STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035120	A. BUILDING _____ B. WING _____	**12/19/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MI CASA NURSING CENTER	**330 SOUTH PINNULE CIRCLE MESA, AZ 85206**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0637 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that a significant change Minimum Data Set (MDS) assessment was completed for one resident (#50). Findings include: Resident #50 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan initiated 03/03/2019 revealed the resident had a nutritional problem or potential nutritional problem related to receiving hospice services. Review of the clinical record revealed the resident was admitted to hospice care on 3/10/19. However, review of the MDS assessments did not reveal a significant change MDS assessment was conducted. During an interview conducted with the MDS nurse (staff #142) on 12/17/19 at 12:56 PM, she stated the resident was started on hospice care on 3/10/19 and that a significant change MDS assessment should have been completed by 3/24/19. In an interview conducted with the Director of Nursing (staff #161) on 12/17/19 at 12:58 PM, she stated resident #50 should have had a significant change MDS assessment done when she started hospice on 3/10/19. Review of the RAI manual dated 10/2019 revealed a significant change in status assessment is required to be performed when a resident enrolls in a hospice program. The assessment reference date (ARD) must be within 14 days from the effective date of the hospice election. The manual also revealed this is to ensure a coordinated plan of care between hospice and nursing home is in place.
F 0640 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that the discharge Minimum Data Set (MDS) assessment was transmitted to the Centers for Medicare and Medicaid Services (CMS) system within 14 days after completion for one resident (#79). The deficient practice could result in lack of resident specific information for quality measure purposes. Findings include: Resident #79 was admitted to the facility on (MONTH) 2, 2019 and discharged from the facility on (MONTH) 17, 2019. Review of the discharge MDS assessment dated (MONTH) 17, (YEAR) revealed the resident was discharged to the community on (MONTH) 17, 2019. The assessment also revealed the Registered Nurse assessment coordinator signed the assessment as complete on (MONTH) 22, 2019. However, review of the CMS system revealed the discharge MDS assessment had not been transmitted. An interview was conducted with two MDS nurses (staff #13 and #142) on (MONTH) 17, 2019 at 3:08 p.m. Staff #142 said when an MDS assessment is marked completed, that meant the assessment is finished. She said when an MDS assessment is marked accepted, that means it had been transmitted to the CMS system. She stated some assessments are transmitted to the CMS system, and some assessments are not transmitted because they were created for insurance and billing purposes. Staff #142 stated all discharge assessments should be transmitted to the CMS system. She said the electronic health record provides a checkpoint that gives instructions on whether or not to submit a MDS assessment to the CMS system. Staff #142 stated the software had given instructions to not submit the discharge assessment, which was why it was not submitted. During an interview conducted with the Director of Nursing (DON/staff # 161) on (MONTH) 18, 2019 at 2:52 p.m., she stated her expectation is that the MDS assessment be completed and submitted in accordance with the regulations. Review of the RAI manual revealed a discharge MDS assessment must be submitted electronically and accepted into the CMS system, within 14 days after completion.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure the care plan was revised for 3 out of 23 sampled residents (#21, #32 and #58). The deficient practice could result in inaccuracies regarding resident care. Findings include: -Resident #32 was admitted to the facility on (MONTH) 7, 2019, with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 14, 2019, revealed a Brief Interview for Mental Status score of 13, which indicated the resident was cognitively intact. The assessment included the resident required extensive assistance for bed mobility, transfers and toilet use. The assessment also included that the resident did not have an indwelling urinary catheter and was occasionally incontinent of urine. A care plan for urinary incontinence dated (MONTH) 1, 2019, included a goal that the resident would have no skin breakdown related to urinary incontinence. Interventions included assisting with toileting as needed, providing incontinence briefs to maintain dignity and providing perineal care as needed. A physician's orders [REDACTED]. Review of a nursing progress note dated (MONTH) 5, 2019, revealed a Foley catheter was inserted. A significant change MDS assessment dated (MONTH) 5, 2019, revealed the resident had an indwelling catheter. The assessment included urinary incontinence and indwelling catheter was triggered and would be addressed in the care plan. However, review of the clinical record revealed no evidence the care plan was updated with goals and interventions for the resident's use of an indwelling urinary catheter. An interview was conducted with a Licensed Practical Nurse (LPN/staff #124) on (MONTH) 18, 2019 at 11:16 a.m. She stated when a nurse receives a new order, that nurse would be expected to update the resident's care plan accordingly. She said the MDS nurse could also update the resident's care plan. An interview was conducted with the Director of Nursing (DON/staff #161) on (MONTH) 18, 2019 at 2:52 p.m. She said updating care plans was an interdisciplinary effort. She said whoever found the change that needed to be made to the care plan could create the update, or they could notify someone who was able to make the update. The DON stated clinical records were

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035120	A. BUILDING _____ B. WING _____	12/19/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MI CASA NURSING CENTER	330 SOUTH PINNULE CIRCLE MESA, AZ 85206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) routinely audited for certain things such as skin conditions, falls or catheters. She said when a change is identified during the audits; the appropriate care plan would be updated. The DON also stated she expected care plans to be updated after completion of the MDS assessment, or within approximately two weeks of completion of the MDS assessment. Review of the facility's policy for the Resident Assessment Instrument and Care Plan reviewed (MONTH) 29, 2019, revealed the MDS assessment would be completed at a minimum upon admission, quarterly, annually, and with a significant change in resident status. The care area process would begin with the care area triggers in the MDS assessment. The information identified using the MDS and Care Area Assessment process would be used to develop an individualized, person-centered care plan. -Resident #21 was admitted to the facility on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician order [REDACTED]. Review of the care plan initiated (MONTH) 27, (YEAR), revealed the resident was receiving oxygen therapy related to ineffective gas exchange. The goal was that the resident would have no signs or symptoms of poor oxygen absorption. Interventions included oxygen via nasal cannula continuously at 2 liter per minute. The quarterly MDS assessment dated (MONTH) 12, 2019 revealed the resident was receiving oxygen therapy. Continued review of the care plan regarding oxygen revealed an intervention initiated (MONTH) 20, 2019 for oxygen via nasal cannula at 4 liters per minute continuously. However, review of the physician's orders [REDACTED]. An interview was conducted on (MONTH) 18, 2019 at 10:14 a.m. with the DON (staff #161). The DON stated the care plan for oxygen would be revised as needed including when the orders for oxygen are changed. She stated the care plan should match the order for oxygen settings. The DON stated they complete regular audits to ensure the care plans are accurate and up to date. -Resident #58 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the care plan initiated 2/9/19 revealed the resident was at risk for falls related to poor safety awareness and impulsive behaviors. The goal was that the resident would not sustain serious injury requiring hospitalization . Interventions were assisting with activities of daily living as needed, keeping the call light within reach and orienting the resident to the room. A review of the clinical record revealed a progress note dated 12/15/19 at 7:05 PM that the resident was found lying on the floor at 6:45 PM. The note included the resident stated I was trying to go to the bathroom when I stood up and fell . The note also included the resident was assessed and had no signs or symptoms of new injuries. However, further review of the care plan did not reveal the care plan was revised to include the fall on 12/15/19 and/or if new interventions were implemented. During an interview conducted with a LPN (staff #185) on 12/19/19 at 9:29 AM, she stated that a resident who has a fall is assessed and neuro checks may be initiated if the fall is unwitnessed. The LPN stated that the next day they make rounds and decide what interventions should be implemented. Staff #185 also stated that an administration staff would update the care plan. After reviewing resident #58's care plan, the LPN confirmed the care plan had not been updated for the fall on 12/15/19. Review of the facility's policy for fall management reviewed (MONTH) 15, 2019, revealed residents will be assessed for fall indicators with any fall event. The interdisciplinary team will review and revise the care plan, if indicated, upon completion of each comprehensive, significant change and quarterly MDS assessment, upon a fall event and as needed thereafter.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, resident and staff interviews and policy review, the facility failed to ensure that one out of four sampled residents (#55) received showers according to the care plan. The deficient practice could result in hygiene needs not being met. Findings include: Resident #55 was admitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. Review of a care plan dated (MONTH) 29, 2019, revealed the resident had Activities of Daily Living (ADL) self-care performance deficit related to [MEDICAL CONDITION]. The care plan included the resident was totally dependent on staff to provide showers twice weekly and as necessary. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 30, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. The assessment included the resident required extensive assistance for transfers, toileting and personal hygiene, and was totally dependent on staff for bathing. Review of the nurse aide documentation for bathing for (MONTH) 2019, revealed no evidence the resident was offered or refused bathing assistance. The documentation included the code NA on (MONTH) 2, 5, 9, 12, 16, 19, 23, 26 and 30. Review of the nurse aide skin check and/or shower sheets for (MONTH) 2019, revealed the resident received a shower on (MONTH) 4 and 25, and the resident refused a shower due to back pain on (MONTH) 21. Review of the nurse aide documentation for bathing for (MONTH) 2019, revealed the code NA on (MONTH) 6, and that the resident refused bathing assistance on (MONTH) 9, 13 and 16. An interview was conducted with the resident on (MONTH) 16, 2019 at 10:14 a.m. He stated that he had not received a shower in over a month. He said that showers were the only time he received assistance shaving his face, and his beard was getting long. The resident's beard was observed to be approximately 0.5 inches long. The resident said he was supposed to receive showers twice a week, but no one came to offer him a shower. He stated that staff would automatically come to take his roommate for a shower twice a week, but no one came for him. Review of the nurse aide skin check/shower sheets for (MONTH) 2019, revealed the resident received a shower on (MONTH) 17, 2019. An interview was conducted with a Certified Nursing Assistant (CNA/staff #65) on (MONTH) 19, 2019 at 10:04 a.m. She said there was a shower schedule that evenly divided shower assignments between the day and evening shifts and allowed each resident to receive a shower twice a week. She said the schedule was based on residents' room numbers. She stated the CNA who provided the shower would fill out a skin check/shower sheet with any observed skin issues and give it to the nurse for review. A follow-up observation and interview was conducted with the resident on (MONTH) 19, 2019 at 10:48 a.m. He stated that he had received his shower and his face had been shaved. The resident was observed to be clean-shaven with a trimmed mustache. He said no one had offered him a shower and he had not refused a shower that week. He said the head nurse came to see him and asked why he did not receive a shower the previous day. He said he told her he did not know it was his shower day, and no one had told him about a shower that day. The resident stated after that conversation he received a shower. He said the only time recently that he remembered refusing a shower was once when he had received a lot of physical therapy and he was tired. An interview was conducted with the Director of Nursing (DON/staff #161) on (MONTH) 19, 2019 at 1:17 p.m. She said the standard routine for residents to receive showers included a schedule where rooms were assigned certain days and times each week for showers. She said the standard frequency for showers was twice a week, but the frequency and shower schedule could be altered based on resident preferences or requests. She said if a resident refused a shower, she would expect staff to re-approach the resident, then notify the nurse and have the nurse re-approach the resident as well. She said if the resident continued to refuse, she might re-approach the resident also. The DON stated that if the resident had a pattern of refusals, there would be a discussion between the resident, staff, and family members as applicable to find out the reason. She stated documentation of resident refusals of showers would be found in the electronic CNA documentation or on the skin check/shower sheets. She said sometimes the nurse or the interdisciplinary team would also write a progress note. The DON stated there was no official audit process for reviewing CNA shower documentation. She said for this resident, his room had been changed in the last few months, and therefore his shower schedule had changed. She also stated the shower schedule had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035120	A. BUILDING _____ B. WING _____	12/19/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MI CASA NURSING CENTER	330 SOUTH PINNULE CIRCLE MESA, AZ 85206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) not been updated in the electronic record for the nurse aides to document. Review of the facility's policy regarding ADLs reviewed (MONTH) 22, 2019, revealed the purpose was to ensure the facility identified and provided needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice to meet each resident's needs. The policy included residents would receive assistance as needed to complete ADLs.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#316) who developed a pressure ulcer received treatment and services consistent with professional standards of practice. The deficient practice could result in care not being provided to residents with pressure ulcers. Findings include: Resident #316 was readmitted on (MONTH) 25, 2019, with [DIAGNOSES REDACTED]. The Braden Scale for predicting pressure ulcer risk and risk factors dated (MONTH) 25, 2019 revealed a score of 12 which indicated the resident was at high risk for pressure ulcers. Review of the clinical record revealed a physician order [REDACTED]. The weekly skin integrity data collection form dated (MONTH) 29, 2019 revealed the resident skin was not intact, there was blanchable redness to the coccyx area, and barrier cream was applied as ordered. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 2, 2019 revealed the resident was independent regarding cognitive skills for daily decision making. The assessment included the resident did not have any pressure ulcers but was at risk for developing pressure ulcers. A weekly skin integrity data collection form dated (MONTH) 6, 2019 revealed the resident's skin was intact. The document included the resident had some redness on the coccyx area, barrier cream was applied, and no open areas were observed. The weekly skin integrity data collection form dated (MONTH) 13, 2019 revealed the skin was intact and that there were no new skin issues. Review of the physician orders [REDACTED]. The skin integrity data collection forms dated (MONTH) 19, 20, and 27, 2019 revealed the resident's skin was not intact, and that there was an open area/wound on the resident's right buttock. The notes also included a treatment was in place. Review of the Treatment Administration Record (TAR) dated (MONTH) 2019 revealed the treatment was provided as ordered to the open area. However, further review of the clinical record revealed no documentation that the right buttock wound was ever thoroughly assessed to include a description of the wound, staging, and measurements. Additional review of the clinical record revealed there was no care plan developed which addressed the pressure ulcer to the right buttock. There was also no intervention on any care plans regarding the care and treatment for [REDACTED]. The discharge MDS assessment dated (MONTH) 30, 2019 revealed the resident was discharged to an acute hospital and had no unhealed pressure ulcers at Stage 1 or higher. An interview was conducted with the Licensed Practical Nurse (LPN/staff #96) who is the wound nurse on (MONTH) 18, 2019 at 2:47 p.m. Staff #96 stated that once she is notified a resident has a break in skin integrity, she assesses the area, initiates a Wound Observation Tool, obtains an order for [REDACTED]. Regarding resident #316, the LPN stated she was not notified the resident had a wound. She stated information regarding skin status is supposed to be passed on during report. However, the LPN stated that she was aware [MEDICATION NAME] was being used for the resident's wound. She also stated that [MEDICATION NAME] is used for pressure ulcers stage 2 and above. On (MONTH) 18, 2019 at 3:20 p.m., an interview was conducted with the Director of Nursing (DON/staff #161). For a resident that has developed a wound, the DON stated her expectation would be for nursing to document the wound on a nursing progress note or complete a skin integrity assessment and notify the physician to obtain a treatment order. The DON stated she would expect the wound care nurse to be notified. She said her expectation would be for the wound care nurse to assess the wound, ensure the appropriate treatment and determine whether or not she would follow the wound. Review of the facility's policy titled Skin Integrity and Pressure Ulcer/Injury Prevention and Management effective (MONTH) 3, 2019, revealed a comprehensive skin inspection/assessment is conducted on admission and re-admission to the facility. The policy included the facility will utilize the Lippincott procedures for pressure injury management, long term care. The Lippincott procedure for pressure injury management, long term care revealed documentation should include the size, location, depth, and stage of the pressure injury; the condition of the wound bed, the presence of eschar, and the status of the peri-wound area. The procedure included the presence and signs of infection and pain, wound care provided and the resident's response to the interventions should be documented. The procedure also included teaching should be provided to the resident and/or family members and their understanding of the teaching, and whether they require follow-up teaching should be documented as well.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy reviews, the facility failed to ensure oxygen therapy was provided to one resident (#21) consistent with professional standards of practice. The deficient practice could result in respiratory complications. Findings include: Resident #21 was admitted to the facility on (MONTH) 12, (YEAR) with [DIAGNOSES REDACTED]. The physician order [REDACTED]. Review of the care plan initiated on (MONTH) 27, (YEAR) revealed the resident was receiving oxygen therapy related to ineffective gas exchange. The goal was that the resident would have no signs or symptoms of poor oxygen absorption. Interventions included observing for signs and symptoms of respiratory distress and reporting to the physician as needed: respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, and accessory muscle use and cough. Further review of the care plan, revealed an intervention initiated (MONTH) 27, (YEAR) for oxygen via nasal cannula at 2 liters per minute continuously and an intervention initiated (MONTH) 20, 2019 for oxygen via nasal cannula at 4 liters per minute continuously However, review of the physician's orders [REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 30, 2019 revealed a score of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. The MDS assessment also included the resident was receiving oxygen therapy. Review of the Medication Administration Record [REDACTED]. An observation was conducted of resident #21 on (MONTH) 16, 2019 at 9:22a.m. One prong of the nasal cannula was observed in the resident's her left nostril and the other prong was resting on her face to the left of her nose. The oxygen concentrator was set at 3 liters per minute. The tubing on the concentrator and the nasal cannula were not labeled with a date which would indicate when they had been changed. A Certified Nursing Assistant (CNA/staff #183) entered the resident's room during this observation and was not observed to check the resident's oxygen concentrator or tubing, and or adjust the resident's nasal cannula. Another observation was conducted of resident #21 on (MONTH) 17, 2019 at 9:26a.m. The resident was observed holding the nasal cannula in her hand. The oxygen concentrator was set at 3 liters per minute. The tubing on the concentrator and the nasal cannula were not labeled with a date to indicate when they were last changed. During this observation, the resident stated the nasal cannula was abrasive to her nostril and she did not like to wear it. An interview was conducted with resident #21 on (MONTH) 18, 2019 at 9:12 a.m. The tubing on the concentrator and the nasal cannula were labeled with the date (MONTH) 18. The resident stated that her oxygen concentrator was changed that morning, about an hour prior to this interview. She stated that when the machine was changed, no one checked to make sure it was working. The resident stated she had not been receiving oxygen since the machine was changed. The concentrator was observed and appeared to be working and was set at 2 liters per minute. The resident stated the tubing is incorrect and that is why

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035120	A. BUILDING _____ B. WING _____	12/19/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MI CASA NURSING CENTER	330 SOUTH PINNULE CIRCLE MESA, AZ 85206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) she is not getting oxygen. Resident #21 also stated she had not alerted staff to the issue as she waved the nasal cannula around. At 9:35a.m., a CNA (staff #48) entered resident #21's room to provide care to resident #21's roommate. Resident #21 was heard telling staff #48 that she had a headache but did not need anything. After exiting the room, staff #48 was heard asking staff #183 to check on resident #21 when staff #183 had a chance. At 9:37a.m., resident #21 turned on her call light. A Licensed Practical Nurse (LPN/staff #74) responded and resident #21 told staff #74 that her oxygen was not working. Resident #21 stated to staff #74 that she had a bad headache but declined pain medication. Staff #74 checked the oxygen machine and informed the resident the machine was working fine. Staff #74 then checked the tubing and found it was twisted and blocking the oxygen flow. Staff #74 fixed the tubing and resident #21 stated she was able to breathe. An interview was conducted with the LPN (staff #74) on (MONTH) 18, 2019 at 9:56 a.m. Staff #74 stated that each time she enters resident #21's room, she checks the oxygen. She stated resident #21 does not like to wear the nasal cannula, but that they encourage her to keep it on. Staff #74 said she did not know how many liters of oxygen were ordered and that she needed to look it up. After reviewing the order, she said the order is for 2-4 liters per minute and that she usually keeps it at 2 liters per minute unless the resident is in distress. She stated the night shift changes the tubing once a week, and that the tubing is be labeled with the date it was changed. Staff #74 stated that when the tubing is changed, the tubing should be checked to make sure it is not twisted or bent to prevent the oxygen flow. Review of the physician orders [REDACTED]. An interview was conducted with the Director of Nursing (DON/ staff #161) on (MONTH) 18, 2019 at 10:14a.m. The DON stated the order for oxygen is usually a range so that the oxygen can be titrated to meet the residents' needs and comfort. Another interview was conducted with the DON on (MONTH) 18, 2019 at 12:46p.m. The DON stated the tubing on the oxygen concentrators is changed weekly, on Sunday. She stated the tubing should be labeled with the date it was changed. The DON stated that she expects staff to check oxygen equipment as they make their rounds and each time they enter the room and to make adjustments as needed. The facility's policy titled Oxygen Administration/ Safety/ Storage/ Maintenance reviewed (MONTH) 15, 2019, revealed oxygen supplies should be changed weekly and when visibly soiled. Equipment should be labeled with the resident name and dated when set up or changed out. The facility's policy regarding physician orders [REDACTED].
F 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Post nurse staffing information every day.** Based on observation, review of nurse staffing information, and staff interview, the facility failed to ensure the nurse staffing information was posted on a daily basis. Findings include: During an observation conducted on (MONTH) 16, 2019 at 8:17a.m., the daily nurse staff posting form was in a frame on the desk of the front receptionist. The daily staff posting form was dated (MONTH) 13, 2019. The posted nurse staffing information included the facility census, the number of Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nursing Assistants (CNA) and the actual hours worked for each shift. Review of the daily staff postings forms for (MONTH) 2019 conducted on (MONTH) 18, 2019 at 1:12p.m., revealed there were daily staff posting forms which had been completed from (MONTH) 1 through (MONTH) 14. An interview was conducted with the Director of Nursing (DON/Staff #161) on (MONTH) 18, 2019 at 2:17p.m. The DON stated she is responsible for posting the daily staffing form. The DON stated that on the weekends, the receptionist is responsible for posting the form. She said in the past, the staffing coordinator would make sure the form was posted, but that staff member has been on leave and she has taken on the responsibility. The DON stated she posts a new staffing form every morning at the beginning of the shift. She stated she has two hours from the start of the morning shift to post a new staffing form. Regarding the staff posting dated (MONTH) 13 that was posted on (MONTH) 16, 2019, the DON stated she would expect the weekend staff to change the posting daily.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observations, staff interviews and policy review, the facility failed to ensure expired medical supplies were not available for resident use. The deficient practice could result in inaccurate laboratory results and increased risk for infection. Findings include: During an observation of station 1 medication storage room conducted with a Registered Nurse (staff #64) on (MONTH) 19, 2019 at 11:38 a.m., the following were observed: -approximately thirty blood collection tubes with an expiration date of (MONTH) 30, 2019, which were stored in a cupboard with other blood collection tubes that were not expired. -Four expired culture swab kits which were stored in a drawer with other culture swab kits that were not expired. One culture swab kit had an expiration date of (MONTH) (YEAR), two kits had expiration dates of (MONTH) (YEAR), and another kit had an expiration date of (MONTH) 2019. An interview was conducted with staff #64 during this observation. She stated that she was responsible for auditing the medication room. She said she checks the room about every two weeks for expired products. During an observation of station 3 medication storage room conducted with a Licensed Practical Nurse (staff #176) on (MONTH) 19, 2019 at 11:56 a.m., the following were observed: -One PICC (peripherally inserted central catheter) line dressing change kit with an expiration date of (MONTH) 30, 2019, which was stored in a cupboard with other dressing change kits that were not expired. -Another PICC line dressing change kit with an expiration date of (MONTH) 31, 2019, which was stored in a cupboard with other dressing change kits that were not expired. The packaging of the kit was partially opened. -Two IV (intravenous) insertion kits with expiration dates of (MONTH) (YEAR) which were stored in a drawer with other IV insertion kits that were not expired. The packaging of one of the kits was partially opened. An interview was conducted with staff #176 during this observation. She stated she was responsible for auditing the medication room. She said the room contained a separate bin for expired medications and items that were to be returned to the pharmacy. An interview was conducted with the Director of Nursing (staff #161) on (MONTH) 19, 2019 at 1:41 p.m. She stated her expectation is that there should not be expired medications or supplies in the medication storage rooms. Review of the facility's policy titled: Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles revised (MONTH) 28, 2019, revealed the following: -The facility should ensure that medications and biologicals that have an expired date on the label, have been retained longer than recommended by manufacturer or supplier guidelines, or have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. -The facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with pharmacy return/destruction guidelines, other applicable law and in accordance with facility policy. -Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis.