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	345109	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY PLACE	24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001

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E 000	Initial Comments An unannounced Recertification survey was conducted on 8/19/19 through 8/22/19 The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #7YL011.	E 000		
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 reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately in the areas of bowel and bladder (Resident #69) and medication (Resident #59) for 2 of 17 sampled residents. The findings included: 1) Resident #69 was admitted to the facility on 5/10/19 and was discharged home on 6/11/19. His diagnoses included a history of malignant neoplasm of the rectum and presence of a colostomy. The admission MDS dated 5/21/19 revealed the resident was cognitively intact. The resident was coded as Not Rated (resident had an ostomy or did not have a bowel movement for the entire 7 days) for bowel incontinence, but not marked with an ostomy present. During an interview with the MDS Nurse #1 on 8/22/19 at 11:05am, she confirmed the resident had a colostomy and it was not marked on the	F 641	-Corrective action for resident #69 was addressed to accurately reflect the resident's status. Resident #69 MDS was corrected by the Minimum Data Set Coordinator Registered Nurse on 8/22/2019 to accurately reflect that the resident had a colostomy present on admission and submitted on 8/27/2019, validation was received. - Corrective action for resident #59 was addressed to accurately reflect the resident's status. Resident #59 MDS was corrected by the Minimum Data Set Coordinator Registered Nurse to accurately reflect the resident receipt of an antidepressant and medication and submitted on 8/27/2019, validation was received. - The facility addressed other residents having the potential to be effected by the accuracy of coding for colostomy and/ or antidepressant medication on the	9/18/19

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

Electronically Signed | 09/03/2019

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F 641	Continued From page 1 MDS assessment. She stated it was an error. An interview was conducted on 8/22/19 at 11:15am with the Director of Nursing. She indicated it was her expectation for the MDS to be coded accurately. 2. Resident #59 was admitted to the facility on 4/30/19 with the diagnoses of non-Alzheimer ' s dementia and depression. The resident ' s quarterly MDS dated 8/5/19 documented the resident had a moderate cognitive deficit. The resident required limited assistance for transfer and toileting and extensive assistance for bathing. The resident ' s active diagnoses were non-Alzheimer's dementia and depression. The resident was coded as having received medication for 7 days of an anti-anxiety. The resident ' s documented Medication Administration Record was reviewed for dates July 30, 2019 to August 22, 2019 which revealed no anti-anxiety was administered. A review of the resident ' s physician orders revealed no anti-anxiety medication ordered for the August 5, 2019 MDS look-back period of July 30, 2019 to August 5, 2019. The documented care plan updated on 5/9/19 addressed depression and anti-depressant side effects. There was no mention of anxiety. On 8/22/19 at 10:30 am an interview was conducted with MDS Nurse #1 who stated that the resident ' s quarterly MDS dated 8/5/19 coded for 7 days of anti-anxiety medication received was an error and would be corrected. An anti-depressant medication was mistaken for an	F 641	Minimum Data Set. The Minimum Data Set Registered Nurse and Director of Nursing will complete an accuracy coding audit on all residents having a physician order for a colostomy and/or physicians order for antidepressant medication by reviewing the MDS's to ensure coding accuracy. - The facility will implement systematic changes by having the Minimum Data Set Registered Nurse or Minimum Data Set Registered Nurse Coordinator review coding on MDS prior to submission to ensure accuracy of MDS. A weekly accuracy audit for the colostomy and antidepressant coding on the Minimum Data Set will be completed by the Minimum Data Set Registered Nurse and/or the Director of Nursing for one month and then monitored until three months of compliance is sustained. - The facility plans to monitor the performance of the MDS accuracy coding plan of action by the Director of Nursing presenting the accuracy audit outcome at the Quality Assurance Committee monthly. This information will be provided to the committee for one month and additional three months until 3 months of compliance is sustained.	

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F 641	Continued From page 2 anti-anxiety medication. On 8/22/19 at 11:30 am an interview was conducted with the Administrator who stated she expected the MDS coding to be accurate.	F 641		
F 656 SS=D	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.	F 656		9/18/19

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F 656	Continued From page 3 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the 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, observation, and staff and resident interview, the facility failed to develop a resident care plan in the areas of medication refusal and hemodialysis fistula management (Residents #15 and #26) and failed to implement the resident care plan in the area of edema (Resident #169) for 3 of 17 residents reviewed. Findings included: 1. Resident #26 was admitted to the facility on 12/4/14 with diagnoses of Alzheimer's disease and depression. The resident ' s care plan last updated on 7/5/19 revealed problem for potential adverse consequences from antidepressant. There was no mention of medication refusal. The resident ' s quarterly Minimum Data Set (MDS) dated 7/9/19 revealed the resident was severely cognitively impaired. The resident required 1 staff physical assistance for most activities of daily living. The active diagnoses were non-Alzheimer's dementia, anxiety, and depression. A review of the resident ' s 3/1/19 to 8/22/19	F 656	Corrective action for resident #26 was completed to the care plan by the Minimum Data Set Registered Nurse on 8/30/2019. The update to the care plan reflects the resident's refusal of medications at times and the need to notify the physician if the resident refuses any medication for three consecutive days. - Corrective action for resident #169 was completed on 8/30/2019, by the Minimum Data Set Registered Nurse to the care plan. The update reflected the resident's need for edema monitoring to lower extremity by a licensed nurse if the edema is +2 or greater and the need to to notify the physician when the edema is +2 or greater. - Corrective action for resident #15 was completed on 8/22/2019, by the Minimum Data Set Registered Nurse. the update reflects the care precautions associated with resident #15's AV fistula, no blood pressure checks and/ or lab work to occur in left arm.	

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F 656	Continued From page 4 nurses ' notes and Medication Administration Record revealed there were several occasions (averaged 7 times per month) that the resident refused most of her medications, including anti-depressants. The resident ' s physician note dated 4/17/19 revealed she was compliant with the health care team. The resident was working with the behavioral team and her dementia was advancing with decline. On 8/20/19 at 3:00 pm an interview was conducted with Nurse Supervisor #2 who stated she was aware that the resident refused her medication occasionally and that the physician was aware. The nurse was not aware that medication refusal was not care planned. An interview was conducted with the physician on 9/21/19 at 9:45 am who stated he was notified that the resident periodically refused her meds due to dementia/behaviors. The physician stated he was notified and had no concerns. An interview was conducted on 9/22/19 at 10:30 with the Director of Nursing who indicated she expected the resident ' s care plan to meet the needs of each individual resident. 2. Resident #169 was admitted to the facility on 12/10/16 with the diagnoses of congestive heart failure, atrial fibrillation, and oxygen dependence. The quarterly MDS dated 8/5/19 documented the resident was severely cognitively impaired. The resident required one-person physical assist for all activities of daily living. The active diagnoses were atrial fibrillation, hypertension, congestive	F 656	- The facility addressed other residents having the potential to be effected by reviewing care plans for residents on a diuretic, residents refusing antidepressants and residents with AV fistulas. A care plan audit will be conducted by the Director of Nursing on 9/4/2019. The audit will included reviewing care plans for residents receiving antidepressants to ensure interventions of refusals of medications and notification to physician if resident refused for three consecutive days was addressed. The care plan audit tool also addressed residents on a diuretic to ensure interventions were in place to monitor edema and notification to physician if 2+ edema or greater was noted. The audit also included reviewing of care plan with residents that have AV fistulas to ensure that care precautions are reflected- no blood pressures checks and/or lab work is taken in indicated arm. - The systematic changes the facility is putting in place is providing education to the Minimum Data Set Registered Nurse and the Minimum Data Set Coordinator to address care plans to have in place for residents refusing antidepressants, residents on diuretic addressing monitoring of 2+ edema and contacting the physician, and precaution of care for residents with a AV fistulas. The education will be provided by the administrator and Minimum Data Set facility consultant. - The facility will also implement an audit	

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F 656	Continued From page 5 heart failure, and dependence on supplement oxygen. The resident received oxygen therapy. The resident ' s care plan dated 8/5/19 revealed a problem for congestive heart failure and approach to notify the physician as needed and to assess for edema. The care plan was noted to be updated on 8/19/19 and the approaches were removed, and a new problem was added for diuretic with an approach to assess edema, determine the severity and to review the resident ' s labs. Nurses ' note dated 8/16/19 at 10:16 pm documented no edema (lower extremities). Nurses ' note dated 8/17/19 documented no edema (lower extremities). Nurses ' note had no other documentation of edema assessment identified in the record from 8/17/19 to 8/21/19. On 8/19/19 at 10:30 am an observation was done of the resident and bilateral lower leg (foot and calf) edema of the right leg +1 and left leg +2 was noted. The resident was wearing socks and sneakers. TED hose were not present at this time. The resident was wearing a nasal cannula with oxygen flowing at 1.5 liters from an oxygen concentrator. The resident appeared tired and was breathing a little deeper when talking. On 8/19/19 at 10:30 am an interview was conducted with the Resident who stated that her edema had increased in her feet and legs over the past couple of days. The resident commented the nurse saw her legs this morning when she gave her the medication. On 8/20/19 at 4:30 pm an observation was done	F 656	to monitor monthly care plans for resident with Congestive Heart Failure that are on a diuretic, contacting the physician when edema is present of 2+ or greater, having care precautions for AV fistulas for resident on dialysis, monitoring care plans for residents on antidepressant medications that refuse their medications, and notification to physician when medications are refused for three consecutive days. This audit will be completed by the Director of Nursing and will continue to be monitored until three months of compliance is sustained. - The facility plans to monitor the performance of the care plan audit by the Director of Nursing presenting the care plan audit outcomes at the Quality Assurance Committee monthly until three consecutive months of compliance is sustained.	

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F 656	Continued From page 6	F 656		

of the resident dressed and sitting in her wheel chair. Her lower leg edema was the same and TED hose were not present.

An interview on 8/20/19 at 4:30 pm was conducted and the resident stated that she did not have shortness of breath but that she had increased weakness. The resident commented that the nurse was aware of her edema.

An observation was done on 8/21/19 at 11:10 am of the resident and Nurse Supervisor #1 observed that the resident was on 3 liters, which was an increase.

A review of the physician communication book was done and there was no communication that the resident had increased edema or need for increased oxygen flow rate.

The resident ' s nurses ' note revealed night shift 8/20/19 documented +1 pitting edema.

On 8/21/19 at 11:20 am an interview was conducted with the resident ' s physician who stated he was not informed that the resident had increased edema, weakness and an increase in oxygen flow rate this morning. The resident was not on his schedule to be seen today.

On 8/21/19 at 11:22 am an observation was done of the Physician assess the resident. The physician commented that the resident ' s edema was up.

Nurse #2 was interviewed on 8/21/19 at 11:24 am and stated that she that noted the "resident ' s edema and the resident was moved up from 2 liters to 3 liters of oxygen this morning because

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F 656	Continued From page 7	F 656		

her pulse oximetry was in the 80's and I had not documented yet." Nurse #2 commented that she had not informed the physician today (care planned).

On 8/22/19 at 10:30 am an interview was conducted wit the DON who stated she expected staff to follow (implement) the care plan.

3. Resident #15 was admitted on 6/17/19 with End Stage Renal Disease.

Review of Resident #15's annual Minimum Data Set (MDS) dated 6/28/19 indicated moderate cognitive impairment with no exhibited behaviors. He was coded for dialysis.

Review of Resident #15's care plan dated 6/26/19 read he required dialysis with an arteriovenous (AV) fistula. (An AV fistula is an abnormal connection between an artery and a vein designed to make a blood vessel wider and stronger to handle the needles that allow blood flow out and return from the dialysis machine). Interventions included observation for signs of infection, assessment for patency by palpitation for a trill (rumbling sensation when touched) and bruit (a rumbling sound heard with a stethoscope). The care plan made no mention of the interventions or precautions regarding blood pressures and lab work should not be done on the AV fistula arm.

Review of the undated Aide Guidelines for Daily Care did not include any instructions related to the care or precautions associated with Resident #15's AV fistula.

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F 656	Continued From page 8 In an interview on 8/21/19 at 2:52 PM, Resident #15 was in his room sitting up in his wheel chair. Observed was his AV fistula to his left forearm. He stated the staff only check his blood pressure in his right arm and his lab work was done usually at dialysis but if anyone tried to draw blood from his left arm, he knew to tell them no since he had an AV fistula in his left arm. In an interview on 8/21/19 at 2:56 PM, Nursing Assistant (NA) #2 stated she was instructed that Resident #15 could not have his blood pressure taken in his left arm because of the AV fistula. She confirmed that no special precaution was on his Guidelines for Daily Care but was aware of the precaution. In an interview on 8/21/19 at 3:10 PM, Nurse #1 stated Resident #15 was not allowed any blood pressures or lab work to his left arm because of his AV fistula. In an interview on 8/22/19 at 11:10 AM, the Director of Nursing (DON) stated Resident #15 was the first dialysis resident in many years. MDS Nurse #2 stated she was not familiar with specific precautions associated with a dialysis access. The DON and MDS Nurse #2 stated it was their expectation that the precautions of no blood pressures or lab work to Resident #15's left arm should be care planned and added to his Guidelines for Daily Care.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		9/18/19

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F 684	Continued From page 9 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff, resident, and Physician interview, the facility failed to assess the resident ' s edema, place TED hose as ordered, and identify development of congestive heart failure for 1 of 4 residents reviewed for respiratory (Resident #169). Findings included: Resident #169 was admitted to the facility on 12/10/16 with the diagnoses of congestive heart failure, atrial fibrillation, and oxygen dependence. The quarterly Minimum Data Set dated 8/5/19 documented the resident was severely cognitively impaired. The resident required one-person physical assist for all activities of daily living. The active diagnoses were atrial fibrillation, hypertension, congestive heart failure, and dependence on supplement oxygen. The resident received oxygen therapy. The resident ' s care plan dated 8/5/19 revealed a problem for congestive heart failure and approach to notify the physician as needed and to assess for edema. The care plan was noted to be updated on 8/19/19 and the approaches were removed, and a new problem was added for diuretic with an approach to assess edema, determine the severity and to review the resident ' s labs.	F 684	- Corrective action for resident #169 was immediately taken when licensed nurse was informed that TED hose were not in place as ordered on 8/21/2019. Physician was notified on 8/21/2019 that oxygen saturations had decreased and an increase in oxygen liters was implemented earlier that morning. Physician was on site and assessed resident on 8/21/2019. During physician assessment on 8/21/2019, the physician noted edema had increased. Physician ordered labs and chest x-ray on 8/21/2019. - The facility will address other residents having the potential to be effected by auditing all residents with TED hose orders to ensure TED hose are in place and orders are on the Medication Administration Record. The facility will address residents with congestive heart failure by ensuring weekly body checks and the last month of nurses notes has been reviewed by the Director of Nursing and or Staff Development Registered Nurse to ensure any edema 2+ or greater has been communicated to the physician and any oxygen saturations below 90 percent has been communicated to the	

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F 684	Continued From page 10 The resident ' s nurses' note dated 8/3/19 to 8/6/19 documented no edema present. Nurses ' note dated 8/7/19 edema was present (amount not documented). Ted hose were ordered. Nurses ' note dated 8/8/19 documented +1 edema pitting edema to lower extremities. Signed by Nurse #2. Nurses ' note dated 8/8/19 at 4 pm documented the resident oxygen desaturated to 83% (order to stay aboe 90%) with use of accessory muscles. Oxygen 3 liters applied with an increase to 95% by Nursing Supervisor #1. At 6:36 pm the chest x-ray resulted pulmonary congestion. Forty milligrams of Lasix (diuretic) was provided now (in addition to the daily Lasix dose). Nurses ' note documented by Nursing Supervisor #2 documented on 8/11/19 revealed the resident had +1 pitting edema (lower extremities). Nurses note dated 8/13/19 documented non-pitting edema (amount not provided). Nurses ' note dated 8/15/19 documented 2 liters oxygen per minute with 93% oxygen saturation and no shortness of breath (no edema documentation). Nurses ' note dated 8/16/19 at 10:16 pm documented no edema (lower extremities). Nurses ' note dated 8/17/19 documented no edema (lower extremities). Nurses ' note had no other documentation of edema assessment identified in the record from 8/17/19 to 8/21/19. On 8/19/19 at 10:30 am an observation was done of the resident and bilateral lower leg (foot, ankle and calf) edema of the right leg +1 and left leg +2 was noted. The resident was wearing socks and sneakers. Ted hose (compression hose to help return edeam to the circulator system) were not	F 684	physician. - The facility will put in place a monitoring audit tool for residents with congestive heart failure which will include monitoring nursing documentation weekly for residents with congestive heart failure to ensure the physician is notified if edema increases to +2 or above, if respiratory saturation drops below 90 percent, and if resident experiences other congestive heart failure symptomatic changes from baseline. The audit tool will also review the TED hose application on the medication administration record to ensure TED order is followed. The Director of Nursing or Staff Development RN will also complete three visual checks a week on residents with TED hose to ensure proper application. The initial audit will be completed on 9/4/2019 by the Director of Nursing. These audits will continue until three months of compliance is sustained. - Education will be provided to all licensed nurses on reading pulse saturations, when to contact physician on pulse saturations, edema, and symptomatic changes that may occur with congestive heart failure residents from baseline that the physician needs to be notified. Education will be provided by the Staff Development Registered Nurse or Director of Nursing. - Education will be provided to all certified nursing assistants on application of TED	

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F 684	Continued From page 11 present at this time. The resident was wearing a nasal cannula with oxygen flowing at 1.5 liters from an oxygen concentrator. The resident appeared tired and was breathing a little deeper when talking. On 8/19/19 at 10:30 am an interview was conducted with the resident who stated that her edema had increased in her feet and legs over the past couple of days. The resident denied shortness of breath or increased weakness. The resident stated she needed her oxygen but was not sure the liter flow rate. The resident commented the nurse saw her (leg edema) this morning when she gave her the medication. On 8/20/19 at 4:30 pm an observation was done of the resident dressed and sitting in her wheel chair. Her lower leg edema was the same and Ted hose were not present. The resident had her nasal cannula in place and the oxygen was flowing at 1.5 liters from the oxygen concentrator. The resident required deeper breathes while talking and mild supraclavicular retraction. An interview on 8/20/19 at 4:30 pm was conducted and the resident stated that she did not have shortness of breath but that she had increased weakness. The resident commented that the nurse was aware of her edema today. An observation was done on 8/21/19 at 11:10 am of the resident trying to get up on her own from the wheel chair. The resident was calling "help me, I need to get to the bathroom." Help was summoned from Nurse Supervisor #1 who observed that the resident was on 3 liters and was not sure of the flow rate and asked for Nurse #2 (assigned nurse) to assist. Nurse Supervisor	F 684	hose. - The congestive heart failure monitoring tool will be completed weekly for a month and then continue until three months of compliance is sustained. The audit tool will monitor edema documentation, notification to physician and oxygen saturation, ted hose application for resident with congestive heart failure. The audit tool will be presented to the Quality Assurance Committee until three months of compliance is noted by the Director of Nursing.	

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#1 commented that she was not comfortable taking the resident to the bathroom on 3 liters. Nurse #2 was not available so other staff assisted. Nurse Supervisor #1 checked the pulse oximetry which was 97% and lowered the resident to 2 liters.

A review of the physician communication book was done and there was no communication that the resident had increased edema or need for increased oxygen.

The resident ' s nurses ' note revealed night shift 8/20/19 documented +1 pitting edema.

On 8/21/19 at 11:20 am an interview was conducted with the resident ' s physician who stated he was not informed that the resident had increased edema, weakness and a need for increased oxygen this morning or edema earlier in the week. The physician further stated he was not informed by the nurse or had written communication in the physician book (housed at the nurses' station). The physician stated he would want to be notified of the resident ' s change in condition. The resident was not on his schedule to be seen today.

On 8/21/19 at 11:22 am an observation was done of the Physician assess the resident. The physician commented that the resident ' s edema was up. Nurse #2 arrived and stood at the doorway.

Nurse #2 was interviewed at 11:24 am and stated that she that noted the "resident ' s edema and the resident was moved up from 2 liters to 3 liters this morning because her oxygen pulse oximetry was in the 80's and I had not documented this

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yet." Nurse #2 stated that she had not informed the physician of the resident ' s change.

Observation of Nurse #2 at time of interview while standing in the resident ' s doorway noted she did not inform the physician of the resident's change while he was present. The resident ' s drop in pulse oximetry reading, increase in oxygen administration, and edema information was relayed to the physician by the Surveyor. Nurse Supervisor #1 remained with the resident during the physician's assessment and then assisted the resident to the bathroom. Upon return from the bathroom the resident was short of breath using accessory muscles, breathing deeper when speaking, and waiting in between words. The resident nodded her head "yes" when asked if she was short of breath. Nurse Supervisor #1 moved the resident from her room to the nurses ' station for closer observation.

Nurse #2 was interviewed 8/21/19 at 11:40 am who stated that she did not inform the physician of the resident's lower pulse oximetry (80s) and need for increase in oxygen flow rate this morning. She commented that she was assigned to the resident yesterday and noted the edema (lower extremities). Nurse #2 acknowledged that the resident was usually on 2 liters of oxygen but increased the oxygen to 3 liters to address the resident's drop in pulse oximetry to the 80's this morning. Nurse #2 was aware that the resident was to wear TED hose on in the am and off in the pm for the edema. She passed medications this morning when the resident was in the bed and did not assess for TED hose. The hose were currently not in place. Nurse #2 commented that the Nursing Assistants were required to place the hose when they get the resident out of bed and

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must not have done that. Nurse #2 was asked about the hose from yesterday that were not observed to be in place and signed for on the Medication Administration Record. She responded that she would notify the physician of increased edema and a drop in oxygen pulse oximetry level but had not informed the physician of the resident's change this morning.

The Administrator was informed on 8/21/19 at 11:55 am of the resident's edema, TED hose, change in assessment and interview with Nurse #2. Administrator stated that it would be addressed and that her behavior was not the expectation.

Physician order dated 8/21/19 for chest x-ray rule out congestive heart failure, fluid overload and labs for medication management and edema.

Chest x-ray was reported on 8/21/19 and faxed to the facility at 6:55 pm. Results were right basilar infiltrate with right pleural effusion, a new development since x-ray of 8/8/19.

Nurses' note dated 8/21/19 family notified of x-ray results. Three extra doses of Lasix 20 milligrams ordered each day and follow up with the infacility provider.

Nurses ' note dated 8/22/19 7:28 am resident ' s pulse oximetry was 90%. Physician ' s Assistant visited and no new orders. Pitting edema +2 left foot and +1 right foot while legs were elevated.

On 9/22/19 at 10:30 am an interview was conducted with the Director of Nursing who stated she expected staff to assess and report any resident changes in condition and place Ted hose

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F 684	Continued From page 15 as ordered.	F 684		
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. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews, the facility failed to administer continuous oxygen at the Physician ordered flow rate for Resident #54 and Resident #64. The facility also failed to store a nebulizer mask in a sealed bag when not in use for Resident #22. This was for 3 of 4 residents reviewed for respiratory care. The findings included: 1. Resident #54 was admitted on 3/12/18 with cumulative diagnoses of Chronic Obstructive Pulmonary Disease and oxygen dependence. Resident #54's annual Minimum Data Set (MDS) dated 7/24/19 indicated moderate cognitive impairment and she exhibited no behaviors. She was coded for the use of oxygen. Resident #54's care plan dated 7/30/19 indicated a potential for altered respiratory status with the intervention administration of oxygen as ordered.	F 695	- Corrective action for resident #54 was adjusted to 2 liters per minute per physicians order,as noted on 8/21/2019 - Corrective action for resident #64 was adjusted to 3 liters per minute per physicians order on 8/21/2019 by hall nurse. - Corrective action for resident #22 nebulizer mask was placed in a sealed bag at his bedside on 8/21/2019 by hall nurse - The facility will address other residents having the potential for incorrect oxygen settings and/or not having proper storage of nebulizer mask when tubing is not in use. The Director of Nursing and/or Medical Records Coordinator will audit all oxygen orders to make sure that orders are correctly reflected on the medication administration record. The Staff	9/18/19

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F 695	Continued From page 16 Review of Resident #54's August 2019 Physician orders read as follows: Administer oxygen at 2 liters per minute (2L/M) per nasal cannula continuous. Review of Resident #54's Medication/Treatment Administration Record for August 2019 indicated staff were to ensure her oxygen was being administer continuously at 2L/M. Licensed nurses initials documented indicated Resident #54 oxygen was administered as ordered with the exception on one omission on 8/11/19 third shift. Nurse #1 initialed off on first shift for 8/19/19, 8/20/19 and 8/21/19. Observations on 8/19/19 at 9:45 AM and again at 3:45 PM revealed Resident #54's continuous oxygen was running at 4L/M via oxygen concentrator. In an observation on 8/20/19 at 10:20 AM, Resident #54 was observed in her room sitting up in her wheelchair. Her oxygen was running a 2L/M via a portable oxygen tank. In an observation on 8/20/19 at 4:10 PM, Resident #54 was observed lying in bed. Her oxygen was running at 4L/M via oxygen concentrator. In an observation on 8/21/19 at 8:55 AM, Resident #54 was observed lying in bed. Her oxygen was running at 4L/M via oxygen concentrator.	F 695	Development Coordinator and/or Director of Nurse will check all nebulizer machines to ensure proper storage bags are present for equipment. - The facility will implement systematic changes by providing education to all licensed nurses on monitoring oxygen flow rate, documenting on the medication administration record each shift. The in-service will also include proper storage of nebulizer mask in a sealed bag when not in use. The Staff Development Coordinator and/ or Director of Nursing will provide this education. The Director of Nursing and /or Staff Development Coordinator will audit physician orders, medication administration records for oxygen use and complete three visual checks a week of oxygen use and two visual checks on nebulizer mask storage. These weekly checks will continue for one month and then continued until three more months of compliance is sustained. - The facility plans to monitor the performance of this oxygen setting and nebulizer mask audit by having the Director of Nursing report findings to the Quality Assurance Committee monthly and continue reporting until three months of compliance is sustained.	

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In an interview on 8/21/19 at 9:10 AM, Nursing Assistant (NA) #1 stated aides were not allowed to adjust oxygen flow rates on either the oxygen concentrators or the portable oxygen tanks. NA #1 stated only a nurse could do that.

In an interview on 8/21/19 at 9:41 AM, the Physician stated it was his expectation that Resident #54's oxygen be administrated continuously at 2L/M as ordered.

In an observation on 8/21/19 at 10:08 AM, Resident #54's oxygen was running at the ordered rate of 2L/M via oxygen concentrator. Interviews conducted at this time with Nurse #2 stated she was not assigned Resident #54 and she was not aware of her ordered oxygen flow rate. Nurse #1 stated he was assigned Resident #54 and he checked her oxygen concentrator rate shortly before 10:00 AM but stated he did not adjust the flow rate from 4L/M down to 2L/M as ordered. The Director of Nursing (DON) stated it was possible the Nurse Supervisor #1 may have made a round and adjusted Resident #54's oxygen to the ordered rate of 2L/M.

In an interview with Nurse Supervisor #1 and the DON on 8/21/19 at 10:15 AM, Nurse Supervisor #1 stated she earlier completed a round on residents prescribed oxygen. She stated during her round, she only assessed oxygen tubing and humidification bottles to ensure they did not need changing. She stated she did not assess oxygen flow rates. The DON stated aides were not allowed to adjust any prescribed oxygen flow

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rates. She stated apparently someone adjusted Resident #54's oxygen rate and it was her expectation that Resident #54's oxygen be administered at the prescribed flow rate of 2L/M as ordered.

In an interview on 8/21/19 at 10:47 AM, the Administrator stated it was her expectation that Resident #54's prescribed oxygen be administered at order flow rate of 2L/M ordered rate.

2. Resident #22 was admitted on 3/8/19 with cumulative diagnoses of Chronic Obstructive Pulmonary Disease and oxygen dependence.

Review of Resident #22's care plan dated 3/18/19 indicated a potential for altered respiratory status with the intervention administration of medications as ordered.

Review of Resident #22's quarterly Minimum Data Set (MDS) dated 7/8/19 indicated he was cognitively intact and exhibited no behaviors.

Review of Resident #22's August 2019 Physician orders read as follows: Administer Albuterol (bronchodilator) nebulizer solution via inhalation three times daily and change the nebulizer mask and tubing weekly.

Review of Resident 22's Medication/Treatment Administration Record for August 2019 licensed nurses initials indicated administration his nebulizer treatments three times daily as ordered.

An interview was conducted with Resident #22 on

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8/19/19 at 9:47 AM. He stated he received nebulizer treatments three times a day. Observed on Resident #22's nightstand was his nebulizer machine with his nebulizer mask placed in a holder section of the machine. There was no observed sealed bag on the nebulizer mask.

In an observation on 8/20/19 at 11:00 AM, Resident #22's nebulizer machine was on his night stand with his nebulizer mask placed in a holder section of the machine. There was no observed sealed bag on the nebulizer mask.

In an observation on 8/20/19 at 4:09 PM, Resident #22's nebulizer machine was on his night stand with his nebulizer mask lying across the top of the night stand with other items. There was no observed sealed bag on the nebulizer mask.

In an observation on 8/21/19 at 8:55 AM, Resident #22's nebulizer machine was on his night stand with his nebulizer mask placed in a holder section of the machine. There was no observed sealed bag on the nebulizer mask.

In an interview on 8/21/19 at 9:41 AM, the Physician stated it was his expectation that Resident #22's nebulizer mask be stored in a sealed bag to prevent contamination and infections.

In an observation with the Director of Nursing

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(DON) and Nurse #1 on 8/21/19 at 10:17 AM, Resident #22's nebulizer machine was on his night stand with his nebulizer mask placed in a holder section of the machine. There was no observed sealed bag on the nebulizer mask. Nurse #1 confirmed the nebulizer mask should be stored in a sealed bag when not in use to control germs. The DON stated it was her expectation that Resident #22's nebulizer mask be stored in a sealed bag when not in use to prevent contamination and infections.

In an interview on 8/21/19 at 10:47 AM, the Administrator stated it was her expectation that Resident #22's nebulizer mask be stored in a sealed bag when not in use to prevent contamination and infections.

3. Resident #64 was originally admitted to the facility on 6/24/16 with diagnoses that included chronic obstructive pulmonary disease (COPD) dependence on supplemental oxygen, congestive heart failure (CHF) and hypertensive heart disease.

The Quarterly MDS dated 8/8/19 revealed the resident had severe cognitive deficits. The staff provided extensive to total assistance for all personal care to include eating. The MDS indicated oxygen therapy was utilized.

Resident #64 had a care plan dated 8/11/19 with goals and interventions for respiratory problems.

A physician order dated 4/2/18 revealed Oxygen

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at 3 liters per nasal cannula continuous and may titrate up to 5 liters as needed for shortness of breath/comfort.

On 8/19/19 at 3:30pm an observation was made of Resident #64 which revealed the oxygen regulator on the concentrator was set at 2.5 liters flow by nasal cannula when viewed horizontally at eye level.

On 8/20/19 at 10:26 am an observation was made of Resident #64 lying in her bed. The oxygen regulator on the concentrator was set at 2.5 liters flow by nasal cannula when viewed at horizontal, eye level.

On 8/21/19 at 9:00am an observation was made of Resident #64 which revealed the oxygen regulator on the concentrator was set at 2.5 liters flow by nasal cannula when viewed at horizontal, eye level.

An interview was conducted with Nurse #1 on 8/21/19 at 9:00 am who stated the oxygen regulator on the concentrator was set at 3 liters when standing over the machine, looking down. Nurse #1 stated when he observed the regulator horizontally at eye level, he could see the flow was set at 2.5 liters. Nurse #1 adjusted the flow to administer 3 liters of oxygen.

On 8/21/19 at 9:55 am an interview occurred with the Medical Director who stated it was his expectation for the oxygen to be delivered at the ordered rate for Resident #64.

During an interview with the Director of Nursing on 8/21/19 at 10:15 am, she indicated it was her expectation for oxygen to be delivered at the

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F 695	Continued From page 22 ordered rate.	F 695		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification/complaint survey of 8/23/18. This was for 1 deficiency originally cited 8/23/18 and was subsequently recited on the current recertification survey of 8/22/19. The recited deficiency was in the area of Minimum Data Set accuracy (medication). The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: The tag is cross referenced to: F-641 Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately in the areas of bowel and bladder (Resident #69) and medication (Resident #59) for 2 of 17 sampled residents. During the prior survey of 8/23/18 Based on record review, observation, and staff interviews,	F 867	-Corrective action for resident #69 was addressed to accurately reflect the resident's status. Resident #69 MDS was corrected by the MDS Coordinator on 8/22/2019 to accurately reflect that the resident had a colostomy present on admission and submitted on 8/27/2019, validation was received. - Corrective action for resident #59 was addressed to accurately reflect the resident's status. Resident #59 MDS was corrected to accurately reflect the resident receipt of an antidepressant and medication and submitted on 8/27/2019, validation was received. - The facility addressed other residents having the potential to be effected by the accuracy of coding for colostomy and/ or antidepressant medication on the Minimum Data Set. The Minimum Data Set Registered Nurse and Director of Nursing will complete an accuracy coding audit on all residents having a physician order for a colostomy and/or physicians	9/18/19

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F 867	Continued From page 23 the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of active diagnosis and antipsychotic medication review (Resident #18), falls (Resident #72), and dental status (Resident #2) for 3 of 27 residents reviewed. On 8/22/19 at 11:30 am an interview was conducted with the Administrator who indicated the root cause for the repeat tag was human error.	F 867	order for antidepressant medication by reviewing the MDS's to ensure coding accuracy. The accuracy audit will be completed on 9/3/2019. - The weekly accuracy audit on the colostomy and antidepressant coding on the Minimum Data Set will be completed by the Minimum Data Set Registered Nurse and Director of Nursing for one month and then monitored until three months of compliance is sustained. - The facility will also complete a Quality Minimum Data Assessment Accuracy Audit reviewing three complete Minimum Data Assessments a month. This Quality Minimum Data Assessment will be completed by the Administrator, Director of Nursing or Minimum Data Assessment Coordinator. This audit will continue for three months and then until three more months of compliance is sustained. - The facility plans to monitor the performance of the plan of action by the Administrator reporting the accuracy audit outcome at the Quality Assurance Committee monthly until three months of compliance is sustained.	