STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345433	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Health Service Regulation, Nursing Home Licensure and Certification Section provided the facility with an amended Statement of Deficiencies on 02/20/15, which included citation F-309. Event ID # 92L311.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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. The facility must record and periodically update the address and phone number of the resident's	F 157		2/17/15

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

Electronically Signed | 02/13/2015

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to promptly notify the physician of a change in condition for 1 of 3 sampled residents. (Resident #4) The findings included: Resident #4 was admitted to the facility 04/30/12 with diagnoses which included: dysphagia, dementia without behavioral disorder and Alzheimers. Review of physician orders in the medical record of Resident #4 on 01/28/15 revealed no orders for use of oxygen. On 01/28/15 at 3:15 PM Resident #4 was observed in bed, on her back with a pulse oximeter (a device which readily assesses oxygen saturation and pulse) on her finger. Resident #4 appeared to be sleeping and did not respond when spoken to. The reading on the pulse oximeter indicated an oxygen saturation of 65% with 90-100% saturation a normal reading on room air. Resident #4 was not wearing oxygen at the time of the observation. NA #3 entered the room at 3:17 PM and reported she was familiar with Resident #4 and that "she didn't look like she normally does." NA #3 removed the oximeter from the finger of Resident #4 and stated the nurse was aware of the low oxygen saturation and was going to call the physician. On 01/28/15 at 3:30 PM Nurse #1 (on duty 7:00 AM-3:00 PM on 01/28/15) was observed	F 157	A. Resident #4 no longer resides at the facility. B. All residents have the potential to be affected by this citation A review of current residents was completed by the Director of Clinical Services, Assistant Director of Clinical Services and Nurse Manager on 2/12/15 to ensure all residents were stable and not experiencing a change in condition. No issues were identified . C. The Director of Clinical Services/Nurse Supervisor in-serviced licensed nursing staff on completing the Situation Background Request (SBAR)form with a change in resident condition to include notification of the physician and responsible party/resident of the change in condition on 2/4/15 thru 2/15/15. The Director of Clinical Services/Nurse Supervisor inserviced Certified Nursing Assistants on notifing the licensed nurse of an observed change in the resident using the Interact tool, Stop and Watch 2/4/15 thru 2/15/15. New licensed nurse employee will be educated on completion of the SBAR form with resident change in condition to include notification of the physician, responsible party/resident during orientation by the Director of Clinical Services/Nurse Supervisor. New Certified Nursing Assistants will be	

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F 157	Continued From page 2 transporting an oxygen concentrator to the room of Resident #4. On 01/28/15 at 4:30 PM Resident #4 was observed in bed with a nasal cannula in place with oxygen being administered at 2 liters a minute. On 01/28/15 at 4:45 PM Nurse #2 (on duty 3:00 PM-11:00 PM on 01/28/15) reported when oxygen saturation levels had earlier been checked on Resident #4 two separate readings were obtained; one at 62% and one at 75%. Nurse #2 stated the low oxygen saturation was a new issue for Resident #4 but, because of it, oxygen was being administered via a nasal cannula at 2 liters per minute. Nurse #2 stated she could tell Resident #4 was not feeling well and that she would check her oxygen saturation later. On 01/28/15 at 5:35 PM Nurse #2 stated she checked Resident #4's oxygen saturation again and obtained a reading of 71% so she increased the flow rate from 2 liters per minute to 3 liters per minute. On 01/28/15 at 6:08 PM Resident #4 was observed in bed with oxygen infusing at 3 liters per minute. A pulse oximeter was observed on the finger of Resident #4 with a displayed oxygen saturation reading of 80%. Nurses documentation in the medical record of Resident #4 indicated: 01/28/15 3:00 PM-11:00 PM This writer informed resident not feeling well and is in bed. Vital signs taken Temperature 99, oxygen saturation at 62%. This writer informed staff to find oxygen concentrator. Writer then started oxygen at 3 liters per minute, saturation up to 81% at 7:30 PM. Oxygen saturation at 91% on 4 liters per minute via nasal cannula. Will continue to monitor 01/28/15 11:00 PM Vital signs: Temperature 99.7, pulse 108, 81% saturation on 3 liters per minute via nasal cannula. Will monitor.	F 157	educated on notifying the licensed nurse of observed changes in resident condition using the Interact tool, Stop and Watch during orientation by the Director of Clinical Services/Nurse Supervisor.. The DCS/Nurse Supervisor will perform Quality Improvement Monitoring of 10 residents medical records for notification of change in condition to physician and responsible party/resident 5 times a week for 8 weeks, then 3 times a week for 8 weeks then 2 times a week for 6 months and/or until substantial compliance is obtained. D. The results of the Quality Improvement Monitoring will be reported to the Quality Assessment Performance Improvement Committee by the Director of Clinical Services/Nurse Supervisor until substantial compliance is obtained. The Quality assessment Performance Improvement Committee members consist of but not limited to the Executive Director, DCS, Assistant DCS, Wound Care Nurse, Medical Director, Social Service, Maintenance Director, and Minimum Data Assessment Nurse.	

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F 157	Continued From page 3	F 157		

01/29/15 5:00 AM Resident resting in bed, rapid respirations at times. Oxygen saturation 94% on 2 liters per minute via nasal cannula.

On 01/29/15 at 9:45 AM Resident #4 was observed in a geri chair with the back of the chair elevated. Resident #4 was not wearing oxygen and appeared to be comfortably resting. On 01/29/15 at 9:50 AM Nurse #3 stated that since the start of her shift on 01/29/15 at 7:00 AM she had checked the oxygen saturation of Resident #4 twice and both times the levels were in the 90s. Nurse #3 was observed checking the oxygen saturation of Resident #4 at the time of the interview and the reading displayed on the pulse oximeter was 86%. Nurse #3 stated she was going to call the physician of Resident #4 and let him know her status.

On 01/29/15 at 9:50 AM Nurse #3 was overheard reporting the concern via a telephone conversation to the physician of Resident #4 noting the resident had experienced low oxygen saturations on 01/28/15 and that the oxygen saturation was currently at 86%. Orders were obtained from the physician for lab work, a chest X-ray and to begin oxygen at 2 liters per minute. Immediately after the conversation with the physician oxygen was observed being placed on Resident #4 via a nasal cannula at 2 liters per minute.

On 01/29/15 at 2:45 PM the physician (MD) of Resident #4 was interviewed. The MD indicated he had not been called about the condition of Resident #4 until 01/29/15 at 9:50 AM. The nurses notes in the medical record of Resident #4 indicating low oxygen saturation on 01/28/15 were read to the MD and he stated he should

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have been notified immediately if the resident's oxygen saturation was at 62%. The MD stated because 62% is such a low reading he would have had staff warm the resident's hands and/or recheck the reading with the pulse oximeter on her ear lobe for accuracy. The MD stated the specific oxygen saturation readings in the 60s-80s had not been reported in the conversation with Nurse #3 when he was called at 9:50 AM. The MD stated that because Resident #4 was not routinely on oxygen the low saturation was of concern and he was awaiting results of the chest X-ray and lab work to assess the situation.

On 01/29/15 at 3:15 PM Nurse #3 stated at the beginning of her shift on 01/29/15 she had been told Resident #4 had been on oxygen due to low oxygen saturation. Nurse #3 stated if she had been told the oxygen saturation levels had been in the 60s-80s on 01/28/15 she would have relayed that also to the physician when he was called at 9:50 AM.

On 01/29/15 at 4:23 PM Nurse #1 (that worked first shift on 01/28/15) stated that it was at the end of her shift on 01/28/15 that staff noted the oxygen saturation dropped on Resident #4. Nurse #1 stated Nurse #2 (that worked 3:00 PM-11:00 PM on 01/28/15) told her she would call the physician of Resident #4 and report the concern as well as obtain orders for initiation of oxygen.

Attempts were made to contact Nurse #2 on 01/29/15 but Nurse #2 was not available for interview. On 01/29/15 at 5:00 PM the acting Director of Clinical Services (DCS) stated he had reviewed nursing notes in the medical record of

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F 157	Continued From page 5 Resident #4 as well as 24 hour shift to shift nursing report sheets from 01/28/15-01/29/15 addressing Resident #4. The DCS stated he noted the physician of Resident #4 had not been notified of the low oxygen saturation until the morning of 01/29/15. The DCS stated the physician should have been immediately called when oxygen saturation was noted at 62% on 01/28/15. The DCS stated he had been in touch with Nurse #2 to inquire about this and Nurse #2 stated she did not call the physician to report the low oxygen saturation because she had been so busy managing the care of residents on the unit during her shift on 01/28/15. The DCS stated there were other nurses present on 01/28/15 during the 3:00 PM-11:00 PM shift and if they had been made aware of the concern they could have assisted Nurse #2 to report the concern with low oxygen saturation to the physician of Resident #4.	F 157		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to feed a resident according to her most recent assessment and feeding plan that had been developed following a modified barium swallow study for 1 of 1 residents (Resident #2). Findings included: Resident #2 was admitted to the facility on	F 282	A. Resident #2 was not injured as a result of this citation B. Residents on modified diets/dysphagia have the potential to be affected by this citation. An audit of current resident's medical records to identify recommendations made by the Speech	2/17/15

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F 282	Continued From page 6 04/01/14 with diagnoses including history of a stroke, attention/concentration deficit and dysphagia. The most recent Minimum Data Set assessment dated 12/22/14 noted the resident with severely impaired cognition and requiring supervised one person assistance for eating. The resident received a mechanically altered and therapeutic diet. Resident #2's care plan reviewed on 12/03/14 included the problem of activity of daily living (ADL) deficit with the resident requiring extensive assistance with various ADL including eating. The care plan problem of potential for weight loss, related to a mechanically altered diet and varied intake, included the intervention dated 11/05/14 for skilled speech therapy (ST) services 5 days a week for 4 weeks for dysphagia, a downgraded diet to pureed textures and a recommended modified barium swallow (MBS) for dysphagia. Review of the medical record revealed an interdisciplinary therapy screen dated 11/06/14 which documented Resident #2 with coughing, a red face and watery eyes noted during food intake. Her diet was downgraded to pureed texture, a MBS study was ordered and skilled ST services were indicated. Review of a MBS report dated 11/13/14 revealed that according the to the facility the resident reportedly shoveled food in her mouth at a fast rate, had a decreased ability to open her oral cavity and displayed a decline in mastication of textures when unsupervised. During the MBS study it was documented the resident was being extremely cautious with her oral intake because she knew she was being monitored, but a caregiver who accompanied the resident was reported as saying that this was not typical for her and if she was unsupervised she literally shoveled food into her mouth with	F 282	Therapist was completed 2/12/15 by the Director of Clinical Services (DCS) Assistant Director of Clinical Services (ADCS) and Nurse Supervisor. Three residents that were recommended to have one-on-one assistance were screened by the Speech Therapist 2/12/15 thru 2/13/15 to identify continued need for assistance and/or to make further recommendations. Care Plans and Kardexes for these residents were reviewed and/or updated by the DCS/Nurse Supervisor. Responsible party was notified of any recommended changes by the Nurse Supervisor 2/12/15 thru 2/13/15. C. The Director of Clinical Services/Nurse Supervisor in-serviced licensed staff and Certified Nursing Assistants regarding following the resident's care plan in relation to the required observation and/or assistance during meal times 2/4/14 thru 2/15/15. The DCS in-serviced the speech therapist on 2/13/15 regarding directly communicating to the DCS/ADCS related to any resident that requires and/or is recommended to have one-on-one assistance during meals upon identification of such. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of residents requiring one-on-one assistance during meal times to ensure one-on-one assistance is provided. Quality Improvement Monitoring will be conducted randomly during meal times 5 times a week for 8 weeks, then 3 times a week for	

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F 282	Continued From page 7 extremely large boluses, resulting in coughing and choking episodes. The report recommended that given the resident's cognitive deficits, lack of inhibition and history of inability to utilize compensatory techniques, the resident should receive 1 to 1 supervision during meals with assistance if needed to ensure that the patient utilized small individual bites of food and sips of fluid. It further recommended that if she was unable to do this with 1 to 1 supervision that she be fed all oral intake as noncompliance with compensatory strategies placed her at a greater risk for aspiration. Review of an individualize feeding plan, dated 11/13/14 and completed by the consultant who performed the MBS study, documented instruction for 1 to 1 supervision and to feed the patient if she was unable to comply with compensatory strategies. This feeding plan was filed in the medical record and a copy was filed in the kardex binder at the nursing station. Filed with the feeding plan in the kardex binder was an undated nurse tech information kardex form which in the eating section was checked "set up" and "dependent on staff." The "supervision" block on this form was unchecked. Review of provider orders dated 11/21/14 revealed instruction, signed by the facility's speech therapist (ST), that Resident #2 was to be fed by caregivers due to her being unable to comply with compensatory strategies (small bites, sips, alternate solids/liquids at a 2 to 1 ratio and using no straws). Review of a ST discharge summary dated 12/04/14 revealed the resident was seen by the ST for 22 days from 11/05/14 to 12/04/14 with the status of the following therapy discharge goals: impaired mastication, maximal	F 282	8 weeks, and then 1 time per month for 4 months and/or until substantial compliance is obtained. D. The results of the Quality Improvement Monitoring will be reported to the Quality Assessment Performance Improvement Committee by the Director of Clinical Services until substantial compliance is obtained. The Quality Assessment Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Wound Care Nurse, Medical Director, Social Service, Maintenance Director, and Director of Minimum Data Assessment Nurse	

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F 282	Continued From page 8	F 282		

tactile cues, caregivers alternate solids to liquids with a ratio of 1 to 2 solids with 1 liquid, caregivers reduce the bolus size to 1 to 2 teaspoons and caregivers employ compensatory strategies to prevent aspiration. The ST documented discharge recommendations which included the resident to be fed. The ST documented that the MBS study was completed and discussed over the phone with the ST consultant.

An observation on 01/29/15 at 12:50 PM revealed Resident #2 was seated for lunch in the restorative dining room with three other residents at her table and no staff members at the table. NA #1 was seated at another table with two other residents and feeding one of those residents. Resident #2's back was to NA #1. Resident #2 was eating a pureed diet with her hands with a large amount of pureed green peas noted on her hands and face. NA #2 was observed entering the restorative dining room and approaching the table where NA #1 was seated to speak to another resident at that table. At 12:56 PM Resident #2 was observed being fed mashed potatoes with a fork by a family member and the family member gave the resident a container of a nutritional shake obtained from outside the facility, which she drank. NA #1 and NA #2 were seated at the other table feeding two other residents. At 1:00 PM the ST was observed in the restorative dining room telling the family member that the nutritional shake brought from outside the facility had to be thickened before the resident could drink it. The ST removed the shake from the resident.

An interview on 01/29/15 at 1:08 PM with the ST revealed Resident #2 should have been fed by

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F 282	Continued From page 9 staff and the order she wrote in November 2014 directing this was still active. She stated sometimes the resident would refuse to let staff feed her, refused to independently use utensils and would rather eat with her hands. She stated staff had not informed her recently of any swallowing concerns. She stated this resident had poor short term memory and poor safety awareness which was why she needed the supervision. An interview on 01/29/15 at 1:40 PM with NA #2 revealed NA #1 was on orientation and doing very well. He stated they both were assigned to the restorative dining room for lunch. He stated NAs knew what was required regarding feeding assistance for residents by looking at the kardex binder at the nursing station. He stated Resident #2 ate a pureed diet, drank honey thickened liquids and could eat independently most of the time, but if her intake was poor she required cueing. He stated sometimes staff had to feed her which she would usually accept. An interview on 01/29/15 at 2:47 PM with the interim director of clinical services (DCS) revealed that a resident requiring 1 to 1 supervision with meals meant that someone had to be with that person. He stated the NA who was busy feeding the other resident in the restorative dining room would not be considered 1:1 supervision for Resident #2. Further interview with the interim DCS on 01/29/14 at 4:00 PM revealed there was no other order in Resident #2's medical record to supersede the ST order dated 11/21/14.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		2/17/15

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F 309	Continued From page 10 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to obtain physician orders prior to use of oxygen for 1 of 3 sampled residents. (Resident #4) The findings included: Resident #4 was admitted to the facility 04/30/12 with diagnoses which included: dysphagia, dementia without behavioral disorder and Alzheimers. Review of physician orders in the medical record of Resident #4 on 01/28/15 revealed no orders for use of oxygen. On 01/28/15 at 3:15 PM Resident #4 was observed in bed, on her back with a pulse oximeter (a device which readily assesses oxygen saturation and pulse) on her finger. Resident #4 appeared to be sleeping and did not respond when spoken to. The reading on the pulse oximeter indicated an oxygen saturation of 65% with 90-100% saturation a normal reading on room air. Resident #4 was not wearing oxygen at the time of the observation. NA #3 entered the room at 3:17 PM and reported she was familiar with Resident #4 and that "she didn't	F 309	A. Resident #4 no longer resides at the facility. B. All Residents have the potential to be affected by this citation. A review of current residents was completed by the Director of Clinical Services (DCS), Assistant Director of Clinical Services (ADCS), and Nurse Manager on 2/12/15 to identify residents that are on oxygen have a current order for oxygen. No issues were identified at that time. C. The DCS/Nurse Supervisor in-serviced nursing staff on completing the Situation Background Assessment Request (SBAR) form with a change in resident condition to include notification of the physician, responsible party of the change of condition on 2/4/15 thru 2/15/15. This in-service also included that prior to applying oxygen to the resident the licensed nurse must notify the physician and obtain an order. New licensed nurse employees will be educated on completion of the SBAR form with resident change in condition to include notification of the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 look like she normally does." NA #3 removed the oximeter from the finger of Resident #4 and stated the nurse was aware of the low oxygen saturation and was going to call the physician. On 01/28/15 at 3:30 PM Nurse #1 (on duty 7:00 AM-3:00 PM on 01/28/15) was observed transporting an oxygen concentrator to the room of Resident #4. On 01/28/15 at 4:30 PM Resident #4 was observed in bed with a nasal cannula in place with oxygen being administered at 2 liters a minute. On 01/28/15 at 4:45 PM Nurse #2 (on duty 3:00 PM-11:00 PM on 01/28/15) reported when oxygen saturation levels had earlier been checked on Resident #4 two separate readings were obtained; one at 62% and one at 75%. Nurse #2 stated the low oxygen saturation was a new issue for Resident #4 but, because of it, oxygen was being administered via a nasal cannula at 2 liters per minute. Nurse #2 stated she could tell Resident #4 was not feeling well and that she would check her oxygen saturation later. On 01/28/15 at 5:35 PM Nurse #2 stated she checked Resident #4's oxygen saturation again and obtained a reading of 71% so she increased the flow rate from 2 liters per minute to 3 liters per minute. On 01/28/15 at 6:08 PM Resident #4 was observed in bed with oxygen infusing at 3 liters per minute. A pulse oximeter was observed on the finger of Resident #4 with a displayed oxygen saturation reading of 80%. Nurses documentation in the medical record of Resident #4 indicated: 01/28/15 3:00 PM-11:00 PM This writer informed resident not feeling well and is in bed. Vital signs taken Temperature 99, oxygen saturation at 62%. This writer informed staff to find oxygen concentrator. Writer then started oxygen at 3	F 309	physician, responsible party/resident and obtaining an order for oxygen prior to applying it to a resident during orientation by the DCS/Nurse Supervisor. The DCS/Nurse Supervisor will perform Quality Improvement Monitoring of 10 resident's to identify if they have oxygen and then check the medical record for a current order 5 times a week for 8 weeks, then 3 times a week for 8 weeks, then 2 times a week for 8 weeks, and then 1 time a week for 6 months and/or until substantial compliance is obtained. D. The results of the Quality Improvement monitoring will be reported to the Quality Assessment Performance Improvement Committee by the DCS/Nurse Supervisor until substantial compliance is obtained. The Quality Assessment performance Improvement Committee consists of but not limited to the Executive Director, DCS, ADCS, Wound Care Nurse, Medical Director, and Minimum Data Assessment Nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345433	A. BUILDING _____ B. WING _____	C 01/29/2015

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liters per minute, saturation up to 81% at 7:30 PM. Oxygen saturation at 91% on 4 liters per minute via nasal cannula. Will continue to monitor
01/28/15 11:00 PM Vital signs: Temperature 99.7, pulse 108, 81% saturation on 3 liters per minute via nasal cannula. Will monitor.
01/29/15 5:00 AM Resident resting in bed, rapid respirations at times. Oxygen saturation 94% on 2 liters per minute via nasal cannula.

On 01/29/15 at 9:45 AM Resident #4 was observed in a geri chair with the back of the chair elevated. Resident #4 was not wearing oxygen and appeared to be comfortably resting. On 01/29/15 at 9:50 AM Nurse #3 stated that since the start of her shift on 01/29/15 at 7:00 AM she had checked the oxygen saturation of Resident #4 twice and both times the levels were in the 90s. Nurse #3 was observed checking the oxygen saturation of Resident #4 at the time of the interview and the reading displayed on the pulse oximeter was 86%. Nurse #3 stated she was going to call the physician of Resident #4 and let him know her status.

On 01/29/15 at 9:50 AM Nurse #3 was overheard reporting the concern via a telephone conversation to the physician of Resident #4 noting the resident had experienced low oxygen saturations on 01/28/15 and that the oxygen saturation was currently at 86%. Orders were obtained from the physician for lab work, a chest X-ray and to begin oxygen at 2 liters per minute. Immediately after the conversation with the physician oxygen was observed being placed on Resident #4 via a nasal cannula at 2 liters per minute.

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On 01/29/15 at 2:45 PM the physician (MD) of Resident #4 was interviewed. The MD indicated he had not been called about the condition of Resident #4 until 01/29/15 at 9:50 AM. The nurses notes in the medical record of Resident #4 indicating low oxygen saturation on 01/28/15 were read to the MD and he stated he should have been notified immediately if the resident's oxygen saturation was at 62%. The MD stated because 62% is such a low reading he would have had staff warm the resident's hands and/or recheck the reading with the pulse oximeter on her ear lobe for accuracy. The MD stated if the reading was truly at 62% he would have expected staff to implement use of oxygen to prevent respiratory distress and then call to report the concern. The MD stated the specific oxygen saturation readings in the 60s-80s had not been reported in the conversation with Nurse #3 when he was called at 9:50 AM. The MD stated that because Resident #4 was not routinely on oxygen the low saturation was of concern and he was awaiting results of the chest X-ray and lab work to assess the situation.

On 01/29/15 at 3:15 PM Nurse #3 stated at the beginning of her shift on 01/29/15 she had been told Resident #4 had been on oxygen due to low oxygen saturation. Nurse #3 stated if she had been told the oxygen saturation levels had been in the 60s-80s on 01/28/15 she would have relayed that also to the physician when he was called at 9:50 AM.

On 01/29/15 at 4:23 PM Nurse #1 (that worked first shift on 01/28/15) stated that it was at the end of her shift on 01/28/15 that staff noted the oxygen saturation dropped on Resident #4. Nurse #1 stated Nurse #2 (that worked 3:00

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PM-11:00 PM on 01/28/15) told her she would call the physician of Resident #4 and report the concern as well as obtain orders for initiation of oxygen.

Attempts were made to contact Nurse #2 on 01/29/15 but Nurse #2 was not available for interview. On 01/29/15 at 5:00 PM the acting Director of Clinical Services (DCS) stated he had reviewed nursing notes in the medical record of Resident #4 as well as 24 hour shift to shift nursing report sheets from 01/28/15-01/29/15 addressing Resident #4. The DCS stated he noted the physician of Resident #4 had not been notified of the low oxygen saturation until the morning of 01/29/15. The DCS stated the physician should have been immediately called when oxygen saturation was noted at 62% on 01/28/15. The DCS stated he had been in touch with Nurse #2 to inquire about this and Nurse #2 stated she did not call the physician to report the low oxygen saturation because she had been so busy managing the care of residents on the unit during her shift on 01/28/15. The DCS stated there were other nurses present on 01/28/15 during the 3:00 PM-11:00 PM shift and if they had been made aware of the concern they could have assisted Nurse #2 to report the concern with low oxygen saturation to the physician of Resident #4. The DCS stated the facility did not have standing orders for use of oxygen and the physician should have been notified prior to use of oxygen for Resident #4.