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	345008	A. BUILDING _____ B. WING _____	C 03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MYERS PARK	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 000	INITIAL COMMENTS An IDR was conducted on May 7, 2018 and the panel upheld F 695 and F 849 but decreased the scope and severity to "D" for no actual harm with the potential for more than minimal harm that is not immediate jeopardy.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578		4/19/18

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

Electronically Signed | 04/16/2018

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F 578	Continued From page 1 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to clarify and communicate code status for 1 of 3 sampled residents receiving hospice services (Resident #67). The findings included: Resident #67 was readmitted to the facility on 1/31/18 with diagnoses that included acute systolic congestive heart failure (CHF) and dementia. A review of the significant change Minimal Data Set (MDS) assessment dated 2/6/18 had documentation coded that Resident #67 was cognitively impaired and was receiving hospice services. A review of the care plan initiated on 2/28/18 revealed Resident #67 was receiving hospice services related to end of life care. Interventions listed respecting the patient and family wishes and to notify hospice of any change in condition or medication changes. A review of the records revealed conflicting	F 578	Resident #67 code status was corrected. A code status validation audit of all facility residents, including those receiving hospice services, has been conducted. To help ensure the deficient practice does not reoccur, the facility will meet with all current Hospice Services to discuss how communicating resident updates and status changes will be conducted. Upon the election of services, Hospice, the facility'□s Interdisciplinary Care Plan Team, and when available, the Resident, and the Resident□'s Family /Responsible Party, will meet to review the plan of care. Thereafter, Hospice Services will be invited to attend all other Resident Care Plan Meetings. For weekly updates or changes in resident status, Hospice will communicate with the resident□s family/responsible party, and the facility□'s nurse or nurse in charge. These changes will be discussed and addressed at the facility'□s weekly Risk Meeting. The facilities Licensed nursing staff will be educated on in process.	

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F 578	Continued From page 2 documents. A MOST (Medical Order Standard of Treatment) form was updated on 2/3/18 to DNR (Do Not Resuscitate) in the front of the chart by hospice staff indicating Resident #67 was a DNR. The physician order dated 5/11/17 read, Full Code and was entered into the electronic health record for Resident # 67. The nurse report sheet with the assignment that included Resident #67 indicated Full Code status. The plan of care for nursing assistants (NA) read, Full Code. An interview on 3/21/18 at 2:26pm with NA #2 revealed she was aware that Resident # 67 was a DNR because she happened to be at the facility on the day the resident arrived back to the facility and the Hospice Nurse was speaking with a family member. She indicated NAs review the electronic plan of care for code status and during the interview she read Resident #67 had a Full Code status listed. An interview on 3/21/18 at 4:56pm with Nurse #3 was conducted. She stated she worked in the facility as needed and had not worked with Resident #67 before this night. During the interview she read on her assignment form that Resident # 67 was a Full Code. She looked in the paper chart during the interview and saw a MOST form updated to DNR code status as of 2/3/18. A review of the telephone encounter noted in the Hospice records dated 3/21/18 read the MDS Coordinator called Hospice to verify if Resident #67 was a DNR or a Full Code. The Hospice Nurse informed the MDS Coordinator that the resident was a DNR according to the MOST form completed upon admission with hospice services on 2/3/18. At this time the MDS Coordinator	F 578	To help ensure this plan of correction is effective, the facility will review all residents receiving Hospice Services code status during its weekly Risk Meeting. The Director of Nursing Services will also conduct a weekly review of a minimum of 7 non-hospice residents code status to ensure accuracy. This audit will be conducted weekly for 4 weeks; Thereafter, the audit will be conducted twice monthly for two months and then once per month for 3 months. Results will be shared with Administrator weekly, and the facility Quality Assurance and Performance Improvement Committee Monthly until substantial compliance is determined.	

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F 578	Continued From page 3 explained to the Hospice nurse that the facility had not been aware of the updated MOST form and an order had not been written. An interview with the Unit Manager on 3/21/18 at 4:30pm revealed she was unaware of the new Hospice group caring for Resident #67 and felt the coordination and communication between the Hospice group and the staff had not happened. An interview on 3/22/18 at 12:02pm with the Director of Nursing (DON) was conducted. The DON stated she was aware of the new Hospice group working with Resident #67 but was not aware they followed a different process for communication on new orders and assessments as the other hospice groups utilized. The DON stated it was her expectation for a change to DNR status to be verbally communicated to the facility so we could have changed the orders and updated the care plan. An interview with the Administrator on 3/22/18 at 2:36pm revealed he expected hospice to communicate any changes to the MOST form so the facility could update the records and better care for the resident.	F 578		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, 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	F 584		4/19/18

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F 584	Continued From page 4 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with Resident #53, a family member, and staff, the facility failed to maintain clean floors for 5 consecutive days in 6 of 20 resident rooms (301, 305, 310, 311, 319 and 321) on 1 of 3 units.	F 584	Rooms cited during the survey (301, 305, 310, 311, 319, 321) have been cleaned. All other facility rooms have been cleaned, swept, and mopped. To help ensure the deficient practice does	

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F 584	Continued From page 5 The findings included: An observation occurred on 3/18/18 from 11:45 AM - 11:50 AM of the perimeter of the floor in resident rooms 301, 305, 310, 311, 319 and 321 which revealed a collection of dust and debris. Behind the doors of these resident rooms was a large collection of dust, debris and trash. Follow up observations of the same rooms at the following dates/times revealed the collection of dust, debris and trash remained on the floor: 3/19/18 from 11:15 AM - 11:20 AM 3/20/18 from 1:30 PM - 1:35 PM 3/21/18 from 11:30 AM - 11:35 AM 3/22/18 from 2:50 PM - 3:00 PM During an interview with Resident #53 (alert and oriented) on 03/19/18 at 10:48 AM, he stated that "Sometimes they leave a little trash on the floor." An interview with a family member of a resident on the 3rd floor occurred on 03/20/18 at 1:20 PM and revealed that she visited the facility almost daily and had concerns with the cleanliness of the floor in resident rooms. The family member stated there was "trash and clutter" behind the room door of a resident that had been "there for months." An interview with Housekeeping Staff (HKS) #1 occurred on 03/22/18 at 2:50 PM. During the interview rooms 301, 305, 310, 311, 319, and 321 were observed with dust, debris and trash which remained on the floor with heavy accumulation of dust, debris, and trash behind resident doors. HKS#1 stated she was routinely assigned to clean resident rooms on the 3rd floor. She described her routine practice when providing	F 584	not reoccur, all facility housekeeping staff will be retrained on the facility□s contracted cleaning service room and floor cleaning process. A monthly cleaning schedule will be implemented to ensure each resident room is deep cleaned monthly and upon discharge of existing residents. Common areas will be addressed daily and as needed. The facility administrator and housekeeping manager will audit each daily deep cleaned room and 3 random daily cleans 4 times weekly, for 4 weeks; Thereafter, the audit will be conducted twice weekly every week for two months, and then once per week every week for 3 months. Results will be shared the contracted housekeeping services Regional Director weekly, and the facility□s monthly Quality Assessment and Performance Improvement (QAPI)Committee monthly until substantial compliance is determined.	

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F 584	Continued From page 6 housekeeping services and stated that she swept, moped, dusted each resident room, emptied trash and cleaned bathrooms. She stated one room was deep cleaned each week per management direction. HSK #1 stated that she cleaned resident rooms on the 3rd floor that day, completed her assignment as best she could and had to leave because she stated "my ride is here." An interview with the Housekeeping Manager (HKM) and observation of resident rooms 301, 305, 310, 311, 319 and 321 on 03/22/18 at 3:00 PM revealed the floors in these rooms had dust, debris and trash remaining on the floors. HKM stated his routine practice was to monitor the house keeping services of his staff 3 times daily, after breakfast, after lunch and before he left for the day. The HKM stated he had not noticed a concern with the cleanliness of the floors in resident rooms on the 3rd floor, but that he expected HKS to maintain floors clean and he would do a better job of monitoring the floors for cleanliness. The Administrator stated in an interview on 03/22/18 at 4:05 PM that he expected HKS to maintain floors in resident rooms clean, daily.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments	F 636		4/19/18

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§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the

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F 636	Continued From page 8 timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to complete Care Area Assessments (CAA) that addressed and provided an analysis of underlying causes and contributing factors for triggered areas of nutrition 2 of 3 sampled residents (Resident #35, 43) and pressure 1 of 3 sampled residents (Resident #245). Finding included: 1. Resident #43 was admitted on 01/08/2018 with diagnoses that included protein malnutrition, diabetes, and Parkinson's disease. Review of the nutrition Care Area Assessment (CAA) dated 01/21/2018 documented there was not a complete analysis of the finding to support proceeding to the care plan. Review of the nutrition assessment dated 03/08/2018 documented the resident with a 5% weight loss. Review of the admission Minimum Data Set	F 636	The CAA for residents #35, #43, and #245 were completed. All other current residents were audited to ensure CAAs (Care Area Assessments) were completed. To help ensure the deficient practice does not reoccur, the facility MDS Coordinator and Director of Nursing Services were reeducated on proper completion resident CAA (Care Area Assessments). The facility□s Interdisciplinary Care Plan Team was also reeducated on proper completion of resident CAAs (Care Area Assessments). The facility MDS Coordinator will conduct a weekly audit of all Admission, Annual, and Significant Change Assessments to ensure CAA (Care Area Assessments) are complete. This audit will be conducted weekly for 4 weeks; Thereafter, the audit will be conducted twice monthly for two months and then once per month for 3	

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F 636	Continued From page 9 (MDS) dated 03/21/2018 documented Resident #43 was on a therapeutic diet and needed extensive assistance with eating. Observation on 03/20/2018 at 10:09 AM of the Resident # 43 revealed she was being fed breakfast by a nurse aide. Interview on 03/22/2018 with the Registered Dietician (RD) at 9:30 AM revealed she was following weight loss for Resident #43. She stated does not complete the Care Area Assessment (CAA). Interview on 03/22/2018 at 9:37 AM with the Dietary Manager (DM) revealed she had completed the Care Area Assessment (CAA) dated 01/21/2018. She stated the analysis should be an exact picture of that resident. Interview on 03/22/2018 at 10:08 AM with the MDS coordinator stated is a collaborative effort doing the Care Area Assessment (CAA). It is my responsibility to see it's there and complete. Interview on 03/22/2018 at 11:42 AM the Director of Nursing (DON) stated the Care Area Assessment (CAA) was driven from all data for that area for the resident. It was to be detailed and individualized for their specific needs. She stated it was her expectation the CAA was complete with a good analysis. 2. Resident # 245 was admitted on 01/17/2018 with diagnoses that included dementia, Lewey body disease and pressure ulcers. Review of the of progress notes dated 01/24/2018 for skin condition documented in the	F 636	months. Results will be shared with Administrator weekly, and the facility Quality Assurance and Performance Improvement Committee Monthly until substantial compliance is determined.	

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weekly care management meeting that Resident #245 was seen by the wound care specialist on 01/24/2018 for her wounds which included a Stage 4 to her sacrum. Treatments were ordered for each of her wounds. It documented supplements, heels boots and an air mattress to aid in wound healing.

Review of the admission MDS dated 1/30/2018 documented Stage 4 pressure ulcer.

Review of the wound specialist note dated 03/14/2018 documented a Stage 4 pressure ulcer.

Review of the CAA dated 01/30/2018 for pressure revealed no analysis of findings.

Observation on 03/20/2018 at 10:45 AM of wound care provided by the Wound Nurse #1 revealed the resident with a Stage 4 wound on her sacrum.

Interview on 03/20/2018 at 10:45 AM with Wound Nurse #1 revealed Resident #245 had had multiple pressure wounds and currently has only one pressure wound being treated. She stated she does daily wound care.

Interview on 03/22/2018 at 08:29 AM the MDS coordinator stated developing a CAA is a collaborative process and other disciplines put in their areas with information. She stated she was the facilitator. She requested information to put in the CAA before closing it. The CAA should be filled out by the respective disciplines, so the pressure CAA would be filled out by the treatment nurse. She stated there was not any information in the pressure CAA and there was room for improvement.

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Interview on 03/22/2018 at 09:56 AM Wound Nurse #1 stated she filled out Section M on the MDS but never Section V for the CAA.

Interview on 03/22/2018 at 10:08 AM with the MDS coordinator stated is a collaborative effort doing the Care Area Assessment (CAA). It is my responsibility to see it's there and complete.

Interview on 03/22/2018 at 11:42 AM the Director of Nursing (DON) stated the Care Area Assessment (CAA) was driven from all data for that area for the resident. It was to be detailed and individualized for their specific needs. She stated it was her expectation the CAA was complete with a good analysis.

3. Resident #35 was admitted to the facility on 03/04/13 with diagnoses which included dementia, blindness and chronic obstructive pulmonary disease.

Review of a Registered Dietician's note dated 01/11/18 revealed Resident #35's physician received notification of weight loss with approval for supplements three times daily and an appetite stimulant.

Review of Resident #35's significant change Minimum Data Set (MDS) dated 01/12/18 revealed an assessment of severely impaired cognition. The MDS indicated Resident #35 required the limited assistance of one person with eating and a loss of 5% percent or more in the last month or more than 10% in the past 6 months. The MDS triggered the Nutrition Care

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Area Assessment (CAA).

Review of Resident #35's Nutritional CAA dated 02/03/18 revealed no documentation of findings with a description of the problem, contributing factors and risk factor related to nutrition. The CAAs listed Resident #35 with "a weight loss of 10% over the last 6 months." There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.

Observation on 03/20/18 at 8:58 AM revealed Resident #35 consumed 50% of the breakfast meal. Nurse Aide (NA) #1 informed Resident #35 of the food location and type with verbal cues.

Interview with NA #1 on 03/20/18 at 9:00 AM revealed Resident #35's intake varied and ranged from 0% to 50% for all meals.

Observation on 03/20/18 at 12:51 PM revealed Resident #35 refused the lunch meal.

Interview with Nurse #1 on 03/21/18 at 10:20 AM revealed Resident #35's acceptance of the thrice daily nutritional supplement ranged from 0% to 100%.

Interview with the Registered Dietician on 03/22/18 at 9:01 AM revealed she monitored Resident #35's nutritional status but her role in the facility did not include documentation in the CAA.

Interview with the MDS Coordinator on 03/22/18 at 9:46 AM revealed she did not document an analysis of findings supporting the decision to proceed or not to proceed to care plan. The MDS

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F 636	Continued From page 13 Coordinator reported the Nutritional CAA did not contain a comprehensive assessment. Interview with the Director of Nursing on 03/22/18 at 9:48 AM revealed she expected staff to document a comprehensive assessment with an analysis of findings.	F 636		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to	F 640		4/19/18

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F 640	Continued From page 14 the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to transmit discharge Minimum Data Set (MDS) information for 3 of 6 sampled discharged residents (Residents #1, #2 and #3). The findings included: 1. Resident #1 was admitted to the facility on 09/19/17 and discharged on 10/02/17. Review of Minimum Data Set (MDS) transmittals revealed an admission MDS dated 09/26/17 was transmitted. There was no transmittal of a discharge MDS for Resident #1. Interview with the MDS Coordinator on 03/22/18 at 2:49 PM revealed a discharge MDS was not transmitted for Resident #1. The MDS	F 640	Discharge Assessments for Residents #1, #2, and #3 were completed. A discharge assessment was completed for all residents discharged June 5, 2017 to March 22, 2018. To help ensure the deficient practice does not reoccur, the facility MDS Coordinator and Director of Nursing Services were reeducated on proper completion of the MDS Discharge Assessment. The facility MDS Coordinator will run a weekly Missing Resident Report to ensure all discharged residents have a completed discharge Assessment. This audit will be conducted weekly for 4 weeks; Thereafter, the audit will be conducted	

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F 640	Continued From page 15 Coordinator reported the omission was an error. Interview with the Director of Nursing on 03/22/18 at 2:52 PM revealed she expected Resident #1's discharge MDS to be transmitted. 2. Resident #2 was admitted to the facility on 12/20/16 and discharged on 11/20/17. Review of Minimum Data Set (MDS) transmittals revealed an admission MDS dated 01/06/17, quarterly MDS dated 04/04/17, 06/30/17 and 09/29/17 were transmitted. There was no transmittal of a discharge MDS for Resident #2. Interview with the MDS Coordinator on 03/22/18 at 2:49 PM revealed a discharge MDS was not transmitted for Resident #2. The MDS Coordinator reported the omission was an error. Interview with the Director of Nursing on 03/22/18 at 2:52 PM revealed she expected Resident #2's discharge MDS to be transmitted. 3. Resident #3 was admitted to the facility on 09/20/17 and discharged on 10/19/17. Review of Minimum Data Set (MDS) transmittals revealed an admission MDS dated 10/04/17 was transmitted. There was no transmittal of a discharge MDS for Resident #3. Interview with the MDS Coordinator on 03/22/18 at 2:49 PM revealed a discharge MDS was not transmitted for Resident #3. The MDS Coordinator reported the omission was an error. Interview with the Director of Nursing on 03/22/18 at 2:52 PM revealed she expected Resident #3's	F 640	twice monthly for two months and then once per month for 3 months. Results will be shared with Administrator and Director of Nursing Services weekly, and the facility Quality Assurance and Performance Improvement Committee Monthly until substantial compliance has been determined.	

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F 640	Continued From page 16 discharge MDS to be transmitted.	F 640		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to develop a care plan to meet the resident care needs for 1 of 3 sampled residents (Resident # 245).	F 657	Resident #245 care plan was updated to help ensure interventions were identified to ensure resident needs were addressed. A review all resident□s care plans was	4/19/18

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F 657	Continued From page 17 Findings included: Resident # 245 was admitted on 01/17/2018 with diagnoses that included dementia, Lewey body disease and pressure ulcers. Review of the of progress notes dated 01/24/2018 for skin condition documented in the weekly care management meeting that Resident #245 was seen by the wound care specialist on 01/24/2018 for her wounds which included a Stage 4 to her sacrum. Treatments were ordered for each of her wounds. It documented supplements, heels boots and an air mattress to aid in wound healing. Review of the care plan dated 01/25/2018 documented a focus area for pressure ulcer and one intervention which was "complete Braden Scale per Living Center Policy". Review of the admission Minimum Data Set (MDS) dated 1/30/2018 documented Stage 4 pressure ulcer. Review of the CAA dated 01/30/2018 for pressure documented "resident is total care". Observations of Resident #245 included: 03/19/2018 at 09:19 AM Resident #245 in bed on air mattress 03/21/2018 at 07:45 AM Resident # 245 positioned on left side in bed, on air mattress 03/21/2018 at 09:00 AM Resident #245 received nutritional supplement for wound healing via feeding tube	F 657	conducted to ensure interventions were identified to help ensure residents needs are addressed. To help ensure the deficient practice does no reoccur, the facility□s Interdisciplinary Care Plan Team has been reeducated on ensuring interventions are identified to address resident needs. The Director of Nursing Services or Unit Manager will review a minimum of 7 residents' care plan during the facility's weekly Risk Meeting to help ensure interventions are identified and resident needs are addressed. This audit will be conducted weekly for 4 weeks; Thereafter, the audit will be conducted twice monthly for two months and then once per month for 3 months. Results will be shared with Administrator weekly, and the facility Quality Assurance and Performance Improvement Committee Monthly until substantial compliance is determined.	

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F 657	Continued From page 18 03/21/2018 at 4:00 PM Resident # 245 positioned with wedge to right side, on air mattress Interview on 03/20/2018 at 10:45 AM with Wound Nurse #1 revealed she provided daily wound care to Resident #245. Intervention including an air mattress, supplement, and boots for her heels were in place to promote wound healing and prevent any new pressure areas. She stated the wound care specialist made rounds weekly. Interview on 03/22/2018 at 05:55 PM the MDS coordinator stated the care plans are her responsibility to complete and the pressure ulcer interventions on "Complete Braden Scale was listed. Interview on 03/22/2018 at 05:57 PM the Director of Nursing (DON) stated she expected care plans to have interventions to meet the residents' care needs and for them to be complete.	F 657		
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 observations, record reviews, staff interviews, Nurse Practitioner (NP) interview, and	F 695	The process leading to the cited deficiency was due to lapse in	4/19/18

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F 695	Continued From page 19 Physician interviews, the facility failed to administer oxygen as care planned by hospice services to 1 of 3 residents sampled for oxygen therapy (Resident #67). The findings included: Residents #67 was admitted on 3/20/17 and readmitted to the facility on 1/28/18 with diagnoses that included acute systolic congestive heart failure (CHF), dementia, and anxiety disorder. A review of the significant change Minimal Data Set (MDS) assessment dated 2/6/18 had documentation coded that Resident #67 was cognitively impaired, had an anxiety disorder and CHF, and was receiving hospice services. A review of the Certification of Terminal illness Attestation Statement dated 2/5/18 with a start date of 2/3/18 for hospice services revealed Resident #67 had presented to the emergency department on 1/28/18 with acute dyspnea (shortness of breath) related to an exacerbation of CHF. Resident #67 had signs of marked hypoxia (absence of enough oxygen in the blood to sustain bodily functions), pleural effusion (fluid buildup between the lungs and chest), and notable cardiomegaly (enlarged heart). During this hospitalization she was treated with aggressive intravenous (IV) diuretics with some success but overall prognosis was slim due to advancing cardiac failure. Resident #67 was transferred back to the nursing facility after an agreement with the family to accept Hospice services to address a palliative approach to care and abandon more options for hospitalizations.	F 695	communication between the facility and the resident's hospice service provider. Resident #67 Hospice Admission orders for oxygen intervention were not implemented as prescribed. Oxygen was provided to resident #67 as ordered on 3.21.18. An audit of all other residents receiving oxygen, including those on hospice services, was conducted to ensure care plans and orders were followed. To help ensure the deficient practice does no reoccur, the facility Interdisciplinary Care Plan Team met with Resident #67 Hospice Provider, on 4.4.18 to discuss how communicating resident updates and status changes will be conducted. The facility has also met with all other facility Hospice Service Providers to discuss communicating resident updates and status changes. On 4.18.18 the Director of Nursing Services will in-service the nursing staff on recognizing resident signs and symptoms of respiratory distress, and how to respond to residents in respiratory distress. In-servicing will also include reeducating the Nursing staff on understanding Resident Care Plans,the care plan purpose, location, and communication and implementation of updates. Nursing staff not present will not be allowed to work until in-servicing has been completed. Upon the election of services, Hospice, the facility'□s Interdisciplinary Care Plan Team, and when available, the Resident,	

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F 695	Continued From page 20 A review of the Hospice care plan dated 2/3/18 revealed Resident #67 had an alteration in respiratory function and interventions included assessing effectiveness and compliance with oxygen therapy. A review of the Hospice care plan dated 2/3/18 for Resident #67 revealed Hospice admission orders were listed under problem and gave interventions to administer oxygen as ordered, when resident had dyspnea, non-verbal indicators demonstrate dyspnea, or dyspnea was assessed by a nurse. Further directions included if symptoms remained uncontrolled after 30 minutes, the clinician may increase oxygen to 3 liters per minute (LPM). If symptoms remained uncontrolled after an additional 30 minutes, the clinician may increase oxygen up to a maximum flow of 4 LPM. A review of the facility care plan for Resident #67 dated 1/31/18 and revised on 2/26/18 revealed no focus or interventions related to respiratory or cardiac functions. A review of the Hospice Nurse routine visit note dated 3/19/18 revealed Resident #67 continued to have periods of increased shortness of breath due to disease progression but continued to breathe on room air. The Hospice Nurse wrote to continue to educate staff on using oxygen as needed for symptom management. A review of the Hospice Service Narrative note for Resident #67 dated 3/19/18 read, the Hospice Nurse instructed Nurse #2 to use oxygen as needed for symptom management. A review of the order summary report for	F 695	and the Resident's Family/Responsible Party, will meet to review the plan of care. Thereafter, Hospice Services will be invited to attend all other Resident Care Plan Meetings. For weekly updates or order changes. Hospice will communicate to the resident□s family/responsible party, and the facility'□s nurse or nurse in charge. These changes will be addressed at the facility'□s weekly Risk Meeting. For all other residents, order changes will be communicated to the resident nurse or nurse in charge and addressed during the facility's weekly Risk Meeting. The facility's Licensed Nursing staff will be educated on this change in process during the 4.18.18 in-servicing. To help ensure this plan of correction is effective, the facility will review all residents receiving Hospice Services for order changes during its weekly Risk Meeting. The Director of Nursing Services or Unit Manager will also conduct a weekly review of a minimum of 7 non-hospice residents for order changes. This audit will be conducted once weekly for 4 weeks; Thereafter, the audit will be conducted twice monthly for two months and then once per month for 3 months. The Director of Nursing Services or Unit Manager will also audit a minimum of 5 nursing staff employees weekly on recognizing resident signs and symptoms of respiratory distress, and how to respond to residents in respiratory distress. Additionally, a minimum of 5 employees weekly will be audited on their knowledge of Care Plans, which would	

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F 695	Continued From page 21 Resident #67 dated 2/2/18 through 3/20/18 revealed no orders to check oxygen saturation or to administer oxygen as needed for shortness of breath or symptoms of dyspnea. A review of the oxygen saturation summary for Resident #67 revealed the last assessment was dated 1/25/18 prior to her rehospitalization that read 97% on room air. An observation on 3/18/18 at 12:33pm revealed Resident #67 was eating lunch in the dining room on 300 Hall. Resident #67 was noted to use accessory muscles periodically through lunch as she ate approximately 50% of her meal. Resident #67 was not receiving portable oxygen at this time. An interview on 3/19/18 at 11:39am with the Hospice Nurse was conducted. She indicated she was aware of Resident #67 having periods of shortness of breath and had assessed the resident to use her accessory muscles to breathe and at times used pursed breathing. The Nurse stated the floor staff were aware of the Hospice care plan located in Resident #67's chart and had been educated to administer oxygen as needed (PRN) when the resident had intermittent shortness of breath. She revealed Nurse #2 stated that no PRN medications had been given over the past 24 hours and no changes with Resident #67 had been assessed. An observation on 3/20/18 at 11:23am revealed Resident #67 was sitting in her wheel chair in the dining room on 300 Hall. She appeared to be uncomfortable, holding her throat at times, using accessory muscles to breathe, and fidgeting with her face and clothes. Resident #67 was not	F 695	include the care plan purpose, location, and communication and implementation of updates. This audit will be conducted once weekly for 4 weeks; Thereafter, the audit will be conducted twice monthly for two months and then once per month for three months. Results will be shared with Administrator weekly, and the facility Quality Assurance and Performance Improvement Committee Monthly until substantial compliance is achieved.	

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receiving portable oxygen at this time.

An observation on 3/21/18 at 9:59am revealed Resident #67 sitting in her wheel chair in the dining room on 300 Hall. She again appeared to be uncomfortable, scratching her back and breathing heavy. Resident #67 was not receiving portable oxygen at this time.

An observation on 3/21/18 at 10:02am revealed Nurse #2 walked up to Resident #67's table to pick up towels but did not address what appeared to be discomfort with the use of accessory muscles and pursed breathing.

An observation on 3/21/18 at 12:31pm revealed Resident #67 in the dining room as lunch was served by staff. Resident #67 sat at the table with her eyes closed, holding her neck, using accessory muscles to breathe, and fidgeting. Resident #67 was not receiving portable oxygen at this time.

An observation on 3/21/18 at 2:23pm of NA #2 performing incontinence care to Resident #67 as she laid flat on her back revealed the resident was moaning and stated, "Oh Lord, oh Lord" repeatedly. It was noted that Resident #67 was using accessory muscles and pursed breathing to breathe. Resident #67 was not receiving portable oxygen at this time. There was no oxygen observed in Resident #67's room.

An interview on 3/21/18 at 2:26pm with NA #2 was conducted. NA #2 revealed that Resident # 67 received Hospice services. NA #2 stated Resident # 67 had never used oxygen before and had no breathing problems that she was aware of. She stated she cared for Resident # 67

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regularly and had a good relationship with her.

An interview on 3/21/18 at 3:10pm with Nurse #2 indicated she was very familiar with Resident #67 and the resident had never had any respiratory concerns that she could remember. She stated oxygen had never been used for Resident # 67 and explained she had gotten really sick in January and was sent out to the hospital and came back on Hospice. Nurse #2 revealed a lady earlier in the week had asked me questions about changes regarding Resident #67 and she replied no. Nurse # 2 explained Resident #67 had always had a lot of anxiety and when she states, "Oh Lord, oh Lord," while moving her shoulders up and down, she was expressing anxiety. Nurse #2 explained the resident got their oxygen saturation levels checked on shower days and during the interview pulled up Resident #67's Oxygen Saturation Summary on the electronic health records. Nurse #2 stated the last reading was checked on 1/25/18. Nurse #2 stated, "It must have been an oversight and we left the orders off when Resident #67 came back from the hospital." Due to the symptoms Resident # 67 was exhibiting, lying flat in bed, using accessory muscles, and pursed breathing, this surveyor requested Nurse #2 check the oxygen level for Resident # 67 during the interview.

An observation on 3/21/18 at 3:25pm revealed Resident #67 lying flat in her bed, using accessory muscles, and pursed breathing. Nurse #2 asked Resident #67 if she wanted her head elevated a little and the resident stated, "Yes, please." The initial assessment of the oxygen saturation level for Resident #67 recorded 85% on room air. Nurse #2 went to get another measuring tool and the oxygen saturation

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recorded 83% on room air on the second assessment.

An interview on 3/21/18 at 3:33pm with Nurse #2 revealed she also observed Resident #67 using her accessory muscles and pursed breathing. She stated she felt bad because she had thought it was the resident's anxiety and had overlooked the difficulty breathing signs and symptoms. She stated she would call Hospice immediately for oxygen orders and talk to the Director of Nursing (DON).

An observation on 3/21/18 at 4:26pm revealed Resident #67 in bed with the head of the bed elevated while she received oxygen via nasal cannula at 2 LPM. No use of accessory muscles or pursed breathing were observed.

An interview with Nurse #2 on 3/21/18 at 4:26pm revealed Resident #67 had an oxygen saturation of 99% on oxygen at 2 LPM. Nurse #2 stated she felt bad because she cared about Resident #67 so much. She stated she was not familiar with the Hospice services Resident #67 was receiving and did not know that the care plan was in the chart. She stated Resident #67 was the first resident in the facility to receive services from the new Hospice group and she had not received any education on what to expect as far as receiving orders and communication. She indicated she had not received any education from the Hospice group regarding Resident # 67.

An interview on 3/21/18 at 4:30pm with the Unit Manager revealed she and the staff had not received any training regarding the new Hospice group and did not know anything about the Hospice care plan. She stated she expected to

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see Hospice notes in the chart like the other Hospice groups utilized in the facility.

An interview on 3/21/18 at 4:44pm with the NP revealed she was unsure of when she last assessed Resident #67. She knew that Resident #67 was receiving Hospice services but did not know it was with a new group. The NP indicated she would recognize respiratory distress as using extra effort to breathe and pursed breathing was an indicator. She explained she would have started Roxanol and administered oxygen with signs and symptoms exhibiting pursed breathing, use of accessory muscles and oxygen saturations reading 83-85%. She revealed in her professional opinion Resident #67 was not in comfort status with the described symptoms.

An interview on 3/21/18 at 4:56pm with Nurse #3 revealed oxygen would be administered through the night due to the assessment from the afternoon.

An interview on 3/21/18 at 5:02pm with NA #3 revealed she had worked in the facility for a few months and had heard Resident #67 state, "Oh Lord, Oh Lord," but no breathing problems that she was aware of.

An interview on 3/22/18 at 8:30am with the facility's Medical Director revealed he was not aware of Resident #67 receiving care from a new Hospice group and did not know they were in the facility. He added that he nor his NP had seen the Hospice care plan. The Medical Director revealed when a resident used pursed breathing and accessory muscles with oxygen saturation levels recorded at 83-85% then he considered the resident really uncomfortable and needing

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oxygen.

An interview on 3/22/18 at 10:50am with Nurse #4 who had assisted Resident #67 during lunch on 3/18/18, stated the resident's chest movements had always been very extra since she had worked with her but was unaware of any breathing problems.

An interview on 3/22/18 at 11:09am with the Hospice Supervisor revealed plans of care and nursing notes were reviewed every 14 days by the Hospice Medical Director.

An interview on 3/22/18 at 11:09am with the Hospice Medical Director revealed oxygen saturation levels were not routinely checked by the Hospice Nurses. He explained that the initial admission notes and care plan were faxed on 2/3/18 to the facility Medical Director. The Hospice Medical Director explained since he did not get a response, he hand-delivered the forms to his medical office. The Hospice Medical Director stated he did not directly know Resident # 67. He stated by the description given it sounded like she was uncomfortable. He explained that if Resident # 67 was suddenly better from applying oxygen then she was clinically better from the oxygen administered indicating Resident #67's quality of life improved.

An observation on 3/22/18 at 11:50pm of Resident # 67 revealed her resting in bed quietly with the head of the bed elevated and receiving oxygen at 2 LPM. No accessory muscles or pursed breathing observed at this time.

An interview on 3/22/18 at 11:52pm with Nurse #2 revealed she could tell Resident # 67 was more

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F 695	Continued From page 27 comfortable on this day with the oxygen in place. She stated her oxygen saturation level had been 99% on 2 liters of oxygen per minute. She indicated Resident #67 had taken off the nasal cannula twice and had decreased her saturation to 79% on room air. After the second time, she had been fine ever since. An interview on 3/22/18 at 12:02pm was conducted with the DON. The DON stated she was aware of the new Hospice group working with Resident #67 but was not aware they followed a different process for communication on new orders and assessments. The DON stated it was her expectation for Hospice to write new orders, flag the new orders, and communicate the new orders to the floor nurse immediately and at all times. The DON stated that Resident # 67 had a change or decline from her baseline and now we know. An interview on 3/22/18 at 2:36pm with the Administrator revealed his expectation from Hospice services was to communicate any changes or addition to services to the team to better care for the resident.	F 695		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the	F 849		4/19/18

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resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.

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F 849	Continued From page 29 (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice	F 849		

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administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:

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F 849	Continued From page 31 (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, Nurse Practitioner (NP) interview, and Physician interviews, the facility failed to maintain communication and coordination of services provided by Hospice and facility personnel related to respiratory care, advanced directives, and discontinued labs for 1 of 3 sampled for hospice services (Resident #67).	F 849	The process leading to the cited deficiency was due to lapse in communication between the facility and the resident's hospice service provider. The facility did not communicate and follow the resident's plan of care as outlined by Hospice. Resident #67 Care Plan was reviewed on 3.21.18.	

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F 849	Continued From page 32 The findings included: Residents #67 was admitted on 3/20/17 and readmitted to the facility on 1/28/18 with diagnoses that included acute systolic congestive heart failure (CHF), dementia, and anxiety disorder. A review of the significant change Minimum Data Set (MDS) assessment dated 2/6/18 had documentation coded that Resident #67 was cognitively impaired, had an anxiety disorder and CHF, and was receiving hospice services. A review of the contract between the Hospice group and the facility was dated 9/2017. According to Appendix 3, Hospice and Nursing Home Areas of Responsibility, the hospice group and the facility were listed as the responsible parties for the Initial Assessment Process, Ongoing Patient Assessment, Plan of Care Development, Plan of Care Review, and Coordination of Care. A review of the Certification of Terminal illness Attestation Statement dated 2/5/18 with a start date of 2/3/18 for hospice services revealed Resident #67 had presented to the emergency department on 1/28/18 with acute dyspnea (shortness of breath) related to an exacerbation of CHF. Resident #67 had signs of marked hypoxia (absence of enough oxygen in the blood to sustain bodily functions), pleural effusion (fluid buildup between the lungs and chest), and notable cardiomegaly (enlarged heart). During this hospitalization she was treated with aggressive intravenous (IV) diuretics with some success but overall prognosis was slim due to advancing cardiac failure. Resident #67 was	F 849	A review of all other residents receiving hospice services, was conducted to ensure the care plans and orders were followed. To help ensure the deficient practice does no reoccur, the facility Interdisciplinary Care Plan Team met with Resident #67 Hospice Provider, on 4.4.18 to discuss how communicating resident updates and status changes will be conducted. The facility has also met with all other facility Hospice Service Providers to discuss communicating resident updates and status changes. On 4.18.17, a review of the facility'□s Hospice Services Agreements will be reviewed by the Administrator, Director of Nursing Services, and Medical Director. On 4.18.17, The facility nursing staff will be educated on Hospice Services and how the communication of updates and status changes will be conducted. Facility Nursing staff will also be reeducated understanding Resident Care Plans, which would include the care plan purpose, location, and communication and implementation of updates. Nursing staff not present will not be allowed to work until in-servicing has been completed. Upon the election of services, Hospice, the facility'□s Interdisciplinary Care Plan Team, and when available, the Resident, and the Resident□'s Family/Responsible Party, will meet to review the plan of care. The facility'□s Nurse Practitioner and Medical Director will also be notified. Thereafter, Hospice Services will be	

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F 849	Continued From page 33 transferred back to the nursing facility after an agreement with the family to accept Hospice services to address a palliative approach to care and abandon more options for hospitalizations. A review of the Hospice care plan dated 2/3/18 revealed Resident #67 had an alteration in respiratory function and interventions included assessing effectiveness and compliance with oxygen therapy. A review of the Hospice care plan dated 2/3/18 for Resident #67 revealed Hospice admission orders were listed under problem and gave interventions to administer oxygen as ordered, when resident had dyspnea, non-verbal indicators demonstrate dyspnea, or dyspnea was assessed by a nurse. Further directions included if symptoms remained uncontrolled after 30 minutes, the clinician may increase oxygen to 3 liters per minute (LPM). If symptoms remained uncontrolled after an additional 30 minutes, the clinician may increase oxygen up to a maximum flow of 4 LPM. A review of the facility care plan for Resident #67 dated 1/31/18 and revised on 2/26/18 revealed no focus or interventions related to respiratory or cardiac functions. A review of the care plan initiated on 2/28/18 revealed Resident #67 was receiving hospice services related to end of life care. Interventions listed respecting the patient and family wishes and to notify hospice of any change in condition or medication changes. A review of the Hospice Nurse routine visit note dated 3/19/18 revealed Resident #67 continued to	F 849	invited to attend all other Resident Care Plan Meetings. For weekly updates or order changes, Hospice will communicate to the resident□s family/responsible party, and the facility'□s nurse or nurse in charge. These changes will be discussed and addressed at the facility'□s weekly Risk Meeting. The facility will also communicate these updates to the Nurse Practitioner and Medical Director. To help ensure this plan of correction is effective, the Director of Nursing or Nurse Manager will review all residents receiving Hospice Services for order changes, updates, and changes in status during the facility'□s weekly Risk Meeting. The Director of Nursing Services or Unit Manager will also communicate directly with resident'□s Hospice Service provider to help ensure effective communication and orders are followed. This communication will be conducted once weekly for 4 weeks; Thereafter, the audit will be conducted twice monthly for two months and then once per month for 3 months. The Director of Nursing Services or Unit Manager will also audit a minimum of 5 employees weekly on their knowledge of Hospice Services and Care Plans. This audit will be conducted once weekly for 4 weeks; Thereafter, the audit will be conducted twice monthly for two months and then once per month for 3 months. Results will be shared with Administrator weekly, and the facility Quality Assurance and Performance Improvement Committee Monthly until substantial	

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have periods of increased shortness of breath due to disease progression but continued to breathe on room air. The Hospice Nurse wrote to continue to educate staff on using oxygen as needed for symptom management.

A review of the Hospice Service Narrative note for Resident #67 dated 3/19/18 read, the Hospice Nurse instructed Nurse #2 to use oxygen as needed for symptom management.

A review of the order summary report for Resident #67 dated 2/2/18 through 3/20/18 revealed no orders to check oxygen saturation or to administer oxygen as needed for shortness of breath or symptoms of dyspnea.

A review of the oxygen saturation summary for Resident #67 revealed the last assessment was dated 1/25/18 prior to her rehospitalization that read 97% on room air.

An observation on 3/18/18 at 12:33pm revealed Resident #67 was eating lunch in the dining room on 300 Hall. Resident #67 was noted to use accessory muscles periodically through lunch as she ate approximately 50% of her meal. Resident #67 was not receiving portable oxygen at this time.

An interview on 3/19/18 at 11:39am with the Hospice Nurse was conducted. She indicated she was aware of Resident #67 having periods of shortness of breath and had assessed the resident to use her accessory muscles to breathe and at times used pursed breathing. The Nurse stated the floor staff were aware of the Hospice care plan located in Resident #67's chart and had been educated to administer oxygen as needed

compliance is achieved.

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(PRN) when the resident had intermittent shortness of breath. She revealed Nurse #2 stated that no PRN medications had been given over the past 24 hours and no changes with Resident #67 had been assessed.

An observation on 3/20/18 at 11:23am revealed Resident #67 was sitting in her wheel chair in the dining room on 300 Hall. She appeared to be uncomfortable, holding her throat at times, using accessory muscles to breathe, and fidgeting with her face and clothes. Resident #67 was not receiving portable oxygen at this time.

An observation on 3/21/18 at 9:59am revealed Resident #67 sitting in her wheel chair in the dining room on 300 Hall. She again appeared to be uncomfortable, scratching her back and breathing heavy. Resident #67 was not receiving portable oxygen at this time.

An observation on 3/21/18 at 10:02am revealed Nurse #2 walked up to Resident #67's table to pick up towels but did not address what appeared to be discomfort with the use of accessory muscles and pursed breathing.

An observation on 3/21/18 at 12:31pm revealed Resident #67 in the dining room as lunch was served by staff. Resident #67 sat at the table with her eyes closed, holding her neck, using accessory muscles to breathe, and fidgeting. Resident #67 was not receiving portable oxygen at this time.

An observation on 3/21/18 at 2:23pm of NA #2 performing incontinence care to Resident #67 as she laid flat on her back revealed the resident was moaning and stated, "Oh Lord, oh Lord"

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repeatedly. It was noted that Resident #67 was using accessory muscles and pursed breathing to breathe. Resident #67 was not receiving portable oxygen at this time. There was no oxygen observed in Resident #67's room.

An interview on 3/21/18 at 2:26pm with NA #2 was conducted. NA #2 revealed that Resident # 67 received Hospice services. NA #2 stated Resident # 67 had never used oxygen before and had no breathing problems that she was aware of. She stated she cared for Resident # 67 regularly and had a good relationship with her.

An interview on 3/21/18 at 3:10pm with Nurse #2 indicated she was very familiar with Resident #67 and the resident had never had any respiratory concerns that she could remember. She stated oxygen had never been used for Resident # 67 and explained she had gotten really sick in January and was sent out to the hospital and came back on Hospice. Nurse # 2 explained Resident #67 had always had a lot of anxiety and when she states, "Oh Lord, oh Lord," while moving her shoulders up and down, she was expressing anxiety. Nurse #2 explained the resident got their oxygen saturation levels checked on shower days. During the interview, the nurse pulled up Resident #67's Oxygen Saturation Summary on the electronic health records. Nurse #2 stated the last reading was checked on 1/25/18. She stated it must have been an oversight and "we" left the orders off when she came back from the hospital. At this time, this surveyor requested staff to check the oxygen level for Resident # 67 due to her lying flat in her bed, using accessory muscles, and pursed breathing.

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An observation on 3/21/18 at 3:25pm revealed Resident #67 lying flat in her bed, using accessory muscles, and pursed breathing. Nurse #2 asked Resident #67 if she wanted her head elevated a little and the resident stated, "Yes, please." The initial assessment of the oxygen saturation level for Resident #67 recorded 85% on room air. Nurse #2 went to get another measuring tool and the oxygen saturation recorded 83% on room air.

An interview on 3/21/18 at 3:33pm with Nurse #2 revealed she also observed Resident #67 using her accessory muscles and pursed breathing. She stated she felt bad because she had thought it was the resident's anxiety and had overlooked the difficulty breathing signs and symptoms. She stated she would call Hospice immediately for oxygen orders and talk to the Director of Nursing (DON).

An observation on 3/21/18 at 4:26pm revealed Resident #67 in bed with the head of the bed elevated while she received oxygen via nasal cannula at 2 LPM. No use of accessory muscles or pursed breathing were observed.

An interview with Nurse #2 on 3/21/18 at 4:26pm revealed Resident #67 had an oxygen saturation of 99% on oxygen at 2 LPM. She stated she was not familiar with the Hospice services Resident #67 was receiving and did not know that the care plan was in the chart. She stated Resident #67 was the first resident in the facility to receive services from the new Hospice group and she had not received any education on what to expect as far as receiving orders and communication. She indicated she had not received any education from the Hospice group regarding Resident # 67.

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An interview on 3/21/18 at 4:30pm with the Unit Manager revealed she and the staff had not received any training regarding the new Hospice group and did not know anything about the Hospice care plan. She stated she expected to see Hospice notes in the chart like the other Hospice groups utilized in the facility.

An interview on 3/21/18 at 4:44pm with the NP revealed she was unsure of when she last assessed Resident #67. She knew that Resident #67 was receiving Hospice services but did not know it was with a new group. The NP indicated she would recognize respiratory distress as using extra effort to breathe and pursed breathing was an indicator. She explained she would have started Roxanol and administered oxygen with signs and symptoms exhibiting pursed breathing, use of accessory muscles and oxygen saturations reading 83-85%. She revealed in her professional opinion Resident #67 was not in comfort status with the described symptoms.

An interview on 3/21/18 at 4:56pm with Nurse #3 revealed oxygen would be administered to Resident #67 through the night due to the assessment from the afternoon.

An interview on 3/21/18 at 5:02pm with NA #3 revealed she had worked in the facility for a few months and had heard Resident #67 state, "Oh Lord, Oh Lord," but there were no breathing problems that she was aware of.

An interview on 3/22/18 at 8:30am with the facility's Medical Director revealed he was not aware of Resident #67 receiving care from a new Hospice group and did not know they were in the

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facility. He added that neither he nor his NP had seen the Hospice care plan. The Medical Director revealed when a resident used pursed breathing and accessory muscles with oxygen saturation levels recorded at 83-85% then he considered the resident really uncomfortable and needing oxygen.

An interview on 3/22/18 at 10:50am with Nurse #4 who had assisted Resident #67 during lunch on 3/18/18, stated the resident's chest movements had always been very extra since she had worked with her but was unaware of any breathing problems.

An interview on 3/22/18 at 11:09am with the Hospice Medical Director revealed oxygen saturation levels were not routinely checked by the Hospice Nurses. He explained that the initial admission notes and care plan were faxed on 2/3/18 to the facility Medical Director. The Hospice Medical Director explained since he did not get a response, he hand-delivered the forms to his medical office. The Hospice Medical Director stated he did not directly know Resident # 67. He stated by the description given it sounded like she was uncomfortable. He explained that if Resident # 67 was suddenly better from applying oxygen then she was clinically better from the oxygen administered indicating Resident #67's quality of life improved.

An observation on 3/22/18 at 11:50pm of Resident # 67 revealed her resting in bed quietly with the head of the bed elevated and receiving oxygen at 2 LPM. No accessory muscles or pursed breathing observed at this time.

An interview on 3/22/18 at 11:52pm with Nurse #2

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revealed she could tell Resident # 67 was more comfortable on this day with the oxygen in place. She stated her oxygen saturation level had been 99% on 2 liters of oxygen per minute. She indicated Resident #67 had taken off the nasal cannula twice and had decreased her saturation to 79% on room air. After the second time, she had been fine ever since.

2. A review of the care plan initiated on 2/28/18 revealed Resident #67 was receiving hospice services related to end of life care. Interventions listed respecting the patient and family wishes and to notify hospice of any change in condition or medication changes.

A review of the records revealed conflicting documents. A MOST (Medical Order Standard of Treatment) form was updated on 2/3/18 to DNR (Do Not Resuscitate) in the front of the chart by hospice staff indicating Resident #67 was a DNR. The physician order dated 5/11/17 read, Full Code and was entered into the electronic health record for Resident # 67. The nurse report sheet with the assignment that included Resident #67 indicated Full Code status. The plan of care for nursing assistants (NA) read, Full Code.

An interview on 3/21/18 at 2:26pm with NA #2 revealed she was aware that Resident # 67 was a DNR because she happened to be at the facility on the day the resident arrived back to the facility and the Hospice Nurse was speaking with a family member. She indicated NAs review the electronic plan of care for code status and during the interview she read Resident #67 had a Full Code status listed.

An interview on 3/21/18 at 4:56pm with Nurse #3

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was conducted. She stated she worked in the facility as needed and had not worked with Resident #67 before this night. During the interview she read on her assignment form that Resident # 67 was a Full Code. She looked in the paper chart during the interview and saw a MOST form updated to DNR code status as of 2/3/18.

A review of the telephone encounter noted in the Hospice records dated 3/21/18 read the MDS Coordinator called Hospice to verify if Resident #67 was a DNR or a Full Code. The Hospice Nurse informed the MDS Coordinator that the resident was a DNR according to the MOST form completed upon admission with hospice services on 2/3/18. At this time the MDS Coordinator explained to the Hospice nurse that the facility had not been aware of the updated MOST form and an order had not been written.

An interview with the Unit Manager on 3/21/18 at 4:30pm revealed she was unaware of the new Hospice group caring for Resident #67 and felt the coordination and communication between the Hospice group and the staff had not happened.

3. A review of a verbal order for Resident #67 dated 2/6/18 received from the Hospice Medical Director read, Discontinue all routine lab work per Hospice recommendations.

A review of the Order Summary Report for Resident #67 revealed a physician order dated 2/2/18 that read, LFT every 6 months for routine acetaminophen therapy in March and September.

A review of lab results revealed Resident #67 had a lab ordered on 3/12/18 for a Hepatic Panel

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F 849	Continued From page 42 (LFT) and was collected on 3/12/18 at 12:41pm. No new orders were initiated after the labs were received. An interview on 3/21/18 at 5:01pm with the Unit Manager revealed the routine lab order for March had not been discontinued when Hospice wrote the order and routine labs were drawn on 3/12/18. The UM stated the order was overlooked and someone did not discontinue the routine lab order. An interview on 3/22/18 at 12:02pm was conducted with the Director of Nursing (DON). The DON stated she was aware of the new Hospice group working with Resident #67 but was not aware they followed a different process for communication on new orders and assessments. The DON stated it was her expectation for Hospice to write new orders, flag the new orders, and communicate the new orders to the floor nurse immediately and at all times. The DON stated that Resident # 67 had a change or decline from her baseline and now we know. The DON added that she had not seen the order to discontinue routine labs for Resident #67 and believed it was overlooked because the staff did not recognize the Hospice Medical Director's name. An interview on 3/22/18 at 2:36pm with the Administrator revealed his expectation from Hospice services was to communicate any changes or addition to services to the team to better care for the resident.	F 849		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		4/19/18

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F 867	Continued From page 43 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews, and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions that the committee put into place in March 2017 and May 2017. This was for three deficiencies cited during the facility's recertification and complaint investigation survey conducted on 2/16/17, F 584, F 636 and F 657 and one deficiency recited during the facility's revisit and complaint survey conducted on 4/10/17, F 584. The deficiencies were in the areas of housekeeping and maintenance services, comprehensive assessments and care plan timing and revision. The continued failure of the facility to sustain compliance, during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a. F 584 Housekeeping and maintenance services. Based on observations, interviews with Resident #53, a family member, and staff, the facility failed to maintain clean floors for 5 consecutive days in 6 of 20 resident rooms (301, 305, 310, 311, 319 and 321) on 1 of 3 units.	F 867	Rooms cited during the survey (301, 305, 310, 311, 319, 321) have been cleaned. The CAA for residents #35, #43, and #245 were completed. Residents #35, #43, and #245 Care Plans were reviewed and updated to accurately reflect the resident's CAA (Care Area Assessment). All resident rooms and common area floors have been swept and mopped. All other current residents CAA (Care Area Assessments) were audited for completion. Current residents Care Plans were also reviewed and updated to accurately reflect residents' CAA (Care Area Assessment). All facility housekeeping staff have been retrained on the facility's contracted cleaning service room and floor cleaning process. A monthly cleaning schedule has been implemented to ensure each resident room is deep cleaned monthly and upon discharge of existing residents. Common areas will be addressed daily and as needed. The MDS Coordinator and Director of Nursing Services have been to recent training sponsored by DHHS. To help ensure the deficient practice does	

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F 867	Continued From page 44 The facility was recited during this survey for F 584 for failure to maintain clean floors in resident rooms. The F 584 was originally cited during a recertification and complaint investigation survey on 2/16/17 for failure to repair a commode, loose faucets on bathroom sinks, an over bed table, cracked window glass, resident wardrobes, broken floor tiles and paint door frames. The F584 was also cited during a revisit and complaint investigation survey on 4/10/17 for failure to secure a loose bathroom grab bar, repair a resident's room door and broken floor tiles. 1b. F 636 Comprehensive assessments. Based on observations, staff interviews and record review, the facility failed to complete Care Area Assessments (CAA) that addressed and provided an analysis of underlying causes and contributing factors for triggered areas of nutrition for 2 of 3 sampled residents (Residents #35 and 43) and pressure ulcers for 1 of 3 sampled residents (Resident #245). The facility was recited during this survey for F 636 for failure to complete care area assessments related to nutrition and pressure ulcers. The F 636 was originally cited during a recertification and complaint investigation survey on 2/16/17 for failure to complete a comprehensive assessment related to cognition and the use of psychoactive medications. 1c. F 657 Care plan timing and revision. Based on observations, staff interviews and record review, the facility failed to develop a pressure ulcer care plan to meet the resident care needs for 1 of 3 sampled residents (Resident # 245).	F 867	not reoccur, a minimum of 5 resident surveys will be conducted weekly to help ensure satisfaction. Bi- Monthly meetings will be held with housekeeping services to review findings. The facility MDS Coordinator will conduct a weekly audit of all Admission, Annual, and Significant Change Assessments to ensure CAA (Care Area Assessments) are complete. A Bi-Monthly Meeting held by the Director of Nursing Services and MDS Coordinator will be conducted with Interdisciplinary Care Plan Team to review CAA (Care Area Assessments) for acceptance. Results will be shared with Administrator twice monthly, and the facility Quality Assurance and Performance Improvement Committee Monthly until substantial compliance is achieved.	

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F 867	Continued From page 45 The facility was recited for F 657 for failure to develop a pressure ulcer care plan. The F 657 was originally cited during a recertification and complaint investigation survey of 2/16/17 for failure to develop a discharge care plan for a resident with active discharge plans. Interview with the Administrator and Director of Nursing (DON) on 03/22/18 at 4:05 PM revealed that the repeat concerns related to housekeeping and maintenance services was originally cited in regards to facility repairs and not housekeeping services, so the QAA monitoring would have focused on maintaining facility repairs and not housekeeping services. The DON stated that the repeat concerns with comprehensive assessments and care plans was related to a communication barrier regarding which staff was responsible for the completion of these tasks and what information to include. The Administrator further stated that he also attributed repeat deficiencies to staff turnover in each of the departments and a need for re-education.	F 867		