

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

MAR 19 2014

PRINTED: 03/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2014
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5533 BURLINGTON ROAD MC LEANSVILLE, NC 27301		
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F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews the facility failed to ensure 1 of 3 residents (resident #14) received proper care and treatment concerning - 1) physician ordered oxygen; 2) follow physician's orders for checking ear padding on the resident's oxygen nasal cannula tubing every shift; 3) clarifying conflicting physician's orders for the amount of oxygen the resident was to receive. Findings include:</p> <p>Resident #14 was re-admitted to the facility on 04/07/2012. The resident's diagnoses included - End Stage Chronic Obstructive Pulmonary Disease (COPD) and Chronic Respiratory failure. The resident's medications included conflicting physician's orders for continuous oxygen therapy (Oxygen at 2Liters/minute via nasal cannula continuous every shift and Oxygen continuous via nasal cannula at 3 Liters/minute secondary to COPD). Other physician's orders included - Pad oxygen tubing behind ears and check oxygen</p>	F 328	<p>Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p> <p>F 328:</p> <p>Specific action taken to correct the deficiency:</p> <p>An immediate clarification order was obtained on 2/26/14 for two liters of oxygen per minute for resident #14.</p> <p>The resident's ear pieces were padded.</p> <p>In-servicing was initiated on 2/26/14 which reviewed the expectation for accurate documentation and task completion with the charge nurses.</p>	3/10/14	

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

H. Ag

Adm

(X6) DATE
3/14/14

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 328	<p>Continued From page 1 tube padding every shift.</p> <p>A review of resident #14's records (hard copy and electronic) indicated the resident's quarterly Minimum Data Set (MDS) assessment dated 11/18/2013 indicated the resident to be cognitively intact. The Basic Interview for Mental Status (BIMS) was scored at 14 out of 15. The MDS indicated the resident had an active diagnosis of COPD and was receiving special treatments which included oxygen therapy. The resident participated in the MDS assessment. Further review of the record indicated a more recent MDS assessment dated 02/06/2013 which indicated the resident to be cognitively intact and having a BIMS score of 15 out of 15. The MDS indicated the resident had an active diagnosis of COPD and was receiving special treatments which included oxygen therapy. The resident participated in the MDS assessment.</p> <p>The resident's Care Plan dated 04/07/2012 with most current update on 02/13/2014 indicated the resident was at risk for respiratory distress related to COPD with the need for continuous oxygen therapy. The facility's goals included the resident would have no signs or symptoms of pneumonia or respiratory distress through the next update on 05/18/2014. The facility's care plan interventions for this care area problem indicated they were supposed to administer the physician ordered oxygen via nasal cannula and administer other breathing treatments and medications for treatment of COPD. The care plan also indicated the resident had a history of skin breakdown and was at risk for skin breakdown and initiated the care area problem on 02/13/2014. The interventions were the nursing staff would pad the oxygen tubing that goes behind the resident's</p>	F 328	<p>Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur:</p> <p>A 100% audit was completed on 2/26/14 for all residents in the facility receiving oxygen. There were no further discrepancies noted.</p> <p>The in-service regarding the expectation for accurate documentation and task completion related to checking oxygen setting per shift, padding as indicated, and proper documentation on the MAR and TAR were completed for all charges nurses on 3/10/14 with the exception of one charge nurse who is PRN and whose phone is out of order; she will not be able to work until the in-service is completed. Documentation omissions and documentation accuracy were stressed.</p> <p>The charge nurse responsible for the MAR changeover first checks was in-serviced on 3/10/14 to ensure that all orders noted on the new MAR pre-printed physician order section that require recopying to a scheduled line item on the MAR are reviewed, validated for accuracy and documented with her initials.</p>	3/10/14	

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F 328	<p>Continued From page 2</p> <p>ears. The care plan intervention did not include information that the facility's nursing staff were supposed to check that the padding on the tubing was there every shift as ordered by the physician.</p> <p>During further review of resident #14's medical record it was revealed the resident's monthly Physician's Order Sheet (POS) dated 02/01-28/2014 which was signed by the physician on 02/04/2014, had a set of conflicting oxygen flow rate orders. On page 2 of the February 2014 POS revealed an order for - Oxygen @ 2 Liters per minute via nasal cannula continuous every shift. On page 3 a hand written order in blue ink documented - O2 continuous via nasal cannula @ 3L secondary to COPD. In the hour column for this order, also in blue ink, was written 7-3, 3-11, 11-7 indicating the shifts on which the resident was to receive the oxygen at 3 liters/minute (continuous 24/7). On page 2 of the POS there was an additional order to - Pad oxygen tubing behind ears and to check for the padding every shift. There were no corresponding verbal or written physician's orders (electronic or hard copy) to indicate which of the two conflicting oxygen flow rate orders was to be used.</p> <p>On 02/24/2014 at 2:30 p.m., an observation of and interview with resident #14 was made. Resident #14 was observed awake and lying on his bed. Resident #14 indicated after lunch he often comes to his room to take a nap but was not sleepy today. The resident was observed receiving oxygen, via a nasal cannula, provided from a floor oxygen concentrator. The floor oxygen concentrator was set at 1.5 Liters/minute. The tubing was observed around the backs of the resident's ears. There was no padding on the</p>	F 328	<p>Foam ear pads ordered as a stock supply item and are kept on the same shelf as other respiratory supply items for use as ordered/needed.</p> <p>100% of the residents on oxygen had their care plans reviewed and all were appropriate.</p> <p>100% of the residents receiving oxygen had CNA. assignment sheets reviewed and the correct 02 liters were noted on all those receiving oxygen for reference.</p> <p>On 2/26/14, Resident #14 was initiated on a frequent check monitor which has been maintained.</p> <p>MARs of those residents on oxygen had q shift checks reviewed.</p> <p>We will monitor our performance to make sure that solutions are sustained.</p> <p>A weekly audit of 100% of residents receiving oxygen, to include proper documentation, will be conducted for one month.</p> <p>Then, a monthly audit will be conducted for four months.</p> <p>Findings will be discussed in the QAA/monthly performance improvement project meetings.</p> <p>Follow-up counseling and training will be provided as indicated.</p>	3/10/14	

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F 328	<p>Continued From page 3</p> <p>tubing behind the resident's ears or elsewhere on the tubing. The oxygen concentrator on the resident's wheelchair was observed to have a nasal cannula attached to it. There was no padding observed on the nasal cannula tubing. The resident was asked if he ever turned on or off the oxygen concentrators or adjusted the flow rates. The resident indicated the nursing assistants turn on and off the oxygen concentrators when they transfer him from his bed to his wheelchair and back. When again asked who sets the flow rate of the oxygen the resident indicated the nursing assistants turn on and off the concentrators and set the flow rates.</p> <p>02/25/2014 at 11:40 a.m., an interview and observation was conducted with resident #14. The resident was seated in his wheelchair. The resident was observed to have on a nasal cannula attached to a portable oxygen concentrator attached to the back of his wheelchair. The resident indicated he wears the nasal cannula and receives concentrated oxygen all of the time. The observation revealed the concentrator on the resident's wheelchair was set at 3 Liters/minute. The resident indicated the nurse's change the tubing every couple of weeks but he wears a nasal cannula even when in bed resting or sleeping. Further observation revealed the resident did not have any ear padding on the tubing behind the resident's ears. The resident was asked if he could adjust the flow rate of the oxygen concentrator attached to the back of his chair. The resident indicated he could not adjust the flow as he could not reach the concentrator's knob (control). The resident demonstrated reaching for the concentrator and was approximately 6-8 inches from the concentrator's controls while leaning to his right (concentrator</p>	F 328	<p>Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	3/10/14	

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F 328	<p>Continued From page 4</p> <p>was observed to be attached in a way that the control area was left of and below the right side hand grip. The resident also indicated he could not use his hands (grip) very well as he needed special silverware with rubber handles so he could eat.</p> <p>On 02/25/2014 at 4:25 p.m., an observation of resident #14 was made while seated in his wheelchair. The observation revealed the oxygen concentrator attached to the resident's wheelchair was set at 3 Liters/minute. Resident #14 was observed to have no padding on the tubing behind his ears to protect the oxygen tubing from chafing on the backs of his ears.</p> <p>On 02/26/2014 at 8:20 a.m., resident #14 was observed in his room sitting up in bed eating his breakfast. The resident was wearing a nasal cannula attached to a floor oxygen concentrator. The floor concentrator was set at 1.5 Liters/minute. There was no padding observed on the tubing behind the resident's ears. The resident was observed to still be eating his breakfast and was using special adaptive built up (large rubber handled) silverware to eat with. When asked if he ever changed the setting (flow rate) of the floor oxygen concentrator the resident indicated - "No, the girls that put me in bed do all that."</p> <p>On 02/26/2014 at 10:45 a.m. an observation of resident #14 was conducted. The resident was observed in his wheelchair in the hall adjacent to his room. The resident was observed to have a nasal cannula on and receiving oxygen from the concentrator attached to the back of his wheelchair. The concentrator was set at 3Liters/minute. There was no padding observed</p>	F 328	<p>Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	3/10/14	

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F 328	<p>Continued From page 5</p> <p>on the cannula tubing behind the resident's ears.</p> <p>On 02/26/2014 at 1:52 p.m., an observation of resident #14 was conducted. The resident was observed lying awake on his bed receiving oxygen via a nasal cannula attached to a floor oxygen concentrator. The oxygen concentrator was observed to be set at 1.5 Liters/minute. The nasal cannula tubing was observed around the ears of the resident. No padding was observed on the tubing around or behind the resident's ears.</p> <p>A review of resident #14's Treatment Administration Record (TAR) for February 2014 revealed the facility's nurses assigned to resident #14 had not checked/signed off the resident 14's treatment order to pad the resident's oxygen tubing every shift for 16 of 75 shifts during the month as of 02/26/2014. The TAR also indicated the facility's nursing staff signed off as checking and ensuring resident 14's nasal cannula tubing was padded on 5 - 1st and 2nd shifts when the resident was observed (see above) to not have any padding on the nasal cannula tubing behind the resident's ears.</p> <p>A review of resident #14's February 2014 Medication Administration Record (MAR) indicated the resident had a hand written order in ink on page 3 for oxygen to be given at a rate of 3 Liters/minute. The number 3 was over scored with the number 2 (also in ink) but leaving the number 3 still visible. The facility's nursing staff assigned to resident #14 signed off the February 2014 MAR on the 1st and 2nd shifts on 02/24/2014 and 02/25/2014 and the 1st shift on 02/26/2014 indicating they had checked and the resident was receiving the correct amount of</p>	F 328	<p>Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	3/10/14	

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F 328	<p>Continued From page 6</p> <p>oxygen on those shifts. The observations noted above indicated the resident was not receiving the correct oxygen rate for either of the two conflicting physician's orders on the resident's February 2014 POS. The February 2014 MAR also indicated resident #14's oxygen flow rate was not checked/signed off for 12 of 75 shifts (3rd shifts) ensuring the resident received the proper physician ordered oxygen.</p> <p>On 02/26/2014 at 2:00 p.m., an interview and observation was conducted with the Evergreens Village charge nurse (Nurse #1) assigned to care for resident #14 (1st shift). Nurse #1 was asked to observe resident #14's in room floor oxygen concentrator and his wheelchair concentrator. During the observation Nurse #1 indicated the floor oxygen concentrator was set at 1.5 Liters/minute. The nurse also observed and indicated there was no padding on the nasal cannula tubing around resident 14's ears (attached to the floor oxygen concentrator) and no padding on the nasal cannula tubing attached to the oxygen concentrator on resident #14's wheelchair. Nurse #1 was asked at what flow rate settings the oxygen concentrators (floor and wheelchair) were supposed to be set at for resident #14. Nurse #1 indicated she was not sure and she would have to check the resident's chart. A review of the physician's orders (POS), MAR, and TAR for resident #14 was conducted with Nurse #1. Nurse #1 indicated there were 2 conflicting oxygen flow rate orders for resident #14 (2 liters/minute and 3liters/minute) and she did not know which flow rate order was correct or how much oxygen resident #14 was supposed to be receiving as she had observed resident #14's floor oxygen concentrator set at 1.5 liters/minute. A review of the chart by Nurse #1 indicated there</p>	F 328	Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.	3/10/14	

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F 328	Continued From page 7 was no other verbal order or other written order to indicate which oxygen flow rate order the staff were supposed to be using. A continued review of resident #14's records was made by the Nurse #1 which included the resident's TAR which indicated the resident was supposed to be wearing a padded oxygen nasal cannula. The TAR was signed off indicating the resident's nasal cannula padding had been checked each shift for both Monday 02/24/2014 and Tuesday 02/25/2014. The nurse indicated she had not yet signed off the TAR for the 1st shift on 02/26/2014 even though the shift was almost over and the resident had worn the unpadded nasal cannula tubing for over 7 of the 8 hour shift. The nurse indicated she knew the oxygen cannula padding order was a treatment order and the resident was supposed to have the padding on the tubing behind the resident's ears but she had not checked the resident (except the observation as noted above with the state surveyor and administering oral medications) today even though the shift had less than 1 hour left. Nurse #1 wanted to conduct a second check of resident #14 for the padding on the nasal cannulas. A second observation was conducted of resident #14 with the Nurse #1. The nurse asked the resident if he had any of the green or gray oxygen cannula pads to pad the nasal cannula tubing behind his ears. The resident indicated he had not had any padding of his nasal cannulas (floor concentrator cannula or wheelchair concentrator cannula) for a while (several days). The nurse again checked both the nasal cannula on the resident's wheelchair concentrator tubing the concentrator tubing the resident was wearing while lying in bed. There were no pads on either nasal cannula's tubing. The nurse also checked in a woven basket on the resident's bedside night	F 328	Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.	3/10/14

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F 328	Continued From page 8 stand and in the night stand drawers for the pads. There were no pads found in the basket or drawers. The nurse indicated the resident was supposed to be wearing padding on each nasal cannula behind his ears. The nurse could not explain why the TAR was signed off for 02/24/2014 and 02/25/2014 even though the resident indicated he had not had any padding on either of his nasal cannulas on those days or why she had not checked the resident's oxygen flow rate or nasal cannula padding today (02/26/2014). A second review of Resident #14's MAR was conducted with Nurse #1. Nurse #1 indicated she had signed off the February 26th's 1st shift order indicating resident #14 was receiving oxygen at 2 liters per minute. Nurse #1 was asked why she signed off the order as her observation revealed resident #14 was receiving oxygen at 1.5 liters per minute. Nurse #1 indicated she had not checked resident #14's oxygen flow rate for either oxygen concentrator (floor/wheelchair) and had not checked resident #14 to ensure he had padding on either nasal cannula tubing during her shift thus far. 02/26/2014 at 2:20 p.m., an interview was conducted with the facility's Director of Nursing (DON). The DON indicated it was her expectation that all conflicting physician's orders should be clarified. The DON also indicated it was also her expectation that all staff were to follow physician's orders and ensure the physician's orders were carried out and the MAR and TAR were signed off appropriately as to what was or was not done.	F 328	Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.	3/10/14	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514			

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F 514	<p>Continued From page 9</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews the facility failed to ensure they kept accurate clinical records for 1 of 3 residents (resident #14) by: 1) not correctly documenting physician ordered nasal cannula ear padding checks every shift, 2) not correctly documenting the resident was receiving the correct amount of physician ordered oxygen every shift, 3) not correctly documenting/clarifying conflicting physician's orders for the amount of oxygen the resident was ordered to receive. Findings Include:</p> <p>Resident #14 was re-admitted to the facility on 04/07/2012. The resident's diagnoses included - End Stage Chronic Obstructive Pulmonary Disease (COPD) and Chronic Respiratory failure. The resident's medications included conflicting physician's orders for continuous oxygen therapy (a. Oxygen at 2Liters/minute via nasal cannula continuous every shift; b. Oxygen continuous via nasal cannula at 3 Liters/minute secondary to</p>	F 514	<p>Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	3/10/14	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2014
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5533 BURLINGTON ROAD MC LEANSVILLE, NC 27301		
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F 514	<p>Continued From page 10 COPD). Other physician's orders included - Pad oxygen tubing behind ears and check oxygen tube padding every shift.</p> <p>A review of resident #14's records (hard copy and electronic) indicated the resident's quarterly Minimum Data Set (MDS) assessment dated 11/18/2013 indicated the resident to be cognitively intact. The Basic Interview for Mental Status (BIMS) was scored at 14 out of 15. The MDS indicated the resident had an active diagnosis of COPD and was receiving special treatments which included oxygen therapy. The resident participated in the MDS assessment. Further review of the record indicated a more recent MDS assessment dated 02/06/2013 which indicated the resident to be cognitively intact and having a BIMS score of 15 out of 15. The MDS indicated the resident had an active diagnosis of COPD and was receiving special treatments which included oxygen therapy. The resident participated in the MDS assessment.</p> <p>The resident's Care Plan dated 04/07/2012 with most current update on 02/13/2014 indicated the resident was at risk for respiratory distress related to COPD with the need for continuous oxygen therapy. The facility's goals included the resident would have no signs or symptoms of pneumonia or respiratory distress through the next update on 05/18/2014. The facility's care plan interventions for this care area problem indicated they were supposed to administer the physician ordered oxygen via nasal cannula and administer other breathing treatments and medications for treatment of COPD. The care plan also indicated the resident had a history of skin breakdown and was at risk for skin breakdown on 02/13/2014 and as an intervention the nursing staff would pad the</p>	F 514	<p>F 514</p> <p>Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p> <p>Specific action taken to correct the deficiency:</p> <p>A clarification order was obtained on 2/26/14 for two liters of oxygen per minute for resident #14 and documentation corrected on the MAR.</p> <p>The resident's ear pieces were padded.</p> <p>In-servicing was initiated on 2/26/14 which reviewed the expectation for accurate documentation and task completion with the charge nurses.</p>	3/10/14	

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F 514	<p>Continued From page 11</p> <p>oxygen tubing that goes behind the resident's ears. The care plan intervention did not indicate the facility's nursing staff were supposed to ensure the padding on the tubing was there every shift as ordered by the physician.</p> <p>During further review of resident #14's medical record it was revealed the resident's monthly Physician's Order Sheet (POS) dated 02/01-28/2014 which was signed by the physician on 02/04/2014, had a set of conflicting oxygen flow rate orders. On page 2 of the February 2014 POS revealed an order for - Oxygen @ 2 Liters per minute via nasal cannula continuous every shift. On page 3 a hand written order in blue ink documented (no start date or time the order was received) - O2 continuous via nasal cannula @ 3L secondary to COPD. In the hour column for this order, also in blue ink, was written 7-3, 3-11, 11-7 indicating the shifts on which the resident was to receive the oxygen at 3 liters/minute (continuous 24/7). On page 2 of the POS there was an additional order to - Pad oxygen tubing behind ears and to check for the padding every shift. There were no corresponding verbal or written physician's orders (electronic or hard copy) to indicate which of the two conflicting oxygen flow rate orders was to be used.</p> <p>On 02/24/2014 at 2:30 p.m., an observation of and interview with resident #14 was made. Resident #14 was observed awake and lying on his bed. Resident #14 indicated after lunch he often comes to his room to take a nap but was not sleepy today. The resident was observed receiving oxygen, via a nasal cannula, provided from a floor oxygen concentrator. The floor oxygen concentrator was set at 1.5 Liters/minute. The tubing was observed around the backs of the</p>	F 514	<p>Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur:</p> <p>A 100% audit was completed on 2/26/14 for all residents in the facility receiving oxygen. There were no further discrepancies.</p> <p>Documentation omissions and documentation accuracy was stressed with those nurses assigned to resident #14.</p> <p>The in-service regarding the expectation for accurate documentation and task completion related to checking oxygen setting per shift, padding as indicated, and proper documentation on the MAR and TAR were completed for all charge nurses on 3/10/14 with the exception of one charge nurse who is PRN and whose phone is out of order; she will not be able to work until the in-service is completed. Documentation omissions and documentation accuracy was stressed.</p> <p>The charge nurse responsible for the MAR changeover first checks was in-serviced on 3/10/14 to ensure that all orders noted on the new MAR pre-printed physician order section that require recopying to a scheduled line item on the MAR are reviewed, validated for accuracy and documented with her initials.</p>	3/10/14	

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F 514	<p>Continued From page 12</p> <p>resident's ears. There was no padding on the tubing behind the resident's ears or elsewhere on the tubing. The oxygen concentrator on the resident's wheelchair was observed to have a nasal cannula tubing attached to it. There was no padding observed on the nasal cannula tubing. The resident was asked if he ever turned on or off the oxygen concentrators or adjusted the flow rates. The resident indicated the nursing assistants turn on and off the oxygen concentrators when they transfer him from his bed to his wheelchair and back. When again asked who sets the flow rate of the oxygen the resident indicated the nursing assistants turn on and off the concentrators and set the flow rates.</p> <p>02/25/2014 at 11:40 a.m., an interview and observation was conducted with resident #14. The resident was seated in his wheelchair. The resident was observed to have on a nasal cannula attached to a portable oxygen concentrator attached to the back of his wheelchair. The resident indicated he wears the nasal cannula and receives concentrated oxygen all of the time. The observation revealed the concentrator on the resident's wheelchair was set at 3 Liters/minute. The resident indicated the nurse's change the tubing every couple of weeks but he wears a nasal cannula even when in bed resting or sleeping. Further observation revealed the resident did not have any ear padding on the tubing behind the resident's ears. The resident was asked if he could adjust the flow rate of the oxygen concentrator attached to the back of his chair. The resident indicated he could not adjust the flow as he could not reach the concentrator's knob (control). The resident demonstrated reaching for the concentrator and was approximately 6-8 inches from the concentrator's</p>	F 514	<p>We will monitor our performance to make sure that solutions are sustained.\\</p> <p>A weekly audit of 100% of residents receiving oxygen, to include proper documentation, will be conducted for one month. Then, a monthly audit will be conducted for four months.</p> <p>In addition, an audit of 10% MAR and TAR records will be conducted weekly for one month and then monthly for four months.</p> <p>The Pharmacy Consultant will monitor on an on-going basis.</p> <p>Findings will be discussed in the QAA/monthly performance improvement project meetings.</p> <p>Follow-up counseling and training will be provided as indicated.</p>	3/10/14	

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F 514	<p>Continued From page 13</p> <p>controls while leaning to his right (concentrator was observed to be attached in a way that the control area was left of and below the right side hand grip. The resident also indicated he could not use his hands (grip) very well as he needed special silverware with rubber handles so he could eat.</p> <p>On 02/25/2014 at 4:25 p.m., an observation of resident #14 was made while seated in his wheelchair. The observation revealed the oxygen concentrator attached to the resident's wheelchair was set at 3 Liters/minute. Resident #14 was observed to have no padding on the tubing behind his ears to protect the oxygen tubing from chafing on the backs of his ears.</p> <p>On 02/26/2014 at 8:20 a.m., resident #14 was observed in his room sitting up in bed eating his breakfast. The resident was wearing a nasal cannula attached to a floor oxygen concentrator. The floor concentrator was set at 1.5 Liters/minute. There was no padding observed on the tubing behind the resident's ears. The resident was observed to still be eating his breakfast and was using special adaptive built up (large rubber handled) silverware to eat with. When asked if he ever changed the setting (flow rate) of the floor oxygen concentrator the resident indicated - "No, the girls that put me in bed do all that."</p> <p>On 02/26/2014 at 10:45 a.m., an observation of resident #14 was conducted. The resident was in his wheelchair in the hall adjacent to his room. The resident was observed to have a nasal cannula on and was receiving oxygen from a portable oxygen concentrator attached to the back of his wheelchair. The concentrator was set</p>	F 514	<p>Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	3/10/14	

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F 514	<p>Continued From page 14</p> <p>at 3Liters/minute. There was no padding observed on the cannula tubing behind the resident's ears.</p> <p>On 02/26/2014 at 1:52 p.m., an observation of resident #14 was conducted. The resident was observed lying awake on his bed receiving oxygen via a nasal cannula attached to a floor oxygen concentrator. The oxygen concentrator was observed to be set at 1.5 Liters/minute. The nasal cannula tubing was observed around the ears of the resident. No padding was observed on the tubing around or behind the resident's ears.</p> <p>A review of resident #14's Treatment Administration Record (TAR) for February 2014 revealed the facility's nurses assigned to resident #14 had not checked/signed off the resident 14's treatment order to pad the resident's oxygen tubing every shift for 16 of 75 shifts during the month as of 02/26/2014. The TAR also indicated the facility's nursing staff signed off as checking and ensuring resident 14's nasal cannula tubing was padded on 5 - 1st and 2nd shifts when the resident was observed (see above) to not have any padding on the nasal cannula tubing behind the resident's ears.</p> <p>A review of resident #14's February 2014 Medication Administration Record (MAR) indicated the resident had a hand written order in ink on page 3 for oxygen to be given at a rate of 3 Liters/minute. The number 3 was over scored with the number 2 (also in ink) but leaving the number 3 still visible. Prior to the overscore the entry on the MAR mirrored the hand written entry on the February 2014 physician's order sheet. The facility's nursing staff assigned to resident</p>	F 514	<p>Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	3/10/14	

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F 514	<p>Continued From page 15</p> <p>#14 signed off the February 2014 MAR on the 1st and 2nd shifts on 02/24/2014 and 02/25/2014 and the 1st shift on 02/26/2014 indicating they had checked and the resident was receiving the correct amount of oxygen on those shifts. The observations noted above indicated the resident was not receiving the correct oxygen flow rate for either of the two conflicting physician's orders on the resident's February 2014 POS. The February 2014 MAR also indicated resident #14's oxygen flow rate was not checked/signed off for 12 of 75 shifts (3rd shifts) ensuring the resident received the proper physician ordered oxygen.</p> <p>On 02/26/2014 at 2:00 p.m., an interview and observation was conducted with the Evergreens Village charge nurse (Nurse #1) assigned to care for resident #14 (1st shift). Nurse #1 was asked to observe resident #14's in room floor oxygen concentrator and his wheelchair concentrator. During the observation Nurse #1 indicated the floor oxygen concentrator was set at 1.5 Liters/minute. The nurse also observed and indicated there was no padding on the nasal cannula tubing around resident 14's ears (attached to the floor oxygen concentrator) and no padding on the nasal cannula tubing attached to the oxygen concentrator on resident #14's wheelchair. Nurse #1 was asked at what flow rate settings the oxygen concentrators (floor and wheelchair) were supposed to be set at for resident #14. Nurse #1 indicated she was not sure and she would have to check the resident's chart. A review of the physician's orders (POS), MAR, and TAR for resident #14 was conducted with Nurse #1. Nurse #1 indicated there were 2 conflicting oxygen flow rate orders for resident #14 (2 liters/minute and 3liters/minute) and she did not know which flow rate order was correct or</p>	F 514	<p>Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	3/10/14	

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F 514	Continued From page 16 how much oxygen resident #14 was supposed to be receiving as she had observed resident #14's floor oxygen concentrator set at 1.5 liters/minute. A review of the chart by Nurse #1 indicated there was no other verbal order or other written order to indicate which oxygen flow rate order the staff were supposed to be using. A continued review of resident #14's records was made by the Nurse #1 which included the resident's TAR which indicated the resident was supposed to be wearing a padded oxygen nasal cannula. The TAR was signed off indicating the resident's nasal cannula padding had been checked each shift for both Monday 02/24/2014 and Tuesday 02/25/2014. The nurse indicated she had not yet signed off the TAR for the 1st shift on 02/26/2014 even though the shift was almost over and the resident had worn the unpadded nasal cannula tubing for over 7 of the 8 hour shift. The nurse indicated she knew the oxygen cannula padding order was a treatment order and the resident was supposed to have the padding on the tubing behind the resident's ears but she had not checked the resident (except the observation as noted above with the state surveyor and administering oral medications) today even though the shift had less than 1 hour left. Nurse #1 wanted to conduct a second check of resident #14 for the padding on the nasal cannulas. A second observation was conducted of resident #14 with the Nurse #1. The nurse asked the resident if he had any of the green or gray oxygen cannula pads to pad the nasal cannula tubing behind his ears. The resident indicated he had not had any padding of his nasal cannulas (floor concentrator cannula or wheelchair concentrator cannula) for a while (several days). The nurse again checked both the nasal cannula on the resident's wheelchair concentrator tubing the	F 514	Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.	3/10/14	

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F 514	<p>Continued From page 17</p> <p>concentrator tubing the resident was wearing while lying in bed. There were no pads on either nasal cannula's tubing. The nurse also checked in a woven basket on the resident's bedside night stand and in the night stand drawers for the pads. There were no pads found in the basket or drawers. The nurse indicated the resident was supposed to be wearing padding on each nasal cannula behind his ears. The nurse could not explain why the TAR was signed off for 02/24/2014 and 02/25/2014 even though the resident indicated he had not had any padding on either of his nasal cannulas on those days or why she had not checked the resident's oxygen flow rate or nasal cannula padding today (02/26/2014). A second review of Resident #14's MAR was conducted with Nurse #1. Nurse #1 indicated she had signed off the February 26th's 1st shift order indicating resident #14 was receiving oxygen at 2 liters per minute. Nurse #1 was asked why she signed off the order as her observation revealed resident #14 was receiving oxygen at 1.5 liters per minute. Nurse #1 indicated she had not checked resident #14's oxygen flow rate for either oxygen concentrator (floor/wheelchair) and had not checked resident #14 to ensure he had padding on either nasal cannula tubing during her shift thus far.</p> <p>02/26/2014 at 2:20 p.m., an interview was conducted with the facility's Director of Nursing (DON). The DON indicated it was her expectation that all conflicting physician's orders should be clarified. The DON also indicated it was also her expectation that all staff were to follow physician's orders and ensure the physician's orders were carried out and the MAR and TAR were signed off appropriately as to what was or was not done.</p>	F 514	<p>Preparation/and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	3/10/14

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