

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

PRINTED: 04/23/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/20/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>AUTUMN CARE OF MOCKSVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1007 HOWARD STREET</b> <b>MOCKSVILLE, NC 27028</b>		
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E 000	Initial Comments	E 000			
F 000	An unannounced Recertification and Complaint survey was conducted on 03/17/19 through 03/20/19. The facility was found in compliance with the requirements CFR 483.73, Emergency Preparedness. Event ID S5M311.	F 000			
F 656 SS=D	INITIAL COMMENTS  This 2567 was posted a day late on 04/04/19 due to miscalculation of the exit date.  Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656	4/14/19		

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

TITLE

(X6) DATE

Electronically Signed

04/16/2019

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

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F 656	<p>Continued From page 1</p> <p>rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interviews, the facility failed to implement a resident centered care plan intervention to anchor catheter tubing for 1 of 3 residents reviewed with an indwelling urinary catheter (Resident #379).</p> <p>Findings Included:</p> <p>Resident #379 was admitted into the facility on 03/01/19 with diagnoses that included benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, sepsis(harmful bacteria in blood stream or tissues) due to e-coli (intestinal bacteria), obstructive uropathy (blockage of urine), and muscle weakness.</p> <p>A review of Resident #379's admission Minimum Data Set Assessment dated 03/09/19 revealed the resident to be moderately cognitively impaired. Resident #379 was coded as requiring extensive assistance with personal hygiene, toilet use, dressing, transfer, and bed mobility.</p>	F 656	<p>This plan of constitutes our written plan of compliance for deficiencies cited; however, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.</p> <p>A catheter anchor was placed on Resident #379 on 3/20/19 by the clinical manager per the care plan intervention. The resident did not suffer any negative outcomes.</p> <p>To identify other residents who have the potential to be affected, a review of care plans for all residents who had catheter was performed by the clinical manager on 3/20/19 to ensure all residents had anchors placed per their care plan.</p>		

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F 656	<p>Continued From page 2</p> <p>Resident #379 was coded as having an indwelling catheter.</p> <p>A review of Resident #379's initial care plan dated 03/09/19 revealed a care plan intervention that stated for the staff to ensure the catheter tubing was anchored and checked every shift.</p> <p>A review of Resident #379's Kardex (a form detailing care and care plan interventions for a specific resident to nurse aides working with the resident) revealed Resident #379's catheter tubing was to be anchored and checked to ensure it was anchored every shift.</p> <p>During an interview with Resident #379 on 03/17/19 at 2:47 PM, he reported when he came to the facility from the hospital his catheter tubing had been anchored to his leg with the use of tape. He continued, stating the tape had since come off and the catheter tubing was not currently anchored to his leg.</p> <p>During an interview with Resident #379 on 03/20/19 at 1:35 PM, it was revealed that Nurse Aide (NA) #3 had provided personal hygiene care to him earlier in the day. He stated NA #3 provided good care but stated his catheter tubing was still not anchored to his leg.</p> <p>During an interview on 03/20/19 at 2:13 PM with NA #3 she indicated she had worked with Resident #379 several times since his admission and confirmed she had given him a bath and completed catheter care on 03/20/19. She reported she noticed that Resident #379's catheter tubing was not anchored to his leg and stated she did not anchor the tubing at that time because "it's something the nurse has to do".</p>	F 656	<p>To prevent this from recurring, on 3/25/19 the unit manager began education to the nursing staff and CNAs on the importance following care plan interventions including anchoring of catheters. All nurses and aides will receive this education.</p> <p>This education will be provided upon orientation for all newly hired/agency staff.</p> <p>To monitor and maintain ongoing compliance, the DON or designee will review each resident with catheters weekly for 12 weeks, to ensure that catheters are anchored based on the residents plan of care. These audits will begin on 4/9/19. Any negative findings will be corrected immediately.</p> <p>The results of the audits will be forwarded to the monthly facility QAPI committee for further review and recommendations for 12 weeks. The DON is responsible for compliance.</p>		

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F 656	Continued From page 3 She reported she was made aware of a resident's care plan interventions by looking at the resident's Kardex which was a part of the resident's electronic medical record. She stated she had access to Resident #379's Kardex and knew his catheter tubing should have been anchored to his leg. NA #3 indicated she had not notified the hall nurse of Resident #379's catheter tubing not being anchored to his leg and did not provide a reason why it had not been reported.  During an interview with Hall Nurse #6 on 03/20/19 at 2:20 PM, he reported it was the hall nurse's responsibility to ensure catheter tubing was anchored to a resident's leg. He stated he relied on the floor NA's to notify him of any issues with catheters when they provided catheter care. He stated he had not been informed the catheter tubing for Resident #379 was not anchored until NA #3 reported it to him after the surveyor spoke with her about it. He further stated it was the responsibility of the hall NAs to monitor the catheter tubing when they provided catheter care and to notify the nurses if the tubing was not anchored.  During an interview with the Director of Nursing on 03/20/19 at 3:10PM, she reported Resident #379's catheter tubing should be anchored to his leg. She reported it was her expectation that resident care plans be implemented and followed as written. She stated it was all floor staff's responsibility to ensure catheter tubing was anchored but the hall nurses were responsible for placing the leg strap.	F 656			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		4/14/19	

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F 658	<p>Continued From page 4</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to initiate a bowel protocol for a resident that had not had a bowel movement in 5 days for 1 of 5 resident sampled for unnecessary medications (Resident #48).</p> <p>The findings included:</p> <p>Review of a documents titled "Admission Protocols in the electronic health record" read in part,</p> <ul style="list-style-type: none"> <li>-Milk of Magnesia (laxative) 30 milliliters (ml) by mouth if no bowel movement in 3 days.</li> <li>-Dulcolax 10 mg suppository if no bowel movement from the laxative.</li> <li>-Enema if no bowel movement from the suppository.</li> </ul> <p>Resident #48 was admitted to the facility on 11/19/18 and most recently readmitted on 12/14/18 with diagnoses that included: constipation and others.</p> <p>Review of the comprehensive minimum data set (MDS) dated 02/05/19 revealed that she was moderately impaired for daily decision making and required extensive assistance of 1 person with toileting. The MDS also indicated that Resident #48 rejected care 1 to 3 days during the assessment reference period and was frequently incontinent of bowel.</p>	F 658	<p>Bowel protocol was initiated on Res #48 on 3/20/19. Resident was monitored to ensure effective results. Resident did not have any negative outcome from observation during survey.</p> <p>To identify other residents who have the potential to be affected by this deficiency, a 100% of all residents <input type="checkbox"/> bowel documentation was checked by the DON on 3/20/19 to ensure all residents have had a bowel movement. Any resident who was identified as not having a bowel movement in 3 days was assessed and bowel protocol initiated.</p> <p>To prevent this from re-occurring, on 3/20/19, the DON initiated in-servicing to the nurses and CNA staff on the bowel protocol including documentation of bowel movements. All nurses and aides will receive this education. Bowel alerts will be reviewed in clinical morning meeting. Any identified concerns will be followed up on, to ensure the bowel protocol is initiated. All new hires will receive education through the orientation process.</p> <p>To monitor ongoing compliance, on 4/9/19 the DON or designee will perform an audit of 10 residents weekly for 12 weeks, to</p>		

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F 658	<p>Continued From page 5</p> <p>Review of a facility bowel movement record indicated that Resident #48 had no bowel movement on 02/24/19, 02/25/19, 02/26/19, 02/27/19, 02/28/19, and 03/01/19.</p> <p>Review of Resident #48's medication administration record (MAR) dated 02/01/19 through 02/28/19 revealed that she had received no milk of magnesia, Dulcolax suppository, or enema as directed by the admission protocol sheet on or after 02/24/19 through 02/28/19.</p> <p>Review of Resident #48's MAR dated 03/01/19 through 03/31/19 revealed that no milk of magnesia, Dulcolax suppository, or enema had been administered as directed by the admission protocol thus far in the month of March 2019.</p> <p>An interview was conducted with Nurse #5 on 03/19/19 at 5:12 PM. Nurse #5 stated that the Nursing Assistants (NA) documented in the medical record each time the resident had a bowel movement and every day the nurses ran a bowel movement report to identify who had not had a bowel movement in 3 days. Nurse #5 stated that when a resident did not have bowel movement for 3 days they were to initiate the bowel protocol that started with milk of magnesia. Nurse #5 confirmed that she worked with Resident #48 on 02/28/19 and 03/01/19 but could not recall if she had appeared on the bowel report or not. She added if she had started the protocol or if she had given her something for constipation it would documented on the MAR.</p> <p>An interview was conducted with Nurse #3 on 03/20/19 at 8:38 AM. Nurse #3 confirmed that she was familiar with Resident #48 and cared for her often. She stated that the NAs documented</p>	F 658	<p>ensure that there has been a bowel movement at least every three days, and that the bowel protocol was initiated as necessary.</p> <p>The results of the audits will be forwarded to the QAPI committee for review and further monitoring.</p> <p>The DON is responsible for compliance.</p> <p>Compliance date is 4/14/19</p>		

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F 658	<p>Continued From page 6</p> <p>the resident bowel movements in the electronic medical record and if there was no bowel movement recorded in 3 days then the nurse was supposed to administer milk of magnesia per the standing order. If the milk of magnesia did not work then they were to give a Dulcolax suppository and continue until the resident had a bowel movement. Nurse #3 confirmed that Resident #48 was not supposed to toilet herself and had not witnessed her going to the bathroom by herself. Nurse #3 could not recall Resident #48 being on the bowel movement report or starting the bowel protocol but stated if she had initiated it, it would be documented in Resident #48's medical record.</p> <p>An interview was conducted with Medication Aide (MA) #1 on 03/20/19 at 9:47 AM. MA #1 confirmed that she had worked with Resident #48 on 02/27/19 and did not recall administering any medications on the bowel protocol sheet for constipation. MA #1 stated that the nurse that was working with her would run the bowel report and then communicate to her which resident had not had a bowel movement in 3 days and then she would administer the medication. MA #1 again confirmed that she did not recall any time that she had been instructed to administer a medication on the bowel protocol to Resident #48.</p> <p>An interview was conducted with NA #2 on 03/20/19 at 10:00 AM. NA #2 stated that when a resident had a bowel movement she would document it in the electronic medical record. She added the nurse would run a bowel movement report everyday and follow up on any resident that has not had a bowel movement in 3 days. NA #2 stated that Resident #48 was not able to toilet</p>	F 658			

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F 658	<p>Continued From page 7</p> <p>herself but was able to alert the staff to her toileting needs. NA #2 confirmed that she had worked with Resident #48 on 02/27/19 and 02/28/19 and could not recall specifically if she had a bowel movement or not but stated if she did she would have documented the bowel movement in the electronic medical record. She added that she could not recall a time when Resident #48 had appeared on the bowel report.</p> <p>An interview was conducted with Nurse #1 on 03/20/19 at 10:03 AM. Nurse #1 stated that each morning she ran a bowel report that included residents who had not had a bowel movement in 3 days and she would initiate the bowel protocol and give milk of magnesia. She confirmed that she cared for Resident #48 on 02/28/19 but could not recall if she was on the bowel report that day or not. Nurse #1 stated that she recalled Resident #48 being on the bowel report in the past but could not specifically recall when. She stated if she would have started the bowel protocol it would be documented in Resident #48's medical record.</p> <p>An interview was conducted with Nurse #4 on 03/20/19 at 10:09 AM. Nurse #4 confirmed that had cared for Resident #48 on 03/01/19 but could not recall if she had appeared on the bowel report that day or not. She did not recall starting the bowel protocol on Resident #48 but stated if she had it would be documented in the medical record.</p> <p>An interview was conducted with the Director of Nursing (DON) on 03/20/10 at 2:30 PM. The DON stated that each morning she ran a bowel movement report and took the report to the nurses to make sure they were following up on</p>	F 658			



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F 658	Continued From page 8 the residents that appeared on the report. The DON stated she could not specifically recall Resident #48 appearing on the record but stated she often toileted herself without the staff knowledge. The DON stated that if Resident #48 appeared on the bowel report as having no bowel movement in 3 days then she expected the Nurse to follow up and see if the resident had a bowel movement and if not then to start the bowel protocol as directed.	F 658			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		4/14/19	

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F 690	<p>Continued From page 9 continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to ensure catheter tubing was anchored to a resident's leg to prevent it from being dislodged for 1 of 3 residents reviewed with indwelling urinary catheter(Resident #379).</p> <p>Findings Included:</p> <p>Resident #379 was admitted into the facility on 03/01/19 with diagnoses that included benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, sepsis (harmful bacteria in blood stream or tissues) due to e-coli (intestinal bacteria), obstructive uropathy (blockage of urine), and muscle weakness.</p> <p>A review of Resident #379's admission Minimum Data Set Assessment dated 03/09/19 revealed resident to be moderately impaired cognitively for daily decision making. Resident was coded as requiring extensive assistance with personal hygiene, toilet use, dressing, transfer and bed mobility. Resident #379 was coded as having had an indwelling catheter.</p> <p>A review of Resident #379's physician orders revealed an order dated 03/05/19 to Anchor</p>	F 690	<p>The catheter anchor was immediately placed on the resident. The resident did not have any negative outcome.</p> <p>To identify other residents who have the potential to be affected by this deficiency, the clinical manager assessed all residents on 3/20/19 that had catheters to ensure that all residents had anchors in place. For residents that refused, education was provided on risks and benefits, and this was documented in the clinical record.</p> <p>To prevent this from re-occurring, beginning 3/20/19 the DON in-serviced the licensed nurses and CNA staff on the importance of ensuring that catheter anchors were in place. The task of observing for anchor placement is added to the task for each shift in the EHR.</p> <p>Education on this expectation will be provided in new hire orientation.</p> <p>To monitor ongoing compliance, starting on 4/14/2019, the DON or designee will</p>		

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F 690	<p>Continued From page 10 catheter tubing and check placement every shift.</p> <p>During an interview with Resident #379 on 03/17/19 at 2:47 PM, he reported when he came to the facility from the hospital his catheter tubing had been anchored to his leg with the use of tape. He continued, stating the tape had since come off and the catheter tubing was not currently anchored to his leg.</p> <p>During an interview with Resident #379 on 03/20/19 at 1:35 PM, it was revealed Nurse Aide (NA) #3 had provided personal hygiene care to him earlier in the day. He stated NA #3 provided good care but stated his catheter tubing was still not anchored to his leg.</p> <p>An interview with NA #3 on 03/20/19 T 2:13PM revealed she had worked with Resident #379 several times since his admission and confirmed she had given him a bath and completed catheter care on 03/20/19. She reported she noticed that Resident #379's catheter tubing was not anchored to his leg at that time and stated she did not anchor the tubing at that time because "it's something the nurse has to do". She indicated she had not reported the tubing was not anchored to Resident #379's leg to the hall nurse and did not provide a reason as to why. She reported she had been informed previously by the Director of Nursing that catheter tubing had to be anchored to a resident's leg but did not specify when. She reported she had not notified the DON of the unsecured catheter tubing.</p> <p>During an interview with Hall Nurse #6 on 03/20/19 at 2:20 PM, he reported it was the hall nurse's responsibility to ensure catheter tubing was anchored to a resident's leg. He stated he</p>	F 690	<p>perform weekly audits on all resident with catheters to ensure anchors are in place or that education is present in the chart for any residents that refuse for 12 weeks.</p> <p>The results of the audits will be forwarded to the QAPI committee for review and further monitoring.</p> <p>The DON is responsible for compliance.</p>		

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F 690	Continued From page 11 relied on the floor NAs to notify him of any issues with catheters when they provided catheter care. He stated he had not been informed the catheter tubing for Resident #379 was not anchored until NA #3 reported it to him earlier in his shift that day. He further stated it was the responsibility of the hall NAs to monitor the catheter tubing when they provided catheter care and to notify the nurses if the tubing was not anchored.  During an interview with the Director of Nursing on 03/20/19 at 3:10 PM, she reported it was her expectation that catheters be anchored to resident's legs as ordered to prevent pulling of the catheter tubing and potential discomfort to the resident. She reported Resident #379's catheter tubing should have been anchored to his leg. She stated it was all floor staff's responsibility to ensure catheter tubing was anchored but the hall nurses were responsible for placing the leg strap.	F 690			
F 695 SS=E	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 review, and staff interview the facility failed to ensure oxygen was administered to the resident as ordered and failed to replace the oxygen tubing after it had been on	F 695	Although resident #25 was discharged during the survey, the oxygen tubing that had been observed on the floor was removed by DON and replaced with	4/14/19	

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F 695	<p>Continued From page 12</p> <p>the floor for 1 of 3 residents sampled with oxygen (Resident #25).</p> <p>The Findings included:</p> <p>Resident #25 was admitted to the facility on 03/11/14 and most recently readmitted on 11/02/17.</p> <p>Resident #25 was discharged from the facility on 03/19/19. Her diagnoses included encephalopathy, cognitive communication deficit, tremor, anxiety, depression, hyperkalemia, kidney failure, and chronic obstructive pulmonary disease.</p> <p>Review of a physician order dated 11/02/17 read, oxygen at 2 liters per minute via nasal cannula.</p> <p>Review of the quarterly minimum data set (MDS) dated 01/11/19 revealed that Resident #25 was severely cognitively impaired for daily decision making and required extensive assistance with activities of daily living. The MDS further revealed that Resident #25 rejected care 1 to 3 days during the assessment reference period and required oxygen. The MDS indicated that no shortness of breath was observed during the assessment reference period.</p> <p>An observation of Resident #25 was made on 03/17/19 at 11:40 AM. Resident #25 was resting in bed with eyes open. She was alert and verbal. There was an oxygen concentrator that was on and set to 1.5 liter per minute. The oxygen tubing and cannula was laying on the floor half way under Resident #25's bed. The oxygen tubing was dated 03/04/19. Nursing Assistant (NA) #1 and Nurse #2 entered the room to get Resident #25 dressed and up to her wheelchair. During the</p>	F 695	<p>tubing on 3/18/19.</p> <p>The residents did not have any negative outcome as a result of this observation.</p> <p>To identify other resident who have the potential to be affected, on 3/18/19 the clinical manger completed 100% audit on all residents to ensure Oxygen was administered as ordered, tubing was dated and stored appropriately.</p> <p>To prevent this from recurring, on 3/21/19 the DON initiated education to the nurses and CNAs on proper storage of oxygen tubing, and the requirement to administer oxygen as ordered. Education will be provided to all nurses and aides.</p> <p>This education will be provided upon orientation for all newly hired/agency staff</p> <p>To monitor and maintain ongoing compliance, starting 4/8/19, the ADON or designee will review 5 residents weekly for 12 weeks, to ensure the tubing is dated stored appropriately, and will ensure that the delivery of oxygen is at the ordered rate. Any negative findings will be corrected.</p> <p>The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.</p> <p>The wound nurse is responsible for compliance.</p>		

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F 695	<p>Continued From page 13</p> <p>care that was provided Resident #25's oxygen tubing remained lying in the floor half way under the bed. Once Resident #25 was dressed and the lift pad placed under her, NA #1 picked up the oxygen tubing and laid it across the oxygen concentrator in the room. Resident #25 was transferred with the sit to stand lift from her bed to wheelchair with the assistance of NA #1 and Nurse #2. Once in the wheelchair that was observed to have no portable oxygen tank on the back of it, Resident #25 was pushed from her room to the television room with no oxygen in place. Resident #25 appeared to be in no respiratory distress.</p> <p>An observation of Resident #25 was made on 03/17/19 at 12:20 PM. Resident #25 was sitting up in her wheelchair in the dining area waiting on her lunch tray. She was observed to have no oxygen cannula on and no portable oxygen tank was on her wheelchair. She appeared to be in no respiratory distress.</p> <p>An observation of Resident #25 was made on 03/17/19 at 3:50 PM. Resident #25 was sitting up in her wheelchair beside her bed. She was observed to have an oxygen cannula in her nose that was dated 03/04/19 and had previously been laying on the floor. The oxygen concentrator was turned to 2 liters per minute and she was in no respiratory distress.</p> <p>An interview was conducted with Nurse #3 at 3:53 PM. Nurse #3 confirmed that she was caring for Resident #25 and confirmed that Resident #25 should have her oxygen on at all time and if she did not her oxygen level would drop very quickly. Nurse #3 further stated that Resident #25 should have a portable oxygen tank on her wheelchair</p>	F 695			

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F 695	<p>Continued From page 14</p> <p>and she was not sure why she did not but indicated she would get one in place. Nurse #3 stated that if the oxygen tubing that was dated 03/04/19 had been laying on the floor then it should have been immediately thrown in the trash and a new cannula applied.</p> <p>An interview was conducted with the Director of Nursing (DON) on 03/17/19 at 3:57 PM. The DON stated that if Resident #25's oxygen tubing had been on the floor then it should have been immediately placed in the trash and a new one applied.</p> <p>An observation of Resident #25 was made on 03/18/19 at 11:29 AM. Resident #25 was observed to be participating in a group activity in the dining area. She was observed to have no oxygen in place and no portable oxygen tank on the back of her wheelchair. She appeared to be in no respiratory distress.</p> <p>An observation of Resident #25 was made on 03/18/19 at 3:11 PM. Resident #25 was observed to be up in her wheelchair in a group music activity. She was smiling and singing along to the music. Resident #25 was observed to have no oxygen in place and no portable oxygen tank on the back of her wheelchair. She appeared to be in no respiratory distress.</p> <p>An observation of Resident #25 was made on 03/19/19 at 9:12 AM. Resident #25 was resting in bed with her eyes open. She was observed to have no oxygen in place. There was an oxygen contractor that was on and set to 2 liters per minute. There was an oxygen cannula laying on the floor that was dated 03/18/19. Resident #25 appeared to be in no respiratory distress.</p>	F 695			

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F 695	Continued From page 15  An observation of Resident #25 was made on 03/19/19 at 10:01 AM. Resident #25 was up in her wheelchair in the common dining area. She was observed to have no oxygen in place and no portable oxygen tank to the back of her wheelchair. She appeared to be in no respiratory distress.  A follow up interview was conducted with the Director of Nursing (DON) on 03/20/19 at 2:14 PM. The DON stated that Resident #25 frequently removed her oxygen and the staff would replace it frequently and encourage her to leave the oxygen in place. The DON stated that she expected Resident #25 to have her oxygen in place as ordered and if the oxygen tubing had been in contact with the floor it should be thrown in the trash and a new cannula applied.	F 695			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		4/14/19	



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F 761	<p>Continued From page 16</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview the facility failed to remove expired medications from 1 of 3 medications carts reviewed (100 hall middle cart).</p> <p>The findings included:</p> <p>Review of a facility policy titled "Storage and Expiration of Medications, Biologicals, Syringes, and Needles" revised 10/31/16 read in part, facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with policy 8.2 return/destruction of expired or discontinued medications.</p> <p>An observation of the middle 100 hall medication cart was made on 03/20/19 at 10:10 AM. In the middle drawer of the medication cart and available for use was a card of 30 Zofran (used for nausea/vomiting) 4 milligram (mg) that contained an expiration date of 12/2018 and card of 29 Phenergan (used for nausea/vomiting) 25 mg that expired 12/31/18.</p> <p>An interview with Nurse #1 was conducted on 03/20/19 at 10:29 AM. Nurse #1 stated that the facility would randomly pick a nurse to go through</p>	F 761	<p>The two expired medications found on the one cart were removed immediately by the DON and returned to pharmacy. No residents were affected by this deficient practice.</p> <p>To identify other residents who have the potential to be affected by this deficiency, a 100% of all medication carts were checked by the clinical manger on 3/23/19 any identified issues were corrected.</p> <p>To prevent this from re-occurring, beginning 3/20/19 the DON began in-servicing to the licensed nursing staff as well as the Medication Aides on proper medication storage. All nurses and medication aides will receive this education.</p> <p>Medication storage policy will be covered in new hire orientation.</p> <p>To monitor ongoing compliance, starting on 4/8/19 the DON or designee will perform a complete audit of 2 medication carts weekly for 12 weeks.</p>		

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F 761	<p>Continued From page 17</p> <p>the medication carts to look for expired medications. She stated that she had not gone through the medication cart but tried to look at the expiration dates of the medications that she was administering. Nurse #1 stated that the expired medications should have been removed from the medication cart and returned to the pharmacy.</p> <p>An interview was conducted with the Consultant Pharmacist (CP) on 03/20/19 at 9:15 AM. The CP stated that she visited the facility monthly and when she did she would review a portion of the medication storage areas each time she visited the facility. The CP stated she would always educate the staff while she was performing the medication storage review so that it could be reviewed during the facility's quality assurance meeting.</p> <p>An interview was conducted with the Director of Nursing (DON) on 03/20/19 at 2:49 PM. The DON stated that she expected the expired medications to be removed from the medication cart and returned to the pharmacy. She stated that the administrative nurses performed a weekly audit to make sure things were dated as they should be. The weekly audits also included checks for cleanliness, expiration dates, and cart neatness. The DON stated that the Assistant Director of Nursing (ADON) had gone through the medication carts last evening and had not caught the expired medications.</p> <p>An interview was conducted with the ADON on 03/20/19 at 3:13 PM. The ADON stated that had gone through the medication carts last evening to make sure everything was dated and stored appropriately but she had not checked the cards for expiration dates.</p>	F 761	<p>The results of the audits will be forwarded to the QAPI committee for review and further monitoring.</p> <p>The DON is responsible for compliance.</p>		

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