of a physician order dated 12/05/17 indicated to place on non-invasive mechanical ventilator at night or if in respiratory distress.

A review of the most recent quarterly Minimum Data Set (MDS) dated 12/21/17 revealed Resident #9 had mild cognitive impairment for daily decision making and required extensive assistance of 2 staff members with activities of daily living. The MDS indicated Resident #9 required oxygen, suctioning, and had a tracheostomy during the assessment reference period but ventilator was not checked on the MDS.

During an interview on 03/08/18 at 12:52 PM, Respiratory Therapist (RT) #1 stated Resident #9 had chronic respiratory failure and was ventilator

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dependent at night.

During an interview on 03/09/18 at 2:51 PM, the Pulmonologist stated Resident #9 had a tracheostomy and could not be weaned from it and she required the non-invasive mechanical ventilator at night and described the device as a "superior form of ventilation." He explained any resident who required the non-invasive mechanical ventilator was ventilator dependent and the settings that Resident #9 required were not available on the traditional continuous positive airway pressure (Cpap) or the Bi-level positive airway pressure (Bi-pap) machines.

During an interview on 03/09/18 at 6:06 PM the former Administrator stated they did not use ventilators in the facility.

During an interview on 03/12/18 at 11:23 AM, the MDS Coordinator explained she had been coming to the facility a couple of days a week to assist a Resident Care Management Director (RCMD) with MDS but he had recently left the facility. She further explained she was hired full time approximately 3 weeks ago and at the present time she was the only MDS staff member at the facility. She stated she did not code ventilators on residents MDS at the facility because she had been told by the RCMD they did not use ventilators at the facility. She explained she had questioned the RCMD about the machines and was told the facility did not use ventilators according to respiratory therapy. She stated she then talked with RT #1 about the machines but was told at that time the non-invasive mechanical ventilators were used as continuous positive airway pressure (C-pap) or the Bi-level positive airway pressure (Bi-pap)

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F 641	Continued From page 28 machines. She stated based on what she was told by RT #1 she coded the non-invasive mechanical ventilators as C-pap/Bipap on the resident's MDS and verified ventilator was not coded on the MDS for Resident #9. She stated it was her expectation for the MDS to be complete and accurate. During an interview on 03/13/18 at 10:52 AM, the current Administrator stated she had been called by corporate staff to come to the facility on 03/09/18. She stated she was just learning about the non-invasive mechanical ventilators the facility had used but it was her expectation for the resident's MDS to be coded accurately. She further stated after review of RT notes which indicated ventilator settings the resident's MDS should be coded for ventilator. 3. Resident #10 was admitted to the facility on 02/23/18 with diagnoses which included Parkinson's disease, chronic respiratory failure, tracheostomy and dependence on a ventilator. A review of the admission Minimum Data Set (MDS) dated 03/02/18 indicated Resident #10 was cognitively intact for daily decision making. The MDS further indicated Resident #10 required extensive assistance with bed mobility, transfers, toileting and hygiene. The MDS also indicated Resident #10 required oxygen, suctioning, and had a tracheostomy during the assessment reference period but ventilator was not checked on the MDS. A review of a physician's history and physical dated 02/26/18 indicated Resident #10 remained ventilator dependent and would be followed closely by pulmonology and respiratory therapy in	F 641		

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regard to his chronic respiratory failure and need for mechanical ventilation at night.

A review of a physician's order dated 02/26/18 indicated to place on non-invasive mechanical ventilator at night and as needed for respiratory distress.

During an interview on 03/08/18 at 12:52 PM, Respiratory Therapist (RT) #1 stated Resident #10 had chronic respiratory failure and was ventilator dependent at night.

During an interview on 03/09/18 at 2:52 PM, the Pulmonologist explained Resident #10 had Parkinson's disease and had determined Resident #10 might not be a good candidate for decannulation (removal of his tracheostomy). He stated Resident #10 required the non-invasive mechanical ventilator at night and described the device as a "superior form of ventilation." He added that any resident who required the non-invasive mechanical ventilator was ventilator dependent and the settings that Resident #10 required were not available on the traditional continuous positive airway pressure (C-pap) or the Bi-level positive airway pressure (Bi-pap) machines.

During an interview on 03/09/18 at 6:06 PM the former Administrator stated they did not use ventilators in the facility.

During an interview on 03/12/18 at 11:23 AM, the MDS Coordinator explained she had been coming to the facility a couple of days a week to assist a Resident Care Management Director (RCMD) with MDS but he had recently left the facility. She further explained she was hired full

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time approximately 3 weeks ago and at the present time she was the only MDS staff member at the facility. She stated she did not code ventilators on residents MDS at the facility because she had been told by the RCMD they did not use ventilators at the facility. She explained she had questioned the RCMD about the machines and was told the facility did not use ventilators according to respiratory therapy. She stated she then talked with RT #1 about the machines but was told at that time the non-invasive mechanical ventilators were used as continuous positive airway pressure (C-pap) or the Bi-level positive airway pressure (Bi-pap) machines. She stated based on what she was told by RT #1 she coded the non-invasive mechanical ventilators as C-pap/Bipap on the resident's MDS and verified ventilator was not coded on the MDS for Resident #10. She stated it was her expectation for the MDS to be complete and accurate.

During an interview on 03/13/18 at 10:52 AM, the current Administrator stated she had been called by corporate staff to come to the facility on 03/09/18. She stated she was just learning about the non-invasive mechanical ventilators the facility had used but it was her expectation for the resident's MDS to be coded accurately. She further stated after review of RT notes which indicated ventilator settings the resident's MDS should be coded for ventilator.

4. Resident #11 was admitted to the facility on 02/09/18 with diagnoses which included acute respiratory failure, chronic obstructive lung disease and tracheostomy.

A review of the admission MDS dated 02/16/18

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indicated Resident #11 was cognitively intact for daily decision making. The MDS also indicated Resident #11 required minimal assistance with transfers but extensive assistance with bed mobility, dressing, toileting and hygiene. The MDS also indicated Resident #11 required oxygen, suctioning, and had a tracheostomy during the assessment reference period but ventilator was not checked on the MDS.

A review of a Pulmonologist progress note dated 02/16/18 indicated Resident #11 needed the non-invasive mechanical ventilator to live.

A review of a physician's order dated 03/01/18 indicated to place on non-invasive mechanical ventilator at night and as needed for respiratory distress.

During an interview on 03/08/18 at 12:52 PM, Respiratory Therapist (RT) #1 stated Resident #11 had chronic respiratory failure and was ventilator dependent at night.

During an interview on 03/09/18 at 2:52 PM, the Pulmonologist explained Resident #11 kept going back and forth to the hospital because of changes in his condition and he required non-invasive mechanical ventilation at night. He described the non-invasive mechanical ventilators as a "superior form of ventilation." He explained any resident who required the non-invasive mechanical ventilator was ventilator dependent and the settings that Resident #11 required were not available on the traditional continuous positive airway pressure (C-pap) or the Bi-level positive airway pressure (Bi-pap) machines.

During an interview on 03/09/18 at 6:06 PM the

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F 641	Continued From page 32 former Administrator stated they did not use ventilators in the facility. During an interview on 03/12/18 at 11:23 AM, the MDS Coordinator explained she had been coming to the facility a couple of days a week to assist a Resident Care Management Director (RCMD) with MDS but he had recently left the facility. She further explained she was hired full time approximately 3 weeks ago and at the present time she was the only MDS staff member at the facility. She stated she did not code ventilators on residents MDS at the facility because she had been told by the RCMD they did not use ventilators at the facility. She explained she had questioned the RCMD about the machines and was told the facility did not use ventilators according to respiratory therapy. She stated she then talked with RT #1 about the machines but was told at that time the non-invasive mechanical ventilators were used as continuous positive airway pressure (C-pap) or the Bi-level positive airway pressure (Bi-pap) machines. She stated based on what she was told by RT #1 she coded the non-invasive mechanical ventilators as C-pap/Bipap on the resident's MDS and verified ventilator was not coded on the MDS for Resident #11. She stated it was her expectation for the MDS to be complete and accurate. During an interview on 03/13/18 at 10:52 AM, the current Administrator stated she had been called by corporate staff to come to the facility on 03/09/18. She stated she was just learning about the non-invasive mechanical ventilators the facility had used but it was her expectation for the resident's MDS to be coded accurately. She further stated after review of RT notes which	F 641		

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F 641	Continued From page 33 indicated ventilator settings the resident's MDS should be coded for ventilator.	F 641		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		

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community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff, former Medical Director and current Medical Director interviews the facility failed to implement care plan interventions by not applying oxygen and a non-invasive mechanical ventilator as stated in the care plan for 1 of 3 residents sampled for respiratory services (Resident #1). When Resident #1 was found by staff without the devices he was deceased.

Immediate Jeopardy began on 03/06/18 when Resident #1 was placed in bed and Nurse #1 did not stop passing night time medications and connect Resident #1 to his oxygen and his non-invasive mechanical ventilator. Approximately 45 minutes later the staff discovered Resident #1 was not breathing and alerted Nurse #1. Nurse #1 realized that she had not connected Resident #1 to his non-invasive mechanical ventilator and entered his room and turned the device on and exited Resident #1's room to find out his code status. After confirming that Resident #1 had Do Not Resuscitate (DNR) order she re-entered Resident #1's room and turned off the non-invasive mechanical ventilator and pronounced Resident #1 dead. Immediate jeopardy was removed on 03/13/18 at 2:20 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower

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F 656	Continued From page 35 scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete educate and ensure monitoring systems put into place for implementing care plan interventions are effective. The findings included: Resident #1 readmitted to the facility on 12/19/15 with diagnoses that included: respiratory failure, heart failure, hypertension, diabetes mellitus, and chronic obstructive pulmonary disease. Review of a care plan initiated 01/05/16 and revised on 01/07/18 read in part, Resident #1 had a tracheostomy related to a respiratory illness. The goal of the stated care plan was Resident #1 would have clear and equal breath sounds bilaterally through the review date and Resident #1 would have no signs or symptoms of infection by the review date. Additional goals of the care plan read, Resident #1 would have no abnormal drainage around his tracheostomy site and Resident #1 would have a temperature within normal limits through the review period. The interventions included: ensure tracheostomy ties were secured at all times (initiated 01/05/16), observe and document restlessness, agitation, confusion, and increased heart rate (initiated 01/05/16), observe and document respiratory rate, depth, and quality every shift as ordered (initiated 01/05/16), oxygen via tracheostomy collar (initiated 01/05/16), report any changes in respiratory status to the nurse (initiated 07/17/17), Resident #1 was to be placed on the non-invasive mechanical ventilator (initiated on 03/24/16 revised on 06/23/17) at night as ordered, suction as needed (initiated on 01/05/16). No changes	F 656		

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were made to the care plan with the revision on 01/07/18.

Review of a physician order dated 05/13/16 read, Respiratory Therapist (RT) to titrate oxygen to keep saturation pulse oximeter greater than 91%.

Review of a physician order dated 07/17/17 read, non-invasive mechanical ventilator at bedtime.

Review of the most recent quarterly Minimum Data Set (MDS) dated 01/02/18 revealed that Resident #1 was mildly cognitively impaired and required limited to extensive assistance from staff with activities of daily living. The MDS further revealed no behaviors or rejection of care were noted. Resident #1 also required oxygen and suctioning and had a tracheostomy during the assessment reference period. Ventilator use was not indicated on the MDS.

Review of a Situation, Background, Assessment, and Recommendation (SBAR) dated 03/09/18 indicated that on 03/06/18 at 10:55 AM Resident #1 was found without signs of life. Resident #1 was assessed for vital signs and none were present. Advance directives were reviewed and Resident #1 was noted to be a Do Not Resuscitate (DNR). The Director of Nursing (DON) and family were notified of Resident #1's death.

An interview was conducted with Nursing Assistant (NA) #1 on 03/09/18 at 3:43 PM. NA #1 stated she routinely cared for and was familiar with Resident #1. She also confirmed that she was caring for him on 03/06/18 on 2nd shift. NA #1 stated it was a routine night on the unit for Resident #1 and at 9:50 PM NA #3 assisted her

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F 656	Continued From page 37 with placing Resident #1 in the bed. After Resident #1 was placed in the bed and care was provided Resident #1 was handed his call bell, urinal, and oxygen tubing. She stated that Resident #1 was able to put his own oxygen on and she handed him the tubing but was not sure if he placed it on himself or not. NA #1 stated they then left the room and returned 35-45 minutes later when the call light was on and they entered room and noticed Resident #1 was not breathing. NA #1 stated she could not recall if he had on his oxygen or not she was so upset that he was not breathing. NA #3 summoned Nurse #1 to the room and confirmed that he was not breathing and was a DNR. NA #1 stated she left the room because she was so upset. An interview was conducted with NA #3 on 03/08/18 at 3:27 PM. NA #3 confirmed that she routinely cared for and was familiar with Resident #1 and was caring for him on 03/06/18 on 2nd shift. NA #3 stated that at approximately 9:50 PM to 10:00 PM with assistance from NA #1 they place Resident #1 in the bed. NA #3 stated that she had removed his oxygen to put him to bed but could not recall if she had replaced it or not. Approximately 30-45 minutes later NA #3 stated that Resident #1's call light was on and she and NA #1 entered his room to see what he needed. She stated that they noticed that Resident #1's chest was not rising or falling and they ran to get Nurse #1. Nurse #1 came into the room and checked his vital signs. She stated she could not recall if Resident #1 had his oxygen on or not. NA #3 stated she was not sure if Resident #1 had been hooked up to his ventilator because Nurse #1 was responsible for that. An interview was conducted with Nurse #1 on	F 656		

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03/08/18 at 3:06 PM. Nurse #1 confirmed that she was working with Resident #1 on 03/06/18 on 2nd shift. Nurse #1 stated that Resident #1 had been his usual self on 03/06/18, he had been up in the wheelchair and had his oxygen in place at 2-3 liters via tracheostomy collar. She stated that at approximately 10:55 PM on 03/06/18 NA #1 and NA #3 stated "Resident #1 is in bed and his tongue is hanging out." Nurse #1 stated she ran to Resident #1's room and he was unresponsive. Nurse #1 directed the NAs to get the crash cart and she went to make sure he had a DNR order in place. She stated that before she left the room to check if Resident #1 had a DNR order she hooked his oxygen to the ventilator and turned it on and when she returned to the room and was sure he had a DNR order she turned the ventilator off. Nurse #1 stated that when she entered Resident #1's room he did not have his oxygen on and she had not had time to place him on his non-invasive mechanical ventilator because she was passing medications. Nurse #1 stated that she pronounced Resident #1 dead at 11:00 PM.

An interview was conducted with the former Medical Director (FMD) on 03/08/18 at 4:41 PM. The FMD stated that she cared for Resident #1 until approximately 02/28/18 and was very familiar with him. The FMD stated that she had never seen Resident #1 without his oxygen and she honestly did not have to see him very often because he was a stable as he could be with a tracheostomy and being ventilator dependent. The FMD stated that if Resident #1 did not have his oxygen or his ventilator on that certainly could have contributed to his death along with his heart disease, lung disease, and hypertension. The FMD stated that she would expect that Resident

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#1 would have his oxygen in place and would be hooked to his non-invasive mechanical ventilator as ordered and as directed by the plan of care.

An interview was conducted with the current Medical Director (CMD) on 03/12/18 at 11:41 AM. The CMD stated that this was only his 3rd time in the facility and he had met and visited with Resident #1 while he was sitting in up in his wheelchair before his passing. The CMD stated that he expected the staff to follow the plan of care and place Resident #1 on his oxygen and on his non-invasive mechanical ventilator as directed by the plan of care.

An interview was conducted with the DON on 03/09/18 at 12:07 PM. The DON stated that Resident #1 required the use of non-invasive life support and that it was usually on when Resident #1 went to bed to assist him with breathing. The DON stated that she expected Nurse #1 to apply Resident #1's oxygen and non-invasive mechanical ventilator as ordered and as directed by the plan of care. She further stated that Resident #1 was able to apply his own oxygen tubing and has known Resident #1 to go long periods of time without his oxygen and it never bothered him before. The DON stated that when Resident #1 was in the bed he usually had his oxygen and non-invasive mechanical ventilator on so maybe the position of lying down had something to do with it.

Credible Allegation of Compliance

F656 Care planning

1. The Resident identified to be affected by the alleged deficient practice.

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At 9:30pm on 3/6/18 Nurse #1 administered medication to resident #1. Resident #1 experienced no distress or change in his baseline condition. Resident #1 swallowed his medication and drink without problems. At 9:50pm Nurse Aide #1 and Nurse Aide #3 assisted resident #1 in preparing for bed. Nurse Aide #1 and Nurse Aide #3 transferred resident #1 via sit to stand lift from the chair to the bed. NA #1 placed resident #1's call light and urinal within reach. NA#1 and NA #3 exited room. At 10:45pm NA#1 exited another resident's room and noted resident #1's call light was on. NA #1 noted that resident #1 had his right leg off of the bed and the call bell in his hand. NA #1 went around the bed to address the call light. Resident #1's tongue was protruding from his mouth. NA #1 stated resident's color was gray. NA #1 went to the door of resident #1's room and yelled for help. NA #3 ran to the nurses' station to get help. At 10:47pm Nurse #1 and Nurse #2 responded to resident #1's room. Nurse #1 placed resident #1 on the respiratory assistive device. Resident #1 noted to be unresponsive. Nurse #2 exited resident #1's room to obtain the crash cart. At 10:55pm Nurse #1 checked resident 's advanced directives and noted resident #1 was a DNR. At 11:00pm Nurse #1 and Nurse #2 assessed resident #1's vital signs and Vital signs were absent. At 11:03pm the Director of Nursing was notified of resident #1's death.

A 24 hour report was sent to the NC Health Care Registry, NCDHHS by the Administrator on 3/10/18 reporting this event. The police were notified by the Administrator on 3/10/18. The NC Board of Nursing was notified via email on 3/10/18 by the Director of Nursing.

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· A Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 3/9/18 and it was determined that the Nurse #1 did not apply oxygen via trach collar and Astral ventilation was not initiated for Resident #1 immediately after the NA # 1 assisted Resident to bed. There was no Respiratory Therapist (RT) on duty to assist Nurse #1 with completion of respiratory related tasks which led to Nurse #1 failing to follow the physician orders to apply the Astral ventilation system. The IDT determined this event was the result of a lack of RT staffing on 2nd shift.

Further Root Cause Analysis was conducted regarding the admission of residents with tracheostomies requiring ventilation assistance. Education was conducted with the Administrator, Director of Nursing, Respiratory therapist and facility Sales Representative by the Division Team regarding admission requirements for residents with tracheostomies on 6/16/17. This education required that no residents with tracheostomies requiring ventilation would be admitted to the facility thereafter. Since 6/16/17, 4 residents exceeding this criteria, have been admitted in error and 1 resident received physician's order to add ventilation assistance due to a decline in status while remaining in the facility

2. Residents with the potential to be affected by the alleged deficient practice.

· Residents with tracheostomies requiring ventilation assistance have the potential to be affected by the alleged deficient practice.
· On 3/9/18 an audit was completed by the Director of Nursing and Nurse Managers, of residents with tracheostomies requiring

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ventilation assistance to ensure care plans were updated to reflect interventions including tracheostomy care, oxygen administration and donning and doffing the Astral/Trilogy device.

· On 3/9/18 Residents #8, #9, #10 and #11 were identified with tracheostomies utilizing respiratory equipment that requiring ventilation assistance was transferred to hospital setting.

3. Systemic Measures

· On 3/9/18 the Director of Nursing and Nurse Managers re-educated licensed nurses regarding following the care plan of residents with tracheostomies requiring ventilation assistance to ensure care planned interventions including oxygen administration and donning and doffing devices providing ventilation assistance are in place.

· On 3/10/18 the District Director of Clinical Services provided education to the Interdisciplinary Team (IDT) regarding the facility's admission capabilities with a focus on resident requiring respiratory assistance. This education includes the following:
-Specific types of respiratory referrals and levels of respiratory support required
-Admission criteria regarding referrals with tracheostomies, which includes the District Director of Clinical Services approval prior to offering placement.
-No ventilation assistance will be provided via Astral/Trilogy or other devices
· On 3/9/18 Respiratory Therapist/Nurse Managers re-educated licensed nurses using the facility's policy for Respiratory/Tracheostomy Care to include suctioning, applying t-collar, and completing a respiratory assessment.

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· On 3/9/18 the Nurse Managers re-educated the Nurse Aides on reporting observations of residents with tracheostomies requiring oxygen administration to include notification of the nurse when oxygen is not applied as required.
· No licensed nurses or nurse aides will work before receiving education after 3/9/18.
· New hires (licensed nurses and nurse aides) will be educated by the Nurse Manager on the facility's policy for Respiratory/Tracheostomy Care during the orientation process.
· All licensed nurses and nurse aides will be educated annually, by the Nurse Manager, for continued proficiency in respiratory/tracheostomy care utilizing the facility's policy for Respiratory/Tracheostomy Care.
· The Director of Nursing or Nurse Managers will review new admissions daily during the clinical meeting to validate physician ordered respiratory equipment is available and applied according to the physician's orders.
· The Director of Nursing or Nurse Managers will audit 10 residents requiring respiratory equipment weekly for 12 weeks to ensure care planned interventions related to respiratory equipment are in place
· The Director of Nursing will report the results of these audits during the weekly QAPI meeting and the committee will make recommendations as needed.
· The facility will no longer admit residents with tracheostomies that require the use of the Trilogy, Astral or other systems that provide ventilation assistance. All referrals with tracheostomies will be reviewed by the District Director of Clinical Services (DDCS) and placement will be offered for only those approved by the DDCS.

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F 656	Continued From page 44 4. The Administrator is responsible for implementing this acceptable plan of correction. Immediate jeopardy was removed on 03/13/18 at 2:20 PM when nursing staff interviews revealed that they had received education on the implementation of care plan interventions specially related to respiratory devices.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to perform incontinent care for a dependent resident for 1 of 3 residents sampled for activities of daily living (Resident #6). The findings included: Resident #6 readmitted to the facility on 04/08/16 with diagnoses that included gastro esophageal reflux disease, history of ileus, and chronic obstructive pulmonary disease. Review of the most recent comprehensive Minimum Data Set (MDS) dated 01/08/18 revealed that Resident #6 was cognitively impaired and required extensive assistance of 1 staff member with toileting. The MDS further revealed that Resident #6 was frequently incontinent of bowel. No behaviors or rejection of	F 677		

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care was noted during the assessment reference period.

A continuous observation was made of Resident #6 on 03/08/18 from 10:09 AM to 10:31 AM. Resident #6 was observed to be resting in bed with a gown on that was pulled up exposing his lower abdomen and legs. There was fecal odor noted immediately upon entering Resident #6's room. There was a large pile of light brown colored soft non formed stool laying between Resident #6's legs that extended from the brief to mid-thigh region. There was also light brown colored soft non formed stool laying on Resident #6's abdomen just above the brief. To the left side of Resident #6's bed was a large pool of yellow liquid on the floor. Resident #6 indicated that he had defecated and urinated on himself and wanted a cup of coffee. Numerous staff members were noted to pass by Resident #6's room during the observation. During the continuous observation the facility's Social Worker (SW) knocked on Resident #6's door and entered the room and was observed to cover Resident #6's lower extremities with a blanket and exit the room. Nursing Assistant (NA) #2 was observed to enter Resident #6's room and turn around and exit the room. She returned a few minutes later with a bag of linen supplies, she entered Resident #6's room delivered the linen supplies and exited the room. Resident #6's roommate entered the room and noted the puddle of fluid on the floor and asked the housekeeper to mop it up.

An interview was conducted with NA #2 on 03/08/18 at 10:32 AM. NA #2 confirmed that she was caring for Resident #6 and was very familiar with him and his needs. NA #2 indicated she was going to start an incontinent round at the other

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F 677	Continued From page 46 end of the hall and work her way towards Resident #6 and would be providing care to him in approximately 20 to 30 minutes. An observation of Resident #6 was made on 03/08/18 at 10:53 AM. Resident #6 was resting in bed with a blanket that covered his lower extremities. There was a strong fecal odor now detected out in the hall directly in front of Resident #6's room. Light brown colored soft non-formed stool was observed to be lying on his lower abdomen just above the brief and the pile of light brown colored non-formed stool continued to ooze down between his legs nearly reaching his knee that was exposed from under the blanket. An observation was made of NA #2 entering Resident #6's room on 03/08/18 at 11:19 AM to provide incontinent care. The fecal odor was now heavily prevalent in the hallway and in Resident #6's room. Upon entering Resident #6's room NA # 2 stated "he had a huge blow out." NA #2 was observed to provide incontinent care to Resident #6 and to remove the linen from his bed that was heavily soiled with light brown colored fecal matter. No skin breakdown was noted to Resident #6's buttock areas, they were slightly red but the skin was intact. Under the sheet the mattress had a large ring that was darker in color indicating the blue mattress was wet. Again Resident #6 indicated that he had defecated and urinated all over himself. NA #2 was observed to dress Resident #6 and place him in his wheelchair. A follow up interview was conducted with NA #2 on 03/08/18 at 11:21 AM. NA #2 explained that she was working the whole hall by herself and	F 677		

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was running behind. She stated that generally Resident #6 was up and dressed when she arrived to work but today he was not. NA #2 stated that she had provided incontinent care to him at around 8:00 AM prior to his breakfast tray arriving and she was just now getting back to him. NA #2 stated that when she delivered linen supplies to his room earlier she had not noted the fecal odor and only when she arrived to provide care to Resident #6 did she detect the fecal odor.

An interview was conducted with the Unit Manager (UM) on 03/09/18 at 10:23 AM. The UM stated she had been in her current role since December 2017. The UM explained that generally she had 4 to 5 NAs on her unit each day and yesterday was the same. She indicated that the unit was fully staffed on 03/08/18 and that NA #2 did not have the entire hall by herself. The UM explained that the 2 nurses on the unit and herself made rounds sporadically throughout the day looking for things that needed to be done like incontinent care. She added that some residents were able to alert the staff that they were incontinent and needed to be clean up but some residents including Resident #6 were routinely checked and changed. The UM stated that it was unacceptable that Resident #6 laid in bed that soiled for that long and that care should have been provided much sooner.

An interview was conducted with the SW on 03/12/18 at 12:55 PM. The SW recalled entering Resident #6's room on 03/08/18 and covering his legs with a blanket. The SW stated she did not see that he was soiled and did not smell the fecal odor. She stated if she would have seen it or smelled she would have immediately went and got the NAs to clean him up. She stated "I just

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noticed he was uncovered and I threw the blanket over his legs" and exited his room.

An interview was conducted with the Director of Nursing (DON) on 03/13/18 at 10:52 AM. The DON stated that she expected NA #2 to provide care as soon as possible and to never leave any resident heavily soiled for as long as Resident #6 was left soiled. She indicated that was unacceptable for Resident #6 to lay soiled for over an hour.

F 695 SS=J — Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) — F 695

§ 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 record review, staff, respiratory therapist, former Medical Director, current Medical Director, and Pulmonologist interviews, the facility failed to apply oxygen and a non-invasive mechanical ventilator as ordered by the physician for 1 of 3 residents sampled for respiratory services (Resident #1). When Resident #1 was found by staff without the physician ordered devices he was deceased.

Immediate Jeopardy began on 03/06/18 when Resident #1 was placed in bed by Nursing Assistant (NA) #1 and #3 and told Nurse # 1 that

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F 695	Continued From page 49 he was ready to be connected to his non-invasive mechanical ventilator. Resident #1's oxygen was removed by NA #3 before transferring Resident #1 to the bed and was not replaced prior to NA #1 and NA #3 exiting Resident #1's room. Nurse #1 was passing her night time medications and did not stop passing her medications to connect Resident #1 to his non-invasive mechanical ventilator. Approximately 45 minutes later the staff discovered Resident #1 was not breathing and alerted Nurse #1. Nurse #1 realized that she had not connected Resident #1 to his non-invasive mechanical ventilator and entered his room and turned the device on. She exited Resident #1's room to find out his code status. After confirming that Resident #1 had a Do Not Resuscitate (DNR) order she re-entered Resident #1's room and turned off the non-invasive mechanical ventilator and pronounced Resident #1 dead. Immediate jeopardy was removed on 03/13/18 at 2:20 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff education and ensure monitoring systems put into place are effective for applying respiratory devices as ordered. The findings included: Review of the manufacturer's instructions for the Astral (non-invasive mechanical ventilation) device read in part, "The Astral device provides mechanical ventilation to both ventilation dependent and non-dependent patients. The indications for use read in part, the Astral devices provides continuous or intermittent ventilator	F 695		

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support for patients weighing more the 11 pounds who require mechanical ventilation. The Astral device is intended to be used in home, institution/hospital and portable applications for both invasive and non-invasive ventilation."

Resident #1 was readmitted to the facility on 12/19/15 with diagnoses that included: respiratory failure, heart failure, hypertension, diabetes mellitus, and chronic obstructive pulmonary disease. Resident #1 expired at the facility on 03/06/18.

Review of a care plan initiated 01/05/16 and revised on 01/07/18 read in part, Resident #1 had a tracheostomy (Trach) related to a respiratory illness. The goals of the stated care plan were Resident #1 would have clear and equal breath sounds bilaterally through the review date. Resident #1 would have no signs or symptoms of infection by the review date. The interventions included: oxygen via trach collar (initiated 01/05/16), Resident #1 was to be placed on a non-invasive mechanical ventilator (initiated on 03/24/16) at night as ordered, suction as needed (initiated on 01/05/16).

Review of the most recent quarterly Minimum Data Set (MDS) dated 01/02/18 revealed that Resident #1 was mildly cognitively impaired for daily decision making and required limited to extensive assistance from staff with activities of daily living. The MDS further revealed no behaviors or rejection of care were noted. Resident #1 also required oxygen and suctioning and had a tracheostomy during the assessment reference period. Ventilator use was not indicated on the MDS.

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Review of a physician order sheet dated 03/01/18 read, Respiratory Therapist (RT) to titrate oxygen to keep saturation pulse oximeter greater than 91%.

Review of a physician order sheet dated 03/01/18 read, non-invasive mechanical ventilator at bedtime.

Review of Treatment Administration Record (TAR) dated 03/01/18 through 03/31/18 revealed, RT/Nursing to place on non-invasive mechanical ventilator at bedtime. The time for application was 9:00 PM. There was no time indicated that Resident #1 was to be removed from the non-invasive mechanical ventilator.

Review of a RT note dated 03/07/18 at 10:06 AM read, Nurse #1 informed RT #1 that Resident #1 had passed away in the night. When asked what happened Nurse #1 stated that the Nursing Assistants (NAs) put Resident #1 to bed around 10:15 PM and they returned to Resident #1's room again at 10:55 PM and found Resident #1 deceased. RT #1 asked Nurse #1 if Resident #1 was placed on tracheostomy collar with oxygen bled in or was he placed on his nocturnal non-invasive mechanical ventilator as ordered. Nurse #1 stated she had not gotten there yet due to her medication pass so she was unsure if he was on his tracheostomy collar or his non-invasive mechanical ventilator at the time of event. RT #1 checked the non-invasive mechanical ventilator event log and it stated that it was powered on at 10:51 PM and stopped at 10:57 PM. There was no as needed (PRN) RT on shift at the time of the event. This note was signed by RT #1.

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An interview was conducted with NA #1 on 03/09/18 at 3:43 PM. NA #1 stated she routinely cared for and was familiar with Resident #1. She also confirmed that she was caring for him on 03/06/18 on 2nd shift. NA #1 stated it was a routine night on the unit for Resident #1 and at 9:50 PM NA #3 assisted her with placing Resident #1 in the bed. After Resident #1 was placed in the bed and care was provided, Resident #1 was handed his call bell, urinal, and oxygen tubing. She stated that Resident #1 was able to put his own oxygen on and she handed him the tubing but was not sure if he placed it on himself or not. NA #1 stated they then left the room and returned 35-45 minutes later when the call light was on. They entered Resident #1's room and noticed he was not breathing. NA #1 stated she could not recall if he had on his oxygen or not, she was so upset that he was not breathing. NA #3 summoned Nurse #1 to the room and confirmed that he was not breathing and had a Do Not Resuscitate (DNR) order. NA #1 stated she left the room because she was so upset.

An interview was conducted with NA #3 on 03/08/18 at 3:27 PM. NA #3 confirmed that she routinely cared for and was familiar with Resident #1 and was caring for him on 03/06/18 on 2nd shift. NA #3 stated that Resident #1 had been his usual self all shift. He was up in his wheelchair on the unit and had his oxygen in place via his tracheostomy and had been to the dining room for dinner. NA #3 stated that at approximately 9:50 PM to 10:00 PM with assistance from NA #1 they placed Resident #1 in the bed. NA #3 stated that she had removed his oxygen to put him to bed but could not recall if she had replaced it or not. Approximately 30-45 minutes later NA #3 stated that Resident #1's call light was on and

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she and NA #1 entered his room to see what he needed. When they entered his room Resident #1 had grabbed the hand rail and turned himself and his legs were coming out of the bed. She stated that NA #1 put his legs back in the bed and as they turned to leave the room they noticed that his chest was not rising or falling and they ran to get Nurse #1. Nurse #1 came into the room and began checking his vital signs and Resident #1 appeared to take a deep breath at one point when Nurse #1 was in the room. NA #3 stated she was not sure if Resident #1 had been hooked up to his ventilator because Nurse #1 was responsible for that. NA #3 stated that after she had put Resident #1 to bed she had communicated to Nurse #1 that he was in the bed and ready for her to hook him up to his machine.

An interview was conducted with Nurse #1 on 03/08/18 at 3:06 PM. Nurse #1 confirmed that she was working with Resident #1 on 03/06/18 on 2nd shift. Nurse #1 stated that Resident #1 had been his usual self on 03/06/18, he had been up in the wheelchair and had his oxygen in place at 2-3 liters via tracheostomy collar. She stated that at approximately 10:55 PM on 03/06/18 NA #1 and NA #3 stated "Resident #1 is in bed and his tongue is hanging out." Nurse #1 stated she ran to Resident #1's room and he was unresponsive. Nurse #1 directed the NAs to get the crash cart and she went to make sure he had a DNR order in place. She stated that before she left the room to check if Resident #1 had a DNR order she hooked up his non-invasive mechanical ventilator and turned it on and when she returned to the room and was sure he had a DNR order in place she turned the ventilator off. Nurse #1 stated that when she entered Resident #1's room he did not have his oxygen on and could not recall if it was

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accessible to him. She further stated she had not had time to place him on his non-invasive mechanical ventilator because she was passing medications. Nurse #1 stated that she had not yet had time to start her tracheostomy care and that was generally when she would put him on the non-invasive mechanical ventilator. She stated that Resident #1 had alarms to his ventilator but because she had not hooked him up yet they were not on. Nurse #1 stated that she and Nurse #2 pronounced Resident #1 dead at 11:00 PM.

An interview was conducted with Nurse #2 on 03/08/18 at 5:06 PM. Nurse #2 confirmed that she was working on the unit where Resident #1 resided on 03/06/18 on 2nd shift. She stated that late in the evening one of the NAs called Nurse #1 to Resident #1's room. Nurse #2 stated she accompanied Nurse #1 to Resident #1's room. Nurse #2 stated that when she entered Resident #1's room he was reclined in bed and seemed to have no life in him and could not recall if he had his oxygen in place or was hooked to the non-invasive mechanical ventilator. Nurse #2 stated she exited his room to grab a pulse oximeter and when she returned Nurse #1 had placed Resident #1 on the non-invasive mechanical ventilator and she checked for a pulse and could not find a pulse. Nurse #1 went to his chart and confirmed that Resident #1 had a DNR order and then Nurse #1 turned the ventilator off and they both auscultated lung sounds for 3-5 minutes. There was none and Resident #1 was pronounced dead.

An interview was conducted with RT #1 on 03/06/18 at 12:52 PM. RT #1 stated Resident #1 had chronic respiratory failure and was ventilator dependent at night. RT #1 stated that Resident #1

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F 695	Continued From page 55 was very cognitively alert and would sporadically take himself off the ventilator but he was not able to put himself on it. He added that Resident #1 usually required between 2-3 liters of oxygen via his tracheotomy collar during the day but the RT was able to adjust that depending on the condition of the resident. RT #1 stated that he arrived to work on 03/07/18 at 5:20 AM and generally Resident #1 would be up in his wheelchair waiting for the RT to get him a new tank of oxygen and on this day he was not. RT #1 questioned Nurse #1 where Resident #1 was at. RT #1 stated she replied, "He was deceased." RT #1 stated he questioned Nurse #1 what happened. He added Resident #1 was very stable and had not been sick, had no increased oxygen needs and was only suctioned maybe 1-2 times a day so he was shocked that he had passed away. Nurse #1 stated that at approximately 10:15 PM on 03/06/18 Resident #1 requested to go to bed so the NAs put him to bed and they went back to check on him at 10:55 PM and he was deceased. RT #1 stated he asked her if Resident #1 had been on his non-invasive mechanical ventilator or his tracheostomy collar and she stated he was not on the non-invasive mechanical ventilator because she was still passing medications and had not had time to hook him up yet. He further indicated he checked the non-invasive mechanical ventilator log and discovered that the ventilator had been turned on and off within just a few minutes. RT #1 stated that there was no RT in the building that night and Nurse #1 should have stopped her medication pass and connected Resident #1 to his non-invasive mechanical ventilator as ordered. RT #1 stated that the nurses were trained to place residents on the non-invasive mechanical ventilator in the absence of a RT.	F 695		

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An interview was conducted with the former Medical Director (FMD) on 03/08/18 at 4:41 PM. The FMD stated that she cared for Resident #1 until approximately 02/28/18 and was very familiar with him. The FMD stated that she had never seen Resident #1 without his oxygen and she honestly did not have to see him very often because he was as stable as he could be with a tracheostomy and being ventilator dependent. The FMD stated that if Resident #1 did not have his oxygen or his ventilator on that certainly could have contributed to his death along with his heart disease, lung disease, and hypertension. The FMD stated that she would expect that Resident #1 would have his oxygen in place and would be hooked to his non-invasive mechanical ventilator as ordered. She stated that Resident #1 did very well during the day with his oxygen hooked via tracheostomy collar but at night he required the extra support of the non-invasive mechanical ventilator which to her knowledge was a traditional ventilator.

An interview was conducted with the Pulmonologist on 03/09/18 at 2:51 PM. The pulmonologist stated that Resident #1 was very stable and he did not have to visit him on routine basis. He stated that Resident #1 was very independent but had chronic respiratory failure with permanent tracheostomy and was dependent on a nocturnal non-invasive mechanical ventilator. The pulmonologist stated that Resident #1 required the non-invasive mechanical ventilator as back up ventilation at night and anyone that required the non-invasive mechanical ventilator was ventilator dependent. He added the non-invasive mechanical ventilator was not a continuous positive airway pressure

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(Cpap) and was not a bi-level positive airway pressure (Bipap). The pulmonologist stated "it is superior form of ventilation." He added that Resident #1's setting were not available via Cpap or Bipap and confirmed that Resident #1 was non-invasively mechanically ventilated via the non-invasive ventilator at night. The pulmonologist stated that without an autopsy he could not confirm that the lack of oxygen or non-invasive mechanical ventilator contributed to Resident #1's death.

An interview was conducted with the current Medical Director (CMD) on 03/12/18 at 11:41 AM. The CMD stated that this was only his 3rd time in the facility and he had met and visited with Resident #1 while he was sitting up in his wheelchair before his passing. The CMD stated he was not familiar with the equipment that was used in the facility like the non-invasive mechanical ventilators he left the management of those devices up to the pulmonologist who visited the facility on a weekly basis. The CMD stated that he expected the staff to follow the physician orders and place Resident #1 on his non-invasive mechanical ventilator as ordered and communicate any issues that arose to himself or the pulmonologist.

An interview was conducted with the Director of Nursing (DON) on 03/09/18 at 12:07 PM. The DON stated that Resident #1 required the use of non-invasive life support and that it was usually on when Resident #1 went to bed to assist him with breathing. The DON stated that Nurse #1 had contacted her on the evening of 03/06/18 and stated that Resident #1 had passed away and was directed as what she needed to do. The DON stated that Nurse #1 did not communicate

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all the facts to her in regards to Resident #1's death. The DON stated that she expected Nurse #1 to apply Resident #1's non-invasive mechanical ventilator as ordered. She further stated that Resident #1 was able to apply his own oxygen tubing and has known Resident #1 to go long periods of time without his oxygen and it never bothered him before. The DON stated that when Resident #1 was in the bed he usually had his oxygen and non-invasive mechanical ventilator on so maybe the position of lying down had something to do with it.

Review of Resident #1's Certificate of Death dated 03/12/18 revealed the immediate cause of death was respiratory failure.

Credible Allegation of Compliance

F695

1. The Resident identified to be affected by the alleged deficient practice.

At 9:30pm on 3/6/18 Nurse #1 administered medication to resident #1. Resident #1 experienced no distress or change in his baseline condition. Resident #1 swallowed his medication and drink without problems. At 9:50pm Nurse Aide #1 and Nurse Aide #3 assisted resident #1 in preparing for bed. Nurse Aide #1 and Nurse Aide #3 transferred resident #1 via sit to stand lift from the chair to the bed. NA #1 placed resident #1's call light and urinal within reach. NA#1 and NA #3 exited room. At 10:45pm NA#1 exited another resident's room and noted resident #1's call light was on. NA #1 noted that resident #1 had his right leg off of the bed and the call bell in his hand. NA #1 went around the bed to address the call light. Resident #1's tongue was protruding

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from his mouth. NA #1 stated resident's color was gray. NA #1 went to the door of resident #1's room and yelled for help. NA #3 ran to the nurses' station to get help. At 10:47pm Nurse #1 and Nurse #2 responded to resident #1's room. Nurse #1 placed resident #1 on the respiratory assistive device. Resident #1 noted to be unresponsive. Nurse #2 exited resident #1's room to obtain the crash cart. At 10:55pm Nurse #1 checked resident's advanced directives and noted resident #1 was a DNR. At 11:00pm Nurse #1 and Nurse #2 assessed resident #1's vital signs and Vital signs were absent. At 11:03pm the Director of Nursing was notified of resident #1's death

A 24 hour report was sent to the NC Health Care Registry, NCDHHS by the Administrator on 3/10/18 reporting this event. The police were notified by the Administrator on 3/10/18. The NC Board of Nursing was notified via email on 3/10/18 by the Director of Nursing.

· A Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 3/9/18 and it was determined that Nurse #1 did not apply oxygen via trach collar and Astral ventilation was not initiated for Resident #1 immediately after the NA # 1 assisted Resident to bed. There was no Respiratory Therapist (RT) on duty to assist Nurse #1 with completion of respiratory related tasks which led to Nurse #1 failing to follow the physician orders to apply the Astral ventilation system. The IDT determined this event was the result of a lack of RT staffing on 2nd shift.

Further Root Cause Analysis was conducted regarding the admission of residents with tracheostomies requiring ventilation assistance. Education was conducted with the Administrator,

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Director of Nursing, Respiratory therapist and facility Sales Representative by the Division Team regarding admission requirements for residents with tracheostomies on 6/16/17. This education required that no residents with tracheostomies requiring ventilation would be admitted to the facility thereafter. Since 6/16/17, 4 residents exceeding this criteria have been admitted in error and 1 resident received physician's order to add ventilation assistance due to a decline in status while remaining in the facility

2. Residents with the potential to be affected by the alleged deficient practice.

· Residents with tracheostomies requiring ventilation assistance have the potential to be affected by the alleged deficient practice.
· On 3/9/18 an audit was completed by the Director of Nursing and Nurse Managers, of residents with tracheostomies requiring ventilation assistance to ensure oxygen and Astral/Trilogy devices were applied according to the physician's orders.
· On 3/9/18 Residents #8, #9, #10 and #11 were identified with tracheostomies utilizing respiratory equipment that requiring ventilation assistance were transferred to hospital setting.

3. Systemic Measures

· On 3/10/18 the District Director of Clinical Services provided education to the Interdisciplinary Team (IDT) regarding the facility's admission capabilities with a focus on resident requiring respiratory assistance. This education includes the following:
-Specific types of respiratory referrals and levels of respiratory support required

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-Admission criteria regarding referrals with tracheostomies which includes the District Director of Clinical Services approval prior to offering placement.
-No ventilation assistance will be provided via Astral/Trilogy or other devices.

· On 3/9/18 Respiratory Therapist/Nurse Managers re-educated licensed nurses using the facility's policy for Respiratory/Tracheostomy Care to include suctioning, applying t-collar, and completing a respiratory assessment.
· On 3/9/18 the Nurse Managers re-educated the Nurse Aides on reporting observations of residents with tracheostomies requiring oxygen administration to include notification of the nurse when oxygen is not applied as required.
· No licensed nurses or nurse aides will work before receiving education after 3/9/18.
· New hires (licensed nurses and nurse aides) will be educated by the Nurse Manager on the facility's policy for Respiratory/Tracheostomy Care during the orientation process.
· All licensed nurses and nurse aides will be educated annually, by the Nurse Manager, for continued proficiency in respiratory/tracheostomy care utilizing the facility's policy for Respiratory/Tracheostomy Care.
· The Director of Nursing or Nurse Managers will review new admissions daily during the clinical meeting to validate physician ordered respiratory equipment is available and applied according to the physician's orders.
· The Director of Nursing or Nurse Managers will audit 10 residents requiring respiratory equipment weekly for 12 weeks to ensure respiratory equipment applied according to the physician's orders.
· The Director of Nursing will report the

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F 695	Continued From page 62 results of the audits during the weekly QAPI meeting and the committee will make recommendations as needed. · The facility will no longer admit residents with tracheostomies that require the use of the Trilogy, Astral or other systems that provide ventilation assistance. All referrals with tracheostomies will be reviewed by the District Director of Clinical Services (DDCS) and placement will be offered for only those approved by the DDCS. 4. The Administrator is responsible for implementing this acceptable plan of correction. Immediate jeopardy was removed on 03/13/18 at 2:20 PM when nursing staff interviews revealed that they had received education on the application of respiratory devices, how to properly care for tracheostomies, and that residents that required non-invasive mechanical ventilation had been discharged from the facility.	F 695		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, Respiratory Therapist, former Medical Director, current Medical Director, and Pulmonologist interviews the facility's Administration failed to	F 835		

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provide leadership and oversight to the facility staff to ensure that a physician ordered non-invasive mechanical ventilator was applied (Resident #1). The facility's Administration also failed to provide leadership and oversight to the facility staff to ensure that the respiratory needs of (Resident #9, #10, and #11) did not exceed the capabilities that the facility was equipped to handle. This affected 4 of 5 sampled residents (Resident #1, #9, #10, and #11).

Immediate Jeopardy began on 03/06/18 when the facility Administration failed to provide oversight and management to ensure that physician ordered respiratory devices were applied. The facility continued to provide non-invasive mechanical ventilation to Resident #9, #10 and #11 until they were discharged from the facility on 03/09/18. The facility management was not aware that the non-invasive mechanical ventilators were being used in manner in which the facility staff was not equipped to handle effectively.
Immediate jeopardy was removed on 03/13/18 at 2:20 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place were effective.

The findings included:

1. This tag is cross referred to F695:

Based on record review, staff, respiratory therapist, former Medical Director, current Medical Director, and Pulmonologist interviews, the facility failed to apply oxygen and a

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F 835	Continued From page 64 non-invasive mechanical ventilator as ordered by the physician for 1 of 3 residents sampled for respiratory services (Resident #1). When Resident #1 was found by staff without the physician ordered devices he was deceased. An interview was conducted with the Director of Clinical Services (DCS) on 03/13/18 at 12:47 PM. The DCS stated that she has worked with this facility since August of 2017 and stated that no one had shared with her the specifics of the unit where Resident #1 resided or the equipment that was being used on that unit. An interview was conducted with the Vice President of Operations (VPO) on 03/13/18 at 12:16 PM. The VPO stated she had recently been reassigned to the facility in November of 2017. She stated that the Administrator at the time had given her a tour of the facility but she had no knowledge of the devices that were being used on the unit. 2. Resident #9 readmitted to the facility on 12/05/17 with diagnoses of acute and chronic respiratory failure with hypercapnia (excessive carbon dioxide in the bloodstream). Review of a physician order dated 12/05/17 read, place on non-invasive mechanical ventilator at night or if in respiratory distress. Review of the most recent quarterly Minimum Data Set (MDS) dated 12/21/17 revealed that Resident #9 was mildly cognitively impaired and required extensive assistance of 2 staff members with activities of daily living. The MDS further indicated Resident #9 had no behaviors or	F 835		

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rejection of care. The MDS indicated that Resident #9 required oxygen, suctioning, and had a tracheostomy. No ventilator use was identified on the MDS.

Review of Medication Administration Record (MAR) dated 03/01/18 through 03/31/18 revealed the following: Place on non-invasive mechanical ventilator at night or if in respiratory distress. The time indicated was 9:00 PM and the staff had initialed it indicating the device had been applied. There was no time indicating what time the device was removed.

An interview was conducted with Respiratory Therapist (RT) #1 on 03/08/18 at 12:52 PM. RT #1 stated that the unit where Resident #9 resided was a specialty unit that accepted residents that had a tracheostomy and required a ventilator 8 hours or less at night. RT #1 stated that Resident #9 required the non-invasive mechanical ventilator at night to manage her respiratory failure and had been at the facility for well over a year or so. RT #1 stated that in June of 2017 the facility had put a temporary hold on admitting residents with tracheostomy's that required the use of the non-invasive mechanical ventilator. Then around November or December of 2017 they stated that they could resume admissions of those resident that required the ventilators but as long as they were only required for 8 hours a day or less. RT #1 stated that if they required the non-invasive mechanical ventilator more than 8 hours a day then the resident could not admit to the facility or would have to be discharged to a traditional ventilator unit. He explained that if there was no RT on the unit at bedtime than the nurse on the unit would place Resident #9 on the non-invasive mechanical ventilator and then the

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RT that was on duty in the morning would generally take her off. The RT further explained that there was no way to track the exact time that Resident #9 was actually on the non-invasive mechanical ventilator. The rule was she usually would go on at bedtime and come off in the morning.

Review of Resident #9's ventilator log along with the RT verified the following days Resident #9 had been on the non-invasive mechanical ventilator greater than 8 hours.

· 02/24/18: the non-invasive mechanical ventilator was turned on 12:15 AM and turned off 9:13 AM (8 hours and 58 minutes)
· 02/25/18: the non-invasive mechanical ventilator was turned on 10:17 PM and turned off at 7:20 AM (9 hours and 3 minutes)
· 03/02/18: the non-invasive mechanical ventilator was turned on 10:07 PM and turned off at 9:42 AM (11 hours and 35 minutes)
· 03/03/18: the non-invasive mechanical ventilator was turned on 12:07 AM and turned off at 8:32 AM (8 hours and 25 minutes)
· 03/06/18: the non-invasive mechanical ventilator was turned on 11:26 PM and turned off at 9:35 AM (10 hours and 9 minutes)

Resident #9 was discharged from the facility on 03/09/18.

An interview was conducted with the current Medical Director (CMD) on 03/12/18 at 11:41 AM. He stated he was new to the facility and this was only his 3rd at the facility. The CMD stated he was not familiar with the equipment that was used in the facility like the non-invasive mechanical ventilators, he left the management of those

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devices up to the pulmonologist who visited the facility on a weekly basis. The CMD stated that he was not aware that the facility was not equipped to handle residents that required greater than 8 hours of ventilator support or he would have questioned it before he came to work at the facility.

An interview was conducted with the pulmonologist on 03/09/18 at 2:52 PM. The Pulmonologist stated that Resident #9 had a tracheostomy and could not be weaned from it. The pulmonologist stated that Resident #9 required the non-invasive mechanical ventilator at night and described the device as a "superior form of ventilation." He added that any resident that required the non-invasive mechanical ventilator was ventilator dependent and the settings that Resident #9 required were not available on the traditional continuous positive airway pressure (Cpap) or the Bi-level positive airway pressure (Bi-pap) machines. The pulmonologist stated that he had made no policy or procedural changes since he had been coming to the facility and that when he walked onto the unit and there were already patients established there.

An interview was conducted with the Director of Clinical Services (DCS) on 03/13/18 at 12:47 PM. The DCS stated that she has worked with this facility since August of 2017 and stated that no one had shared with her the specifics of the unit where Resident #1 resided or the equipment that was being used on that unit.

An interview was conducted with the Vice President of Operations (VPO) on 03/13/18 at 12:16 PM. The VPO stated she had recently been

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reassigned to the facility in November of 2017. She stated that the Administrator at the time had given her a tour of the facility but she had no knowledge of the devices that were being used on the unit.

An interview was conducted with the Director of Nursing (DON) on 03/09/18 at 12:07 PM. The DON stated that Resident #9 required the use of non-invasive life support and that it was usually on when Resident #9 went to bed to assist her with breathing. The DON stated that most of the time the RT would apply them at bedtime and remove then in the morning. She added that if there was no RT on duty the nurses were trained to place Resident #9 on her the non-invasive mechanical ventilator and if necessary to remove her from the device as well.

A follow up interview was conducted with the DON on 03/13/18 at 10:52 AM. The DON stated that when she came to work at the facility in August 2017 she was told the specialty unit where Resident #9 resided accepted patients that had tracheostomies and required the non-invasive mechanical ventilators when they were transitioning home. She stated it was portrayed to her as a short term unit where residents came to be decannulated (removal of the tracheostomy) and then discharged home. The DON stated that to her knowledge the non-invasive mechanical ventilator were ventilator machines that had the capability to function as a Cpap and Bi-pap machine. The DON stated that when she began working at the facility she was told that Resident #9 could not be decannulated but opted to stay here at the facility because she had no help in the community. She added that as long as the residents were on the non-invasive

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ventilator devices less than 8 hours then the facility did not require any special license to operate and Resident #9 was fine to stay in the facility because she was only on the non-invasive mechanical ventilator at night.

3. Resident #10 was admitted to the facility on 02/23/18 with diagnoses which included Parkinson's disease, chronic respiratory failure, tracheostomy and dependence on a ventilator.

A review of the admission Minimum Data Set (MDS) dated 03/02/18 indicated Resident #10 was cognitively intact for daily decision making. The MDS further indicated Resident #10 required extensive assistance with bed mobility, transfers, toileting and hygiene and had no behaviors or rejection of care. The MDS also indicated Resident #10 required oxygen, suctioning, and had a tracheostomy. No ventilator use was identified on the MDS.

A review of a physician's history and physical dated 02/26/18 indicated Resident #10 remained ventilator dependent and would be followed closely by pulmonology and respiratory therapy in regard to his chronic respiratory failure and need for mechanical ventilation at night.

A review of a physician's order dated 03/01/18 indicated to place on non-invasive mechanical ventilator at night and as needed for respiratory distress.

A review of a Medication Administration Record (MAR) dated 03/01/18 through 03/31/18 indicated to place on non-invasive mechanical ventilator at bedtime. The time indicated was 9:00 PM and the staff had initialed it indicating the device had been

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applied. There was no time indicating what time the device was removed.

During an interview on 03/08/18 at 12:52 PM Respiratory Therapist (RT) #1 explained the unit where Resident #10 lived was a specialty unit that accepted residents that had a tracheostomy and required a ventilator 8 hours or less at night. RT #1 stated that Resident #10 had recently been admitted to the facility and required the non-invasive mechanical ventilator at night to manage his respiratory failure. RT #1 explained in June of 2017 the facility had put a temporary hold on admitting residents with tracheostomy's that required the use of the non-invasive mechanical ventilator. He further explained around November or December of 2017 he was told by the former Administrator they could resume admissions of those residents that required the ventilators as long as they only required the mechanical ventilator for 8 hours a day or less. RT #1 stated if a resident required the non-invasive mechanical ventilator more than 8 hours a day then the resident could not be admitted to the facility or they would have to be discharged to a traditional ventilator unit. He explained if there was no RT on the unit at bedtime the nurse on the unit would place Resident #10 on the non-invasive mechanical ventilator and then the RT that was on duty in the morning would generally take him off. The RT further explained the general rule was Resident #10 usually went on the ventilator at bedtime and came off in the morning.

During an observation with RT #1 on 03/09/18 at 3:45 PM of Resident #10's ventilator log contained inside the monitor for the ventilator RT #1 verified the following days Resident #10 had

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been on the non-invasive mechanical ventilator greater than 8 hours.

" 02/24/18: the non-invasive mechanical ventilator was turned on at 11:57 PM and was turned off at 8:28 AM (8 hours and 31 minutes)
" 03/02/18: the non-invasive mechanical ventilator was turned on at 10:07 PM and was turned off at 9:42 AM (11 hours and 35 minutes)

Resident #9 was discharged from the facility on 03/09/18.

During an interview on 03/09/18 at 2:52 PM, the Pulmonologist explained Resident #10 had Parkinson's disease and he determined Resident #10 might not be a good candidate for decannulation (removal of his tracheostomy). He stated Resident #10 required the non-invasive mechanical ventilator at night and described the device as a "superior form of ventilation." He added that any resident who required the non-invasive mechanical ventilator was ventilator dependent and the settings that Resident #10 required were not available on the traditional continuous positive airway pressure (C-pap) or the Bi-level positive airway pressure (Bi-pap) machines. The Pulmonologist stated he had made no policy or procedural changes since he had been coming to the facility and when he walked into the unit there were already patients established there.

During an interview on 03/12/18 at 11:41 AM, the current Medical Director (CMD) stated he was new to the facility and today was only his third visit at the facility. The CMD explained he was not familiar with the non-invasive mechanical ventilators and he left the management of those

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devices up to the Pulmonologist who visited the facility on a weekly basis. The CMD stated he was not aware the facility was not equipped to handle residents that required greater than 8 hours of ventilator support or he would have questioned it before he came to work at the facility.

During an interview on 03/13/18 at 12:47 PM, the District Director of Clinical Services (DDCS) stated she had worked with the facility since August of 2017 and stated no one had shared with her the specifics of the unit where Resident #10 lived or the ventilator equipment that was being used on that unit.

During an interview on 03/13/18 at 12:16 PM, the Vice President of Operations (VPO) stated she had recently been reassigned to the facility in November of 2017. She further stated the Administrator at the time had given her a tour of the facility but she had no knowledge of the non-invasive mechanical ventilators that were being used on the unit.

During an interview on 03/09/18 at 12:07 PM, the Director of Nursing (DON) stated Resident #10 required the use of non-invasive life support and that it was usually put on when Resident #10 went to bed to assist him with breathing. The DON further stated most of the time the RT would apply the non-invasive mechanical ventilators at bedtime and remove then in the morning. She explained if there was no RT on duty the nurses were trained to place Resident #10 on his non-invasive mechanical ventilator and could remove him from the non-invasive mechanical ventilator.

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During a follow up interview on 03/13/18 at 10:52 AM the DON explained when she came to work at the facility in August 2017 she was told the specialty unit where Resident #10 lived accepted residents who had tracheostomies and required the non-invasive mechanical ventilators when they were transitioning to go home. She stated it was portrayed to her as a short term unit where residents came to be decannulated (removal of the tracheostomy) and then discharged home. The DON further stated to her knowledge the non-invasive mechanical ventilators had the capability to function as a C-pap and Bi-pap machine. The DON explained as long as residents were on the non-invasive ventilator devices less than 8 hours then the facility did not require any special license to operate. She stated she did not make the decision to accept residents who required a non-invasive mechanical ventilator but RTs worked with the Pulmonologist and they made decisions to accept residents who required non-invasive mechanical ventilation.

4. Resident #11 was admitted to the facility on 02/9/18 with diagnoses which included acute respiratory failure, chronic obstructive lung disease and tracheostomy.

A review of the admission MDS dated 02/16/18 indicated Resident #11 was cognitively intact for daily decision making. The MDS also indicated Resident #11 required minimal assistance with transfers but extensive assistance with bed mobility, dressing, toileting and hygiene and had no behaviors or rejection of care. The MDS also indicated Resident #11 required oxygen, suctioning, and had a tracheostomy. No ventilator use was identified on the MDS.

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A review of a Pulmonologist progress note dated 02/16/18 indicated Resident #11 needed the non-invasive mechanical ventilator to live.

A review of a physician's order dated 03/01/18 indicated to place on non-invasive mechanical ventilator at night and as needed for respiratory distress.

A review of a Medication Administration Record (MAR) dated 03/01/18 through 03/31/18 indicated to place on non-invasive mechanical ventilator at bedtime. The time indicated was 9:00 PM and the staff had initialed it indicating the device had been applied. There was no time indicating what time the device was removed.

During an interview on 03/08/18 at 12:52 PM Respiratory Therapist (RT) #1 explained the unit where Resident #11 lived was a specialty unit that accepted residents that had a tracheostomy and required a ventilator 8 hours or less at night. RT #1 stated that Resident #11 had been recently admitted to the facility and required the non-invasive mechanical ventilator at night to manage his respiratory failure. RT #1 explained in June of 2017 the facility had put a temporary hold on admitting residents with tracheostomy's that required the use of the non-invasive mechanical ventilator. He further explained around November or December of 2017 he was told by the former Administrator they could resume admissions of those residents that required the ventilators as long as they only required the mechanical ventilator for 8 hours a day or less. RT #1 stated if a resident required the non-invasive mechanical ventilator more than 8 hours a day then the resident could not be

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admitted to the facility or they would have to be discharged to a traditional ventilator unit. He explained if there was no RT on the unit at bedtime the nurse on the unit would place Resident #11 on the non-invasive mechanical ventilator and then the RT that was on duty in the morning would generally take him off. The RT further explained the general rule was Resident #11 usually went on the ventilator at bedtime and came off in the morning.

During an observation with RT #1 on 03/09/18 at 3:45 PM of Resident #10's ventilator log contained inside the monitor for the ventilator RT #1 verified there were no dates when Resident #11 had been on the non-invasive mechanical ventilator greater than 8 hours.

Resident #9 was discharged from the facility on 03/09/18.

During an interview on 03/09/18 at 2:52 PM, the Pulmonologist explained Resident #11 kept going back and forth to the hospital because of changes in his condition and he required non-invasive mechanical ventilation at night. He described the non-invasive mechanical ventilators as a "superior form of ventilation." He explained any resident who required the non-invasive mechanical ventilator was ventilator dependent and the settings that Resident #11 required were not available on the traditional continuous positive airway pressure (C-pap) or the Bi-level positive airway pressure (Bi-pap) machines. The Pulmonologist stated he had made no policy or procedural changes since he had been coming to the facility and when he walked into the unit there were already patients established there.

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During an interview on 03/12/18 at 11:41 AM, the current Medical Director (CMD) stated he was new to the facility and today was only his third visit at the facility. The CMD explained he was not familiar with the non-invasive mechanical ventilators and he left the management of those devices up to the Pulmonologist who visited the facility on a weekly basis. The CMD stated he was not aware the facility was not equipped to handle residents that required greater than 8 hours of ventilator support or he would have questioned it before he came to work at the facility.

During an interview on 03/13/18 at 12:47 PM, the District Director of Clinical Services (DDCS) stated she had worked with the facility since August of 2017 and stated no one had shared with her the specifics of the unit where Resident #10 lived or the ventilator equipment that was being used on that unit.

During an interview on 03/13/18 at 12:16 PM, the Vice President of Operations (VPO) stated she had recently been reassigned to the facility in November of 2017. She further stated the Administrator at the time had given her a tour of the facility but she had no knowledge of the non-invasive mechanical ventilators that were being used on the unit.

During an interview on 03/09/18 at 12:07 PM, the Director of Nursing (DON) stated Resident #11 required the use of non-invasive life support and that it was usually put on when Resident #11 went to bed to assist him with breathing. The DON further stated most of the time the RT would apply the non-invasive mechanical ventilators at bedtime and remove then in the morning. She

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explained if there was no RT on duty the nurses were trained to place Resident #10 on his non-invasive mechanical ventilator and could remove him from the non-invasive mechanical ventilator.

During a follow up interview on 03/13/18 at 10:52 AM the DON explained when she came to work at the facility in August 2017 she was told the specialty unit where Resident #10 lived accepted residents who had tracheostomies and required the non-invasive mechanical ventilators when they were transitioning to go home. She stated it was portrayed to her as a short term unit where residents came to be decannulated (removal of the tracheostomy) and then discharged home. The DON further stated to her knowledge the non-invasive mechanical ventilators had the capability to function as a C-pap and Bi-pap machine. The DON explained as long as residents were on the non-invasive ventilator devices less than 8 hours then the facility did not require any special license to operate. She stated she did not make the decision to accept residents who required a non-invasive mechanical ventilator but RTs worked with the Pulmonologist and they made decisions to accept residents who required non-invasive mechanical ventilation.

Credible Allegation of Compliance

F835 Administration

1. The Resident identified to be affected by the alleged deficient practice.

At 9:30pm on 3/6/18 Nurse #1 administered

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medication to resident #1. Resident #1 experienced no distress or change in his baseline condition. Resident #1 swallowed his medication and drink without problems. At 9:50pm Nurse Aide #1 and Nurse Aide #3 assisted resident #1 in preparing for bed. Nurse Aide #1 and Nurse Aide #3 transferred resident #1 via sit to stand lift from the chair to the bed. NA #1 placed resident #1's call light and urinal within reach. NA#1 and NA #3 exited room. At 10:45pm NA#1 exited another resident's room and noted resident #1's call light was on. NA #1 noted that resident #1 had his right leg off of the bed and the call bell in his hand. NA #1 went around the bed to address the call light. Resident #1's tongue was protruding from his mouth. NA #1 stated resident's color was gray. NA #1 went to the door of resident #1's room and yelled for help. NA #3 ran to the nurses' station to get help. At 10:47pm Nurse #1 and Nurse #2 responded to resident #1's room. Nurse #1 placed resident #1 on the respiratory assistive device. Resident #1 noted to be unresponsive. Nurse #2 exited resident #1's room to obtain the crash cart. At 10:55pm Nurse #1 checked resident's advanced directives and noted resident #1 was a DNR. At 11:00pm Nurse #1 and Nurse #2 assessed resident #1's vital signs and Vital signs were absent. At 11:03pm the Director of Nursing was notified of resident #1's death.

A 24 hour report was sent to the NC Health Care Registry, NCDHHS by the Administrator on 3/10/18 reporting this event. The police were notified by the Administrator on 3/10/18. The NC Board of Nursing was notified via email on 3/10/18 by the Director of Nursing.

" A Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 3/9/18 and it was

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determined that the Nurse #1 did not apply oxygen via trach collar and Astral ventilation was not initiated for Resident #1 immediately after the NA # 1 assisted Resident to bed. There was no Respiratory Therapist (RT) on duty to assist Nurse #1 with completion of respiratory related tasks which led to Nurse #1 failing to follow the physician orders to apply the Astral ventilation system. The IDT determined this event was the result of a lack of RT staffing on 2nd shift.

Further Root Cause Analysis was conducted regarding the admission of residents with tracheostomies requiring ventilation assistance. Education was conducted with the Administrator, Director of Nursing, Respiratory therapist and facility Sales Representative by the Division Team regarding admission requirements for residents with tracheostomies on 6/16/17. This education required that no residents with tracheostomies requiring ventilation would be admitted to the facility thereafter. Since 6/16/17, 4 residents exceeding this criteria, have been admitted in error and 1 resident received physician's order to add ventilation assistance due to a decline in status while remaining in the facility

2. Residents with the potential to be affected by the alleged deficient practice.

" Residents with tracheostomies requiring ventilation assistance have the potential to be affected by the alleged deficient practice.
" On 3/9/18 an audit was completed by the Director of Nursing and Nurse Managers, of residents with tracheostomies requiring ventilation assistance to ensure oxygen and Astral/Trilogy devices were applied according to the physician's orders.

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" On 3/9/18 an audit was completed by the Director of Nursing and Nurse Managers, of residents with tracheostomies requiring ventilation assistance to ensure care plans were updated to reflect interventions including tracheostomy care, oxygen administration and donning and doffing the Astral/Trilogy device.
" On 3/9/18 Residents #8, #9, #10 and #11 were identified with tracheostomies utilizing respiratory equipment that requiring ventilation assistance was transferred to hospital setting.

3. Systemic Measures

" On 3/9/18 the facility Administrator was suspended by the Region Vice President of Operations (RVPO). An Interim Administrator was established with supervision to be provided by the RVPO at least 3 times per week to ensure adherence to the plan of correction. The change of administrator form was faxed to the NCDHHS on 3/10/18 by the RVPO. On 3//10/18, the District Director of Clinical Services provided education to the Interim Administrator regarding all aspects of the plan of correction.
" On 3/10/18 the District Director of Clinical Services provided education to the Interdisciplinary Team (IDT) regarding the facility's admission capabilities with a focus on resident requiring respiratory assistance. This education includes the following:
-Specific types of respiratory referrals and levels of respiratory support required
-Admission criteria regarding referrals with tracheostomies which includes the District Director of Clinical Services approval prior to offering placement
-No ventilation assistance will be provided via Astral/Trilogy or other devices

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F 835	Continued From page 81 " The Director of Nursing and Nurse Managers re-educated licensed nurses and nurse aides on Abuse and Neglect Prevention beginning on 3/10/18. Beginning 3/10/18 No staff will be allowed to work until the training is complete. This education also included ensuring staff awareness that failure to provide respiratory equipment and services such as tracheostomy care and oxygen administration as ordered by the physician, can constitute resident neglect. The NHA and DON will have a no tolerance approach to any deviation from the policy. " On 3/9/18 Respiratory Therapist/Nurse Managers re-educated licensed nurses using the facility's policy for Respiratory/Tracheostomy Care to include suctioning, applying t-collar, and completing a respiratory assessment. " On 3/9/18 the Director of Nursing and Nurse Managers re-educated licensed nurses regarding following the care plan of residents with tracheostomies requiring ventilation assistance to ensure care planned interventions including oxygen administration and donning and doffing devices providing ventilation assistance are in place. " On 3/9/18 the Nurse Managers re-educated the Nurse Aides on reporting observations of residents with tracheostomies requiring oxygen administration to include notification of the nurse when oxygen is not applied as required. " No licensed nurses or nurse aides will work before receiving education after 3/9/18. " New hires (licensed nurses and nurse aides) will be educated by the Nurse Manager on the facility's policy for Respiratory/Tracheostomy Care during the orientation process. " All licensed nurses and nurse aides will be educated annually, by the Nurse Manager, for continued proficiency in respiratory/tracheostomy	F 835		

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F 835	Continued From page 82 care utilizing the facility's policy for Respiratory/Tracheostomy Care. " The Director of Nursing or Nurse Managers will review new admissions daily during the clinical meeting to validate physician ordered respiratory equipment is available and applied according to the physician's orders. " The Director of Nursing or Nurse Managers will audit 10 residents requiring respiratory equipment weekly for 12 weeks to ensure respiratory equipment applied according to the physician's orders. " The Director of Nursing or Nurse Managers will audit 10 residents requiring respiratory equipment weekly for 12 weeks to ensure care planned interventions related to respiratory equipment are in place. " The Director of Nursing will report the results of this morning during the weekly QAPI meeting and the committee will make recommendations as needed. " The facility will no longer admit residents with tracheostomies that require the use of the Trilogy, Astral or other systems that provide ventilation assistance. All referrals with tracheostomies will be reviewed by the District Director of Clinical Services (DDCS) and placement will be offered for only those approved by the DDCS. 4. The facility Administrator is responsible for implementing this acceptable plan of correction. Date of Compliance: 3/12/18 Immediate jeopardy was removed on 03/13/18 at 2:20 PM when nursing staff interviews revealed they had received education on the application of respiratory devices, use of respiratory equipment and suctioning of residents. The interviews also	F 835		

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confirmed staff had received training regarding how to properly care for tracheostomies and to provide care according to physician's orders. The staff interviews also revealed that residents who required use of non-invasive mechanical ventilators had been discharged from the facility.

F 838 SS=D

Facility Assessment
CFR(s): 483.70(e)(1)-(3)

§483.70(e) Facility assessment.
The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and

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(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete the facility assessment to include the resident population of residents who were provided respiratory services and who required use of non-invasive mechanical ventilators. The facility also failed to include Respiratory Therapist staffing in the facility assessment who provided respiratory services.

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Findings included:

A review of a facility document titled in part Facility Assessment dated 11/27/17 revealed sections labeled Cardiac/Respiratory Treatments and Special Treatments and Resident Care Needs included ventilators but the average number of residents per month was listed as zero. A section labeled staffing plan with a listing of staff positions revealed it was blank for Respiratory Therapist.

During an interview on 03/08/18 at 12:52 PM Respiratory Therapist (RT) #1 explained the facility had accepted residents who had a tracheostomy and required a ventilator 8 hours or less at night. He further explained in June of 2017 the facility had put a temporary hold on admitting residents with tracheostomy's that required the use of the non-invasive mechanical ventilator but around November or December of 2017 he was told by the former Administrator they could resume admissions of those residents that required the ventilators as long as they only required the non-invasive mechanical ventilator for 8 hours a day or less.

During an interview on 03/09/18 at 2:51 PM, the Pulmonologist stated he had been coming to the facility for approximately 2 years and the facility provided a non-invasive mechanical ventilator at night for residents who were ventilator dependent and required supplemental ventilation when they were sleeping. He further stated he had made no policy or procedural changes since he had been coming to the facility and when he walked into the unit there were already patients established there.

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F 838	Continued From page 86 During a follow up interview on 03/12/18 at 10:45 AM RT #1 stated he did the staffing schedule for RTs and he sent a text message by phone to the RTs and they signed up for shifts to work. He explained they usually had 14-16 hours of RT coverage on most days and they typically worked from 10:00 AM to between 3:00 PM and 5:00 PM to see the new admissions. He stated he did not know why the non-invasive mechanical ventilators or RT staffing was not included on the facility assessment. During an interview on 03/12/18 at 11:41 AM, the current Medical Director stated he was new to the facility and today was only his third visit at the facility. He further stated he was not familiar with the non-invasive mechanical ventilators but left the management of those devices up to the Pulmonologist who visited the facility on a weekly basis. During an interview on 03/13/18 at 10:52 AM the Director of Nursing (DON) explained when she came to work at the facility in August 2017 she was told the facility accepted residents who had tracheostomies and required the non-invasive mechanical ventilators. She explained department managers participated with completion of the facility assessment and everyone was assigned a section. She stated she was responsible for the sections that pertained to nursing and the former Administrator completed the administrative sections. She further stated she was not responsible for respiratory therapy services and did not complete those sections. During an interview on 03/13/18 at 11:10 AM the new Administrator stated it was her expectation	F 838		

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F 838	Continued From page 87 the facility assessment should have included non-invasive mechanical ventilators since that was a service the facility had provided. She further stated the population of residents and Respiratory Therapist staffing should have been included in the facility assessment. During an interview on 03/13/18 at 12:16 PM, the Vice President of Operations (VPO) stated she had been reassigned to the facility in November of 2017. She confirmed she had not participated with completion of the facility assessment. During an interview on 03/13/18 at 12:50 PM, the District Director of Clinical Services (DDCS) stated she had worked with the facility since August of 2017 and stated no one had shared with her the specifics of the unit where residents required use of the non-invasive mechanical ventilators. She stated it was her understanding the former Administrator did the facility assessment and some of his team had probably helped him with it.	F 838		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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	F 865		

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requirements of this section.

§483.75(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 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 on February 09, 2018 following a complaint survey and subsequently recited in March 13, 2018 on the current complaint survey. The repeat deficiency was in the area of notification (F580). The deficiency was recited during the facility's current complaint survey. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.

The findings included:

This tag is cross referred to:

F580: Based on record review and staff interviews the facility failed to notify the resident's primary physician after the resident was not connected to a non-invasive mechanical ventilator or provided oxygen as ordered by the physician and was found deceased for 1 of 3 residents sampled for respiratory services (Resident #1).

During the complaint survey 02/09/17, this regulation was cited for failure to notify the medical provider of an elevated Sodium (NA)

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F 865	Continued From page 89 level and of a STAT lab that was not obtained as ordered for 1 of 1 residents sampled for laboratory services (Resident #2). An interview was conducted with the Director of Nursing (DON) and the Administrator on 03/13/18 at 2:20 PM. The DON stated that the Quality Assurance (QA) committee met on a monthly basis and included the Administrator, DON, all department heads, Minimum Data Set (MDS) nurse, Medical Director (MD), and the Pharmacist attended quarterly. She explained that they talked about issues in the facility that had come up and any surveys that had occurred and what the plan of correction was. The DON stated that they would track the progress from month to month and when the committee felt comfortable with the results of the monitoring they would resolve the issue and move on to the next one. The DON stated that she had identified issues with the laboratory process at the facility and had a Performance Improvement Plan (PIP) in place to help with those issues. She indicated the audits from the 02/09/18 survey were still in progress and had been going well with no further issues identified. She added that this time she planned to approach the education with the staff a little differently than last time. She stated that she planned to educate the 3rd shift staff in the same manner as the rest of the staff during their shift when they were most alert and able to retain the very important information. She indicated that in the past they had required the 3rd shift staff to stay over after their shift for education when they were tired and had other places to be which distracted them from retaining the information. The DON stated that the building was definitely going through a culture change and it was presenting some challenges but was confident	F 865		

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F 865	Continued From page 90 that they would be able to achieve success.	F 865		