| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 115687 | A. Building<br>B. Wing | 04/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Willowbrooke Court at Lanier Village Estates | 4145 Misty Morning Way<br>Gainesville, GA 30506 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47146<br><br>Based on observations, staff interviews, record review, and review of the facility's policy titled Baseline Care Plan, the facility failed to implement interventions for oxygen therapy for one of seven residents (R) (R290) receiving oxygen therapy. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs, and a diminished quality of life.<br><br>Findings include:<br><br>Review of the facility's policy titled Baseline Care Plan, last review date of 5/2018 under Policy revealed, To strive to initiate a baseline care plan for a resident based upon the medical plan and nursing assessment, which includes the instructions needed to provide person-centered care and meets the professional stands of quality care. Under the section titled Procedure revealed, Number two. The baseline care plan should address the residents' immediate needs and include the minimum healthcare information necessary to properly care for the resident including, but not limited to: b. physician orders and d. therapy services.<br><br>Review of the electronic medical record (EMR) revealed R290 admitted to the facility on [DATE] with diagnoses that included but not limited to dyspnea, interstitial pulmonary disease, chronic respiratory failure with hypoxia, and syncope and collapse.<br><br>Review of R290's care plan indicated a focus of receiving oxygen therapy related to chronic respiratory failure with interventions that included but not limited to oxygen via nasal cannula at two liters per minute, initiated on 4/19/2024.<br><br>Observation on 4/26/2024 at 10:35 am revealed R290 was observed wearing a nasal cannula and receiving oxygen via concentrator with flow meter set at three liters per minute.<br><br>Observation on 4/26/2024 at 1:49 pm revealed R290 sitting up in a recliner in her room wearing a nasal cannula and receiving oxygen via concentrator with flow meter set at three liters per minute.<br><br>Observation on 3/27/2024 at 8:01 am revealed R290 sitting up in her recliner eating breakfast wearing a nasal cannula and receiving oxygen via concentrator with flow meter set at three liters per minute.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and Interview with Licensed Practical Nurse (LPN) AA on 4/27/2024 at 8:15 am revealed R290 sitting up in recliner wearing a nasal cannula and receiving oxygen via concentrator with flow meter set at three liters per minute. LPN AA verified R290's oxygen flow meter was set at three liters per minute and that the physician order for oxygen was for two liters per minute via nasal cannula. LPN AA confirmed that it was the nurses responsibility to check and verify the flow meter was set to the setting specified by the physician orders.<br><br>Interview on 4/27/2024 at 10:45 am with the Director of Nursing (DON) revealed her expectation was for the nursing staff to monitor and verify the concentrator flow rate to be set at the rate ordered by the physician.<br><br>Interview on 4/28/2024 at 8:30 am with Registered Nurse (RN) Care Coordinator BB revealed that the nurses are expected to review and implement the interventions listed on the resident's care plan.<br><br>Interview on 4/28/2024 at 8:45 am with RN CC revealed that the floor nurse's responsibility related to the care plan was to initiate the baseline care plan on admission, this includes review orders and family and resident requests, to assist with the development of the baseline care plan. She stated the floor nurse was expected to follow the care plan and verify the care provided was included in the care plan. She stated she usually reviewed orders and care plans prior to the start of her shift to verify and reconcile orders with the care plan.<br><br>Interview with RN DD on 4/28/2024 at 9:00 am revealed the care plan was a communication tool, which opened communication with all staff, so everyone would be on the same page when providing care for each resident. She stated the care plan communicates with nurses, Certified Nursing Assistants (CNAs), and other staff what interventions are needed in relationship to the residents' orders and needs. She revealed nurses should update the care plan to include new interventions.<br><br>Interview on 4/28/2024 at 9:25 am with the Assistant Director of Nursing (ADON) revealed care planning was addressed every morning during stand-up meetings. She stated the nursing supervisor rounded every morning and discussed with the floor nurses any resident concerns or needs and that they review the 24-hour report. She revealed that during the morning stand up meeting any concerns, issues, resident needs, and updates from the 24-hour report are communicated with the entire interdisciplinary team (IDT). She stated the care coordinator in the past would update the care plan immediately during this meeting as needed. She stated implementation of the care plan included addressing the Treatment Administration Record (TAR) for nurses and the task list for the CNAs. She also stated the care profile was updated and all staff were able to see this in the banner of the EMR. She stated nurses are expected to implement the interventions identified in the care plan and follow physician orders related to the oxygen flow rates.<br><br>Cross Reference F695 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47146<br><br>Based on observations, staff interviews, record review, and review of the facility's policies titled Person Centered, Interdisciplinary Care Planning and Care Conference, and Catheter Care, Indwelling, the facility failed to develop a person-centered care plan with interventions that addressed performing catheter care for one of three residents (R) (R24) with an indwelling urinary catheter. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs, and a diminished quality of life.<br><br>Findings include:<br><br>Review of the facility's policy titled Person Centered, Interdisciplinary Care Planning and Care Conference last revised date 10/2022, under the section titled, Policy revealed, To strive to develop, review, and revise the person-centered interdisciplinary care plan for each resident in order to identify resident needs, establish measurable goals/objectives, interventions, and timeframes to enable the resident to attain/maintain his/her optimal level of physical, mental, and psychosocial functioning. Person Centered The focus on the resident as the center of control. Each resident is supported in making his/her own choices in identifying what is important to him/her regarding daily routines, preferred activities, and a meaningful life. Under the section titled, Procedure revealed, Number five. Ensures that the interdisciplinary person-centered care plan addresses the following: Residents personal and cultural preferences, Residents' preferences and potential for future discharge.<br><br>Review of the facility's policy titled Catheter Care, Indwelling last revised date 7/2022, under the section titled Procedure, Number 22 revealed, Ensure the care plan reflects the following:<br><br>a. Type of catheter tubing.<br><br>b. Routine care of catheter, tubing, drainage bag.<br><br>c. Interventions to minimize catheter-related injury, pain, encrustation, excessive urethral tension, accidental removal, or obstruction of urine overflow.<br><br>d. Outcomes and/or effects of goals and interventions.<br><br>e. Complications associated with catheter usage.<br><br>f. Urology consult if indicated.<br><br>Review of the electronic medical record (EMR) revealed R24 was admitted to the facility with diagnoses that included but not limited to hydronephrosis with renal and ureteral calculous obstruction, urinary tract infections (UTI), methicillin resistant staphylococcus aureus (MRSA) infection, artificial openings of the urinary tract, chronic kidney disease, urethral stricture, and obstructive and reflux uropathy.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R24's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated R24 was cognitively intact. Section GG (Functional status) revealed R24 required partial/moderate assistance during self-care admission performance of toileting. Section H (Bowel and Bladder) revealed R24 had an indwelling urinary catheter and an ostomy.<br><br>Review of R24's care plan indicated a focus on bilateral nephrostomy tubes (initiated 4/1/2024) Interventions included: empty nephrostomy tubes as ordered, enhanced barrier precautions, follow up with MD (Medical Doctor) as ordered, monitor for s/sx (signs and symptoms) of infection. Further review of care plans revealed a focus for an indwelling catheter (initiated on 3/26/2024) Interventions included: monitor for s/sx of discomfort on urination and frequency, monitor/document pain/discomfort due to catheter and monitor/record/report to MD for s/sx UTI. There were no care plan interventions that addressed performing catheter care.<br><br>Observation on 4/27/2024 at 9:29 am of R24 in the shower performing self-catheter care with Certified Nursing Assistant (CNA) EE standing on the other side of shower curtain observing R24 perform catheter care.<br><br>Interview on 4/27/2024 at 9:24 with CNA EE revealed that R24 was documented as stand-by assist for catheter care. She stated he usually did his own catheter care while he showered. She revealed that while R24 showers she observes him performing his catheter care to verify that he completes the care correctly. She stated that if she notices him doing anything incorrectly, she redirects him in his care. She further stated once the catheter care was completed the CNA would report to the nurse and the nurse would document catheter care was completed in R24's eTAR.<br><br>Interview on 4/27/2024 at 11:45 am with Licensed Practical Nurse (LPN) AA revealed she reviewed R24's care plan, latest MDS assessment, and the task tab in the EMR. She verified and confirmed she could not locate documentation that R24 had been assessed as stand-by assistance for catheter care. She verified and confirmed that the nurse document catheter care three times a day on the eTAR. She stated the CNA's have a tablet which they document in the EMR which may indicate the type of assistance R24 required for catheter care.<br><br>Interview on 4/27/2024 at 11:45 am with CNA EE revealed that the tablet she uses to document care for residents listed catheter care as a task. She verified and confirmed the task did not indicate the type of assistance R24 required for catheter care. She stated she knew he was stand-by assist for catheter care because she knew R24. She stated she could not identify how the CNA determines the type of assistance R24 required for catheter care in the EMR.<br><br>Interview on 4/27/2024 at 12:50 pm with the Registered Nurse (RN) Care Coordinator BB confirmed there was no care plan developed for R24 to self-perform catheter care. She stated that she runs a report everyday of new orders obtained from the physician and she develops/revises care plans based on the new orders entered in the EMRs for the facility's residents. She stated she has only been working in the facility since 4/22/2024 and was unaware R24 was performing self-catheter care.<br><br>Interview with the Director of Nursing (DON) on 4/27/2024 at 12:54 pm revealed her expectation related to development of care plans was for the Care Coordinator to run a report of new orders and develop/revise care plans based upon new orders entered into resident's medical records.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Cross Reference F690 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>47146<br><br>Based on observations, staff interviews, record review, and review of the facility's policy titled Catheter Care, Indwelling, the facility failed to assess one out of three residents (R) (R24) with an indwelling urinary catheter for self-performance of catheter care prior to allowing the resident to perform catheter care without staff direct assistance.<br><br>Findings include:<br><br>Review of the facility's policy titled Catheter Care, Indwelling last revised date 7/2022 under the section titled Policy revealed, To strive to prevent contamination and catheter associated urinary tract infections and complications. Under the section titled Procedure number five revealed, Catheter care can be given during am or pm care as follows:<br><br>a. Assist the resident into a supine position.<br><br>b. Inspect the outside of the catheter where the catheter enters the meatus. Look for encrusted material or suppurative drainage and report any findings to the nurse.<br><br>c. Inspect the tissue around the urinary meatus for irritation or swelling and report any findings to the nurse.<br><br>d. Wash the meatal catheter junction and catheter tubing with soap and water, rinse and dry well.<br><br>f. Draw back the foreskin, wash carefully around the catheter and replace the fore skin<br><br>on the male resident.<br><br>Review of R24's electronic medical record (EMR) revealed he was admitted to the facility with diagnoses that included but not limited to hydronephrosis with renal and ureteral calculous obstruction, urinary tract infections (UTI), methicillin resistant staphylococcus aureus (MRSA) infection, artificial openings of the urinary tract, chronic kidney disease, urethral stricture, and obstructive and reflux uropathy.<br><br>Review of R24's most recent Minimum Data Set (MDS) assessment (Medicare five -day) dated 4/18/2024 revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated R24 was cognitively intact. Section GG (Functional) revealed no functional limitations of upper and lower extremities, he was assessed to require partial/moderate assistance with toileting and lower body dressing. Section H (Bowel and Bladder) revealed R24 had an indwelling catheter and ostomy.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the EMR revealed physician's orders for R24 included but were not limited to flush nephrostomy tubes with 10 milliliters of normal saline daily as needed for blockage (start date 4/26/2024), clean both nephrostomy sites with warm water, pat dry, apply drain sponge to nephrostomy and cover with transparent dressing daily on Tuesday and as needed, assess for warmth, leakage, pus, breaks in tube every shift on Tuesdays (start date 4/30/2024), empty and document output from catheter and bilateral nephrostomy tubes three times a day, monitor urine output and document nephrostomy drain output three times a day (start date 4/16/24). There were no orders for R24 to perform self-catheter care.<br><br>Review of the EMR revealed there was no evidence that an assessment had been completed for R24 to self-perform catheter care.<br><br>Review of the April 2024 Electronic Treatment Record (eTAR) revealed documentation of urinary catheter care documented three times a day and enhanced barrier precautions documented each shift by the nurse.<br><br>Observation made on 4/27/2024 at 9:29 am of R24 in the shower with Certified Nursing Assistant (CNA) EE standing outside of the curtain watching R24 self-perform catheter care. R24 used soap and water to clean the urinary meatus and catheter tubing from the meatus to the bifurcation in the tube at the balloon port and the urine drainage port. He thoroughly rinsed the area with clean water using a handheld shower head.<br><br>Interview on 4/27/2024 at 9:24 am with CNA EE stated R24 was stand-by assist for catheter care. She stated he usually did his own catheter care while he showered. She stated once the catheter care was completed the CNA reported the activity to the nurse who would document the care in R24's medical record.<br><br>Interview on 4/27/2024 at 11:45 am with Licensed Practical Nurse (LPN) AA revealed that R24's care plan, latest MDS assessment, and the task list located in the EMR did not specify R24 was assessed as stand-by assist for catheter care. She confirmed and verified she could not locate any documentation in the EMR that stated R24 had been assessed as stand by assist for catheter care. She stated the care was documented each shift by the nurse on the electronic Treatment Administration Record (eTAR).<br><br>Interview on 4/27/2024 at 11:50 am with the Director of Nursing (DON) verified the e-TAR indicated catheter care was to be completed each shift for R24. She stated her expectation was when a resident requests to perform their own catheter care, the nurse on the floor should call the physician to request an order for self-care. She further stated that nursing should perform an assessment to verify the resident was able to perform self-catheter care.<br><br>Interview on 4/27/2024 at 12:50 pm with Registered Nurse (RN) Care Coordinator BB revealed if a resident request to perform self-catheter care, the nurse should assess and educate the resident regarding signs and symptoms of infection and proper performance of catheter care. She stated the nurse should then notify the physician to obtain an order and enter the order into the EMR. She stated her first day in the facility was Monday 4/22/2024, therefore she was unaware of R24's performance of self-catheter care.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A request was made for a policy related to resident assessment for self-catheter care but was not provided by the facility.<br><br>Cross Reference F656 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47146<br><br>Based on observations, staff and resident interviews, record review, and review of the facility's policies titled Oxygen Administration/Safety and Use and Care of Equipment, the facility failed to follow physician's order for oxygen therapy and failed to ensure the oxygen concentrator had a filter while in use for one out of seven residents (R) (R290) who receive oxygen via the concentrator.<br><br>Findings include:<br><br>Review of the policy titled Oxygen Administration/Safety with review date of 10/18, revealed the policy was to strive to improve oxygenation, provide comfort to resident's experiencing respiratory difficulties and provide safety precautions during the administration of oxygen. The section titled Procedure, step number one revealed obtain a physicians' order for the use of oxygen (i.e., continuous, as needed, number of liters, etc.). Step number four stated adjust the oxygen flow as ordered by the resident's physician. Step number nine revealed check the resident and oxygen flow frequently to assure the maintenance of the correct flow rate and proper functioning of the concentrator/cylinder.<br><br>Review of the policy titled Use and Care of Equipment reviewed 11/20, revealed the policy was to strive to provide clean or sterile resident care equipment in order to reduce the possibility of equipment becoming contaminated that may cause infections. Under the section titled Clean Equipment Protocols, number nine addressed Respiratory Equipment and sub-section a addressed Oxygen Materials, number five revealed oxygen concentrator filters are cleaned and or replaced weekly.<br><br>Review of the electronic medical record (EMR) revealed R290 was admitted to the facility with diagnoses that included but were not limited to dyspnea, interstitial pulmonary disease, chronic respiratory failure with hypoxia, and syncope and collapse.<br><br>Review of R290's EMR revealed the Admission Minimum Data Set (MDS) assessment dated [DATE] was in process and had not been completed related to the resident's recent admission.<br><br>Review of the EMR revealed a nursing assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated R290 was cognitively intact.<br><br>Review of R290's care plan indicated a focus of care on receiving oxygen therapy related to chronic respiratory failure which included an intervention but was not limited to oxygen settings: Oxygen via nasal cannula at two liters per minute (initiated on 4/19/2024).<br><br>Review of R290's EMR revealed physician's orders that included but was not limited to oxygen at two liters per minute via nasal cannula (started 4/18/2024).<br><br>Review of the EMR revealed nurses documented on the electronic medication administration record (eMAR) oxygen saturations twice a day ranging from 94 to 98 percent on oxygen via nasal cannula.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observations and Interview on 4/26/2024 at 10:35 am of R290 working with physical therapy in her room. R290 was wearing nasal cannula with oxygen infusing from the concentrator at three liters per minute. R290 revealed she had worn her oxygen continuously since her admission into the facility. She revealed prior to admission, she only wore oxygen when walking because she became short of breath easily.<br><br>Observation on 4/26/2024 at 12:30 pm revealed R290's oxygen concentrator was missing the filter on the back of the machine.<br><br>Observations on 4/26/2024 at 1:49 pm revealed R290 sitting up in a recliner in her room wearing a nasal cannula and the flow meter on the oxygen concentrator was set at three liters per minute with the filter missing from the back of the concentrator.<br><br>Observations made on 4/27/2024 at 8:01 am observed R290 sitting up in a recliner in her room wearing a nasal cannula and eating breakfast. The oxygen concentrator flow meter was set at three liters per minute with the filter missing from the back of the oxygen concentrator.<br><br>Observation and interview on 4/27/2024 at 8:15 am with Licensed Practical Nurse (LPN) AA, confirmed R290's orders for oxygen at two liters via nasal cannula. LPN AA observed and confirmed R290's oxygen concentrator flow meter was set at three liters per minute in addition to the oxygen concentrator not having a filter. She revealed that all oxygen tubing and humidifier bottles were changed weekly on night shift. She stated she thought filters were cleaned one to two times a week but was not sure. She stated she was not sure which night this task was completed on but when tubing and humidifier bottles are changed the nurse should label them with the date. She further stated she was not sure where this task was documented because it was not on her eMAR.<br><br>Interview on 4/27/2024 at 10:05 am with the Director of Nursing (DON) confirmed R290 had physician orders for oxygen at two liters per minute via nasal cannula. She confirmed the admitting nurse should obtain the oxygen concentrator for newly admitted resident and verify the filter was in place and clean before placing the concentrator in use. She stated oxygen tubing should be changed on Sunday nights. She revealed the admission nurse should initiate the change tubing orders and when tubing was changed, the nurse should document this on the eMAR. She stated each disposable component of the oxygen concentrator (nasal cannula and humidifier bottle) should be labeled with the date it was changed. She stated her expectation of staff was upon admission if a resident has an order for oxygen to initiate oxygen by obtaining a concentrator with a clean filter and set up with a nasal cannula and humidifier if needed and to label each component and the date initiated. She stated she expected the flow meter to be set on the rate ordered by the physician. She also stated she expected during nursing rounds the nurses should be checking the flow meter rate and verifying the rate was set at the physician's ordered rate. She stated she expected the night shift nurse on Sundays to change the tubing set up and clean the filter each week.<br><br>Cross Reference F655 |