

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345229</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>PEAK RESOURCES - SHELBY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 NORTH MORGAN STREET</b> <b>SHELBY, NC 28150</b>		
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F 000	INITIAL COMMENTS  The survey team entered the facility on 02/24/2021 to conduct an unannounced complaint investigation and exited on 02/24/21. Additional information was obtained offsite through 03/12/2021. The Administrator provided a revision to the Immediate Jeopardy Removal Plan on 3/23/21. Therefore, the exit date was changed to 03/23/2021. There was one allegation investigated it was substantiated.  The facility was notified on 03/05/2021 of Immediate Jeopardy identified after management quality review:  Immediate Jeopardy was identified at:  CFR 483.12 at tag F600 at a scope and severity (J)  Immediate Jeopardy began on 11/07/2020 and was removed on 03/06/2021.  The tag F600 constituted Substandard Quality of Care.  An extended survey was conducted on 03/11/2021.	F 000			
F 580 SS=D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)  §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		4/8/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/19/2021

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 580	Continued From page 1 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).  §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to	F 580			

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F 580	<p>Continued From page 2</p> <p>room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the Physician when a resident began to experience a change of condition for 2 of 3 residents reviewed for notification of change (Resident #1 and Resident #2).</p> <p>Findings included:</p> <p>1. Resident #1 was re-admitted into the facility on 07/07/20 with diagnosis which included cerebrovascular accident (CVA), anxiety and asthma.</p> <p>Review of Resident #1's most recent quarterly Minimum Data Set (MDS) dated 10/07/20 revealed she was alert and oriented. Resident #1 required extensive assistance of one staff member for most activities of daily living (ADL). Resident #1 was coded as not receiving oxygen therapy during the assessment period.</p> <p>Review of Resident #1's care plan dated 06/16/17 and revised on 11/09/20 revealed a focus area for respiratory care due to Resident #1 being at risk for shortness of breath related to a history of asthma. An intervention included notifying the Physician if shortness of breath occurred.</p> <p>Review of a Physician order for Resident #1 dated 07/30/20 revealed if the resident was experiencing any of the following symptoms including shortness of breathing or difficulty breathing to notify the Physician.</p>	F 580	<p>F580</p> <p>This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.</p> <p>Residents Affected:</p> <p>Resident #1 was discharged to the hospital on November 7, 2020 at 9:30 am and did not return to the facility.</p> <p>Resident #2 was discharged to the hospital on November 7, 2020 and returned to the facility on November 13, 2020 with a diagnosis of pneumonia related COVID 19 infection.</p> <p>Residents with potential to be affected:</p> <p>All residents identified with a change in condition have the potential to be affected by the alleged deficient practice. All residents <input type="checkbox"/> medical records were reviewed for an identified change in condition during the past 14 days to</p>		

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F 580	<p>Continued From page 3</p> <p>Review of a nursing progress note dated 11/07/20 at 3:54 PM written by Nurse #1 revealed Resident #1's Responsible Party (RP) had called and stated Resident #1 sounded short of breath. Nurse #1 checked on Resident #1 to find she had an oxygen saturation level of 72% (normal range 92-100%). The note revealed Nurse #1 initiated oxygen at 4 liters per minute (lpm) and Resident #1's oxygen level began to rise to 89%, 90% to 92%.</p> <p>Review of a nursing progress note dated 11/07/20 at 4:41 PM written by Nurse #1 revealed she had gone into Resident #1's room to find the nasal cannula tubing on the resident's forehead instead of in her nose. Resident #1's oxygen saturation level was at 70%. Nurse #1 replaced the nasal cannula into Resident #1's nose correctly and her oxygen saturation level increased to 90% on 4 liters of oxygen.</p> <p>On 02/24/20 at 9:25 AM an interview was conducted with Resident #1's Responsible Party (RP). During the interview he stated he had spoken to Resident #1 on the afternoon of 11/07/20 in which she sounded out of breath and stated to him she felt short of breath. The RP stated he hung up the phone with Resident #1 and called Nurse #1. Nurse #1 then went into the room and checked her oxygen saturation level which was low. He stated he was told Nurse #1 initiated supplemental oxygen at that time. The RP stated he called Resident #1 back two hours later to ask how she was doing, and she was still short of breath. When he asked her if she was wearing oxygen, she stated no. The RP then called the nurses station and spoke with Nurse #1 to tell her what Resident #1 had said. He stated when the nurse went into the room the resident</p>	F 580	<p>ensure that the appropriate notifications to the physician or physician extender and resident representative were conducted.</p> <p>This review included a review of the residents' nursing progress notes, vital signs, and physician orders to assess for changes in the residents medical and/or mental condition that would require physician or physician extender and resident representative notification. This audit was completed by the Administrator and reviewed by the Regional Clinical Manager on 3/18/2021. All residents had appropriate documentation of notification of physician or physician extender and resident representative. No other resident was adversely affected by the alleged deficient practice.</p> <p>System changes:</p> <p>1. The Regional Clinical Manager reviewed the policy for Change in a Resident's Condition on March 18, 2021.</p> <p>This policy includes the following:</p> <p>The nurse will notify the resident's attending physician or on-call physician when there has been:</p> <ul style="list-style-type: none"> <li>" An accident or incident involving the resident.</li> <li>" A discovery of injuries of an unknown source.</li> <li>" A reaction to medication.</li> <li>" A significant change in the resident's</li> </ul>		

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F 580	<p>Continued From page 4</p> <p>was in fact not wearing her oxygen, she placed the oxygen back into Resident #1's nose and her oxygen level increased. The RP stated when he called back, he spoke with Nurse #2 and asked how Resident #1 was doing. She stated to him she hadn't been into the room yet, but she would check on her. The RP stated he told Nurse #2 he wanted Resident #1 sent to the hospital for an evaluation. The interview revealed Nurse #2 called him back and stated she had spoken with the Director of Nursing and Nurse Practitioner who both recommended the resident not be sent to the hospital because she appeared to be in no respiratory distress at that time. He was told if he wanted her sent to the hospital, he could call Emergency Medical Services (EMS) himself in which he did.</p> <p>On 02/24/21 at 11:13 AM an interview was conducted with Nurse Aide (NA) #1. She stated on 11/07/20 she was taking care of Resident #1. NA #1 stated Resident #1 was acting strange and confused during the morning, so she notified Nurse #1. NA #1 stated around 11:00 AM she told Nurse #1 the resident was breathing heavy and had not eaten her breakfast meal which was noticed when she picked up the trays. NA #1 stated she did not know if Nurse #1 went into Resident #1's room to check on her. She stated around 2:00 PM she went back into Resident #1's room to find her in the same condition continuing to experience heavy breathing so she notified Nurse #1 again. The interview revealed Resident #1's responsible party had called Nurse #1 as well and notified her of Resident #1's shortness of breath. When Nurse #1 entered the room to obtain an oxygen saturation level NA #1 stated it was in the 70% range (normal 92-100%). She stated Nurse #1 then ran down the hall to obtain</p>	F 580	<p>physical/emotional/mental condition.</p> <p>" A need to alter the resident's medical treatment significantly.</p> <p>" Refusal of treatment or medications (i.e. two (2) or more consecutive times).</p> <p>" A need to transfer the resident to a hospital/treatment center.</p> <p>" A discharge without proper medical authority.</p> <p>" Instructions to notify the physician of changes in the resident's condition.</p> <p>Unless otherwise instructed by the resident, the nurse will notify the resident's next-of-kin or representative when:</p> <p>" The resident is involved in any accident or incident that results in an injury including injuries of an unknown source and has the potential of requiring physician intervention.</p> <p>" There is a significant change in the resident's physical, mental, or psychosocial status; (i.e. a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).</p> <p>" A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to start a new form of treatment.</p> <p>" There is a need to change the resident's room assignment.</p> <p>" A decision has been made to discharge the resident from the facility; and/or</p> <p>" It is necessary to transfer the resident</p>		

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F 580	<p>Continued From page 5</p> <p>an oxygen concentrator and applied oxygen to Resident #1 via a nasal cannula. The interview revealed after Nurse #1 applied oxygen to Resident #1 she still seemed confused removing the oxygen tubing causing her oxygen level to drop.</p> <p>On 02/24/21 at 10:07 AM an interview was conducted with Nurse #1. She stated on 11/07/20 she was responsible for Resident #1 during the 7:00 AM to 7:00 PM shift. Nurse #1 stated she had received a phone call from Resident #1's responsible party around 3:30 PM who said she was experiencing shortness of breath and needed oxygen. She stated she did not recall NA #1 coming to her and saying anything was wrong with Resident #1 however it had been a while and she may have forgotten. Nurse #1 stated she went into the resident's room with the RP still on the phone and checked her oxygen level to find a low reading. The interview revealed she ran from the resident's room to get an oxygen concentrator and initiated oxygen via nasal cannula at 4 liters and Resident #1's oxygen saturation level improved. Nurse #1 stated she received a second call from Resident #1's RP around 4:30 PM stating the resident was still experiencing shortness of breath and to go and check on her. When she entered the room Resident #1 did not have her oxygen on and her oxygen saturation level was low again. She stated she placed the nasal cannula back into Resident #1's nose and her oxygen level increased to 90%. The interview revealed she passed the information along to the second shift nurse during shift change however did not notify a Physician of Resident #1's change of condition requiring supplemental oxygen. She stated she did not feel like she needed to since the resident's oxygen level had increased on 4</p>	F 580	<p>to a hospital/treatment center.</p> <p>Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.</p> <p>The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p> <p>No changes were made to the policy.</p> <p>2. One on one education was provided to Nurse # 1 and Nurse #3 by the Director of Nursing on the policy Change in a Resident Condition. This was completed on February 26, 2021 .</p> <p>3. All licensed nursing staff will be educated by the Staff Development Coordinator, Director of Nursing and/or Nurse Supervisor regarding the Change in Resident Condition policy. This education was initiated on 3/18/2021 by the Administrator and Regional Clinical Manager and will continue to be provided to all licensed nursing staff. This will be completed by 4/1/2021. Any licensed nursing staff out on leave of absence or on PRN status will be educated prior to returning to their assignment by the Staff Development Coordinator, Director of Nursing and/or Nurse Supervisor. Newly hired licensed nursing staff will be educated during orientation by the Staff Development Coordinator.</p>		

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F 580	<p>Continued From page 6</p> <p>liters.</p> <p>On 02/24/21 at 10:20 AM an interview was conducted with Nurse #2. She stated she was responsible for Resident #1 on 11/07/20 during the 7:00 PM to 7:00 AM shift. Nurse #2 stated she had received report from Nurse #1. During the interview she stated she was not informed during shift change that Resident #1 had experienced a change requiring the need for supplemental oxygen. She stated Resident #1 had not worn oxygen prior to that day. The interview revealed Resident #1's RP had called her around 8:30 PM during the middle of her medication pass stating he wanted Resident #1 sent to the hospital for an evaluation. The interview revealed she had received report and started her medication pass not making it to Resident #1's room yet. Nurse #2 stated she went into Resident #1's room to find her in no respiratory distress. She stated she obtained vital signs and they were within normal limits however did not chart them and couldn't not remember what they were. She notified the Director of Nursing (DON) who was in the building and the Nurse Practitioner on call. The Nurse Practitioner ordered a nebulizer treatment every 4 hours as needed and a chest x-ray. Nurse #2 stated the NP told her if the family wanted to call Emergency Medical Services they could however if the resident was in no respiratory distress, she didn't see the need to send them out. She stated the RP contacted Emergency Medical Services (EMS) and Resident #1 was transported to the hospital at 9:30 PM.</p> <p>Review of the hospital records dated 11/07/20 at 10:00 PM revealed Resident #1 had a diagnosis of COVID-19 pneumonia and pulmonary</p>	F 580	<p>Monitoring:</p> <p>An audit tool was developed to ensure the physician or physician extender and the resident representative have been notified of any change in the resident medical and/or mental condition.</p> <p>The audit tool consists of the following:</p> <ul style="list-style-type: none"> <li>" The resident physician has been notified of the residents change in condition</li> <li>" The Resident representative has been notified of the resident change of condition</li> <li>" Appropriate clinical documentation is evident.</li> </ul> <p>During the morning clinical team meeting, Monday through Friday, the Director of Nursing and/or Nursing Supervisor will review the progress notes, vital signs, and physician orders of all residents to review for any change in condition requiring medical intervention or an alteration in the current plan of care and proper notification of physician and resident representative from the previous 24 hours. During the Monday clinical team meeting, the Director of Nursing and/or Nurse Supervisor will review the same documentation for Friday through Sunday. Audits will be completed on 100% of the residents with an identified change in status daily, Monday through Friday x 2 weeks, then 50% of the residents weekly</p>		

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F 580	<p>Continued From page 7</p> <p>embolism with hypoxia. The report revealed Resident #1 was too lethargic to give any additional history when seen in the Emergency Room and her responsible party had given the information. Resident #1's vital signs at the hospital were temperature 102, heart rate 95, blood pressure 127/52 and oxygen saturation level of 92% on 4 liters of oxygen.</p> <p>On 02/24/21 at 12:39 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated Resident #1 was a full code and if there was a change of condition the nurse was responsible for notifying the Physician immediately. She stated she was in the facility on 11/07/20 working on another hall during night shift. The DON stated Nurse #2 had come to her stating the RP wanted Resident #1 sent to the hospital but that her assessment was the resident was in no respiratory distress. The DON stated she did not go assess the resident herself but told Nurse #2 to just let the Physician know the resident was in no respiratory distress.</p> <p>On 02/25/21 at 8:30 AM an interview was conducted with the facility Nurse Practitioner (NP). She stated she would expect the nursing staff to notify her if they had a resident who previously did not require oxygen therapy, placed on supplemental oxygen due to a low oxygen saturation level in the 70 % range. The NP stated that would be considered a change in condition and would need to be addressed immediately.</p> <p>On 02/24/21 at 10:21 AM an interview was conducted with the Medical Director (MD). He stated when he reviewed the NP notes from 11/07/21 he saw the responsible party had requested Resident #1 be sent to the hospital for</p>	F 580	<p>x 4 weeks, then 25% of the residents every two weeks x 6 weeks. The results of the audits will determine the need for further monitoring.</p> <p>Audits will be completed on 100% of the residents with an identified change in status daily, Monday through Friday x 2 weeks, then 50% of the residents weekly x 4 weeks, then 25% of the residents every two weeks x 6 weeks. The results of the audits will determine the need for further monitoring.</p> <p>QAPI: The results of the audits will be brought to the monthly QAPI meeting by the DON for review and recommendations.</p> <p>Completion date: April 8, 2021</p>		



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F 580	<p>Continued From page 8</p> <p>an evaluation despite the nurse's assessment that the resident was experiencing no respiratory distress. The MD stated hypoxia (the absence of enough oxygen in the tissue to sustain bodily function) did not equal respiratory distress. The interview revealed he did not send residents out for respiratory distress unless they were in active accessory muscle distress which it did not seem like Resident #1 was in as evidenced by her oxygen saturation level increasing with supplemental oxygen use. He stated she was noted to be confused which meant she probably did not have the mentation at that time for supplemental oxygen to be useful which is why she was removing it. The MD stated the NP had ordered a nebulizer treatment and chest x-ray when Nurse #2 notified her. He stated looking at the summary of the notes from 11/07/20 since he wasn't in the building the situation was a clinical decision and if a responsible party was insistent the resident go to the hospital then they would be told it was their right to call emergency medical services. The interview revealed it was the facility protocol to place residents on prophylactic lovenox (blood thinner) when diagnosed with COVID-19. He stated she was diagnosed with COVID-19 pneumonia at the hospital and had a pulmonary embolism which could not have been prevented if she had been sent to the hospital any sooner than she was. The interview revealed Resident #1 was hypoxic was placed on supplemental oxygen with her oxygen saturation improving yet still threw a clot and ended up with a pulmonary embolism. He stated there was no way the facility could have known that was occurring.</p> <p>2. Resident #2 was re-admitted into the facility on 11/13/20 with diagnosis which included acute</p>	F 580			

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F 580	<p>Continued From page 9 respiratory disease (COVID 19).</p> <p>Review of Resident #2's most recent quarterly Minimum Data Set (MDS) dated 11/18/20 revealed she was alert and oriented. Resident #1 required extensive assistance of one staff member for most activities of daily living (ADL). Resident #1 was coded as receiving oxygen therapy during the assessment period.</p> <p>Review of Resident #2's care plan dated 02/25/20 revealed a focus area for respiratory care. An intervention included oxygen therapy as ordered.</p> <p>Review of Resident #2's November 2020 Physician orders revealed an order initiated on 12/05/19 which read, "Maintain oxygen saturation levels greater than 90% every shift."</p> <p>Review of a Physician order for Resident #2 dated 07/30/20 revealed if the resident was experiencing any of the following symptoms including shortness of breathing or difficulty breathing to notify the Physician.</p> <p>Review of Resident #2's vital signs on 11/07/20 revealed the following:</p> <ul style="list-style-type: none"> <li>- 11/07/20 at 3:09 AM: Oxygen saturation level of 76% on 2 liters of supplemental oxygen.</li> <li>- 11/07/20 at 3:20 AM: Oxygen saturation level of 75% on 2 liters of supplemental oxygen.</li> <li>- 11/07/20 at 6:55 AM: Oxygen saturation level of 75% on 2 liters of supplemental oxygen.</li> <li>- 11/07/20 at 12:01 PM: Oxygen saturation level of 66% on 4 liters of supplemental oxygen.</li> </ul> <p>On 02/25/20 at 8:55 AM an interview was conducted with Nurse #3. She stated she was</p>	F 580			

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F 580	<p>Continued From page 10</p> <p>responsible for Resident #2 during third shift on 11/06/20 from 11:00 PM to 7:00 AM. Nurse #3 stated she remembered Resident #2 experiencing a low oxygen saturation level but did not remember if she had notified the Physician or oncoming first shift nurse. She stated if she did notify the Physician it would have been listed under the facilities notification system called Urgent and could be pulled up. Nurse #3 stated during that time she was new to the facility and was still learning as a new nurse.</p> <p>On 02/25/21 at 9:05 AM an interview was conducted with Nurse #1. She stated on 11/07/20 she was responsible for Resident #2 during the 7:00 AM to 7:00 PM shift. The interview revealed she did not receive anything in report regarding Resident #2's low oxygen saturation levels. She stated she was not aware of anything until she went into Resident #2's room at 11:30 AM to obtain vital signs and received an oxygen saturation level of 62% on 2 liters of supplemental oxygen via nasal cannula. She stated Resident #2 was alert but lethargic due to a diagnosis of COVID-19. Nurse #1 stated from Resident #2's appearance you could not tell her oxygen saturation level was low. The interview revealed she increased Resident #2's oxygen to 4 liters and notified the Physician who gave orders to send the resident to the hospital for an evaluation.</p> <p>Review of the Event report dated 11/07/20 at 4:00 PM revealed Resident #2 was sent to the hospital due to an onset of respiratory distress. The nurse had increased her oxygen and notified the Physician. Resident #2's vital signs upon transfer were Oxygen saturation level of 66% on 4 liters of supplemental oxygen, temperature 100.8, blood</p>	F 580			

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F 580	<p>Continued From page 11</p> <p>pressure 127/63 and respirations 18 beats per minute.</p> <p>Review of Resident #2's hospital records dated 11/07/20 revealed she was admitted from the facility to the hospital with hypoxia and oxygen saturation levels ranging in the 70%. Resident #2 was placed on 15 liters via a non-rebreather mask once at the hospital and was confirmed COVID-19 positive. Resident #2's respiratory status was documented as diminished air entry bilateral with bilateral rhonchi. Resident #2's hospital diagnosis include pneumonia due to COVID-19 virus, bilateral pneumonia and respiratory failure with hypoxia.</p> <p>Review of the facilities notification system revealed no record of Nurse #3 notifying the Physician of Resident #2's low oxygen saturation levels.</p> <p>On 02/24/21 at 12:39 PM an interview was conducted with the Director of Nursing (DON). She stated Resident #2 was sent to the hospital on the same day as Resident #1 and both residents had a status of full code. The interview revealed she was unaware of Resident #2 experiencing an oxygen saturation level in the 70% range throughout the early morning on 11/07/20 and stated those numbers should have been reported to the Physician via the communication board. Upon review she stated she could not find where Nurse #3 had notified the Physician regarding Resident #2's oxygen level. The interview revealed Nurse #3 was new to the facility and may have just been placed off of orientation.</p> <p>On 02/25/21 at 8:30 AM an interview was</p>	F 580			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 580	Continued From page 12 conducted with the facility Nurse Practitioner (NP). She stated she would expect the nursing staff to notify her if they had a resident who had a low oxygen saturation level of 75 to 76% for a period of almost 4 hours. The NP stated that would be considered a change in condition and would need to be addressed immediately.  On 02/26/20 at 8:40 AM an interview was conducted with the Medical Director (MD). He stated he was not familiar with Resident #2 however on 11/07/20 her vital signs should have been reported to the on-call Physician. The MD stated they should be notified immediately of a change in condition where a resident has an oxygen level in the 70% range, and it should not have went on for an extended period of time. The interview revealed his expectation was for the responsible nurse to notice the abnormal vital sign, keep the resident comfortable and call the on-call Physician so orders could be obtained, and the situation be resolved.	F 580			
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		4/8/21	

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F 600	<p>Continued From page 13</p> <p>physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to identify the seriousness of low oxygen saturation levels, assess the residents, provide nursing and medical interventions, identify the urgent need for medical attention or notify the physician for residents who experienced a low oxygen saturation levels. As a result, Resident #2 maintained a low oxygen saturation level ranging from 66% to 76% (normal range greater than 92%) for a 9-hour period resulting in a hospitalization. Resident #2 was confirmed to be hypoxic (deprivation of adequate oxygen supply at the tissue level) and was diagnosed with severe acute respiratory failure and COVID-19 pneumonia and was placed on a BiPAP (machine that pushes air into the lungs). Resident #1 had a sudden onset of low oxygen saturation of 72% and oxygen therapy was initiated without ongoing assessments. A family member contacted Emergency Medical Services and had Resident #1 transferred to the hospital where the resident was diagnosed with COVID-19 pneumonia and pulmonary embolism with hypoxia. This was for 2 of 3 sampled residents reviewed for respiratory care (Resident #1 and Resident #2).</p> <p>Immediate Jeopardy began on 11/07/20 when Resident #1 and #2 both had acute changes of condition with the high likelihood for serious outcomes, and the facility failed to respond with medical services. The immediate jeopardy was removed on 03/06/21 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The</p>	F 600	<p>F600</p> <p>This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.</p> <p>Affected residents:</p> <p>Resident #1 was admitted to the hospital on 11/07/2020 with Covid-19 pneumonia and pulmonary embolism. Resident #1 did not return to the facility.</p> <p>Resident #2 was admitted to the hospital on 11/07/2020 with hypoxia. Resident was treated at the hospital and subsequently returned to the facility on 11/13/2020.</p> <p>Residents with potential to be affected:</p> <p>An audit was completed by the Administrator on 03/05/2021. The Administrator reviewed all residents who are currently on oxygen therapy or have received oxygen therapy in the last 72 hours to determine if any other resident had episodes of oxygen desaturation and</p>		

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F 600	<p>Continued From page 14</p> <p>facility remains out of compliance at a lower scope and severity level of "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective.</p> <p>The findings included:</p> <p>1. Resident #2 was admitted to the facility on 10/04/19 with a diagnosis which included chronic obstructive pulmonary disease (COPD).</p> <p>Review of Resident #2's most recent annual Minimum Data Set (MDS) dated 11/02/20 revealed she was cognitively intact. Resident #2 required extensive assistance of one staff member for most activities of daily living (ADL). Resident #2 was coded as not receiving oxygen therapy during the assessment period.</p> <p>Review of Resident #2's November 2020 Physician orders revealed an order initiated on 12/05/19 which read, "Maintain oxygen saturation levels greater than 90% every shift."</p> <p>Review of Resident #2's active care plan initiated on 02/25/20 revealed a focus area for respiratory care. An intervention included oxygen therapy as ordered.</p> <p>Review of a Physician order for Resident #2 dated 07/30/20 revealed if the resident was experiencing any of the following symptoms including shortness of breathing or difficulty breathing to notify the Physician.</p> <p>Review of Resident #2's November 2020 Physician orders revealed an order initiated on 08/13/20 which read, "Oxygen to be maintained</p>	F 600	<p>if so, was the MD/NP/PA notified and appropriate interventions applied. In addition, all physician orders for oxygen administration were reviewed to ensure that all orders had parameters for notification of MD/NP/PA. All physician orders state to notify the MD/NP/PA for oxygen saturations &lt;90% and to maintain oxygen saturations &gt;90%. There were 17 additional potentially affected residents, however, no additional residents were identified as having been affected by the alleged deficient practice. All 17 residents had orders for parameters of notification. No resident had oxygen saturations &lt;90%.</p> <p>System Changes:</p> <p>Nurse # 1 and Nurse #3 was educated by the Director of Nursing on 02/26/2021 regarding the importance of oxygen saturation readings; to notify MD/NP/PA of any oxygen saturation level &lt;90% and to increase the oxygen administration to maintain the oxygen saturation level &gt;90% or per instruction on physician order.</p> <p>Oxygen-Nebulizer Administration Guideline was reviewed by the Regional Clinical Manager on 03/05/2021. Parameters were added to the guideline on 03/05/2021 to notify MD/NP/PA of any oxygen saturation level &lt;90% and to increase the oxygen administration to maintain the oxygen saturation level &gt;90% or per instruction on physician order.</p>		

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F 600	<p>Continued From page 15 at 2-3 liters due to a low oxygen saturation level."</p> <p>Review of a nursing progress note dated 11/04/20 revealed Resident #2 was tested in the facility for COVID-19 with a positive result via a medical lab.</p> <p>Review of Resident #2's vital signs on 11/07/20 revealed the following:</p> <ul style="list-style-type: none"> <li>- 11/07/20 at 3:09 AM: Oxygen saturation level of 76% on 2 liters of supplemental oxygen.</li> <li>- 11/07/20 at 3:20 AM: Oxygen saturation level of 75% on 2 liters of supplemental oxygen.</li> <li>- 11/07/20 at 6:55 AM: Oxygen saturation level of 75% on 2 liters of supplemental oxygen.</li> <li>- 11/07/20 at 12:01 PM: Oxygen saturation level of 66% on 4 liters of supplemental oxygen.</li> </ul> <p>Review of nursing progress notes and nursing assessments dated 11/07/20 revealed no documented assessments by Nurse #3.</p> <p>On 02/25/20 at 8:55 AM an interview was conducted with Nurse #3. She stated she was responsible for Resident #2 during third shift on 11/06/20-11/7/20 from 11:00 PM to 7:00 AM. Nurse #3 stated she remembered Resident #2 experiencing a low oxygen saturation level but did not remember if she had notified the Physician or oncoming first shift nurse. She stated if she did notify the Physician it would have been listed under the facility's notification system called Urgent and could be pulled up. Nurse #3 stated during that time she was new to the facility and was still learning as a new nurse. The interview revealed she did not recall turning Resident #2's supplemental oxygen up from 2 liters during the night but remembered her being on oxygen due to a diagnosis of COVID with shortness of breath.</p>	F 600	<p>All licensed nursing staff will be educated by the Administrator, the Director of Nursing, and/or the Staff Development Coordinator regarding the following:</p> <ol style="list-style-type: none"> <li>1. Oxygen saturation refers to the amount of oxygen that's in the bloodstream. The body requires a specific amount of oxygen in the blood to function properly.</li> <li>2. The normal range of oxygen saturation for adults is 94 to 99 percent.</li> <li>3. Oxygen saturations must be maintained &gt;90%. If blood oxygen levels are too low, the body may not work properly. Hypoxemia can cause mild problems such as headaches and shortness of breath. In severe cases, it can interfere with heart and brain function.</li> <li>4. Oxygen administration will be increased to maintain oxygen level &gt;90% or as instructed by physician order.</li> <li>5. The MD/NP/PA must be notified when oxygen saturation levels are below 90%.</li> <li>6. If oxygen saturations are below 90% and the resident presents with other clinical signs of respiratory distress, including shortness of breath, cyanosis, elevated heart rate, and/or mental status changes, MD/NP/PA and EMS must be notified immediately.</li> <li>7. Comprehensive assessments are important for all residents on oxygen</li> </ol>		



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F 600	<p>Continued From page 16</p> <p>The interview revealed she had obtained Resident #2's vital signs on the morning of 11/07/20 at 3:09 AM, 3:20 AM, and 6:55 AM.</p> <p>Review of the facility's notification system revealed no record of Nurse #3 notifying the Physician of Resident #2's low oxygen saturation levels.</p> <p>A follow-up interview was conducted with Nurse #3 on 03/12/21 at 12:10 PM. She stated she knew Resident #2 was using supplemental oxygen when she came onto her shift and knew she had an order to maintain her oxygen level greater than 90%. She stated nobody had reported to her that Resident #2 was short of breath when she came on shift. The interview revealed she did not notice that Resident #2 was experiencing shortness of breath or showing signs of respiratory distress and indicated the resident was resting, and her color was pink.</p> <p>Review of the Event report dated 11/07/20 at 4:00 PM written by Nurse #1 revealed Resident #2 was sent to the hospital due to an onset of respiratory distress. The nurse had increased her oxygen and notified the Physician. Resident #2's vital signs upon transfer were: Oxygen saturation level of 66% on 4 liters of supplemental oxygen, temperature 100.8, blood pressure 127/63 and respirations 18 beats per minute.</p> <p>On 02/25/21 at 9:05 AM an interview was conducted with Nurse #1. She stated on 11/07/20 she was responsible for Resident #2 during the 7:00 AM to 7:00 PM shift. The interview revealed she did not receive anything in report from Nurse #3 regarding Resident #2's low oxygen saturation levels. She stated she was not aware of Resident</p>	F 600	<p>therapy to assess for any signs and symptoms of respiratory distress.</p> <p>8. All residents receiving oxygen therapy will be assessed for signs and symptoms of respiratory distress every shift or as ordered by the MD/NP/PA.</p> <p>9. All residents receiving oxygen therapy will have oxygen saturations monitored every shift or as ordered by the MD/NP/PA.</p> <p>10. All physician orders for oxygen therapy will have parameters to notify the MD/NP/PA of oxygen saturations less than 90% or as instructed by MD/NP/PA order.</p> <p>The Staff Development Coordinator and Administrator initiated the education for all licensed nursing staff on 03/05/2021. The Director of Nursing, Staff Development Coordinator, Nursing Supervisors and/or Administrator will provide the education to all licensed nurses prior to the start of their next shift. Education was completed on March 11, 2021. Any licensed nurse out on leave or on PRN status will be educated prior to returning to duty. Any newly hired licensed nurse will be educated during orientation by the Staff Development Coordinator.</p> <p>All Certified Nursing Assistants will be educated by the Administrator, the Director of Nursing and/or the Staff Development Coordinator on signs and symptoms of respiratory distress, including shortness of breath, difficulty</p>		

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F 600	<p>Continued From page 17</p> <p>#2's low oxygen saturation levels until she went into Resident #2's room at 11:30 AM to obtain vital signs and received an oxygen saturation level of 62% on 2 liters of supplemental oxygen via nasal cannula. She stated Resident #2 was alert but lethargic due to a diagnosis of COVID-19. Nurse #1 stated Resident #2's color was good and she didn't appear short of breath. She stated you could not tell her oxygen saturation level was low. The interview revealed she increased Resident #2's oxygen to 4 liters around 11:30 AM and notified the Physician who gave orders to send the resident to the hospital for an evaluation.</p> <p>Review of Resident #2's hospital records dated 11/07/20 revealed she was admitted from the facility to the hospital with hypoxia (deprivation of adequate oxygen supply at the tissue level) consistent with COVID-19 pneumonia and oxygen saturation levels ranging in the 70%. Resident #2 was placed on 15 liters via a non-rebreather mask once at the hospital and was confirmed COVID-19 positive. Resident #2's oxygen saturation level would not maintain above 90% on the 15 liters with a non-rebreather mask and she was placed on a bipap (machine that pushes air into the lungs). Resident #2's respiratory status was documented as diminished air entry bilateral with bilateral rhonchi. Resident #2's hospital diagnosis included pneumonia due to COVID-19 virus, bilateral pneumonia and respiratory failure with hypoxia. Resident #2 was hospitalized for further evaluation and was placed on the medications Remdesivir (antiviral medication) and Dexamethasone (steroid) and steadily improved. She was discharged on 11/13/20 on 1-2 liters of supplemental oxygen and noted to be in a stable condition.</p>	F 600	<p>breathing, cyanosis, elevated heart rate, and/or mental status changes and that they are required to report these signs and symptoms to the nursing staff immediately.</p> <p>The Staff Development Coordinator and Administrator will initiate the education for all Certified Nursing Assistants on 03/06/2021. The Staff Development Coordinator, the Director of Nursing, Nursing Supervisors, and/or the Administrator will provide the education to all Certified Nursing Assistant's prior to the start of their next shift. Education was completed on March 11, 2021. Any Certified Nursing Assistant out on leave or on PRN status will be educated prior to returning to duty. Any newly hired Certified Nursing Assistant will be educated during orientation by the Staff Development Coordinator.</p> <p>Monitoring:</p> <p>An audit will consist of the following: O2 saturation which is pulled from vital sign report daily. The Director of Nursing, Staff Development Coordinator, and the Nursing Supervisors will review 100% of all residents on oxygen therapy daily Monday through Friday in morning clinical meeting. The Director of Nursing and/or Nursing Supervisors will open and review the vital sign report in the electronic health record to ensure that the MD/NP/PA has been notified of any resident with oxygen saturation levels less than 90% and ensure that appropriate medical care has</p>		

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F 600	<p>Continued From page 18</p> <p>On 02/24/21 at 12:39 PM an interview was conducted with the Director of Nursing (DON). She stated Resident #2 was sent to the hospital on 11/07/20 and had a status of full code. The interview revealed she was unaware of Resident #2 experiencing an oxygen saturation level in the 70% range throughout the early morning on 11/07/20 and stated those numbers should have been reported to the Physician via the communication board immediately. Upon review she stated she could not find where Nurse #3 had notified the Physician regarding Resident #2's oxygen level. The interview revealed Nurse #3 was new to the facility and may have just been placed off orientation. She stated her expectation was for the nurses on the hall to be aware if a resident was experiencing a change of condition and immediately notify the Physician on call and this information was incorporated into the facility's orientation for new nurses.</p> <p>On 02/25/21 at 8:30 AM an interview was conducted with the facility Nurse Practitioner (NP). She stated she would expect the nursing staff to notify her if they had a resident who had a low oxygen saturation level of 76% to 66% for a period of almost 9 hours. The NP stated that would be considered a change in condition and would need to be addressed immediately.</p> <p>On 02/26/21 at 8:40 AM an interview was conducted with the Medical Director (MD). He stated he was not familiar with Resident #2 however on 11/07/20 her vital signs should have been reported to the on-call Physician. The MD stated they should be notified immediately of a change in condition where a resident has an oxygen level in the 70% range, and it should not</p>	F 600	<p>been obtained. On the weekend, the Nursing Supervisor will print and review the vital sign report in the electronic health record to ensure that the MD/NP/PA has been notified of any resident with oxygen saturation levels less than 90% and ensure that appropriate medical care has been obtained. These audits will be conducted daily x 2 weeks, weekly x 4 weeks, then monthly x 1 month. The results of the audits will determine the need for further monitoring.</p> <p><b>QAPI</b></p> <p>The results of the audits will be brought to the monthly QAPI meeting by the Director of Nursing for review and recommendations.</p> <p>Completion date: April 8, 2021</p>		

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F 600	<p>Continued From page 19</p> <p>have gone on for an extended period of time. The interview revealed his expectation was for the responsible nurse to notice the abnormal vital sign, keep the resident comfortable and call the on-call Physician so orders could be obtained, and the situation be resolved.</p> <p>2. Resident #1 was re-admitted into the facility on 07/07/20 with diagnosis which included cerebrovascular accident (CVA) and asthma.</p> <p>Review of Resident #1's most recent quarterly Minimum Data Set (MDS) dated 10/07/20 revealed she was alert and oriented. Resident #1 required extensive assistance of one staff member for most activities of daily living (ADL). Resident #1 was coded as not receiving oxygen therapy during the assessment period.</p> <p>Review of Resident #1's care plan dated 06/16/17 and revised on 11/09/20 revealed a focus area for respiratory care due to Resident #1 being at risk for shortness of breath related to a history of asthma. An intervention included notifying the Physician if shortness of breath occurred.</p> <p>Review of a Physician order for Resident #1 dated 07/30/20 revealed if the resident was experiencing any of the following symptoms including shortness of breathing or difficulty breathing to notify the Physician.</p> <p>Review of Resident #1's nursing progress note dated 11/04/20 revealed she was diagnosed with COVID-19 on this date.</p> <p>Review of Resident #1's November 2020 Physician standard orders for oxygen/ respiratory therapy revealed the nurses could place residents</p>	F 600			

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F 600	<p>Continued From page 20</p> <p>on supplemental oxygen as needed for a low oxygen saturation level. The order did not specify how many liters of oxygen to apply.</p> <p>Review of a nursing progress note dated 11/07/20 at 3:54 PM written by Nurse #1 revealed Resident #1's Responsible Party (RP) had called and stated Resident #1 sounded short of breath. Nurse #1 checked on Resident #1 to find she had an oxygen saturation level of 72% (normal range 92-100%). The note revealed Nurse #1 initiated oxygen at 4 liters per minute (lpm) and Resident #1's oxygen level began to rise to 89%, 90% to 92%.</p> <p>Review of a nursing progress note dated 11/07/20 at 4:41 PM written by Nurse #1 revealed she had gone into Resident #1's room to find the nasal cannula tubing on the resident's forehead instead of in her nose. Resident #1's oxygen saturation level was at 70%. Nurse #1 replaced the nasal cannula into Resident #1's nose correctly and her oxygen saturation level increased to 90% on 4 liters of oxygen.</p> <p>On 02/24/21 at 11:13 AM an interview was conducted with Nurse Aide (NA) #1. She stated on 11/07/20 she was taking care of Resident #1. NA #1 stated Resident #1 was acting strange and confused during the morning, so she notified Nurse #1. NA #1 stated around 11:00 AM she told Nurse #1 the resident was breathing heavy and had not eaten her breakfast meal which was noticed when she picked up the trays. NA #1 stated she did not know if Nurse #1 went into Resident #1's room to check on her. She stated around 2:00 PM she went back into Resident #1's room to find her in the same condition continuing to experience heavy breathing so she notified</p>	F 600			

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F 600	<p>Continued From page 21</p> <p>Nurse #1 again. The interview revealed Resident #1's responsible party had called Nurse #1 as well and notified her of Resident #1's shortness of breath. When Nurse #1 entered the room to obtain an oxygen saturation level NA #1 stated it was in the 70% range (normal 92-100%). She stated Nurse #1 then ran down the hall to obtain an oxygen concentrator and applied oxygen to Resident #1 via a nasal cannula. The interview revealed after Nurse #1 applied oxygen to Resident #1 she still seemed confused removing the oxygen tubing causing her oxygen level to drop.</p> <p>On 02/24/21 at 10:07 AM an interview was conducted with Nurse #1. She stated on 11/07/20 she was responsible for Resident #1 during the 7:00 AM to 7:00 PM shift. Nurse #1 stated she had received a phone call from Resident #1's responsible party around 3:30 PM who said she was experiencing shortness of breath and needed oxygen. She stated she did not recall NA #1 coming to her and saying anything was wrong with Resident #1 however it had been a while and she may have forgotten. Nurse #1 stated she went into the resident's room with the RP still on the phone and checked her oxygen level to find a low reading. The interview revealed she ran from the resident's room to get an oxygen concentrator and initiated oxygen via nasal cannula at 4 liters and Resident #1's oxygen saturation level improved. Nurse #1 stated she received a second call from Resident #1's RP around 4:30 PM stating the resident was still experiencing shortness of breath and to go and check on her. When she entered the room Resident #1 did not have her oxygen on and her oxygen saturation level was low again. She stated she placed the nasal cannula back into Resident #1's nose and</p>	F 600			

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F 600	<p>Continued From page 22</p> <p>her oxygen level increased to 90%. The interview revealed she passed the information along to the second shift nurse during shift change however did not notify a Physician of Resident #1's change of condition requiring supplemental oxygen. She stated she did not feel like she needed to since the resident's oxygen level had increased on 4 liters.</p> <p>On 02/24/21 at 10:20 AM an interview was conducted with Nurse #2. She stated she was responsible for Resident #1 on 11/07/20 during the 7:00 PM to 7:00 AM shift. Nurse #2 stated she had received report from Nurse #1. During the interview she stated she was not informed during shift change that Resident #1 had experienced a change requiring the need for supplemental oxygen. She stated Resident #1 had not worn oxygen prior to that day. The interview revealed Resident #1's RP had called her around 8:30 PM during the middle of her medication pass stating he wanted Resident #1 sent to the hospital for an evaluation. The interview revealed she had received report and started her medication pass not making it to Resident #1's room yet. Nurse #2 stated she went into Resident #1's room to find her in no respiratory distress. She stated she obtained vital signs and they were within normal limits however did not chart them and could not remember what they were. She notified the Director of Nursing (DON) who was in the building and the Nurse Practitioner on call. The Nurse Practitioner ordered a nebulizer treatment every 4 hours as needed and a chest x-ray. Nurse #2 stated the NP told her if the family wanted to call Emergency Medical Services they could however if the resident was in no respiratory distress, she didn't see the need to send them out. She stated the</p>	F 600			

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F 600	<p>Continued From page 23</p> <p>RP contacted Emergency Medical Services (EMS) and Resident #1 was transported to the hospital at 9:30 PM.</p> <p>Review of the Nurse Practitioner (NP) computerized communication board revealed on 11/7/21 at 8:41 PM Nurse #2 notified the on-call NP that Resident #1's son was requesting she go to the hospital for an evaluation. Nurse #2 wrote to the NP that Resident #1 was in no distress but the residents Responsible Party (RP) would feel better if she went out. The note revealed Resident #1 kept taking her nasal cannula out of her nose which caused her oxygen level to drop and Nurse #2 had taped the cannula in place on the resident's nose. The NP gave orders to obtain a 2-view chest x-ray and nebulizer treatments as needed for shortness of breath and wheezing but stated she did not agree hospitalization was necessary. She stated if the family wanted the resident sent to the hospital, they could call emergency medical services (EMS).</p> <p>On 02/24/20 at 9:25 AM an interview was conducted with Resident #1's Responsible Party (RP). During the interview he stated he had spoken to Resident #1 on the afternoon of 11/07/20 in which she sounded out of breath and stated to him she felt short of breath. The RP stated he hung up the phone with Resident #1 and called Nurse #1. Nurse #1 then went into the room and checked her oxygen saturation level which was low. He stated he was told Nurse #1 initiated supplemental oxygen at that time. The RP stated he called Resident #1 back two hours later to ask how she was doing, and she was still short of breath. When he asked her if she was wearing oxygen, she stated no. The RP then called the nurses station and spoke with Nurse #1</p>	F 600			



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F 600	<p>Continued From page 24</p> <p>to tell her what Resident #1 had said. He stated when the nurse went into the room the resident was in fact not wearing her oxygen, she placed the oxygen back into Resident #1's nose and her oxygen level increased. The RP stated when he called back, he spoke with Nurse #2 and asked how Resident #1 was doing. She stated to him she hadn't been into the room yet, but she would check on her. The RP stated he told Nurse #2 he wanted Resident #1 sent to the hospital for an evaluation. The interview revealed Nurse #2 called him back and stated she had spoken with the Director of Nursing and Nurse Practitioner who both recommended the resident not be sent to the hospital because she appeared to be in no respiratory distress at that time. He was told if he wanted her sent to the hospital, he could call Emergency Medical Services (EMS) himself in which he did.</p> <p>On 02/24/21 at 12:39 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated Resident #1 was a full code and if there was a change of condition the nurse was responsible for notifying the Physician immediately. She stated she was in the facility on 11/07/20 working on another hall during night shift. The DON stated Nurse #2 had come to her stating the RP wanted Resident #1 sent to the hospital but that her assessment was the resident was in no respiratory distress. The DON stated she did not go assess the resident herself but told Nurse #2 to just let the Physician know the resident was in no respiratory distress.</p> <p>Review of the hospital records dated 11/07/20 at 10:00 PM revealed Resident #1 had a diagnosis of COVID-19 pneumonia and pulmonary embolism with hypoxia. The report revealed</p>	F 600			

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F 600	<p>Continued From page 25</p> <p>Resident #1 was too lethargic to give any additional history when seen in the Emergency Room and her responsible party had given the information. Resident #1's vital signs at the hospital were temperature 102, heart rate 95, blood pressure 127/52 and oxygen saturation level of 92% on 4 liters of oxygen. The treatment plan for Resident #1 included low dose heparin (blood thinner) for treatment of the pulmonary embolism and to initiate her on Dexamethasone (steroid). On 11/10/21 Resident #1 was seen emergently at the bedside for acute hypoxia, overnight she had experienced an increased reaction to Covid-19 Pneumonia with spiking fevers and more shortness of breath. Resident #1 was intubated and placed in the Intensive Care Unit (ICU). Resident #1's oxygen saturation levels were in the 70% ' s. A discussion was had with Resident #1's RP to transition the resident into comfort care.</p> <p>On 02/25/21 at 8:30 AM an interview was conducted with the facility Nurse Practitioner (NP). She stated she would expect the nursing staff to notify her if they had a resident who previously did not require oxygen therapy, placed on supplemental oxygen due to a low oxygen saturation level in the 70 % range. The NP stated that would be considered a change in condition and would need to be addressed immediately.</p> <p>On 02/24/21 at 10:21 AM an interview was conducted with the Medical Director (MD). He stated when he reviewed the NP notes from 11/07/21 he saw the responsible party had requested Resident #1 be sent to the hospital for an evaluation despite the nurse's assessment that the resident was experiencing no respiratory distress. The MD stated hypoxia (the absence of</p>	F 600			

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F 600	<p>Continued From page 26</p> <p>enough oxygen in the tissue to sustain bodily function) did not equal respiratory distress. The interview revealed he did not send residents out for respiratory distress unless they were in active accessory muscle distress which it did not seem like Resident #1 was in as evidenced by her oxygen saturation level increasing with supplemental oxygen use. He stated she was noted to be confused which meant she probably did not have the mentation at that time for supplemental oxygen to be useful which is why she was removing it. The MD stated the NP had ordered a nebulizer treatment and chest x-ray when Nurse #2 notified her. He stated looking at the summary of the notes from 11/07/20 since he wasn't in the building the situation was a clinical decision and if a responsible party was insistent the resident go to the hospital then they would be told it was their right to call emergency medical services. The interview revealed it was the facility protocol to place residents on prophylactic blood thinner when diagnosed with COVID-19. He stated she was diagnosed with COVID-19 pneumonia at the hospital and had a pulmonary embolism which could not have been prevented if she had been sent to the hospital any sooner than she was. The interview revealed Resident #1 was hypoxic was placed on supplemental oxygen with her oxygen saturation improving yet still threw a clot and ended up with a pulmonary embolism. He stated there was no way the facility could have known that was occurring.</p> <p>The facility Administrator was notified of the immediate jeopardy on 03/05/21 at 9:06 AM.</p> <p>The facility Administrator was notified of an additional example of immediate jeopardy on 3/23/21 at 11:40 AM.</p>	F 600			

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F 600	<p>Continued From page 27</p> <p>The facility provided the following credible allegation of Immediate Jeopardy removal:</p> <p>#1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:</p> <p>1. Resident #2 tested positive for Covid-19 on 11/04/2020. Resident #2 had been ordered supplemental oxygen at 2-3 liters per minute to maintain oxygen saturations above 90% written on 08/13/2020. On 11/07/20 at 3:09 AM, Resident #2 oxygen saturation was documented to be 76% on 2 liters of supplemental oxygen. On 11/07/20 at 3:20 AM Resident #2 oxygen saturation was documented to be 75% on 2 liters of supplemental oxygen. On 11/07/20 at 6:55 AM Resident #2 oxygen saturation was documented to be 75% on 2 liters of supplemental oxygen. Nurse #3 did not notify Resident #2 physician/nurse practitioner or physician assistant (MD/NP/PA) of the low oxygen saturation levels nor did Nurse #3 increase Resident #2 oxygen as was ordered by the MD. There is no documentation that the resident was assessed by Nurse #3. On 11/07/20 at 11:30 AM, Nurse #1 noted that Resident #2 oxygen saturation was 62%. Oxygen was being administered at 2 liters per minute. Nurse #1 increased the resident's oxygen to 4 liters per minute and notified the resident's physician. Resident #2 was transferred to the emergency room for evaluation and treatment.</p> <p>The alleged non-compliance resulted from the failure of Nurse #3 to identify that the oxygen desaturations were life threatening, to assess the Resident #2, to increase Resident #2's oxygen</p>	F 600			

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F 600	<p>Continued From page 28</p> <p>per MD order, and by not notifying the MD/NP/PA of the life-threatening situation. These failures delayed Resident #2 from getting medical attention. Nurse #3 could not recall if she reported the desaturations to the MD/NP/PA or the oncoming nurse on 11/07/2020. Resident #2 was admitted to the hospital on 11/07/2020 with hypoxia. Resident was treated at the hospital and subsequently returned to the facility on 11/13/2020 for care post hospitalization for Bilateral Pneumonia secondary to Covid-19 virus. While hospitalized, she required high-flow nasal cannula and received Remdesivir (broad-spectrum antiviral medication) and Dexamethasone (corticosteroid). She steadily improved and upon return required oxygen at 1-2 liters per minute via nasal cannula.</p> <p>2. Resident #1 was re-admitted into the facility on 07/07/20 with diagnosis which included cerebrovascular accident (CVA), anxiety and asthma. On 11/07/20 at 3:54 PM, Nurse #1 documented in the resident progress notes that Resident #1 's Responsible Party (RP) had called and stated Resident #1 sounded short of breath. Nurse #1 checked on Resident #1 to find she had an oxygen saturation level of 72%. The note revealed Nurse #1 initiated oxygen at 4 liters per minute (1pm) and Resident #1's oxygen level began to rise to 89%, 90% to 92%.</p> <p>The nursing progress note, dated 11/07/20 at 4:41 PM written by Nurse #1, revealed she had gone into Resident #1's room to find the nasal cannula tubing on the resident's forehead instead of in her nose. Resident #1's oxygen saturation level was at 70%. Nurse #1 replaced the nasal cannula into Resident #1's nose correctly and her oxygen saturation level increased to 90% on 4</p>	F 600			

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F 600	<p>Continued From page 29</p> <p>liters of oxygen.</p> <p>Nurse #1 did not notify Resident #2 physician/nurse practitioner or physician assistant (MD/NP/PA) of the sudden onset of low oxygen saturation levels nor did Nurse #1 notify the physician/nurse practitioner of Resident #1's change of condition requiring supplemental oxygen.</p> <p>On 11/07/2020 at 8:30 PM, Nurse #2 revealed that Resident #1's RP had called her around 8:30 PM during the middle of her medication pass stating he wanted Resident #1 sent to the hospital for an evaluation. Nurse #2 stated she was not informed during shift change that Resident #1 had experienced a change requiring the need for supplemental oxygen. Nurse #2 stated she went into Resident #1's room to find her in no respiratory distress. She stated she obtained vital signs and they were within normal limits however, she did not chart them and couldn't not remember what they were. She notified the Director of Nursing (DON) who was in the building and the Nurse Practitioner on call. The Nurse Practitioner ordered a nebulizer treatment every 4 hours as needed and a chest x-ray. Nurse #2 stated the NP told her if the family wanted to call Emergency Medical Services they could however if the resident was in no respiratory distress, she didn't see the need to send them out. She stated the RP contacted Emergency Medical Services (EMS) and Resident #1 was transported to the hospital at 9:30 PM.</p> <p>Review of the hospital records dated 11/07/20 at 10:00 PM revealed that Resident #1 had a diagnosis of Covid-19 pneumonia and pulmonary</p>	F 600			

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F 600	<p>Continued From page 30</p> <p>embolism. Resident #1 did not return to the facility.</p> <p>The alleged non-compliance resulted from the failure of Nurse #1 to identify that the oxygen desaturations were life threatening, to assess the Resident #1, and by not notifying the MD/NP/PA of the life-threatening situation. These failures delayed Resident #1 from getting medical attention.</p> <p>An audit was completed by the Administrator on 03/05/2021. The Administrator reviewed all residents who are currently on oxygen therapy or have received oxygen therapy in the last 72 hours to determine if any other resident had episodes of oxygen desaturation and if so, was the MD/NP/PA notified and appropriate interventions applied. In addition, all physician orders for oxygen administration were reviewed to ensure that all orders had parameters for notification of MD/NP/PA. All physician orders state to notify the MD/NP/PA for oxygen saturations &lt;90% and to maintain oxygen saturations &gt;90%. There were 17 additional potentially affected residents, however, no additional residents were identified as having been affected by the alleged deficient practice. All 17 residents had orders for parameters of notification. No resident had oxygen saturations &lt;90%.</p> <p>#2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>Nurse #3 was educated by the Director of Nursing on 02/28/2021 regarding the importance of oxygen saturation readings; to notify MD/NP/PA of any oxygen saturation level &lt;90%</p>	F 600			

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F 600	<p>Continued From page 31</p> <p>and to increase the oxygen administration to maintain the oxygen saturation level &gt;90% or per instruction on physician order.</p> <p>Oxygen-Nebulizer Administration Guideline was reviewed by the Regional Clinical Manager on 03/05/2021. Parameters were added to the guideline on 03/05/2021 to notify MD/NP/PA of any oxygen saturation level &lt;90% and to increase the oxygen administration to maintain the oxygen saturation level &gt;90% or per instruction on physician order.</p> <p>All licensed nursing staff will be educated by the Administrator, the Director of Nursing, and/or the Staff Development Coordinator regarding the following:</p> <ol style="list-style-type: none"> <li>1. Oxygen saturation refers to the amount of oxygen that's in the bloodstream. The body requires a specific amount of oxygen in the blood to function properly.</li> <li>2. The normal range of oxygen saturation for adults is 94 to 99 percent.</li> <li>3. Oxygen saturations must be maintained &gt;90%. If blood oxygen levels are too low, the body may not work properly. Hypoxemia can cause mild problems such as headaches and shortness of breath. In severe cases, it can interfere with heart and brain function.</li> <li>4. Oxygen administration will be increased to maintain oxygen level &gt;90% or as instructed by physician order.</li> <li>5. The MD/NP/PA must be notified when oxygen saturation levels are below 90%.</li> </ol>	F 600			



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F 600	Continued From page 32  6. If oxygen saturations are below 90% and the resident presents with other clinical signs of respiratory distress, including shortness of breath, cyanosis, elevated heart rate, and/or mental status changes, MD/NP/PA and EMS must be notified immediately.  7. Comprehensive assessments are important for all residents on oxygen therapy to assess for any signs and symptoms of respiratory distress.  8. All residents receiving oxygen therapy will be assessed for signs and symptoms of respiratory distress every shift or as ordered by the MD/NP/PA.  9. All residents receiving oxygen therapy will have oxygen saturations monitored every shift or as ordered by the MD/NP/PA.  10. All physician orders for oxygen therapy will have parameters to notify the MD/NP/PA of oxygen saturations less than 90% or as instructed by MD/NP/PA order.  The Staff Development Coordinator and Administrator initiated the education for all licensed nursing staff on 03/05/2021. The Director of Nursing, Staff Development Coordinator, Nursing Supervisors and/or Administrator will provide the education to all licensed nurses prior to the start of their next shift. Any licensed nurse out on leave or on PRN status will be educated prior to returning to duty. The Director of Nursing will be responsible for tracking staff that have not received the education. The Staff Development Coordinator, Nursing Supervisors and the Director of Nursing	F 600			

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F 600	<p>Continued From page 33</p> <p>were notified of this responsibility on 03/05/2021 by the Administrator. Any newly hired licensed nurse will be educated during orientation.</p> <p>All Certified Nursing Assistants will be educated by the Administrator, the Director of Nursing and/or the Staff Development Coordinator on signs and symptoms of respiratory distress, including shortness of breath, difficulty breathing, cyanosis, elevated heart rate, and/or mental status changes and that they are required to report these signs and symptoms to the nursing staff immediately.</p> <p>The Staff Development Coordinator and Administrator will initiate the education for all Certified Nursing Assistants on 03/06/2021. The Staff Development Coordinator, the Director of Nursing, Nursing Supervisors, and/or the Administrator will provide the education to all Certified Nursing Assistant ' s prior to the start of their next shift. Any Certified Nursing Assistant out on leave or on PRN status will be educated prior to returning to duty. The Director of Nursing will be responsible for tracking staff that have not received the education. The Director of Nursing, Nursing Supervisors, and Staff Development Coordinator were notified of this responsibility on 03/05/2021 by the Administrator. Any newly hired Certified Nursing Assistant will be educated during orientation.</p> <p>The Administrator educated the Director of Nursing, Staff Development Coordinator, and the Nursing Supervisors on 03/05/2021 that all residents on oxygen therapy will be reviewed daily, Monday through Friday in morning clinical meeting. The Director of Nursing and/or Nursing Supervisors will open and review the vital sign</p>	F 600			

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F 600	<p>Continued From page 34</p> <p>report in the electronic health record to ensure that the MD/NP/PA has been notified of any resident with oxygen saturation levels less than 90% and ensure that appropriate medical care has been obtained. On the weekend, the Nursing Supervisor will print and review the vital sign report in the electronic health record to ensure that the MD/NP/PA has been notified of any resident with oxygen saturation levels less than 90% and ensure that appropriate medical care has been obtained. These reports will be given to the Director of Nursing and/or Staff Development Coordinator for review.</p> <p>TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION FOR IMMEDIATE JEOPARDY REMOVAL.</p> <p>The Administrator and the Director of Nursing will be ultimately responsible to ensure the implementation of credible allegation to remove this alleged immediate jeopardy.</p> <p>Immediate Jeopardy Removal Date: 03/06/2021</p> <p>On 03/11/21, the facility's credible allegation of immediate jeopardy removal was validated by review of documentation regarding staff training of the importance of oxygen saturation readings, notifying the provider of any oxygen saturation level &lt;90% and increasing oxygen administration to maintain the oxygen saturation level &gt;90% or per physician instruction. Staff interviews revealed receipt of training related to the normal range of oxygen saturation, the importance of keeping oxygen saturation &gt;90%, oxygen administration to keep oxygen level &gt;90%, notifying the provider of an oxygen saturation &lt;90%, monitoring residents receiving oxygen</p>	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 35 therapy every shift for signs and symptoms of respiratory distress, monitoring the oxygen level of residents receiving oxygen therapy every shift, and ensuring physician orders for oxygen administration have parameters to notify the provider of an oxygen saturation <90%. The facility's date of IJ removal of 03/06/21 was validated.	F 600			