STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 12/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

(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 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 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the facility staff, Nurse Practitioner (NP) and Medical Doctor (MD), the facility failed to notify the NP or	F 157	A. **Resident #2 no longer resides at the facility.** **Nurse involved in the incident was educated on 12/10/15 regarding change in condition involving low oxygen saturations and reporting such to the Physician/Nurse Practitioner in a timely manner.** B. **We audited all residents on oxygen with COPD back to 12/8/15 to identify if there were any residents with change in condition and that this was communicated to the provider.** C. **The Director of Clinical Services educated all nurses on obtaining and documenting oxygen saturation levels and notifying if outside parameters per doctor's order. All nurses began education on 12/11/15 and completed by 12/14/15. New hires will be educated upon hire during orientation.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/12/16

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	Continued From page 1 MD of low oxygen saturation levels for 1 of 1 residents (Resident #2) reviewed with a diagnosis of chronic obstructive pulmonary disease (COPD). The findings included: Resident #2 was admitted to the facility on 11/13/15 from the hospital after receiving treatment for spinal vertebral collapse. Her cumulative diagnoses included COPD exacerbation; hypoxemia (low oxygenation of the arterial blood); and dyspnea (shortness of breath). An admission Minimum Data Set (MDS) assessment was not available due to the resident having a short length of stay at the facility. The resident's admission orders included: oxygen at 2 Liters (L)/minute (min) as needed (PRN) and check oxygen (O2) saturation levels every shift to keep O2 sats (oxygen saturation levels) greater than (>) 90 percent (%). A review of the resident's medical record included a Daily Skilled Nurse's Note dated 11/14/15. The Nurse ' s Note included the following results for the resident ' s oxygen saturation levels: 7AM - 3PM-Nurse's Notes (late entry for 10:00 AM) indicated the resident oxygen saturation level was 81% on 2 L/min O2 via nasal cannula. There was no documentation to indicate either the resident's MD or NP was notified of a low oxygen saturation level on 11/14/15. A review of the resident's medical record included a Daily Skilled Nurse's Note dated 11/15/15. The Nurse's Note included the following results for the resident's oxygen saturation levels: 7AM - 3PM-- Nurse ' s Notes indicated the	F 157	D. **The Director of Clinical Services or her designee will monitor all residents on oxygen saturation with COPD to ensure that any change of conditions regarding respiratory conditions have followed the oxygen saturation parameters and notification of Medical Director/Nurse Practitioner was made timely. This monitoring will take place weekly for 3 months.** **The Director of Clinical Services will report all monitoring to the Quality Assurance Performance Improvement Committee monthly for 3 months for continued substantial compliance and/or revision.** 1/5/16	

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resident's oxygen saturation level was 86% and oxygen was applied at 2 L/min via nasal cannula. No additional O2 sats were noted during this shift. There was no documentation to indicate either the resident's MD or NP was notified of a low oxygen saturation level on 11/15/15.

Further review of Resident #2's medical record included Physical Therapy Encounter Notes dated 11/16/15 (no time was specified). The Encounter Notes included a notation which documented that on first approach, the resident's O2 level was 82%. The O2 level was noted as 92 % while the resident was supine and while the resident was sitting at the edge of the bed, the resident ' s O2 dropped to 79%. After 5 minutes, the O2 level was 84%. The resident was returned to the supine position and after 10 minutes the O2 level returned to 90%.

A review of the resident's medical record included a Daily Skilled Nurse's Note dated 11/16/15. The Nurse's Note included the following results for the resident's oxygen saturation levels:
7AM - 3PM (no time was specified)-Nurse ' s Notes indicated the resident's oxygen saturation level was 86% while on oxygen at 2 L/min via nasal cannula. No additional O2 sats were noted during this shift.
There was no documentation in the medical record to indicate either the resident ' s MD or NP was notified of a low oxygen saturation level on 11/16/15.

A review of Resident #2's medical record included Physical Therapy Encounter Notes dated 11/17/15 (no time was specified). The Encounter Notes included a notation which revealed the O2 was monitored during treatment. The O2 level

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was recorded as 78% after transferring. After 6 minutes, resting O2 level returned to 90%.

There was no documentation to indicate either the resident's MD or NP was notified of a low oxygen saturation level on 11/17/15.

A review of Resident #2's medical record included Physical Therapy Encounter Notes dated 11/18/15 (no time was specified). The Encounter Notes included a notation which revealed the resident ' s O2 level was 79% after bed mobility and 87% following a 7-minute rest. Resident #2 was very insistent on sitting in the chair; she was assisted to the chair and the O2 levels dropped to 72%. After resting, the O2 level was reported as 79%. Resident #2 was assisted back to bed and the O2 dropped to 75%. When she was supine for 8 minutes, the O2 was reported as having, "only increased to 81%." The note documented nursing was informed of Resident #2's decreased O2 saturation level. Reportedly, nursing staff indicated this was the resident's baseline. The note documented nursing was told that Resident #2 ' s O2 levels had been higher with the therapist over last two days.

The Daily Skilled Nurse's Note dated 11/18/15 included a notation from the 7 AM - 3 PM nursing shift which revealed the resident participated with therapy and with strength and mobility in the morning. Her O2 sat was reported as 88% on 2 L; oxygen was titrated up to 4 L/min and the O2 sat increased to 92%. Resident #2 was noted as stable at that point. There was no documentation to indicate either the resident's MD or NP was notified of a low oxygen saturation level or need to titrate the oxygen up to 4 L/min.

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Further review of the 11/18/15 Daily Skilled Nurse's Note written by the 7 AM - 3 PM nursing shift revealed that at approximately 11:25 AM, the resident was observed to be nonresponsive in her bed. The resident's O2 sat was noted to be 75%. This note also indicated the facility's NP was at her bedside and an order was received to send Resident #2 out to the Emergency Department for hypoxia.

An interview was conducted with the facility's NP on 12/10/15 at 10:13 AM and a follow-up telephone interview was conducted on 12/10/15 at 3:30 PM. The NP recalled on the morning of 11/18/15, the resident's family came to the nursing station and asked for someone to look at the resident. The NP responded to the family's request and went to the resident's room to assess her. During the assessment, she asked the hall nurse about the resident's vital signs and the nurse reported these were normal except for her O2 sats being in the 70s. The NP reported she had not been notified of Resident #2 having a low O2 sat at any point in time during her stay at the facility. Upon inquiry as to when she would have expected to be notified of a low O2 sat for this resident, the NP stated she would have wanted any abnormal vital signs (including oxygen saturation levels) to be communicated to her. The NP indicated an oxygen saturation level of 85% or less would have warranted an emergency call to the NP or MD. She reported being very upset about the situation and indicated she needed the nursing staff to communicate with her when vital signs were noted to be low.

An interview was conducted on 12/10/15 at 1:45 PM with the Nurse #1. Nurse #1 was identified as the nurse who had admitted Resident #2 on

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11/13/15 and cared for the resident during the 1st nursing shift on 11/14/15, 11/15/15, 11/16/15, 11/17/15 and 11/18/15. During the interview, the nurse recalled Resident #2 ' s O2 sats had dropped to less than 90% one or two days prior to 11/18/15. Nurse #1 stated she told the NP about the low O2 sats at that time and felt her concerns were dismissed. The NP reportedly told Nurse #1 that low oxygen saturation levels were common for a resident with COPD. The nurse acknowledged she did not document the discussion with the NP. Upon inquiry as to when the nurse thought she should notify the MD or NP of a low O2 sat, Nurse #1 stated she would need to call the NP or MD if the resident's O2 sats fell below 90 and failed to come back up after titrating (increasing the concentration of) the oxygen provided. The nurse also noted she would need to contact the NP or MD if any resident was in respiratory distress. Additionally, Nurse #1 stated she would need to document in the resident's medical record when a provider was notified of a resident having a low oxygen saturation level.

An interview was conducted on 12/10/15 at 2:38 PM with the facility ' s Director of Nursing (DON). During the interview, the DON indicated the hall nurse needed to notify the MD or NP of any issues with low O2 sats, even if the NP had informed her that low oxygen saturation levels were a part of Resident #2's disease process. The DON also stated the MD or NP notification of concerns needed to be documented in the resident's medical record.

An interview was conducted on 12/10/15 at 3:07 PM with the Physical Therapy Assistant (PTA) who worked with the resident on 11/16/15, 11/17/15, and the morning of 11/18/15. Although

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her records were not timed, the PTA reported her therapy session with Resident #2 would have been before 10:00 AM on 11/18/15. The PTA remembered treating the resident, recalling the treatments didn ' t tend to be very physical and, "it involved a lot of checking to be sure her O2 sats were within reasonable limits." She recalled on 11/18/15, Resident #2's O2 sats did not come back up so she laid her back down and told the hall nurse about the O2 sats being low. The PTA could not recall the identity of the nurse but reported it was the hall nurse on duty. The nurse told the PTA that the resident's oxygen saturation levels reported were "kind of within her normal range."

An interview was conducted on 12/10/15 at 5:30 PM with Nurse #2. Nurse #2 was identified as the hall nurse who cared for Resident #2 during the 2nd nursing shift on 11/16/15 and 11/17/15. During the interview, the nurse reported Resident #2 tended to take her oxygen off and when she did, her O2 sats dropped to around the 80's and low 90's. When the O2 sats dropped, the nurse reported she would put the resident ' s oxygen back on and her O2 sats would come up. Nurse #2 reported she did not contact the MD or NP in regards to low oxygen saturation levels for the resident.

A telephone interview was conducted on 12/11/15 at 9:24 AM with Nurse #3. Nurse #3 was assigned to care for Resident #2 during 2nd shift on 11/14/15. The nurse did not specifically recall Resident #2 and was unable to provide information regarding the resident's oxygen saturation levels or notification of the resident's MD or NP.

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A telephone interview was conducted on 12/11/15 at 9:29 AM with Nurse #4. Nurse #4 was assigned to care for Resident #2 during 2nd shift on 11/15/15. The nurse did not specifically recall Resident #2 and was unable to provide information regarding the resident ' s oxygen saturation levels or notification of the resident ' s MD or NP.

A telephone interview was conducted on 12/14/15 at 11:07 AM with Nurse #5. Nurse #5 was assigned to care for Resident #2 during 3rd shift on 11/14/15, 11/16/15, and 11/17/15. The nurse did not specifically recall Resident #2 and was unable to provide information regarding the resident ' s oxygen saturation levels or notification of the resident ' s MD or NP.

A telephone interview was conducted on 12/14/15 at 11:40 AM with Nurse #6. Nurse #6 was assigned to care for Resident #2 during 3rd shift on 11/13/15 and 11/15/15. The nurse did not specifically recall Resident #2 and was unable to provide information regarding the resident ' s oxygen saturation levels or notification of the resident's MD or NP. However, the nurse reported she would have documented in the medical record if she needed to contact the MD or NP for a concern about the resident.

A telephone interview was conducted on 12/15/15 at 8:20 AM with Resident #2's MD (who was also the facility's Medical Director). During the interview, the physician stated he likely would not have been the one notified of a concern regarding low O2 sats for the resident. He reported if the notification was done on weekdays between 8AM - 5PM, the notification would have been made to his NP who was in the building 5 days a week. If

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F 157	Continued From page 8 notification was made to the provider after 5 PM or on weekends, the physician on call would have received it (which may or may not have been him). Upon inquiry, the physician indicated a provider should have been notified so the resident could be assessed further if her oxygen saturation levels wouldn't come up or stay up. During the interview, the discrepancy between the NP and nurse interviews regarding notification of the provider was discussed. The physician stated, "Here's how I address this-if not documented, it wasn't done."	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 record review and interviews with the facility staff, Nurse Practitioner (NP), and Medical Doctor (MD), the facility failed to obtain and monitor a resident's oxygen saturation levels as ordered by the physician for 1 of 1 residents (Resident #2) reviewed with a diagnosis of chronic obstructive pulmonary disease (COPD). The findings included: Resident #2 was admitted to the facility on 11/13/15 from an acute care hospital after	F 309		

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F 309	Continued From page 9 receiving treatment for spinal vertebral collapse. Her cumulative diagnoses included COPD exacerbation; hypoxemia (low oxygenation of the arterial blood); and dyspnea (shortness of breath). An admission Minimum Data Set was not available due to the resident having a short length of stay at the facility. The resident's admission orders included: oxygen at 2 Liters (L)/minute (min) as needed (PRN) and check oxygen (O2) saturation levels every shift to keep O2 sats (oxygen saturation levels) greater than (>) 90 percent (%). A review of Resident #2's Nursing Admission Assessment completed on 11/13/15 at 5:45 PM (2nd nursing shift) included a notation which indicated Resident #2's oxygen saturation level was 93% with continuous oxygen provided via nasal cannula. A review of the resident ' s medical record included a Daily Skilled Nurse's Note dated 11/13/15. The Nurse's Note was divided into three nursing shifts (11 PM - 7 AM; 7 AM - 3 PM; and 3 PM - 11 PM). No additional oxygen saturation levels were noted on that date. A review of the resident's medical record included a Daily Skilled Nurse's Note dated 11/14/15. The Nurse's Note included the following results for the resident's oxygen saturation levels: 11PM - 7AM- No oxygen saturation levels were noted. 7AM - 3PM-Nurse's Notes (late entry for 10:00 AM) indicated the resident oxygen saturation level was 81% on 2 L/min O2 via nasal cannula. 3PM - 11PM-No oxygen saturation levels were noted.	F 309	**A. Resident #2 no longer resides at the facility.** **B. Director of Clinical Services and Unit Managers checked orders on all residents receiving oxygen on 12/11/2015 to assure that orders were correct and that parameters were defined.** **C. The Director of Clinical Services reeducated all nurses on obtaining and documenting oxygen saturation per doctor's order. All nurses began education on 12/11/15 and completed by 12/14/15. New hires will be educated upon hire during orientation.**	

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F 309	Continued From page 10 A review of the resident's medical record included a Daily Skilled Nurse's Note dated 11/15/15. The Nurse's Note included the following results for the resident's oxygen saturation levels: 11PM-7AM---No oxygen saturation levels were noted. 7AM - 3PM-- Nurse ' s Notes indicated the resident's oxygen saturation level was 86% and oxygen was applied at 2 L/min via nasal cannula. No additional O2 sats were noted during this shift. 3PM-11PM- No oxygen saturation levels were noted. Further review of Resident #2's medical record included Physical Therapy Encounter Notes dated 11/16/15 (no time was specified). The Encounter Notes read, in part: "...On first approach of pt (patient), O2 levels 82% and unable to raise into 90's. Informed nursing. On second approach O2 levels 92 in supine. Upon sitting on edge of bed, O2 dropped to 79%. After 5 minutes O2 levels 84%. Pt returned to supine and after 10 minutes O2 levels returned to 90%..." A review of the resident's medical record included a Daily Skilled Nurse's Note dated 11/16/15. The Nurse's Note included the following results for the resident's oxygen saturation levels: 11PM - 7AM- No oxygen saturation levels were noted. 7AM - 3PM-Nurse's Notes indicated the resident's oxygen saturation level was 86% while on oxygen at 2 L/min via nasal cannula. No additional O2 sats were noted during this shift. 3PM - 11PM- No oxygen saturation levels were noted.	F 309	D. **The Director of Clinical Services or designee will review documentation of oxygen administration to ensure oxygen saturations are documented as prescribed. They will review 5 residents with oxygen weekly for 1 month, then 3 residents weekly for 1 month and 1 resident weekly for 1 month.** **The Director of Clinical Services will report all monitoring to the Quality Assurance Performance Improvement Committee monthly for 3 months for continued substantial compliance and/or revision.**	1/5/16

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A review of Resident #2's medical record included Physical Therapy Encounter Notes dated 11/17/15 (no time was specified). The Encounter Notes included a notation which read in part: "...O2 monitored throughout treatment, O2 after transferring 78, after 6 minutes resting O2 levels returned to 90%."

A review of the resident's medical record included a Daily Skilled Nurse's Note dated 11/17/15. The Nurse's Note included the following results for the resident's oxygen saturation levels:

11PM - 7AM- No oxygen saturation levels were noted.

7AM - 3PM- No oxygen saturation levels were noted.

3PM - 11PM- No oxygen saturation levels were noted.

The Daily Skilled Nurse's Note dated 11/18/15 included:

11PM-7AM- No oxygen saturation levels were noted.

A review of Resident #2's medical record included Physical Therapy Encounter Notes dated 11/18/15 (no time was specified). The Encounter Notes included a notation which read in part: "...After bed mobility O2 levels 79. Following 7 minute rest O2 87. Pt very insistent on sitting in chair, assisted pt to chair, O2 levels dropped to 72%. After resting O2 levels 79%. Assisted pt back to bed, O2 dropped to 75%. When supine for 8 minutes, O2 only increased to 81%. Informed nursing of decreased saturation level, nursing responds that this is pt's baseline. Informed nursing that O2 levels has been higher with therapist over last two days. "

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The Daily Skilled Nurse ' s Note dated 11/18/15 included the following narrative which read, in part:
7AM -3PM- " ... Part (participated) with therapy and with strength and mobility in am (morning). O2 sat 88% on 2 L. Titrate up to 4 L SpO2 (O2 sat) increased 92%. Resident stable... "
Further review of the 11/18/15 Daily Skilled Nurse ' s Note revealed at approximately 11:25 AM the resident was observed to be nonresponsive in her bed. The resident ' s O2 sat was noted to be 75%. This note also indicated the facility ' s NP was at her bedside and an order was received to send Resident #2 out to the Emergency Department for hypoxia.

An interview was conducted with the facility's NP on 12/10/15 at 10:13 AM and a follow-up telephone interview was conducted on 12/10/15 at 3:30 PM. During the interviews, the NP reported she had not been made aware Resident #2 had experienced low O2 saturation levels during her stay at the facility.

An interview was conducted on 12/10/15 at 1:45 PM with the Nurse #1. Nurse #1 was identified as the nurse who had admitted Resident #2 on 11/13/15 and cared for the resident during the 1st nursing shift on 11/14/15, 11/15/15, 11/16/15, 11/17/15 and 11/18/15. Nurse #1 reported O2 sats were ordered every shift for this resident. She stated the O2 sats would typically be documented in the Nurse's Notes or on the Medication Administration Record (MAR).

An interview was conducted on 12/10/15 at 3:07 PM with the Physical Therapy Assistant (PTA) who worked with the resident on 11/16/15, 11/17/15, and the morning of 11/18/15. Although

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her records were not timed, the PTA reported her therapy session with Resident #2 would have been before 10:00 AM on 11/18/15. The PTA remembered the resident, recalling that the treatments didn't tend to be very physical and, "it involved a lot of checking to be sure her O2 sats were within reasonable limits." She recalled that on 11/18/15, Resident #2's O2 sats did not come back up, so she laid her back down and told the hall nurse about the O2 sat being low. The PTA could not recall the identity of the nurse. The nurse told the PTA that the resident's oxygen saturation levels reported were "kind of within her normal range."

An interview was conducted on 12/10/15 at 5:30 PM with Nurse #2. Nurse #2 was identified as the hall nurse who cared for Resident #2 during the 2nd nursing shift on 11/16/15 and 11/17/15. Nurse #2 reported the resident's O2 sats were checked at least every shift. Upon inquiry as to where the O2 sat results were documented, the nurse stated they would be either in the Nurse's Notes or on the MAR. However, she also reported that not all of the O2 sats may be recorded in the medical record, stating it was, "just something I do when I round."

An interview was conducted on 12/11/15 at 10:05 AM with the facility's Director of Nursing (DON). During the interview, the DON acknowledged one page of Resident #2's MAR was missing and not available for review. She reported the missing MAR may have contained additional O2 sat levels checked by the nursing staff. The DON indicated she would have expected Resident #2 ' s O2 sats to be completed and documented at least each shift as ordered by the physician.

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F 309	Continued From page 14 A telephone interview was conducted on 12/14/15 at 11:07 AM with Nurse #5. Nurse #5 was assigned to care for Resident #2 during 3rd shift on 11/14/15, 11/16/15, and 11/17/15. The nurse did not specifically recall Resident #2 and was unable to provide information regarding the resident's oxygen saturation levels. Upon inquiry, Nurse #5 reported O2 sats would likely be documented on the resident's MAR. A telephone interview was conducted on 12/14/15 at 11:40 AM with Nurse #6. Nurse #6 was assigned to care for Resident #2 during 3rd shift on 11/13/15 and 11/15/15. The nurse did not specifically recall Resident #2 and was unable to provide information regarding the resident's oxygen saturation levels. However, the nurse reported O2 sats would be documented on the resident ' s MAR. A telephone interview was conducted on 12/15/15 at 8:20 AM with Resident #2's MD (who was also the facility's Medical Director). During the interview, the physician's orders requesting O2 sats be checked each shift and the missing documentation of the oxygen saturation levels were discussed. When asked what his expectation would be in regards to monitoring and documenting O2 saturation levels, the physician responded "That's an integral part of the management of this patient."	F 309		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		

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F 520	Continued From page 15 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the facility staff, the facility's Quality Assessment and Assurance Committee failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 6/12/15 and the complaint investigation dated 10/6/15 in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies on physician notification (F157) from the recertification survey of 6/12/15, on the complaint investigation of 10/6/15, and again on the current complaint investigation of 12/15/15. The facility also had a pattern of repeat deficiencies on the provision of care and services to promote the well-being of residents (F309)	F 520	**A. The Executive Director conducted a Quality Assurance and Improvement Committee meeting on 12/30/15 to discuss the recitation of tags 157 and 309 and to review Plan of Correction for F157 and F309.** **B. All residents residing in the facility have the potential to be affected.** **C. The Executive Director reeducated the Interdisciplinary team and members of the Quality Assurance and Improvement Committee by 12/30/15 regarding accurately reporting and revising current action plans as well as developing and implementing a new action plan to assure state and federal compliance in the facility. Any Interdisciplinary Team member that has not received the Quality Assurance and Improvement education prior 12/30/15 will be unable to work until he/she has received the Quality Assurance and Improvement education.**	

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F 520	Continued From page 16 from the recertification survey of 6/12/15 and again, on the current complaint investigation of 12/15/15. The findings include: Example 1) This tag is cross referenced to F157: Physician/Family Notification of Changes. Based on record review and interviews with the facility staff, Nurse Practitioner (NP) and Medical Doctor (MD), the facility failed to notify the NP or MD of low oxygen saturation levels for 1 of 1 residents (Resident #2) reviewed with a diagnosis of chronic obstructive pulmonary disease (COPD). During the recertification survey of 6/12/15, the facility was cited for F157 for failing to notify the physician of daily weight changes in accordance with the parameters specified and as ordered by the physician for a resident with a diagnosis of congestive heart failure and history of edema; and failing to notify the physician of bleeding gums for a resident who was receiving Coumadin (an anticoagulant or blood thinner) and at risk for bleeding. On the complaint investigation of 10/6/15, the facility was re-cited for F157 for failing to notify the physician/nurse practitioner of the lab results for a wound culture requiring medication changes for treatment of a wound infection; for failing to notify the nurse practitioner of urinalysis results that required further orders; and for failing to notify the wound physician an X-ray to rule out osteomyelitis was not obtained. On the current complaint investigation, the facility was again re-cited for failing to notify the physician of low oxygen saturation levels for a resident diagnosed with COPD.	F 520	**D. The Interdisciplinary Team including the facility Medical Director, the Regional Vice President of Operations or the Regional Director of Clinical Services will meet monthly on the third Tuesday of each month to conduct the facility's Quality Assurance and Performance Improvement meeting. Special attention will be given to assessing the effectiveness of the monitoring of repeat deficiencies F157 and F309 and the prevention of any new repeat deficiencies. Should any interdisciplinary team member find that the facility may need an Impromptu Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Executive Director will organize a meeting and notify all team members in order for a revision to any present action plan or for a need for a new action plan in order to maintain compliance in the facility. Quality Assurance monitoring will take place at each**	

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F 520	Continued From page 17 A telephone interview was conducted on 12/15/15 at 1:57 PM with the facility's Administrator. The Administrator reported the facility's Quality Assurance Committee met monthly and as needed. The Committee included all of the facility's Department Heads and the Medical Director. The Administrator stated an emergency Committee meeting was held on 11/11/15 and included a discussion of physician notification. Audit tools had been put into place for lab work and to make sure the resident's physician and families were promptly notified of these. Additionally, the Administrator reported an audit tool was in place to monitor new residents with special needs and necessary referrals. This audit tool included a focus on oxygen and oxygen tubing. Example 2) This tag is cross referenced to: F309: Provision of care and services to promote the well-being of residents. Based on record review and interviews with the facility staff, Nurse Practitioner (NP), and Medical Doctor (MD), the facility failed to obtain and monitor a resident's oxygen saturation levels as ordered by the physician for 1 of 1 residents (Resident #2) reviewed with a diagnosis of chronic obstructive pulmonary disease (COPD). During the recertification survey of 6/12/15, the facility was cited for F309 for failing to obtain, monitor and assess increases in a resident's daily weight as ordered by the physician for a resident with a diagnosis of congestive heart failure and a history of edema. On the current recertification survey, the facility was re-cited for failing to monitor a resident's oxygen saturation levels as ordered by the physician for a resident diagnosed with COPD.	F 520	**Quality Assurance and Performance Improvement meeting monthly and any impromptu meetings held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance Improvement committee.**	1/5/16

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