

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

PRINTED: 05/09/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345392	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/05/2018
NAME OF PROVIDER OR SUPPLIER AMBASSADOR REHAB & HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2051 COUNTRY CLUB ROAD WADESBORO, NC 28170	
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E 000	Initial Comments	E 000		
E 001 SS=F	<p>An unannounced recertification survey was conducted from 04/02/18 to 04/05/18.</p> <p>Establishment of the Emergency Program (EP) CFR(s): 483.73</p> <p>The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>*[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>*[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to establish and maintain a comprehensive emergency preparedness. (EP) plan which described the facility's comprehensive approach to meeting health, safety and security needs for their staff and resident population</p>	E 001		4/25/18
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE
Electronically Signed				04/23/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 001	<p>Continued From page 1</p> <p>during an emergency or disaster situation. The facility failed to address how the facility would coordinate with the local officials during an emergency or disaster, failed to show evidence of a full-scale community based test of their EP plan and failed to provide evidence of staff training the EP plan. The findings included:</p> <p>Review of the facility EP plan manual provided by the facility with policies and procedures was conducted. The manual did not contain a written established comprehensive EP program that met the federal requirements.</p> <p>Interview on 04/05/18 at 9:00 AM, the Administrator stated she was aware of the missing elements in the facility EP plan and stated she was having some difficulty coordinating with local officials and her corporate office.</p>	E 001	<p>on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.</p> <p>E 0001</p> <ol style="list-style-type: none"> 1. On 4/18/18 the Administrator contacted the County Emergency Services Chief to establishing a facility based test with emergency services involvement. A meeting is scheduled for 5/1/18 to review the facility emergency plan and community participation in an exercise at the facility. 2. The Administrator will review the Emergency Preparedness Plan by 4/24/18 to ensure the plan covers health, safety and security needs of the staff and residents. 3. The Administrator has initiated training for the facility staff on the Emergency Preparedness Plan as of 4/16/18. 4. The Administrator and Maintenance Director will review the Emergency Preparedness Plan monthly for 3 months and quarterly thereafter to ensure the Emergency Plan continues to be up to date to meet the health, safety and security needs of the staff and residents. The Administrator will submit a report to the QAPI Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up as needed. 		

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E 001	Continued From page 2	E 001			
F 625 SS=C	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <ul style="list-style-type: none"> (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to provide 3 of 3 sampled residents and/or resident representatives with written notice</p>	F 625	<p>Completion Date: 4/25/18</p> <p>F 625 1. Residents #20 was re-admitted to the facility on 3/1/18.</p>	4/25/18	

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F 625	<p>Continued From page 3</p> <p>of the bed hold policy upon the resident's transfer to the hospital (Resident #49, #20, #40). The findings included:</p> <p>1. Resident #49 was admitted to the facility on 11/30/11 with diagnoses to include schizophrenia, anxiety and depression.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 3/16/18 indicated Resident #49 was severely impaired in cognition.</p> <p>A physician's order dated 3/2/18 stated to send Resident #49 to the emergency room related to fever/ nausea and vomiting.</p> <p>A nursing note dated 3/3/18 at 2:25 AM indicated Resident #49 was admitted to (name) hospital.</p> <p>A review of Resident #49's hard copy and electronic medical records revealed no documentation or evidence that Resident #49 or her representative were notified of the facility ' s bed hold policy upon her transfer to the hospital on 3/2/18. The medical record indicated Resident #49 returned to the facility on 3/9/18.</p> <p>2. Resident #20 was admitted to the facility 3/13/17 with diagnoses to include peripheral vascular disease, diabetes and end stage renal disease on dialysis.</p> <p>The Significant Change MDS dated 2/9/18 indicated Resident #20 was cognitively intact.</p> <p>Medical record review revealed Resident #20 was hospitalized 2/21/18 until 3/1/18. A review of Resident #20 ' s hard copy and electronic medical records revealed no documentation or evidence</p>	F 625	<p>Resident #40 was re-admitted to the facility on 2/5/18.</p> <p>Resident #49 was re-admitted to the facility on 3/9/18.</p> <p>2. An audit was completed by the Director of Nursing on 4/16/18 of resident transferred out of the facility since 4/6/18 to ensure a bed hold policy was provided upon transfer as required.</p> <p>3. Licensed Nurses were educated on 4/6/18 by Director of Nursing and the Assistant Director of Nursing related to the requirements of providing the Bed Hold Policy and documentation with each transfer.</p> <p>The Unit Manager, Director of Nursing, Social Worker, and Medical Records were educated on 4/20/18 by the Administrator related to the requirements of providing the resident representative with a copy of the Bed Hold Policy as required. The Unit Manager will be responsible for completion.</p> <p>4. The Director of Nursing or the Administrator will complete an audit weekly for 4 weeks and monthly for 2 months to ensure the Bed Hold Policies continues to be provided to the residents upon transfer to the hospital. The Administrator will complete an audit weekly for 4 weeks and monthly for 2 months to ensure Bed Hold Policies continues to be provided to resident represented as required. The Director of Nursing and the Administrator will submit</p>		

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F 625	Continued From page 4 that Resident #20 was notified of the facility's bed hold policy upon his transfer to the hospital on 2/21/18. He returned to the facility on 3/1/18. 3. Resident #40 was admitted to the facility on 7/7/15 with diagnoses to include schizophrenia, depression and psychotic disorder. The Quarterly MDS dated 3/7/18 indicated Resident #40 was cognitively intact. A review of Resident #40's hard copy and electronic medical records revealed no documentation or evidence that Resident #40 was notified of the facility's bed hold policy upon her transfer to the hospital on 2/1/18. The medical record indicated Resident #40 returned to the facility on 2/5/18. An interview was conducted with the Director of Nursing and Administrator on 4/5/18 at 3:16 PM. The Director of Nursing stated the bed hold policy had not been given to any residents and/or responsible parties/ family members as of 4/5/18. The Director of Nursing said all three of the residents (#49, #20, #40) had returned from the hospital to their own rooms except Resident #49. Resident #49 was moved to a different room at family request. She stated the facility had always been able to offer the resident/ family a bed when then came back from the hospital. She stated the educational process had been started as of 4/5/18. Prior to 4/5/18, no one had been responsible to give the resident/ family a copy of the bed hold policy.	F 625	a report the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring the Bed Hold Policy and follow-up. Completed Date: 4/25/18		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		4/25/18	

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F 641	<p>Continued From page 5</p> <p>§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 (MDS) assessment in the area of psychotropic drug for 1 of 5 sampled residents reviewed (Resident #42). Findings included:</p> <p>Resident #42 was admitted to the facility on 3/28/13 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 3/9/18 indicated that Resident #42's cognition was intact and he had not received anti-anxiety drug during the assessment period.</p> <p>On 2/3/18, Resident #42 had a physician ' s order for Diazepam (anti-anxiety drug) 5 milligrams (mgs.) 1 tablet by mouth in the morning for anxiety.</p> <p>Resident #42's Medication Administration Records (MARs) for March 2018 were reviewed. The MARs revealed that Resident #42 had received Diazepam on March 5-9, 2018, total of 5 days.</p> <p>On 4/4/18 at 2:25 PM, MDS Nurse #1 and MDS Nurse #2 were interviewed. They both verified that Resident #42 had received Diazepam for 5 days in March and the quarterly MDS assessment dated 3/9/18 should have been coded for the use of the anti-anxiety drug. Both MDS Nurses acknowledged that the MDS dated 3/9/18 was inaccurate.</p>	F 641	<p>F641</p> <ol style="list-style-type: none"> 1. Resident #42's MDS Assessment was corrected and resubmitted to include the use of psychotropic drugs on 4/5/18 by the MDS Coordinator. 2. An audit was completed of the current residents on 4/9/18 by the MDS Coordinator and Director of Nursing to ensure MDS are coded per the resident's status as required. There were no additional assessments identified during this audit. 3. The MDS Coordinators were re-educated on 4/10/18 by the Regional Clinical Reimbursement Specialist related to the requirements of coding MDS according to the resident's status. 4. The Regional Clinical Reimbursement Specialist, Director of Nursing, and/or the Administrator will complete an audit of 4 MDS's weekly for 4 weeks and monthly for 2 months to ensure MDS continue to be coded as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. <p>Complete date: 4/25/18</p>		

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F 641	Continued From page 6 On 4/5/18 at 3:10 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.	F 641			
F 693 SS=E	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, observation and Registered Dietician and staff interview, the facility failed to provide tube feedings as ordered by the physician for 3 of 3 sampled residents reviewed for tube feeding (Residents #39, #12 & #56). Findings include:	F 693	F 693 1. Resident #12's pump settings was adjusted by the Licensed Nurse on 4/3/18 to the rate ordered by physician. Resident #56's pump settings was adjusted by the Licensed Nurse on 4/3/18	4/25/18	

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F 693	<p>Continued From page 7</p> <p>1. Resident #39 was admitted to the facility on 12/2/17 with multiple diagnoses including seizure disorder. The significant change in status Minimum Data Set (MDS) assessment dated 3/2/18 indicated that Resident #39's cognition was intact and she was receiving tube feeding.</p> <p>Resident #39's care plan dated 3/2/18 was reviewed. One of the care plan problems was "I receive tube feeding which places me at risk for aspiration". The goal was "I will be free of complications from use of enteral feedings during this 90 day review period". The approaches included "to provide my enteral feeding formula as ordered".</p> <p>On 3/26/18, Resident #39 had a physician's order for enteral feed-continuous Jevity 1.5 at 40 cubic centimeter (cc) per hour x (for) 22 hours to allow for activities of daily living (ADL) care.</p> <p>On 4/2/18 at 10:10 AM, 11:08 AM, 3:25 PM and on 4/3/18 at 2:30 PM, Resident #39 was observed in bed. She was not receiving continuous enteral feeding.</p> <p>On 4/3/18 at 2:35 PM, NA #1 (assigned to resident) was interviewed. She stated that she worked on first shift and she had not seen Resident #39 receiving tube feeding during her shift. She added that Resident #39 only received tube feeding at night.</p> <p>On 4/3/18 at 2:38 PM, Nurse #2 was interviewed. She stated that she was assigned to Resident #39 on 4/2/18 and 4/3/18 on first shift. Nurse #2 stated that Resident #39 only received tube feedings at night and not during the day according to the physician's order. She reviewed</p>	F 693	<p>to the rate ordered by physician. Resident #39 was evaluated by the dietician and the FNP on 4/3/18 with new orders noted.</p> <p>2. An audit was completed of the current resident's tube feeding orders by the Director of Nursing on 4/3/18 to ensure physician's orders are followed as required. There were no additional residents identified in the audit.</p> <p>3. The Licensed Nurses were reeducated by the Director of Nursing on 4/9/18 related to the requirements of providing tube feeding per physician's orders.</p> <p>4. The Director of Nursing, and/or the Administrator will complete a visual observation audit of all tube feed residents weekly for 4 weeks, monthly for 2 months to ensure tube feedings continue to be provided per physician's orders. The Director of Nursing and/or Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.</p> <p>Completion Date 4/25/18</p>		

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F 693	<p>Continued From page 8</p> <p>the physician's orders for Resident #39 and acknowledged that the order was continuous tube feeding for 22 hours.</p> <p>On 4/3/18 at 3:38 PM, the Registered Dietician (RD) was interviewed. She stated that her records indicated that Resident #39 should be receiving continuous tube feeding at 40 cc/hr. for 22 hours. The RD indicated that she expected nursing staff to follow the physician's orders for tube feeding.</p> <p>On 4/5/18 at 3:10 PM, the Director of Nursing (DON) was interviewed. The DON acknowledged that Resident #39 had an order for continuous tube feeding at 40 cc/hr. for 22 hours. She stated that she expected the nurses to follow physician's orders for tube feeding.</p> <p>2. Resident #12 was admitted to the facility 5/23/17 with last readmission 1/20/18. Cumulative diagnoses included diabetes, other protein calorie malnutrition and gastrostomy tube (tube placed in the abdomen for feeding nutrition).</p> <p>Medical record review revealed a physician's order dated 3/15/18 for Glucerna 1.2 (supplement used for diabetic residents) at 60 cubic centimeters (cc)/ hour continuously via gastrostomy tube for seven days. Glucerna 1.2 at 65 cc/ hour continuously.</p> <p>A Significant Change Minimum Data Set dated 3/28/18 indicated Resident #12 was moderately impaired in cognition. She was totally dependent on staff for eating. Weight was documented as 130 pounds with weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. 51% or more for proportion of total</p>	F 693			

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F 693	<p>Continued From page 9</p> <p>calories the resident received through parenteral or tube feeding. Average fluid intake per day by IV or tube feeding: 501 cubic centimeters (cc)/ day.</p> <p>A Care Area Assessment (CAA) for feeding tubes dated 3/29/18 stated Resident #12 received nutrition via gastrostomy tube. Proceed to care plan.</p> <p>A CAA for nutritional status dated 3/29/18 stated Resident #12 received nutrition via gastrostomy tube. She had an order for pleasure foods with honey thick liquids. There was noted weight decline despite intervention. Physician and family were aware.</p> <p>A care plan dated 5/26/17 and last revised 4/3/18 stated Resident #12 required nutrition/ caloric needs via tube feeding. Interventions included, in part, to provide tube feeding formula as ordered.</p> <p>A review of weights for Resident #12 revealed the following: 3/7/18 129 pounds; 3/14/18 129.5 pounds; 3/21/18 129.5 pounds; 3/28/18 129 pounds.</p> <p>On 4/2/18 at 3:08 PM, an observation of Resident #12 revealed the tube feeding was off and not running. A second check at 3:47 PM revealed the tube feeding was off and not running. The tube feeding bag did not indicate what type of supplement was in the tube feeding bag.</p> <p>On 4/03/18 at 9:00 AM, an observation of Resident #12's tube feeding was conducted. The tube feeding was running at 60 cc/hr.</p>	F 693			

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F 693	<p>Continued From page 10</p> <p>On 4/3/18 at 2:30 PM, Resident #12's tube feeding was running at 60 cc/hour.</p> <p>On 4/3/18 at 2:30 PM, an interview was conducted with Nurse #1 who stated Resident #12 was on a continuous feed of Glucerna 1.2. Nurse #1 reviewed the physician orders and the Medication Administration Record for April 2018. She stated the feeding should be running at 65 cc/hour. An observation was conducted at bedside and revealed the tube feeding was being administered at 60 cc/ hr. Nurse #1 stated the rate/amount of feeding being administered was wrong. She reset the tube feeding rate to 65cc/hour. Nurse #1 said it was her responsibility to monitor and make sure it was running correctly per physician orders. She also stated the tube feeding bag that was hung yesterday was not labeled correctly and should have been labeled with name, the kind of supplement running, initialed and dated.</p> <p>On 4/3/18 at 3:30 PM, an interview was conducted with the RD. She stated if the supplement was given at 60 cc/hour instead of 65 cc/hour, there would be a difference of 144 calories/ day or around 1 pound. per month. The RD said she expected Resident #12 to receive her nutritional supplement as ordered at 65cc/ hour. The tube feeding bag was not labeled with the nutritional supplement being administered. She said she expected the information on the tube feeding bag to identify what type of supplement was being administered and she expected physician orders to be followed regarding the rate of the tube feeding.</p> <p>3. Resident #56 was admitted 07/08/16 with cumulative diagnoses of Cerebral Vascular Accident, dysphagia and a feeding tube.</p>	F 693			

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F 693	<p>Continued From page 11</p> <p>A review of Resident #56 physician order dated 02/12/18 read his feeding rate was changed from 55 cubic centimeters (cc) per hour for 22 hours down to 50cc per hour for 22 hours.</p> <p>Resident #56's weights on 02/10/18 weight was 175 pounds.</p> <p>Resident #56's quarterly Minimum Data Set (MDS) dated 03/21/18 indicated he was cognitively intact and exhibited no behaviors. He was coded as total assistance with all his activities of daily living and a feeding tube for all nutrition.</p> <p>Resident #56's weight on 03/28/18 weight was 179 pounds.</p> <p>Observation on 04/02/18 at 10:56 AM, Resident #56's tube feeding was running at 55cc per hour.</p> <p>Observations on 04/03/18 at 9:25 AM and again at 2:20 PM, Resident #56's tube feeding was running at 55cc per hour.</p> <p>Observation and interview on 04/03/18 at 3:15 PM, Nurse #3 confirmed the order written 02/12/18 to decrease Resident #56's tube feeding to 50cc per hour. Observation revealed the tube feeding was running at the ordered rate of 50cc per hour. Nurse #3 stated she did not adjust his tube feeding rate.</p> <p>Interview on 04/03/18 at 3:25 PM, the Director of Nursing (DON) stated she noticed his tube feeding was running at 55cc per hour around 3:00 PM and adjusted it to 50cc per hour since that</p>	F 693			

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F 693	Continued From page 12 was the ordered rate. Interview on 04/03/18 at 3:30 PM, the Registered Dietician stated she recommended a decrease to Resident #56's tube feeding rate in February 2018 because he had no skin issues and noticed a gradual increase in his weight. She stated her expectation was that Resident #56's tube feeding would have been running at the ordered 50cc per hour because her March nutritional calculations were based on his tube feeding running at the ordered rate of 50cc per hour and not 55cc per hour.	F 693			
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, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to follow physician 's orders for respiratory care (changing of oxygen bottle used to humidify oxygen on oxygen concentrator) for one of one residents reviewed for respiratory care (Resident #7). The	F 695	F695 1. Resident #7's humidified oxygen was provided by the Licensed Nurse on 4/3/18. 2. An audit was completed by the Director	4/25/18	

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F 695	<p>Continued From page 13 findings included:</p> <p>Resident #7 was admitted to the facility 10/30/17. Cumulative diagnoses included acute hypoxemic respiratory failure, congestive heart failure and acute respiratory failure from acute bronchitis</p> <p>A Quarterly Minimum Data Set (MDS) dated 1/5/18 indicated Resident #7 was cognitively intact.</p> <p>A care plan dated 11/8/17 and last reviewed on 1/8/18 stated Resident #7 received oxygen therapy as needed for shortness of breath. Goal: Resident #7 will have no signs/ symptoms of poor oxygen absorption through the review date. Interventions included, in part, oxygen as ordered.</p> <p>A review of April 2018 's physician ' s orders revealed the following orders related to oxygen use: Change O2 bottle on oxygen concentrator as needed. Change O2 bottle, clean concentrator filter, replace nasal cannula/mask/storage bag every night shift every Sunday. O2 at 2 liters every shift for shortness of breath.</p> <p>A review of the April 2018 Medication Administration Record (MAR) indicated the order to change O2 bottle, clean concentrator filter, replace nasal cannula/ mask/ storage bag was done on 4/1/18.</p> <p>On 4/2/18 at 3:28 PM, an observation of Resident #7 ' s oxygen concentrator revealed there was no oxygen bottle (O2) used to humidify the oxygen on the oxygen concentrator. Resident #7 stated she had not seen an oxygen bottle on the concentrator.</p>	F 695	<p>of nursing on 4/5/18 to ensure oxygen is provided per physician's orders including humidified oxygen. There were no other residents identified during this audit.</p> <p>3. Licensed nurses were reeducated on 4/9/18 by the Director of Nursing and the Assistant Director of Nursing related to the requirements of providing oxygen including humidified oxygen per physician's orders.</p> <p>4. The Director of Nursing, and/or the Administrator will complete a visual observation audit weekly for 4 weeks and monthly for 2 months to ensure oxygen continues to be provided per physician's orders including humidified oxygen. The Director of Nursing and/or Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.</p> <p>Completion Date: 4/25/18</p>		

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F 695	Continued From page 14	F 695			
F 757 SS=D	<p>On 4/4/18 at 8:20 AM, a second observation of Resident #7 ' s oxygen concentrator was conducted with the Director of Nursing. There was no oxygen bottle on the oxygen concentrator. The Director of Nursing stated the oxygen concentrator should have had a humidified O2 water bottle attached to the concentrator.</p> <p>Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)</p> <p>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and Nurse Practitioner (NP) and staff interview, the facility failed to monitor the heart rate and to hold the Coreg (an</p>	F 757	<p>F757</p> <p>1. Resident #8's monitoring for pulse on</p>	4/25/18	

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F 757	<p>Continued From page 15</p> <p>antihypertensive drug) as ordered by the physician for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #8). Findings included:</p> <p>Resident #8 was originally admitted to the facility on 5/1/13 with multiple diagnoses including hypertension. The significant change in status Minimum Data Set (MDS) assessment dated 1/16/18 indicated that Resident #8's cognition was intact.</p> <p>Resident #8's physician's orders were reviewed. On 11/14/17, there was an order for Coreg 12.5 milligrams (mgs.) give 3 tablets by mouth every morning and at bedtime for hypertension - hold for systolic blood pressure (SBP) of < (less than) 100 and heart rate of < 65.</p> <p>Resident #8's Medication Administration Records (MARs) were reviewed. The MARs for March and April 2018 revealed that the heart rate was not checked prior to administering the Coreg.</p> <p>Resident #8's vital signs were checked once a week and were recorded electronically. The heart rates were:</p> <p>12/3/17 at 3:43 PM - 58 beats per minute (bpm) 12/13/17 at 1:33 PM - 58 bpm 12/27/17 at 3:10 PM - 47 bpm 1/6/18 - at 2:35 PM - 58 bpm 1/17/18 at 1:36 PM - 55 bpm 1/24/18 at 3:47 PM - 57 bpm 2/7/18 at 4:00 PM - 54 bpm 2/14/18 at 1:44 PM - 54 bpm 2/21/18 at 3:56 PM - 47 bpm 2/28/18 at 2:08 PM - 52 bpm 3/14/18 at 6:18 PM - 54 bpm 3/21/18 at 3:57 PM - 52 bpm</p>	F 757	<p>the electronic medication record was completed by the Licensed Nurse on 4/4/18.</p> <p>2. An audit was completed by the Director of Nursing on 4/20/18 to ensure vital signs were taken and medication administered per physician's order. Identified issues were corrected by the Director of Nursing 4/20/18.</p> <p>3. The Licensed Nurses were reeducated on 4/10/18 by the Director of Nursing on the requirements of following Physician's order in Medication Administration with vital sign parameters.</p> <p>4. The Director of Nursing and/or the Assistant Director of Nursing will complete an audit weekly for 4 weeks, monthly for 2 months to ensure orders medication with parameters continue to be administration per physician's orders. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.</p> <p>Completion Date: 4/25/18</p>		

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F 757	Continued From page 16 On 4/4/18 at 2:25 PM, Nurse #1 (assigned to Resident #8) was interviewed. She stated that she was not checking the heart rate before administering the Coreg to Resident #8. She was not aware of the order to hold the Coreg if the heart rate was below 65. Nurse #1 added that the MAR did not indicate to check the resident's heart rate. She also stated that the Nurse Aides were checking the resident's vital signs weekly and were recorded under vital signs in the computer. On 4/4/18 at 2:30 PM, the Nurse Practitioner (NP) was interviewed. She stated that the order was to hold the Coreg if the SBP was below 100 and the heart rate was below 65 and she expected the staff to follow this order. The NP added that the Coreg and its parameters was ordered by the cardiologist. On 4/5/18 at 3:10 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to check the heart rate prior to administering the Coreg and to hold the medication per doctor's order. The DON also stated that the MAR should have a space for the heart rate to remind the nurses.	F 757			
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Atmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F 865		4/25/18	

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F 865	<p>Continued From page 17</p> <p>§483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>§483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification survey of 03/16/17. This was for one deficiency recited during a recertification and complaint survey of 04/05/18 in the areas of Resident Assessments at F641 (F278), Quality of Care at F693 (F322) and Pharmacy Services at F757 (F329). The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain and effective Quality Assessment and Assurance program.</p> <p>The findings include:</p> <p>This citation is cross referenced to:</p> <p>F641 - Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of psychotropic drug for 1 of 5 sampled residents reviewed (Resident #42).</p> <p>F693 - Based on record review, observation and</p>	F 865	<p>F 865</p> <p>1. The QA Process was re-evaluated by the Administrator and the Director of Nursing on 4/20/18 including the monitoring of F641, F693 and F757. The Administrator and the Director of Nursing reviewed the Federal Regulation for F641, F693 and F757 on 4/20/18.</p> <p>2. The Administrator and Director of Nursing will review QA minutes and QA audits for the past 6 months by 4/24/18 to identify any need for additional monitoring.</p> <p>3. On 4/16/18 the Administrator received training by the Corporate Trouble Shooting Administrator related to the requirements of F865. The Quality Assurance Committee Members will be reeducated by the Administrator on 4/24/18 related to maintaining implemented procedures and follow up monitoring of the interventions or procedures that are implemented in order to sustain compliance as required.</p>		

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F 865	<p>Continued From page 18</p> <p>Registered Dietician and staff interview, the facility failed to provide tube feedings as ordered by the physician for 3 of 3 sampled residents reviewed for tube feeding (Residents #39, #12 & #56).</p> <p>F757 - Based on record review and Nurse Practitioner (NP) and staff interview, the facility failed to monitor the heart rate and to hold the Coreg (an antihypertensive drug) as ordered by the physician for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #8).</p> <p>Interview on 04/05/18 at 3:05 PM, the Administrator acknowledged understanding of reciting of F 641, F693 and F757 during the recertification and complaint survey of 04/05/18. The Administrator stated there had been no changes in the MDS department and no significant staff turn-over. The Administrator stated the facility completed the audit tools, took results of the audits to QA and held team discussions after the last recertification survey of 03/16.17. She stated she was unsure how the repeat citations were again found on the recertification and complaint survey of 04/05/18.</p>	F 865	<p>4. The Administrator and/or Cooperate Administrator will complete audits monthly for 1 year to ensure systems and process continue to be monitored and follow up completed as required. The Administrator will be responsible for monitoring and follow up.</p> <p>Completion Date: 4/25/18</p>		