

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

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/09/2012
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/HE	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944
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F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; 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); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and physician interview and facility record review the facility failed to notify the</p>	F 157	<p>F157</p> <p>"Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p> <ol style="list-style-type: none"> 1. Resident # 1 no longer resides in facility. 2. Facility resident current medical records were reviewed for period last 30 days to assure that attending physician and/or responsible party were notified if indicated regarding acute changes in conditions on 8/31/2012 by Director of Nursing and/or designee. <p>Facility Licensed Staff were provided re-education regarding procedure when resident has acute change condition and/or change, to include notification on 8-11-2012 and on going by facility staff development coordinator. Licensed staff that has not received the re-education will be re-educated prior to their next scheduled shift. Newly hired licensed staff will receive training during their orientation.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Jessica S. Walker RN, CNA TITLE
9/5/12 (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>physician for an acute change in resident condition and unsuccessful oxygen saturation measurement for 1 of 3 (resident #1) sampled residents.</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility 7/12/12. Her diagnoses included; diabetes, hypertension, history of gastrointestinal bleed with anemia, heart attack, atrial fibrillation, dysphagia with history of aspiration pneumonia and peripheral vascular disease.</p> <p>The five day minimum data set (MDS) assessment for resident #1 dated 7/20/12 was reviewed. She was not coded as cognitively impaired for daily decision making. She required extensive assistance of two people for bed mobility and was dependent on two people for transfers. She required extensive assistance of one person for dressing, eating, toileting and personal hygiene. Resident #1 was dependent on one person for bathing. She was coded as frequently incontinent of bladder and always incontinent of bowel. She had a wheelchair for an assistive device. The assessment indicated resident #1 had shortness of breath with exertion and required oxygen therapy as a resident but did not require oxygen therapy prior to her admission.</p> <p>The fourteen day MDS assessment for resident #1 dated 7/27/12 was reviewed. The assessment revealed she was moderately impaired for daily decision making. She required extensive assistance of two people for bed mobility and was dependent on two people for transfers. She required extensive assistance of one person for</p>	F 157	<p>3. Systemic measures implemented to ensure the same alleged deficient practice does not recur include:</p> <p>The 24-hour report, Physician orders and change of condition reports will be reviewed by the Interdisciplinary team Monday through Friday to identify residents who have had changes in their treatment plan and if indicated to validate notification to Physician and Responsible party daily for 4 weeks than bimonthly for one month. Negative finding will be addressed when noted.</p> <p>4. The Director of Nursing will reported findings to the Quality Assessment and Assurance Committee monthly x 3 The Quality Assessment and Assurance and Assurance Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance.</p>	9/6/2012	

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F 157	<p>Continued From page 2</p> <p>dressing, eating, toileting and personal hygiene. Resident #1 was dependent on one person for bathing. She was coded as always incontinent of bowel and bladder and had a wheelchair for an assistive device. The assessment indicated resident #1 had shortness of breath at rest and required oxygen therapy as a resident but did not require oxygen therapy prior to her admission.</p> <p>Resident #1 did not have a care plan related to shortness of breath or oxygen use.</p> <p>A physical therapist (PT) note for resident #1 dated 7/18/12 indicated during therapy resident #1 was noted to have coolness and cyanosis (blueness of skin indicating tissue near the skin surface had low oxygen) to her fingers and left toes. Her oxygen saturation measured 78%. (Oxygen saturation is an indicator of the percentage of hemoglobin saturated with oxygen at the time of the measurement. The reading, obtained through pulse oximetry, uses a light sensor containing two sources of light that are absorbed by hemoglobin and transmitted through tissues to a photo detector. The amount of light transmitted through the tissue is then converted to a digital value representing the percentage of hemoglobin saturated with oxygen. Normal oxygen saturation values are 97% to 99% in the healthy individual. "Oxygen Saturation Monitoring by Pulse Oximetry" written by the American Association of Critical-Care Nurses.) The nurse was notified.</p> <p>A nursing daily skilled summary sheet (an assessment sheet with body systems and boxes to check for assessment of the systems) dated 7/18/12 at 7:00 PM was reviewed. The narrative note revealed resident #1 had an oxygen</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>saturation in the "80's." Oxygen was initiated at 2 liters per minute via nasal cannula. A box indicating oxygen use was checked and "2 liters" was handwritten in the space provided. The oxygen saturation box was checked and "92%" was handwritten in the space provided. There was no assessment of resident #1's respiratory system documented.</p> <p>A physician's order dated 7/18/12 at 4:30 PM was reviewed. The order read for oxygen to be administered at 2 liters a minute via nasal cannula on an as needed (PRN) basis for shortness of breath or low oxygen saturations. There were no parameters to define what "low" oxygen saturation was considered. The order also read for oxygen saturation levels to be checked twice a day. The order was signed by nurse #1 and the physicians name was followed by a backslash and the nurse's name. The order was not signed by the physician.</p> <p>A nursing daily skilled summary sheet dated 7/22/12 at 5:15 PM indicated resident #1 did not have any signs or symptoms of respiratory distress. The narrative note also mentioned that the resident's hands were cold and the nurse was unable to obtain her oxygen saturation measurement.</p> <p>A nursing daily skilled summary sheet dated 7/27/12 revealed a box indicating oxygen use was checked. The oxygen saturation box was checked but an oxygen saturation was not recorded. A narrative nurse's note indicated oxygen at 2 liters a minute was applied in the afternoon but there was no acute shortness of breath. The nurse documented she was unable to</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>obtain resident #1's oxygen saturation due to her hands being very cold. No oxygen saturations were recorded for 7/27/12. A third shift nurse's note dated 7/28/12 at 5:50 am indicated that the resident was talking and took her last breath, cardiopulmonary resuscitation was started and the resident was sent to the hospital.</p> <p>Oxygen saturation measurements for resident #1 were not recorded twice daily as ordered on 7/21/12, 7/22/12, 7/24/12 or 7/27/12. Oxygen saturation measurements were only recorded once a day on 7/25/12 and 7/26/12. There was no explanation of why oxygen saturations were not recorded except on 7/22/12 and 7/27/12 and there was no documentation of physician notification.</p> <p>A facility procedure titled; "Oxygen Administration" was reviewed. Item #6 under procedure read; "Monitor the resident for signs of hypoxemia (low oxygen level) as appropriate." Item G read; "Cyanosis, cool, clammy skin."</p> <p>On 8/8/12 at 4:10 PM nurse #1 was interviewed with the administrator present. Nurse #1 indicated that resident #1 was normally alert and oriented to herself and her family. Nurse #1 indicated on 7/18/12 resident #1 had been out of the facility to a physician's appointment. She said the weather outside was very hot that day and when resident #1 returned from her physicians appointment she "was not acting like herself." Nurse #1 stated "she did not have any rapid or short breaths she was just not as alert." Nurse #1 said she checked resident #1's oxygen saturation around 3:00 PM and her oxygen saturation measured in the 80's. Nurse #1 indicated she called the physicians</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>office and reported the low oxygen saturation to a nurse in the office. She could not recall who she spoke with. Nurse #1 said the nurse at the physician's office gave her orders for oxygen as needed. Nurse #1 said the nurse at the physician's office did not give her parameters for use other than for "shortness of breath and low oxygen saturation." Nurse #1 indicated that oxygen saturation less than 90% is considered low per the facility guidelines. Nurse #1 said she administered oxygen at 2 liters per minute via nasal cannula to resident #1. She recalled within a few minutes resident #1's oxygen saturation returned to normal and as well as her mental status. Nurse #1 recalled that resident #1 was still wearing oxygen when her shift ended 7/18/12 at 7:00 PM. Nurse #1 said she listened to resident #1's lung sounds on 7/18/12 and her breath sounds were clear. Nurse #1 said she did not document the assessment because the nurses only document by exception if something is abnormal and resident #1's assessment was normal.</p> <p>On 8/9/12 at 8:15 AM nurse #3 was interviewed. Nurse #3 said on 7/22/12 she was unable to obtain an oxygen saturation measurement on resident #1. Nurse #3 indicated she did not notify the physician because the resident did not display any signs or symptoms of shortness of breath. Nurse #3 said she passed the information along in shift report to the next nurse but was unsure if that nurse obtained a measurement. Nurse #3 said on 7/27/12 she was not able to obtain an oxygen saturation measurement and she did not notify the physician because resident #1 did not have any signs of shortness of breath.</p>	F 157			

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F 157	Continued From page 6 On 8/9/12 at 9:12 AM the physician said he did not have any record of his office being contacted for resident #1 regarding low oxygen saturation levels. The physician said resident #1 was in his office the morning of 7/18/12 and she was stable without concerns related to her respiratory system. The physician said he would have expected the facility to notify him of an oxygen saturation less than 90% or the inability obtain an oxygen saturation measurement. He said he would expect that an order for PRN oxygen to have parameters for use and he would have possibly ordered additional diagnostic tests to investigate why resident #1 needed oxygen. The physician said he visited the facility on 7/22/12 and examined resident #1 but could not recall if she had oxygen on at the time. He said on 7/22/12 resident #1 was stable and her lungs were clear bilaterally. He was not able to recall if he reviewed the 7/18/12 order for oxygen or explain why the order had not been signed. On 8/9/12 at 9:23 AM the Administrator indicated she expected the physician to be notified of any acute change in condition, if a nurse could not obtain an oxygen saturation measurement or obtained an oxygen saturation measurement of less than 90%. The administrator also indicated that resident #1 had been discussed in morning meetings and the facility staff felt the low oxygen saturation on 7/18/12 was an isolated incident due to the heat, the resident's age and co-morbidities.	F 157			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279			

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F 279	<p>Continued From page 7 comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview the facility failed to develop a comprehensive care plan for oxygen use for 1 of 3 sampled residents (resident #1).</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility 7/12/12. Her diagnoses included; history of gastrointestinal bleed with anemia, heart attack, atrial fibrillation, dysphagia with history of aspiration pneumonia and peripheral vascular disease.</p> <p>The five day minimum data set (MDS) assessment for resident #1 dated 7/20/12 was reviewed. She was not coded as cognitively</p>	F 279	<p>F279</p> <p>"Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p> <ol style="list-style-type: none"> 1. Resident #1 related to resident no longer resides at the facility. 2. Facility residents have the potential to be affected by the same alleged deficient practice. <p>Facility residents identified that require use of oxygen medical record were reviewed to ensure each physician order contained orders for routine saturation checks and parameters regarding saturation results on 8-10-12 by Director of Nursing. The residents identified care plans were reviewed during audit as well on 8-10-12. Newly admitted residents will be reviewed in the morning meeting to ensure that residents with physician orders for oxygen have saturation checks and parameters.</p>		

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F 279	<p>Continued From page 8</p> <p>impaired for daily decision making. She required extensive assistance of two people for bed mobility and was dependent on two people for transfers. She required extensive assistance of one person for dressing, eating, toileting and personal hygiene. Resident #1 was dependent on one person for bathing. She was coded as frequently incontinent of bladder and always incontinent of bowel. She had a wheelchair for an assistive device. The assessment indicated resident #1 had shortness of breath with exertion and required oxygen therapy as a resident but did not require oxygen therapy prior to her admission.</p> <p>The fourteen day MDS assessment for resident #1 dated 7/27/12 was reviewed. The assessment revealed she was moderately impaired for daily decision making. She required extensive assistance of two people for bed mobility and was dependent on two people for transfers. She required extensive assistance of one person for dressing, eating, toileting and personal hygiene. Resident #1 was dependent on one person for bathing. She was coded as always incontinent of bowel and bladder and had a wheelchair for an assistive device. The assessment indicated resident #1 had shortness of breath at rest and required oxygen therapy as a resident but did not require oxygen therapy prior to her admission.</p> <p>Resident #1 did not have a care plan related to shortness of breath or oxygen use.</p> <p>A physical therapy (PT) note for resident #1 dated 7/18/12 indicated during therapy resident #1 was noted to have coolness and cyanosis (blueness of skin indicating tissue near the skin surface had low oxygen) to her fingers and left toes. Her</p>	F 279	<p>3. Systemic Measures put into place to ensure the same alleged deficient practice does not recur include:</p> <p>The Resident Care Management Director and the Resident Care Management Coordinator were provided re-educated on 8-16 by Teresa WelcherRN, LNHA, on the process of using the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care to include resident identified with respiratory medical conditions.</p> <p>The 24-hour report, Physician orders and change of condition reports will be reviewed by the Interdisciplinary team Monday through Friday to identify residents who have received orders for oxygen therapy to assure that each have orders for saturation checks and a comprehensive care plan put into place daily for 4 weeks than bimonthly for one month. Negative finding will be addressed when noted.</p> <p>4. The Resident Care Director and the Administrator will analyze the results of the care plan reviews for trends. The Resident care Director will report results to the Quality Assessment and Assurance Committee monthly x 3. The Quality Assessment and Assurance and Assurance Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance.</p> <p style="text-align: right;">9/06/12</p>	

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F 279	<p>Continued From page 9</p> <p>oxygen saturation measured 78%. The nurse was notified. (Oxygen saturation is an indicator of the percentage of hemoglobin saturated with oxygen at the time of the measurement. The reading, obtained through pulse oximetry, uses a light sensor containing two sources of light that are absorbed by hemoglobin and transmitted through tissues to a photo detector. The amount of light transmitted through the tissue is then converted to a digital value representing the percentage of hemoglobin saturated with oxygen. Normal oxygen saturation values are 97% to 99% in the healthy individual. "Oxygen Saturation Monitoring by Pulse Oximetry" written by the American Association of Critical-Care Nurses.)</p> <p>A nursing daily skilled summary sheet (an assessment sheet with body systems and boxes to check for assessment of the systems) dated 7/18/12 at 7:00 PM was reviewed. The narrative note revealed resident #1 had an oxygen saturation in the "80's." Oxygen was initiated at 2 liters per minute via nasal cannula.</p> <p>A physician's order dated 7/18/12 at 4:30 PM was reviewed. The order read for oxygen to be administered at 2 liters a minute via nasal cannula on an as needed (PRN) basis for shortness of breath or low oxygen saturations. There were no parameters to define what "low" oxygen saturation was considered. The order also read for oxygen saturation levels to be checked twice a day.</p> <p>A nursing daily skilled summary sheet dated 7/19/12 at 12:15 PM was reviewed. The nurse's narrative note indicated oxygen at 2 liters per minute via nasal cannula was in use.</p>	F 279			

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F 279	Continued From page 10 A nursing daily skilled summary sheet dated 7/24/12 at 10:35 AM revealed a nurse's note for third shift (11:00 PM - 7:00 AM) indicated resident #1's continuous oxygen was intact. A nursing daily skilled summary sheet dated 7/27/12 indicated oxygen at 2 liters a minute was applied in the afternoon but there was no acute shortness of breath. On 8/9/12 at 9:23 AM the Director of Nursing said she expected resident #1 or any resident on oxygen to have a care plan for oxygen use. On 8/14/12 at 9:20 AM the MDS nurse was interviewed. The MDS nurse indicated she received information for the 5 day assessment from the PT notes that resident #1 had shortness of breath on exertion and required oxygen therapy. She said she used the information from the 7/22/12 nurses note; "the residents hands were cold and the nurse was unable to get a pulse oximetry reading" for the 14 day assessment that resident #1 had shortness of breath at rest. She indicated the nurse's notes revealed resident #1 had continued to use oxygen therapy on an as needed basis. The MDS nurse said oxygen use or shortness of breath does not trigger the care area assessment section which is used to develop care plans. The MDS nurse stated that unless a resident had a respiratory diagnosis she did not care plan for oxygen use. The MDS nurse said resident #1 did not have a care plan for oxygen use.	F 279			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328			

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F 328	<p>Continued From page 11</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility record review the facility administered oxygen on an as needed basis with no parameters for use and failed to monitor oxygen saturation levels as ordered by the physician for 1 of 3 sampled residents reviewed (resident #1).</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility 7/12/12 as a full code (cardiopulmonary resuscitation was wanted in the event the resident stopped breathing or her heart stopped). Her diagnoses included; diabetes, hypertension, history of gastrointestinal bleed with anemia, heart attack, atrial fibrillation, dysphagia with history of aspiration pneumonia and peripheral vascular disease.</p> <p>The five day minimum data set (MDS) assessment for resident #1 dated 7/20/12 was reviewed. She was not coded as cognitively impaired for daily decision making. She required</p>	F 328	<p>F328</p> <p>"Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p> <ol style="list-style-type: none"> 1. Resident #1 no longer resides at the Facility. 2. Facilities residents have the potential to be affected by the same alleged deficient practice include residents with physician orders for oxygen therapy and/or saturation monitoring. <p>Facility residents requiring oxygen therapy and/or saturation monitoring were reviewed on 8-11-2012 by Director of Nursing /designee to assure each resident has orders complete with parameters for use identified on order and on care plan.</p>		

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F 328	<p>Continued From page 12</p> <p>extensive assistance of two people for bed mobility and was dependent on two people for transfers. She required extensive assistance of one person for dressing, eating, toileting and personal hygiene. Resident #1 was dependent on one person for bathing. She was coded as frequently incontinent of bladder and always incontinent of bowel. She had a wheelchair for an assistive device. The assessment indicated resident #1 had shortness of breath with exertion and required oxygen therapy as a resident but did not require oxygen therapy prior to her admission.</p> <p>The fourteen day MDS assessment for resident #1 dated 7/27/12 was reviewed. The assessment revealed she was moderately impaired for daily decision making. She required extensive assistance of two people for bed mobility and was dependent on two people for transfers. She required extensive assistance of one person for dressing, eating, toileting and personal hygiene. Resident #1 was dependent on one person for bathing. She was coded as always incontinent of bowel and bladder and had a wheelchair for an assistive device. The assessment indicated resident #1 had shortness of breath at rest and required oxygen therapy as a resident but did not require oxygen therapy prior to her admission.</p> <p>Resident #1 did not have a care plan related to shortness of breath or oxygen use.</p> <p>A nursing admission assessment dated 7/12/12 indicated resident #1's pulse was 70 beats per minute and regular and she had no edema (swelling). Her respiratory rate was regular and she had no dyspnea (difficulty breathing). Resident #1's breath sounds were clear bilaterally</p>	F 328	<p>2. Systemic Measures put into place to ensure the same alleged deficient practice does not recur include.</p> <p>Facility Licensed Staff were provided re-education started on 8-11-2012 and on going, on the procedure to write a complete order for the administration of oxygen to include saturation parameters. Licensed staff that has not received the re-education will be re-educated prior to their next scheduled shift. Newly hired licensed staff will receive training during their orientation.</p> <p>The 24-hour report, Physician orders and change of condition reports will be reviewed by the Interdisciplinary team Monday through Friday to identify residents who have orders for Oxygen therapy to assure parameters are established if needed for oxygen administration, daily for 4 weeks than bimonthly for one month. Negative finding will be addressed when noted. DON/Designee will monitor All Medication Administration Records for those resident who are receive oxygen therapy to validate compliance with Physician orders, weekly for 4 weeks than bimonthly for one month.</p>	
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F 328	<p>Continued From page 13 and she did not require oxygen therapy.</p> <p>No respiratory concerns were documented for resident #1 on the nursing daily skilled summary sheet (an assessment sheet with body systems and boxes to check for assessment of the systems) or nurse's notes from 7/13/12 through 7/17/12.</p> <p>A Physical Therapy (PT) evaluation note for resident #1 dated 7/13/12 was reviewed. The note revealed resident #1 had an oxygen saturation of 95% at rest during her evaluation. (Oxygen saturation is an indicator of the percentage of hemoglobin saturated with oxygen at the time of the measurement. The reading, obtained through pulse oximetry, uses a light sensor containing two sources of light that are absorbed by hemoglobin and transmitted through tissues to a photo detector. The amount of light transmitted through the tissue is then converted to a digital value representing the percentage of hemoglobin saturated with oxygen. Normal oxygen saturation values are 97% to 99% in the healthy individual. "Oxygen Saturation Monitoring by Pulse Oximetry" written by the American Association of Critical-Care Nurses.)</p> <p>A PT note for resident #1 dated 7/18/12 indicated during therapy resident #1 was noted to have coolness and cyanosis (blueness of skin indicating tissue near the skin surface had low oxygen) to her fingers and left toes. Her oxygen saturation measured 78%. The nurse was notified.</p> <p>A nursing daily skilled summary sheet dated 7/18/12 at 7:00 PM was reviewed. The narrative</p>	F 328	<p>4. Results of the audits will be reported to the Quality Assessment and Assurance Committee monthly x 3 months by the Director of Nursing. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified. The Quality Assessment and Assurance Committee will develop and implement additional interventions as needed to ensure continued compliance.</p>	9/06/12
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F 328	<p>Continued From page 14</p> <p>note revealed resident #1 had an oxygen saturation in the "80's." Oxygen was initiated at 2 liters per minute via nasal cannula. A box indicating oxygen use was checked and "2 liters" was handwritten in the space provided. The oxygen saturation box was checked and "92%" was handwritten in the space provided. There was no assessment of resident #1's respiratory system documented.</p> <p>The shift report sheet (used for reporting concerns between shifts but is not a part of a residents medical record) dated 7/18/12 indicated that resident #1 had oxygen as needed and two oxygen saturations were recorded; 92 % and 93%.</p> <p>A physician's order dated 7/18/12 at 4:30 PM was reviewed. The order read for oxygen to be administered at 2 liters a minute via nasal cannula on an as needed (PRN) basis for shortness of breath or low oxygen saturations. There were no parameters to define what "low" oxygen saturation was considered. The order also read for oxygen saturation levels to be checked twice a day. The order was signed by nurse #1 and the physicians name was followed by a backslash and the nurse's name. The order was not signed by the physician.</p> <p>A nursing daily skilled summary sheet dated 7/19/12 at 12:15 PM was reviewed. The nurse's narrative note indicated oxygen at 2 liters per minute via nasal cannula was in use but did not differentiate if the oxygen was already in place or was placed by the nurse. A box indicating oxygen use was checked. The oxygen saturation box was checked and "90%" was handwritten in the space</p>	F 328		
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F 328	<p>Continued From page 15 provided.</p> <p>The shift report sheet dated 7/19/12 noted resident #1's oxygen saturation level was 91% in the evening shift (3:00 PM -11:00 PM) section but did not indicate if the resident was on oxygen or room air.</p> <p>A nursing daily skilled summary sheet dated 7/20/12 at 7:00 PM was reviewed. A box indicating oxygen use was checked and "2 liters prn" was handwritten in the space provided. The oxygen saturation box was checked and "91%" was handwritten in the space provided.</p> <p>The shift report sheet dated 7/20/12 noted resident #1's oxygen saturation level was 92% in the night shift (11:00 PM - 7:00 AM) section but did not reveal if the resident was on oxygen or room air.</p> <p>There was an additional nursing daily skilled summary sheet dated 7/20/12 at 11:00 PM with the box indicating oxygen use checked but no oxygen saturation recorded.</p> <p>There was no nursing daily skilled summary sheet for 7/21/12. The shift report sheet dated 7/21/12 did not have any oxygen saturation documented. There was also no documentation to support if resident #1 had supplemental oxygen in use or was on room air.</p> <p>A nursing daily skilled summary sheet dated 7/22/12 at 5:15 PM indicated resident #1 did not have any signs or symptoms of respiratory distress. The narrative note also mentioned that the resident's hands were cold and the nurse was</p>	F 328		
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F 328	<p>Continued From page 16</p> <p>unable to obtain her oxygen saturation measurement.</p> <p>There was no documentation of resident #1's oxygen saturation on the shift report sheet dated 7/22/12.</p> <p>A nursing daily skilled summary sheet dated 7/23/12 at 4:30 PM revealed a box indicating oxygen use was checked and "prn" was handwritten in the space provided. The oxygen saturation box was checked and "97-98% RA (room air)" was handwritten in the space provided.</p> <p>The shift report sheet dated 7/23/12 revealed resident #1's oxygen saturation was 97% in the day shift (7:00 AM - 3:00 PM) section and 97-98% in the evening shift section.</p> <p>A nursing daily skilled summary sheet dated 7/24/12 at 10:35 AM revealed a box indicating oxygen use was checked and "prn" was handwritten in the space provided. The oxygen saturation box was not checked but an oxygen saturation was not recorded. A nurse's note for third shift indicated resident #1's continuous oxygen was intact.</p> <p>There was no documentation of resident #1's oxygen saturation on the shift report sheet dated 7/24/12.</p> <p>A nursing daily skilled summary sheet dated 7/25/12 at 6:30 PM revealed a box indicating oxygen use was checked and "prn" was handwritten in the space provided. The oxygen saturation box was checked and "98% RA" was</p>	F 328		

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F 328	<p>Continued From page 17 handwritten in the space provided.</p> <p>There was no documentation of resident #1's oxygen saturation on the shift report sheet dated 7/25/12. Resident #1's oxygen saturation was only recorded once on 7/25/12.</p> <p>A nursing daily skilled summary sheet dated 7/26/12 revealed a box indicating oxygen use was checked and "prn" was handwritten in the space provided. The oxygen saturation box was checked and "97% RA" was handwritten in the space provided.</p> <p>The shift report sheet dated 7/26/12 revealed resident #1's oxygen saturation was 97% in the day shift section. Resident #1's oxygen saturation was only recorded once on 7/26/12.</p> <p>A nursing daily skilled summary sheet dated 7/27/12 revealed a box indicating oxygen use was checked. The oxygen saturation box was checked but an oxygen saturation was not recorded. A narrative nurse's note indicated oxygen at 2 liters a minute was applied in the afternoon but there was no acute shortness of breath. The nurse documented she was unable to obtain resident #1's oxygen saturation due to her hands being very cold. No oxygen saturations were recorded for 7/27/12. A third shift nurse's note dated 7/28/12 at 5:50 am indicated that the resident was talking and took her last breath, cardiopulmonary resuscitation was started and the resident was sent to the hospital.</p> <p>There were no oxygen saturation measurements recorded on the medication administration record (MAR) or the treatment administration records</p>	F 328		
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F 328	<p>Continued From page 18</p> <p>(TAR) for July 2012. The 7/18/12 physicians order for oxygen administration and oxygen saturation checks were not transcribed onto the MAR or TAR.</p> <p>Oxygen saturation measurements for resident #1 were not recorded twice daily as ordered on 7/21/12, 7/22/12, 7/24/12 or 7/27/12. Oxygen saturation measurements were only recorded once a day on 7/25/12 and 7/26/12. There was no explanation of why oxygen saturations were not recorded except on 7/22/12 and 7/27/12 and no documentation of physician notification.</p> <p>On 8/8/12 at 4:10 PM nurse #1 was interviewed. She said she was the nurse who called the physicians office and received the 7/18/12 physician's order for PRN oxygen and for oxygen saturation checks twice a day. She said that orders for PRN oxygen are supposed to have parameters but the physician office did not give her specific number parameters and she did not clarify the order. She said that orders are supposed to be transcribed onto the MAR and she was not sure why the orders were not transcribed onto the MAR. Nurse #1 indicated that oxygen saturation checks are supposed to be documented on the MAR but because they order had not been transcribed onto the MAR they had not been documented. Nurse #1 said there was a facility protocol to administer oxygen if oxygen saturation was less than 90%. She indicated resident #1 had not used oxygen, displayed signs of shortness of breath or had an oxygen saturation less than 90% during any shift she had worked since she initially administered the oxygen on 7/18/12. Nurse #1 reviewed the resident chart and stated she had worked with</p>	F 328			

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F 328	<p>Continued From page 19</p> <p>resident #1 on 7/20/12, 7/23/12, 7/25/12 and 7/26/12.</p> <p>On 8/8/12 at 7:50 PM nurse #2 was interviewed. She indicated that 7:00 PM on 7/27/12 until 7:00 AM on 7/28/12 was the first time she had ever worked with resident #1. She said resident #1 had on oxygen when her shift started and she recalled the residents oxygen saturation check was 96-97%. She said she could not recall specifically how much oxygen resident #1 was on but it was being delivered via nasal cannula. Nurse #2 said she thought she documented resident #1's oxygen saturation on the MAR but thought she also documented it on the shift report sheet. Nurse #2 said resident #1 did not have any complaints or exhibit signs of shortness of breath; she was not able to explain why the oxygen saturation had not been documented.</p> <p>On 8/9/12 at 8:15 AM nurse #3 was interviewed. Nurses notes and facility staff sheets indicated that nurse #3 worked with resident #1 7:00 AM until 7:00 PM on 7/19/12, 7/22/12, 7/24/12 and 7/27/12. Nurse #3 recalled that resident #1 was started on oxygen therapy but could not recall the date or why she was started on oxygen. Nurse #3 indicated that oxygen saturation measurements are supposed to be recorded on the nursing daily skilled summary sheet and on the MAR. Nurse #3 could not recall if resident #1 had oxygen in place on 7/19/12 or if she initiated the oxygen after her oxygen saturation measured 90%. Nurse #3 could not recall if resident #1 had oxygen in place on 7/22/12 and said she did not notify the physician she could not obtain an oxygen saturation measurement. Nurse #3 could not remember if resident #1 had oxygen in place on</p>	F 328			

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F 328	Continued From page 20 7/24/12 and did not know why she had not documented an oxygen saturation measurement, she could not recall specifically that she had checked resident #1's oxygen saturation on 7/24/12. Nurse #3 said on 7/27/12 resident #1 did not have oxygen on until in the afternoon. She said she attempted to obtain an oxygen saturation on resident #1 and was unable to so she applied oxygen at 2 liters a minute via nasal cannula. She said resident #1 did not display any signs or symptoms of shortness of breath and voiced no complaints. On 8/9/12 at 9:23 AM the Director of Nursing (DON) and the Administrator were interviewed. The DON said it was the responsibility of the nurse who received the order to transcribe the order onto the MAR. The DON said she expected the order for twice daily oxygen saturation checks to be transcribed on the MAR and that the nurses would record the oxygen saturation checks on the MAR. The Administrator said she expected the staff to use the facility respiratory reference if an order for PRN oxygen was ordered and no parameters for use were given.	F 328			
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility record review the facility failed to ensure that 2 of 2 oxygen cylinders used for emergency	F 456			

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F 456	Continued From page 21 intervention were functioning properly. Findings include: On 8/9/12 at 12:15 PM two oxygen tanks were observed on the crash cart by the nursing station. Both gauges read empty. The Director of Nursing (DON) used an oxygen key to turn on the regulator. When the DON turned the key, oxygen leaked from the regulator attachment site and did not exit from the correct port, the gauge remained on empty. The DON attempted to turn the second tank on. The second oxygen tank also leaked from the regulator site when the DON turned the oxygen on. On 8/9/12 at 12:20 PM the DON stated the oxygen tanks she attempted to turn on were the oxygen tanks that would be used in an emergency. She indicated it was the responsibility of the third shift (11:00 PM to 7:00 AM) nurse to check the crash cart nightly for the inventory list of equipment which included two oxygen tanks. The DON said there was not a policy or an expectation of the staff to ensure the equipment on the crash cart was functioning.	F 456	F-456 "Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." 1. Residnet #1 no longer resides in The facility. 2. Facility residents have the potential to be effected by the alleged deficient practice. The maintenance director immediately on 8/9/12 removed from use and replaced the two tanks from the oxygen storage room and installed two regulators and he tested each for functioning. In addition he placed two regulators on top of the crash cart along with extra o-rings. Facilities Licensed Staff were provided re-education on 8-11-2012 and on going, on the procedure to check functionality and availability of the equipment on the crash cart Licensed staff that have not received the re-education will be re-educated prior to their next scheduled shift. Newly hired licensed staff will receive training during their orientation. The Director of Nursing will validate weekly the completeness of the audits and the functionality of the equipment. Negative findings will be corrected when noted.		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514			

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F 514	<p>Continued From page 22</p> <p>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review the facility failed to completely and accurately document oxygen administration and resident response to oxygen therapy for 1 of 3 sampled residents (resident #1).</p> <p>Findings include:</p> <p>A facility procedure titled; "Oxygen Administration" SSP 0901.01 revised December 2010 was reviewed. Under the documentation section the procedure read; "In the nurse's notes and treatment administration record and/or medication administration record, record; 1) Date and time of oxygen administration, 2) Type of delivery device, 3 oxygen flow rate and 4) Resident's vital signs, skin color, respiratory effort and lung sounds when indicated."</p> <p>Resident #1 was admitted to the facility 7/12/12. Her diagnoses included; diabetes, hypertension, history of gastrointestinal bleed with anemia, heart attack, atrial fibrillation, dysphagia with history of aspiration pneumonia and peripheral vascular disease.</p> <p>A nursing admission assessment dated 7/12/12 indicated resident #1's pulse was 70 beats per minute and regular and she had no edema (swelling). Her respiratory rate was regular and</p>	F 514	<p>3. Systemic Measures put into place to ensure the alleged deficient practice does not recur include: Licensed Nurses will include in their crash carts checks the functionality of the equipment. The director of Nursing will implement a weekly check to validate the functioning of the equipment, times Weekly x 4 weeks and monthly times 2 months. The Maintenance Director will also include checking the crash cart equipment weekly. New Oxygen tanks have been ordered for the crash cart that have a factor-installed regulator, training is in place and on going for licensed staff. Results will be discussed in The Interdisciplinary Team Meeting. Additional interventions will be implemented as determined necessary.</p> <p>4. Results of the audits will be reported to the Quality Assessment and Assurance Committee monthly x 3 months by the Director of Nursing. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified. The Quality Assessment and Assurance Committee will develop and implement additional interventions as needed to ensure continued compliance.</p>	9/06/12	

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F 514	<p>Continued From page 23</p> <p>she had no dyspnea (difficulty breathing). Resident #1's breath sounds were clear bilaterally and she did not require oxygen therapy.</p> <p>No respiratory concerns were documented for resident #1 on the nursing daily skilled summary sheet or nurse's notes from 7/13/12 through 7/17/12.</p> <p>A PT note for resident #1 dated 7/18/12 indicated during therapy resident #1 was noted to have coolness and cyanosis (blueness of skin indicating tissue near the skin surface had low oxygen) to her fingers and left toes. Her oxygen saturation measured 78%. (Oxygen saturation is an indicator of the percentage of hemoglobin saturated with oxygen at the time of the measurement. The reading, obtained through pulse oximetry, uses a light sensor containing two sources of light that are absorbed by hemoglobin and transmitted through tissues to a photo detector. The amount of light transmitted through the tissue is then converted to a digital value representing the percentage of hemoglobin saturated with oxygen. Normal oxygen saturation values are 97% to 99% in the healthy individual. "Oxygen Saturation Monitoring by Pulse Oximetry" written by the American Association of Critical-Care Nurses.) The nurse was notified.</p> <p>A nursing daily skilled summary sheet for resident #1 (an assessment sheet with body systems and boxes to check for assessment of the systems) dated 7/18/12 at 7:00 PM was reviewed. The narrative note revealed resident #1 had oxygen saturation in the "80's." Oxygen was initiated at 2 liters per minute via nasal cannula. A box</p>	F 514	<p>F-514</p> <p>"Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p> <p>1. Resident # 1 no longer resides in The facility.</p> <p>2. Facility residents have the potential to be affected by the same alleged deficient practice. An audit is being conducted to assure complete and accurate documentation of oxygen administration and resident response to oxygen therapy, orders are in place to identify date and time of oxygen administration, type of delivery device, and oxygen flow rate. Licensed Staff re-education was started on 8-11-2012 and on going, documenting oxygen administration and response to oxygen therapy. Licensed staff that has not received the re-education will be re-educated prior to their next scheduled shift. Newly hired licensed staff will receive training during their orientation</p>	
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F 514	<p>Continued From page 24</p> <p>indicating oxygen use was checked and "2 liters" was handwritten in the space provided. The oxygen saturation box was checked and "92%" was handwritten in the space provided. There was no assessment of resident #1's respiratory system documented.</p> <p>A physician's order for resident #1 dated 7/18/12 at 4:30 PM was reviewed. The order read for oxygen to be administered at 2 liters a minute via nasal cannula on an as needed (PRN) basis for shortness of breath or low oxygen saturations. There were no parameters to define what "low" oxygen saturation was considered. The order also read for oxygen saturation levels to be checked twice a day. The order was signed by nurse #1 and the physicians name was followed by a backslash and the nurse's name. The order was not signed by the physician.</p> <p>A nursing daily skilled summary sheet dated 7/19/12 at 12:15 PM was reviewed. The nurse's narrative note indicated oxygen at 2 liters per minute via nasal cannula was in use for resident #1 but did not differentiate if the oxygen was already in place or was placed by the nurse. A box indicating oxygen use was checked. The oxygen saturation box was checked and "90%" was handwritten in the space provided.</p> <p>A nursing daily skilled summary sheet for resident #1 dated 7/20/12 at 7:00 PM was reviewed. A box indicating oxygen use was checked and "2 liters prn" was handwritten in the space provided. The oxygen saturation box was checked and "91%" was handwritten in the space provided. There was no documentation to support if oxygen was in use or had been discontinued.</p>	F 514	<p>3. Systemic measures to be implemented to ensure the same alleged deficient practice does not recur include: The 24-hour report, Physician orders and change of condition reports will be reviewed by the Interdisciplinary team Monday through Friday to identify residents who have new orders for oxygen therapy to assure appropriate orders, weekly for 4 weeks than bimonthly for one month. Negative finding will be addressed when noted</p> <p>4. Results of the audits will be reported to the Quality Assessment and Assurance Committee monthly x 3 months by the Director of Nursing. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified. The Quality Assessment and Assurance Committee will develop and implement additional interventions as needed to ensure continued compliance</p>	9/06/12

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F 514	<p>Continued From page 25</p> <p>There was an additional nursing daily skilled summary sheet for resident #1 dated 7/20/12 at 11:00 PM with the box indicating oxygen use checked but no oxygen saturation recorded.</p> <p>There was no nursing daily skilled summary sheet for resident #1 on 7/21/12.</p> <p>A nursing daily skilled summary sheet dated 7/22/12 at 5:15 PM indicated resident #1 did not have any signs or symptoms of respiratory distress. The narrative note also mentioned that the resident's hands were cold and the nurse was unable to obtain her oxygen saturation measurement. There was no documentation to support if oxygen was in use.</p> <p>A nursing daily skilled summary sheet for resident #1 dated 7/23/12 at 4:30 PM revealed a box indicating oxygen use was checked and "prn" was handwritten in the space provided. The oxygen saturation box was checked and "97-98% RA (room air)" was handwritten in the space provided.</p> <p>A nursing daily skilled summary sheet dated 7/24/12 at 10:35 AM revealed a box indicating oxygen use was checked and "prn" was handwritten in the space provided. The oxygen saturation box was not checked but an oxygen saturation was not recorded. A nurse's note for third shift indicated resident #1's continuous oxygen was intact. There was no documentation to support when oxygen therapy had been initiated or why oxygen therapy was initiated.</p> <p>A nursing daily skilled summary sheet for resident</p>	F 514		

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F 514	<p>Continued From page 26</p> <p>#1 dated 7/25/12 at 6:30 PM revealed a box indicating oxygen use was checked and "pm" was handwritten in the space provided. The oxygen saturation box was checked and "98% RA" was handwritten in the space provided. There was no documentation to support when resident #1's oxygen therapy had been discontinued.</p> <p>A nursing daily skilled summary sheet for resident #1 dated 7/26/12 revealed a box indicating oxygen use was checked and "pm" was handwritten in the space provided. The oxygen saturation box was checked and "97% RA" was handwritten in the space provided.</p> <p>A nursing daily skilled summary sheet dated 7/27/12 revealed a box indicating oxygen use was checked. The oxygen saturation box was checked but an oxygen saturation was not recorded. A narrative nurse's note indicated oxygen at 2 liters a minute was applied in the afternoon but there was no acute shortness of breath. The nurse documented she was unable to obtain resident #1's oxygen saturation due to her hands being very cold. No oxygen saturations were recorded for 7/27/12. A third shift nurse's note dated 7/28/12 at 5:50 am indicated that the resident was talking and took her last breath, cardiopulmonary resuscitation was started and the resident was sent to the hospital.</p> <p>There were no oxygen saturation measurements recorded on the medication administration record (MAR) or the treatment administration records (TAR) for July 2012. The 7/18/12 physicians order for oxygen administration and oxygen saturation checks were not transcribed onto the MAR or TAR.</p>	F 514			

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F 514	<p>Continued From page 27</p> <p>On 8/8/12 at 4:10 PM nurse #1 was interviewed. She indicated that oxygen saturation measurements were supposed to be documented on the medication administration records or in the nurse's notes. Nurse #1 indicated the order for oxygen was not transcribed onto the medication administration record therefore the oxygen saturations had not been documented on the medication administration record. She said resident #1 had only required oxygen while she was assigned to the resident on 7/18/12 and she had documented the oxygen administration in her nurse's notes. Nurse #1 indicated oxygen administration or discontinuation as well as the residents response to treatment was supposed to be documented in the nurse's notes.</p> <p>On 8/8/12 at 7:50 PM nurse #2 was interviewed. She indicated that 7:00 PM on 7/27/12 until 7:00 AM on 7/28/12 was the first time she had ever worked with resident #1. She said resident #1 had oxygen in place when her shift started and she recalled her oxygen saturation check was 96-97%. She said she could not recall specifically how much oxygen resident #1 was on but it was being delivered via nasal cannula. Nurse #2 said she thought she documented resident #1's oxygen saturation on the MAR but thought she also documented it on the shift report sheet (not part of the residents medical record). Nurse #2 was not able to explain why the oxygen saturation had not been documented. Nurse #2 indicated oxygen administration, discontinuation and resident response to oxygen therapy was supposed to be documented in the nurse's notes.</p> <p>On 8/9/12 at 8:15 AM nurse #3 was interviewed.</p>	F 514			

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F 514	<p>Continued From page 28</p> <p>Nurses notes and facility staff sheets indicated that nurse #3 worked with resident #1 7:00 AM until 7:00 PM on 7/19/12, 7/22/12, 7/24/12 and 7/27/12. Nurse #3 recalled that resident #1 was started on oxygen therapy but could not recall the date or why she was started on oxygen. Nurse #3 indicated that oxygen saturation measurements are supposed to be recorded on the nursing daily skilled summary sheet and on the MAR. Nurse #3 could not recall if resident #1 had oxygen in place on 7/19/12 or if she initiated the oxygen after her oxygen saturation measured 90%. Nurse #3 could not recall if resident #1 had oxygen in place on 7/22/12. She could not remember if resident #1 had oxygen on place on 7/24/12 and did not know why she had not documented an oxygen saturation measurement. Nurse #3 said on 7/27/12 resident #1 did not have oxygen on until in the afternoon. Nurse #2 indicated oxygen administration, discontinuation and resident response to oxygen therapy was supposed to be documented in the nurse's notes.</p> <p>The Director of Nursing (DON) was interviewed on 8/9/12 at 1:50 PM. The DON said she expected the nursing staff to document per the facility policy which included; the time and amount of oxygen applied and the response to oxygen therapy. She also expected the nursing staff to document when oxygen was discontinued and the residents response to oxygen discontinuation.</p>	F 514			