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SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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E 000	Initial Comments A recertification survey was conducted on 10/28/19 through 10/31/19 by the Division of Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID #9BFI11.	E 000		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Physician interviews the facility failed to administer oxygen at the physician prescribed dose for 4 of 6 residents sampled for respiratory care (Resident #10, Resident #8, Resident #55 and Resident #346). The findings included: 1. Resident #10 was readmitted to the facility on 01/30/19 with diagnoses that included: end stage renal disease, chronic obstructive pulmonary disease (COPD), acute pulmonary edema and others. Review of a physician's order dated 01/30/19 read, oxygen at 2-4 liters per nasal canula.	F 695	Please accept this Plan of Correction(POC) as Surry Community Health and Rehabilitation Center's credible allegation of compliance. Preparation and execution of this POC does not constitute admission or agreement with the findings of non-compliance. The POC is being provided in pursuit to federal and state requirements which require an acceptable plan of correction as a condition of continued certification. Date of alleged compliance is November 25, 2019. F695 Respiratory/Tracheostomy Care and Suction	11/25/19

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

Electronically Signed | 11/21/2019

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F 695	Continued From page 1 Review of a quarterly Minimum Data Set (MDS) dated 07/26/19 revealed that Resident #10 was moderately impaired for daily decision making and required extensive assistance with activities of daily living. The MDS further revealed that Resident #10 required the use of oxygen during the assessment reference period and no shortness of breath was identified. Review of a care plan revised on 08/02/19 read, Resident #10 had oxygen therapy related to respiratory illness, COPD, pulmonary fibrosis, and respiratory care. The goal of the care plan read, Resident #10 will have no complications related to COPD. The interventions included: oxygen as ordered via nasal canula. Review of Resident #10's oxygen saturation (amount of oxygen in the blood) from 10/01/19 through 10/31/19 revealed the levels were between 88-99%. An observation of Resident #10 was made on 10/28/19 at 12:13 PM. He was resting in bed with eyes open. He was alert and verbal and indicated he had just returned from dialysis. He had oxygen in his nose via a nasal canula. The oxygen concentrator was sitting next to his bed and was set to deliver 5 liters of oxygen. No shortness of breath was noted. An observation of Resident #10 was made on 10/29/19 at 10:26 AM. He was resting in bed with his eyes closed. He had oxygen in his nose via a nasal canula. The oxygen concentrator was sitting next to his bed and was set to deliver 5 liters of oxygen. No shortness of breath was noted.	F 695	CFR(s):483.25(I) 1. The facility failed to administer oxygen at the physicians prescribed dose for 4 of 6 residents. Resident numbers 10,8,55 and 346 were immediately assessed for adverse outcomes with none noted. Oxygen was administered per physicians order. 2. All residents who require the use of oxygen are at risk for this deficient practice. An audit was performed by the Director of Nursing on 11/1/2019 of current residents with orders for oxygen. No other issues were noted. 3. Reeducation regarding oxygen orders being maintained per physician order will be completed by 11/23/2019 for licensed nursing staff by the Director of Nursing , Assistant Director of Nursing, Unit Managers and Unit Coordinators. This education will extend into the orientation process for all newly hired licensed nurses. Director of Nursing/Nurse Management will audit 5 residents per shift X 4 weeks, then random audits of 10 resident per week will be performed X 8 weeks. 4. The Director of Nursing will be responsible for implementing this plan of Correction and all findings will be brought to QAPI monthly X 3 months to evaluate the effectiveness and amend as needed.	

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An observation of Resident #10 was made on 10/29/19 at 1:50 PM. Resident #10 was resting in bed with his eyes closed. He had oxygen in his nose via a nasal canula. The oxygen concentrator was sitting next to his bed and was set to deliver 5 liters of oxygen. No shortness of breath was noted.

An observation of Resident #10 was made on 10/30/19 at 1:50 PM. Resident #10 was resting in bed with his eyes open and indicated he just returned from dialysis. He had oxygen in his nose via a nasal canula. The oxygen concentrator was sitting next to his bed and was set to deliver 5 liters of oxygen. No shortness of breath was noted.

An interview and observation were conducted with Nurse #1 on 10/30/19 at 3:52 PM. Nurse #1 confirmed he was caring for and was familiar with Resident #10. He stated that Resident #10 was prescribed 2-4 liters of oxygen to maintain an oxygen saturation above 92%. Nurse #1 observed Resident #10's oxygen concentrator and confirmed that it was set to deliver 5 liters of oxygen. He added that at times Resident #10's oxygen level dropped when the staff were getting him ready for dialysis and they probably turn it up to help him. He added that when Resident #10 had stabilized back out the staff should turn his oxygen back down to the physician prescribed amount of oxygen. Nurse #1 stated it was ok to temporarily turn the oxygen up to 5 liters but if he continued to require that much oxygen then the physician should be notified for new orders. He continued to say that Resident #10 was unable to adjust the oxygen concentrator himself due to the contractures in his hands. He added that he was

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expected to check the oxygen concentrator during his shift but had not yet done so and was not aware that the concentrator was not set on the physician prescribed amount of oxygen.

An observation of Resident #10 was made on 10/30/19 at 4:12 PM. Resident #10 was resting in bed with eyes open and was alert and verbal. He had oxygen in his nose via a nasal canula. The oxygen concentrator was sitting next to his bed and was set to deliver 5 liters of oxygen. No shortness of breath was noted.

An interview was conducted with the Unit Manager (UM) on 10/31/19 at 9:54 AM. The UM stated that the nurses were expected to check the oxygen flow rate at least once a shift. She confirmed that the Resident #10 should have been on the physician prescribed dose of oxygen and if he required more then what was prescribed, she would expect the nurse to contact the physician for additional orders. The UM stated that she had witnessed Resident #10 become short of breath and ask the staff to turn up his oxygen so he could catch his breath but added it should be returned to what he was ordered when he stabilized, or the physician notified.

An interview was conducted with the Administrator on 10/31/19 at 10:06 AM. The Administrator stated that she expected the staff to follow the physician orders and administer the correct dose of oxygen. She added that she had spoken to the Physician and he was going to make some adjustments to Resident #10's orders.

An interview was conducted with the Director of Nursing (DON) on 10/31/19 at 10:06 AM. The

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DON stated that the Nurses were expected to monitor and check the oxygen flow rate every shift. If the oxygen was not on what was prescribed, she would expect the nurse to change the flow rate to the correct dose. She added that Resident #10's oxygen level sometimes dropped during care and the staff would turn it up temporarily but once he stabilized it should be returned to the correct dose of oxygen or the physician should be notified.

An interview was conducted with the Physician on 10/31/19 at 11:16 AM. The Physician stated that because Resident #10 sometimes needed the increase oxygen he was going to review his orders and give the staff some leniency with his orders. He added that Resident #10 was a very complex patient and needed some flexibility in his orders for staff to adjust it when they need too but of course expected the staff to follow the orders provided.

2. Resident #8 was readmitted to the facility on 07/23/19 with diagnoses that included: acute/chronic respiratory failure and others.

Review of a physician order dated 07/23/19 read, oxygen via nasal canula at 2 liters continuously.

Review of a care plan revised on 07/23/19 read, Resident #8 required oxygen therapy. The goal read, Resident #8 will have no signs or symptoms of poor oxygen absorption through the review date. The interventions included: oxygen via nasal canula as indicated.

Review of a quarterly Minimum Data Set (MDS) dated 07/30/19 revealed that Resident #8 was moderately impaired for daily decision making

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and required total assistance with activities of daily living. The MDS further indicated Resident #8 required oxygen and was short of breath on exertion and when laying flat.

Review of Resident #8's oxygen saturation (amount of oxygen in blood) from 10/01/19 through 10/31/19 revealed that the level was 96-100%.

An observation of Resident #8 was made on 10/28/19. Resident #8 was resting in bed with eyes open and had a flat affect. Her head of bed was elevated, and she had oxygen in her nose via a nasal canula. There was an oxygen concentrator sitting next to her bed and was set to deliver 3 liters of oxygen. No shortness of breath was noted.

An observation of Resident #8 was made on 10/29/19 at 10:31 AM. Resident #8 was resting in bed with eyes open and had a flat affect. Her head of bed was elevated, and she had oxygen in her nose via a nasal canula. There was an oxygen concentrator sitting next to her bed and was set to deliver 3 liters of oxygen. No shortness of breath was noted.

An observation of Resident #8 was made on 10/29/19 at 1:52 PM. Resident #8 was resting in bed with eyes open and had a flat affect. Her head of bed was elevated, and she had oxygen in her nose via a nasal canula. There was an oxygen concentrator sitting next to her bed and was set to deliver 3 liters of oxygen. No shortness of breath was noted.

An observation of Resident #8 was made on 10/30/19 at 10:18 AM. Resident #8 was resting in

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bed with eyes open and had a flat affect. Her head of bed was elevated, and she had oxygen in her nose via a nasal canula. There was an oxygen concentrator sitting next to her bed and was set to deliver 3 liters of oxygen. No shortness of breath was noted.

An observation of Resident #8 was made on 10/30/19 at 1:52 PM. Resident #8 was resting in bed with eyes open and had a flat affect. Her head of bed was elevated, and she had oxygen in her nose via a nasal canula. There was an oxygen concentrator sitting next to her bed and was set to deliver 3 liters of oxygen. No shortness of breath was noted.

An interview and observation were conducted with Nurse #1 on 10/30/19 at 3:52 PM. Nurse #1 confirmed he was caring for and was familiar with Resident #8. He stated that Resident #8 was prescribed 2 liters of oxygen. Nurse #1 observed Resident #8's oxygen concentrator and confirmed that it was set to deliver 3 liters of oxygen and adjusted it back to 2 liters. Nurse #1 stated that Resident #8 was unable to adjust the oxygen concentrator because she could not reach it. He added that he was expected to check the oxygen concentrator during his shift but had not yet done so and was not aware that the concentrator was not on the physician prescribed amount of oxygen and it should have been.

An interview was conducted with the Unit Manager (UM) on 10/31/19 at 9:54 AM. The UM stated that the nurses were expected to check the oxygen flow rate at least once a shift and confirmed that the Resident #8 should have been on the physician prescribed dose of oxygen.

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An interview was conducted with the Administrator on 10/31/19 at 10:06 AM. The Administrator stated that she expected the staff to follow the physician orders and administer the correct dose of oxygen. She added that she had spoken to the Physician and he was going to make some adjustments to Resident #8's orders.

An interview was conducted with the Director of Nursing (DON) on 10/31/19 at 10:06 AM. The DON stated that the Nurses were expected to monitor and check the oxygen flow rate every shift. If the oxygen was not on what was prescribed, she would expect the nurse to change the flow rate to the correct dose.

An interview was conducted with the Physician on 10/31/19 at 11:16 AM. The Physician stated that he was going to make some adjustments to Resident #8's orders and give the staff some leniency with her orders. He added that he expected the staff to follow the orders provided.

3. Resident #55 was admitted to the facility on 08/08/19 and readmitted on 09/16/19 with diagnoses that included chronic obstructive pulmonary disease (COPD), sleep apnea and others.

A physician's order dated 09/16/19 specified Resident #55 was to have her oxygen saturations monitored and 2 liters of continuous oxygen through a nasal cannula.

A physician's progress note dated 09/19/19 read, "2 liters of continuous oxygen."

The most recent Minimum Data Set (MDS) dated 09/23/19 specified the resident's cognition was

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moderately impaired and she received supplemental oxygen.

A care plan reviewed on 09/23/19 related to the use of oxygen for COPD specified oxygen via a nasal cannula was to be used as indicated.

According to the medical record, oxygen saturations were monitored every shift by a nurse and documented on the Medication Administration Record (MAR).

On 10/28/19 at 10:43 AM PM Resident #55 was in bed wearing a nasal cannula. The resident stated she felt bad and was waiting on a chest x-ray. Her oxygen concentrator was on and set at 3 liters of continuous oxygen.

On 10/29/19 at 9:55 AM Resident #55 was in bed wearing her nasal cannula hooked to an oxygen concentrator. The concentrator was set at 3 liters.

On 10/30/19 at 3:08 PM Resident #55 was in bed wearing her nasal cannula hooked to an oxygen concentrator. The concentrator was set at 3 liters. Nurse #2 was in the room and stated Resident #55's oxygen saturations were checked every shift and been running 94-96% (normal). Nurse #2 was asked about the concentrator settings and adjusted the oxygen settings to 2 liters because the concentrator was set to 3 liters. She reported she was unaware of the wrong setting and had not checked the concentrator that day. She also reported the resident was not capable of adjusting the machine and she had no knowledge of when or how the settings had been increased.

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On 10/31/19 at 9:20 AM the Unit Manager was interviewed and explained that residents requiring oxygen were monitored every shift. She specified monitoring included checking a resident's oxygen saturation and checking the concentrator settings. She added that families would often adjust oxygen settings without notifying the nurse. The Unit Manager explained she would check an oxygen concentrator setting every time she went in the room to make sure it was correct. She stated nurses assigned to residents with oxygen should check the concentrator settings at least every shift.

On 10/31/19 at 10:35 AM the Director of Nursing (DON) was interviewed and explained the process for monitoring oxygen saturations and flow rate for residents was that an order for the flow rate was received and entered into the medical record. She added nurses were response for monitoring the flow rate every shift. The DON explained that nurses were also expected to document that they monitored the concentrator settings on the MAR. The DON reviewed Resident #55's MAR that specified the concentrator settings had been checked every shift. The DON was unable offer an explanation why Resident #55's oxygen settings were wrong if the nurses had been checking the concentrator every shift according to the MAR.

4. Resident #346 was admitted to the facility on 10/09/19 with diagnoses that included chronic respiratory failure and others.

A physician's order dated 10/09/19 specified to monitor oxygen saturations and administer continuous oxygen at 2 liters via nasal cannula.

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The admission Minimum Data Set (MDS) dated 10/16/19 specified the resident's cognition was intact and she received supplemental oxygen.

A care plan reviewed on 10/16/19 related to the use of oxygen for COPD (chronic obstructive pulmonary disease) specified oxygen via a nasal cannula was to be used as indicated.

According to the medical record, oxygen saturations were monitored every shift and documented on the Medication Administration Record (MAR).

On 10/28/19 at 2:48 PM observations made of Resident #346 revealed she was in bed wearing a nasal cannula and her oxygen concentrator was set to 2.5 liters. Resident #346 had her eyes closed and did not respond when her name was called to be interviewed.

On 10/29/19 at 10:00 AN and 12:53 PM observations made of Resident #346 revealed she was in bed wearing a nasal cannula and her oxygen concentrator was set to 2.5 liters.

On 10/30/19 at 9:28 AM Resident #346 was in bed wearing her nasal cannula and the oxygen concentrator set at 2.5 liters.

On 10/30/19 at 10:24 AM Nurse #2 entered the room to administer medications to Resident #346. Nurse #2 used a pulse oximeter to monitor Resident #346's oxygen saturation. The reading was 92.0%. Nurse #2 did not check the oxygen concentrator's settings.

On 10/31/19 at 9:20 AM the Unit Manager was interviewed and explained that residents requiring

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oxygen were monitored every shift. She specified monitoring included checking a resident's oxygen saturation and checking the concentrator settings. She added that families would often adjust oxygen settings without notifying the nurse. The Unit Manager explained she would check an oxygen concentrator setting every time she went in the room to make sure it was correct. She stated nurses assigned to residents with oxygen should check the concentrator settings at least every shift. The Unit Manager was notified of Resident #346's wrong settings on her concentrator and reported she would check the machine.

On 10/31/19 at 10:35 AM the Director of Nursing (DON) was interviewed and explained the process for monitoring oxygen saturations and flow rate for residents was that an order for the flow rate was received and entered into the medical record. She added nurses were response for monitoring the flow rate every shift. The DON explained that nurses were also expected to document that they monitored the concentrator settings on the MAR.