

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

PRINTED: 10/20/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E210 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 10/20/2016 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER FRANKLIN HEALTHCARE OF PEABODY, LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 PEABODY PEABODY, KS 66866 | | |
| (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 | F 000 | | | |
| F 157 SS=D | <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> | F 157 | | | |

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

TITLE

(X6) DATE

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

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| F 157 | <p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 47 residents. The sample included 6 residents. Based on observation, record review and interview the facility failed to adequately monitor and thoroughly assess respiratory status and seek physician involvement over a 2 day period for 1 sampled resident (#1), who had significant respiratory distress and decline in physical health.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1's 10/4/16 physician order sheet indicated the resident had diagnoses of (COPD) chronic obstructive pulmonary disease (a disease that affects the lungs, causing reduced airflow, which makes it hard to breathe), asthma (disorder of narrowed airways that causes wheezing and shortness of breath), and advanced pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred. This thickened, stiff tissue makes it more difficult for the lungs to work properly). <p>The significant change (MDS) Minimal Data Set assessment, dated 9/21/16, indicated the resident had a (BIMS) Brief Interview of Mental Status score for 15, which indicated the resident had intact cognition. The MDS indicated the resident required continuous oxygen therapy.</p> <p>The 9/26/16 care plan directed nursing to administer the resident's oxygen per rate and route of the physician's orders. The care plan indicated staff would place "no smoking oxygen in use" signs on the resident's room door and would change all the oxygen tubing weekly. The care</p> | F 157 | | | |

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| F 157 | <p>Continued From page 2</p> <p>plan instructed staff to monitor the resident for cyanosis (appearance of a blue or purple coloration of the skin), and hypoxia (a condition where the tissues are not oxygenated adequately, usually due to an insufficient concentration of oxygen in the blood). The care plan instructed staff to check the resident's oxygen tubing each shift to make sure it was free of kinks and ensure the tubing was secured (behind the resident's ear, ensure the resident's oxygen concentrator was in proper working order). The care plan instructed the nurse to keep the resident's call light within reach, and check the resident's humidifier jar on the oxygen concentrator each shift to ensure adequate water was in the container. The care plan instructed the nurse to keep the resident's oxygen saturation between 90-96%, and to notify the physician if the resident's oxygen saturation dropped below 70% or as specified by the physician.</p> <p>The 6/30/16 at 3:55 PM physician order instructed staff to change oxygen setting to 2 liters per nasal cannula and change Albuterol (drug used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases) nebulizer (a machine used to change medication from a liquid to a mist so that it can be more easily inhaled into the lungs) treatment to every 2 hours as needed. (The previous order on 4/13/16 instructed staff to administer oxygen to the resident at 1 liter per nasal cannula during the day and 2 liters during the night for dyspnea (difficulty breathing).</p> <p>The 9/26/16 at 9:00 PM, nurse's note indicated the resident complained of being short of air and requested his/her prn (as needed) Albuterol</p> | F 157 | | | |

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| F 157 | <p>Continued From page 3</p> <p>inhaler (portable device for administering a drug that is to be breathed in, used for relieving asthma and other bronchial or nasal congestion).</p> <p>The 9/27/16 at 6:30 AM, nurse's note indicated the resident's oxygen saturation was 88% on 2 liters of oxygen per nasal cannula. The note indicated the resident displayed slow movements, drowsiness and he/she admitted to forgetting to put his/her oxygen back on during the night after using the bathroom.</p> <p>The 9/27/16 at 1:15 PM nurse's note indicated the resident had a persistent dry cough, his/her lungs were clear, and his/her oxygen saturation dropped into the 70's after the resident had a coughing episode.</p> <p>The clinical record lacked evidence that staff assessed the resident after 1:15 PM, to follow up on the decreased oxygen saturation level.</p> <p>The 9/27/16 at 3:15 PM, physician order instructed staff to discontinue prior oxygen orders and begin oxygen per nasal cannula and titrate oxygen to keep oxygen saturation 92% or above.</p> <p>The 9/27/16 at 8:00 PM, nurse's note indicated the resident's oxygen saturation continued to decrease, the resident panted, had shortness of breath and the nasal cannula was not effective for the resident. The note indicated the nurse tried an oxygen mask, and with time and relaxation, the resident's oxygen saturation was 93% on 4 liters of oxygen.</p> <p>The clinical record lacked evidence the facility notified the physician or reassessed the resident in a timely manner.</p> | F 157 | | | |

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| F 157 | <p>Continued From page 4</p> <p>The 9/27/16 at 11:00 PM, nurse's note indicated the resident's oxygen saturation was 78% with simple mask. Staff reapplied the nasal cannula at 3 liters of oxygen, and the resident's saturation improved slowly to 93%. The note indicated the resident's respirations were shallow, labored, and his/her lungs were diminished (almost non existant breath sounds) in the bases. The resident had scattered wheezes in his/her upper lung lobes, heart rate in the 130's,(normal heart rate is 60-100 beats per minute), respirations 32 (normal respirations are 12 to 16 breaths per minute), and staff encouraged the resident to breath in through his/her nose and out through his/her mouth. This helped and the resident's respiration rate lowered to 24, and his/her heart rate came down to 116 beats per minute.</p> <p>The clinical record lacked evidence the facility notified the physician or reassessed the resident in a timely manner.</p> <p>The 9/27/16 at 12:50 PM, nurse's note indicated the resident's oxygen saturation was 89% on 2 liters of oxygen per nasal cannula. The nurse cut the resident's finger nails, which were long and curved under the tip of nail and his/her oxygen saturation after the nurse trimmed his/her nails trimmed was 82%.</p> <p>The clinical record lacked evidence the facility notified the physician or reassessed the resident in a timely manner.</p> <p>The 9/28/16 at 07:00 AM, nurse's note (over 18 hours since last assessment) indicated the resident was hyperventilating (breathing that was deeper and more rapid than normal) and</p> | F 157 | | | |

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| F 157 | <p>Continued From page 5</p> <p>"appeared to be purposeful". The note indicated the nurse encouraged the resident to slow down and concentrate on even respirations. The note indicated the resident had signs and symptoms of air hunger (respiratory distress marked by gasping, labored breathing), and his/her oxygen saturation was 72%. Staff placed oxygen on him/her at 3.5 liters per nasal cannula, and with coaching from the nurse his/her oxygen saturation increased to 94%. The note indicated the nurse told the resident to be conscious of what/how he/she was doing. The resident had a shower with assistance of staff, had no oxygen on while in the shower, and complained of being too cold to go out to breakfast, and the nurse encouraged the resident to warm up and independently go to breakfast later. The note indicated the nurse told the resident he/she needed to be as active as possible.</p> <p>The clinical record lacked evidence the facility reassessed the resident including checking the resident's oxygen saturation.</p> <p>Review of the medical record revealed no documentation the nurse contacted the physician for instructions regarding the care of the resident's change of status which included continued drops in oxygen saturations, hyperventilations, air hunger, shallow respirations, diminished lung sounds, and increased heart rate and respirations.</p> <p>The 9/28/16 at 10:16 AM, nurse's note (over 3 hours since the last assessment when the resident's oxygen saturation was 72% and the nurse increased the oxygen to 3.5 liters before his/her shower) indicated direct care staff called the nurse to the resident's room. When he/she</p> | F 157 | | | |

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| F 157 | <p>Continued From page 6</p> <p>arrived the resident was hypoxic (a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level), lips and nail beds were blue, respirations 46, and oxygen saturation 56%. The note indicated the nurse increased the resident's oxygen again to 3.5 liters, tried to slow the resident's breathing by breathing with him/her. The note indicated the resident seemed anxious, unable to slow breathing, tried breathing through a straw, and unable to follow the nurse's directions. The note indicated the resident had no anxiety medications. The note indicated the resident's blood pressure was 138/72, heart rate 42 beats per minute, oxygen saturation 73% and starting to fall. The note indicated the nurse called the physician and received order to send the resident to the (ER) emergency room.</p> <p>The 9/28/16 at 11:30 AM, emergency room nursing assessment indicated the resident arrived at the ER by ambulance with severe tachypnea (abnormally rapid breathing. In adult humans at rest, any rate between 12-20 breaths per minute is normal) at 50 breaths per minute, on 15 liters of oxygen by (NRB) non-rebreather (device used in medicine to assist in the delivery of oxygen therapy. An NRB requires that the patient can breathe unassisted, but unlike low flow nasal canula, the NRB allows for the delivery of higher concentrations of oxygen) mask. The resident's oxygen saturation was 93%, and the resident had a productive cough with green/yellow/red mucus, fever, chest pain, sore throat, headache, lungs had wheezes, used his/her accessory muscles to breathe, and had a heart rate of 128 beats per minute. The assessment indicated hospital staff obtained a urinalysis and chest x-ray. The assessment indicated the resident's diagnosis</p> | F 157 | | | |

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| F 157 | <p>Continued From page 7</p> <p>was urosepsis (secondary infection and a form of sepsis that initially developed in the urinary tract) / (UTI) urinary tract infection (An infection of the kidney (bean shaped organ which filters the blood), ureter (the duct by which urine passes from the kidney to the bladder), bladder(organ that collects urine), or urethra (tube that allows urine to pass out of the body)/sepsis (a life-threatening bacterial infection of the blood). The assessment indicated the local hospital transferred the resident to a regional hospital.</p> <p>On 10/13/16 at 10:30 AM, Nurse Aide A stated he/she was working on 9/28/16 and he/she thought the facility should have sent the resident to the hospital sooner.</p> <p>On 10/12/16 at 11:01 AM, Nurse B stated he/she was the nurse on duty on 9/28/16 and about 8:30 AM the resident put his/her call light on and reported his/her hands hurt, requested something for the pain, and he/she placed a warm towel on the resident's hands. Nurse B told the resident he/she would tell the (CMA) Certified Medication Aide to administer the resident's scheduled pain medication. Nurse B stated he/she meant to go back and check on the resident in about 10 minutes, but it was approximately 20 minutes before he/she returned to the resident's room, and the resident was asleep. Nurse B stated about 9:30 AM, a nurse aide came and told him/her the resident said he/she could not breathe. When he/she arrived the resident had his/her oxygen kinked on the oxygen concentrator, and his/her oxygen saturation was 89%. Nurse B stated once he/she unkinked the tubing the resident's oxygen saturation went up and the resident was breathing fine and he/she left the room. Nurse B stated at 10:15 AM an aide</p> | F 157 | | | |

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| F 157 | <p>Continued From page 8</p> <p>came and told him/her the resident was having trouble breathing, and when he/she arrived in the resident's room he/she was hyperventilating and kept saying he/she could not stop breathing fast. Nurse B stated he/she could not get the resident to stop hyperventilating, checked the resident's oxygen saturation and it was 54%. The resident couldn't get settled down, but his/her oxygen saturation did come up to 73%. Nurse B stated he/she was getting alarmed, but figured the resident was just mad at him/her for getting him/her in the shower earlier that morning, because that was the kind of thing the resident would do when he/she was mad at staff. Nurse B stated the resident had an as needed breathing treatment, but he/she did not give it to the resident because his/her lungs were clear. Nurse B stated the resident was having difficulty breathing, he/she told the aide to stay with the resident then went to call the physician and received an order to send the resident to the ER.</p> <p>On 10/13/16 at 2:55 PM, Administrative Nurse C stated on 9/27/16- 9/28/16 the resident had a change in condition and he/she expected the nurse to call the emergency room physician or notify the primary care physician immediately when the resident's heart rate was 130 bpm (the resident's heart rate was 130 bpm 16 1/4 hours prior to staff contacting the physician and transferring the resident to the emergency room). Administrative Nurse C stated there was a paper taped in the nurse's station, at the time of the resident's change in condition, stating parameters that the nurse should have followed, regarding when the nurse should call the physician. The paper stated the following: Resting pulses >110(bpm) beats per minute, <55 bpm, or 110 bpm and patient has dyspnea or</p> | F 157 | | | |

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| F 157 | <p>Continued From page 9</p> <p>palpitations Respirations > 24, <10/minute. (unless has diagnosis of (COPD) or normally has respirations of 24) Call the physician, to report the above DO not fax.</p> <p>On 10/13/16 at 5:17 PM, Nurse D stated he/she was the nurse on duty in the hospital ER room on 9/28/16, when the resident was brought in by ambulance. Nurse D stated when the resident arrived at the ER he/she was lethargic (fell asleep while talking to the nurse), and in pretty serious shape. Nurse D stated the resident was on 15 liters of oxygen by nonrebreather mask and the resident's oxygen saturation was 91-92%. Nurse D stated generally when a person was on 15 liters with a nonrebreather mask, their oxygen saturation would be 99-100%. Nurse D stated the resident's respirations were 36, blood pressure was 92/66, and the resident's heart rate was tachycardic (a heart rate that exceeds the normal resting rate of 100 beats per minute) at 132 bpm. Nurse D stated he/she called the facility to ask what had been going on prior to the resident being brought to the ER.</p> <p>On 10/17/16 at 10:15 AM, Nurse Practitioner E stated he/she expected the staff to call the physician right away when the resident continued to have a decline in oxygen saturation requiring need for increased oxygen. Nurse Practitioner E stated the resident's outcome would have been different if the facility had sent the resident to the hospital sooner.</p> <p>The facility's 4/2011 Change in a Resident's Condition or Status policy stated the nurse supervisor/charge nurse will notify the resident's attending physician or on call physician when</p> | F 157 | | | |

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| F 157 | Continued From page 10 there was a significant change in the resident's physical/emotional/mental condition or need to transfer the resident to a hospital/treatment center. The facility's 4/2007 Measuring Respirations policy stated the following abnormal respirations should be promptly reported to the nurse supervisor when a resident had the following: Shallow respirations (breathes with only the upper part of the lungs). Abdominal respirations (breathing comes mostly from the stomach muscles). Irregular respirations (the resident's breathing changes and the rate of the rise and fall of the chest is irregular(not steady).The policy stated normal respirations for an adult is from 12 to 18 bpm. Stertorous respirations (noisy). The facility failed seek physician involvement over a 2 day period for 1 sampled resident (#1), who had significant respiratory distress and decline in physical health. | F 157 | | | |
| F 309 SS=J | 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: | F 309 | | | |

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| F 309 | <p>Continued From page 11</p> <p>The facility had a census of 47 residents. The sample included 6 residents. Based on observation, record review and interview the facility failed to adequately monitor and thoroughly assess respiratory status and seek physician involvement over a 2 day period for 1 sampled resident (#1), who had significant respiratory distress and decline in physical health. This failure placed the resident in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1's 10/4/16 physician order sheet indicated the resident had diagnoses of (COPD) chronic obstructive pulmonary disease (a disease that affects the lungs, causing reduced airflow, which makes it hard to breathe), asthma (disorder of narrowed airways that causes wheezing and shortness of breath), and advanced pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred. This thickened, stiff tissue makes it more difficult for the lungs to work properly). <p>The significant change (MDS) Minimal Data Set assessment, dated 9/21/16, indicated the resident had a (BIMS) Brief Interview of Mental Status score for 15, which indicated the resident had intact cognition. The MDS indicated the resident required continuous oxygen therapy.</p> <p>The 9/26/16 care plan directed nursing to administer the resident's oxygen per rate and route of the physician's orders. The care plan indicated staff would place "no smoking oxygen in use" signs on the resident's room door and would change all the oxygen tubing weekly. The care plan instructed staff to monitor the resident for</p> | F 309 | | | |

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| F 309 | <p>Continued From page 12</p> <p>cyanosis (appearance of a blue or purple coloration of the skin), and hypoxia (a condition where the tissues are not oxygenated adequately, usually due to an insufficient concentration of oxygen in the blood). The care plan instructed staff to check the resident's oxygen tubing each shift to make sure it was free of kinks and ensure the tubing was secured (behind the resident's ear, ensure the resident's oxygen concentrator was in proper working order). The care plan instructed the nurse to keep the resident's call light within reach, and check the resident's humidifier jar on the oxygen concentrator each shift to ensure adequate water was in the container. The care plan instructed the nurse to keep the resident's oxygen saturation between 90-96%, and to notify the physician if the resident's oxygen saturation dropped below 70% or as specified by the physician.</p> <p>The 6/30/16 at 3:55 PM physician order instructed staff to change oxygen setting to 2 liters per nasal cannula and change Albuterol (drug used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases) nebulizer (a machine used to change medication from a liquid to a mist so that it can be more easily inhaled into the lungs) treatment to every 2 hours as needed. (The previous order on 4/13/16 instructed staff to administer oxygen to the resident at 1 liter per nasal cannula during the day and 2 liters during the night for dyspnea (difficulty breathing).</p> <p>The 9/26/16 at 9:00 PM, nurse's note indicated the resident complained of being short of air and requested his/her prn (as needed) Albuterol inhaler (portable device for administering a drug</p> | F 309 | | | |

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| F 309 | <p>Continued From page 13</p> <p>that is to be breathed in, used for relieving asthma and other bronchial or nasal congestion).</p> <p>The 9/27/16 at 6:30 AM, nurse's note indicated the resident's oxygen saturation was 88% on 2 liters of oxygen per nasal cannula. The note indicated the resident displayed slow movements, drowsiness and he/she admitted to forgetting to put his/her oxygen back on during the night after using the bathroom.</p> <p>The 9/27/16 at 1:15 PM nurse's note indicated the resident had a persistent dry cough, his/her lungs were clear, and his/her oxygen saturation dropped into the 70's after the resident had a coughing episode.</p> <p>The clinical record lacked evidence that staff assessed the resident after 1:15 PM, to follow up on the decreased oxygen saturation level.</p> <p>The 9/27/16 at 3:15 PM, physician order instructed staff to discontinue prior oxygen orders and begin oxygen per nasal cannula and titrate oxygen to keep oxygen saturation 92% or above.</p> <p>The 9/27/16 at 8:00 PM, nurse's note indicated the resident's oxygen saturation continued to decrease, the resident panted, had shortness of breath and the nasal cannula was not effective for the resident. The note indicated the nurse tried an oxygen mask, and with time and relaxation, the resident's oxygen saturation was 93% on 4 liters of oxygen.</p> <p>The clinical record lacked evidence the facility notified the physician or reassessed the resident in a timely manner.</p> | F 309 | | | |

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| F 309 | <p>Continued From page 14</p> <p>The 9/27/16 at 11:00 PM, nurse's note indicated the resident's oxygen saturation was 78% with simple mask. Staff reapplied the nasal cannula at 3 liters of oxygen, and the resident's saturation improved slowly to 93%. The note indicated the resident's respirations were shallow, labored, and his/her lungs were diminished (almost non existant breath sounds) in the bases. The resident had scattered wheezes in his/her upper lung lobes, heart rate in the 130's,(normal heart rate is 60-100 beats per minute), respirations 32 (normal respirations are 12 to 16 breaths per minute), and staff encouraged the resident to breath in through his/her nose and out through his/her mouth. This helped and the resident's respiration rate lowered to 24, and his/her heart rate came down to 116 beats per minute.</p> <p>The clinical record lacked evidence the facility notified the physician or reassessed the resident in a timely manner.</p> <p>The 9/27/16 at 12:50 PM, nurse's note indicated the resident's oxygen saturation was 89% on 2 liters of oxygen per nasal cannula. The nurse cut the resident's finger nails, which were long and curved under the tip of nail, and his/her oxygen saturation after the nurse trimmed his/her nails trimmed was 82%.</p> <p>The clinical record lacked evidence the facility notified the physician or reassessed the resident in a timely manner.</p> <p>The 9/28/16 at 07:00 AM, nurse's note (over 18 hours since last assessment) indicated the resident was hyperventilating (breathing that was deeper and more rapid than normal) and "appeared to be purposeful". The note indicated</p> | F 309 | | | |

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| F 309 | <p>Continued From page 15</p> <p>the nurse encouraged the resident to slow down and concentrate on even respirations. The note indicated the resident had signs and symptoms of air hunger (respiratory distress marked by gasping, labored breathing), and his/her oxygen saturation was 72%. Staff placed oxygen on him/her at 3.5 liters per nasal cannula, and with coaching from the nurse his/her oxygen saturation increased to 94%. The note indicated the nurse told the resident to be conscious of what/how he/she was doing. The resident had a shower with assistance of staff, had no oxygen on while in the shower, and complained of being too cold to go out to breakfast, and the nurse encouraged the resident to warm up and independently go to breakfast later. The note indicated the nurse told the resident he/she needed to be as active as possible.</p> <p>The clinical record lacked evidence the facility reassessed the resident including checking the resident's oxygen saturation.</p> <p>Review of the medical record revealed no documentation the nurse contacted the physician for instructions regarding the care of the resident's change of status which included continued drops in oxygen saturations, hyperventilations, air hunger, shallow respirations, diminished lung sounds, and increased heart rate and respirations.</p> <p>The 9/28/16 at 10:16 AM, nurse's note (over 3 hours since the last assessment when the resident's oxygen saturation was 72% and the nurse increased the oxygen to 3.5 liters before his/her shower) indicated direct care staff called the nurse to the resident's room. When he/she arrived the resident was hypoxic (a condition in</p> | F 309 | | | |

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| F 309 | <p>Continued From page 16</p> <p>which the body or a region of the body is deprived of adequate oxygen supply at the tissue level), lips and nail beds were blue, respirations 46, and oxygen saturation 56%. The note indicated the nurse increased the resident's oxygen again to 3.5 liters, tried to slow the resident's breathing by breathing with him/her. The note indicated the resident seemed anxious, unable to slow breathing, tried breathing through a straw, and unable to follow the nurse's directions. The note indicated the resident had no anxiety medications. The note indicated the resident's blood pressure was 138/72, heart rate 42 beats per minute, oxygen saturation 73% and starting to fall. The note indicated the nurse called the physician and received order to send the resident to the (ER) emergency room.</p> <p>The 9/28/16 at 11:30 AM, emergency room nursing assessment indicated the resident arrived at the ER by ambulance with severe tachypnea (abnormally rapid breathing. In adult humans at rest, any rate between 12-20 breaths per minute is normal) at 50 breaths per minute, on 15 liters of oxygen by (NRB) non-rebreather (device used in medicine to assist in the delivery of oxygen therapy. An NRB requires that the patient can breathe unassisted, but unlike low flow nasal canula, the NRB allows for the delivery of higher concentrations of oxygen) mask. The resident's oxygen saturation was 93%, and the resident had a productive cough with green/yellow/red mucus, fever, chest pain, sore throat, headache, lungs had wheezes, used his/her accessory muscles to breathe, and had a heart rate of 128 beats per minute. The assessment indicated hospital staff obtained a urinalysis and chest x-ray. The assessment indicated the resident's diagnosis was urosepsis (secondary infection and a form of</p> | F 309 | | | |

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| F 309 | <p>Continued From page 17</p> <p>sepsis that initially developed in the urinary tract) / (UTI) urinary tract infection (An infection of the kidney (bean shaped organ which filters the blood), ureter (the duct by which urine passes from the kidney to the bladder), bladder(organ that collects urine), or urethra (tube that allows urine to pass out of the body)/sepsis (a life-threatening bacterial infection of the blood). The assessment indicated the local hospital transferred the resident to a regional hospital.</p> <p>On 10/13/16 at 10:30 AM, Nurse Aide A stated he/she was working on 9/28/16 and he/she thought the facility should have sent the resident to the hospital sooner.</p> <p>On 10/12/16 at 11:01 AM, Nurse B stated he/she was the nurse on duty on 9/28/16 and about 8:30 AM the resident put his/her call light on and reported his/her hands hurt, requested something for the pain, and he/she placed a warm towel on the resident's hands. Nurse B told the resident he/she would tell the (CMA) Certified Medication Aide to administer the resident's scheduled pain medication. Nurse B stated he/she meant to go back and check on the resident in about 10 minutes, but it was approximately 20 minutes before he/she returned to the resident's room, and the resident was asleep. Nurse B stated about 9:30 AM, a nurse aide came and told him/her the resident said he/she could not breathe. When he/she arrived the resident had his/her oxygen kinked on the oxygen concentrator, and his/her oxygen saturation was 89%. Nurse B stated once he/she unkinked the tubing the resident's oxygen saturation went up and the resident was breathing fine and he/she left the room. Nurse B stated at 10:15 AM an aide came and told him/her the resident was having</p> | F 309 | | | |

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| F 309 | <p>Continued From page 18</p> <p>trouble breathing, and when he/she arrived in the resident's room he/she was hyperventilating and kept saying he/she could not stop breathing fast. Nurse B stated he/she could not get the resident to stop hyperventilating, checked the resident's oxygen saturation and it was 54%. The resident couldn't get settled down, but his/her oxygen saturation did come up to 73%. Nurse B stated he/she was getting alarmed, but figured the resident was just mad at him/her for getting him/her in the shower earlier that morning, because that was the kind of thing the resident would do when he/she was mad at staff. Nurse B stated the resident had an as needed breathing treatment, but he/she did not give it to the resident because his/her lungs were clear. Nurse B stated the resident was having difficulty breathing, he/she told the aide to stay with the resident then went to call the physician and received an order to send the resident to the ER.</p> <p>On 10/13/16 at 2:55 PM, Administrative Nurse C stated on 9/27/16- 9/28/16 the resident had a change in condition and he/she expected the nurse to call the emergency room physician or notify the primary care physician immediately when the resident's heart rate was 130 bpm (the resident's heart rate was 130 bpm 16 1/4 hours prior to staff contacting the physician and transferring the resident to the emergency room). Administrative Nurse C stated there was a paper taped in the nurse's station, at the time of the resident's change in condition, stating parameters that the nurse should have followed, regarding when the nurse should call the physician. The paper stated the following: Resting pulses >110(bpm) beats per minute, <55 bpm, or 110 bpm and patient has dyspnea or palpitations</p> | F 309 | | | |

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| F 309 | <p>Continued From page 19</p> <p>Respirations > 24, <10/minute. (unless has diagnosis of (COPD) or normally has respirations of 24)</p> <p>Call the physician, to report the above DO not fax.</p> <p>On 10/13/16 at 5:17 PM, Nurse D stated he/she was the nurse on duty in the hospital ER room on 9/28/16, when the resident was brought in by ambulance. Nurse D stated when the resident arrived at the ER he/she was lethargic (fell asleep while talking to the nurse), and in pretty serious shape. Nurse D stated the resident was on 15 liters of oxygen by nonrebreather mask and the resident's oxygen saturation was 91-92%. Nurse D stated generally when a person was on 15 liters with a nonrebreather mask, their oxygen saturation would be 99-100%. Nurse D stated the resident's respirations were 36, blood pressure was 92/66, and the resident's heart rate was tachycardic (a heart rate that exceeds the normal resting rate of 100 beats per minute) at 132 bpm. Nurse D stated he/she called the facility to ask what had been going on prior to the resident being brought to the ER.</p> <p>On 10/17/16 at 10:15 AM, Nurse Practitioner E stated he/she expected the staff to call the physician right away when the resident continued to have a decline in oxygen saturation requiring need for increased oxygen. Nurse Practitioner E stated the resident's outcome would have been different if the facility had sent the resident to the hospital sooner.</p> <p>The facility's 4/2011 Change in a Resident's Condition or Status policy stated the nurse supervisor/charge nurse will notify the resident's attending physician or on call physician when</p> | F 309 | | | |

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| F 309 | <p>Continued From page 20</p> <p>there was a significant change in the resident's physical/emotional/mental condition or need to transfer the resident to a hospital/treatment center.</p> <p>The facility's 4/2007 Measuring Respirations policy stated the following abnormal respirations should be promptly reported to the nurse supervisor when a resident had the following:</p> <p>Shallow respirations (breathes with only the upper part of the lungs). Abdominal respirations (breathing comes mostly from the stomach muscles). Irregular respirations (the resident's breathing changes and the rate of the rise and fall of the chest is irregular(not steady).The policy stated normal respirations for an adult is from 12 to 18 bpm. Stertorous respirations (noisy).</p> <p>The facility failed to adequately monitor and accurately assess the respiratory status for Resident #1, who had significant respiratory distress without physician notification over a span of 2 days.</p> <p>The facility's failure to adequately monitor, thoroughly assess, provide consistent interventions and to promptly obtain medical intervention placed Resident #1 in immediate jeopardy.</p> <p>The immediate jeopardy was abated on 10/18/16, when the facility implemented inservice education to staff regarding physical assessment of the resident, facility's policy for notification of change in condition, and notifying the nurse of a change in resident condition.</p> | F 309 | | | |

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