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	345370	A. BUILDING _____ B. WING _____	C 07/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 000	INITIAL COMMENTS A complaint survey was conducted from 7/11/19 to 7/12/19. There were 8 total complaint allegations with 2 of those allegations substantiated. See Event #IP6Q11.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585		8/9/19

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

Electronically Signed | 08/02/2019

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F 585	Continued From page 1	F 585		

facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions

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F 585	Continued From page 2 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and resident interviews, the facility failed to file a grievance for a voiced concern for 1 of 3 residents reviewed for dignity and respect (Resident #1). Finding included: Resident #1 was admitted to the facility on 6/21/19 with the current diagnoses of transient ischemic attack, muscle spasm, and hypertension. Resident #1 Minimum Data Set dated 6/28/19 revealed Resident #1 was cognitively intact. No moods or behaviors were noted. The resident	F 585	This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. Resident #1 was interviewed by the Director of Social Services, and stated that he had not had any problems with any staff members in the facility, and that he didn't feel anyone was rude to him, but if he had, that he would report it to the Administrator, Social Worker, or any manager. In addition, all alert and oriented residents were interviewed by the	

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F 585	Continued From page 3 required extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. The resident had impairment of 1 side of his upper and lower extremities. A review of grievances from 6/21/19 through 7/11/19, revealed there was only one grievance regarding Resident #1, which involved ADL care dated 6/26/19. Review of Resident #1 medical record revealed there was no other grievances or complaints investigated or documented. Resident #1 was interviewed on 7/11/19 at 4:07 PM. He stated a staff member was rude to him on the night shift (unable to recall date) after he pushed his call bell. He stated a nursing assistant (NA) entered the room and said, "what do you want". He thought this response was rude. He stated his family reported the incident to the social worker, who said she would speak to the staff member. He stated the facility did not follow up on the concern. He stated he had not seen the NA since the incident. Nurse #6 was interviewed on 7/11/19 at 11:43 AM. He stated the resident was alert and oriented. He stated the resident first arrived at the facility around 6/28/19. He stated around that time the resident's family complained to him, stating the third shift nursing assistant came to his door and stated, "what do you want" instead of asking, "how can I help." He stated the incident was reported and he thought the nursing assistant was taken off the resident's assignment. He stated the next morning when the resident's family told him this, he reported it to the clinical	F 585	Director of Social Services and Activity Director, with no positive results related to grievances. Interviews were completed on July 12, 2019. All residents have the potential to be affected so an inservice was completed by the Staff Development Coordinator with all staff regarding our facility grievance process including to whom they report grievances on July 12, 2019. The Social Worker will conduct 5 resident interviews weekly for 4 weeks to ensure no resident has unresolved grievances. Results will be reported in the monthly QA meetings until substantial compliance has been achieved.	

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manager (charge nurse).

The charge nurse was interviewed on 7/11/19 at 1:55 PM. She stated the resident was alert and oriented. She stated, the resident had a care conference (unable to recall date) and the resident's family mentioned a situation where a staff member was rude to the resident. The resident's family did not want to mention the staff member's name. The Director of Nursing was notified and dealt with the issue from there. She revealed she was not notified of this event before the care plan meeting.

The charge nurse was interviewed again on 7/11/19 at 3:51 PM. There was no grievance filed for this issue. She stated the social worker usually had a sheet and would write down any concerns, so they could be addressed. She stated she didn't think this was a big concern but that it was just mentioned.

The Social Worker was interviewed on 7/11/19 at 3:33 PM. She stated she heard there was an NA who was rude to the resident and she thought the NA was in-serviced on the situation. She did not think the incident was witnessed. She did not know if anything was done after the incident. The only grievance completed regarding this resident was for bathing. She stated anyone could complete a grievance form. The grievance form would be returned to her and she would formulate a grievance follow up letter for the patient and/or family.

The Director of Nursing (DON) was interviewed on 7/11/19 at 2:04 PM. She stated the resident's family came to her office (date unknown) and stated a staff member was rude to the resident.

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The family did not want to reveal which staff member it was. She stated the assistant director of nursing (ADON) handled the concern and would know more about it.

The ADON was interviewed on 7/11/19 at 2:22 PM. She stated she needed to talk to the charge nurse about the concern of staff being rude to Resident #1.

The DON was interviewed again on 7/11/19 at 3:44 PM. A grievance was never filed for it (regarding staff being rude to Resident #1). She thought during the care plan meeting there was a discussion about the incident. However, she did not attend the staff meeting. She stated if there was a grievance voiced during a care plan meeting, then a grievance would be filed, and the complaint would be investigated.

The Administrator was interviewed on 7/11/19 at 3:51 PM. He revealed the social worker kept the grievance log. He was never informed of this conflict/issue between Resident #1 and a staff member. He stated a specific name of the alleged staff was never given, so there was nothing to investigate. He stated the resident's family stated (to other staff), they didn't want to get anyone in trouble and the resident never voiced anything about the concern. He stated it was everyone's responsibility to file a grievance if a concern was brought up.

The Administrator was interviewed on 7/12/19 at 12:14 PM. He stated anyone could complete a grievance, the grievance would be discussed and then filed with the social worker. When a resident/person voiced a concern that they could not handle immediately, then a grievance should

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F 585	Continued From page 6 be filed. He stated this incident regarding Resident #1 was different because it was a generalized complaint, so they were unable to act on it. He stated he would expect for grievances to be filed in a timely manner and that the issue would be addressed.	F 585		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and facility staff and physician interview, the facility failed to provide the continuous positive airway pressure (CPAP) device as ordered and signed on the Medication Administration Record that the device was administered/placed (Resident #3) for 1 of 2 residents reviewed for CPAP management. Findings included: Resident #3 was admitted to the facility on 6/17/19 with respiratory failure and aspiration pneumonia. A review of Resident #3 ' s physician order dated 7/2/19 resident may use home CPAP machine at home settings timed 9 pm. A review of Resident #3 ' s Medication Administration Record (MAR) for July 2019 for CPAP machine at home settings timed 9 pm (signatures for each day/time 7/1/19 - 7/10/19).	F 658	This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. The order for the CPAP machine for Resident #3 was changed from twice daily to once daily on July 12, 2019. Nurse #5 was counseled regarding signing off on orders when completed. All nurses were inserviced by the ADON on following orders as written, including documentation of a resident's refusal of care. All patients receiving oxygen have the ability to be affected so an inservice was completed by the ADON with all nursing staff regarding policies and procedures related to respiratory services on July 12, 2019. All Oxygen orders have been	8/9/19

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F 658	Continued From page 7 A review of Resident #3 ' s care plan dated 7/1/19 revealed respiratory deficit: CPAP may be used with home settings (no time for placement was provided). A review of Resident #3 ' s 5-day Minimum Data Set dated 7/8/19 revealed the resident had clear speech, was understood and understands. His vision was severely impaired. The resident ' s cognition was moderately impaired with a memory deficit. The resident required total dependence for all activities of daily living. Active diagnoses were respiratory failure and pneumonia. On 7/11/19 at 10:30 am an interview was conducted with Resident #3 who stated "no" to question of whether he had received his CPAP each night (resident was not able to state which nights he did not receive the CPAP). On 7/11/19 at 12:05 pm an interview was conducted with Resident #3 ' s physician who stated the resident requested his CPAP for every night and an order was provided after the family provided the at-home settings. The resident was comfortable with his CPAP placed each evening and removed in the morning (placed once a day). The physician expected the staff to follow their policy. A review of Resident #3 ' s medication administration record (MAR) dated July 11, 2019 at 10 pm revealed Nurse #5 signed for CPAP mask and device placement/usage. On 7/11/19 at 11:30 pm an observation was done of Resident #3 who was in his bed with the head	F 658	verified to insure they are correct. The unit manager will conduct daily audits of all new orders in the facility for 1 week and then weekly for 4 weeks. The results of these audits will be reported in the monthly QA meetings until substantial compliance has been achieved.	

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of the bed elevated. The resident was receiving oxygen from a concentrator set at 2 liters via nasal cannula. The resident was alert and able to answer simple questions. Nurse #3 (night shift 11:00 pm to 7:00 am) entered the resident ' s room to obtain the call light from off the floor and commented "the CPAP was not placed on evenings. He (the evening nurse 3:00 pm to 11:00 pm from the previous shift) must have been busy." Nurse #3 proceeded to place the CPAP mask on Resident #3.

On 7/11/19 at 11:35 pm an interview was conducted with Nurse #3 who was familiar and assigned to Resident #3 and stated that the resident wanted his CPAP each night and had a history of respiratory failure. She stated that the resident ' s CPAP order was for placement at 10:00 pm and evening shift was responsible. She further inidicated she was not aware the CPAP was not placed until she entered the room at 11:35 pm. The evening nurse had already left the facility.

On 7/12/19 at 10:10 am an interview was conducted with Nurse #5 who was assigned to Resident #3 on evening shift (3:00 - 11:00 pm) on 7/11/19. Nurse #5 commented that he was not familiar with the resident. He asked Resident #3 at 10:00 pm if he was ready to have his CPAP mask placed and the resident stated no he was watching a movie. Nurse #5 directed the resident to use the call light when he was ready to have his CPAP mask placed. Nurse #5 stated he signed the 7/11/19 10:00 pm MAR for CPAP placement after the resident declined and the mask was not placed, and he did not write a nursing note that the CPAP was not placed due to decline. He commented that the resident did not

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F 658	Continued From page 9 use his call light, and he did not return to the resident ' s room on his shift. Nurse #5 stated that he informed the oncoming night nurse (could not remember her name) during shift change report that he did not place Resident #3 ' s CPAP mask. He commented that he should not have signed for the CPAP mask because staff coming behind him could assume the CPAP mask was already in place if the resident was not observed. Nurse #5 stated that he signed for an order that was not done and also stated that he will not sign the MAR for a physician order in the future unless it was completed. On 7/12/19 at 12:30 pm an interview was conducted with the Director of Nursing (DON) who stated she expected nursing staff to sign the MAR when the order was completed and if the resident declined to document in the nurses note and report at shift change. Staff should not sign the MAR if the order was not completed. The DON stated she was not aware that Nurse #5 had signed for Resident #3 ' s CPAP placement which was not done. The DON commented that the resident received his CPAP mask in the evening on evening shift as he had at home.	F 658		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		8/9/19

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F 695	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and facility and physician interview, the facility failed to clean and store the continuous positive airway pressure (CPAP) mask, to properly place the CPAP mask and to follow the physician ' s order for placement according to industry standard (Residents #3 and #7) for 2 of 2 residents reviewed for CPAP management. Findings included: A review of the facility CPAP cleaning policy dated 2019 ("The compliance store, LLC") date of implementation was blank which was provided by the Administrator revealed hand hygiene and gloves before touching the CPAP, for humidification use sterile water and empty the chamber completely after each use and wipe dry, and to clean the mask (CPAP) with warm soapy water daily after use, dry well and cover with plastic bag or completely enclose in machine storage when not in use. 1. Resident #3 was admitted to the facility on 6/17/19 with respiratory failure and aspiration pneumonia. Resident #3 ' s physician order dated 6/17/19 revealed administer oxygen to maintain saturation >90%. Order dated 6/21/19 for CPAP may use home machine at home settings (resident wore the CPAP at bedtime for the night). A review of Resident #3 ' s physician order dated 7/2/19 resident may use home CPAP machine at	F 695	This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. The CPAP machines for Residents #3 and #7 were dated, cleaned, and stored properly on July 12, 2019. The word "sterile" has been changed to "distilled" in the facility policy and procedure. All residents using oxygen have the ability to be affected. An audit was completed to ensure proper storage and cleaning of all CPAP machines in the building on July 12, 2019. An inservice was provided by the ADON to all nursing staff related to the proper storage and cleaning of oxygen equipment, including CPAP machines, and ensuring proper documentation including a resident's refusal of care on July 12, 2019. A unit manager will perform checks on 5 residents with respiratory orders daily for 1 week and then weekly for 4 weeks to ensure all CPAP machines in the building are stored and cleaned properly each day for 1 week and then weekly for 4 weeks. The results of these audits will be reported in the monthly QA meetings until substantial compliance is achieved.	

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home settings timed 9 pm.

A review of Resident #3 ' s Medication Administration Record (MAR) for July 2019 revealed CPAP machine at home settings may use timed 9 pm and was signed for each time and each date (7/1/19 - 7/10/19).

Resident #3 ' s care plan dated 7/1/19 revealed respiratory deficit: CPAP may use with home settings (time for use was not provided).

Resident #3 ' s 5-day Minimum Data Set dated 7/8/19 revealed the resident had clear speech, was understood and understands. His vision was severely impaired. The resident ' s cognition was moderately impaired with a memory deficit and required total dependence for all activities of daily living. Active diagnoses were respiratory failure and pneumonia.

On 7/11/19 at 10:30 am an observation was done of Resident #3 who was in his bed with the head of bead (HOB) elevated to 30 degrees. The resident was alert and had no respiratory distress and oxygen via nasal cannula was flowing at 2 liters per minute. The resident was able to answer questions with simple sentences. The CPAP mask was sitting on the night stand, tubing was not dated and was not secured in a plastic bag or within a secured device.

On 7/11/19 at 10:30 am an interview was conducted with Resident #3 who stated "no" to question of whether he had received his CPAP each night. The resident could not recall how often.

On 7/11/19 at 12:05 pm an interview was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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conducted with Resident #3 ' s physician who stated that he was aware that the resident ' s family provided a CPAP on 6/18/19, he was provided the settings on 6/21/19 and ordered for the CPAP to be used with at-home settings at bedtime. The resident was required to have the HOB elevated and to his knowledge this was being done. The physician agreed and expected that the CPAP needed to be provided each night at bedtime, cleaned after each use and stored in a closed container to prevent any contamination. He expected the facility to follow their policy.

On 7/11/19 at 3:00 pm an observation was done of Resident #3 who was in his bed with a nasal cannula in place and oxygen flowing. The CPAP mask was sitting on the bedside table not in a container.

On 7/11/19 at 11:30 pm an observation was done of Resident #3 who was in his bed with the head of the bed elevated. The resident was receiving oxygen from an oxygen concentrator set at 2 liters via a nasal cannula. The resident was alert and able to answer simple questions. Nurse #3 (night shift 11:00 pm to 7:00 am) entered the resident ' s room to obtain the call light off the floor and commented "the CPAP was not placed on evenings. He (the evening nurse prior shift tonight 3:00 pm to 11:00 pm) must have been busy." Nurse #3 proceeded to place the CPAP mask (no gloves) over the nasal cannula and tightened the straps to secure the mask and prevent air leak. The resident began to flinch in his face because the nasal cannula was being compressed into his face. The nurse struggled to get the CPAP mask in place securely, but the nasal cannula was in the way. After being asked if a CPAP was usually placed over a nasal

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	345370	A. BUILDING _____ B. WING _____	C 07/12/2019

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cannula, the nurse removed the nasal cannula and properly placed the CPAP mask.

On 7/11/19 at 11:35 an interview was conducted with Nurse #3 who was familiar and assigned to Resident #3 and stated, after being asked if the CPAP was to be placed on top of a nasal cannula, that she would have figured out to remove the nasal cannula. She stated that you do not place a CPAP mask over a nasal cannula, the oxygen would be fed through the device. She commented that the resident wanted his CPAP each night at bedtime and had a history of respiratory failure, and the resident ' s CPAP order was for placement at 10:00 pm and evening shift was responsible for placing the CPAP but it was not placed this evening. The nurse commented she cleaned the inside of the CPAP mask with alcohol after use at the end of night shift and if the CPAP device had a humidification reservoir it was refilled. She was not familiar with the facility policy to clean the CPAP mask with warm soapy water, allow to dry and to cover with plastic bag or a sealed device, and that the humidification reservoir was to be emptied and dried when not used. Nurse #3 commented that the facility used distilled water and sterile was not normally used.

On 7/12/19 at 10:10 am an interview was conducted with Nurse #5 who was assigned to Resident #3 on evening shift (3:00 -11:00 pm) on 7/11/19 commented that he was not familiar with the resident. The nurse stated that he asked Resident #3 at 10:00 pm if he was ready to have his CPAP mask placed and the resident declined. He stated he informed the resident to place his call light on when he was ready to have his CPAP. He stated he signed for placement of the

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CPAP but did not complete the order and did not document that the resident declined. The nurse stated he was aware that a CPAP mask was required to be cleaned with warm soapy water after each use, allowed to dry, and placed in a secure container.

On 7/11/19 at 2:05 pm an interview was conducted with the Director of Nursing (DON) who stated that the staff used distilled water for CPAP humidification. The DON expected the mask to be cleaned after use and placed by night staff as ordered or evening staff if scheduled for 3:00 pm - 11:00 pm. She was not aware that the facility policy indicated that sterile water was to be used for CPAP humidification. She also stated assigned staff was expected to manage the CPAP: to make sure the CPAP was cleaned and stored in a plastic bag or within the device, to refill the reservoir with distilled water, and when completed to clean the CPAP and empty/dry the reservoir.

2. Resident #7 was admitted to the facility on 6/28/19 with the diagnoses of acute respiratory failure with hypoxia, acute diastolic congestive heart failure, chronic obstructive pulmonary disease, and dependence on oxygen.

A review of Resident #7 ' s initial Minimum Data Set dated 6/28/19 revealed the resident entered from an acute hospital. The resident had an intact cognition.

A review of Resident #7 ' s care plan dated 7/1/19 revealed no initial or comprehensive care plan for respiratory or cardiac diagnosis and treatment.

On 7/11/19 at 11:30 am an interview was

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conducted with Resident #7 who stated he brought his CPAP from home and washed his mask after each use at home when he was able. The resident stated that the open gallon of water on the night stand was the water used in his CPAP machine and he had not witnessed staff clean his CPAP mask since his admission nor had they stored the CPAP mask in a bag or other device. He was bedbound at present and unable to manage his CPAP. The resident stated that he used a urinal and placed it on the bedside table next to the CPAP mask because that was the only place available and staff would then empty the urinal for him. He also commented that the other night "the nurse was unable to get his CPAP going and went without the CPAP for that night." Resident #7 stated he did not inform the facility staff of his concern.

On 7/11/19 at 11:30 am an observation was done of Resident #7 in his room. The water for CPAP was not labeled sterile and was open without a cap in a clear gallon plastic jug. The CPAP mask was sitting on the night stand and not in a bag or other enclosure device. The CPAP device was not in use and had a half-full reservoir.

On 7/11/19 at 12:05 pm an interview was conducted with Resident #7 ' s physician who stated that he was aware that the resident provided his own CPAP mask and device from home during his admission to the facility. The physician agreed and expected that the CPAP needed to be provided each night by staff, cleaned after each use and stored in a container to prevent any contamination. The facility was expected to follow their policy.

On 7/11/19 at 11:07 pm an observation was done

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of Resident #7 who was in his bed supine and flat, sleeping and wearing his CPAP mask. The CPAP humidifier water reservoir was noted to be empty.

On 7/11/19 at 11:11 pm an interview was conducted with Nurse #1 who stated she offered the CPAP to Resident #7 at 8 pm as ordered and he was not ready to wear the CPAP at this time. The nurse indicated she did not document the refusal and if the resident had his CPAP on now, he placed it himself. Nurse #1 also stated that she did not check Resident #7 ' s CPAP mask or device when she offered to place the CPAP and the CPAP mask was found in the resident ' s night stand drawer with his other personal items (not in a plastic bag or other storage device). She stated she directed the resident to place his call light on when he was ready to have his CPAP placed but she did not return to the resident ' s room from 8:00 pm to the end of her evening shift at 11:00 pm to offer CPAP placement and the resident had not used his call light for assistance. The nurse stated she was not familiar with the facility CPAP policy nor the resident because she was new and further stated she didn ' t know if the resident was independent with his CPAP and did not know what was in the resident ' s care plan. The nurse stated she was aware that the CPAP reservoir required water during usage and commented that this was the first time she was assigned to Resident #7 and her 3rd week at the facility, and she was still learning. Nurse #1 stated the night nurse would be responsible to place the CPAP if the resident declined during her shift.

On 7/11/19 at 11:19 pm an interview was conducted with Nurse #2 who stated she has been assigned to Resident #7 and would be

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responsible to place his CPAP this night shift. The nurse indicated that she had not washed the resident ' s CPAP mask after use and it had not been stored in a plastic bag or other secured device. The nurse commented that she was not familiar with the facility ' s CPAP use and management policy and the facility currently used distilled water for the CPAP humidification reservoir. She also commented that she was not aware the policy required the water reservoir to be emptied and dried after use and the CPAP mask was to be washed with warm soapy water and allowed to dry before storage. The nurse stated she would check on the resident now (for proper CPAP placement).

On 7/11/19 at 2:05 pm an interview was conducted with the Director of Nursing (DON) who stated that the staff used distilled water for CPAP humidification and she expected the mask to be cleaned with warm soapy water after use and placed by night staff as ordered or evening staff if scheduled for 3:00 pm - 11:00 pm. The DON was not aware that Resident #7 stated his CPAP mask was not cleaned, the nurse could not get the CPAP operating the other night, and the resident did not wear his CPAP for that night. She was not aware that the facility policy indicated that sterile water was to be used for CPAP humidification. She expected staff assigned to manage the CPAP to make sure it was cleaned and stored in a plastic bag or within the device, to refill the reservoir with distilled water, and when completed to clean the CPAP and empty/dry the reservoir.