STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 1/7/19 through 1/10/19. The facility was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID # T8Q711.	E 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		2/7/19

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

Electronically Signed | 02/04/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean wheelchair and maintain a positioning cushion device in good repair for 1 of 3 sampled residents reviewed for adaptive equipment. (Resident # 20) Findings: During an observation on 01/07/19 at 9:56 AM Resident # 20 was observed sitting in his wheelchair in the hallway outside of his room. The resident's wheelchair (w/c) was observed to be very unclean with a heavy accumulation of what appeared to be dried food and beverage substances which had accumulated on the wheelchair's inner and outer frames, both arm rests, and seat. Some of the accumulated dried substances on the resident's w/c appeared to be scrambled eggs, milk shake, jelly, spaghetti, and bread. A positioning cushion device was observed in the left side of the wheelchair. The cushion's hard plastic cover was stained, jagged, torn, and most of the plastic was missing. When resident was asked about the condition of his w/c and his positioning cushion device, he was unable to verbalize a response.	F 584	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? The wheelchair for resident # 20 was washed and inspected. The cushion was thrown away and a new cushion was ordered. Resident was referred to therapy for seating and positioning evaluation. How will you identify other residents	

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F 584	Continued From page 2 During an observation on 01/08/19 at 3:11 PM Resident # 20 was observed sitting in his wheelchair beside the 100 hall nurses station. The resident's wheelchair (w/c) was again observed to be very unclean with a heavy accumulation of what appeared to be dried food and beverage substances which had accumulated on the wheelchair's inner and outer frames, both arm rests, and seat. A positioning cushion device was observed in the left side of the wheelchair. The cushion's hard plastic cover was jagged, torn, and most of the plastic was missing. An interview was conducted on 01/08/19 at 3:21 PM with Nursing Assistant (NA) # 50 who stated she had not noticed Resident #20's w/c positioning cushion was torn, or his w/c being unclean. She said that the NA who assists resident to transfer from the bed to his w/c was responsible for placing the positioning cushion in his w/c. NA #50 verified that the w/c was unclean and said she did not know who was responsible for cleaning it. She did not remove the torn positioning cushion from the resident's w/c. An interview conducted on 01/08/19 at 3:56 PM with Nurse #21 revealed Resident # 20 has a positioning device cushion in his w/c to aide with his positioning because he leans forward and slides down in his w/c. She said she had not noticed the position support cushion was stained, jagged, and torn, or his w/c was soiled. She said the NA that assists the resident out of bed into his w/c is responsible for placing the position cushion in his w/c and for cleaning the w/c. Nurse #21 did not remove the torn positioning cushion from the resident's w/c.	F 584	having the potential to be affected by the same deficient practice and what corrective action will be taken? All the resident□s wheelchairs and positioning cushions have been washed and audited for torn and jagged edges. Items that are torn, jagged, or in need of repair will be ordered and replaced. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Housekeeping and Nursing staff will be In-serviced starting on 1/31/19 by the Administrator and/or the Clinical Competency Coordinator to the importance and procedure of maintaining and monitoring wheelchairs and positioning cushions for cleanliness and in good condition. The housekeeping department will clean chairs monthly and as needed. The nursing staff will wipe off any debris noted on wheelchairs and positioning cushions when assisting residents either into or out of their chairs. Heavily soiled items will be washed before use. Any wheelchairs or positioning cushions noted to have torn, jagged edges or in need of repair will be noted in the Housekeeping / maintenance communication books or in the facilities online maintenance repairs request system. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality	

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F 584	Continued From page 3 An interview conducted on 01/09/19 at 4:32 PM with the director of nursing (DON) revealed that Resident #20 is assisted with ADLs and positioning as needed. DON stated he had observed the jagged and torn position support cushion and he had already removed it due to potential risk for injury or a skin tear to the resident. He said it was his expectation that equipment observed to be in disrepair would be removed and replaced by the NA that places the position cushion in resident's w/c. He verified that resident's w/c was soiled, and he said he would have it cleaned. He said it was his expectation that wheelchairs would be cleaned by NAs as needed.	F 584	assurance program will be put in place for monitoring to assure continued compliance. The cleanliness and condition of wheelchairs and positioning cushions will be audited as follows; 10 residents chairs and positioning cushion a day/ 5 times a week for 4 weeks. Then 2 times a week for 2 months. After that the wheelchairs and positioning cushions will be audited for repair and replacement during their monthly cleaning. The audits will be conducted by Housekeeping Supervisor, Maintenance Director, Administrator or designee. The results of the audits will be presented to the Quality Assurance Performance Improvement committee monthly until 3 months of sustained compliance is observed then quarterly thereafter Date of Compliance: February 07, 2019	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 637		2/7/19

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F 637	Continued From page 4 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete a significant change comprehensive Minimum Data Set (MDS) assessment within 14 days of the Hospice enrollment date for 1 of 1 resident (Resident # 38) reviewed for Hospice services and failed to complete a significant change MDS assessment for 1 of 2 residents (Resident #84) who had significant changes in behaviors, weight and medications between a 5 day MDS and a 14 day MDS assessment. The findings included: 1. Resident #38 was admitted to the facility on 5/29/18 with diagnoses that included, in part, non-Alzheimer's dementia, congestive heart failure and diabetes. A review of the quarterly Minimum Data Set (MDS) assessment dated 8/15/18 revealed Resident #38 had moderately impaired cognition. A review of the medical record revealed Resident #38 was admitted to Hospice services on 10/9/18. A review of a significant change MDS assessment dated 10/16/18 revealed the assessment was in progress. Further review of the assessment revealed sections B, F, G, H, I, L, N and O had not been completed. An interview was completed with the MDS Nurse on 1/8/19 at 11:00 AM. She said a significant change assessment was in process for 10/16/18	F 637	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? Resident #38 completed significant change was transmitted on 1/21/2019 Resident #84 After the MDS 5-day ARD 11/26/18 section e, no changes. Section K 0200 weight 280 to 190 was corrected due to data entry error. Section N medications, resident was on 7 days of antianxiety and antidepressants with 6 days of diuretics. MDS corrected an closed on 2/01/19. The 14 day was corrected with K0200 with weight at 190. Section N medications corrected 7 days of antianxiety, antidepressants and diuretics. On comparison no Significant Change would have been warranted. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. An audit of all residents with a Quarterly, Annual, Significant Change OBRA assessment will be completed by the Interdisciplinary Team (comprised of the Case Mix Director, Dietary Manager, Skin Integrity Nurse, Activities Director, Social Worker and the Director of Health Services) to identify any significant	

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F 637	Continued From page 5 since Resident #38 was admitted to Hospice but had not been completed. The MDS Nurse reported she was behind schedule with MDS assessments and was working as fast as she could. An interview was completed with the Administrator on 1/10/19 at 2:01 PM. She stated it had been discussed in meetings that the MDS assessments were "a little behind" and the facility had a part time consultant who helped out with the assessments. The Administrator stated she expected the MDS assessments be completed within the required time frame. 2. Resident #84 was originally admitted to the facility on 3/6/18 and was re-admitted on 10/25/18 with diagnoses which included: cerebral infarction, atrial fibrillation, chronic obstructive pulmonary disease, dysphagia, anxiety, and depression. Review of the MDS indicated Resident #84 had significant changes in his behaviors, weight, and medications during the assessment periods between the 5-day MDS dated 11/26/18 and the 14-day MDS dated 12/3/18. Section E of the 5-day MDS indicated Resident #84 had no behaviors, but Section E of the 14-day MDS indicated the resident showed behaviors not directed towards others during 4-6 days of observations. Section K of the 5-day MDS indicated the resident weighed 280 pounds, but the 14-day MDS documented the resident weighed 190 pounds.	F 637	change in status from the prior OBRA assessment. An Audit will be conducted by the MDS Nurse or Interdisciplinary Team Member 25% of all current Patients with a completed quarterly or Annual assessment will be reviewed by the interdisciplinary team weekly to identify any changes that would warrant the completion of a Significant Change in Status Assessment. The weekly audits will occur weekly until 100% complete. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The MDS coordinator, Dietary Manager, Activities Director, Social Worker and Skin Integrity Nurse will complete re-education of the OBRA completion requirements, which was assigned by the Administrator on 1/17/19. The MDS Nurse or an Interdisciplinary Team Member will review the RUGS Analysis for changes in the in Status assessment with the completion of each new assessment and bring forward to the Interdisciplinary Team to make the determination if a Significant Change Assessment is needed and document on the Significant Change Audit tool until substantial compliance is determined through QAPI. The Financial Counselor will notify the interdisciplinary team of Hospice Admission and Discharge date during Case Mix Meetings. How will the corrective action be	

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F 637	Continued From page 6 Section N of the 5-day MDS indicated the resident did not receive any psychotropic, antibiotic, diuretic, pain or antipsychotic medications. Section N of the 14-day MDS showed the resident did not receive any of these medications during the assessment look-back period. During an interview on 1/10/19 at 3:45 p.m., the MDS Coordinator revealed that during the 11/26/18 ARD (assessment reference date) she and nursing staff were unable to locate the Resident #84's medication administration record. She stated the Social Worker was responsible for assessing the resident's behaviors and completing the behavior section of the MDS; however, there were no changes in the resident's behaviors. The MDS Coordinator also revealed the Dietary Manager was responsible for completing section K of the MDS. During an interview on 1/10/19 at 3:55 p.m., the Dietary Manager stated the weight recorded on the 5-day MDS was recorded in error and the weight recorded on the 14-day MDS was completed by facility staff.	F 637	monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The Administrator and Director of Healthcare Services will verify the results of the reviews and Significant Change Assessment completion utilizing the Significant Change audit tool 1 x weekly for 4 weeks, and then 1x monthly for 3 months or until substantial compliance is met. The findings will be reported to the Quality Assurance Performance Improvement committee monthly for 3 months or until substantial compliance is achieved. Date of Compliance: February 07, 2019	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to conduct quarterly Minimum Data	F 638	What Corrective action will be accomplished for the residents found to	2/7/19

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F 638	Continued From page 7 Set (MDS) assessments for 2 of 20 residents reviewed for Resident Assessments (Resident # 20 and Resident #29). Findings: Resident # 20 was admitted to the facility on 7/28/16 with diagnoses of: history of cerebrovascular accident, right sided hemiplegia, aphasia, muscle weakness, mood disorder, and anxiety disorder. A review of Resident # 20's MDS assessments revealed resident's last completed assessment was a quarterly assessment dated 9/20/18 Further review of Resident # 20's assessments revealed a annual assessment dated 3/28/18 that been completed. There was no quarterly completed in June 2018. An interview was conducted on 01/10/19 at 02:43 PM with the MDS coordinator who acknowledged that Resident # 20 should have had a MDS quarterly assessment completed in June 2018 and an Assessment Reference Date (ARD) date of 06/21/18. During an interview with the Director of Nursing (DON) on 01/10/18 at 04:03 PM, he stated that it was his expectation that quarterly MDS assessments would be completed as required.	F 638	have been affected by the deficient practice? A Quarterly Review Assessment was completed for Resident # 20 on and for Resident # 29 on 1/20/19. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? " Late quarterly assessment Care plans will be reviewed by Interdisciplinary team to identify any need for a change in plan of care for assessments that are currently late " Quarterly assessments that are already late will be scheduled so that ten assessments are completed each week until all is done " Quarterly assessments that are coming due, we will complete no later than 92 days from prior OBRA assessment What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The Administrator initiated education on 1/17/19 covering MDS per disciplines required section. for the Dietary Manager, MDS Coordinator, Social Worker, Activities Director and Skin Integrity Nurse on the requirements of completing quarterly MDS assessments within 92 days of the previous assessment as	

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F 638	Continued From page 8	F 638	required. The Assessment calendar will be provided to and reviewed by the Interdisciplinary Team in morning meeting. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The Administrator and the Director of Health Services will review the due Quarterly Assessments 5 days a week for 4 weeks, then weekly for 2 months and then quarterly thereafter until compliance has been maintained for 3 quarters. The findings will be reported to the Quality Assurance Performance Improvement Committee monthly for 3 months and quarterly thereafter until compliance for 3 quarters has been achieved. Date of Compliance: February 07, 2019	
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		2/7/19

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F 692	Continued From page 9 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow physician orders for obtaining weights (Resident #2 & Resident #55) and; the facility failed to complete nutritional assessments since 3/23/17 for 1 of 4 residents (Resident #29) reviewed for nutrition. Findings included: 1. Resident #2 was admitted to the facility on 1/2/18 with diagnoses that included heart failure, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD), and dementia. A review of the quarterly Minimum Data Set (MDS) assessment dated 11/6/18 revealed Resident #2 had moderately impaired cognition. Review of physician orders and of the medication administration record (MAR) revealed an order from 3/19/18 that stated that Resident #2 was to be weighed with weight recorded daily. Review of weight records and of the MAR revealed the last weight obtained was on 12/3/18	F 692	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? Resident #2 Physician order was review and weight was obtained as ordered by the physician Resident #55 Physician order was review and weight was obtained as ordered the physician Resident # 29 Nutritional assessment was completed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit was completed by the Director Of Health Service on 1/25/2019 on all residents and residents with daily and weekly weight were identified An audit was completed by the Director of Health Services on 1/25/2019on all residents with Nutritional assessment and	

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F 692	Continued From page 10 at 286.5 lbs. During an interview with the Director of Nursing on 1/10/19 at 5:15 PM, he stated that it was his expectation that physician orders were followed and that weights were obtained and recorded as ordered by the physician. 2. Resident #55 was admitted to the facility on 10/30/18 with diagnoses that included heart failure, hypertension (high blood pressure), end stage renal disease (ESRD), respiratory failure, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (OSA), and severe pulmonary hypertension. A review of the admission Minimum Data Set (MDS) assessment dated 11/6/18 revealed Resident #2 was cognitively intact. Review of physician orders and of the medication administration record (MAR) revealed an order placed on 12/28/18 to obtain a weight now, every day for 7 days, and then weekly. Review of weight records and of the MAR revealed the last weight obtained was on 12/21/18 at 415 lbs. During an interview with the Director of Nursing on 1/10/19 at 5:15 PM, he stated that it was his expectation that physician orders were followed and that weights were obtained and recorded as ordered by the physician. 3. Resident #29 was originally admitted to the facility on 6/11/15 and readmitted on 8/10/15 with diagnoses which included: multiple sclerosis, epilepsy, dementia with behavioral disturbance, and pyridoxine deficiency.	F 692	residents that have Nutritional assessment due was identified and completed What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The Clinical Competency Coordinator, Director of Health Services and /or Nurse Manager began education of the Licensed Nurses on obtaining and recording daily and weekly weight as ordered by physician are completed on 1/25/2019. The licensed Nurses that are not educated by 2/7/15 will be removed from the schedule until education is completed. This education has been incorporated into the general orientation for the newly hired Licensed Nurses. The Licensed Nurses will maintain daily and weekly weight log on each nursing station and document any refusal in the nursing note, plan of care and notify physician accordingly. The Registered Dietician was educated by the Vice President of Nutrition and Dinning services on 1/11/2019 on completing the Nutritional assessment timely per policy How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The Director of Health Services and /or	

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F 692	Continued From page 11 A review of the clinical records revealed the facility had not completed a Nutritional Screening and Assessment for Resident #29 since 3/23/17. The most recent Dietary MDS Progress Note was completed during May 2018. Review of the quarterly minimum data set (MDS) dated 10/5/18 indicated Resident #29 was severely, cognitively impaired; required assistance with eating; weighed 91 pounds; had no weight loss or gain; and received a mechanically altered, therapeutic diet. The Care Plan, updated 10/29/18, revealed Resident #29 was at risk for nutritional deficiency due to receiving mechanical soft foods with ground meats and thin liquids. Approaches included: the Registered Dietician would evaluate the resident's current nutritional status and discuss goals for weight. The resident's weight was recorded on the Care Plan as 132 pounds. During an observation on 1/07/19 at 1:01 p.m., Resident #29 was observed in the dining room eating a mechanical soft meal assisted by a nursing assistant. During an interview on 1/10/19 at 6:37 p.m., the Director of Nursing stated the facility indivertibly overlooked completing the nutritional assessments for Resident #29.	F 692	Nurse manager will validate the log daily and ensure proper documentation in the Medication Administration Record. The Dietary Manager will maintain a current calendar of all Nutritional Assessment that are due and completed. The Director Of Health Services and/or Nurse Manager will monitor the log daily for thirty days, then weekly for four weeks, then monthly thereafter until six consecutive months of compliance is maintained then quarterly thereafter. The Director of Health Services will track and trend data and report the analysis of finding to the Quality Assurance and performance Improvement Committee monthly until three months of continued compliance is maintained and then quarterly thereafter. Date of Compliance: February 07, 2019	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		2/7/19

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F 695	Continued From page 12 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, and provider interviews' the facility failed to follow orders to monitor, document, and report oxygen saturation (SpO2) results and failed to document the application of a continuous positive airway pressure (CPAP) machine as ordered for 1 of 1 residents reviewed for CPAP (Resident #55) usage. Findings Include: The resident was originally admitted to the facility on 10/30/18 with diagnoses including heart failure, hypertension (high blood pressure), end stage renal disease (ESRD), diabetes mellitus (DM), pneumonia (PNA), respiratory failure (RF), chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (OSA), morbid obesity, and severe pulmonary hypertension. Based on the admission MDS from 11/6/18 the resident is cognitively intact, had rejection of care 1-3 days of that assessment period, requires one to two-person extensive assistance, is occasionally incontinent of both bowel and bladder, and required oxygen therapy. Review of the Resident #55's discharge summary from 10/30/18 revealed discharge orders to continue to wear CPAP at night for OSA.	F 695	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? Resident #55 CPAP was discontinued on 1/25/2019 because of multiple refusals. Resident #55 orders for oxygen was verified and placed on the Medication administration record on 1/25/2019. . How will you identify other residents having the potential to be affected by the same deficient practice and what corrected action will be taken? An audit was conducted by the Director of Health Services on all residents to identify any residents who had orders for C-PAP, Bi- PAP, oxygen, nebulizer and Trilogy. Audit was completed on 1/25/2019. Twenty-seven residents□ respiratory orders were verified and placed on Medication Administration Record. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?	

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F 695	Continued From page 13 Review of the facility's Nursing Admission Assessment on 10/30/18 revealed documentation for Oxygen at 4 Liters (L) via nasal cannula (NC) with SpO2 of 96%. There was no documentation on the assessment about the resident requiring or having a CPAP machine. Review of the supply records revealed the CPAP machine was ordered by the supply coordinator on 11/1/18 and arrived on 11/1/18. Review of the physician orders and the November medication administration record (MAR) 2018 revealed orders placed for oxygen 3L via NC & SpO2 results documented every shift and CPAP to be worn at night. There was no documentation beside the order for the CPAP application at night and no resident refusal notes in the nursing notes for the entire month of November 2018. November MAR 2018 revealed that the resident's oxygen saturations from 11/3/18 to 11/31/18 were 92-98% with oxygen at 3L via nasal cannula. December MAR 2018 revealed that there was no order to obtain oxygen saturations, and there was no order to apply the CPAP at night. Review of physician orders revealed that these orders were not discontinued. There were no oxygen saturation results documented and no respiratory changes documented in the nursing notes from 12/1/18 to 12/11/18. An SBAR was completed on 12/11/18 for Resident #55 documenting his complaints of being cold, decreased oxygen saturations, increased shortness of breath, and increased	F 695	The Clinical Competency Coordinator, Director of Healthcare Services and/or Nurse Managers began education of the Licensed Nurses regarding documenting the application of continuous positive airways pressure machine and monitoring and recording oxygen saturation result and documenting any refusal in the nurses note and plan of care and notifying the physician accordingly on 1/25/2019. Licensed nurses that are not educated by 2/7/2019 will be removed from the schedule until education is completed. This education has been incorporated into the general orientation for newly hired licensed nurses. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The Director of Healthcare Services and/or Nurse Managers will monitor the log daily for thirty days, then weekly for four weeks, then monthly thereafter until six consecutive months of compliant is maintained then quarterly thereafter. The Director of Healthcare Services will tract and trend the data from the grooming observations and report the analysis of findings to the Quality Assurance and Performance Improvement Committee monthly until three months of continued compliance is maintained then quarterly	

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F 695	Continued From page 14 confusion. His SpO2 was documented as 61% on 5L on CPAP, a nebulizer treatment was completed, and the resident's oxygen saturation increased to 72%. The provider was notified, and an order was placed to send the resident to the hospital. The CPAP mask was sent with the resident and EMS to the hospital. Review of hospital records from 12/11/18 through 12/21/18 revealed Resident #55 was admitted to the hospital with diagnoses of acute on chronic exacerbation heart failure and COPD exacerbation. Review of the discharge summary from 12/21/18 revealed the resident returned to the facility with discharge orders for IV Rocephin and to continue CPAP as needed and nightly. Review of physician orders from 12/21/18 showed an order was placed for BiPap on 9pm off 9am. The MAR from 12/11/18 to 12/28/18 revealed the resident had the machine applied as ordered. Review of Nursing Notes revealed a note by Nurse #1 on 12/27/18 that stated Resident #55 was drowsy, confused - asking for dinner at breakfast. He was wearing oxygen at 3 L via NC with SpO2 88%. The provider was notified and Nurse #1 was told to continue to monitor oxygen saturations. No other nurse's notes, assessments, or oxygen saturations were documented until 12/28/18. Review of an SBAR (nurse to provider documentation tool) on 12/28/18 stated that the resident had shortness of breath and altered mental status. SpO2 was 66%. The provider	F 695	thereafter Date of Compliance: February 7, 2019	

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F 695	Continued From page 15	F 695		

was notified, and orders were placed to send the resident to the hospital.

Review of the hospital admission summary revealed the resident had a COPD exacerbation and returned to facility on 12/28/18 with orders for Omnicef 300mg x 7 days for treatment.

During an interview with Nurse #1 on 1/9/19 at 2:07 PM she stated that nurses are responsible for transcribing the orders to the next month's MAR. she didn't remember when the resident got his CPAP machine and did not know why there was no documentation for the CPAP being used or not, but that he refused to wear it at times. She stated that she remembered when the resident returned from the hospital on 12/21/18 he had a CPAP machine in his room. She stated that on 12/27/18 the resident was confused and had an 88% oxygen saturation. She stated that she notified the provider and was asked to continue to monitor his oxygen saturations per her nurse's note. When asked to look for further oxygen saturations documented after she spoke to the provider, she could not find any. When asked if she remembered getting anymore after the call to the provider was made, she stated she didn't remember but that if she had checked any more she would have documented them in the MAR. Review of the record for 12/27/18 revealed no additional oxygen saturations, respiratory assessments, or cognitive assessments were documented.

During an interview with the Nurse Practitioner (NP) on 1/9/19 at 2:44 PM she stated that she remembered speaking with Nurse #1 on 12/27/18 and had told her to monitor Resident #55's SpO2 closely for changes. She did not recall the nurse

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F 695	Continued From page 16 calling with any follow-up SpO2 results on 12/27/18. She stated that it was her expectation that the nurse would have checked the resident's SpO2 more often to make sure they were trending up and not going down, and that if breathing treatments were done that they should have been done, documented, and reported to her. She stated that the staff definitely should have continued to monitor the oxygen saturations throughout the day and night to know when to apply the CPAP to help maintain higher oxygen levels, but that she could not say without a doubt that if they would have monitored his SpO2 as ordered that it would have prevented his readmission on 12/28/18 due to his history of acute on chronic episodes of CO2 retention and other comorbidities. During an interview on 1/9/19 at 3:15 PM with Nurse #2 she stated that the resident has had his CPAP machine since he was admitted to the facility in October. She did not know why she had not documented the CPAP on the MAR, and that he refused to wear his CPAP on a regular basis. During an interview with the Director of Nursing on 1/10/19 at 5:15 PM he stated that it was his expectation that Nurse #1 would have followed the NP's orders and continued to monitor Resident #55's SpO2 results throughout the day and night on 12/27/18. He also stated that it was his expectation that all orders be followed and documented on the MAR accordingly, including CPAP application, SpO2 results, and anytime the resident refused to wear his mask. Any refusals should have bee reported to the NP as well.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		2/7/19

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F 761	Continued From page 17 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to secure boxes of Vitamin A and D multipacks (100 hall treatment cart and 200 hall nurses' station) and failed to secure 1 (100 hall) of 3 treatment carts. Findings: 1. a. During an observation on 01/07/19 at 02:47 PM, the 100 hall treatment cart that was located across from the nurses' station was	F 761	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? No resident was affected by this deficient practice How will you identify other residents having the potential to be affected by the same deficient practice and what	

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F 761	Continued From page 18	F 761		

observed to be unlocked with the push in lock observed to be in the out position. There were no staff observed in area where the treatment cart was located.

b. During another observation on 01/07/19 at 03:59 PM, the 100 hall treatment cart that was located across from the nurses' station was observed to be unlocked with the push in lock observed to be in the out position. There were no staff observed in area where the treatment cart was located.

An interview was conducted with Nurse # 20 on 01/07/19 at 04:04 PM who verified the 100 hall treatment cart was unlocked. She locked the cart and said she did not know who had left the cart unlocked.

During an interview with the Director of Nursing on 01/09/119 at 09:02 AM he revealed that it was his expectation that treatment carts would be locked when staff was not in view of the carts and that medications would be properly stored and not left unattended.

2. a. 01/08/19 at 02:12 PM an observation was made of an opened box of multipacks of Vitamin A and D ointment behind the 200 hall nurses' station on top of the rack that held the residents' medical charts. There were no staff viewed in the area where the box was located.

An interview was conducted with Nurse #21 on 01/08/19 at 2:17 PM who stated that she did not know who had left the boxes of multipacks of Vitamin A and D unattended.

During an interview with the DON on 01/08/19 at

corrective action will be taken?

The Treatment cart was locked, and the pack of Vitamin A & D ointment multipack was removed and secured
What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?
The Clinical Competency Coordinator, Director of Health Services/ or Nurse Manager began education of the Licensed Nurses regarding locking the treatment cart at all times when not in use and to properly store medications and biological on 2/4/2019. The Licensed Nurses that are not educated by 2/7/2019 will be removed from the schedule until education is completed. The education has be incorporated into the general orientation for newly hired Licensed nurses.

How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.

The Director of Health Services or Nurse Manager will conduct random check 3 times daily to ensure that the treatment cart is locked when not in use and ensure that all medications and biological are stored properly and not left unattended.
The Director of Health Services and /or Nurse Manager will validate the log daily for thirty days, then weekly for four weeks,

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F 761	Continued From page 19 02:37 PM he was shown the box of Vitamin A and D ointment multipacks that were located on top of the 200 hall chart rack. He removed the box. He stated his expectations were that medications would be stored in the proper places.	F 761	then monthly thereafter until six consecutive months of compliance is maintained then quarterly thereafter. The Director of Health Services will track and trend the data and report the analysis of finding to the Quality Assurance and Performance Improvement Committee monthly until three months of continue compliance is maintained then quarterly thereafter Date of Compliance: February 07, 2019	