STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WINSTON SALEM	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 5/10/21 through 5/13/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # MIJO11.	E 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications that were left at bedside for 1 of 1 sampled resident. (Resident #1). The findings included: Resident #1 was admitted to the facility on 4/7/20 with diagnoses that included, in part, type 2 diabetes mellitus, chronic pain and gastroesophageal reflux disorder. A quarterly Minimum Data Set assessment dated 1/4/21 revealed Resident #1 was cognitively intact. An observation on 5/10/21 at 10:56 AM revealed a one-ounce plastic cup containing 5 Tums tablets. During an interview with the resident, she stated she could have them at the bedside. Resident #1 stated she did not know if she had an assessment completed.	F 554	¿ Resident #1 was immediately educated on ordering OTCs online as the facility can provide these for her. A self-medication administration assessment of OTCs has been provided to ensure the resident #1 is properly accessed for administering her own OTCs. ¿ Resident was immediately educated on the facility ordering all OTCs versus resident ordering them offline. ¿ On 5/26/2021 the DON completed 100% audit for all current residents for interest in self-administration of medications. This is a resident right and any residents who were interested were assessed for the ability to be able to self-administer. The audit revealed that there were 2 out of 44 current residents that were interested in self-administering medications to themselves. ¿ The nursing staff were reeducated by the Administrator/DON on the right to	5/28/21

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

Electronically Signed | 05/28/2021

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F 554	Continued From page 1 On 5/11/21, an interview was conducted with Nurse #1. She stated she didn ' t know how the Tums got on Resident #1 ' s bedside but she wasn ' t supposed to have them. Nurse #1 added Resident #1 did have an order for the Tums. An observation on 5/13/21 at 9:50 AM revealed a small bottle of unlabeled artificial tears on Resident #1 ' s bedside table. Resident #1 stated she uses the eye drops herself and didn ' t know who left them there. A comprehensive medical record review conducted on 5/13/21 did not include an assessment to self-administer medications was completed on Resident #1. On 5/13/21 at 9:55 AM, Nurse #2 was interviewed. She stated she administered Resident #1 ' s artificial tear drops from the medication cart and she did not see the artificial tears that were on Resident #1 ' s bedside table. Nurse #2 added Resident #2 was not supposed to self-administer her medications. On 5/13/21 at 10:15 AM, an interview was conducted with the Director of Nursing (DON) who stated Resident #1 ordered medications online and had them delivered to her. The DON added Resident #1 was educated that she could not have them at bedside and the nurses have what she needs. The DON was unsure if Resident #1 had an assessment completed to self-administer medications.	F 554	self-administer medication process. ¿ The nursing staff will notify the MD of any residents in the future who wishes to self-administer their own medications, so the doctor can access for medical appropriateness of self-administration. ¿ The IDT will determine if a resident is able to self-administer meds and assess as appropriate with the MD involvement. ¿ A list of items that the facility provides will be sent to the families on what items are to be brought into the facility verses what items the facility will provide. This will be added to the admissions packet as well. ¿ During any time of the resident’s stay if the resident wishes to self-administer the IDT will look at the resident and do an assessment with the MD involvement to determine if the resident can administer meds. ¿ The DON is responsible that the residents are appropriately assessed for self-administering meds. ¿ The DON will monitor each newly admitted resident via the audit tool during clinical post the 72-hour care plan meeting for any interest in the “right to self-administration” needs weekly for four weeks and monthly for three months. ¿ The DON will track and trend the results via the audit tool and report the findings to the QA (Quality Assurance) committee to determine the need for continued monitoring or alteration to the established plan to ensure compliance. ¿ The DON is responsible for the Plan of Correction.	

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F 558	Continued From page 2	F 558		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, family member and staff interviews, the facility failed to place call lights within reach to allow for the residents to request staff assistance for 2 of 2 residents (Resident #41 and Resident #10) reviewed for accommodation of needs. The findings included: Resident #41 was admitted to the facility on 4/22/21 with diagnoses of osteomyelitis of vertebra lumbar region. An admission Minimum Data Set assessment dated 4/30/21 revealed Resident #41 had moderately impaired cognition. Resident #41 required minimal assistance with bed mobility and dressing and was occasionally incontinent of bowel and bladder. Resident #41 had a pain level of 6 and received scheduled and as needed pain medications and had a fall prior to admission. An observation on 5/10/21 at 10:40 AM revealed Resident #41 ' s call light was not in reach. The observation revealed a call bell component was inserted into the wall for Resident #41 and Resident #10, but the cord was not attached that reached the residents. The call bell cord was	F 558	Resident #41 and #10 call bells were immediately fixed and in good working order when the facility found the deficient practice on 5/11/2021. On 5/11/21 the Maintenance Director completed an 100% audit for all call bells being used in the building. This audit included that the call bells were in reach and in good working order. The audit revealed that in addition to the previous mentioned residents there were 0 out of 46 current residents with call bells properly functioning and in reach. The nursing staff were reeducated by the Administrator/DON on checking that call bells are in reach and properly functioning. The nursing staff will notify the Maintenance Director of any call bells not properly functioning via an immediate work order. The IDT will do angel rounds that checks the call bells in reach and that they are properly functioning. The maintenance director will do 100% weekly rounds of all rooms to ensure call lights are properly functioning. The IDT are responsible that the residents	5/28/21

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F 558	Continued From page 3 observed under Resident #41 ' s bed. Resident #10 ' s call bell cord was observed hanging on the headboard. An observation on 5/11/21 at 8:10 AM revealed Resident #41 ' s call light was still not in reach and the cord was still not attached. Resident #10 ' s call light cord was not attached to the wall component. On 5/11/21 at 11:20 AM, Resident #41 ' s call light was still not in reach and the cord was not attached. On 5/11/21 at 11:20 AM, an interview was conducted with a family member of Resident #41 revealed everything was going well in the facility. Resident #41 stated "yeah, except I can ' t reach the call bell to call the nurse". The resident was observed looking under the bed for the call bell. On 5/11/21 at 11:20 AM, Resident #10 was interviewed. He stated he rarely used his call bell but he might need it sometime if he had a fall or something occurred where he couldn ' t call out for help. On 5/11/21 at 11:30 AM, Nurse #1 was interviewed. She stated she didn ' t notice the call light wasn ' t attached to the wall. She stated she picked the call bell up for Resident #41 and placed it on his bed but didn ' t notice the cord wasn ' t attached. On 5/11/21 at 1:15 PM, Nurse Aide (NA) #2 was interviewed. She stated she did not arrive on duty until after nine and didn ' t notice the call bed wasn ' t in reach or attached to the wall.	F 558	call bells are in reach and in good working order. The Maintenance Director/NHA will monitor that 100% room rounds are done weekly to identify any malfunctioning of the call light system and that they are in reach, weekly for four weeks and monthly for three months. The Maintenance Director will track and trend the results via the audit tool and report the findings to the QA (Quality Assurance) committee to determine the need for continued monitoring or alteration to the established plan to ensure compliance. The Maintenance Director/NHA is responsible for the Plan of Correction.	

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F 558	Continued From page 4 On 5/11/21 at 1:20 PM, the Maintenance Director was interviewed. He stated the administrative staff had a list of about 4-5 rooms they are to audit each day and the call bell being in reach was one of the items to check off. He stated if the component was in the wall, but no cord was attached, it probably meant the call bell was not functioning at one time. On 5/11/21 at 2:10 PM, the Administrator was interviewed. She stated the call bells for Resident #41 and Resident #10 must have been malfunctioning at one time and that was why the cords were removed and the stubs remained. She stated that should be part of the room audit, to check if the call cord was attached to the wall.	F 558		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual	F 577		5/28/21

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F 577	Continued From page 5 to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post the results of the most recent survey of the facility. Findings included: The Aspen Central Office database system was reviewed and revealed the most recent survey at the facility was a follow up survey completed on 4/20/21. Other surveys in the past six months included an infection control/complaint investigation survey on 1/22/21 and a complaint investigation survey on 2/24/21. During a tour of the facility on 5/11/21 at 2:10 PM an observation was made of survey results located in a notebook in a plastic bin on the hallway of the second floor. The most recent survey results in the notebook were from December 2019. An interview was completed with the Administrator on 5/11/21 at 2:15 PM. She stated the facility had several survey results notebooks and the Medical Records Director placed the survey results in the notebooks. She said she had to investigate why the most recent survey results were not in the notebook. On 5/11/21 at 2:59 PM the Medical Records Director was interviewed. She explained the	F 577	There were no residents affected by this practice. On 5/14/21 the NHA completed an 100% audit to ensure (3) years of survey material included in the survey binder. This audit included that there was (1) binder for the 1st floor and (1) binder for the 2nd floor and are up to date. The binders will be placed outside of the 1st and 2nd floor dining rooms in a basket on the wall, accessible to residents, legal representatives of residents, and family members. The residents will be reeducated to the locations of the survey material and what the material includes. The NHA will ensure 2567 and POCs are printed upon completed of a survey. The NHA will be responsible that the survey binders are updated as needed and kept up to date upon the exit of a survey and completion of a plan of correction. The NHA will monitor that the survey binders are updated upon the exit of every survey by putting a QAPI in place to monitor is indefinite. This will be reported in our monthly QAPI meetings to include,	

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F 577	Continued From page 6 Administrator received the survey results and said if the survey results were given to her (Medical Records Director) she placed them in the survey results notebook. She added in the past six to nine months no one had given her any survey results to place in the notebook. On 5/11/21 at 2:50 PM the Administrator provided a notebook binder titled, "Survey 2021," that included survey results from a complaint investigation survey completed on 2/24/21. The facility's plan of correction was not included in the survey results. The binder also included survey results from a complaint investigation at a sister facility on 1/15/21. The survey results from the follow up survey on 4/20/21 were not included in the notebook. During an interview with the Administrator on 5/11/21 at 3:35 PM she stated either she or the Director of Nursing placed survey results in the notebook. She added the 2021 survey results notebook was at the nurse's desk on the first floor. She explained the reason the survey results from the 2/24/21 complaint investigation survey were only on the first floor was because the deficient practice affected a first floor resident.	F 577	"surveys conducted for the month?" and "was the survey binder updated to add 2567 and POC?" The NHA will audit this practice once every month to ensure that best practice is on-going and an audit will be put in place. The NHA is responsible for the Plan of Correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately code	F 641	Modifications were completed to fix the deficient practice of the MDS coding	5/28/21

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F 641	Continued From page 7 the Minimum Data Set (MDS) assessment in the areas of restraints and diagnoses for 2 of 5 residents (Resident #41 and Resident #23) and in the area of discharge status for 1 of 1 resident (Resident #42) reviewed for discharge to the community. The findings included: 1. Resident #41 admitted to the facility on 4/22/21 with diagnoses of sepsis and osteomyelitis. A wandering assessment dated 4/22/21 revealed Resident #41 kept going to the door and wanting to leave. A baseline care plan dated 4/22/21 revealed Resident #41 was an elopement risk and a wander guard was placed on Resident #41. An interview conducted with Nurse #3 on 5/11/21 revealed Resident #41 was looking for the exit as soon as he was admitted. He would wander into other residents ' rooms on third shift. She stated he had a wander guard in place since admission. A review of the Medication Administration Record for April 2021 revealed Resident #41 received Amitriptyline the 7 days of the MDS ' s look back period. A physician's progress note dated 5/7/21 listed depression under history and chronic active conditions. An admission Minimum Data Set (MDS) assessment dated 4/30/21 revealed Resident #41 received an antidepressant 7 days of the look back period. Depression was not coded on the	F 641	errors for residents #41 and #23. Diagnoses codes have been fixed on their MDS diagnoses page. A 100% audit was conducted to ensure there were no other residents affected. On 5/26/2021 the MDS Coordinator completed an 100% audit to ensure all diagnoses codes were accurate for anyone who were taking medications for anxiety or depressions. The audit reviewed that all current residents have the proper diagnoses codes in place. The audit revealed that there were currently 0 out of 44 current residents with anxiety and depression diagnoses codes in place that were being treated. The MDS Coordinator will be responsible to ensure all diagnoses codes are in accurately. The MDS Coordinator and MD will communicate weekly on changes and/or additions to new diagnoses and treatments to all resident□s plan of care. The MDS Coordinator will review all MD weekly progress notes and updates for accuracy. The MDS Coordinator will monitor that proper diagnoses codes have been established to the MDS diagnoses page for new diagnoses/treatments occurring with anxiety and depression weekly for four weeks and monthly for three months. The MDS coordinator will track and trend the results via the audit tool and report the findings to the QA (Quality Assurance) committee to determine the need for	

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F 641	Continued From page 8 assessment in the area of active diagnoses and wander guard was not coded in the area of restraints. On 5/12/21 at 3:49 PM, an interview was conducted with the MDS nurse. She stated depression did not get added to the MDS because it wasn ' t added to the diagnosis page and should have been. She added she did not see Resident #41 ' s use of a wander guard in the notes during the lookback period. 2. Resident #23 admitted to the facility on 2/2/21 with diagnoses of chronic pain and hypertension. Review of the physician orders revealed Resident #23 received Paxil for depression and Klonopin for anxiety. A review of the Medication Administration Record for March 2021 revealed Resident #23 received paxil and klonopin as ordered for 7 days of the look back period. A review of the care plan revealed focus on depression and anxiety with antidepressant and antianxiety use. A pharmacy review dated 5/3/21 revealed "endorses depression" and "long time anxiety". A review of an admission MDS dated 3/14/21 revealed Resident #23 received an antidepressant and an antianxiety medication 7 days of the assessments look back period but anxiety and depression were not added in the area of active diagnoses. On 5/12/21 at 3:49 PM, an interview was conducted with the MDS nurse. She stated	F 641	continued monitoring or alteration to the established plan to ensure compliance. The MDS Coordinator is responsible for the Plan of Correction. --- --- Modifications were done to fix the deficient practice of the wander guard not being coded accurately as restraints for resident #41. A 100% audit was conducted to ensure there were no other residents affected by this coding error. On 5/26/2021 the MDS Coordinator completed an 100% audit to ensure all wander guards were captured in the MDS lookback period as restraints. The audit reviewed that all current residents have the proper MDS coding for their wander guard during the MDS look back. The 100% audit revealed that there were 0 out of 44 current residents that have the proper coding for the MDS lookback period with wander guards being coded correctly as restraints. The MDS Coordinator will be responsible to ensure all wander guards are coded accurately. The MDS Coordinator and clinical team will be educated on completing wander guard assessments upon admission and upon any time a resident is exhibiting a wandering behavior. The MDS Coordinator will review with the IDT wander guards each week during our weekly risk meeting.	

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F 641	Continued From page 9 anxiety and depression did not get added to the MDS because it wasn ' t added to the diagnosis page and should have been. 3. Resident #42 was admitted to the facility on 3/2/20. Cumulative diagnoses included, in part, diabetes, hypertension and osteoarthritis. Resident #42 discharged to an assisted living facility on 3/18/21. The discharge MDS assessment dated 3/18/21 revealed Resident #42's discharge status was to "another nursing home or swing bed." On 5/13/21 at 9:17 AM an interview was completed with the Social Worker. She said Resident #42 was issued a 30 day notice of discharge from the facility and was placed at an assisted living facility. During an interview with the MDS Nurse on 5/13/21 at 9:42 AM, she stated she was responsible for sections A, G, H, I, J, M, O and P of the discharge MDS assessment and verified she completed Resident #42's discharge MDS assessment. She thought when Resident #42 discharged from the facility he went to another nursing home and was unaware he instead went to an assisted living facility. She added if she knew he went to assisted living she would have coded the discharge status portion as "community discharge," since assisted living discharges were coded under the community discharge category. She had been informed by the facility Social Worker that Resident #42 went to another facility and interpreted that as another nursing home.	F 641	The IDT will review that a wandering assessment is completed for those showing signs of wandering behaviors. The MDS Coordinator will monitor residents with wander guards to ensure that they have been assessed appropriately with an assessment in place and coded accurately in the MDS as restraints per the Assessment Reference Dates weekly for four weeks and monthly for three months. The MDS coordinator will track and trend the results via the audit tool and report the findings to the QA (Quality Assurance) committee to determine the need for continued monitoring or alteration to the established plan to ensure compliance. The MDS Coordinator is responsible for the Plan of Correction. ---------- A modification was done immediately to fix the coding error for the discharge status that occurred with the resident discharging to the community versus a facility for resident #42. The resident discharged to an ALF and should have been coded to the community but instead was coded to a facility. An 100% audit was conducted for the previous 60 days of discharges to ensure there were no other residents affected by this coding error. On 5/26/2021 the MDS Coordinator completed an 100% audit to ensure all residents who discharged in the last 60	

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F 641	Continued From page 10 The Administrator was interviewed on 5/13/21 at 10:26 AM. She shared she thought any facility discharge was coded under the nursing home discharge status. She said if assisted living discharges were supposed to be coded under community discharge then it should have been coded as such. The Administrator added there was a regional MDS staff consultant who routinely audited MDS assessments and completed trainings with the MDS nurse.	F 641	days were coded correctly on the MDS to their appropriate discharge destination. The audit revealed that there were 0 out of 52 discharged residents that were coded accurately on the MDS discharge destination. The MDS Coordinator will be responsible to ensure all MDS discharge codes are accurate to the discharge destination. The MDS Coordinator will communicate in PDPM weekly with the SW the accurate discharge plan for every resident. The MDS Coordinator will be responsible for ensuring all discharge MDS are coded accurately. The MDS Coordinator will monitor and audit weekly during PDPM the accuracy of all discharge plans for MDS coding for four weeks and monthly for three months. The MDS coordinator will track and trend the results via the audit tool and report the findings to the QA (Quality Assurance) committee to determine the need for continued monitoring or alteration to the established plan to ensure compliance. The MDS Coordinator is responsible for the Plan of Correction.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		5/28/21

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	345149	A. BUILDING _____ B. WING _____	05/13/2021

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F 695	Continued From page 11 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review, the facility failed to obtain a physician's (MD) order for oxygen therapy for 1 of 2 residents (Resident # 94) reviewed for respiratory care. The findings included: Resident #94 was admitted to the facility on 4/9/21. She discharged to the hospital on 4/13/21 and re-admitted to the facility on 4/16/21. She discharged again to the hospital on 4/19/21 and re-admitted to the facility on 4/30/21. Diagnoses included, in part, heart failure, pulmonary hypertension, bradycardia and epilepsy. The 5 day Minimum Data Set assessment dated 4/19/21 revealed Resident #94 had severely impaired cognition. She had shortness of breath or trouble breathing with exertion and when lying flat. The use of oxygen was not coded on the assessment. The baseline care plan, updated 4/30/21, did not include information about the use of oxygen. On 5/10/21 at 11:09 AM an observation was made of Resident #94. She was in bed and oxygen had been applied via nasal cannula. The oxygen concentrator indicated the oxygen ran at two and a half (2.5) liters. During an observation of Resident #94 on 5/11/21 at 2:08 PM, the resident was in bed with oxygen	F 695	A written order was immediately put in place for continuous O2 for resident #94. The OT performing the pulmonary program was educated on communication to nursing and the MD for changes in oxygen and pulmonary status. On 5/14/2021 the DON completed an 100% audit to ensure all residents who had oxygen or were using a C-pap/Bi-pap were audited for orders in place. The 100% audit revealed that there were 0 out of 43 current residents that had O2 with written orders in place. Education completed to all nursing staff to ensure an order is in place when using any type of treatment, oxygen, and/or medication no matter the time duration for all resident□s continuity of care. The DON and Rehab director will use communication forms to relay information in regards to daily status changes in residents. The DON will be responsible for ensuring all orders are in place for O2 treatments. The DON and Rehab Director will monitor and audit weekly during Risk meeting that all O2/C-Pap/Bi-Pap orders are in place and appropriate for each resident for four weeks and monthly for three months. This will be ongoing. The DON will track and trend the results	

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F 695	Continued From page 12 on via nasal cannula. The oxygen concentrator indicated the oxygen ran at 2.5 liters. Resident #94 was observed seated on the side of her bed on 5/12/21 at 10:14 AM. She wore oxygen via nasal cannula at 2.5 liters. On 5/13/21 at 11:29 AM the resident was observed with oxygen on while she sat on the edge of her bed. Vital sign information was reviewed for Resident #94 in the electronic health record (EHR) and revealed the resident received oxygen on the following dates: 4/30/21 at 7:07 PM, 4/30/21 at 9:19 PM, 5/1/21 at 11:31 AM, 5/1/21 at 6:25 PM, 5/2/21 at 11:13 AM, 5/2/21 at 7:29 PM and 5/11/21 at 7:08 PM. The Active Orders Summary Report which was provided by the Director of Nursing (DON) on 5/12/21 at 9:54 AM was reviewed and revealed there was no order for oxygen listed on the orders. Nurse Aide #1 (NA #1) was interviewed on 5/12/21 at 10:16 AM. She shared Resident #94 wore oxygen "ever since I've worked with her." NA #1 said when she assisted the resident with dressing, Resident #94 always reminded her to put the oxygen back on when she was finished. She added the resident became short of breath when oxygen was not applied. NA #1 stated she wasn't sure why the resident wore oxygen and added Resident #94 always had it on when she worked with her. During an interview with Nurse #2 on 5/12/21 at 11:05 AM, she reported Resident #94 went to the	F 695	via the audit tool and report the findings to the QA (Quality Assurance) committee to determine the need for continued monitoring or alteration to the established plan to ensure compliance. The DON is responsible for the Plan of Correction.	

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F 695	Continued From page 13	F 695		

hospital with respiratory issues, bradycardia and heart failure and "came back with oxygen." She explained typically if a resident was on oxygen there was an order from the MD. Staff had not applied oxygen to a resident unless there was an order for it, or if the resident had difficulty breathing, in which case staff applied the oxygen then called the MD for an order. During the interview with Nurse #2, the active orders were reviewed in the EHR and an order for oxygen was not found. Nurse #2 said usually when a resident returned from the hospital, oxygen orders were either on the hospital discharge summary or were given verbally by the nurse at the hospital when report was given to the facility nurse. Nurse #2 confirmed she was on duty when Resident #94 returned from the hospital and said she couldn't remember if she received report from the hospital prior to Resident #94's arrival. "I probably put most of the orders in and overlooked the oxygen. She would have had oxygen on when she was brought in by the ambulance and we would have switched it right over from theirs to ours."

The hospital discharge summary, dated 4/30/21 was reviewed and there was no information in the summary regarding oxygen requirements.

Interviews were completed with the DON on 5/13/21 at 10:20 AM and 11:13 AM, during which she expressed she didn't know when the oxygen concentrator was initially brought into Resident #94's room and oxygen applied to the resident. She said the resident had been placed on a pulmonary program with the therapy department which included the use of oxygen.

Occupational Therapist (OT) #1 was interviewed on 5/13/21 at 11:36 AM. He explained Resident

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F 695	Continued From page 14	F 695		

#94 was on a cardio-pulmonary program with therapy. The program included obtaining vital signs, oxygen saturations, respiratory rate, blood pressure and heart rate prior to the start of therapy to ensure the resident's vitals were within normal limits. Vitals were obtained before, during and after the therapy session. The goal was that oxygen saturations were above 88% to "avoid oxygen." OT #1 reported when he evaluated Resident #94 on 4/30/21 her oxygen saturations were less than 88% which indicated the need for oxygen. He added her saturations dropped to 87% after she completed therapy activities. OT #1 said he could not remember if he applied oxygen to Resident #94 when the oxygen saturations dropped below 88%. He was unable to recall if he notified nursing of the drop in oxygen saturations and added, "probably not if I didn't put it in my note."

On 5/12/21 at 11:30 AM an interview was completed with the Director of Nursing (DON). She explained if a resident needed oxygen the facility obtained orders for it from the MD. She added if it was an emergency situation the facility applied the oxygen then called the MD for an order. She said Resident #94 had episodes of seizure activity and her oxygen saturation decreased which is why she needed supplemental oxygen.