STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 12/22/2021

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WESTWOOD HILLS NURSING AND REHABILITATION CENTER	1016 FLETCHER STREET WILKESBORO, NC 28697

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E 000	Initial Comments An unannounced recertification survey and complaint investigation were conducted from 12/13/21 through 12/16/21. Additional information was obtained through 12/22/21. Therefore, the exit date was changed to 12/22/21. The facility was found to be in compliance with the requirement CR 483.73, Emergency Preparedness. Event ID# Y72U11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 12/13/21 through 12/16/21. Additional information was obtained through 12/22/21. Therefore, the exit date was changed to 12/22/21. There were a total of 8 allegations investigated and 2 were substantiated. Event ID#Y72U11. Past Non-Compliance was identified at: CFR 483.25 at F 693 at a scope and severity of J. The tag F 693 constituted Substandard Quality of Care. An extended survey was conducted on 12/22/21.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		2/4/22

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

Electronically Signed | 01/21/2022

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F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to provide a dignified dining experience by standing over residents while providing feeding assistance for 2 of 3 residents reviewed for dignity (Resident #67 and Resident #66).	F 550	Residents number 66 & 67 will be provided a dignified dining experience by the nursing staff while being assisted with feeding by staff who are at eye level and sitting during the mealtime. On 1/4/2022, The MDS Nurse Coordinator	

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F 550	Continued From page 2 The findings include: 1. Resident #67 was admitted to the facility on 06/09/21 with diagnoses that included Parkinson's Disease and Alzheimer's Disease. The quarterly Minimum Data Set (MDS) assessment dated 11/19/21 revealed Resident #67 sometimes understood others and sometimes made self-understood and had long and short term memory problems. The MDS also indicated the Resident required extensive assistance with eating. On 12/13/21 from 12:35 PM to 12:44 PM a continuous observation was made of Nurse Aide (NA) #1 standing at Resident #67's bedside while feeding the Resident her lunch. The Resident's head of bed was in an upright position and the NA stood above the Resident's eye level during the dining experience. There was a chair in the room that was available for the NA to use. 2. Resident #66 was admitted to the facility on 08/24/20 with diagnoses that included Alzheimer's Disease. The annual Minimum Data Set (MDS) 11/17/21 revealed Resident #66's cognition was severely impaired, and she required extensive assistance with eating. On 12/13/21 from 12:45 PM to 1:01 PM a continuous observation was made of NA #1 standing at Resident #66's bedside while feeding the Resident her lunch. The Resident's head of bed was in an upright position and the NA stood above the Resident's eye level during the dining	F 550	identified, by the Minimum Data Set (MDS), the resident□s requiring assistance with meals. They will be provided a dignified dining experience by the nursing staff while being assisted with feeding by staff who are at eye level and sitting during the mealtime. Retraining was provided to NA #1 on 12/14/21, by the Administrator on the provision of dignity while assisting a resident who needs assistance with meals. The nursing staff was trained on providing dignity while assisting a resident with meals, by the Staff Development Coordinator (SDC) or Nursing Manager. This will be completed by 01/28/2022. This training for providing dignity will be included in orientation for all new hires in the nursing department by the SDC or nurse manager. An audit tool, Monitoring Resident Dignity During Feeding, was developed. These audits began 1/4/2022, with retraining if indicated. The Monitoring Resident Dignity During Feeding tool has been and will continue to be used for auditing. This audit will be completed, 3x week x 4 weeks, then weekly x 4 weeks by the SDC or Nursing Manager. Retraining will be provided at the time as needed if indicated. The Quarterly Executive QA committee will review the results of the audits 1-time monthly for 2 months and approve recommendations for follow up as indicated or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QA monitoring.	

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F 550	Continued From page 3 experience. There was a chair in the room that was available for the NA to use. An interview was conducted with Nurse Aide #1 on 12/13/21 at 3:02 PM. The NA explained that when she fed on the hall, she always stood by the residents' bedside but when she fed in the dining room she always sat in a chair because it was important to sit at eye level with the residents. The NA stated she did not like to sit down and feed the residents because she had a bad back. During an interview with Unit Manager (UM) #1 on 12/15/21 at 12:12 PM she explained that the staff should sit down and feed the residents because it could be intimidating to the resident for someone to hover over them and risk them not eating at all. The UM stated the facility was their home and the residents should be made to feel comfortable. An interview was conducted with the Director of Nursing (DON) on 12/15/21 at 2:52 PM. The DON explained that nurse aides were taught in class to sit at the residents' side and feed them at eye level in order to provide a dignified dining experience. During an interview with the Administrator on 12/16/21 at 12:01 PM she explained that her expectation was for the nurse aides to be seated at eye level in order to give the residents their undivided attention.	F 550		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		2/4/22

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F 584	Continued From page 4	F 584		

comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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F 584	Continued From page 5 Based on observations and resident and staff interviews, the facility failed to repair an exterior window screen that obstructed a resident view for 1 of 2 residents and broken window blinds for 1 of 2 windows reviewed (Room 311). The facility failed to clean resident walls and ceilings in 3 of 10 resident rooms (Rooms 311, 506, and 510). The facility failed to remove dead bugs from light fixtures on the 500 hall, light fixtures in 2 of 3 resident rooms and the window sill in 1 of 3 resident rooms (Room #'s 512, 513, 516 and the 500 hall). The facility failed to maintain functional privacy curtains for 8 of 8 residents privacy curtains (Room 514, 511, 505, 506, 508, 507, 510, and 512). The facility failed to clean light fixture and air circulation vents in 3 of 3 resident rooms and the dining room (Room 511, 512, 514 and the dining room.) These observations occurred on 2 of 4 resident halls (300 and 500 Halls) and the dining room. Findings included: Window Screen and blinds: 1 a. An observation on 12/13/21 at 11:34 AM revealed a window screen to have a visible slit in the center (Room 311). An observation on 12/16/21 at 9:07 AM revealed the exterior window screen of an occupied resident room (Room #311) to contain an approximately 18 inch slit and claw type marks on the surface. The screen had been partially pulled up at the bottom which partially obstructed the view from the inside of the resident room. b. An observation on 12/16/21 at 9:27 AM revealed the window blinds to be broken (Room 510).	F 584	The window screen was removed in Room 311 by the Maintenance Director on 1/21/2022. Window blinds were replaced in Rm 510 by the maintenance on 1/21/2022. The walls in Room 311 were washed by the housekeeping staff on 1/4/2022, and the wallpaper repaired by the maintenance. The wall was cleaned by the housekeeping staff in Room 506 on 1/4/2022. The ceiling was cleaned/painted in Room 510 along with the wallpaper repair by the sink by maintenance on 1/21/2122. The window seal was cleaned by the housekeeping department in Room 512 on 1/4/2022. The light fixtures in the hallway of 500, along with the lights in both 513 and 516 were cleaned by housekeeping on 1/4/2022. The privacy curtains in Rooms 514, 511, 505, 506, 508,507,510, 512 were inspected for cleanliness and being off the tracks. They were replaced and or rehung for appropriate coverage by the housekeeping staff during the week of December 20, 2021. The light fixture in Room 511 was cleaned by the housekeeping staff on 12/23/2021. The large light fixture in the dining area was cleaned by the housekeeping department the week of December 20, 2021. The air vent in Room 512 was cleaned by housekeeping 12/23/2021. The vent in room 511 was cleaned along with the light fixtures above the beds on 12/23/2021. The vent in Room 514 was cleaned by the housekeeping department on 12/23/2021. All rooms on the Dementia unit were	

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F 584	Continued From page 6 Walls and Ceiling: 2 a. An observation on 12/13/21 at 11:36 AM revealed brown spots on the walls near the bed, closet, and window of room (Room 311). An observation on 12/16/21 at 9:07 AM revealed brown streaks running down the walls next to the sink and bathroom doors along with the wallpaper peeling up near the sink (Room 311). Nickel size spots of a brown substance were visible on the wall next to the foot of the resident's bed and brown spots near the white wall board used as a protective barrier attached to the wall (Room 311). b. An observation on 12/16/21 at 9:16 AM revealed dark brown substances from the doorway to the nightstand on the wall (Room 506). c. An observation on 12/16/21 at 9:27 AM revealed large brown oblong shaped spot on the ceiling measuring 6" x 4" (inches)and another one measuring approximately 16" x 6" on the right side of the light fixture. Another brown spot on the ceiling near the bathroom measuring approximately 8" x 3". The wallpaper was observed to be peeling away from the wall near the bathroom sink (Room 510) Dead Bugs: 3 a. An observation on 12/13/21 at 11:23 AM revealed 2 dead bugs in the window sill below the window blinds (Room 512). An observation on 12/16/21 at 9:30 AM revealed	F 584	inspected by the housekeeping supervisor for appropriately hung curtains, clean curtains, walls for cleanliness, vents for fuzz and windows and light fixtures for dirt and bugs. This was completed by 1/6/2022. Retraining of all housekeeping staff was completed by the housekeeping supervisor by 1/20/2022. A Housekeeping monitoring tool was and will be utilized to audit the areas of concern. This audit will be completed by the housekeeping supervisor and or the administrator weekly x 4, then every 2 weeks x 4 weeks, beginning 1/17/2022 Any issues of concern will be addressed at the time The Quarterly Executive QA committee will review the results of the audits 1-time monthly x 2 months and prove recommendations for follow up as indicated or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QA monitoring.	

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3 dead bugs in the window sill below the window blinds (Room 512).

b. An observation on 12/16/21 at 9:25AM revealed dead bugs in the light fixtures in the hallway (Hallway 500).

c. An observation on 12/16/21 at 9:38 AM revealed there were bugs and dirt under the plastic light fixture covering (Room 513).

d. An observation on 12/16/21 at 9:40 AM revealed there were bugs and dirt under the plastic light fixture covering (Room 516).

Curtains:

4. a. An observation on 12/13/21 at 11:05 AM revealed a curtain with the originally white netting near the top partially bleed to pink over a portion of the curtain and 2 rivets off the runner and detached from the track (Room 514).

b. An observation on 12/13/21 at 11:18 AM revealed a privacy curtain with the 3 rivets off the runner and detached from the track on the ceiling causing a portion of the curtain to sag downwardly (Room 511).

c. An observation on 12/16/21 at 9:15 AM revealed a curtain with 3-4 rivets off the track and detached from the track causing the curtain to sag. The curtain had three rivets off the track and dirty on the lower ½ of the curtain (Room 505).

d. An observation on 12/16/21 at 9:16 AM revealed the curtain with 2 rivets off the track (Room 506)

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e. An observation on 12/16/21 at 9:18 AM revealed a privacy curtain which was stuck in the track and unable to allow curtain to close greater than an approximately 18-inch area (Room #508)

f. An observation on 12/16/21 at 9:20 AM revealed a curtain with 2 rivets off the track (Room #507).

g. An observation on 12/16/21 at 9:27 AM revealed large brown areas of visible dirt and sticky substance on the privacy curtain (Room 510).

h. An observation on 12/16/21 at 9:30 AM revealed a curtain with 5 rivets off the track (Room 512).

Dirty Light Fixtures and Vents:

5 a. An observation on 12/13/21 at 11:18 AM revealed a light fixture that contained debris inside the plastic covering (Room 511).

b. An observation on 12/16/21 at 9:22 AM revealed a large light fixture in the dining area with brown stains on the plastic surface and a collection of dead bugs under the plastic covering (Dining Room).

c. An observation on 12/16/21 at 9:30 AM revealed the air vent near the bathroom with a ½ "thick fuzzy substance covering the vent (Room 512).

d. An observation on 12/16/21 at 9:32 AM revealed the air vent near the bathroom with a ½ "thick fuzzy substance covering the vent along with dirt and bugs in the light fixtures above the

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F 584	Continued From page 9	F 584		

beds (Room 511).

e. An observation on 12/16/21 at 9:36 AM revealed the air vent near the bathroom with a ½ "thick fuzzy substance covering the vent (Room 514).

An interview with Housekeeper # 1 on 12/16/21 at 2:20 PM revealed he was responsible for cleaning resident rooms. He indicated he was responsible to report all damaged surfaces, curtains, and bugs to the supervisor. Housekeeper #1 stated he had not noticed any of the items observed on the unit during his daily cleaning but had been attempting to get the major areas cleaned and had not reported the damages he had been trained to report.

An interview with the Housekeeping (EVS) /Maintenance Supervisor on 12/16/21 at 2:35 PM revealed she was recently made responsible for both housekeeping and maintenance departments. She indicated staff had been taught to log concerns into an electronic tracking system, but she had not been granted access since she took over the position. The EVS Supervisor explained someone from corporate came once a month to check on major concerns and they maintained the access to the electronic log. She stated she expected all areas in resident rooms and resident care units to be cleaned and be free from bugs daily, curtains to be maintained on their tracks and in working condition, light fixtures to be cleaned monthly and when debris is visible.

An interview with the Administrator on 12/16/21 at 3:52 PM revealed staff had been trained to log request in the electronic tracking system, but she

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F 584	Continued From page 10 was aware staff had also been taught to place the logs on a paper form if it was urgent. She also expects all resident care areas to be maintained in functional order and surfaces to be cleaned and free from bugs and dirt.	F 584		
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 review and staff interview the facility failed to accurately code the Minimum Data Set in the area of dialysis for 1 of 1 resident that received dialysis services (Resident #88). The findings included: Resident #88 was admitted to the facility on 06/11/21 with diagnoses that included end stage renal disease and dependence on renal dialysis. Review of dialysis communication sheets dated 11/19/21 and 11/21/21 indicated that Resident #88 had received dialysis and no acute issues were noted. The communication sheet contained Resident #88's vital signs and weight and the staff signature from the local dialysis center. Review of the quarterly Minimum Data Set (MDS) dated 11/25/21 indicated that Resident #88 was cognitively intact for daily decision making and required limited assistance with activities of daily living. The diagnoses section of the MDS revealed that Resident #88 had end stage renal disease however dialysis was not checked on the	F 641	The MDS for resident #88 was corrected on 12/15/2021, for correct coding of dialysis by the MDS Nurse Coordinator. MDS Nurse is no longer employed by this facility. A review of the current census was completed by the MDS Nurse Coordinator on 12/27/2021, and no other resident was identified to be receiving dialysis.. The regional MDS consultant completed training with the MDS Nurse Coordinator on 1/24/2022 on the coding of dialysis residents on the MDS. An audit will be conducted monthly x6, beginning in January 2022, for coding for any dialysis residents in the facility. This will be completed by the Assistant Director of Nursing (ADON) or Nursing Manager. Any identified issues will be reviewed for correction. The Quarterly Executive QA committee will review the results of the audits 1-time	2/4/22

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F 641	Continued From page 11 MDS indicating Resident #88 had not received dialysis during the assessment reference period. The MDS was completed by former MDS Nurse #1. MDS Nurse #1 was interviewed via phone on 12/15/21 at 3:04 PM. MDS Nurse #1 confirmed that she used to work at the facility from August 2021 to December 2021. She recalled Resident #88 and stated that she regularly received dialysis and would refuse from time to time but never more than one treatment at a time. MDS Nurse #1 stated that the lack of coding on the quarterly MDS dated 11/25/21 to reflect dialysis was an oversight on her part and the facility should process a correction due to transcription error. The Administrator was interviewed on 12/16/21 at 11:31 AM. The Administrator stated MDS Nurse #1 made a mistake when coding the quarterly MDS dated 11/25/21 probably because we had not had any residents that received dialysis for a while and was just an oversight on her part. The Director of Nursing (DON) was interviewed on 12/16/21 at 2:07 PM. The DON stated that she expected the MDS to be coded accurately and updated accordingly.	F 641	monthly x 2 months and prove recommendations for follow up as indicated or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QA monitoring.	
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	F 656		2/4/22

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F 656	Continued From page 12 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. (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 observations, record reviews and staff and Resident interviews the facility failed to implement the care plan intervention for oxygen	F 656	Resident #5 received humidified oxygen via concentrator per water bottle 24 hours a day until 1/9/2022 when Hospice	

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F 656	Continued From page 13 humidification for 1 of 1 Resident reviewed for choices (Resident #5). The finding included: Resident #5 was admitted to the facility on 06/30/21 with diagnoses that included respiratory failure and chronic obstructive pulmonary disease. A review of Resident #5's Physician orders dated 06/30/21 included continuous oxygen at four liters per minute via nasal cannula. Resident #5's care plan initiated 07/01/21 and revised 07/19/21 revealed a potential for ineffective breathing pattern related to chronic obstructive pulmonary disease with interventions of administering oxygen at four liters and to attach water for humidification per the Resident's request. The quarterly Minimum Data Set (MDS) dated 09/09/21 revealed Resident #5 was cognitively intact and required oxygen therapy. On 12/13/21 at 11:54 AM an observation was made of Resident #5 in bed sleeping with continuous oxygen via nasal cannula administered at four liters per minute. The water bottle attached to the oxygen system for humidification was empty. On 12/13/21 at 4:04 PM a second observation made of Resident #5's water bottle while the Resident was sleeping. The water bottle remained empty. During an interview with Nurse #1 on 12/13/21 at	F 656	discontinued the order for humidified oxygen. All other residents were identified on 1/10/2022, via their care plan, who desired or had an order for humidified oxygen. This was completed by the MDS Nurse Coordinator. For the residents identified for humidified oxygen, this information was transcribed to the MAR for the nurse/med aide to check on the presence of the water bottle each shift. This requires documentation from the staff member to indicate the water is in place. The licensed staff was retrained by the SDC or unit manager on the importance of the humidified air, following the care plan, and the documentation on the EMAR. This was completed by 1/26/2022. This is being included in all orientation for licensed staff. An audit tool for Humidified Oxygen was developed to monitor the presence of the water bottle for the identified residents. This audit will be completed by the ADON or Nurse Manager 2x week x 4 weeks, then weekly x 4 weeks. This began 1/10/2022. Any identified issues will be reviewed for corrective action. The Quarterly Executive QA committee will review the results of the audits 1-time monthly x 2 months and approve recommendations for follow up as indicated or appropriate for continued compliance in this area and to determine the need for and or frequency of	

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F 656	Continued From page 14 4:14 PM the Nurse accompanied the Surveyor to Resident #5's room (who was still sleeping) and observed the water bottle remained empty. The Nurse explained that every nurse who entered the room should monitor for the need to replace the water bottle. On 12/15/21 10:11 AM an interview was conducted with Medication Aide (MA) #1 who confirmed that she worked with Resident #5 on 12/13/21 and explained that she glanced at the Resident's water bottle on the oxygen system and meant to inform the nurse of the need to replace it but she forgot. The MA indicated that the medication aides and nurse aides could only monitor the humidification bottles for water but that only the nurses could replace the humidification bottles on the oxygen systems. An interview was conducted with the Director of Nursing (DON) on 12/15/21 at 3:00 PM who explained that all staff should be checking the water bottles when they enter the room and they could inform the nurse of the need to replace it. The DON stated the humidification should be maintained as requested on Resident #5's care plan. A review of Resident #5's Care Guide dated 12/16/21 indicated oxygen with humidification per the Resident's request. During an interview with the Minimum Data Set (MDS) Nurse #2 on 12/16/21 at 11:55 AM she explained that if an intervention was important enough to be included on the Resident #5's care plan then it was her expectation for the staff to implement the intervention.	F 656	continued QA monitoring.	

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F 656	Continued From page 15 During an interview with the Administrator on 12/16/21 at 11:58 AM she stated if Resident #5 requested humidification for the oxygen system to be applied then the humidification should be maintained, and the care plan should be followed.	F 656		
F 693 SS=J	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to follow a physician order to stop a tube feeding after 16 hours per the physician order for 1 of 1 resident (Resident #64) reviewed for feeding tubes. This caused Resident #64 to vomit, have bilateral adventitious	F 693	Past noncompliance: no plan of correction required.	1/21/22

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(abnormal) lung sounds and was in visible distress with an oxygen saturation level of 81% and necessitated an emergent transfer to the Emergency Room (ER) to be assessed for aspiration.

The Findings Included:

Resident #64 was admitted to the facility on 01/20/15 with diagnoses that included aphasia, gastroparesis, and dysphagia.

A review of Resident #64's electronic physician orders revealed an order dated 11/08/21 for Peptamen (type of parental nutrition) 1.5, infuse at 75 milliliters per hour for a continuous 16 hours. Additional review of Resident #64's physician orders revealed an order dated 11/11/21 that read "in the morning disconnect tube feeding at 6:00 AM".

A review of Resident #64's quarterly Minimum Data Set Assessment dated 11/15/21 revealed Resident #64 to be severely impaired for daily decision making. She was coded as requiring total assistance with eating and was coded as having a feeding tube while admitted to the facility, receiving 51% or more of her total calories via feeding tube.

Review of the Medication Administration Record (MAR) dated 11/01/21 through 11/30/21 indicated that Resident #64's Peptamen 1.5 was to be turned on at 2:00 PM and turned off at 6:00 AM and had been initialed by Nurse #2 indicating the tube feeding had been stopped at 6:00 AM on 11/13/21.

Attempted phone call with Nurse #2 was

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completed on 12/14/21 at 4:20 PM with no answer. A voicemail was unable to be left due to the mailbox being full.

A review of a nursing progress note written by Nurse #1 on 11/13/21 at 2:02 PM read "called to room by hall nurse [Nurse #3] to assess [Resident #64]. Resident [#64] observed sitting up at 45 degrees, seeming to be having difficulty breathing. Bilateral rhonchi and crackles noted. Emesis observed on [Resident # 64's] chest and clothing. Heart rate at 130 [beats per minute], oxygen saturation at 81% on nasal cannula at 2 liters per minute. Resident [#64] visibly distressed. Orders received to transfer to emergency department for evaluation and treatment as indicated, first responders requested with emergent transfer."

During an interview with Nurse #1 on 12/14/21 at 3:18 PM, she reported she was familiar with Resident #64 and verified she was working as the weekend supervisor on 11/13/21. She stated she was contacted by the hall nurse, Nurse #3, on 11/13/21 due to Resident #64 having respiratory distress. She stated Resident #64 was supposed to be on a 16-hour continuous tube feeding and believed that the night nurse, Nurse #2, had forgotten to disconnect the tube feeding resulting in Resident #64 receiving more feeding than what was ordered. Nurse #1 reported when she went to the room to assess Resident #64, she was receiving oxygen via nasal cannula, so she suctioned her, checked Resident #64's airway, and then called the on-call physician for further orders. She reported Resident #64 was sent out to the emergency department for evaluation and treatment.

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An interview with Nurse #3 via telephone call on 12/15/21 at 11:27 AM revealed she remembered Resident #64 and was assigned to her on 11/13/21 from 7:00 AM to 3:00 PM on 11/13/21. She reported it was the first time she had worked with Resident #64 as she was an agency nurse and new to the facility. Nurse #3 stated there were no concerns throughout the shift and she checked the placement of Resident #64's feeding tube to see if there was any residual feeding when she provided her morning medications around 9:00 AM. Nurse #3 reported she did not believe Resident #64 had any scheduled medications to be given at lunch time and received most of her medications in the morning. Nurse #3 stated when she went in to restart Resident #64's feeding, she noticed Resident #64 "looked different" and was breathing fast. Nurse #3 immediately went to Nurse #1 because she did not know what Resident #64's baseline was and was aware Nurse #1 would. Nurse #3 stated she and Nurse #1 went to Resident #64's room and Nurse #1 assessed resident, checked her airway, and turned off the feeding tube. Nurse #3 stated the head of the bed was elevated and there was a trace amount of regurgitation on Resident #64's clothing and was the color of feeding tube fluid. Nurse #3 reported she provided ordered tube flushes during the day at the scheduled times and reported there were no noted issues or distress prior to 2:00 PM when she went into the room to restart the tube feeding.

Review of an Emergency Department (ED) Provider Note dated 11/13/21 at 2:48 PM read, in part, "69- year- old female presents to the emergency department via emergency medical services (EMS) from [local nursing facility] for aspiration. EMS reports initial oxygen saturation

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levels (SpO2) in the 70's. SpO2 rose to 89% on 15 liters via non-rebreather. EMS states the patient's skin appeared mottled upon their arrival. Patient arrives with MOST (medical orders for scope of treatment) form and Do Not Resuscitate for comfort measures only." The progress note continued, stating Resident #64 was noted with a fever while at the emergency department with respiratory distress due to a "history of recent aspiration, likely pneumonia". According to the note, resident was treated for "fever with respiratory distress, history of recent aspiration likely pneumonia." Treatment included treating the fever with Tylenol and "air hunger addressed with some [intravenous] IV morphine". According to the note, no chest x-ray was taken, and resident was stable to discharge back to the facility without admission to the hospital after a few hours with no new orders.

A nurse's note dated 11/13/21 at 6:27 PM indicated Resident #64 had returned to the facility from the emergency department via EMS. The ED Nurse had reported the Resident's temperature was 103.5. The nurse noted Resident #64's oxygen was titrated up to 4 liters/minute and she appeared calm and comfortable.

A review of physician progress note dated 11/16/21 revealed Resident #64 was seen for follow-up and management of medical problems including end-stage dementia with psychosis and a recent emergency room visit for aspiration pneumonia. The physician noted Resident #64 had some respiratory distress and was transferred to the hospital recently. Due to her being comfort measures only she was treated symptomatically with morphine and she returned

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to the facility. The physician documented the Resident did not appear to be in any distress but remained a high risk for decompensation.

A Registered Dietitian (RD) progress note dated 11/17/21 indicated Resident #64 was recently hospitalized for aspiration, which was likely due to the diagnosis of gastroparesis and the medical error of continuous feeding running for 24 hours. The RD noted Resident #64 had been tolerating the tube feeding regimen that week with no signs or symptoms of intolerance or distress.

An interview with Nurse Aide #1 on 12/14/21 at 5:33 PM, she verified she was working on Resident #64's hall on 11/13/21 but was not assigned to the Resident. She reported she remembered towards the end of the shift, Resident #64 had to be sent out to the hospital due to aspirating and vomiting. She stated she remembered the head of the bed was elevated and does not remember Resident #64 being in any distress during her shift before being asked to clean her up for transportation to the emergency department.

Attempts to contact the Nurse Aide assigned to Resident #64 on 11/13/21 for the 7:00 AM to 3:00 PM shift during the investigation were not successful.

An interview with the Director of Nursing on 12/14/21 at 4:53 PM revealed she was aware of the incident regarding Resident #64's feeding tube not being stopped on 3rd shift by Nurse #2. She reported the incident was processed and investigated as a medication error. She verified Resident #64's feeding tube should have been disconnected at 6:00AM on 11/13/21 by Nurse #2

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and it was not. She stated when she spoke to Nurse #2 during the investigation, Nurse #2 reported she assumed the feeding tube was continuous for 24 hours at a time and she did not verify the order on the Medication Administration Record (MAR) before she signed off on it. The Director of Nursing reported once Nurse #2 signed off on the MAR, Nurse #3 would not have received any notification regarding the feeding until 2:00 PM when she would have received a notification to start another 16-hour feeding. She reported at 2:00 PM, when Nurse #3 received that notification, she immediately reported it to Nurse #1 who went and assessed Resident #64, found her in distress and sent her to the emergency room for evaluation and treatment.

During a follow up interview with the DON on 12/15/21 at 3:56 PM she reported when she questioned Nurse #2 during her investigation, she stated Nurse #2 indicated "it was just oversight". She reported she had tried to reach back out to Nurse #2 but had not received a return call. The DON reported Nurse #2 should not have signed off on a physician order as done if it had not been completed. She stated orders should be signed off on as they are completed, not before.

During an interview with the Medical Director on 12/15/21 at 9:27 AM he reported he was notified of the incident regarding Resident #64's tube feeding being left running for an additional 8 hours. He stated he believed she was sent out to the emergency room after aspirating and was sent back. He reported he assessed the resident a few days later and did not note any concerns or injury to Resident #64 related to tube feeding being left running for longer than it was supposed to.

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The facility provided the following Corrective Action Plan with a completion date of 12/07/21:

"Identify those recipients who have suffered, a serious adverse outcome as a result of the noncompliance

Resident #64 is alert but very confused, she is rarely/never understood, Minimum Data Set Brief Interview for Mental Status score was unable to be performed, she has no ability to make cognitive decisions. Resident has long and short-term memory loss. Resident's diagnosis is Aphasia, Gastroparesis, Dysphagia, Gastrostomy Status, Alzheimer's. Resident has tube feeding via gastrostomy tube Peptamen 1.5 at 75 ml/hour for 16 hours. Tube feeding is stopped at 6:00 am and restarted at 2:00 pm per Medical Director orders. On 11/13/21, Nurse #2, the nurse working 11pm to 7am did not turn off resident's tube feeding at 6:00 am, Nurse #2 signed off she had turned it off. Nurse #3 working the 7am to 3pm shift contacted the Nurse #1, the RN weekend supervisor midafternoon and made her aware Resident #64 tube feeding was on a continuous feeding when the order was for 16 hours. Nurse #1 reported, Nurse #3 told her Nurse #2 did not stop the tube feeding at 6:00am. Nurse #3 assessed the resident and found she was on O2 at 2 liters via nasal cannula, her airway and lung sounds were checked and due to the resident being in respiratory distress Nurse #3 contacted the on-call physician, and the resident's resident representative. The decision was made to send resident #64 to the Emergency Room for evaluation and treatment. The resident was seen in the Emergency Room, she was given IV Morphine for respiratory distress and Tylenol for

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fever. The Emergency Room doctor called and spoke with resident representative and the decision was made to send resident back to the facility due to DNR with comfort measures. The resident returned to the facility with the following Clinical Impressions from the Emergency Room, they were: Fever in adult, Respiratory distress, DNR (do not resuscitate) Nurse #3 noted the resident was calm and in no acute distress. The resident was seen by the Medical Director on 11/16/21 status post the emergency room visit, with no new orders. The Corporate Registered Dietitian saw the resident on 11/17/21 with no new orders, the RN nurse consultant for Medicare Replacement extender saw the resident on 12/2/21 with no new orders or recommendations. Resident has had no further issues with her tube feeding and no further respiratory distress.

The root cause discussed and identified by the Quality Assurance Performance Improvement (QAPI) team, was Nurse #2 signed the order to turn the tube feeding off at 6:00 am on 11/13/21 but did not go to the resident room and turn the feeding off. Nurse #3 gave the resident her medication and flushes as ordered through the shift. At 2:00pm when Nurse #3 went to turn the tube feeding on she found the feeding had not been turned off at 6:00am.

"Identify those recipients who are or are likely to suffer, a serious adverse outcome as a result of the noncompliance

All residents receiving feedings via a gastrostomy tube that are not continuous 24-hour feeding are at risk for receiving their tube feeding for longer than the Medical Director ordered length of time. There are no other residents currently residing in

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the facility with a tube feeding.

All residents admitted to the facility that have non-continuous tube feeding will have an order to turn the tube feeding off at the specified time and another order to verify the tube feeding was turned off. The order will be on the Medication Administrative Record with written instructions of time to start the tube feeding and time to stop the tube feeding. The order will have a large capitalized note stating "DISCONNECT TUBE FEEDING AT (TIME ORDERED) and another order to "CONFIRM ENTERAL TUBE FEEDING IS TURN OFF" The Corporate Registered Dietitian, will review all current and new admissions tube feeding orders and make recommendations as appropriate for resident tube feeding formula and rate at which the tube feeding is running. All new admissions are reviewed daily through the interdisciplinary team meeting (IDT) conducted daily for quality assurance, any negative findings are corrected immediately, and additional training will begin.

"Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

¢ The Director of Nursing (DON) was notified on 11/13/21 by Nurse #1 immediately upon finding the resident #64 in distress and Nurse #1 was sending the resident to the Emergency Room.
¢ The Director of Nursing (DON) on 11/13/21, instructed Nurse #1 the RN supervisor to begin in-servicing on Continuous enteral feeding vs Timed Enteral feedings, to include ensuring the order is carried out as written and proper point of

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care documentation to sign the completed order after the task or medication is given with Nurse #3 and all nursing currently working.

¢ On 11/13/21, the spoke with Nurse #2, took her statement and in-serviced her Continuous enteral feeding vs Timed Enteral feedings, to include ensuring the order is carried out as written and proper point of care documentation to sign the completed order after the task or medication is given.

¢ 11/14/21 The QAPI Adverse Event PIP (Performance Improvement Plan) initiated and the formal monitoring tool was initiated by the DON.

¢ Monitoring began on 11/14/21 by the Unit Manager and RN supervisor to visually inspect that Resident #64's tube feeding was indeed discontinued at 6:00am. If there were any negative findings, it was to be corrected immediately and the DON was made aware for additional training per Monitoring Tool. The Tube Feeding audit will be conducted daily x 1week, weekly x 4 weeks and monthly x 1 month.

¢ The DON/Assistant Director of Nursing (ADON) on 11/15/21 began in-servicing all nurses on staff and nurses from the agency. All nurses were educated by 11/15/21. All new hires, PRN or new agency nurses are tracked by the DON and educated on tube feedings during their orientation or their return to work.

¢ 11/15/21 Interdisciplinary quality team reviewed the event, (IDT) in the interdisciplinary team meeting. Meeting is held as part of QAPI 5 days a week. Minutes from 11/13/21 and 11/14/21 done by RN supervisor Nurse #1. In-servicing was continued by the DON/ADON/Staff Development Coordinator (SDC) to ensure all nurses were in-serviced. It was determined by the interdisciplinary quality team the QAPI Adverse

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Event Audit and the Tube Feeding monitoring tool to verify the tube feeding was turned off, to check for negative findings or additional training needed and the name of the auditor would begin immediately. The audit will be conducted daily x 1week, weekly x 4 weeks and monthly x 1 month

¢ 11/16/21 QAPI Quarterly meeting was held, the Medical Director was in attendance and this QAPI Adverse Event was discussed. He agreed with the improvement plan, in-services and monitoring tools.

¢ 12/4/21 the DON and ADON in review of resident event during Interdisciplinary quality team meeting it was decided for further prevention of a re-occurrence of tube feeding not being turned off would write a large capitalized note on the turn off order at 6:30am order "DISCONNECT TUBE FEEDING AT 6:00am" and to add an order for 7:30am to confirm tube feeding was turned off. "CONFIRM ENTERAL TUBE FEEDING IS TURN OFF" The DON will be responsible to ensure that the order is completed on all residents that have a timed tube feeding. All new orders for current and new admissions are reviewed at a minimum of 5 days a week to ensure accuracy in the interdisciplinary quality team meeting and directed by the DON.

¢ The DON will report the results of audits at the monthly QAPI meetings for 3 months. Additional audits will be completed if determined necessary by the QAPI team.

The facility alleged compliance on 12/07/21.

The Corrective Action Plan was validated on 12/22/21 and concluded the facility implemented an acceptable corrective action plan on 12/07/21. The facility provided training to all nursing staff, amended the physician orders to trigger a

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F 693	Continued From page 27 verification a timed enteral feed had been stopped, and initiated monitoring tools to ensure the new policies and procedures were followed. The Corrective Action Plan was reviewed during QAPI meeting held on 11/15/21. The weekly monitoring logs for residents with feeding tubes were reviewed for the month of December 2021 with no concerns identified. Review of the nursing staff in-service sheets on feeding tubes revealed the nursing staff had initialed as receiving the in-services training. Interviews conducted with nursing staff from first, second, and third shifts revealed they had received the in-service trainings on feeding tube policies and procedures as stated by the facility.	F 693		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Medical Doctor interview the facility failed to obtain a physician order for a resident to receive dialysis and for the care and monitoring of the resident's dialysis access site for 1 of 1 resident reviewed for dialysis (Resident #88). The findings included: Resident #88 was admitted to the facility on 06/11/21 with diagnoses that included end stage	F 698	Resident #88 no longer resides in the facility. The MDS Nurse Coordinator reviewed the census in addition to the MDS and did not identify any other resident receiving dialysis in the facility on 12/30/2022. Inservice training was provided by the SDC or Nurse Manager to all licensed staff regarding the need for an order and	2/4/22

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F 698	Continued From page 28 renal disease and dependence on renal dialysis. Review of the quarterly Minimum Data Set (MDS) dated 11/25/21 revealed that Resident #88 was cognitively intact for daily decision making and required limited assistance with activities of daily living. The diagnoses section of the MDS revealed that Resident #88 had end stage renal disease however dialysis was not checked on the MDS indicating Resident #88 had not received dialysis during the assessment reference period. Review of a care plan revised on 11/29/21 read in part, Resident #88 has end stage renal disease and is at risk for complications due to hemodialysis. The interventions included dialysis on Monday, Wednesday, and Friday, communicate with dialysis center as indicated, assess resident upon return from dialysis, do not draw blood or take blood pressure in arm with access site (left arm), maintain dressing as ordered, monitor access site for bleeding and/or signs of infection, monitor vital signs, and monitor for changes in level of consciousness, skin turgor, oral mucosa, or heart/lung sounds. Review of Resident #88 active order summary printed on 12/16/21 revealed no physician order for dialysis and no order for care or monitoring of the dialysis access site. The Charge Nurse from the local Dialysis center was interviewed on 12/21/21 at 9:37 AM. The Charge Nurse stated that when Resident #88 left dialysis she would have a pressure dressing over her access site, and it was required to be removed 4-6 hours after treatment by the facility staff she also stated that the staff at the facility should be assessing the access site to make sure	F 698	monitoring with documentation of a dialysis resident access site. This inservicing was provided and completed by 1/24/2022. This is also included in orientation on any new licensed staff by the SDC or nurse manager. An audit ool,Dialysis Audit Tool will be utilized for monitoring orders and site monitoring by the RN Unit managers or DON. There are currently no dialysis residents in the facility. These audits will be performed monthly x3. The Quarterly Executive QA committee will review the results of the audits 1-time monthly x 2 months and approve recommendations for follow up as indicated or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QA monitoring	

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it does not close and that would include listening to the bruit (the swooshing sound of dialysis fistula) with a stethoscope and feeling for a thrill (a vibration felt over the fistula). The Charge Nurse indicated that these instructions generally were included in the resident's orders at the facility where they live.

MDS Nurse #2 was interviewed on 12/15/21 at 2:38 PM and reported that Resident #88 did regularly receive dialysis and could not explain why there was not a physician order for Resident #88 to receive dialysis. MDS Nurse #2 stated that the staff should be monitoring Resident #88's access site at least daily to ensure no bleeding or signs of infection.

MDS Nurse #1 was interviewed on 12/15/21 at 3:12 PM and stated she worked at the facility from August 2021 to December 2021 and knew that Resident #88 regularly received dialysis. She further explained that Resident #88 was the only dialysis resident and she had not been at the facility long enough to know about her dialysis order. MDS Nurse #1 stated that she recalled an order to remove a pressure dressing after dialysis but stated she did not recall seeing an order for any care or maintenance to Resident #88's dialysis access site. She added that Resident #88 was alert and oriented and would let someone know if something was going on with it.

Unit Manager #1 was interviewed on 12/16/21 at 10:10 AM and confirmed that there should be a physician order for dialysis. She stated that Resident #88 had received dialysis since her admission in June 2021. UM #1 also confirmed that she was responsible for entering most of the orders in the facility and was just an oversight on

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F 698	Continued From page 30 her part. She further state that the facility staff really did not do much with Resident #88's dialysis access site except they should definitely be monitoring for infection and bleeding. The Administrator was interviewed on 12/16/21 at 11:31 AM. The Administrator confirmed that UM #1 entered most of the orders at the facility and it was just an oversight on her part. She stated that the facility had not had a dialysis resident in a long time, and they reviewed the orders in the morning stand up meeting but just missed ensuring that Resident #88 had a physician order in place for her dialysis and for the care and maintenance of her access site. The Director of Nursing (DON) was interviewed on 12/16/21 at 2:07 PM. The DON stated she absolutely expected Resident #88 to have a physician order for dialysis and should have been put in upon admission by UM #1. She added the physician order should include the care and monitoring of Resident #88's dialysis access site. The Medical Doctor (MD) was interviewed on 12/21/21 at 10:28 AM. The MD stated that he generally did not write specific orders for dialysis and he assumed the facility staff would just enter the order into the electronic system and he would sign off on it. He stated the important thing was that she was getting to/from dialysis 3 times a week. The MD further stated that the facility staff did not have to do anything to the access site and no monitoring was required because she went to dialysis every other day. He stated that once the facility got her to dialysis, and they managed the rest from there.	F 698		
F 842 SS=D	Resident Records - Identifiable Information	F 842		2/4/22

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F 842	Continued From page 31 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 32 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews, the facility failed to maintain an accurate recording of a tube feeding on the Medication Administration Record for 1 of 1 resident reviewed for tube feeding (Resident #64). The Findings Included: Resident #64 was admitted to the facility on	F 842	A QI report was completed with a complete investigation for the tube feeding documentation on Resident #64. This was initiated on 11/13/2021 by the RN Supervisor. A review of the current census and the MDS was completed by the MDS Nurse Coordinator on 11/22/2021, and no other resident was identified to be receiving	

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F 842	Continued From page 33 01/20/15 with diagnoses that included aphasia, gastroparesis, and dysphagia. A review of Resident #64's physician orders revealed an order dated 11/08/21 for Peptamen (liquid nutrition) 1.5, infuse at 75 milliliters per hour for a continuous 16 hours. Additional review of physician orders revealed an order dated 11/11/21 that read, in the morning disconnect tube feeding at 6:00 AM. Review of Resident #64's Medication Administration Record (MAR) revealed Nurse #2 signed off on the following order at 6:00 AM on 11/13/21 as being complete: - Enteral Feed Order - in the morning Disconnect tube feed at 6 am. Attempted phone call with Nurse #2 was completed on 12/14/21 at 4:20 PM with no answer. A voicemail was unable to be left due to the mailbox being full. An interview with the Director of Nursing on 12/14/21 at 4:53 PM revealed she was aware of the incident regarding Resident #64's tube feeding not being disconnected on 3rd shift on 11/13/21 by Nurse #2. She reported the incident was processed and investigated as a medication error. She stated when she spoke to Nurse #2 during the investigation, Nurse #2 reported she assumed the feeding tube was continuous for 24 hours and she did not verify the order on the Medication Administration Record (MAR) before she signed off on it. During a follow up interview with the DON on 12/15/21 at 3:56 PM she reported when she questioned Nurse #2 during her investigation, she	F 842	tube feedings. There are currently no other tube feeders in this facility. The DON, ADON and SDC completed retraining on proper documentation of tube feeding with all licensed staff by 12/7/2021. Documentation accuracy is included in orientation to all licensed staff. An audit tool Tube Feeding Audit Tool was developed to monitor the documentation of the tube feeding. This tool was used daily x 30 days, then weekly x 4, then monthly x1. Issues, if any, were addressed at the time. The Quarterly Executive QA committee will review the results of the audits 1-time monthly x 2 months and approve recommendations for follow up as indicated or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QA monitoring	

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F 842	Continued From page 34 stated Nurse #2 indicated "it was just oversight". She reported she had tried to reach back out to Nurse #2 but had not received a return call. The DON reported Nurse #2 should not have signed off on a physician order as done if it had not been completed. She stated orders should be signed off on as they are completed, not before.	F 842		