STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	**200 WILLOW RD HILLSBORO, KS 67063**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #161181 and #162316. This 2567 was electronically sent to the facility on 08/03/21.	F 000		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense.	F 576		

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

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 576	Continued From page 1 §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: The facility reported a census of 46 residents with 10 residents that attended the Resident Council meeting. Based on interview and record review, the facility failed to ensure facility residents' right to receive mail by not delivering mail to the residents on Saturdays. Findings Included: - Interview on 07/27/21 at 02:15 PM, with 10 residents that attended Resident Council meeting revealed that the facility does not deliver mail on Saturdays to any of the residents. Interview on 07/28/21 at 10:01 AM, with Dietary staff BB revealed the task of Saturday mail delivery was previously performed by the Activity Director, a now vacant position. Interview on 07/28/21 at 12:32 PM, with Licensed Nurse G who worked every other weekend revealed no one has passed mail on Saturday in a couple months. Social Services staff passed mail during the week. Interview on 07/29/21 at 11:37 AM, with Social Services Staff X revealed the Administrator told	F 576		

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F 576	Continued From page 2 her the facility did not receive mail on Saturdays. Interview on 07/29/21 at 11:44 AM, with Postal Worker GG revealed the post office was willing to deliver the mail to the facility on Saturdays, but the facility instructed the post office not to deliver the mail on Saturdays. Interview on 07/29/21 at 11:54 AM, with Administrative Staff A revealed on or around March 29, 2021, the facility instructed the post office to not deliver the mail on Saturdays because the facility was not delivering the mail to the residents on Saturdays. A facility policy titled "Right to Send and Receive Mail," dated 12/21/20, instructed mail will be delivered to the elder on the day it is received by the facility. If the facility had mail delivered to a post office box, the facility would arrange for mail pick up on the day the mail was delivered to the post office box. The facility failed to ensure residents of the facility received mail on Saturdays.	F 576		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be	F 582		

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charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the

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facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 46 residents. Based on record review and interview, the facility failed to provide Notice to Medicare Provider Non-coverage (NOMNC) to two of the three residents reviewed, of his or her right to an expedited review of a services termination for Resident (R)18 and R34.

Findings included:

- The "SNF [skilled nursing facility] Beneficiary Protection Notification Review," revealed that Resident (R)34's last covered day of skilled services ended on 04/19/21 and the facility initiated the discharge from Medicare A services when benefit days were not exhausted. The facility failed to provide R34 a NOMNC prior to discharge from skilled services.

The "SNF Beneficiary Protection Notification Review," revealed that Resident (R)18's last covered day of skilled services ended on 04/29/21 and the facility initiated the discharge from Medicare A services when benefit days were not exhausted. The facility failed to provide R 18 a NOMNC prior to discharge from skilled services

On 07/29/21 at 10:05 AM, Social Services staff X, stated that she only provided an "Advanced Beneficiary Notice" when residents with a planned discharge from skilled services had days remaining.

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F 582	Continued From page 5 On 07/29/21 at 10:19 AM, Administrative Staff A stated she expected the NOMNC to be provided when appropriate. The facility policy "Medicare Denial Notices," dated 12/03/19, indicated that when a resident no longer required skilled services provided as a Medicare benefit, the social service director, as assigned by the facility administrator will issue a Notice of Denial Medicare Coverage letter no later than three calendar days prior to the planned discharge. The denial letter will contain both CMS (Centers for Medicare and Medicaid Services) form 10123 (NOMNC) and CMS form 10055 (Advanced Beneficiary Notice). The facility failed to provide NOMNC which included the residents' right to an expedited review of a services termination for R18 and R34.	F 582		
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	F 657		

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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:
The facility reported a census of 46 residents with 21 selected for review. Based on observation, interview, and record review, the facility failed to revise Resident (R)25's care plan following falls.

Findings included:

- The "Physician Orders," dated 06/21/21, for Resident (R)25, included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of the knee, weakness, pain in left hip, pain in left knee, muscle weakness, and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 04/05/21, assessed R25 with a "Brief Interview of Mental Status" (BIMS) score of 14, which indicated cognition intact. R25 required limited assistance of one staff for bed mobility, transfers, toilet use, walking in room, and locomotion on and off unit. She required supervision and setup

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for walking in the corridor, extensive assist of one staff for dressing, and used a walker for mobility. R25's balance during transitions and walking were not steady and was only able to stabilize with staff assistance. She had two or more non-injury falls since the prior assessment.

The "Annual MDS," dated 06/21/21, assessed R25 with a BIMS score of 12, which indicated moderate cognitive impairment. She used a walker and a wheelchair for mobility and had one fall with injury that was not major. Her assistance with cares, balance during transitions and walking, and falls with no injury did not change from the prior MDS assessment.

The "Falls Care Area Assessment" (CAA), dated 06/28/21, revealed that R25's BIMS score indicated some cognitive impairment. Her diagnosis of Atrial fibrillation (rapid, irregular heart) contributed to impaired circulation, therefore impaired oxygenation of blood to organs and tissues, which could contribute to confusion and activity intolerance. R25 had pain at knees which could affect her balance and gait. These factors increased her risk of falls with injury.

The "Care Plan," dated 07/06/21, included R25 had a potential for injury related to falls and included these interventions:

1. On 10/06/20 15-minute visual checks. The staff discontinued the intervention on 03/17/21.

2. On 08/13/20, transfer with use of gait belt and front wheeled walker with use of gait belt for mobility. The floors to her room were to be kept uncluttered and her favored items to be in reach as well as the call light. A note to be in place to

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her walker as a visual cue to remember to use the walker when walking.

3. On 09/15/20, R25's door will be kept ajar for ease of safety observation.

4. On 10/06/20, a pressure call pad to be used as R25 forgets to call for staff assistance.

5. On 10/09/20, the staff were to not hook the call light cord to her walker due to her fall risk.

6. On 10/18/20, R25 to have a winged mattress (elevated sides at the head and the foot of the bed) to define the edge of the bed.

7. On 12/16/20, R25 to have a call light pendant for use.

8. On, 06/16/21, R25 to have "Dycem" (a non-slip material) in place to the seat of her wheelchair to prevent sliding out of her wheelchair.

9. On 06/26/21, R25's wheelchair to be kept in the hallway to prevent her from transferring herself without staff assistance to decrease fall risk.

Review of R25's electronic medical record (EMR), revealed R25 fell on these dates: 01/29/21 at 07:46 PM, 01/29/21 at 09:29 PM, 05/27/21 at 09:10 PM, 06/15/21 at 09:10 PM, 06/25/21 at 08:25 PM, and 07/03/21 at 06:45 PM.

The "Care Plan" lacked an intervention to prevent further falls following the fall on 01/29/21 at 07:46 PM.

The "Care Plan" lacked an intervention to prevent

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further falls and 15-minute checks were in place on the care plan prior to the fall on 01/29/21 at 09:29 PM.

The "Care Plan" lacked a new intervention to prevent further falls following the fall on 07/03/21.

On 07/29/21 at 09:44 AM, R25's daughter arrived to her room and placed the walker in front of her, when R25 stood up her alarm sounded and staff responded right away.

On 07/29/21 at 02:54 PM, Licensed Nurse (LN) G, stated after a resident fall, we come up with a new intervention to prevent falls and the intervention then goes on the care plan. If the intervention was not on the care plan staff would communicate to Administrative Nurse D or Administrative Nurse E so they can add the intervention to the care plan.

On 07/29/21 at 03:15 PM, Administrative Nurse E stated when a resident had a fall, the nurses add the intervention to the care plan. The interdisciplinary team reviewed the falls and try to make sure an intervention was in place.

On 07/29/21 at 03:34 PM, Administrative Nurse D stated when a resident falls, the nurse was to put a new intervention on the care plan, if they do not know how to add the intervention to the care plan then they include the intervention in the fall packet they completed when a resident falls.

On 07/29/21 at 04:04 PM, Administrative Nurse E stated that the care plan lacked interventions for the falls on 01/29/21, the fall on 05/27/21, and the fall on 07/03/21.

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F 657	Continued From page 10 The facility policy "Care Planning Policy," dated 01/20/20, included that care plans will be updated as needed with interventions pertaining to changes such as fall approaches, accidents, incidents, etc. The facility failed to revise one Resident (R)25's care plan following falls.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 46 residents with 21 selected for review including two residents reviewed for falls. Based on observation, interview, and record review, the facility failed to implement new interventions for one Resident (R)25 following falls. Findings included: - The "Physician Orders," dated 06/21/21, for Resident (R)25, included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of the knee, weakness, pain in left hip, pain in left knee, muscle weakness, and	F 689		

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dementia (progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 04/05/21, assessed R25 with a "Brief Interview of Mental Status" (BIMS) score of 14, which indicated cognition intact. R25 required limited assistance of one staff for bed mobility, transfers, toilet use, walking in room, and locomotion on and off unit. She required supervision and setup for walking in the corridor, extensive assist of one staff for dressing, and used a walker for mobility. R25's balance during transitions and walking were not steady and was only able to stabilize with staff assistance. She had two or more non-injury falls since the prior assessment.

The "Annual MDS," dated 06/21/21, assessed R25 with a BIMS score of 12, which indicated moderate cognitive impairment. She used a walker and a wheelchair for mobility and had one fall with injury that was not major. Her assistance with cares, balance during transitions and walking, and falls with no injury did not change from the prior MDS assessment.

The "Falls Care Area Assessment" (CAA), dated 06/28/21, revealed that R25's BIMS score indicated some cognitive impairment. Her diagnosis of Atrial fibrillation (rapid, irregular heart) contributed to impaired circulation, therefore impaired oxygenation of blood to organs and tissues, which could contribute to confusion and activity intolerance. R25 had pain at knees which could affect her balance and gait. These factors increased her risk of falls with injury.

The "Care Plan," dated 07/06/21, included R25 had a potential for injury related to falls and

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included these interventions:

1. On 10/06/20 15-minute visual checks. The staff discontinued the intervention on 03/17/21.

2. On 08/13/20, transfer with use of gait belt and front wheeled walker with use of gait belt for mobility. The floors to her room were to be kept uncluttered and her favored items to be in reach as well as the call light. A note to be in place to her walker as a visual cue to remember to use the walker when walking.

3. On 09/15/20, R25's door will be kept ajar for ease of safety observation.

4. On 10/06/20, a pressure call pad to be used as R25 forgets to call for staff assistance.

5. On 10/09/20, the staff were to not hook the call light cord to her walker due to her fall risk.

6. On 10/18/20, R25 to have a winged mattress (elevated sides at the head and the foot of the bed) to define the edge of the bed.

7. On 12/16/20, R25 to have a call light pendant for use.

8. On, 06/16/21, R25 to have "Dycem" (a non-slip material) in place to the seat of her wheelchair to prevent sliding out of her wheelchair.

9. On 06/26/21, R25's wheelchair to be kept in the hallway to prevent her from transferring herself without staff assistance to decrease fall risk.

Review of R25's electronic medical record (EMR),

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revealed R25 fell on these dates: 01/29/21 at 07:46 PM, 01/29/21 at 09:29 PM, 05/27/21 at 09:10 PM, 06/15/21 at 09:10 PM, 06/25/21 at 08:25 PM, and 07/03/21 at 06:45 PM.

The "Notes," dated 01/29/21 at 07:46 PM, revealed R25 was found on the floor in her room and stated she hit her head, the staff found a "small goose egg" on the back of her head that measured 1.0 centimeters (cm) by 1.0 cm. R25 reported she was leaning on the brown table to close her blinds and the table moved and she fell to the floor.

The "Care Plan" lacked an intervention to prevent further falls following the fall on 01/29/21 at 07:46 PM.

The "Notes," dated 01/29/21 at 09:29 PM, revealed that R25 was found sitting on the floor in her room, her walker was next to the wall away from her. R25 reported that she stood up to walk, but her legs were too weak, and she slipped to the floor. She stated that she hit her head, but nothing hurt, and the nurse did not find any injuries. The staff placed R25 on 15-minute checks and encouraged her to call for assistance when she needed to get up.

The "Care Plan" lacked an intervention to prevent further falls and 15-minute checks were in place on the care plan prior to the fall.

The "Notes," dated 05/27/21 at 10:38 PM, revealed R25 fell at approximately 09:10 PM, her call light/pressure alarm was sounding and when staff approached her room her walker blocked the doorway and she was lying on the floor on her back with her head propped up against a dresser.

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R25 stated she was trying to get in her wheelchair, it rolled away from her, and she fell to the floor. R25 had an abrasion measuring approximately 2.5 cm by 1.25 cm to her mid lower back and a 1.0 cm diameter "knot" to the left base of her skull that the resident reported it had been there for years. R25 stated she bumped her head and she received a medication that thins the blood; therefore, she was sent to the emergency room for evaluation and treatment if needed. The staff determined the root cause of her fall was intermittent confusion and her unawareness of her limitations due to having a urinary tract infection. The intervention included in the notes for the fall was that R25 would complete the course of an antibiotic Cephalexin (medication used to treat infections). The facility failed to implement an immediate intervention to prevent further falls.

The "Notes," on 07/03/21 at 09:31 PM, revealed R25 fell approximately at 06:45 PM in the "C" hallway. R25 stated she got up to chase after a resident that came in her room and stole her things. She was found lying on her right side holding her head and claimed to have hit her head. The staff found a contusion (bruise) in the middle of the back of her head and she complained of head and right hip pain. The chair alarm did not go off when she got up, but it was plugged in and on.

The "Care Plan" lacked a new intervention to prevent further falls following the fall on 07/03/21.

On 07/29/21 at 09:44 AM, R25's daughter arrived to her room and placed the walker in front of her, when R25 stood up her alarm sounded and staff responded right away.

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On 07/29/21 at 01:58 PM, Certified Nurse Aide (CNA) O stated that after a resident falls the staff get together as a group and discuss why the resident may have fallen and talk about what could be done to keep them from falling again.

On 07/29/21 at 02:54 PM, Licensed Nurse (LN) G, stated after a resident falls, sometimes the staff will meet as a group to try to figure out what the resident was doing if they were unable to say what happened, and would come up with a new intervention to prevent falls. The intervention then goes on the care plan and if the intervention was not on the care plan staff would communicate to Administrative Nurse D or Administrative Nurse E so they can add the intervention to the care plan.

On 07/29/21 at 03:15 PM, Administrative Nurse E stated when a resident falls, the nurses should answer the five "why's" and come to a conclusion on what might help prevent a reoccurring fall. The nurses add the intervention to the care plan. The interdisciplinary team reviews the falls and try to make sure an intervention was in place. Administrative Nurse E confirmed the intervention for the fall on 05/27/21 was not an appropriate intervention to prevent further falls and should have had an intervention in place to keep the wheelchair from rolling. She also verified the intervention for 15-minute checks following one of her falls on 01/29/21 was a duplicate intervention.

On 07/29/21 at 03:34 PM, Administrative Nurse D stated when a resident falls, the nurse was to put a new intervention on the care plan, if they do not know how to add the intervention to the care plan then they include the intervention in the fall packet they completed when a resident falls.

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F 689	Continued From page 16 Administrative Nurse D confirmed that an antibiotic was not an appropriate intervention to prevent further falls. On 07/29/21 at 04:04 PM, Administrative Nurse E stated that the care plan lacked interventions for the falls on 01/29/21, the fall on 05/27/21, and the fall on 07/03/21. The facility policy "Fall Follow-up Protocol," dated 02/03/21, included that fall interventions are documented on the care plan with interventions to prevent further falls based on the determined casual factors at the time of the initial follow-up. The facility failed to implement new interventions and appropriate interventions for one Resident (R)25 following falls to prevent reoccurring falls.	F 689		
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: The facility reported a census of 46 residents with 21 selected for review including one resident reviewed for respiratory care. Based on observation, interview, and record review, the facility failed to properly store oxygen tubing and suction machine tubing, failed to change out the	F 695		

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oxygen concentrator humidifier bottle, and failed to change/clean the suction machine canister. These practices increased the risk of Resident (R)38 developing a respiratory infection.

Findings included:

- The "Physician Orders," dated 07/06/21, for Resident (R)38, included diagnoses of obstructive sleep apnea (disorder of sleep characterized by periods without respirations), and hypoxia (inadequate supply of oxygen).

The "Significant Change Minimum Data Set" (MDS), dated 01/28/21, assessed R38 with a "Brief Interview of Mental Status," (BIMS) score of nine, which indicated moderate cognitive impairment and used oxygen while and while not a resident.

The "Quarterly MDS," dated 07/09/21, assessed R38 with the same BIMS score and did not require oxygen.

The "Care Plan," dated 04/24/21, indicated that R38 had use of respiratory services related to his diagnoses of hypoxemia and sleep apnea. He required an oxygen concentrator and staff managed changing and cleaning or related equipment: tubing, filters, and humidifier as per facility policy.
R28 used oxygen at night prior to an infection with COVID-19 and currently required oxygen during the daytime hours to keep his oxygen saturation levels greater than 90 percent.

The "Physician Orders," dated 07/06/21, included:

1. On 01/15/21, oral suctioning, as needed,

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throughout the day, when excessive saliva was noted.

2. On 01/25/21, change the oxygen tubing, and clean and change oxygen filter on the first and 15th monthly.

3. On 01/28/21, oxygen at one to four liters via a nasal cannula to keep oxygen saturations above 90 percent. Attempt to titrate down the oxygen to keep saturations greater than 90 percent and continue with nocturnal oxygen.

The "Medication Administration Record" (MAR), dated June 2021, revealed that R38 required oxygen and the staff changed his oxygen tubing on the first, but not the 15th. R38 also required suctioning on 06/07/21.

The "MAR," dated July 2021, revealed R38 required oxygen, did not require suctioning, and the staff changed his oxygen tubing on the first and the 15th.

On 07/27/21 at 08:25 AM, Certified Nurse Aide (CNA) N removed the oxygen nasal cannula tubing from R38 and placed the cannula on top of the oxygen concentrator. The nasal cannula had a date of 07/15/21 on it.

On 07/27/21 at 01:01 PM, R38 was in his room without his oxygen nasal cannula in place while staff assisted him with lunch.

On 07/27/21 at 01:26 PM, R38 was in his recliner in his room without his oxygen nasal cannula tubing in place, which remained on top of the oxygen concentrator. A suction machine was on the table next to his recliner with the tubing from

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the suction canister between the table and the wall.

On 07/28/21 at 08:01 AM, R38 was up in his room sitting in his wheelchair. His oxygen nasal cannula tubing was on the floor, with the tubing dated 07/15/21. The humidifier bottle on the oxygen concentrator had a date of 05/13 written on it. The suction machine tubing continued to be between the table and the wall with the end of it dangling against the wall. The suction canister with light brown discoloration and unable to determine if any fluids were in the canister. The canister and tubing lacked a date that the staff changed it.

On 07/28/21 at 08:07 AM, Licensed Nurse (LN) H stated that R38 required suctioning "few and far between" and she had not received in report that he required the staff to suction him in a while. LN H stated it had been well over two weeks since R38 required suctioning.

On 07/28/21 at 03:23 PM, R38's oxygen nasal cannula tubing remained on the floor and there were no changes to the suction machine tubing or canister from the prior observation.

On 07/28/21 at 03:24 PM, CNA N stated that oxygen tubing should be stored in a plastic bag when not being used.

On 07/28/21 at 03:26 PM, LN H stated that the night shift staff change the oxygen humidifier bottles and the oxygen nasal cannula tubing, and she thought it was done on a weekly basis. The oxygen nasal cannula tubing should be rolled up and place in a bag when not in use and the suction machine tubing should be in a bag. LN H

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F 695	Continued From page 20 confirmed the oxygen humidifier bottle had a date of 05/13 and the suction catheter was not in a bag and should be. The canister was not clean. LN H confirmed that the MAR lacked information on when the humidifier bottle should be changed or management of the suction canister and tubing. On 07/28/21 at 04:01 PM, Administrative Nurse D stated the frequency for changing the oxygen tubing was in the MAR and the humidifier bottles should be changed out when staff changed the oxygen tubing. When the oxygen was not being used the cannula should be stored in a bag. The suction machine canister and tubing should be dated, and the suction catheter should be kept in a bag when not in use. The suction canister should be cleaned after use. The facility policy "Oxygen Administration," dated 01/20/20, indicated that the oxygen tubing and humidifier bottle will be replaced every two weeks and as needed. The facility policy "Oral Suctioning," dated 01/20/20, lacked instruction for cleaning of suction canister after use or storage of suction catheter when not in use. The facility failed to properly store oxygen tubing and suction machine tubing, failed to change out the oxygen concentrator humidifier bottle, and failed to clean/change the suction canister. These practices increased the risk of Resident (R)38 developing a respiratory infection.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

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§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 46 residents. The sample included 21 residents with six residents reviewed for unnecessary medications. Based on record review and interview, the facility failed to accurately administer medications when staff gave R21 medications intended for R4 in

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error.

Findings included:

- The undated "Physician Order," revealed diagnoses which included diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with neuropathy (disease of one or more nerves causing numbness or weakness), chronic kidney disease, and hypertensive (high blood pressure) heart disease with heart failure.

R21's "Care Plan," dated 03/21/21, directed staff to give medications as ordered and monitor for effectiveness.

A "Nurses' Note," dated 05/09/21 at 01:22 AM, documented on 05/08/21, at approximately 10:45 PM, Certified Medication Aide (CMA) R administered the following medications to R 21:

1. Ferrous sulfate (iron supplement) 325 milligrams (mg) by mouth.

2. Pravastatin (medication for high cholesterol) 40 mg by mouth.

3. Tramadol (pain medication) 50 mg by mouth.

4. Verapamil ER (relaxes the blood vessels so heart does not have to pump as hard) 180 mg.

The "Nurses Note," dated 05/05/21, further documented the resident refused assessment at that time. Staff notified the physician, representative, and Administrative Nurse D of the medication error at 11:59 PM. The physician directed staff to continue monitoring the resident

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at approximately 01:15 AM, the resident requested pain medication and staff gave Tylenol 500 mg. His vital signs included blood pressure of 138/84 millimeters of Mercury (mmHg) and pulse of 75 beats per minute.

"Vital Signs," dated May 2021, documented R21's pulse range from 58 to 76 beats per minute.

Review of the resident's current "Physician Orders" revealed the resident lacked orders for medications given in error on 05/08/21 at 10:45 PM.

On 07/29/21 at 08:54 AM, Certified Medication Aide (CMA) R administered medication to R21. His blood pressure was 167/83 and his pulse was 83 beats per minute. He received, by mouth, Jardance 25 mg for diabetes, Losartan 50 mg for hypertensive heart disease with heart failure, Coreg 3.125 which had parameter to hold for heart rate less than 50 beats per minute, and divalproex sodium 25 mg for seizures. All medication was given as per physician order.

On 07/27/21 at 08:39 AM, Administrative Nurse D reported CMA R was an agency CMA. The R21 and R4 resident's rooms were next to each other. CMA R walked in the wrong room and gave R21 the medications ordered for R4. R 21 was monitored by the nurses and had no adverse effects. Administrative Nurse D stated she expected staff to identify residents before giving medications and expected medications to be given as the physician ordered.

The facility lacked a policy which addressed resident identification prior to medication administration.

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F 755	Continued From page 24 The facility failed to accurately administer medications when staff gave R 21 another resident's medications in error.	F 755		