

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2021
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345413 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 08/05/2021 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER FLESHERS FAIRVIEW HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 CANE CREEK ROAD FAIRVIEW, NC 28730 | | |
| (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 | E 000 | | | |
| F 000 | An unannounced Recertification survey was conducted on 08/02/21 through 08/05/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # FJKS11. | F 000 | | | |
| F 583 SS=D | INITIAL COMMENTS A recertification survey was conducted 08/02/21 through 08/05/21. Event ID# FJKS11. Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release | F 583 | | 8/23/21 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/23/2021

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 583 | <p>Continued From page 1</p> <p>of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, staff and family interviews, the facility failed to ensure full personal privacy was provided for 1 of 3 residents reviewed for dignity and respect. The failure resulted in a naked resident being visible to visitors, staff, and other residents (Resident # 39).</p> <p>The findings included:</p> <p>1. Resident # 39 was admitted to the facility on 6/16/2021 with diagnoses of unspecified dementia with behavioral disturbances, Alzheimer's, and cognitive communication deficit.</p> <p>The admission Minimum Data Set (MDS) dated 6/21/2021 revealed Resident # 39 was moderately cognitively impaired. She required limited assistance of one person for dressing and personal hygiene.</p> <p>A review of Resident # 39's care plan dated 7/1/2021 revealed a care plan category of impaired thought processes due to dementia with a goal to maintain stable cognition. Interventions included monitor for psychoactive medication side effects, monitor behavior on an ongoing basis. Report any changes in mental and cognitive status to MD.</p> | F 583 | <p>Facility policy states "the resident has the right to be treated with dignity and respect... Cubicle curtains are available for privacy."</p> <p>Affected resident was clothed, covered and door shut at the time the incident was brought to their attention. She is currently being seen regularly by the psychiatrist for behaviors and the nurses are documenting on it in the progress notes. The disrobing is a recent event though and was first noticed about a week before our survey.</p> <p>MDS Coordinator has added this specific behavior to her care plan.</p> <p>Other residents may have potential to be affected by this if they have been identified as having this behavior. At this time we have no other residents with this behavior.</p> <p>In-service training was conducted with nursing staff on 8/20/2021 through 8/23/2021 by the DON, ADON and Weekend Supervisor reviewing residents rights to privacy and dignity. The need to</p> | | |

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| F 583 | <p>Continued From page 2</p> <p>Review of nurse's progress notes dated 7/27/2021, 7/30/2021, and 8/2/2021 revealed documentation of nursing staff having discovered the resident in her room unclothed.</p> <p>Observation of Resident # 39 on 8/2/2021 at 9:45 AM revealed the door to the resident's room was standing open. The resident was lying naked on the bed closest to the door. An incontinence brief was under Resident # 39 but was not fastened in place. There were no obvious articles of clothing in sight on the bed, the floor, or on any furniture close by the bed. The resident did not respond to voice and did not make eye contact.</p> <p>An interview with a Nurse Aide (NA) # 1 on 8/2/2021 at 9:50 AM revealed the resident often removed her clothing. NA # 1 could not specify how long the resident had been exposed. The NA stated she had not realized the resident was naked and exposed to hallway traffic. NA # 1 was observed to look around the bed, on the floor and furniture, but could not locate any discarded clothing. NA # 1 stated the resident should not have been exposed and her dignity should have been maintained.</p> <p>An interview with Nurse # 2 on 8/2/2021 at 10:00 AM revealed she did not consistently work on the unit. She stated she was slightly familiar with Resident # 39 and was aware that she had behaviors of removing her clothing. She stated staff could not predict when Resident # 39 removed her clothes. Nurse # 2 said the resident's dignity and privacy should have been preserved by replacing her clothing, pulling the privacy curtain, or shutting the door.</p> <p>A telephone interview with Resident # 39's family</p> | F 583 | <p>protect the privacy and dignity of all our residents. Privacy and Dignity are reviewed with all staff upon hire and yearly. Specifically for this resident, frequent checks to ensure clothing has not been removed, keeping the cubicle curtain or door closed to prevent the disrobing from being visible to others in the hall way when and if it does occur, etc. Ensuring nurse is notified when behavior occurs so that incident can be documented.</p> <p>DON or designee to ensure monitoring of the resident's privacy being maintained by observing all residents in their rooms at least 5 times weekly at various times to verify they are adequately provided privacy, either by pulling the privacy curtain or closing the door. Monitoring will continue until compliance is maintained for 1 month or longer if the QAPI committee recommended it.</p> <p>Documentation of the monitoring will be maintained and presented at the QAPI meetings by the DON/ADON where corrective action will be evaluated for effectiveness and changes made to the corrective action as needed.</p> <p>Person responsible for monitoring compliance-Nursing at the direction of DON and ADON</p> <p>Corrective action completed 8/23/21</p> | | |

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| F 583 | <p>Continued From page 3</p> <p>member on 8/3/2021 at 9:33 AM revealed the family was not aware of the resident's behaviors of removing her clothes. The family stated Resident # 39 was normally a "demure" person and would not normally have allowed herself to be exposed while naked.</p> <p>Observation of Resident # 39 on 8/4/2021 at 8:29 AM revealed the resident's door standing open. The resident was sitting on the bed closest to the door with no pants on. The resident was wearing a shirt and an incontinence brief. She startled to voice but did not respond verbally or make eye contact.</p> <p>An interview with the facility Medical Director (MD) on 8/4/2021 at 2:40 PM revealed he was aware of the resident's behaviors of removing her clothing. He stated psychiatric services were monitoring the behavior and making recommendationsThe MD stated he expected staff to maintain dignity of all residents despite their behaviors.</p> <p>An interview with Nurse # 1 on 8/5/2021 at 12:38 PM revealed she was familiar with Resident # 39. The Nurse stated the resident did not randomly remove her clothing for the first month after being admitted to the facility. She revealed the behavior had been occurring for the last few weeks. Nurse # 1 acknowledged the resident should not have been exposed to others while naked.</p> <p>An interview with Director of Nursing (DON) on 8/5/2021 at 1:23 PM revealed she was aware that Resident # 39 had been removing her clothing. She could not explain why staff had not covered the resident and preserved her privacy. The DON</p> | F 583 | | | |

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| F 583 | Continued From page 4 stated at the very least, staff should have pulled the privacy curtain over the open doorway to prevent the resident's exposure. The DON stated her expectation of staff was to maintain privacy of every resident in the facility. | F 583 | | | |
| F 641 SS=E | 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 observations, record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately for the oral/dental status for 2 of 2 residents reviewed for dental health (Resident #18 and #28) and inaccurately coded for having received an anticoagulant for 1 of 5 residents reviewed for unnecessary medications (Resident #29) and 1 of 1 resident reviewed for respiratory care (Resident # 41). The findings included: 1. Resident #18 was admitted to the facility on 8/15/18 with diagnoses including peripheral vascular disease and non-Alzheimer's dementia. On 8/2/21 at 10:57am, Resident #18 was lying in bed with her mouth partially open. An observation of the lower front teeth revealed dark teeth with black spots. The annual Minimum Data Set (MDS) assessment dated 5/11/21 indicated there were no obvious or likely cavity or broken natural teeth. | F 641 | Residents identified with dental assessment inaccuracies have been reassessed and corrections done on the MDS assessments. Resident with anticoagulant inaccuracy -MDS assessment has been corrected. COPD diagnosis has been added to the resident who previously did not have the diagnosis correctly added on the MDS assessment. All residents in the facility had the potential for being affected by the inaccurate coding on the MDS assessment. During this time one of our MDS Coordinators was retiring and training a new MDS Coordinator. Aspirin is a known anticoagulant and the new coordinator incorrectly identified this on the MDS even though the MDS rules do not count it as one. She has completed her initial training and both current MDS coordinators have completed the Resident Assessment Coordinators Certification as | 8/25/21 | |

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| F 641 | <p>Continued From page 5</p> <p>An interview was conducted with the MDS Coordinator on 8/4/21 at 9:14am. She stated the Registered Dietitian (RD) performed the dental assessments on all residents.</p> <p>An interview was conducted with the RD on 8/4/21 at 12:43pm. She stated she conducted the dental assessments on all residents since she was hired approximately 3 years ago. She stated she was not comfortable conducting the dental assessments nor had she been trained to do so. She stated she asked the nurse aides, nurses and the speech therapists about the residents' dental condition. She stated she continued to perform this task since she was told it was her responsibility. She stated she had not assessed Resident #18's dental status.</p> <p>An interview was conducted 8/4/21 at 1:57pm with Nurse #3. She stated she had occasionally assisted the RD with the dental assessments. She stated she observed residents for loose dentures, if they were pocketing food or if they had difficulty swallowing. She stated she examined a couple resident's mouths in the past but not often. She had not examined Resident #18's mouth or teeth.</p> <p>A second interview was conducted with the MDS Coordinator on 8/4/21 at 3:17pm. The MDS Coordinator stated the likely dental cavities should have been coded on the MDS as there are lots of reasons to know there are issues with the teeth and gums such as risks for endocarditis and chewing problems.</p> <p>An interview was conducted with the Director of Nursing (DON) on 8/5/21 at 1:07pm The DON</p> | F 641 | <p>of 8/23/2021.</p> <p>In-service training by the DON with the MDS coordinators on 08/23/21 involving the incidents above- Anticoagulants and diagnosis on the MDS. In-service training by the DON and Administrator with the dietician on 8/25/21 on the dental assessment part of the MDS and how to code the areas accurately and correctly.</p> <p>DON will monitor all new assessments for accuracy with diagnosis coding and anticoagulant use. Any discrepancies will be addressed with the MDS Coordinators immediately. Documentation of the monitoring will be maintained and presented by the DON at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Monitoring will continue until compliance maintained for one month or longer if the QAPI committee recommends.</p> <p>Care Plan Coordinators will monitor the dental section of the MDS that the Dietician completes on all new assessments. Documentation will be turned into the DON and reported at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed.</p> <p>Person responsible for monitoring compliance: DON, ADON, Care Plan Coordinators</p> | | |

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| F 641 | <p>Continued From page 6</p> <p>stated the cavities should have been coded on the MDS for Resident #18.</p> <p>2. Resident #28 was admitted 12/10/19 with diagnoses including non-Alzheimer's dementia and seizure disorder.</p> <p>On 8/2/21 at 11:40am, Resident #28 was sitting in a reclining chair with her mouth open. Her upper and lower teeth were visible with discoloration and dark black and brown areas noted.</p> <p>The significant change Minimum Data Set (MDS) assessment dated 2/27/21 indicated there were no obvious or likely cavity or broken natural teeth.</p> <p>An interview was conducted with the MDS Coordinator on 8/4/21 at 9:14am. She stated the Registered Dietitian (RD) performed the dental assessments on all residents.</p> <p>An interview was conducted with the RD on 8/4/21 at 12:43pm. She stated she conducted the dental assessments on all residents since she was hired approximately 3 years ago. She stated she was not comfortable conducting the dental assessments nor had she been trained to do so. She stated she asked the nurse aides, nurses and the speech therapists about the residents' dental condition. She stated she continued to perform this task since she was told it was her responsibility</p> <p>An interview was conducted 8/4/21 at 1:57pm with Nurse #1. She stated she had occasionally assisted the RD with the dental assessments. She stated she observed residents for loose dentures, if they were pocketing food or if they had difficulty swallowing. She stated she</p> | F 641 | Corrective Action completed: 8/25/21 | | |

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| F 641 | <p>Continued From page 7</p> <p>examined a couple resident's mouths in the past but not often. She had not examined Resident #28's mouth or teeth.</p> <p>A second interview was conducted with the MDS Coordinator on 8/4/21 at 3:17pmThe MDS Coordinator stated the dental cavities should have been coded on the MDS as there are lots of reasons to know there are issues with the teeth and gums such as risks for endocarditis and chewing problems.</p> <p>An interview was conducted with the Director of Nursing (DON) on 8/5/21 at 1:07pm. The DON stated the likely cavities should have been coded on the MDS for Resident #28.</p> <p>3. Resident #29 was admitted to the facility on 10/27/05.</p> <p>A review of Resident #29's quarterly Minimum Data Set (MDS) dated 6/8/21 indicated Resident #29 had been coded under Section N Medications as having received an anticoagulant medication for 7 out of 7 days.</p> <p>A review of Resident #29's physician orders for June 2021 revealed no orders for anticoagulant medication.</p> <p>On 8/4/21 at 3:24 PM an interview was conducted with MDS Coordinator #1 who stated Resident #29 had been on an anticoagulant medication in February 2021 and March 2021 and had been coded as being on an anticoagulant medication on her yearly MDS dated 3/9/21 but Resident #29 was no longer on an anticoagulant medication and it had been incorrectly coded on her quarterly MDS dated 6/8/21. The MDS Coordinator #1</p> | F 641 | | | |

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| F 641 | <p>Continued From page 8</p> <p>stated that was her mistake and the quarterly MDS dated 6/8/21 for Resident #29 would be modified and submitted to reflect that Resident #29 was not on anticoagulant medication.</p> <p>On 8/5/21 at 12:53 PM an interview was conducted with the Director of Nursing (DON) who stated it was her expectation that Resident #29's quarterly MDS dated 6/8/21 would have been accurately coded under Section N Medications to reflect she was not using anticoagulant medication. The DON stated her expectation was the quarterly MDS dated 6/8/21 would be modified and submitted to accurately reflect Resident #29 not using anticoagulant medication.</p> <p>4. Resident # 41 was admitted to the facility on 3/28/2017. Resident # 41 was diagnosed with chronic obstructive pulmonary disease in 2019.</p> <p>Her annual Minimum Data Set (MDS) dated 7/5/2021 revealed she was moderately cognitively impaired. The resident was coded for shortness of breath while lying flat and the use of oxygen. COPD was not coded on the MDS.</p> <p>An interview with the facility Medical Director (MD) on 8/4/2021 at 2:40 PM revealed Resident # 41 did have a diagnosis of COPD. The MD stated the resident could use the oxygen as needed if she wanted to but did not require it on a consistent basis.</p> <p>An interview with MDS Nurses # 1 and # 2 on 8/4/2021 at 3:15 PM revealed a resident with a diagnosis of COPD and an order for oxygen, should have been coded to include the COPD.</p> | F 641 | | | |

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| F 641 | Continued From page 9 An interview on 8/5/2021 at 1:23 PM with the Director of Nursing (DON) revealed she was aware that Resident # 41 wore oxygen. The DON stated her expectation was for diagnosis and MDS to accurately reflect resident's diagnosis and treatment. | 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 | F 656 | | 8/23/21 | |

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| F 656 | <p>Continued From page 10</p> <p>desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and staff and physician interviews the facility failed to update the comprehensive care plan for 1 of 4 residents reviewed for accidents (Resident # 38).</p> <p>The findings included:</p> <p>Resident # 38 was admitted to the facility on 2/19/2021 with diagnoses of dementia, cognitive dysfunction, syncope, and collapse (temporary loss of consciousness due to a drop in blood pressure). She was readmitted on 7/24/2021.</p> <p>The quarterly Minimum Data Set (MDS) dated 7/14/21 indicated that Resident # 38 was severely cognitively impaired. She required extensive assistance of one person for bed mobility and transfers. Resident # 38 was coded as having multiple falls in the 6 months prior to admission. She was also coded as not being steady during transitions/walking and required human assistance to stabilize herself.</p> <p>Resident # 38's care plans available at the nurses' station dated 6/4/2021 showed a care plan focus on falls risk. The goal was for the</p> | F 656 | <p>Care plan was updated for the affected resident to reflect the interventions for fall that were in place with the physicians order.</p> <p>Any resident with fall risk interventions are at risk for being effected by this. DON/ADON have reviewed all residents with fall risk to ensure that the physician orders and care plan interventions are all up to date and matching.</p> <p>In-service training with the MDS Coordinators on 8/23/21 by the DON regarding updating care plans.</p> <p>DON or assigned staff to monitor all new orders 5 days a week for all residents for fall interventions and safety devices to ensure they have been added to the care plans. Documentation will be turned into the DON and reported at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Monitoring will continue until compliance maintained for one</p> | | |

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| F 656 | <p>Continued From page 11</p> <p>resident to not sustain a significant fall related injury, as evidenced by no injury more serious than a bruise, abrasion, or skin tear. Interventions included a pressure sensitive alarm to bed. Following readmission on 7/24/2021 a care plan dated 8/4/2021 showed a focus of falls risk. The goal was for the resident to not sustain a significant fall related injury, as evidenced by no injury more serious than a bruise, abrasion, or skin tear. Interventions did not include the ordered fall mat, bed against wall, M-rail, or pressure sensitive alarm to bed.</p> <p>The fall risk tool indicated Resident # 38 overestimated her abilities and forgot her limitations. Further review of the medical record showed Physician's orders as follows: 5/31/2021 - Therapy to evaluate and treat as indicated for fall prevention and decline. 7/24/2021 - Pressure sensitive alarm to bed 7/24/2021 - Fall mat to bedside 7/24/2021 - Bed against wall 7/26/2021 - M-rail (bed assist handle) to right side of bed 7/26/2021 - Physical Therapy evaluate and treat as indicated.</p> <p>The Nurse Aide task list dated 7/24/2021 revealed the following interventions were to be placed by Nursing staff: bed and chair alarm, M-Rail to right side of bed, pressure sensitive alarm to bed, fall mat to bedside.</p> <p>An interview with MDS Nurse # 1 and MDS Nurse # 2 on 8/4/2021 at 3:15 PM revealed residents who fell should have a care plan for the interventions as ordered by the MD. The MDS Nurses indicated they read nurses notes every day and updated care plans by hand on the</p> | F 656 | <p>month or longer if the QAPI committee recommends.</p> <p>Person Responsible for monitoring compliance: DON</p> <p>Corrective Action completed: 8/23/21</p> | | |

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| F 656 | Continued From page 12 copies located at the nurses' station. An interview with the Director of Nursing (DON) on 8/5/2021 at 1:23 PM revealed she was aware Resident # 38 was a high falls risk. The DON was not aware the ordered falls interventions were not on the care plan for Resident # 38. When asked to explain why the orders were not on the care plan nor put into place, the DON could not offer an explanation. She stated she would make sure staff were educated on care plans and use of falls interventions. An interview with the facility Medical Director (MD) on 8/4/2021 at 2:40 PM revealed Resident # 38 was forgetful regarding her mobility status. The MD stated he expected all ordered interventions to be care planned. | F 656 | | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement care planned interventions for a resident with falls for 1 of 4 residents reviewed for accidents (Resident # 38). The findings included: | F 689 | Fall Mat was placed on floor beside bed of affected resident per the fall intervention orders. Any resident with fall or safety risk has the potential to be affected by this practice. All residents with fall risk and safety | 8/23/21 | |

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| F 689 | <p>Continued From page 13</p> <p>Resident # 38 was admitted to the facility on 2/19/2021 with diagnoses of dementia, cognitive dysfunction, syncope, and collapse (temporary loss of consciousness due to a drop in blood pressure).</p> <p>The quarterly Minimum Data Set (MDS) dated 7/14/2021 indicated Resident # 38 was severely cognitively impaired. She required extensive assistance of one person for bed mobility and transfers. Resident # 38 was coded as having multiple falls in the 6 months prior to admission as well as falls since admission to the facility. Her MDS also revealed she was not steady during transitions/walking and required human assistance to stabilize herself.</p> <p>Resident # 38's care plan dated 6/4/2021 revealed a care plan focus of falls risk. The goal was for the resident to not sustain a significant fall related injury, as evidenced by no injury more serious than a bruise, abrasion, or skin tear. Interventions included bed alarm to bed, ensure resident wears non-skid soled shoes when out of bed, remind resident not to ambulate or transfer without assistance.</p> <p>A review of the medical record fall risk assessment showed Resident # 38 was assessed as high risk for falls on 3/4/2021, 7/2/2021, and 7/26/2021. The fall risk tool indicated Resident # 38 overestimated her abilities and forgot her limitations.</p> <p>A review of facility incident reports dated May 2021 through July 2021 revealed Resident # 38 experienced four falls: 5/26/2021 at 3:10 PM Fall - unwitnessed. Found</p> | F 689 | <p>interventions were reviewed to ensure that all interventions were in place as ordered.</p> <p>In-service done with nursing staff on 8/20/21 - 8/23/21 by the DON, ADON and Weekend Supervisor on the use of fall interventions and safety devices. Where to find what is ordered for a specific resident and how to document use.</p> <p>DON or designee to monitor all fall interventions, safety devices and other interventions ordered to prevent accidents 3 times weekly to ensure they are in use as ordered. Documentation will be turned into the DON and reported at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Monitoring will continue until compliance maintained for three months or longer if the QAPI committee recommends.</p> <p>Person responsible for monitoring compliance: DON</p> <p>Corrective Action completed: 8/23/21</p> | | |

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| F 689 | <p>Continued From page 14</p> <p>lying on floor on back in horizontal position. Had one shoe on and one shoe off. Regular socks on. Immediate post-incident action: Put on gripper socks.</p> <p>6/10/2021 at 6:00 PM Fall with head injury - witnessed Resident stood up from wheelchair without assistance, took several steps before falling face-first onto the nurses' station. Resident was wearing gripper socks inside her bedroom slippers. Incident report indicates "ask about possible wheelchair alarm". Neurological check flowsheet completed by staff.</p> <p>7/7/2021 at 7:00 PM Fall with no head injury - witnessed and assisted. Resident noted to be standing in front of wheelchair. Staff approached and resident leaned toward staff who assisted resident to the floor. Small skin tear to right hand. Shoes on. Incident report indicates "wheelchair alarm to be placed."</p> <p>7/22/2021 at 4:14 AM Found on floor. Resident found lying in floor in front of sink. Laceration above right eye, hair matted with blood, large knot in front of right ear. Resident complained of right-side pain. MD order obtained to send to ED for evaluation. No fall mat in place beside bed. Immediate post-incident action: Notify care plan team. Bed alarm, chair alarm, fall mat placed. Resident admitted to hospital on 7/22/2021.</p> <p>Further review of the medical record showed Physician's orders as follows: 5/31/2021 - Therapy to evaluate and treat as indicated for fall prevention and decline. 7/24/2021 - Pressure sensitive alarm to bed 7/24/2021 - Fall mat to bedside</p> <p>Observation of Resident # 38 on 8/2/2021 at 09:45 AM revealed the resident lying on her back with eyes closed in a bed turned with the left side</p> | F 689 | | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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| F 689 | <p>Continued From page 15</p> <p>of the bed against the wall. Large yellow bruising, stitches and scabs were noted to the right side of her face and head. There were no fall mats on the floor beside the bed. A bed alarm was not visible. Her room was located half way between the nurses' station and the end of the hall.</p> <p>Observation of Resident # 38 on 8/4/2021 at 8:33 AM revealed the resident sitting upright in bed, green bruising, and scabs visible to right side of face, neck, and jaw. Stitches intact to right forehead. Resident was eating breakfast from overbed table. No fall mat was in place. Nurse Aide # 1 was observed to enter the room at 8:35 AM and leave the room without placing the fall mat. Further observation of the resident on 8/4/2021 at 10:39 AM showed the resident in bed with no fall mat in place beside the bed.</p> <p>An interview with Nurse Aide (NA) # 1 on 8/5/2021 at 12:33 PM revealed Resident # 38 was on her permanent assignment. NA # 1 stated gripper socks, bed alarms, and fall mats were used to help prevent fall injuries.</p> <p>An interview with Nurse # 1 on 8/5/2021 at 12:38 PM revealed Resident # 38 was part of her regular assignment. The Nurse stated the resident forgot she was not steady enough to walk. Nurse # 1 stated Resident # 38 did not attempt to get up frequently, but staff were instructed to look in on her when walking down the hall. She could not explain why the fall interventions had not been put in place. Nurse # 1 stated all falls were reported to the MDS Nurses and they implemented interventions and care plans.</p> <p>An interview with MDS Nurse # 1 and MDS Nurse</p> | F 689 | | | |

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| F 689 | Continued From page 16 # 2 on 8/4/2021 at 3:15 PM revealed residents who fell should have a care plan for the interventions ordered by the MD. The MDS Nurses indicated they read nurses notes every day and updated care plans by hand on the copies located at the nurses' station when falls occurred. They reported they did not actually implement the interventions. An interview with the Director of Nursing (DON) on 8/5/2021 at 1:23 PM revealed the last 24 hours falls were discussed daily in the manager's meetings. She stated specific interventions were not discussed and MDS Nurses read orders daily and were responsible for initiating the care plan and providing interventions to staff. The DON stated no specific staff member was assigned to put the falls interventions in place. She stated she would make sure staff were educated on use of falls interventions. An interview with the facility Medical Director (MD) on 8/4/2021 at 2:40 PM revealed Resident # 38 was forgetful regarding her mobility status. The MD stated he expected all ordered falls precautions to be in use as soon as the risk was determined. | F 689 | | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, | F 695 | | 8/23/21 | |

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| F 695 | <p>Continued From page 17 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, staff and physician interviews the facility failed to provide oxygen therapy with a physician's order for 1 of 2 residents reviewed for respiratory care (Resident # 35). The facility failed to develop a care plan for the use of supplemental oxygen for 2 of 2 residents reviewed for respiratory care (Resident #35 and Resident # 41).</p> <p>1. Resident # 35 was admitted to the facility on 3/20/2019 with diagnoses of non-traumatic brain dysfunction and non-Alzheimer's dementia.</p> <p>Her quarterly Minimum Data Set dated 7/17/2021 revealed she was mildly cognitively impaired. The MDS further revealed Resident # 35 did not have a respiratory diagnosis, no episode of shortness of breath and no code for oxygen therapy.</p> <p>Resident # 35's medical record revealed no diagnosis for oxygen therapy. There was no physician's order for oxygen therapy.</p> <p>Review of Resident #35's care plans revealed there was no care plan that respiratory care.</p> <p>An observation of Resident # 35 on 8/5/2021 at 12:28 PM revealed the resident lying in bed on her right side wearing O2 via NC. The O2 concentrator was on and the rate of delivery was set on 2 L/m.</p> <p>An interview with Nurse Aide (NA) # 1 on 8/4/2021 at 9:22 AM was completed in Resident # 35's room. NA # 1 revealed Resident # 35 was</p> | F 695 | <p>Oxygen for affected resident was removed from the room after it was assessed it was not needed.</p> <p>All residents on oxygen were verified that they had orders and that the oxygen is being used as ordered to ensure no other resident is affected by this practice. All residents that do not have oxygen orders were checked to ensure they were not using oxygen</p> <p>In-service training with nursing staff on 8/20/21 - 8/23/21 by the DON, ADON and Weekend Supervisor on following physician orders and documenting the use of Oxygen correctly, and not placing oxygen on a resident without an order.</p> <p>DON or designee to monitor all residents on oxygen weekly at the time the tubing is changed to ensure the physician orders are being followed accurately. Monitoring will also include a visual check of resident rooms to ensure residents who do not have an order are not placed on oxygen. Documentation will be turned into the DON and reported at the QAPI meetings where corrective action will be evaluated for effectiveness and changes made as needed. Monitoring will continue until compliance maintained for one month or longer if the QAPI committee recommends.</p> | | |

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| F 695 | <p>Continued From page 18</p> <p>part of her regular assignment. The resident was wearing O2 via NC set at 2 L/m. The NA stated Resident # 35 put her oxygen on and took it off whenever she wanted to. The NA said she did not recall any episodes in which the resident displayed shortness of breath.</p> <p>An interview with MDS Nurse # 2 on 8/4/2021 at 9:53 AM revealed she could not locate an order or a diagnosis for oxygen.</p> <p>An interview with MDS Nurse # 1 on 8/4/2021 at 9:59 AM disclosed that she had reviewed orders back to 2020 and could not locate an order for oxygen.</p> <p>An interview with Nurse # 2 on 8/4/2021 at 12:56 PM disclosed Resident # 35 takes her O2 on and off. Nurse # 2 stated the resident liked to mess with things and would wind the tubing up and stick it on her wheelchair or around her ankle. The nurse stated staff must keep an eye on her to make sure she is wearing her oxygen. Nurse # 2 stated she did not know what diagnosis required the resident to wear O2, but she thought it may have been started during the pandemic.</p> <p>An interview with the Medical Director (MD) on 8/4/2021 at 2:40 PM revealed Resident # 35 did not need oxygen regularly. He stated she did not have a chronic respiratory disease but had occasional breathing difficulties based on obesity. He stated an order for oxygen should have been in the medical record.</p> <p>An interview on 8/5/2021 at 1:23 PM with the Director of Nursing (DON) revealed she was aware that Resident # 35 wore oxygen. When</p> | F 695 | <p>Person responsible for monitoring compliance: DON Corrective Action completed: 8/23/21</p> | | |

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| F 695 | <p>Continued From page 19</p> <p>asked to locate a diagnosis and order for oxygen in the medical record, the DON was unable to do so. The DON stated her expectation was for staff to document Physician's orders with corresponding diagnoses prior to implementing treatment. The DON stated oxygen should have been included in the care plan.</p> <p>2. Resident # 41 was admitted to the facility on 3/28/2017. Resident # 41 was diagnosed with chronic obstructive pulmonary disease in 2019. Her annual Minimum Data Set (MDS) dated 7/5/2021 revealed she was moderately cognitively impaired. Resident # 41 was coded as independent for bed mobility and transfers. The resident was coded for shortness of breath while lying flat and the use of oxygen.</p> <p>Physician's orders dated 2/2/2021 showed an order for oxygen at 2 liters per minute (L/min) to maintain oxygen saturation above 90 %. A review of oxygen saturations listed on the Medication Administration Record (MAR) dated 7/5/2021 through 8/3/2021 showed saturations of greater than 90 %.</p> <p>Resident # 41's care plan dated 7/15/2021 did not address oxygen therapy.</p> <p>Observation of Resident # 41 on 8/4/2021 at 8:27 AM revealed the resident sitting up in wheelchair, eating breakfast. The resident was not wearing oxygen and had no signs of respiratory distress.</p> <p>An interview with Nurse # 2 on 8/4/2021 at 12:56 PM revealed Resident # 41 wore oxygen at times in the late evening or in the morning. Nurse # 2 informed the resident took cough medicine regularly and did not have strength to cough up</p> | F 695 | | | |

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| F 695 | <p>Continued From page 20</p> <p>her phlegm. When Resident # 41 coughed, she needed oxygen.</p> <p>An interview with the facility Medical Director (MD) on 8/4/2021 at 2:40 PM revealed Resident # 41 did have a diagnosis of COPD. The MD stated the resident could use the oxygen as needed if she wanted to but did not require it on a consistent basis.</p> <p>An interview with MDS Nurses # 1 and # 2 on 8/4/2021 at 3:15 PM revealed a resident with a diagnosis of COPD and an order for oxygen, should have had a care plan that included the diagnosis and treatment. MDS Nurses # 1 and # 2 indicated if no mention of oxygen was in the physician's notes in the previous 60 days, it would not be coded on the MDS and would not have a care plan. The MDS Nurses further revealed active diagnoses should be captured on the MDS and care plan.</p> <p>An interview on 8/5/2021 at 1:23 PM with the Director of Nursing (DON) revealed she was aware that Resident # 41 wore O2. When asked to locate a care plan for the use of oxygen the DON was unable to locate one. The DON was asked to review the Medication Administration Record for Resident # 41. The DON revealed nurses were documenting the use of oxygen during the day daily. When asked to explain why Resident # 41 was not observed wearing oxygen, the DON could offer no clarification. The DON stated her expectation was for orders, care plans and MDS to accurately reflect resident's diagnosis and treatment.</p> | F 695 | | | |