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	345520	A. BUILDING _____ B. WING _____	C 11/08/2019

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MAGNOLIA GARDENS CENTER FOR NURSING AND REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

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E 000	Initial Comments An unannounced Recertification survey was conducted on 11/4/19 through 11/8/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# TO3M11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 11/4/19 through 11/8/19. Event ID# TO3M11. 1 of the 13 complaint allegations were substantiated resulting in a defiency, F576. Immediate Jeopardy (IJ) was identified at CFR 483.12 at tag F600 at a scope and severity of J. The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy (IJ) began on 10/12/19 and was removed on 11/8/19. An extended survey was conducted.	F 000		
F 584 SS=D	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, 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	F 584		12/15/19

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

Electronically Signed | 12/05/2019

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F 584	Continued From page 1 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: Based on observations and staff interviews, the facility failed to maintain a clean and safe environment by failure to maintain a clean floor, clean walls or prevent electrical wires from being accessible in three of eighteen rooms (rooms 220, 104 and 123) reviewed for environment. Findings included: 1. An observation conducted on 11/4/19 at 12:15	F 584	F 584 Safe clean comfortable 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 11/6/19 rooms #220 and #105 were both deep cleaned by The Housekeeping Director to ensure there were no urine,fecal matter, and or blood on any	

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F 584	Continued From page 2 PM revealed a large puddle a yellowish-brown liquid inside the resident ' s closet and extended out into the resident ' s room from under the closet door covering the length of three floor tiles in room 220 for bed number one. During an observation conducted on 11/5/19 at 11:52 AM a dried yellow substance was observed on the floor inside the closet for bed number one of room 220. The dried yellow substance appeared to have originated at the wall of the back of the closet and extended toward the front of the closet and did not extend into the resident ' s room or beyond the closet door. During an interview with the Maintenance Director (MD) conducted on 11/6/19 at 9:20 AM he stated there was a resident in the room adjacent to 220 and he had urinated in his closet and the urine would travel under the wall dividing the two closets and into the closet of room 220. An observation was conducted in conjunction with an interview with the Housekeeping Director (HD) during a round on 11/6/19, which started at 9:43 AM. The observation revealed a dried yellow substance was observed on the floor inside the closet for bed number one of room 220. The dried yellow substance appeared to have originated at the wall of the back of the closet and extended toward the front of the closet and did not extend into the resident's room or beyond the closet door. When a paper towel was rubbed over the dried substance it appeared yellow on the paper towel and had a urine odor to it. The HD stated the rooms were mopped daily and typically the housekeeper would not look into the resident ' s closet nor mop the floor in the resident ' s closet.	F 584	walls,floors,door frame and light switch fixtures. On 11/6/19 The Maintenance Director repaired the electrical outlet in room #123. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All other rooms were audited on 11/6/19 by the Housekeeping Director to ensure there were no other rooms that had urine,fecal matter, or blood on any walls,floors,door frame and light fixtures. All electrical outlets in residents rooms were audited On 11/6/19 by the Maintenance Director to make sure they were operable and in good repair. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Daily monitoring tool will be used by the houskeeping director 5x a week for 4 weeks, 3x a week for 4 weeks, and 1x a week for 4 weeks to monitor for cleanliness of the rooms. Daily rounds will be done by the interdiscplinary team (IDT) 5 x a week for 4 weeks, 3x a week for 4 weeks and 1 x a week for 4 weeks. to ensure rooms are safe/clean/comfortable/and have a homelike environment. On 11/11/19 The Administrator re-educated the Housekeeping staff and IDT on keeping the resident rooms and facility clean and to observe for soiled areas in rooms and visualizing electrical outlets while making rounds. Visual inspections by the Administrator, Housekeeping Director or	

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F 584	Continued From page 3 An interview conducted on 11/8/19 at 1:03 PM with the facility Administrator revealed his expectation was for resident rooms, and adjacent areas, such as closets and bathrooms to have been kept clean and sanitary. 2. An observation of the resident bathroom in room 105 was conducted on 11/4/19 at 2:57 PM. The observation revealed multiple areas with brown matter splattered the on walls and the door frame for the bathroom. During an observation conducted on 11/5/19 at 5:05 PM multiple areas with brown matter were observed to have been splattered the on walls and the door frame for the bathroom. During an interview with the Maintenance Director (MD) conducted in conjunction with a round on 11/6/19 which started at 9:20 AM multiple areas with brown matter were observed to have been splattered the on walls and the door frame for the bathroom. In addition, red dried smear marks were observed on the faceplate cover for the light switch for the bathroom. The MD stated the brown scattered matter on the walls and door frame did not appear to have been where brown paint may have been exposed but appeared it may have been feces and the red dried smear marks on the light switch appeared to have been blood. Further observation revealed a roll of toilet paper sitting on the tank of the toilet which also had brown matter on it and appeared as if it had been wet due to the toilet paper having been swollen at some spots and frayed or torn in others. The MD disposed of the toilet paper in the track receptacle.	F 584	Maintenance Director of 7 residents rooms will be performed 5x week for 4 weeks and 3 X a week for 4 weeks and weekly X 4 weeks to ensure the rooms are safe/clean/comfortable/and have a homelike environment. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator will report the findings to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.	

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F 584	Continued From page 4	F 584		

During an interview with the Housekeeping Director (HD) conducted in conjunction with a round on 11/6/19 which started at 9:43 AM multiple areas with brown matter were observed to have been splattered the on walls and the door frame for the bathroom. In addition, red dried smear marks were observed on the faceplate cover for the light switch for the bathroom. The HD stated it was her expectations for resident bathrooms to have been cleaned daily as part of routine room cleaning.

An interview conducted on 11/8/19 at 1:03 PM with the facility Administrator revealed his expectation was for resident rooms, and adjacent areas, such as closets and bathrooms to have been kept clean and sanitary.

3. An observation of room 123 on 11/4/19 at 1:11 PM, on 11/05/19 at 5:01 PM and on 11/6/19 at 9:30 AM revealed an electrical box containing 4 electrical outlets was dislodged from the wall. Due to the dislodgement from the wall the box was approximately 1-2 inches from the wall which allowed visibility of at least two insulated wires which traveled from the electrical box to a hole in the sheetrock. The electrical outlet was located between the beds for room 123 at approximately waist level.

An interview and observation were completed with the Maintenance Director (MD) during a round conducted on 11/6/19 at 9:54 AM. The fourth observation revealed the electrical box containing 4 electrical outlets was still dislodged from the wall. Due to the dislodgement from the wall the box was approximately 1-2 inches from the wall which allowed visibility of at least two insulated wires which traveled from the electrical

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F 584	Continued From page 5 box to a hole in the sheetrock. The electrical outlet was located between the beds for room 123 at approximately waist level. The MD stated the electrical box was loose from the wall and he stated the electrical outlet needed to have been securely connected to the wall with no gaps allowing visibility and accessibility to the wires behind and within the electrical outlet box. The MD stated he was unaware of the loose electrical outlet box and he would have the electrical outlet properly secured to the wall immediately. The MD communicated the need of the repair to the Maintenance Assistant during the round to have the electrical box properly secured. An interview conducted on 11/8/19 at 1:03 PM with the facility's Administrator revealed his expectation was for all electrical boxes be properly secured and safe.	F 584		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		12/11/19

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F 600	Continued From page 6 by: Based on observation, record review, resident, staff and physician interviews, the facility neglected to notify the physician of an initial abnormal elevated potassium (K+) level of 5.4 millimoles per liter (mmol/L), report a change of condition to nursing staff at the oncoming shift, obtain a medication as ordered by the physician for an elevated K+ level of 6.9 mmol/L, and follow physician orders to administer Kayexalate for treatment of hyperkalemia (high potassium level) resulting in an intensive care hospitalization for hyperkalemia for 1 of 1 residents sampled for hospitalization. The resident was discharged from the hospital and readmitted to the facility on 10/19/19 (Resident #20). Immediate Jeopardy began on 10/12/19, when Resident #20 did not receive medical treatment for a change in condition. Immediate Jeopardy was removed on 11/08/19 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings include: Resident #20 was admitted to the facility on 10/09/10. His diagnoses included a history of acute and chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease (progressive lung disease), diabetes, peripheral vascular disease (restricted blood flow to the arms or legs), chronic kidney disease, depression, and anxiety.	F 600	1. Management of Resident who is subject of this citation: On the morning of 10/14/19 at the change of shift report nurse #1 communicated the status of resident #1 which was stable, according to 0252 assessment note, although a critical lab was called to the on-call physician and the orders were received but the kayexalate had not been given. Nurse #1 also stated that pharmacy was going to deliver the Kayexalate. Nurse # 2 went to resident #1 room completed an assessment and called the resident□s primary care physician, to update her on the resident□s status and the inability to administrator the Kayexalate. The physician gave an order to send to Emergency room for evaluation. Resident #1 was admitted to the hospital on 10/14/19 for treatment of multiple health problems including hyperkalemia as the 5th diagnosis on the list with primary diagnosis at admission being Cardiomyopathy and Chronic Renal Disease. Resident #1 was discharged back to the facility on 10/19/19 having fully recovered from the hyperkalemia. 2. Measure taken to assure no other residents were similarly affected: To assure no other residents were impacted by the failure to provide physician ordered treatment in a timely manner, physician orders beginning on 10/14/19 were reviewed by the Director of nursing and her team on 11/7/19. Nursing administration obtains, reviews the labs and delivers to the units for physician	

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F 600	Continued From page 7 The most recent quarterly Minimum Data Set (MDS) dated 08/26/19 revealed Resident #20 was cognitively intact. The MDS revealed he required setup assistance with bed mobility, extensive assistance with transfers, and setup assistance with eating of meals. Resident #20's K+, Blood Urea Nitrogen (BUN), and creatinine levels comparisons were made from a Complete Metabolic Panel (CMP) drawn on 09/11/19. The lab indicated Resident #20's K+ level of 4.5 mmol/L was found to be in the normal lab specified range (3.3-5.1 mmol/L). His BUN and creatinine level on 09/11/19 were elevated with a BUN level of 21.7 (mg/dl) milligrams per deciliter and a creatinine level at 2.52 mg/dl. The normal range for BUN is 6.0-20 mg/dl. The normal range for creatinine is between 0.50-1.20 mg/dl. On 10/11/19, a lab order for a Brain Natriuretic Peptide (BNP) to rule out dehydration was made by the physician. There were no nurses note to indicate the status of the resident on 10/11/19 that indicated potential for dehydration. The order for the BNP was not followed as ordered, but instead, a Basic Metabolic Panel (BMP) was obtained at 5:42 AM on 10/12/19 and sent to the lab. The BMP lab results were faxed to the facility on 10/12/19 at 11:19 AM. The lab reports indicated an elevate K+ level of 5.4 mmol/L, elevated Blood Urea Nitrogen (BUN) of 29.0 mg/dl, and an elevated creatinine level of 2.74 mg/dl. The nurses note on 10/12/19 nor the scanned lab indicated acknowledgement of the lab or	F 600	notification and the labs are then placed in the lab book for the physician to review. In addition, on 11/7/19 the Director of nursing and her team audited critical lab reports beginning with 10/14/19 and going forward to today, 11/7/19. No other examples of critical labs without appropriate response were noted. 3. Measures to assure this failure does not reoccur: To assure all nurses understand the serious commitment to follow professional standards by responding to changes in condition with prompt reports to the physician followed by vigilant implementation of orders in a timely manner, on 11/7/19 the Director of Nursing assisted by the Regional Director of Operations, an RN, the Regional Director of Clinical Services, an RN, in-serviced all nurses on: 1) actions to be taken when critical lab values are received including notifying the Director of Nursing of the value and the orders given; 2) the signs and symptoms associated with hyperkalemia and the significance of elevated levels; 3) the importance of following physician□s orders in a timely manner, especially those associated with critical lab values; 4) notifying the physician if, for any reason, the nurse is unable to carry out a physician□s order; 5) The process associated with using medications from the emergency kit including referring to the list provided and attached to the outside of the box that	

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notification of the physician on 10/12/19. The scanned lab was signed by the physician on 10/15/19 after the resident was admitted to the hospital.

There was no documentation the night of 10/12/19 of a change of status in Resident #20's condition or indicating a change of lab orders from a BNP to a BMP.

On 11/6/19, an unsuccessful attempt was made to contact Nurse #2 who was the nurse on duty during the night shift on 10/12/19 when the order for the BUN was not followed as written and a BMP was obtained in its place and sent to the lab for testing.

A nurse's note, written by Nurse #3 on 10/12/19 at 2:09 PM did not indicate Resident #20 had a change in status and was given an as needed dose of Oxycodone 10-325 mg for pain.

Nursing assistant (NA) #4 was interviewed on 11/06/19 at 4:09 PM. NA #4 stated she worked with Resident #20 on 10/12/19 and revealed she had reported changes such as shortness of breath, the need for additional physical assistance, and lethargy to the nurse during her shift.

An interview with NA #5 on 11/07/19 at 10:13 AM, NA #5 revealed she first noticed changes with Resident #20 on 10/12/19 during the second shift. She stated she observed him sitting outside on the front patio alone when she arrived for her shift. She attempted to speak to him, but he didn't respond as he normally would. She stated shortly after her shift began, she again observed him sitting alone near the nurses' station with his eyes

shows the name of the medications included in the kit in both generic and non-generic terms;
6) how to request and receive medications after hours that are needed for a STAT situation;
7) prevention, recognition, reporting of Abuse, neglect, misappropriation, mistreatment and exploitation of residents.
8) While the CNA responded as expected by notifying the nurse of the resident□s declined condition, all C NAs received in-service on 11/8/19 to reinforce the importance of reporting any change in condition to their nurse as well as remaining aware of any further changes. Any nurse who was not present in the facility at the time of this in-service will be contacted by telephone for the same in-service and asked to review and sign the in-service documents prior to being permitted to work in the facility.

The administrator will report findings to the quality assurance and performance improvement committee quarterly to evaluate the effectiveness of the interventions to determine if continued monitoring is necessary or if modification is needed to be made for ongoing monitoring.

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rolled back in his head, saying he was dizzy, and needed to go back to bed. She further revealed she made the nurse on duty aware of her observation and was told it was just his medications and told to make sure she applied his oxygen once he was in bed. She said she assisted him to bed. Later in her shift, she reported he was more confused, speech slurred, and needing total assistance for his activities of daily living (ADL) care. She said the agency nurse told her not to be concerned it was just from his medications.

An interview with NA #1 on 11/6/19 at 4:15 PM revealed NA #1 had worked with Resident #20 on both 10/12/19 and 10/13/19. She said she noticed he was needing a lot more assistance that usual and she had to use the mechanical lift to transfer him because he could not bear weight on 10/12/19. She stated she reported his changes to his nurse on both days.

An interview with Nurse #3 on 11/06/19 at 3:00 PM, Nurse #3 stated she was the nurse who had worked with Resident #20 on 10/12/19 and 10/13/19 on both 1st and a portion of 2nd shift (7:00 AM- 7:00 PM). She stated on that weekend, Resident #20 was not himself. Nurse #3 stated when she came on duty on 10/12/19 at 7:00 AM Nurse #2 did not report to her that Resident #20 had a change in condition or an elevated potassium level. She further explained that several NAs had made her aware he was requiring more assistance on 10/12/19, but he otherwise appeared to be stable. Nurse #3 revealed she observed the resident in the morning of 10/13/19, he appeared lethargic, very confused, and not wanting to get up as he usually would. She revealed she thought the change may

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have been related to him getting used to his new pain medication that had recently been started. She reported later that day, he became increasingly confused and had shallow respirations, but would respond when called by name. She stated she called the on-call provider that evening and was given orders to obtain a complete blood count and a complete metabolic panel (CBC/CMP). She explained that although staff had reported he wasn't himself and had major changes in ability to complete his ADLs, she didn't think he was in acute distress and it was changes from his medication but made the provider aware anyway. She said the labs were drawn and she reported this to the oncoming shift nurse.

A nurse's note dated 10/13/19 at 6:24 PM, written by Nurse #3, indicated Resident #20 was lethargic but he had voiced he was not feeling well. It stated he refused the Embeda (narcotic pain med used to treat moderate to severe pain) stating it was making him sick and that the on-call provider was notified and requested a CBC/CMP be drawn and gave orders to hold the Embeda pending lab results.

Resident #20's lab report indicated the CBC and CMP were drawn on 10/13/19 at 08:25 PM and sent to the hospital. It further indicated a critical K+ level of 6.9 mmol/L was called by lab employee #1 to Nurse #4 on 10/13/19 at 10:31 PM. The lab results were signed by Nurse #4 and a note that the on-call provider was contacted was written on the scanned lab report.

Review of physician orders revealed an order was received on 10/13/19 for Resident #20 to receive Kayexalate (Sodium Polystyrene Sulfonate

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Suspension 15 grams/60 milliliter) give 30 grams x 2. This medication used to treat elevated potassium in the blood.

An interview with Nurse #4 on 11/7/19 at 8:57 AM revealed she worked with Resident #20 on 10/13/19 during the third shift when the critical potassium value was called to her by the lab. She stated she didn't recall the level, but when asked if 6.9 mmoL/L was accurate, she stated yes, I think that's right. She stated she called the on-call provider and was given orders to give Kayexalate for the elevated K+ level. She stated when she looked for the medication, it was not found in the backup supply on the night of 10/13/19. Nurse #4 stated she did not see the urgency of obtaining the medication from the backup pharmacy as the facility pharmacy said they could send the medication in the tote on the following days delivery and therefore Nurse #4 did not notify the physician. When asked if Resident #20 had any signs and symptoms of distress on 10/13/19, she stated the vital signs provided by the NA were stable and he was already in bed sleeping. When asked specifically if she performed a physical assessment on the resident after receiving the abnormal lab values, she again said no, he was sleeping, and his vitals were stable.

A nurse's notes written on 10/14/19 at 8:11 AM by Nurse #5 revealed a change of condition form titled Situation, Background, Assessment and Request (SBAR) was completed for Resident #20 which noted an altered level of consciousness, increase assistance with ADL's, slurred speech, weakness or hemiparesis (numbness or paralysis of an extremity) with recommendations to go to the emergency room.

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An interview on 11/05/19 at 12:09 PM with Nurse #5, she stated she was the regular day shift nurse (7:00 AM-3:00 PM) on weekdays. She said she was the nurse on duty that obtained the order to send Resident #20 to the hospital on the morning of 10/14/19. She reported she went in to see the resident shortly after getting report on Monday morning 10/14/19 and noticed he was lethargic, had increased tremors, muscle weakness, slurred speech, and he had some difficulty breathing requiring oxygen. She stated he had rapid breathing and used his accessory muscles to facilitate breathing. She stated she applied oxygen when he refused his Bilevel Positive Airway Pressure (bi-pap) device due to anxiousness. She reported she had no report from the previous shift from Nurse #4 that indicated any change in the resident's condition. She further reported she checked his chart and recognized he had abnormal lab values over the weekend and orders weren't followed to give Kayexalate for elevated K+ level. She notified the residents physician and received orders to send Resident #20 to the hospital for evaluation. She reported staff notified her that they had to feed him due to his lethargy on the morning of discharge to the hospital. She further stated she considered any value outside of the parameters given to be serious but very serious if the lab calls with a critical lab value. She stated she made the unit manager and the Director of Nursing (DON) aware of the abnormal lab and that the medication was not given as ordered.

An interview with the Unit Manager on 11/05/19 at 12:45 PM revealed she was familiar with Resident #20's recent hospitalization. She reported he was pleasant and cooperative with care. He occasionally refused care when he did

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not feel well, but this occurred rarely. She was working on the morning of Resident #20's discharge on 10/14/19 and observed the resident to be increasingly confused, some respiratory difficulty, difficulty vocalizing his needs, and talking nonsense. She was aware the hall nurse was preparing the resident to be discharged. She stated she was made aware the orders for Kayexalate for an elevated K+ level was not followed, but unclear why the back-up pharmacy was not utilized. She was unsure who the back-up pharmacy was since the facility had recently changed pharmacy services. She stated if a medication is unavailable, staff are to report the delay in administration to the provider and request order clarification.

The October 2019 Medication Administration Record (MAR) indicated an order to discharge Resident #20 to the emergency room which was signed on 10/14/19 at 9:36 AM.

A hospital emergency room history and physical (ER H&P) dated 10/14/19 at 10:39 AM indicated Resident #20 presented to the emergency room with an altered mental status of lethargy, was only alert and oriented x 1, but was able to answer to his name. He had gurgling with his breathing and a wet hacky cough of which he was protecting his airway upon initial exam and an ordered chest x-ray resulted in intravenous (IV) antibiotic treatment for questionable pneumonia. He was unable to follow commands but expressed pain on examination of his lower extremity. Emergency room labs included an ongoing elevated K+ level of 6.1 mmol/L, a BUN of 41 mg/dl, and a creatinine of 4.00 mg/dl.

The assessment and plan note electronically

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signed by the hospital attending physician on 10/15/19 at 6:55 PM stated Resident #20's primary diagnosis to be hyperkalemia. He further wrote Resident #20 was critically ill with multiple life-threatening conditions including multiple organ system dysfunction/failure, oxygenation/ventilation instability requiring frequent modifications of support, fluctuations in neurological function requiring evaluation and intervention, correction and monitoring of serious electrolyte abnormalities and fluid volume titration. It further indicated Resident #20's hyperkalemia was treated in the emergency room with Kayexalate and Calcium gluconate.

A hospital lab report dated 10/18/19 revealed Resident 20's K+ level was 3.9 mmol/L which is within the normal range.

The hospital Intensive Care Unit- history and physical (ICU-HP) discharge summary dated 10/19/19 at 12:00 PM specified hyperkalemia was the primary discharge diagnosis without any diagnosis resolution prior to discharge, however, a discharge K+ level was unavailable. It further indicated Resident #20 spent several days (10/14/19 through 10/17/19) in the intensive care unit (ICU) where he underwent intubation with an endotracheal tube placement allowing increase aeration of the lungs and nasogastric tube, and bi-pap services. He was found to be in metabolic acidosis with a creatinine of 4.00 mg/dl which since improved to the resident's baseline.

The medical record indicated Resident #20 was hospitalized from 10/14/19 to 10/19/19. He was readmitted to the facility on 10/19/19 in fair condition.

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An observation on 11/04/19 at 11:22 AM revealed Resident #20 lying in bed on his back. An interview with Resident #20 on 11/4/19 at 11:22 AM revealed he recalled being hospitalized twice recently, but unable to recall detailed reasons related to the hospitalizations.

An observation of Resident #20 on 11/05/19 at 10:52 AM revealed the resident lying in bed on his back with the blind closed, lights off, and the door open.

An interview with the Director of Nursing (DON) on 11/05/19 at 1:30 PM, the DON stated she was made aware of Resident #20's recent hospitalizations. She stated Resident #20 had experienced increased confusion, hypersomnolence, and even fallen a couple times during recent episodes of AMS. She further explained the resident had labs drawn over the weekend of 10/12/19-10/13/19 that resulted in an abnormally high K+ level and orders were given for Kayexalate. She was aware the orders weren't followed by Nurse #4. She further explained she believed that Kayexalate is normally a medication that is kept in their back up supply but stated if the facility was out on that night the nurse should have asked the pharmacy for alternative ways to obtain the medication to not delay administration. She stated the nurse should have notified the provider in the event the medication was unavailable in back-up stock and requested further direction. She revealed she was unsure who the back-up pharmacy was currently, but it should have been utilized to obtain this medication. She stated she would obtain an updated protocol since the facility had recently switched pharmacy suppliers.

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An interview conducted with Resident #20's physician on 11/05/19 at 3:00 PM revealed the physician believed the lack of following orders given for Kayexalate was a major medication error and lack of awareness of abnormal labs on 10/12/19 prevented on-call physicians from treating Resident #20's condition timely. She further revealed failure to give this medication put the resident at increase cardiac risk. She stated she was not happy when she was made aware the medication had not been administered. She further revealed she was not notified until Monday morning when orders were given to send him to the hospital for evaluation of lethargy, slurred speech, breathing difficulties, and increase confusion.

An interview with Director of Nursing (DON) on 11/07/19 at 4:17 PM, she revealed the nurses should have reported any labs drawn and their lab values for Resident #20 to the oncoming shift on the weekend of 10/12/19-10/13/19. She further stated the lab values for Resident #20's lab results on 10/12/19 should have been reviewed from the lab reporting system and Resident #20's physician notified of all abnormal lab values. She stated all of Resident #20's orders should have been entered and followed as directed. She stated the Nurse #4 should have reported the urgency of need for medications to pharmacy when new orders are obtained, and Nurse #4 should have requested alternative means to obtain the medication. She said Nurse #4 should have notified the physician when the order could not be followed as given on 10/13/19. She further revealed Nurse #4 should have performed ongoing assessments and document them accordingly in the medical record timely for Resident #20. She said all care changes should

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F 600	Continued From page 17 have been added to the plan of care with Resident#20's change of condition. The Administrator, DON, and Corporate consultants were made aware of the immediate jeopardy on 11/6/19 at 1:30 PM. _____ _____ _____ F 600 Credible Allegation of Removal of Immediate Jeopardy Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance According to the clinical record, Resident #20 was experiencing nausea and vomiting on 10/11/19. The physician ordered "Give 4 mg [Zofran] by mouth every 6 hours as needed for nausea and vomiting until 10/15/19. Take 1 tablet by mouth every 6 hours as needed for 5 days". The record indicates the first dose was given at 9:38 pm on 10/11/19 and the result was "effective". While the record does not accurately portray, interview with the nurse indicates that a Basic Metabolic Panel was ordered by the physician when the Zofran was ordered. This lab was received on 10/12/19 with a potassium value of 5.4. As the prescribed normal range was 3.3 to 5.1. The lab results were faxed at 11:12 am and the nurse did not act on this value, instead placing it in the physician's binder for later review. According to the record, the nurse #2 did not notify the physician of this first potassium lab value and upon interview with nurse #2 she did not communicate the potassium level with the next shift. Because the resident continued to be lethargic on 10/13/19, at approximately 6:11 pm, Nurse #3	F 600		

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completed a physical assessment and contacted the physician to report that the resident continued to be lethargic; less communicative. This assessment is not recorded in the clinical record but was described in interview with Nurse #3 and resulted in the order for the STAT (medical term used to define urgent) comprehensive metabolic panel and complete blood count which were drawn and submitted. The note at 6:11 pm on 10/13 supports this action. Nurse #3 reported that labs were ordered to oncoming nurse # 1 when giving report to leave for the day. The nurse's note states "lethargic" at 9:35 pm on 10/13/19.

On 10/14/2019, at 02:52 AM, the clinical record indicated that Nurse #1 answered the facility phone and received a call from the laboratory reporting a critical Potassium value of 6.9 for Resident #20. Nurse #1 called the physician and reached the on-call physician. She informed the on-call physician of the potassium level and was given an order to administer 2 doses of 30 cubic centimeters (CC) of Kayexalate. Nurse #1 went to the emergency kit and checked for kayexalate but did not find it. The nurse failed to check the Listing attached to the emergency kit which was also available in the notebook on each medication cart, and states "Kayexalate": then the generic name "Sodium Polystyrene Sulfonate". The bottle in the emergency kit included only the generic name," Sodium Polystyrene Sulfonate" which was not familiar to the nurse. She failed to realize the generic form of kayexalate was in the box. Nurse #1 then contacted the pharmacy and was advised the medication would be sent out on the next run which was expected to arrive between 4:00 am and 6:00 am on 10/14/19.

The nurse did not notify the physician that she had not found the kayexalate or notify the Director

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of Nursing that she had a critical value and was unable to administer the ordered treatment. Neither did she contact the pharmacy by phone to request assistance or emergency back-up resources.
The nurse's note at 2:52 am states "writer called on-call with high potassium STAT lab of 6.9. Received orders to administer two doses Kayexalate 30gm. Orders transcribed. Respirations were even and non-labored. Resident remained lethargic but readily responsive to verbal stimuli. And the vital sign is within normal limits.
On the morning of 10/14/19 at the change of shift report nurse #1 communicated the status of resident #20 which was stable, according to the 2:52 am assessment note, although a critical lab was called to the on-call physician and the orders were received but the kayexalate had not been given. Nurse #1 also stated that pharmacy was going to deliver the Kayexalate. Nurse # 2 went to resident #20 room at approximately 8:00 am completed an assessment and called the resident's primary care physician, to update her on the resident's status and the inability to administrator the Kayexalate. The physician gave an order to send to Emergency room for evaluation.
Resident #20 was admitted to the hospital on 10/14/19 for treatment of multiple health problems including hyperkalemia as the 5th diagnosis on the list with primary diagnosis at admission being Cardiomyopathy and Chronic Renal Disease. Resident #20 was discharged back to the facility on 10/19/19 having fully recovered from the hyperkalemia.
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

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when the action will be complete
To assure no other residents were impacted by the failure to recognize a condition that requires physician intervention, to notify the physician in a timely manner, and if unable to execute orders received the nurse has a responsibility to notify the physician. On 11/7/19 the Director of nursing and her team audited critical lab reports beginning with 10/14/19 and going forward to today, 11/7/19. No other examples of critical labs without appropriate response were noted.
To assure all nurses respond to changes in condition with prompt reports to the physician and implementation of orders in a timely manner, on 11/7/19 the Director of Nursing assisted by the Regional Director of Operations, an RN, the Regional Director of Clinical Services, an RN, in-serviced all nurses on:
1) actions to be taken when critical lab values, as identified by the lab as critical values are received including notifying the Director of Nursing of the value and the orders given;
2) the signs and symptoms associated with hyperkalemia
3) the importance of following physician's orders in a timely manner, especially those associated with critical lab values;
4) notifying the physician if, for any reason, the nurse is unable to carry out a physician's order;
5) The process associated with using medications from the emergency kit including referring to the list provided and attached to the outside of the box that shows the name of the medications included in the kit in both generic and non-generic terms;
6) how to request and receive medications after hours that are needed for a STAT situation;
7) prevention, recognition, reporting of Abuse, neglect, misappropriation, mistreatment and

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exploitation of residents.
8) While the certified nursing assistant (CNA) responded as expected by notifying the nurse of the resident's declined condition, Reeducation for CNA's began on 11/8/19 to reinforce the importance of reporting any change in condition to their nurse as well as remaining aware of any further changes. No CNA will be permitted to take an assignment until re-education is completed.

Any nurse who was not present in the facility at the time of this in-service will be contacted by telephone for the same in-service and asked to review and sign the in-service documents prior to being permitted to work in the facility.
All new hires will receive this in-service as part of orientation.
The facility alleges the removal of the immediate jeopardy on 11/8/2019. The Administrator is responsible for assuring corrective actions are sustained.

Validation of the facility's immediate jeopardy removal plan was completed as evidenced by interviews with staff members and residents. Staff reported audits of critical lab values were performed and in-service training that was specified in the IJ removal plan was conducted as planned. Interviews with nursing staff indicated they were knowledgeable on the signs and symptoms of hyperkalemia, how to respond when a resident experiences a change in condition, what to do when they receive abnormal laboratory results, the importance of following physician orders and notifying the physician and how to request medications after hours. Interviews with nursing assistants revealed they were knowledgeable on notifying a nurse when a

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F 600	Continued From page 22 change in a resident's condition occurs. There were no concerns or reports of neglect by staff or residents interviewed. The facility's immediate jeopardy removal date of 11/08/19 was validated.	F 600		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete a resident assessment within 14 days of the Assessment Reference Date (ARD) for 2 of 14 (Resident #47 and Resident #52) reviewed for timely completion of Minimum Data Set (MDS) assessments. Findings included: 1. Resident #47 was originally admitted to the facility on 10/4/16 and was most recently readmitted on 6/4/18. Review of Resident #47 ' s most recent MDS assessments revealed a quarterly assessment with an Assessment Reference Date (ARD) of 10/1/19. Further review revealed the assessment had been completed on 10/21/19. The Final Validation Report dated 10/30/19 was reviewed. The report included a warning message indicating Resident #47 ' s MDS assessment with an ARD of 10/1/19 had been	F 638	F638 1. Corrective action the resident found to have been affected by the deficient practice: Resident #47 The quarterly assessment was completed on 10/21/19 by the Minimun Data Set (MDS) Coordinator and transmitted and accepted in the state data base Resident # 59 Quarterly assessment was completed on 10/20/19 by the MDS Coordinator and transmitted and accepted in the state data base. 2. Corrective action for other residents having the potential to be affected by the same deficient practice. On 11/15/19 the MDS Coordinator reviewed the assessments calendar and validation reports with focus on late assessments. No other assessments were found to be late. 3. Systemic changes made to ensure that	12/15/19

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F 638	Continued From page 23 completed late and the completion date was more than 14 days after the ARD. An interview was conducted on 11/7/19 at 2:46 PM with the MDS Corporate Consultant. The Consultant reviewed Resident #47 ' s quarterly MDS assessment dated 10/1/19 and stated it had been completed on 10/21/19, which was late. During another interview which took place on 11/8/19 at 10:15 AM, the Consultant further explained that it was the company ' s expectation was to have MDS assessments completed within 13 days of the ARD as allowed per the federal regulations. An interview conducted on 11/8/19 at 10:15 AM with the facility Administrator. The Administrator revealed his expectation was for MDS assessments to be completed timely. 2. Resident #59 was admitted to the facility on 10/18/18. Review of Resident #59 ' s most recent MDS assessments revealed a quarterly assessment with an ARD of 10/3/19. Further review revealed the assessment had been completed on 10/20/19. The Final Validation Report dated 10/30/19 was reviewed. The report included a warning message indicating Resident #59 ' s MDS assessment with an ARD of 10/3/19 had been completed late and the completion date was more than 14 days after the ARD. An interview was conducted on 11/7/19 at 2:46 PM with the MDS Corporate Consultant. The Consultant reviewed Resident #59 ' s quarterly	F 638	the deficient practice will not recur. On 12/4/19 the MDS Coordinator together with the Administrator and the Director of Nursing reviewed quarterly MDS assessments to ensure there were no other late assessments. No other quarterly assessments were found to be late. The Interdisciplinary Team (IDT) was provided with the in progress list that shows the assessment reference date and due dates of each assessment on 12/4/19 to ensure each discipline completes their part in the quarterly MDS assessment. On 11/25/19 the Administrator and the Director of Nursing re-educated the IDT (including MDS nurses, the Social Worker, the Director of Recreational Services and, the Dietary Manager) on the requirement of completing quarterly MDS assessments not less frequently than once every 3 months and must be completed within 14 days of the assessment reference date. Education was completed on 11/25/19. Any new hires to join the IDT will be educated on the requirement of completing quarterly MDS assessments not less frequently than once every 3 months and within 14 days of the assessment reference date by the Administrator and/or the Director of Nursing during new hire orientation.Plans to monitor its performance to make sure that solutions are sustained. The Administrator, the Director of Nursing and MDS Nurses will review due assessments 5 days a week for 4 weeks, 3 days a week x 4 weeks, and weekly x 4 weeks to	

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F 638	Continued From page 24 MDS assessment dated 10/3/19 and stated it had been completed on 10/20/19, which was late. During another interview which took place on 11/8/19 at 10:15 AM, the Consultant further explained that it was the company ' s expectation was to have MDS assessments completed within 13 days of the ARD as allowed per the federal regulations. An interview conducted on 11/8/19 at 10:15 AM with the facility Administrator. The Administrator revealed his expectation was for MDS assessments to be completed timely.	F 638	ensure they are completed with 14 days of the assessment reference date. The administrator, the director of Nursing and MDS nurses will review the validation reports weekly to ensure the MDS□s are reviewed and completed within 14 days of the assessment reference date. The Administrator, the Director of Nursing and MDS Nurses will review assessment in progress report during the daily interdisciplinary team meeting 5 x weekly x 4 weeks and then weekly for 2 months. 4. The Administrator will report findings to the Quality Assurance and Performance Improvement committee quarterly to evaluate the effectiveness of the interventions to determine if continued monitoring is necessary or if modifications need to be made for ongoing monitoring	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655		12/15/19

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F 655	Continued From page 25 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan that included minimum healthcare information to provide effective, person-centered care for a resident who was to receive nothing by mouth (NPO) and had a feeding tube for 1 of 2 residents who received feedings administered by a feeding tube (Resident 171). Findings included:	F 655	F655 Baseline Care Plan 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #171 was no longer a resident in the facility at the time of survey. 2. Address how the facility will identify	

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F 655	Continued From page 26 Resident #171 was admitted to the facility on 10/21/19 from the hospital and was discharged to the hospital on 10/27/19. The resident ' s diagnoses included the following: Open Reduction Internal Fixation of a left hip fracture, history of laryngeal (throat) cancer, feeding tube placement for recurrent aspiration pneumonia, and chronic kidney disease. A review of the physicians' orders for Resident #171 revealed an order dated 10/21/19 which detailed the resident was to be NPO. Further review revealed a feeding tube order which detailed the resident was to receive 1.5 360 milliliter (ml) cans every day at 6:00 AM, 10:00 AM, 2:00 PM, and 6:00 PM. The order included 1 360 ml can to be administered at 10:00 PM and all administration of tube feeding was to include flushing the feeding tube before and after with 60 ml of water. A review of Resident #171 ' s baseline care plan with an effective date of 10/21/19 revealed documented information regarding eating included the resident required no setup or physical help from staff. No information regarding the resident ' s NPO status or tube feeding status was discovered in the baseline care plan. Resident 171 ' s nursing notes were reviewed and documentation regarding the resident having received tube feeding was noted on 10/22/19 and 10/26/19. A discharge return anticipated Minimum Data Set (MDS) with an Assessment Reference Date of 10/27/19 had resident #171 coded as having had	F 655	other residents having the potential to be affected by the same deficient practice: On 11/15/19 a review of baseline care plans for admissions starting 11/15/19 by the Director of Nursing (DON) of current residents with nothing by mouth orders and/or tube feedings on admission to ensure the plan of care is reflective. No other residents were identified for NPO or tube feeding status. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 11/14/19 The Minimum Data Set(MDS)nurse/Director of Nursing (DON) re-educated the licensed nurses to start the baseline care plan on admission. On 12/11/19 the Administrator/DON re-educated the licensed nurses that residents who are NPO or have tube feeding, this information is to be documented in Section 3B of the baseline care plan. Starting on 11/26/19 the MDS nurse will bring the base line care plan to the interdisciplinary team meeting morning 5 x week for review to ensure the base line is reflective of the resident□s status. The DON will audit all baseline care plans on admissions weekly for 12 weeks to ensure the care plan is reflective of those that have an nothing by mouth or tub feeding order. 4. Indicate how the facility plans to monitor its performance to make sure that	

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F 655	Continued From page 27 a feeding tube. An interview conducted on 11/7/19 at 3:24 PM with the MDS Coordinator for the facility and the MDS Corporate Consultant. The Coordinator and the Consultant reviewed the baseline care plan for Resident #171 and stated the resident ' s NPO status and information regarding the resident ' s feeding tube status was not included in the baseline care plan. The Coordinator stated there was not a place on the baseline care plan to document the resident was NPO nor was there a place to document the resident received nutrition via a feeding tube. The Consultant stated information such as if a resident is NPO, receiving nutrition via a feeding tube, or other specialized dietary matters was information which needed to be on the resident ' s baseline care plan, and it was her expectation that information be communicated on the baseline care plan. An interview conducted on 11/8/19 at 1:03 PM with the facility Administrator revealed his expectation was for a resident ' s baseline care plan to have been accurate and communicate information regarding the resident ' s dietary status.	F 655	solutions are sustained; the DON will report the results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations and determine the need for further auditing beyond the three (3) months	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		12/15/19

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F 695	Continued From page 28 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, manufacturer ' s manual review, and staff interviews, the facility failed to clean respiratory equipment (Resident #41) for 1 of 2 residents reviewed for respiratory care. The findings included: The manufacturer ' s operator ' s manual for the oxygen concentrator contained a Routine Maintenance section. The manufacturer ' s routine maintenance included the cabinet filters on each side of the cabinet should be removed and cleaned at least once a week depending on environmental conditions. Resident #41 was admitted to the facility on 3/27/18. The resident ' s cumulative diagnoses included: heart failure, peripheral vascular disease, dementia, anxiety, depression, dyspnea, chronic obstructive pulmonary disease, heart disease, and pain. Review of Resident #41 ' s most recent Minimum Data Set assessments revealed a quarterly assessment with an Assessment Reference Date of 9/25/19. Review of the assessment revealed the resident was coded as having been cognitively intact and was coded as having received oxygen therapy at the facility. Resident #41 ' s Medication Administration Record (MAR) for 11/1/19 through 11/7/19 was reviewed. The review revealed the resident had an order, dated 4/6/18, to receive continuous oxygen at 4 liters per minute 4L/PM via nasal	F 695	F695 1. Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice. Resident #41 oxygen concentrator filter was cleaned immediately upon identification of the dust on the filter on 11/08/19. 2. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. On 11/8/19 All resident□s requiring the use of oxygen concentrators were visually checked for the dust and cleanliness prior to the end of the survey. All filters were cleaned and replaced. 3. Systemic changes to ensure the deficient practice will not occur: As of 12/04/19, all clinical staff have been educated on the appropriate way to clean the oxygen concentrator filters and the frequency of cleaning the filters. The nurse/med aide will visually verify that the filter is free of dust and debris weekly and as needed. Newly hired clinical staff will receive training on the cleaning of oxygen concentrator filters during orientation. Orders were established for each resident that requires a concentrator to ensure filters are cleaned per manufacturer recommendations.	

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F 695	Continued From page 29 canula. The administration of the oxygen was signed by the nurse for the reviewed period. Further review of the MAR reveled an order to change the nebulizer (a device utilized to administer aerosol medications) set up and bag weekly and as needed as bedtime every 7 day(s) and place in labeled oxygen bag and tie the bag to the handle of the nebulizer machine. An observation conducted in the room of Resident #41, on 11/4/19 at 1:11 PM, revealed the oxygen concentrator in operation and the resident was wearing a nasal cannula connected to the concentrator while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the left and right sides of the machine. A second observation conducted in the room of Resident #59, on 11/5/19 at 5:01 PM, revealed the oxygen concentrator in operation and the resident was wearing a nasal cannula connected to the concentrator while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the left and right sides of the machine. A third observation conducted in the room of Resident #59, on 11/6/19 at 9:30 AM, revealed the oxygen concentrator in operation and the resident was wearing a nasal cannula connected to the concentrator while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the left and right sides of the machine.	F 695	4. How facility plans to implement the corrective action and evaluate for its effectiveness. The unit manager or nursing supervisor will perform audits of 5 concentrators weekly x 12 weeks to ensure the filters are free of dust and debris. The DON will present the results of the audit at the monthly QAPI meetings. The QAPI Committee is responsible for reviewing any trends or reoccurring issues and making modifications or recommendations to the ongoing monitoring or audits.	

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F 695	Continued From page 30	F 695		

An interview with Nurse #9 was conducted in conjunction with a fourth observation in the room of Resident #41 on 11/7/19 at 9:30 AM revealed the oxygen concentrator in operation and the resident was wearing a nasal cannula connected to the concentrator while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the left and right sides of the machine. Nurse #3 stated the filters on the oxygen concentrator did not appear to be clean. The nurse stated the filters were to be cleaned weekly when the oxygen and nebulizer tubing were changed on the third shift. The nurse stated it did not appear as the filters on the oxygen had been cleaned during the most recent tubing change.

An interview with the Director of Nursing (DON) was conducted in conjunction with an observation in the room of Resident #41 on 1/30/19 at 9:37 AM revealed nurse #9 had cleaned the filters on the oxygen concentrator and was replacing them at the time of the observation. The DON stated the filters on the oxygen concentrator should have been checked whenever the nasal canula tubing was changed. The DON further stated she would attempt to identify if the facility had a policy regarding the cleaning of the filters on the oxygen concentrator and would provide it if she were to discover one. Closer observation of the oxygen concentrator revealed a side compartment access removable door which had raised letters which read, "Filter Access and Humidifier Adapter Storage." When the door was removed the inside compartment revealed information for the maintenance of the machine which stated the cabinet filters were to be cleaned weekly and replaced as needed. The DON stated it was her

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F 695	Continued From page 31 expectation for the filters on the oxygen concentrators to be maintained in a clean condition and to follow the manufacturer ' s recommendations. An interview conducted on 11/8/19 at 1:03 PM with the facility Administrator revealed his expectation was for the filters on the oxygen concentrators to be cleaned according to factory expectations.	F 695		