

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155166	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/04/2015
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NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00180845, IN00180963, IN00181057, IN00181176, IN00181528, and IN00181621.</p> <p>Complaint IN00180845-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00180963-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00181057-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00181176-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00181528-Substantiated. Federal/State deficiencies related to the allegations are cited at F224, F226, and F328.</p> <p>Complaint IN00181621-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: September 1, 2, 3, and 4,</p>	F 0000	<p><b>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</b></p>	

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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2015	<p>Facility number: 000083 Provider number: 155166 AIM number: 100289670</p> <p>Census bed type: SNF/NF: 133 Total: 133</p> <p>Census payor type: Medicare: 14 Medicaid: 107 Other: 12 Total: 133</p> <p>Sample: 17 Supplemental sample: 1</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on September 13, 2015.</p>			

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F 0224 SS=D Bldg. 00	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was free from misappropriation of resident property, related to a medication used for someone other than the resident whose name was on the label, for 1 resident in a supplemental sample of 1. (Resident #V and RN #5)</p> <p>Finding includes:</p> <p>During an observation on 09/04/15 at 10:53 a.m., RN #5 was observed removing medication from a resident's medication card obtained from the East Front Medication Cart, which was located in front the East Unit Nurses' Station. RN #5 closed the drawer of the Medication Cart, locked the cart and walked into a small room where the time clock was located and used the time</p>	F 0224	<p><b>F224 – Mistreatment/Neglect/Misappropriation</b></p> <p>It is the practice of this provider to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>The medication that was pulled from Resident V's medication card as pointed out by the Surveyor was replaced by the facility.</li> <li>RN #5 is no longer</li> </ul>	10/04/2015

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	<p>clock.</p> <p>During an interview after RN #5 used the time clock, RN #5 indicated the medication pulled from the resident's medication card was Excedrin. RN #5 indicated she had a head-ache and had been at the facility since 11 p.m. and she removed two white pills from her front uniform pocket. RN #5 stated, "I can replace them." RN #5 indicated the two white pills had been removed from Resident #V's medication card.</p> <p>RN #5 then went to the Medication Cart and removed Resident #V's medication card, the label on the card indicated the medication was Excedrin XS. RN #5 indicated she was unsure what the facility policy was for taking medications for self use from a resident and again indicated she had this medication at home and would bring medication in from home to replace this medication.</p> <p>RN #5 then indicated this was misappropriation of resident's property and indicated it was not the policy of the facility to bring medications from home to replace the residents.</p> <p>Resident #V's record was reviewed on 09/04/15 at 11 a.m. The resident's diagnoses included, but was not limited</p>		<p>employed at the facility.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by this finding.</li> <li>· All resident medication cards were reconciled against the pharmacy delivery sheet and against each resident's MAR and physician's order to ensure all resident medications are present and accounted for.</li> <li>· ED/DNS/designee will be responsible for the Customer Care Program in which resident interviews are conducted weekly regarding care and services provided by staff.</li> <li>· All staff in-services will be conducted on or before 10/4/15. This in-service will review the facility Abuse Prohibition, Reporting and Investigation policy with a special emphasis on the definition of, as well as specific examples of, misappropriation of resident property.</li> <li>· Staff interviews will be conducted by the ED/designee at least weekly regarding Abuse Prohibition, Reporting and Investigation to ensure staff is</li> </ul>	

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	<p>to, stroke and chronic lower back pain.</p> <p>A Physician's Order, dated 11/25/14, indicated an order for Added Strength Headache Relief (aspirin-acetaminophen-caffeine) tablet 250-250-65 milligrams every 12 hours as needed for migraine.</p> <p>This Federal Tag relates to complaint IN00181528.</p> <p>3.1-28(a)</p>		<p>aware of and can accurately state examples of all types of abuse including misappropriation of resident property.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· The ED/DNS/designee will be responsible for the Customer Care Program in which resident interviews are conducted weekly regarding care and services provided by staff.</li> <li>· All staff in-services will be conducted on or before 10/4/15. This in-service will review the facility Abuse Prohibition, Reporting and Investigation policy with a special emphasis on the definition of, as well as specific examples of, misappropriation of resident property.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:</b></p> <ul style="list-style-type: none"> <li>· Ongoing compliance with this corrective action will be monitored through the facility CQI program.</li> <li>· Staff interviews will be conducted by the ED/designee at</li> </ul>	

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F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure the facility's abuse policy was followed, related to misappropriation of resident's property for 1 of 1 residents in a supplemental sample of 1. (Resident #V	F 0226	least weekly regarding Abuse Prohibition, Reporting and Investigation to ensure staff is aware of and can accurately state examples of all types of abuse including misappropriation of resident property.  · The ED/DNS/designee will be responsible for completing the CQI Audit Tool titled, "Abuse Prohibition and Investigation" weekly for 3 weeks and monthly for 6 months.  · If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.  <b>By what date the systemic changes will be completed:</b>  Compliance Date = 10/4/15.  <b>F226 – Develop/Implement Abuse/Neglect, etc. Policies</b>  It is the practice of this provider to develop and implement written policies and procedures that	10/04/2015	

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	<p>and RN #5)</p> <p>Finding includes:</p> <p>During an observation on 09/04/15 at 10:53 a.m., RN #5 was observed removing medication from a resident's medication card obtained from the East Front Medication Cart, which was located in front the East Unit Nurses' Station. RN #5 closed the drawer of the Medication Cart, locked the cart and walked into a small room where the time clock was located and used the time clock.</p> <p>During an interview after RN #5 used the time clock, RN #5 indicated the medication pulled from the resident's medication card was Excedrin. RN #5 indicated she had a head-ache and had been at the facility since 11 p.m. and she removed two white pills from her front uniform pocket. RN #5 stated, "I can replace them." RN #5 indicated the two white pills had been removed from Resident #V's medication card.</p> <p>RN #5 then went to the Medication Cart and removed Resident #V's medication card, the label on the card indicated the medication was Excedrin XS. RN #5 indicated this was misappropriation of resident's property.</p>		<p>prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>· The medication that was pulled from Resident V's medication card as pointed out by the Surveyor was replaced by the facility.</li> <li>· RN #5 is no longer employed at the facility.</li> </ul> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by this finding.</li> <li>· All resident medication cards were reconciled against the pharmacy delivery sheet and against each resident's MAR and physician's order to ensure all resident medications are present and accounted for.</li> <li>· ED/DNS/designee will be responsible for the Customer Care Program in which resident interviews are conducted weekly</li> </ul>	

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	<p>Resident #V's record was reviewed on 09/04/15 at 11 a.m. The resident's diagnoses included, but was not limited to, stroke and chronic lower back pain.</p> <p>A Physician's Order, dated 11/25/14, indicated an order for Added Strength Headache Relief (aspirin-acetaminophen-caffeine) tablet 250-250-65 milligrams every 12 hours as needed for migraine.</p> <p>A facility policy, dated 07/15, titled, "Abuse Prohibition, Reporting, and Investigation", received from the Administrator as current, indicated, "...to protect residents from abuse including...misappropriation of resident property...Abuse is the will...Misappropriation of Resident Funds or Property-the deliberate...use of a resident's belongings or money without the resident's consent...Includes any medication dispensed in the name of a resident...will not permit residents to be subjected to abuse by anyone, including employees..."</p> <p>This Federal Tag relates to complaint IN00181528.</p> <p>3.1-28(a)</p>		<p>regarding care and services provided by staff.</p> <ul style="list-style-type: none"> <li>All staff in-services will be conducted on or before 10/4/15. This in-service will review the facility Abuse Prohibition, Reporting and Investigation policy with a special emphasis on the definition of, as well as specific examples of, misappropriation of resident property.</li> <li>Staff interviews will be conducted at least weekly by the ED/designee regarding Abuse Prohibition, Reporting and Investigation to ensure staff are aware of and can accurately state examples of all types of abuse including misappropriation of resident property.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>The ED/DNS/designee will be responsible for the Customer Care Program in which resident interviews are conducted weekly regarding care and services provided by staff.</li> <li>All staff in-services will be conducted on or before 10/4/15. This in-service will review the facility Abuse Prohibition, Reporting and Investigation policy with a special emphasis on the</li> </ul>		

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			<p>definition of, as well as specific examples of, misappropriation of resident property.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:</b></p> <ul style="list-style-type: none"> <li>· Ongoing compliance with this corrective action will be monitored through the facility CQI program.</li> <li>· Staff interviews will be conducted at least weekly by the ED/designee regarding Abuse Prohibition, Reporting and Investigation to ensure staff are aware of, and can accurately state examples of, all types of abuse including misappropriation of resident property.</li> <li>· The ED/DNS/designee will be responsible for completing the CQI Audit Tool titled, "Abuse Prohibition and Investigation" weekly for 3 weeks and monthly for 6 months.</li> <li>· If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</li> </ul> <p><b>By what date the systemic changes will be completed:</b></p>	

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F 0328 SS=G Bldg. 00	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents' were administered oxygen as ordered by the Physicians' and were thoroughly assessed for the need for oxygen, related to discontinuing a resident's oxygen without a Physician's order and not assessing the oxygen saturation levels after the discontinuation. The resident had also been prescribed morphine (narcotic pain medication), the resident's oxygen levels decreased, the resident was transferred to the hospital and required intubation (Resident #R) and a resident's oxygen was not administered on the correct flow rate (Resident #U), for 2 of 3 residents reviewed for oxygen in a total sample of 17. (Resident #R and #U)</p> <p>Findings include:</p>	F 0328	<p>Compliance Date = 10/4/15.</p> <p><b>F328 – Treatment/Care for Special Needs</b></p> <p>It is the practice of this provider to ensure that residents receive proper treatment and care for special services.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>· All residents with orders for oxygen administration are receiving assessments for the ongoing need for oxygen and are receiving follow up assessments and measurement of oxygen saturation levels when orders for oxygen are discontinued.</p>	10/04/2015			

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	<p>1. Resident #R's record was reviewed on 09/02/15 at 2:24 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), right lower lobe pneumonia, rheumatoid arthritis, and dementia. The resident had been admitted into the facility on 03/27/15.</p> <p>The Hospital Transfer Orders, dated 03/27/15, included the diagnosis of community acquired pneumonia and an order for oxygen at 2 liters (2 L).</p> <p>The Physician's Recapulation Orders, dated 03/27/15 through 04/01/15, indicated the following oxygen orders:</p> <p>03/28/15-Oxygen at 2 lpm (liters per minute) per nasal cannula as needed (discontinued on 03/28/15)</p> <p>03/28/15-Oxygen at 2 lpm as needed every 12 hours (discontinued on 03/30/15)</p> <p>03/30/15-Oxygen at 2 lpm per nasal cannula as needed twice a day (discontinued on 03/30/15)</p> <p>03/30/15-Oxygen at 2 liters per nasal cannula. May titrate to keep sats (oxygen saturation levels) &gt;92% (above 92%)</p>		<ul style="list-style-type: none"> <li>· All residents with oxygen administration orders are receiving the correct flow rate per physician's order.</li> </ul> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>· <b>All resident orders will be reviewed.</b> Any resident requiring special services such as respiratory care or administration of oxygen will be identified and reviewed by the Nurse Management Team.</li> <li>· This review will ensure that physician's orders match the necessary treatment and that any needed assessments, physician notification, follow up oxygen saturation levels and documentation and care plans are completed and updated as required.</li> <li>· Any resident with orders for oxygen administration will be reviewed by the Nurse Management Team to ensure that oxygen is being administered on the correct flow rate per physician's order and that all physicians' orders related to oxygen use and respiratory care are being followed.</li> </ul>	

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	<p>every shift (discontinued on 04/01/15 at discharge)</p> <p>03/28/15-Oxygen sats bi-monthly as needed (discontinued on 03/30/15)</p> <p>03/28/15-Oxygen sats as needed (discontinued on 03/30/15)</p> <p>03/30/15-Oxygen sats bi-monthly on the first and fifteenth of the month.</p> <p>A Physician's Order, dated 03/29/15, indicated morphine extended release, 60 mg (milligrams) every eight hours.</p> <p>A Professional Resource, titled, "Nursing 2014 Drug Handbook", page 951-954, reviewed on 09/03/15 at 7 p.m., indicated, "...morphine sulfate...adverse reactions...respiratory depression..."</p> <p>A Respiratory Therapy Evaluation, dated 03/27/15, indicated the resident had decreased breath sounds in all lobes of the lungs with wheezing in the lower lobes, had an oxygen saturation of 93% on room air and had an order for oxygen at 2 lpm by nasal cannula.</p> <p>The Ventilator Flowsheet (oxygen monitoring form by Respiratory Therapy), dated 03/15, indicated the resident had oxygen at 2 liters</p>		<p><b>Any new admission, re-admission and/or new orders for oxygen therapy have been reviewed by the DNS/Nurse Management Team to ensure accuracy.</b></p> <p><b>Physician's Orders are reviewed and audited daily by the DNS/designee. New admissions and re-admissions orders are reviewed the next business day by the IDT. All residents with new orders for respiratory care, oxygen or changes in oxygen therapy are reviewed daily by the IDT.</b></p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>All nursing staff will be in-serviced on or before 10/4/15. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to treatment and care of residents receiving oxygen or respiratory therapy services as well as follow up assessments related to oxygen saturation levels when oxygen administration orders are changed or when oxygen is initiated or discontinued.</p> <p>The DNS and/or designee, Charge Nurses, Respiratory Therapist and/or Weekend Nurse</p>	

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	<p>continuously on March 27, 28, and 29, 2015. The oxygen saturation was assessed on 03/30/15 in the morning (no actual time documented) and was 96% (required by order to be above 92%). There were no further initials to indicate the oxygen was continued on 03/30/15 after the oxygen saturation level was obtained. There were no results of an oxygen saturation assessment being completed after the morning of March 29, 2015.</p> <p>An Oxygen Rounds form, dated 03/30/15, no time documented indicated the resident's oxygen was pulled (discontinued) and the Nurse was notified.</p> <p>There was no Nurses' Progress Notes to indicated the resident's Physician had been notified for an order to discontinue the oxygen.</p> <p>There was no Physician's Order to indicated the oxygen had been discontinued by the Physician.</p> <p>The Medication Administration Record, dated 03/15, indicated by initials the resident had received the morphine 60 mg on 03/30/15 and 03/31/15 at 1 a.m., 9 a.m., and 5 p.m.</p>		<p>Manager will be responsible for ensuring that any new orders or changes in oxygen administration or respiratory therapy orders as well as initiation or discontinuation of oxygen or respiratory therapy orders have appropriate follow up documentation and assessments per physician's order.</p> <ul style="list-style-type: none"> <li>· The DNS and/or designee, Charge Nurses and/or Weekend Nurse Manager will be responsible for inspections of all resident rooms and oxygen equipment to ensure oxygen and respiratory therapy care and services are being administered per physician's order.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:</b></p> <ul style="list-style-type: none"> <li>· Ongoing compliance with this corrective action will be monitored through the facility CQI program.</li> <li>· The DNS/designee will be responsible for completing the CQI Audit Tool: "Oxygen Therapy" weekly for 6 months.</li> <li>· If threshold of 90% is not met, an action plan will be developed.</li> <li>· Findings will be submitted</li> </ul>	

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	<p>The Nurses' Progress Notes indicated: A Nurses' Progress note, dated 03/28/15 at 4:36 a.m., indicated, lung sounds diminished in the bases of the lungs.</p> <p>A 72-hour Admission Shift Charting, dated 03/30/15 at 3:04 p.m., indicated no oxygen had been used.</p> <p>The Nurses' Progress Notes indicated: 03/31/15 at 8:36 a.m., head of the bed is elevated to prevent shortness of breath while lying flat due to COPD. 03/31/15 at 2:15 p.m.-Family was concerned due to the resident was usually more awake and had been informed by the staff the resident had been up all day and when transferred to bed the resident had been yelling. 03/31/15 at 10:12 p.m.-No adverse reaction to the morphine. 04/01/15 at 7:35 a.m.-No adverse reaction to the morphine. 04/01/15 at 9:25 a.m.-The resident was observed in distress and was pale. The Respiratory Therapist was called to the room and the resident's oxygen saturation was 72% (the oxygen had been pulled by the RT on 03/30/15), a non-rebreather mask had been initiated and oxygen was administered at 15 liters and the resident was transferred by ambulance to the Emergency Room. 04/01/15 at 3:04 p.m.-The resident had been admitted into the hospital with</p>		<p>to the CQI Committee for review and follow up.</p> <p><b>By what date the systemic changes will be completed:</b></p> <p>Compliance Date = 10/4/15.</p>	

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	<p>respiratory distress and had been intubated.</p> <p>The Emergency Room Notes, dated 04/01/15, indicated the resident's diagnoses included, but were not limited to, acute respiratory failure and pneumonia.</p> <p>A Physician's Consultant History and Physical, dated 04/02/15, indicated, "...family suggested that overnight.. was without his oxygen and this morning... was found unresponsive in respiratory distress...confirmed acute hypoxic respiratory failure, was intubated and placed on mechanical ventilator..."</p> <p>The Hospital Discharge Summary, dated 04/04/15, indicated, "...Bilateral lung infiltrates. Healthcare-associated pneumonia...Acute respiratory failure...hypoxic and was brought to the emergency room...In the ER he was in respiratory failure and was intubated..."</p> <p>During an interview on 09/02/15 at 4:05 p.m., LPN #1 indicated she had not taken care of the resident prior to 04/01/15 and when she went into the resident's room she found the resident in distress.</p> <p>During an interview on 09/02/15 at 4:21 p.m., RT (Respiratory Therapist) #2</p>			

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	<p>indicated when Resident #R arrived at the facility there had been no oxygen being administered and the resident's oxygen saturation was 93% and applied oxygen on the resident at 2 liters due to the Physician's Order for oxygen at 2 liters.</p> <p>During an interview on 09/02/15 at 4:21 p.m. the Medical Records Nurse, indicated all the changes in the oxygen orders were clarification of the orders and the original order should have been written as oxygen at 2 liters per nasal cannula. May titrate to keep sats &gt;92%.</p> <p>During an interview on 09/03/15 at 8:05 a.m., the RT Supervisor indicated RT #3 had discontinued the oxygen because the oxygen saturation was 96% on room air. She indicated RT #3 had notified the Nurse, because the RT's were not allowed to obtain the orders. The RT Supervisor indicated the resident's Physician would have needed to be called for the order to discontinue the oxygen. She indicated Respiratory Therapy did not have a protocol on checking the resident's oxygen saturations and they, "spot check" to see how the resident was doing. She indicated there had not been an assessment with the discontinuation of the oxygen and there was not a policy to complete an assessment with the discontinuation of oxygen.</p>			

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	<p>During an interview with the RN Corporate Consultant and the West Unit Manager on 09/03/15 at 10:37 a.m., the RN Corporate Consultant indicated there should have been a documented assessment and oxygen saturations completed. The West Unit Manager indicated the oxygen saturations should have been assessed with the discontinuation of the oxygen and there had been none documented after the oxygen had been discontinued. The West Unit Manager indicated there had been no order received from the Physician to discontinue the oxygen. She indicated LPN #1 had been assigned to the resident on 03/30/15 and should have been the Nurse to notify the Physician for a discontinuation order.</p> <p>During an interview on 09/04/15 at 8:13 a.m., the RN Corporate Consultant indicated the facility did not have a policy on weaning a resident off oxygen.</p> <p>During an interview on 09/04/15 at 10:17 a.m., RT #3 indicated she could not remember what Nurse she talked to when she discontinued the oxygen.</p> <p>2. Resident #U was observed on 09/03/15 at 8:03 a.m. and 09/04/15 at 9:21 a.m. The resident's oxygen was being</p>			

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	<p>administered at 2.5 liters per nasal cannula.</p> <p>During an interview on 09/04/21 at 9:21 a.m., LPN #4 indicated the resident's oxygen was set at 2.5 liters and the Physician's Order was for 3 liters per nasal cannula.</p> <p>Resident #U's record was reviewed on 09/04/15 at 9:25 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and fractured femur.</p> <p>A Physician's Order, dated 05/29/15, indicated oxygen at 3 liters per nasal cannula continuously.</p> <p>A care plan, dated 05/29/15, indicated the resident had a potential of impaired gas exchange related to congestive heart failure. The approaches included, administer oxygen as indicated.</p> <p>An undated facility policy, received from the RN Corporate Consultant as current on 09/04/15 at 8:13 a.m., titled, "Oxygen Therapy and Devices", indicated, "...Oxygen is a drug which must be ordered by a physician...Apply device to the patient with appropriate liter flow..."</p> <p>This Federal Tag relates to complaint</p>			

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

PRINTED: 10/06/2015

FORM APPROVED

OMB NO. 0938-0391

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