STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00413639. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00413639 - Federal deficiencies related to the allegations are cited at F695. Survey dates: August 1, 2, 3, and 4, 2023 Facility number: 000128 Provider number: 155223 AIM number: 100289650 Census Bed Type: SNF/NF: 101 Total: 101 Census Payor Type: Medicare: 6 Medicaid: 43 Other: 52 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 10, 2023.	F 0000		
F 0695 SS=J Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 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,			

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

Jerod Williams 08/22/2023

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	is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure a resident's bilevel positive airway pressure (BIPAP) equipment (machine used to provide assistance during inspiration and expiration) was implemented upon hospital discharge, and failed to assess the resident's change in condition after not receiving a BIPAP for 3 days for 1 of 4 residents reviewed for quality of care (Residents B). Based on observation, record review, and interview, the facility failed to ensure a resident with a continuous positive airway pressure (CPAP) machine had physician orders and a plan of care for the CPAP machine for 1 of 4 residents reviewed for quality of care (Resident E). The immediate jeopardy began on 7/21/23 when Resident B returned from the hospital with orders for the resident to wear a BIPAP after the resident was in the intensive care unit (ICU) due to hypercapnia (elevated carbon dioxide [CO2] levels) on 7/17/23 requiring treatment with a BIPAP machine. The resident's BIPAP was not unboxed or set up until 7/24/23. The resident was lethargic on 7/24/23 and 7/25/23. No follow-up or physician notification on the resident's change in condition or follow-up related to the 3 days without the BIPAP were completed. The resident died on 7/26/23. The Administrator was notified of the immediate jeopardy at 4:04 p.m. on 8/2/23. The immediate jeopardy was removed on 8/4/23, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not	F 0695	**F-695 – Respiratory Care** Disclaimer Statement: The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegation in the notification of Immediate Jeopardy. The facility is completing the allegation of compliance because it is required by state and federal law. The facility disagrees with and disputes the alleged deficiency as stated in the notification of immediate jeopardy at the scope and severity at which they are cited. Further, the facility disputes and disagrees with the accuracy of statements and other information relied upon in support of the alleged deficiencies. This includes, but is not limited to, the alleged content/summary of interviews, the chronological timing sequencies of events and contact with healthcare professionals, and the description of the care and supervision provided to residents. The facility reserves it's right to continue disputing, appealing, and contesting these alleged	08/07/2023

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	immediate jeopardy. Findings include: 1. During an interview on 8/1/23 at 9:16 a.m., Family Member 2 indicated Resident B was in the hospital from 7/5/23 to 7/13/23 with diagnoses of high CO2 levels of 99 milliequivalents per liter (mEq/L) (normal range is 23 to 30 mEq/L). The resident was placed in the ICU where she was put on a BIPAP machine to "blow off" the CO2. The resident discharged to the nursing facility on 7/13/23. On 7/17/23 Resident B was sent back to the hospital and again diagnosed with high CO2 levels and was placed on BIPAP in the ICU. When the resident went back to the facility on 7/21/23 she had orders to have a BIPAP at the skilled nursing facility. Family visited on 7/24/23 and found the BIPAP still in the plastic wrap in the box sitting on the bedside stand. The facility never took the machine out of the original package. Staff told family they had no idea she needed the BIPAP and indicated they had no orders from the hospital. The resident became lethargic, unresponsive, and subsequently died. Nursing staff should have known to call and clarify with the hospital or the physician if they were not sure of the resident's orders. During an interview on 8/1/23 at 9:16 a.m., Family Member 1 indicated when they visited Resident B on 7/24/23 around noon, the resident was found to be lethargic, slow to respond, and was not wearing her BIPAP. Family Member 1 found the BIPAP in the box in the resident's room. Family Member 1 unpackaged the BIPAP, set it up, and put it on Resident B. The facility staff had no answers for their lack of actions in implementing the BIPAP. There was a therapist, an aide, and Resident B in the room when Family Member 1		deficiencies and any action related to and arising therefrom in any other forum as needed. **Residents Affected-** **What corrective actions will be accomplished for residents found to have been affected by the deficient practice—** 1. Resident expired on 7/26/23, therefore, no corrective action could be taken for identified resident. 2. At the time of survey, CPAP settings for Resident E were obtained, physician was notified of the settings, and physician gave the order for use of the CPAP on 8/4/23. Resident E's CPAP use was added to the care plan on 8/2/23. **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken-** An audit was conducted by the Director of Nursing (DON) on August 2, 2023, to identify residents with respiratory orders. Identified residents have been reviewed to ensure they have the required equipment, medication, and assessments, as ordered. Any discrepancies were corrected at the time of the audit.	

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	spoke with the Administrator about having to set up the BIPAP. Resident B had been back from the hospital for 3 days. Family Member 1 should not have had to set the BIPAP up. On 7/26/23 at 1:11 a.m. (family lived out of state in a time zone 1 hour behind the facility) they received a call Resident B had died. The nursing facility completely ignored Resident B's care. The facility knew the resident was retaining CO2 and had 2 hospital stays in July due to high CO2. The facility should have been monitoring and treating her condition. Family Member 1 was so upset they texted Family Member 2 and provided a screen shot of the text message with a time stamp. Screen shot of text, dated 7/24/23 at 11:44 a.m., indicated: Family Member 1: "very lethargic, not very responsive. Opens her eyes and grins and back shut again. The CPAP [sic] machine had never been opened and put on her. She's been back here for three nights." Family Member 2: "Oh. Did you ask them why?" Family Member 1: "They had no idea she was supposed to have it on" Family Member 2: "Why" Family Member 1: "No communication at this place or from doctor at [hospital name]" Resident B's record was reviewed on 8/1/23 at 9:25 a.m. Diagnoses on Resident B's profile included but were not limited to chronic obstructive pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed airflow from the lungs), and respiratory failure (serious condition that makes it difficult to breath on one's own when the lungs can't get enough oxygen into the blood). Hospital records, dated 7/5/23 to 7/12/23,		Residents with respiratory orders were assessed by the DON on August 2, 2023, to ensure appropriate orders and treatments were in place. Any identified concerns were addressed and corrected at the time of assessment. Further, a 60 day “look back” audit was done by the DON on August 2, 2023, to detect any condition changes in the residents identified. **Training** **What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur—** All licensed nursing staff have been in-serviced by the DON/ADON/Designee on August 2, 2023, and August 3, 2023, on re-admission procedure, assessing for respiratory symptoms and change of condition, following physician orders, and notifying the physician of missing orders, staff cannot work until such in-servicing is completed. All QMAs and CNAs have been in-serviced by the DON/ADON/Designee on August 2, 2023, and August 3, 2023, on	

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	indicated Resident B presented to the emergency department (ED) with respiratory distress, oxygen saturations 60% on room air (normal 95 - 100%), she was placed on high flow oxygen at 10 L. ABG's (arterial blood gas analysis measuring the balance of oxygen and carbon dioxide in the blood to see how well the lungs are working) on arrival notable PCO2 (Partial pressure of carbon dioxide in arterial blood) at 99 millimeters of mercury (mmHg) (normal range is 35 to 45 mmHg) and PO2 (partial pressure of oxygen) at 69 mmHg (normal range 75-100 mm Hg) indicating high levels of carbon dioxide and low levels of oxygen in the resident's blood. Resident was placed on BIPAP and put in ICU for advanced care and further monitoring. Diagnoses during the admission included exacerbation COPD, encephalopathy (brain disease that alters brain function and structure), and acute hypercapnia respiratory failure (an increase in arterial carbon dioxide due to respiratory failure or increased CO2 production, treated by wearing a CPAP or BIPAP machine). A progress note, dated 7/15/23 at 9:19 a.m., indicated the resident was able to make needs and wants known. Resident transferred with the assist of one staff. A progress note, dated 7/16/23 at 3:11 a.m., indicated the resident was alert and oriented to self with confusion. Able to voice needs, ambulates with standby assistance. A progress note, dated 7/17/23 at 4:22 p.m., resident had an episode of choking at lunch today, was able to clear airway on her own. Resident heart rate at this time was 105 (normal 60 - 100) beats per minute. A few hours later resident found to have heart rate of 115, and shallow respirations. Resident transferred to nearby		respiratory symptoms and notifying the licensed nurses of any resident change of condition and cannot work until such in-servicing is completed. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined, as necessary. Knowledge was measured by a POST TEST that required 100% accuracy of answers to “pass.” No licensed nursing staff, to include newly hired staff, agency staff, staff on leave, PRN staff or any other licensed nursing staff will work until they successfully complete the in-service and pass the test. **Monitoring-** **How the corrective actions will be monitored to be sure the deficient practice does not recur—i.e., what quality assurance program will be put into place and by what date the systemic changes for each deficiency will be completed—** DON/Designee, daily on scheduled days of work, will audit at least 5 random residents who have respiratory orders for 8 weeks to ensure compliance with required equipment, medication, and assessments; and will assess	

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	hospital for evaluation and treatment, she was admitted. Hospital records, dated 7/17/23 to 7/21/23, indicated Resident B presented to the ED with respiratory distress, her CO2 level was 138, she was immediately put on a BIPAP and admitted to ICU. Resident was not responding to any stimuli upon arrival. Admitting diagnosis was chronic respiratory failure with hypoxia and hypercapnia. A Discharge Summary from the hospital, dated 7/21/23, indicated three orders, a. Respiratory assistive device, Bi-level, pressure capability (BIPAP). Description: humidifier, heated, used with positive airway pressure device. Type of BIPAP: without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device). The instructions lacked documentation of frequency or times the BIPAP was to be worn. b. Amoxicillin-clavulanate (Augmentin an antibiotic) 875-125 milligrams (mg) give 1 tablet by mouth twice daily for 8 doses, for pneumonia caused by inhaling substance into the lungs. c. Anoro Ellipta 62.5-2.5 microgram (mcg) inhaler (non-steroidal medication used to treat COPD) give 1 puff by inhalation daily. An Admission/Re-Admission Screener, dated 7/21/23, indicated Resident B was admitted from the hospital for respiratory failure. The resident's respiration rhythm was irregular, and breath sounds diminished in the right and left upper and lower lungs. The resident was on a BIPAP, and oxygen per nasal cannula. A physician's order written by Registered Nurse (RN) 6, dated 7/21/23, indicated oxygen at 2 liters		for appropriate orders and treatment; then 3 random residents weekly for 4 months. Any concerns will be immediately addressed and corrected. Results will be further reviewed in QAPI, and an action plan may be established as a result of trends. Any action plan will be monitored by the Administrator weekly until resolved. DON/Designee, daily, on scheduled days of work, ongoing, during morning clinical meeting, will audit the charts of any new admissions, or re-admissions, since the previous meeting, 5 times a week for 8 weeks, then weekly for 4 months, to ensure physician orders are correctly transcribed and followed. Any concerns will be immediately addressed and corrected. Results will be further reviewed in QAPI, and an action plan may be established as a result of trends. Any action plan will be monitored by the Administrator weekly until resolved. These reviews will be conducted for a minimum of 6 months as a part of the morning clinical meeting process and will continue to be ongoing after the 6 months. DON/Designee, daily, on scheduled days of work, ongoing, during morning clinical meeting,	

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	(L) per nasal cannula continuously for shortness of breath. A physician's order written by the Director of Nursing (DON), dated 7/21/23, indicated BIPAP at bedtime related to respiratory failure, unspecified with hypoxia (deficiency in the amount of oxygen reaching the tissues in the body). BIPAP settings: ST (spontaneous time) 15, IPAP (inspiratory pressure) 5, (optimal level is 4, with maximum 10, the higher level will help the lungs inflate to a larger volume and help with the clearance of CO2), EPAP (expiratory pressure) 28%. A physician's order, dated 7/21/23, indicated BIPAP every shift related to respiratory failure, unspecified with hypoxia. Resident to wear BIPAP at all times while sleeping day and night. BIPAP settings: ST 15, IPAP 5, (EPAP expiratory pressure) 28%. A Medication Administration Record (MAR), dated July 2023, indicated Registered Nurse (RN) 10 signed as having put the BIPAP machine on the resident on 7/21/23, 7/22/23, and 7/23/23. In a progress notes, dated 7/21/23 at 3:20 p.m., RN 6 documented report received from local hospital, Resident B was to return to the facility, after being admitted to the hospital on 7/17/2023 for respiratory failure and aspiration pneumonia. Resident was currently on oral antibiotics, and she was using a BIPAP along with 2 L O2 per nasal cannula (NC). The resident was a 1 assist with transfers, and currently in route per facility van. A progress note, dated 7/21/23 at 6:40 p.m., RN 6 documented resident arrived at approximately 4:30 p.m. She had been in bed since her return,		will review the progress notes of all residents, to identify any respiratory symptoms, or other changes of condition. Any concerns will be immediately addressed and corrected. Results will be further reviewed in QAPI, and an action plan may be established as a result of trends. Any action plan will be monitored by the Administrator weekly until resolved. These reviews will be conducted for a minimum of 6 months as a part of the morning clinical meeting process and will continue to be ongoing after the 6 months. An AD HOC QAPI meeting was held August 3, 2023, conducted by Jerod Williams, HFA, at which time the IDT (Interdisciplinary Team) reviewed and discussed the AOC. Members of the IDT include—with respect to HIPAA: 1) Administrator 2) Director of Nursing 3) Assistant DON 4) Business Office Manger 5) MDS Coordinator 6) Social Services Director 7) Activities Director 8) Housekeeping/Laundry Supervisor 9) Maintenance Director 10) Rehab Director 11) RVP/RDO/RNC/MDS	

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	non-responsive to verbal and tactile stimulation. O2 in place per NC at 2 L, uses BIPAP at HS (bedtime). A progress note, dated 7/22/23 at 5:01 a.m., LPN 10 documented the resident's only medication was an inhaler. A care plan for Resident B, dated 7/24/23, indicated the resident required the use of BIPAP due to respiratory failure with hypoxia. The goal was for the resident to be regulated with use of the BIPAP. Interventions included ensure mask/cannula fit properly and was functioning properly, ensure that the pressure settings of the device reflected what was ordered, ensure the device was functioning properly and refer to care manual as needed, notify the physician of any changes, observed oxygen saturations and vital signs as needed, and observed for side effects (i.e., headache, skin irritation, stomach bloating, nasal congestion, runny nose, anxiety, and claustrophobia). A progress notes, dated 7/24/23 at 6:46 a.m., indicated the resident to be alert and oriented to person. Resident B transferred with the assist of 2 staff. The Medicare 5 day Minimum Data Set (MDS) assessment, completed on 7/25/23, assessed the resident as having had oxygen therapy before and after admission, no invasive respiratory equipment, and no respiratory therapy. A progress notes, dated 7/25/23 at 4:31 a.m., indicated resident alert and oriented to self. Assist of 1 staff for activities of daily living (ADL's, daily self-care activities) and 2 staff with transfers using a mechanical lift. Resident was quiet, did not eat		Consultant (may attend If present) 12) Pharmacy Consultant/Dietician (may attend if present) 13) Medical Director/Nurse Practitioner Daily, on scheduled days of work, QAPI meetings will be conducted to review audit results and develop action plans, as necessary, if trends are identified. Any concerns will be immediately addressed and corrected. Daily QAPI meetings will continue until the facility has been placed back into substantial compliance by IDOH. Thereafter, weekly QAPI meetings will be conducted to review audit results and develop action plans, as necessary, if trends are identified. Weekly QAPI meetings will continue for 6 months. Any concerns will be immediately addressed and corrected.	

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	any evening meal, and had been sleeping throughout night with BIPAP on. A progress notes, dated 7/25/23 7:49 a.m., indicated resident was alert and oriented to person. Transferred with the assist of 2 staff, and total assist with ADL's. A progress notes, dated 7/26/23 at 2:21 a.m., patient was checked on by nurse about 2:00 a.m. and found to be deceased. Resident record lacked documentation the physician was notified of the BIPAP not having been administered as ordered from 7/21/23 to 7/24/23 or the resident's declining condition. The record lacked documentation that follow up assessments of the resident were completed related to not having the BIPAP administer after being admitted with a history of high CO2 levels. During an interview, on 8/1/23 at 10:54 a.m., the Director of Nursing (DON) indicated, Resident B returned from the hospital on Friday 7/21/23 with orders for BIPAP at bedtime (HS). On Monday 7/24/23 the resident was not waking up during the day, so the DON changed the order for the resident to have BIPAP anytime she was in bed sleeping. DON indicated she had not been aware of the incident of family members being mad related to the BIPAP still being in the box when they visited, or that they had involved the Administrator in the incident, due to that being her day off. During an interview on 8/1/23 at 11:38 a.m., the Administrator indicated he had never spoke to Family Member 2, but he did remember a conversation with Family Member 1. The Administrator could not remember the timeline,			

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	but they spoke around noon one day, and had a good conversation. Family Member 1 informed him they had found the resident's BIPAP still in the box, and as the family member had set it up before they felt comfortable putting it together. The Administrator had not seen the BIPAP in the box. He went to see the nurse on the unit, Licensed Practical Nurse (LPN) 8, for clarification of the orders and was told the order read for the BIPAP to be worn at night. Then he went to the DON and had the order changed to be worn when in bed. As the resident was sleeping a lot of the time, it made sense to put it on thru the day and not just at bedtime. During a review of Resident B's record, on 8/1/23 at 2:35 p.m., with the Administrator, DON, and Regional Nurse Consultant, the DON indicated the resident was originally admitted to an area hospital on 7/5/23 and had orders for a BIPAP machine and oxygen while in ICU. Before being discharged the resident was on back to breathing on room air. The resident admitted to the nursing home on 7/13/23 with diagnoses of encephalopathy, and acute hypercapnia respiratory failure secondary to COPD exacerbation. Her only medication order at that time was an inhaler. On 7/17/23 the resident went back to the hospital due to tachycardia (high heart rate). The resident was alert, oriented and responsive when she left the facility. When Resident B reached the ED she was not responding to stimuli and was admitted with diagnoses of shortness of breath (SOB), possible aspiration pneumonia although an x-ray showed no infiltrates, and was ordered for antibiotic for empiric (based on experience and observation rather than on systemic logic) reasons. On 7/21/23 Resident B returned to the facility with orders for oxygen at 2 L, BIPAP, and inhaler, and antibiotics			

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	for empiric reasons. RN 6, the admitting nurse, indicated when the resident arrived at the facility, she got the BIPAP out of the medication room, and put it on the nurse's cart for the night nurse to put in room. The night nurse LPN 10 told the DON she could not remember if she set up the BIPAP or not. During an interview on 8/2/23 at 10:53 a.m., OTR (Occupational Therapist Registered) 7 indicated on 7/24/23 she had been in the room with Resident B to do her initial OT (occupational therapy) evaluation for the current visit, and during that time assisted to get her up in a chair for the family member to feed her. This was the last time she saw the resident awake. She did not awake the next day for therapy when checked on a few different times. On 7/24/23 Family Member 1 indicated they had taken the BIPAP out of the box and set it up. The family member was asking the OTR questions about the resident's BIPAP orders, and explained to OTR the resident's course of stay in the hospital and why the BIPAP machine was set up the way it was to lower the resident's CO2 levels. The OTR indicated she had never seen a BIPAP set up as this one and that questions about the BIPAP set up needed to be addressed by the nurse. But when LPN 8 was asked, she did not know the answers either. During an interview on 8/2/23 at 11:08 a.m., LPN 8 indicated she had a discussion with Resident B's family member on 7/2/423 about the BIPAP orders and she explained to them at that time the BIPAP orders were for hours of sleep at night. Family Member 1 told her the resident had not had the BIPAP on the night before, so he had set it up and put it on her. The Administrator spoke with the family about the BIPAP orders, and after their conversation the orders for the BIPAP were			

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	changed to have the resident wear anytime she was sleeping or in bed. On 7/24/23 the evening nurse LPN 12 had a hard time getting the BIPAP on the resident and had to get help from an agency nurse to put it on. LPN 8 indicated she had never seen the resident wearing the BIPAP until after the order was changed on 7/24/23. Upon review of the interdisciplinary team notes in Resident B's record, LPN 8 indicated there was no documentation the physician had seen the resident after her re-admission on 7/21/23, no documentation of the resident not getting her BIPAP per orders, no documentation the physician was made aware of the resident not getting her BIPAP per orders from 7/21 to 7/24, or how the resident tolerated always having the BIPAP on 7/25/23. LPN 8 indicated the physician visited residents in the facility on Thursdays, but at this time he was out of the country. During a phone interview, on 8/2/23 at 11:53 a.m., the primary care physician (PCP) indicated he routinely visited the facility in person weekly and was available via phone at any time to the staff for resident concerns. The resident was re-admitted to the facility on Friday 7/21/23 and expired Wednesday 7/26/23, he did not see her during that time. He did not receive a call from the facility regarding the resident not receiving her BIPAP per orders, or that she had a decline in condition during her stay. The resident had many co-morbidities that contributed to her death. He would have ordered BIPAP at night only for treatment of the exacerbation of COPD. To treat a diagnosis of acute hypercapnia respiratory failure possibly secondary to acute COPD exacerbation, he would have ordered the BIPAP full time to help reduce the CO2 levels. In his opinion the primary cause of death could have been related to the			

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	aspiration pneumonia which unfortunately happened and was being treated with antibiotics. But the buildup of CO2 from not having the BIPAP as ordered certainly could have contributed to her death. His question was if the resident still had above average CO2 levels before discharge from the hospital, why was the BIPAP ordered only for bedtime? Review of hospital discharge records available indicated there was no frequency documented for the BIPAP. The DON indicated she would contact the hospital for orders to clarify. During an interview on 8/2/23 at 12:25 p.m., Certified Nursing Aide (CNA) 13 indicated she had cared for Resident B during her stay. She was assigned to care for the resident on 7/24/23. She entered the room when Family Member 1 was visiting and indicated the resident's BIPAP had still been in the box, and the family member had set it up and put it on the resident. The resident was sleepier and "kind of nonresponsive" the last few days she was at the facility. She primarily worked day shift but at times would come in a 2:00 a.m. She had never seen Resident B wearing a BIPAP until the afternoon of 7/24/23. Attempts to contact LPN 10 multiple times during the survey were unsuccessful. During an interview on 8/2/23 at 12:49 a.m., RN 6 indicated on 7/21/23 she had worked a 2:00 p.m. to 6:00 p.m. shift. RN 6 had taken report from a hospital nurse and was told the resident would return with orders to have oxygen and BIPAP at night. RN 6 indicated she took the boxed BIPAP machine out of the mediation room and sat it on the mediation cart inside the nurse's station for the on-coming nurse LPN 10 to find and apply as ordered. Before leaving RN 6 gave report to LPN			

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	10. RN 6 indicated, the hospital had faxed Resident B's orders to include the BIPAP ahead of the resident's return, and another nurse had put the orders into a queue to be activated when the resident arrived. When she heard the resident was coming, she activated the order and put in the BIPAP settings. RN 6 indicated she could not remember the specific orders for frequency at this time and was not sure if the orders from the hospital matched the orders input into the resident's electronic medical record (EMR). During an interview on 8/2/23 at 2:35 p.m., the DON indicated ahead of Resident B's re-admission orders on 7/21/23, the DON had received orders for the BIPAP and contacted the contracted durable medical equipment supplier for respiratory supplies, and the supplier had preset the BIPAP settings according to the physician's orders. The BIPAP arrived on 7/20/23 ahead of the resident's return and was stored in the medication room. Upon review of re-admission/hospital paperwork for 7/21/23, the DON indicated she could not find orders for frequency of the BIPAP, either at bedtime or to be always worn when in bed. When a resident was admitted to the facility, the receiving nurse was responsible for making sure resident orders were correct, and hospital orders matched the orders in the EMR. The DON indicated she had not been made aware Resident B had not received her BIPAP for 3 days upon re-admission, she would have notified the physician immediately for further instructions. DON indicated she was the nurse who changed the order on 7/24/23 per the Administrator's request for the resident to wear her BIPAP when in bed. DON indicated she had gotten the order by calling the physician but did not document in the resident record she had spoken to the physician or the reasoning for changing the order.			

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	During an interview on 8/2/23 at 2:40 p.m., LPN 4 indicated he and his peers had been helping to input physician's orders on 7/21/23 as there were multiple resident admissions. He did not remember writing orders for Resident B and had no knowledge of her BIPAP orders. During an interview on 8/2/23 at 3:25 p.m., the Administrator indicated after finding the resident had not been wearing her BIPAP as ordered for 3 days, he had not back tracked to figure out why the order had been dropped. He thought the issue was resolved, so he moved on. There was no follow up completed with staff to determine the root cause of the entire situation. During an interview on 8/4/23 at 12:30 p.m., RN 5 indicated she had cared for Resident B on the day shifts of 7/21/23, 7/22/23, and 7/23/23. She had never seen the resident wearing a BIPAP when she arrived at work in the morning and had no knowledge of the resident having a BIPAP machine or physician's orders to wear one. During an interview on 8/4/23 at 12:48 p.m., CNA 14 indicated she was the aide assigned to care for Resident B from 6:00 p.m. to 6:00 a.m. on the nights of 7/21/23, 7/22/23, and 7/23/23. The resident required total care with her ADL's, and she never saw her out of bed. CNA 14 indicated the resident was observed to wear oxygen per NC from a concentrator that sat on the right side of her bed. She did not remember seeing Resident B wearing a BIPAP on those nights she cared for her, and never saw any BIPAP equipment in the room. 2. On 8/4/23 at 10:40 a.m., Resident E was observed sitting in a low to the ground wheelchair			

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	at bedside, with a blue mechanical lift pad under her. A CPAP machine was sitting on the bedside stand and an oxygen concentrator beside the bedside stand and behind the resident. The resident was alert, oriented, and talkative about the circumstances that led her to be in the nursing home. Resident E indicated, approximately 10 years ago she had participated in a sleep study. That was when she had been given the CPAP machine to wear when sleeping, the machine still had the same original settings. Her last visit to a pulmonologist (physician who specializes in the respiratory system) was about 2 years ago. The day prior, 8/3/23, staff had come into her room and rinsed the filter in her CPAP and hung a respiratory sign on her door, they had not done those things before. Resident E's record was reviewed on 8/3/23 at 2:45pm. The census information indicated the resident was admitted on 5/16/23, with diagnoses that included, but were not limited to, sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). An Admission/Re-Admission Assessment, dated 5/16/23, indicated oxygen at 2 L and CPAP, there was no documentation to indicate frequency for use of the CPAP. A physician's order, dated 8/2/23, indicated oxygen at 2L via CPAP at bedtime in the evenings for shortness of breath. The order lacked documentation of CPAP settings. MARs dated May, June, and July 2023, indicated there was no documentation to indicate a CPAP was worn at night for shortness of breath or sleep			

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	apnea. A MAR, dated August 2023, indicated a new order 8/3/23 for oxygen at 2L via CPAP at bedtime in the evening for shortness of breath, 7:00 p.m. to 11:00 p.m. Interdisciplinary notes, dated July and August 2023, indicated there was no nursing or physician documentation related to the resident using a CPAP at night, respiratory status related to CPAP use, or tolerance to the CPAP at current settings. During an interview on 8/4/23 at 9:52 a.m., the DON indicated during an audit on 8/2/23 she found that Resident E had no orders for her CPAP. The resident had admitted to the facility in May 2023 and brought her CPAP machine from home with preset settings from another oxygen company the facility did not use. The DON indicated she had known the resident had a CPAP and knew she had worn it for years while home and in the facility at night since being admitted. The DON indicated she just did not realize the resident had no physician's order to use the CPAP while in the facility. The DON indicated once she realized Resident E had no order for the CPAP, she wrote an order on 8/2/23 for the resident to have the CPAP at bedtime for shortness of breath. The family of Resident E had visited on the evening of 8/3/23, and the DON was able to obtain history of the CPAP use, but she now needed to contact the physician to get his order for use. The DON indicated she had no orders for settings on the CPAP machine, could not verify the settings as it had come from home and had been preset in the past, and had not notified the physician before writing the orders for CPAP use on 8/2/23.			

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	A care plan for Resident E, dated 5/17/23, indicated she required oxygen use due to low oxygen saturations. The goal was for the resident to have no complications from oxygen use. Interventions included change oxygen tubing/apply oxygen tubing per facility policy, labs as ordered by physician, medications per physician's orders, oxygen as ordered per physician, and report changes to the physician as needed. The resident record lacked a care plan for need and use of a CPAP machine until 8/3/23 during the survey. "National Library of Medicine, Biotech Information" at https://www.sleepfoundation.org/sleep-apnea/hypercapnia, (August 1, 2023) was retrieved on 8/1/23. The guidance included an explanation of hypercapnia. " ...Hypercapnia occurs when the concentration of carbon dioxide in the bloodstream rises above a certain level. This can upset the acid-base balance in the bloodstream and cause a range of mild to severe symptoms. Hypercapnia is considered a sign of a larger issue instead of being a standalone disease. It can occur suddenly, or it can exist in chronic form. Symptoms included labored or shallow breathing, wheezing, altered consciousness or confusion, fever, flushed skin, sweating profusely, fatigue or sleepiness, headache or nausea, and irritability ...." On 8/2/23 at 2:35 p.m., DON provided a Physician's Orders - (Following Physician Orders) policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...It is the policy of the facility			

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	to follow the orders of the physician. At the time of admission, the facility must have orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission ...3. Orders that accompany the resident on admission will be clarified by the physician through action of the nurse who will contact the physician for clarification upon the resident's admission...." On 8/2/23 at 2:35 p.m., DON provided a Change in Resident's Condition or Status policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...It is the policy of the facility to ensure that the resident's attending physician and representative are notified of changes in the resident's condition or status. 1. The nurse will notify the resident's attending physician when ...There is a significant change in the resident's physical, mental, or psychological status. There is need to alter the resident's treatment plan significantly ...6. The nurse will record in the resident's medical record any changes in the resident's medical condition or status ...." On 8/1/23 at 3:15 p.m., the DON provided a BIPAP/CPAP policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...To provide non-invasive breathing support for residents who are diagnosed with obstructive sleep apnea [ONA], COPD, CHF, and neuromuscular disease ...BIPAP-[bi-level positive airway pressure] provides assistance during inspiration and expiration ... IPAP- [inspiratory positive airway support] this is the inspiratory pressure that is set when BIPAP is used. EPAP- [expiratory positive airway pressure] this is the expiratory pressure			

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	that is set when BIPAP is used. Equipment: BIPAP/CPAP machine, face mask when head gear and straps-may be full face, partial face or nasal, oxygen source and tubing [as ordered], humidification source [if applicable], pulse oximetry. 1. Verify physician's order for pressure, oxygen, and parameters for pulse oximetry ...2. Assemble equipment ...6. Check equipment function - follow manufacturer's recommendations. 7. Place mask over resident's face. 8. Turn machine on. 9. Attach headgear and straps -verify there are no air leaks 10. Check pulse oximetry as per physician order ...11. Monitor the resident throughout the night for any adverse reactions. 12. Report any issues or problems to the physician as appropriate. 13. Document in the progress notes the resident comfort and response to the efficacy of the current treatment ...." The immediate jeopardy that began on 7/21/23 was removed on 8/4/23 when the facility ensured residents with respiratory orders had the required equipment, medication, and assessments as ordered. The facility ensured all residents with respiratory orders were assessed for appropriate orders and treatment. Staff were in-serviced on re-admission procedure, assessing for respiratory symptoms and change of condition, following physician orders, and notifying the physician of missing orders. The facility created a plan to monitor for implementation of orders for respiratory equipment and respiratory care. This Federal tag relates to Complaint IN00413639. 3.1-47(a)(6)			