STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255213	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADVILLE CONVALESCENT HOME	300 HWY 556/ROUTE 2 BOX 66 MEADVILLE, MS 39653

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey from 12/3/19 to 12/5/19 . During the survey, The SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F641, F644, F656, F657, and F695. The census at time of survey was 58, and the facility was licensed for 60 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessment, related to hospice for Resident #50, anti-coagulant medications for Resident #25, and oxygen therapy for Resident #30; for three (3) of 20 residents MDS assessments reviewed. Findings include: Review of the "Long-Term Care Facility Resident Assessment Instrument (RAI) Version 3.0 Manual", revised October 2019, revealed the RAI process is the basis for the accurate assessment of each resident. Resident #50 Review of Resident #50's Significant Change Minimum Data Set (MDS) assessment, with an	F 641	Tag 0641 1. Corrective action was accomplished for resident #50 by the Minimum Data Set (MDS) nurse doing a correct MDS following the RAI manual on 12/05/19 to include resident being on Hospice care. Corrective action for resident #50 was done on 12/05/19 by updating the resident care plan to include Hospice Care. Corrective action was accomplished for resident #30 by the MDS nurse completing a correct MDS following the RAI manual to include oxygen use on 12/05/19. The care plan was updated to include oxygen use on 12/05/19. Corrective action was accomplished for resident #25 by the MDS nurse doing a corrected MDS following the Resident	12/30/19

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

Electronically Signed | 12/30/2019

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F 641	Continued From page 1 Assessment Reference Date (ARD) of 11/15/19, revealed, "Special Treatments and Programs", documented, "none of the above", and "Hospice" was left blank. Review of Resident #50's physician's orders, dated 11/4/19, revealed an order to admit to hospice, related to Liver Cancer. During an interview, on 12/05/19 at 12:55 PM, Registered Nurse (RN) #1/MDS Coordinator, confirmed Resident #50's MDS, with an ARD of 11/15/19, was not accurately coded for hospice, and it would affect the Care Area Assessments (CAAs), which trigger care plans. RN #1 stated the Resident Assessment Instrument (RAI) manual is followed to complete the MDS correctly. Resident #30 Review of Resident #30's most recent Quarterly MDS assessment, with an ARD of 10/21/19, revealed the assessment did not document oxygen therapy. Observations of Resident #30 on 12/03/19 at 10:13 AM, 11:55 AM, 2:50 PM, and 3:39 PM; and on 12/04/19 at 8:51 AM, revealed Resident #30 was lying in bed with oxygen via nasal cannula (NC). A review of Resident # 30's December 2019 physician's orders, dated 2/15/19, revealed an order for oxygen at two (2) liters per nasal cannula, as needed for shortness of breath. An interview, on 12/05/19 at 9:40 AM, with the MDS/Care Plan Nurse/Licensed Practical Nurse (LPN) #1, confirmed Resident #30 had been on oxygen at the time of the most recent quarterly	F 641	Assessment Instrument (RAI) manual on 12/05/19 to correctly document Plavix as an anti-platelet, not an anti-coagulant. The care plan was also updated on 12/05/19 to reflect this change from anti-coagulant to anti-platelet. 2. All residents of the facility have the potential to be affected by this practice. 3. One on One Inservice was given on 12/05/19 by the Director of Nursing to the MDS nurses to check all documentation on all MDS's prior to transmission for accuracy. All care plans will be checked by the Registered Nurse (RN) MDS coordinator for accuracy at time of transmission. A weekly log will be kept by the RN MDS coordinator to ensure all careplans have been checked. This will begin on 12/29/19 on a weekly basis and continue for 6 months. 4. A weekly log will be kept by the RN MDS coordinator to ensure all care plans have been checked. This will begin on 12/29/19 and continue for 6 months. The MDS RN coordinator will bring the weekly logs to all Quality Assurance meetings for 6 months to assure compliance by the Quality Assurance Committee. 5.	

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F 641	Continued From page 2 MDS assessment, dated 10/21/19. LPN #1 confirmed Resident #30's assessment was not marked to indicate the resident received oxygen, while a resident of the facility. LPN #1 stated it was overlooked when the assessment was completed. Resident #25 Review of Resident #25's Quarterly MDS assessment, with an ARD of 10/15/19, revealed the resident received an Anti-coagulant medication for four (4) days. Review of physician orders, dated 12/14/16, revealed Resident #25 had an for Plavix 75 milligrams (mg), by mouth for circulation. There was no order for an anti-coagulant medication for Resident #25. During an interview, on 12/05/19 at 12:42 PM, LPN #1/Care Plan Nurse, and the Director of Nursing (DON), stated Resident #25's MDS assessment was marked to indicate the resident was taking an anticoagulant, but the MDS assessment was incorrectly marked, because Plavix is an anti-platelet, not an anti-coagulant.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		12/30/19

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F 644	Continued From page 3 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to refer a resident for a Level II screening, when she was identified with a newly evident serious mental disorder, for one (1) of five (5) resident Pre-admission Screening and Resident Review (PASARR)s reviewed, Resident #31. Findings include: Review of the facility's "Admission to Facility + Admission Checklist", revised 11/28/17, revealed a Pre-Admission Screening (PAS) must be completed prior to admission. The policy did not address if a resident was later assessed or identified with newly evident or possible serious mental diagnosis, or a related condition, to refer the resident for a Level II screening. Review of Resident #31's Pre-Admission Screening, dated 08/21/18, documented the resident had no major mental illness, but was taking psychotropic medications. Review of a letter from the state-designated screening authority, dated 08/27/18, indicated	F 644	Tag 0644 1. The corrective action for resident #31 was taken on 12/05/19 by the Pre-Admission Screening (PAS) Licensed Practical Nurse (LPN) completing a corrected PAS and submitting it for Level II Pre-Admission Screening and Resident Review (PASARR) evaluation. The resident was assessed by the Registered Nurse (RN) charge nurse on return from the behavior unit with new diagnosis and medicine change. The medication nurses monitored the resident for any adverse affects from medicine and change in behavior daily for seven days. The PAS LPN assessed the residents chart and behavior on 12/05/19 when the level II was discovered missing, prior to sending a new PAS. No problems were noted with resident or in resident's chart. 2. All residents of the facility have the potential to be affected by this deficient practice. 3. The PAS nurse was provided new guidelines by the State Medicaid office on submitting Level II PASARR screenings	

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F 644	Continued From page 4 Resident #31 had a Negative Level I screening, and was appropriate for nursing home placement. No Level II screening was required at the time of admission to the facility. A review of Resident # 31's History and Physical, dated 08/21/19, from admission for a Geri-psyche stay, revealed the resident was involved in disagreements with other residents and made threatening remarks. A review of Physician's Orders for, Resident # 31, revealed an order, dated 08/28/19, of return to the facility from a hospital stay with a change in medications including addition of Risperdone 1 milligram (mg), three (3) tablets at hour of sleep (HS), for Bipolar Disorder. There was no indication in the medical record that the resident had been referred for a level II screening, with this new diagnosis and medication prescribed. An interview on 12/04/19 at 11:35 PM, with Licensed Practical Nurse (LPN) #2, revealed Resident #31 was hospitalized at a Geri-psyche unit a few months ago, because she became threatening to staff and others. An interview on 12/04/19 at 11:50 AM, with the Director of Nursing (DON), revealed she did not think Resident #31 had been referred for a level II screening, after being diagnosed with Bipolar Disorder, and being prescribed Risperdone. The DON confirmed the resident went out for a Geri-psyche hospitalization, related to her becoming threatening to staff and other residents. An interview on 12/05/19 at 8:50 AM, with LPN #3, revealed she completed the PAS form when residents were admitted. LPN #3 confirmed	F 644	with all new mental diagnosis on all residents on 12/05/19. The new guidelines were reviewed by the Director of Nursing (DON) with the PAS nurse and she added the changes to her assessment binder. The PAS nurse will look at all new orders on a daily basis to ensure no new diagnosis/mental health/medications are missed. This was started on 12/05/19. 4. The Quality Assurance (QA) nurse will check all new orders daily for changes in mental diagnosis that require a new PASARR evaluation and bring all changes to the Quality Assurance meetings for review and to ensure compliance by the Quality Assurance committee. This will be done for each Quality Assurance meeting for six months.	

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F 644	Continued From page 5 Resident # 31 had a negative level I screening, so the resident did not get referred for a level II screening on admission. LPN #3 stated she was unaware she should refer a resident for a level II PASARR evaluation, if a resident was identified with a newly evident or possible serious mental diagnosis. LPN #3 confirmed Resident #31 was threatening staff and other residents and was admitted to Geri-psyche. LPN #3 confirmed Resident #31 returned with a diagnosis of Bipolar Disorder, and had orders for Risperdone, an anti-psychotic medication.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable 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	F 656		12/30/19

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F 656	Continued From page 6 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan, related to hospice for Resident #50, and failed to develop a care plan, related to oxygen usage, for Resident #30; for two (2) of 20 comprehensive care plans reviewed. Findings include: Review of the facility's "Comprehensive Plan of Care", policy, with a revised date of 11/28/17, revealed the facility would develop a comprehensive plan of care for each resident, which would include the services to be furnished, to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Resident #50	F 656	Tag 0656 1. Corrective action for resident #50 was taken on 12/05/19 by the MDS nurse updating the care plan reflecting Hospice care. The Minimum Data Set (MDS) nurses were inserviced by the Director of Nursing (DON) on 12/05/19 regarding checking all orders during assessment period to ensure all boxes are checked appropriately on the MDS and the care plans updated accordingly. Corrective action for resident #30 was completed on 12/05/19 by updating care plan to include oxygen use and shortness of breath. 2. All residents in the facility have the potential to be affected by this practice.	

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F 656	Continued From page 7 Review of Resident #50's comprehensive care plan, with target dates of 12/15/19, revealed he did not have a care plan related to hospice services. Review of Resident #50's physician's orders, dated 11/4/19, revealed an order to admit the resident to Hospice services, related to a diagnosis of Liver Cancer. An interview, on 12/04/19 at 12:07 PM, with Registered Nurse (RN) #1/MDS Coordinator, confirmed Resident # 50's did not have a comprehensive care plan, related to Hospice services. She stated the care plan should have been developed, so the staff would be aware of the change in status. An interview, on 12/05/19 at 12:19 PM, with the Director of Nursing (DON), revealed the expectation was to develop a comprehensive care plan, after a comprehensive assessment; and Resident #50's care plan should have included the Hospice admission. Resident #30 Review of Resident #30's current comprehensive care plan, with target dates of 1/25/20, revealed no care plan related to shortness of breath or oxygen use. Observations on 12/03/19 at 10:13 AM, 11:55 AM, 2:50 PM, and 3:39 PM; and on 12/04/19 at 8:51 AM, revealed Resident #30 was lying in bed with oxygen (O2) usage from an oxygen concentrator. Review of Resident #30's December 2019 physician's orders, revealed an order, dated 2/15/19, for oxygen 2 liters per minute via nasal	F 656	3. The Registered Nurse (RN) Minimum Data Set(MDS) coordinator will check all care plans for accuracy with each MDS transmission to ensure all orders during assessment period have been updated beginning 12/29/19. A weekly log will reflect a record of checking care plans for accuracy and will be kept by the RN MDS coordinator to ensure all care plans have been checked. This log will begin by 12/29/19 and will continue for 6 months. 4. The RN MDS coordinator will bring the care plan logs to the Quality Assurance meetings for review by the Quality Assurance committee to ensure compliance at every QA meeting for 6 months.	

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F 656	Continued From page 8 cannula as needed, related to shortness of breath. An interview, on 12/05/19 at 9:40 AM, with the Care Plan Nurse/Licensed Practical Nurse (LPN) #1, confirmed Resident #30 did not have a care plan developed for oxygen use. LPN #1 stated there should be a care plan to address the resident's shortness of breath and the use of oxygen. LPN #1 stated the resident had been using oxygen for several months.	F 656		
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	F 657		12/30/19

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F 657	Continued From page 9 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to revise the care plan, related to the use of oxygen, for one (1) of three (3) care plans reviewed for oxygen, Resident #31. Findings Include: Review of the facility's "Comprehensive Assessment and Re-Assessment", policy, revised 11/28/17, revealed any change in a resident's condition would require an immediate re-assessment, with changes in the plan of care, reflecting the change in condition. Review of Resident #31's Comprehensive Care Plan, initiated 08/27/19, revealed the resident at risk for pneumonia, related to a history of pneumonia, a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), and Asthma. There was also a care plan for smoking, which included the resident could go out to smoke with family and friends, but it did not address oxygen use. There was an intervention to administer medications as ordered, but not specific to include the use of oxygen. An observation on 12/03/19 at 10:32 AM, revealed Resident #31 in the hallway, at the door of her room, with oxygen (O2) administered via nasal cannula at 2 liters (L) per minute, with a portable O2 tank attached to the back of her wheelchair.	F 657	Tag 0657 1. Corrective action for Resident #31 done on 12/05/19 by updating care plan to include oxygen use. The charge nurse Licensed Practical Nurse (LPN) placed a sign on the resident door on 12/05/19. An order was obtained from the resident's Medical Doctor (MD) on 12/09/19 to use oxygen on a continuous basis at 2 liters per nasal canula. All nurses on schedule were in-serviced by the Registered Nurse (RN) Staff Educator on 12/04/19 to observe residents oxygen tank level every shift and upon returning from smoking. All smoking equipment is kept locked in the medication room so the residents are brought to the nurses station before and after smoking to ensure oxygen tanks are removed and replaced by a nurse. All nurses were also in-serviced to document every shift in the resident's Medical Record the oxygen is in use and the correct rate is used. Nurses not on schedule will be in-serviced upon hire and upon next working schedule. The DON educated the daughter regarding use of ordered rate of oxygen on 12/04/19. The above noted nurses in-service will ensure the oxygen tanks are removed and replaced by the nurses and not the daughter. 2. All residents that use oxygen in the facility have the potential to be affected by	

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F 657	Continued From page 10 Review of the December 2019 physician's orders, dated 10/29/18, for Resident #31, revealed orders for O2 saturation (sat) levels every (Q) shift; if below 90 percent (%), place O2 at 2L per minute, via nasal cannula. Observations on 12/03/19 at 11:12 AM, and 2:46 PM, revealed Resident #31 in the dining room, with O2 at 3L per minute, administered from a portable O2 tank. An observation and interview, in Resident #31's room, on 12/04/19 at 8:39 AM, revealed the oxygen concentrator was set on 2L per minute and the resident received the oxygen via bilateral nasal cannula. Resident #31 stated she had always been on 2L of oxygen. The resident stated the nurses check her Oxygen level two (2) or three (3) times a day. An interview on 12/04/19 at 11:45 AM, with the DON, confirmed she would expect the nurses to check O2 administration for residents, to make sure it is being administered at the correct rate. The DON stated the care plan should be revised to include Oxygen use, specific to Resident #31. An interview, on 12/05/19 at 8:35 AM, with the Care Plan Nurse/LPN #1, confirmed Resident #31 was care planned for COPD, Asthma, and history of Pneumonia, with an intervention to administer medications as ordered. LPN #1 stated she believed the care plan covered oxygen, as it is a medication, but it would be better to revise the care plan, to specifically address the use of oxygen for the resident, to make the care plan more person-centered. LPN #1 confirmed Resident #31 had been using oxygen for several months.	F 657	this practice. 3. All care plans of residents using oxygen were checked by the Minimum Data Set (MDS) nurse and updated accordingly. An in-service was given on 12/05/19 by the RN staff educator to all nurses to observe all oxygen tanks for proper rate of use every shift and upon returning from smoking. The in-service includes for nurses to remove oxygen tanks from wheelchair and replace them upon return from smoking. 4. The Quality assurance nurse will observe the documentation of oxygen use to ensure the correct dose ordered is being administered and checked every shift on a weekly basis for six months. The medication nurse will document every shift on the oxygen observation log in the medical administration record. The QA nurse will bring her weekly observation check list to all Quality Assurance meetings for the committee to review for six months. 5. The corrective action will be completed by 12/29/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255213	A. BUILDING _____ B. WING _____	12/05/2019

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents were administered oxygen therapy, per physician's order, for two (2) of three (3) residents reviewed for respiratory care, Resident #30 and Resident #31. Findings Include: Review of the facility's "Oxygen Policy", dated 06/23/17, revealed oxygen would be used with specific physician's orders and should never be above three (3) liters (L), without special physician's orders. The Medication Administration Record (MAR) is used to document continuous oxygen usage. The Oxygen Flow Sheet is used for PRN (as needed) oxygen usage. Resident #30 A review of Resident #30's December 2019 physician's orders, revealed an order dated 02/15/19, for Oxygen (O2) at two (2) Liters (L) via nasal cannula (NC) as needed (PRN), related to shortness of breath (SOB).	F 695	Tag 0695 1.Corrective action for resident #30 was done on 12/04/19 by placing a sign for Oxygen in Use on the door by the charge nurse License Practical Nurse (LPN). The care plan was updated to reflect the use of oxygen. The nurses were in-serviced by the Staff Educator Registered Nurse (RN) on observation of oxygen use to ensure ordered liter was in use and document accordingly. The smoking equipment is locked in the medication room and only nurses have access. The resident is brought to the nurses desk before and after smoking to ensure a nurse removes and replaces the oxygen tank and the proper rate is administered. Corrective action for resident #31 was done on 12/04/19 by in-servicing nurses to remove oxygen tanks from her wheelchair and not allow daughter to turn off or turn on. When resident returns from smoking the nurse is to set the rate of oxygen use. The daughter was educated on 12/04/19 by the Director of Nursing	12/30/19

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F 695	Continued From page 12 Observations of Resident #30, on 12/03/19 at 10:13 AM, 11:55 AM, 2:50 PM, and 3:39 PM; and on 12/04/19 at 8:51 AM, revealed Resident #30 was lying in bed with oxygen being administered via nasal cannula to both nostrils at 3.5 liters (L) per minute from an oxygen concentrator. There was no "Oxygen in Use" sign (no smoking) on the door or posted in the room. In an interview, on 12/03/19 at 11:55 AM, Resident #30's daughter stated the resident had been on O2 for some time and she was unsure what the setting was supposed to be on. The resident's daughter stated she never adjusted the oxygen concentrator; only nurses do. During an interview, on 12/04/19 at 11:45 AM, the DON revealed she expected nurses to monitor oxygen periodically throughout the day, to ensure it was being administered at the correct rate. The DON stated she would expect the nurses to observe and document every shift, the O2 saturation level for the resident, and the rate of administration, accurately on the Medication Administration Record (MAR) or the oxygen flow chart. The DON stated there should have been an "Oxygen in Use" sign on the resident's door. In an interview, on 12/04/19 at 4:01 PM, LPN #4 stated she completed Resident #30's MAR for O2 use. LPN #4 stated she marks the MAR after checking O2 saturation levels for each resident. LPN #4 stated she did not check to see that the O2 was set at 2L per minute, for Resident #30, but she should have. Resident #31 Review of the physician's orders, dated 10/29/18,	F 695	(DON) to allow the nurses at the desk to remove and replace the oxygen tanks and to set the rate. 2. All residents using oxygen have the potential to be affected by this practice. 3. The nurses were in-serviced by the Staff Educator RN on 12/04/19 to observe and document oxygen use to ensure the correct rate is being used and also to replace oxygen tank after resident smokes to ensure daughter doesn't change rate. The nurses keep the portable oxygen tanks in the medication room during smoking times to ensure only nurses remove and replace them. 4. The Quality assurance nurse will observe the documentation of oxygen use to ensure the correct dose ordered is being administered and checked every shift on a weekly basis for six months. The medication nurse will document every shift on the oxygen observation log in the medical administration record. The QA nurse will bring her weekly observation check list to all Quality Assurance meetings for the committee to review for six months.	

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F 695	Continued From page 13	F 695		

revealed Resident #31 had an order for O2 sats every (Q) shift, and if below 90 percent (%), place O2 at 2L via NC.

An observation, on 12/03/19 at 10:32 AM, revealed Resident #31 in hallway, at the door to her room, with O2 being administered via nasal cannulas at 2L per minute, with a portable oxygen tank attached to the back of her wheelchair. At 10:34 AM, on 12/3/19, Resident # 31 was observed to go outside on the back patio area with visitors to smoke; she had no oxygen being administered.

An observation on 12/03/19 at 11:12 AM, of Resident #31 in the dining room, revealed O2 being administered via bilateral NC at 3L per minute from a portable O2 tank.

An observation on 12/03/19 at 2:46 PM, revealed Resident #31 in the dining room, during an activity, with O2 being administered via bilateral NC at 3L per minute from a portable O2 tank.

An observation on 12/03/19 at 3:36 PM, revealed O2 being administered to Resident #31 at 2L per minute, via bilateral NC, from a portable tank on her wheelchair.

An observation and interview, in Resident #31's room, on 12/04/19 at 8:39 AM, revealed the resident was being administered O2 at 2L per minute, via bilateral NC, from an oxygen concentrator. The resident stated she has been on oxygen continuously for several months and had been on 2L of oxygen since she had been using it. The resident stated her daughter turned off her oxygen, prior to her smoking yesterday, and back on after she finished, once she was

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F 695	Continued From page 14	F 695		

inside. The resident stated her daughter was an Emergency Medical Technician (EMT) and had training on the use of oxygen. The resident stated she was unaware her O2 was being administered at 3L per minute for a period of time yesterday, but it should have been 2L. The resident stated the nurses check her oxygen level two (2) or three (3) times a day. The resident suggested a Certified Nursing Assistant (CNA) may have put her oxygen level on 3L, after she smoked yesterday, she was unsure, because they sometimes turn the oxygen on/off before and after smoke breaks.

During an observation of Resident #31, and interview with LPN #2, on 12/04/19 at 11:30 AM, revealed Resident #31 lying in bed with O2 being administered via NC at 3.5 L per minute, via the oxygen concentrator. LPN #2 stated the O2 should be at 2L and adjusted to the rate to 2L. LPN #2 stated she had not checked the resident's oxygen, prior to this observation; she didn't normally work this hall.

During an interview on, 12/04/19 at 11:35 PM, RN #1 revealed Resident #31 and all residents were monitored by staff when smoking, however, Resident #31's daughter did come and take her out to smoke on occasion. RN #1 stated sometimes staff were not aware when the resident's daughter visited, but she was an EMT and knew how to turn off oxygen. RN #1 stated staff should check periodically, to make sure the O2 level was correct, and it was possible the resident's daughter turned the O2 on and put it at 3L per minute.

An interview on 12/04/19 at 11:45 AM, with the DON, confirmed Resident #31's daughter (an

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F 695	Continued From page 15 EMT) visits and takes the resident out to smoke. She indicated the daughter might manipulate the oxygen administration. The DON stated she would expect the nurses to check O2 administration for residents, to make sure it is being administered at the correct rate.	F 695		

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	255213	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		12/30/19

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

Electronically Signed | 01/02/2020

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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K 918	Continued From page 1 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to properly test the emergency generator as per NFPA 110 section 8.4.2. The deficient practice affected the entire facility on day of survey. Findings include: During document review on 12/10/19 at 10:00 AM, the facility could not provide documentation showing the weekly inspections of the generator from 4/15/19 to 9/23/19, and the monthly load tests of the generator from 3/18/19 to 12/10/19 (day of survey).	K 918	1. Tag 0918 Corrective action was taken for this deficiency by the administrator training the new maintenance supervisor on appropriate documentation of generator inspections. This was done upon hire and the deficiency occurred before this date. 2. All residents of the facility have the potential to be affected by this practice. 3. The maintenance supervisor will do generator inspections every Monday and document appropriately. 4. The Maintenance supervisor will bring generator documentation logs to all Quality Assurance meetings for approval by the Quality Assurance Committee. 5. This corrective action will be completed by December 29, 2019.	

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E 000	Initial Comments ********** Survey conducted on 12/10/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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