STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155661	A. BUILDING 00 B. WING	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OWEN VALLEY REHABILITATION AND HEALTHCARE CENTER	920 W HIGHWAY 46 SPENCER, IN 47460

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 5, 6, 7, 8 and 9, 2023 Facility number: 010892 Provider number: 155661 AIM number: 200229560 Census Bed Type: SNF/NF: 68 SNF: 7 Total: 75 Census Payor Type: Medicare: 7 Medicaid: 50 Other: 18 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 13, 2023.	F 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective March 21, 2023. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the Plan of Correction (POC) and supporting documents submitted.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for a resident with falls for 1 of 3 residents reviewed for accidents. (Resident 60) Finding includes:	F 0641	**F641-Accuracy of Assessments** **This facility does ensure that assessments are accurate.** **1. Corrective actions taken:** In regard to the Minimum Data Set	03/29/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Patterson	DON	03/28/2023

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	Resident 60's clinical record was reviewed on 3/9/23 at 10:00 a.m. The diagnosis included, but was not limited to, Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 11/20/22, indicated the resident had not fallen since admission or prior assessment either with injury or with no injury. The prior assessment was dated 8/26/22. A review of the Fall-Initial Occurrence Note, indicated the resident had a fall with injury on 10/9/22 and had a fall with no injury on 10/30/22. During an interview on 3/9/23 at 11:48 a.m., the Director of Clinical Services indicated the Quarterly MDS assessment, dated 11/20/22, was incorrect and they missed the falls on 10/9/22 and 10/30/22. On 3/9/23 at 3:39 p.m., the Director of Clinical Services indicated the facility did not have a policy related to MDS. They used the RAI (Resident Assessment Instrument) manual. A review of the Resident Assessment Instrument (RAI) Version 3.0 Manual, Section J1900 indicated, " ... Determine the number of falls that occurred since admission/entry or reentry or prior assessment [OBRA or Scheduled PPS] and code the level of fall-related injury for each ..." 3.1-31(d)		(MDS) assessments for the 1 of 3 residents reviewed for accidents Resident #60. The MDS Coordinator corrected the deficiency when the surveyor identified the error. **2. How other residents were identified:** The MDS assessments were reviewed for Residents who have had a fall for accuracy. **3. Measures in place/system changes:** The DON/Designee will audit all new MDS assessments for accuracy related to falls for a period of four months. **See attached audit form and in servicing.** **4. Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance of F641 Accuracy of Assessments and corrective actions as indicated at least quarterly during the scheduled quarterly meetings and as needed. Following the quarterly quality assurance compliance reviews and no facility inaccuracies in MDS assessments related to falls the committee will discuss revisions at that time. **5.** Date of Compliance: March 29, 2023.	

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the			

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	community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure an activities of daily care (ADL) care plan was developed for 2 of 6 residents reviewed for ADL's. (Resident 60, Resident 16) Findings include: 1. Resident 60's clinical record was reviewed on 3/9/23 at 10:00 a.m. The diagnosis included, but was not limited to, Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 11/20/22, indicated the resident was extensive assistance of 1 for activities of daily living (ADL's). A review of the care plans lacked documentation of a current care plan for ADL's. 2. Resident 16's clinical record was reviewed on 3/9/23 at 2:55 p.m. The diagnosis included, but was not limited to, Alzheimer's disease. The Significant Change MDS assessment dated, 1/6/23, indicated the resident was dependent of 2 person's for ADL's. A review of the care plans lacked documentation	F 0656	**F656-Careplan Implementation** **This facility does ensure residents care plans are implemented.** **1. Corrective actions taken:** Regarding residents #16 and #60, the residents ADL (Activity of Daily Living) care plans were implemented when identified. **2. How other residents were identified:** Residents' ADL care plans were reviewed to determine if any other residents ADL care plans were not implemented. New residents care plans will be reviewed on admission for compliance. **See attached audit form and in servicing.** **3. Measures in place/system changes:** The Director of Nursing (DON)/designee will audit all new admissions for compliance with ADL care plans. The DON/designee audits will be completed on residents upon	03/29/2023

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	of a current care plan for ADL's. During an interview on 3/9/23 at 4:15 p.m., the Assistant Director of Nursing (ADON) indicated the facility was still working to get all care plans updated for Resident 60 and Resident 16 since the facility was purchased by another company in 2022. 3.1-35(a)		admission for a period of (4) months. **See attached DON/designee MDS nurse audits.** **4. Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance of F 656 for implementation of ADL care plans and corrective actions as indicated at least quarterly during the scheduled quarterly meetings. Following the quarterly quality assurance compliance reviews and no resident missing ADL care plans the QA committee will discontinue the monitoring. **5.** Date of Compliance: March 29, 2023. F656 ATTACHMENTS: NURSING CARE PLAN AUDITS REGARDING ADL IMPLEMENTATION. INSERVICING FORMS	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for 4 of 6 residents reviewed for activities of daily living. (Resident 39, Resident 178, Resident 24, Resident 56)	F 0677	**F677-ADL Care for Dependent Residents** **This facility does ensure dependent residents receive ADL care.** **1. Corrective actions taken:**	03/29/2023

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	Findings include: 1. On 3/6/23 at 10:50 a.m., Resident 39 was observed in bed in her room with whiskers approximately 1/2 inch long on her chin. On 3/8/23 at 2:40 p.m., Resident 39 was observed in bed in her room with whiskers approximately 1/2 inch long on her chin. On 3/9/23 at 10:30 a.m., Resident 39 was observed in the activity area with whiskers approximately 1/2 inch long on her chin. During an interview on 3/8/23 at 2:25 p.m., the resident indicated she would rather have not had whiskers on her chin. On 3/9/23 at 10:45 a.m., Resident 39's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, muscle weakness, and hypothyroidism. The Quarterly MDS (Minimum Data Set) assessment, dated 1/17/23 indicated the resident required extensive physical assistance of 1 person for personal hygiene. 2. On 3/6/23 at 11:00 a.m., Resident 178 was observed in bed in his room with whiskers approximately 1/2 inch long under his nose and on his chin and jaw. On 3/8/23 at 12:41 p.m., Resident 178 was observed in bed in his room with whiskers approximately 1/2 inch long under his nose and on his chin and jaw. On 3/9/23 at 9:50 a.m., Resident 178 was observed		Regarding residents #24, #39, #56 and #178 auditing forms are in place to ensure residents who require assistance with ADL care is completed. In servicing was completed with all staff on ADL care. **2. How other residents were identified:** The facility DON/designee completes daily rounds on 3 dependent residents to ensure residents receive ADL care. **See attached DON/Designee auditing tool, and in servicing forms.** **3. Measures in place/system changes:** The Director of Nursing (DON)/designee(s) will audit 3 dependent residents in the facility for ADL care. The DON/designee audits will be ongoing daily for one week, weekly for four weeks and monthly for a period of four months. **4. Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance of F 677 for residents who are dependent for ADL care and the corrective actions as indicated at the next quarterly meeting. Following the quarterly quality assurance compliance reviews and no residents with ADL care issues the committee will discontinue audits.	

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	in bed in his room with whiskers approximately 1/2 inch long under his nose and on his chin and jaw. During an interview on 3/8/23 at 12:45 p.m., Resident 178 indicated he usually did not have whiskers on his face and would like to have been shaven. He was unable to shave himself due to his weakness and required assistance. On 3/8/23 at 1:00 p.m., Resident 178's clinical record was reviewed. The diagnoses included but were not limited to, osteomyelitis and heart failure. A care plan, initiated 3/2/23, indicated the resident required the physical assistance of 1 person for personal hygiene. 3. On 3/6/23 at 2:35 p.m., Resident 24 was observed in his bed with whiskers approximately 1/4 inch long under his nose and on his chin and jaw. On 3/8/23 at 11:05 a.m., Resident 24 was observed in his bed with whiskers approximately 1/4 inch long under his nose and on his chin and jaw. On 3/9/23 at 10:10 a.m., Resident 24 was observed in his bed with whiskers approximately 1/4 inch long under his nose and on his chin and jaw. During an interview on 3/9/23 at 10:15 a.m., Resident 24 indicated he usually did not have whiskers on his face and would like to have been shaven. Staff did not often offer to shave him. On 3/8/23 at 1:10 p.m., Resident 24's clinical record was reviewed. The diagnoses included, but were not limited to, Parkinson's disease and venous insufficiency.		**5.** Date of Compliance: March 29, 2023. F677 ATTACHMENTS: NURSING AUDIT FORM. INSERVICING SHEETS.	

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	The Annual MDS assessment, dated 11/27/22, indicated the resident required limited assistance of 1 person for personal hygiene. 4. On 3/6/23 at 10:36 a.m., Resident 56 was observed with facial whiskers and brown substance beneath his nails On 3/7/23 at 11:36 a.m., Resident 56 was observed with facial whiskers and brown substance beneath his nails. During an interview at that time, his wife indicated she wished the staff would do better about shaving his facial hair. On 3/8/23 at 11:05 a.m., Resident 56 was observed with facial whiskers and brown substance beneath his nails. On 3/9/23 at 10:22 a.m., Resident 56 was observed with brown substance beneath his nails and his whiskers were unevenly shaved. On 3/9/23 at 11:00 a.m., Resident 56's clinical record was reviewed. The diagnoses included, but were not limited to, hemiplegia (paralysis) and hemiparesis (weakness) on his dominant side and aphasia (a disorder that affects a person's ability to communicate) following cerebral infarction (stroke). The Quarterly MDS assessment, dated 11/19/22, indicated the resident was totally dependent on staff with personal hygiene, and had one-sided impairment in his upper and lower extremities. An 8/4/22 ADL (activities of daily living) care plan, indicated the resident had impairment in functional status in regard to transfers, bed mobility, toileting, and eating. The care plan did not include interventions which addressed his personal hygiene.			

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	During an interview on 3/9/23 at 10:55 a.m., the Director of Clinical Services indicated the residents needed to be shaved and whiskers needed to be removed. During an interview on 3/9/23 at 2:22 p.m., CNA (Certified Nursing Assistant) 1 indicated she tried to shave the residents every day and it's an understanding that the men should be offered a shaved every day. On 3/9/23 at 2:55 p.m., the Director of Clinical Services provided the facility policy, "Grooming," revised on 1/25/18, and indicated it was the policy currently used. A review of the policy indicated, "...observe condition of resident nails, hair, and facial hair...shave...clean debris from around and under finger and toe nails ..." 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to document in the clinical record a skin tear (a wound that happens when the layers of skin separate or peel back) for a resident with a skin tear for 1 of 3 residents reviewed for skin conditions. (Resident 12)	F 0684	**F684-Quality of Care** **This facility does ensure dependent residents receive Quality of Care.** **1. Corrective actions taken:** Regarding resident #12, auditing	03/29/2023

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	Findings include: During an observation on 3/6/23 at 10:05 a.m., Resident 12 was observed to have a Band-Aid and a purple bruise on her right forearm. During an interview on 3/7/23 at 1:45 p.m., Resident 12 indicated about a week ago, she was being transferred with a mechanical lift and the sling caused the bruise and the skin tear on her right arm. During an observation on 3/8/23 at 10:10 a.m., Certified Nursing Assistant (CNA) 2 and CNA 3 were observed to transfer Resident 12 with mechanical lift. At that time, Resident 12 was observed to have a white dressing on her right forearm. During an observation on 3/9/23 at 11:03 a.m., the Assistant Director of Nursing (ADON) removed the white dressing on Resident 12's right forearm. She indicated there was a skin tear on her right forearm. At that time, Resident 12 indicated she had gotten a skin tear during a transfer with mechanical lift. On 3/9/23 at 10:45 a.m., Resident 12's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral palsy (impaired muscle coordination) and diabetes mellitus. Resident 12's Progress notes dated 3/1/23 through 3/8/23 lacked documentation of a skin tear to right forearm. Resident 12's Non-Pressure Assessment dated 3/2/23 at 7:14 p.m., lacked documentation of Resident 12's skin tear.		forms are in place to ensure residents who obtain skin tears are documented and physician orders are in place. All residents are reviewed daily in the clinical meeting and weekly during the Clinically at risk monitoring meeting. In servicing was completed for all staff. **2. How other residents were identified:** Residents were audited for skin tears. Residents with skin tears will have documentation in place and physicians orders. **See attached DON/Designee skin auditing tool.** 3. **Measures in place/system changes:** The Director of Nursing (DON)/designee(s) will audit residents in the facility for skin tears. The DON/designee audits will be ongoing daily for one week, weekly for four weeks and monthly for a period of four months. **4. Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance of F 684 for residents with skin tears and corrective actions as indicated at the next quarterly meeting. Following the quarterly quality assurance compliance reviews and no residents with skin tears without documentation and a physician's order then the	

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	During an interview on 3/8/23 at 10:19 a.m., CNA 2 indicated Resident 12 skin was fragile. She had a skin tear on her right forearm. During an interview on 3/9/23 at 11:37 a.m., the ADON indicated Resident 12 had a skin tear on her right forearm. When a resident received a skin tear, the nurse would document the skin tear in the clinical record, call physician and family. Resident 12's skin tear on her right forearm was not documented in her clinical record. On 3/9/23 at 12:45 p.m., the Director of Clinical Services provided the facility policy, "Pressure Injury and Skin Condition Assessment," dated 2/19/21 and indicated this was the policy currently being used by the facility. A review of the policy indicated..."3. A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse..." 3.1-37(a)		committee will discontinue audits. **5.** Date of Compliance: March 29, 2023. F684 ATTACHMENTS: NURSING AUDIT FORM. INSERVICING SHEETS.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates			

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	that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review the facility failed to ensure staff assessed and addressed the needs of residents with significant weight loss for 2 of 5 residents reviewed for nutrition. (Resident 66, Resident 33) Findings include: 1. On 3/8/23 at 12:18 p.m., Resident 66 was observed eating lunch in the main dining room. He was slowly eating bites and staff were observed to encourage him to eat. On 3/6/23 at 2:41 p.m., Resident 66's clinical record was reviewed. The diagnoses included, but were not limited to, dysphagia (difficulty swallowing) following cerebral infarction (stroke), one-sided hemiplegia (paralysis) and hemiparesis (weakness), vitamin deficiency, and gastro-esophageal reflux disease (GERD). The Quarterly Minimum Data Set (MDS) assessment, dated 11/27/22, indicated the resident required supervision (oversight, encouragement, or cueing) with eating. Review of the resident's monthly weight report the following: - In September 2022, the resident weighed 145 pounds (lbs.)	F 0692	**F692-Nutrition/Hydration Maintenance** **This facility does ensure residents nutrition/hydration maintenance is monitored.** **1. Corrective actions taken:** Resident #33, and Resident #66 were reviewed and interventions implemented for weight loss. Residents will be reviewed for weight loss during the Clinically at Risk monitoring weekly meeting and daily during Clinical meeting. **2. How other residents were identified:** Residents in the facility were reviewed for weight loss. **3. Measures in place/system changes:** The Director of Nursing/Designee will audit residents weekly for the Clinically at-risk monitoring meeting. The Registered Dietician recommendations will be reviewed and recommendation will be implemented as ordered. The DON/designee audits will be ongoing daily for one week, weekly for four weeks and monthly	03/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155661	A. BUILDING 00 B. WING	03/09/2023

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	- In October 2022, the resident weighed 146.4 lbs. - In November 2022, the resident weighed 145 lbs. - In December 2022, the resident weighed 126 lbs. - In January 2023, the resident weighed 127.2 lbs. - In February 2023, the resident weighed 124.4 lbs. - In March 2023, the resident weighed 124.2 lbs. This was a significant weight loss of 14.34% over 6 months. A 2/2/23 physician's progress note indicated the resident had experienced weight loss, "... unacceptable decline..." and staff were to "... continue aggressive - fortified supplements [to] determine highest level of food consistency appropriate..." for the resident. She continued, "... look into carnation inst. [instant] breakfast [a powdered instant drink that is manufactured with protein, vitamins, and minerals], etc." A 2/2/23 nutritional note, indicated the resident had significant weight loss of 14.2%. The Registered Dietician indicated the resident should receive Ensure (a nutritional shake) once a day versus twice a day to prevent excessive intake. A 2/27/23 nutritional assessment, indicated the resident experienced significant weight loss of 14% over 180 days. The Registered Dietician indicated staff should continue the current plan of care and the resident did not need any new nutritional interventions, despite the clinical record which assessed a continued weight loss.		for a period of four months. **See attached: Audit tools and in servicing.** **4. Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance of F 692 for weight loss and corrective actions as indicated at least quarterly during the scheduled quarterly meetings. Following the quarterly quality assurance compliance reviews and no resident weight loss identified the committee will discuss discontinuing from QA. **5.** Date of Compliance March 29, 2023. F692 ATTACHMENTS: AUDIT TOOLS INSERVICING TOOLS	

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	A 2/27/23 care plan indicated the resident was at nutritional risk related to a greater than 14% weight loss over 180 days. During an interview on 3/10/23 at 3:39 p.m., the Director of Clinical Services indicated further interventions should have been implemented for the resident.2. During an observation on 3/8/23 on 12:16 p.m., Resident 33 was observed to be feeding herself fried chicken and cheese potatoes. On 3/8/23 at 11:43 a.m., Resident 33's clinical record was reviewed. The diagnoses included, but were not limited to, hemiparesis (paralysis on one side of the body), mood disorder, anemia, and diabetes mellitus. Resident 33's weights indicated the following: - On 9/9/22 at 5:03 p.m., her weight was 193.5 pounds. - On 10/17/22 at 1:48 p.m., her weight was 186.5 pounds. - On 11/25/22 at 2:28 p.m., her weight was 181.9 pounds. - On 12/5/22 at 4:51 p.m., her weight was 184.3 pounds. - On 1/2/23 at 5:02 p.m., her weight was 172.8 pounds. - On 2/3/23 at 7:18 p.m., her weight was 168.2 pounds. - On 3/6/23 at 8:07 a.m., her weight was 169.8 pounds. This was a significant 12.25 percent weight loss over six months. A care plan, dated 2/10/23, indicated Resident 33 was at nutritional risk related to weight loss. The intervention was registered dietician evaluation as needed.			

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	A progress note, dated 2/10/23 at 4:28 p.m., indicated Resident 33 had significant weight loss. The RD recommended an updated blood sugar and A1C (blood test which measures the average blood sugar levels over the past 3 months). The clinical record lacked documentation of a physician notification of the RD recommendations of updated blood sugar and A1C. During an interview on 3/8/23 12:59 p.m., the Assistant Director of Nursing (ADON) indicated the clinical record lacked documentation of the physician being notified of the RD recommendation dated 2/10/23. On 3/9/23 at 2:00 p.m., the Director of Clinical Services provided the facility policy, "Nutritional Monitoring," undated, and indicated this was the policy currently being used by the facility. A review of the policy indicated..."6. Assess factors affecting appropriate nutritional intake and take corrective action..." 3.1-46(a)(1)			
F 0695 SS=D 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, 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.			

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	Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice. There was not an order for the oxygen and the equipment was not dated. (Resident 178) Finding includes: On 3/6/23 at 11:00 a.m., Resident 178 was observed in bed in his room receiving 2 liters of oxygen via a nasal cannula from an oxygen concentrator machine (a machine that takes in air from the room to filter out nitrogen in order to provide higher amounts of oxygen for oxygen therapy). The oxygen humidifier bottle, oxygen tubing, and nasal cannula were not labeled with a time or date. On 3/8/23 at 12:41 p.m., Resident 178 was observed in bed in his room receiving 2 liters of oxygen via a nasal cannula from an oxygen concentrator machine. The oxygen humidifier bottle, oxygen tubing, and nasal cannula were not labeled with a time or date. On 3/9/23 at 9:50 a.m., Resident 178 was observed in bed in his room receiving 2 liters of oxygen via a nasal cannula from an oxygen concentrator machine. The oxygen humidifier bottle, oxygen tubing, and nasal cannula were not labeled with a time or date. During an interview on 3/9/23 at 9:55 a.m., the resident indicated he constantly needed the oxygen delivery from the machine and nasal cannula. On 3/8/23 at 1:00 p.m., Resident 178's clinical record was reviewed. The diagnoses included, but were not limited to, osteomyelitis and heart failure.	F 0695	**F695-Respiratory Care** **This facility does ensure residents have orders for the use of oxygen.** **1. Corrective actions taken:** Regarding resident #178, the resident had orders placed for oxygen, and all residents were audited for the use of oxygen and compliance with physician's orders. **See attached oxygen audit form.** **2. How other residents were identified:** Residents in the facility will be observed to determine if they use any oxygen. Residents using oxygen will then be audited for physician orders for the use of oxygen. The DON/designee audits will be ongoing daily for one week, weekly for four weeks and monthly for a period of four months. **See attached DON/Designee oxygen audit tool.** **3. Measures in place/system changes:** Residents with oxygen were reviewed for compliance. The Director of Nursing (DON)/designee(s) will audit residents in the facility for use of oxygen ongoing every month for a period of (4) months. **See attached DON/designee oxygen audit tool.** **4. Monitoring of corrective actions taken:** The Quality	03/29/2023

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	The clinical record lacked a physician order for oxygen therapy for the resident. During an interview on 3/9/23 at 10:55 a.m., the Director of Clinical Services indicated there was no physician order for the oxygen, and the oxygen humidifier bottle, oxygen tubing, and nasal cannula were not labeled with a date or time. On 3/9/23 at 2:55 p.m., the Director of Clinical Services provided the facility's Oxygen Therapy policy, undated, and indicated it was the policy currently used by the facility. A review of the policy indicated, "...verify MD [medical doctor] order for oxygen...oxygen tubing, nasal cannula...are changed every 7 days...change humidifier jar every 7 days..." 3.1-47(a)(6)		Assurance and Improvement committee will review compliance of F 695 for oxygen use and corrective actions as indicated at least quarterly during the scheduled quarterly meetings. Following the quarterly quality assurance compliance reviews and no resident oxygen usage without physician order concerns, the committee will remove from QA. **5.** Date of Compliance: March 29, 2023 F695 ATTACHMENTS: NURSING OXYGEN AUDIT FORM INSERVICING FORM	