STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045414	A. BUILDING ______ B. WING ______	C 09/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OZARK HEALTH NURSING CENTER	2500 HIGHWAY 65 SOUTH CLINTON, AR 72031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #12938 was substantiated (all or in part) with deficiencies cited at F157 and F309.	F 000		
F 157 SS=J	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by:	F 157		

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

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

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F 157	Continued From page 1	F 157		

Complaint #12938 was substantiated (all or in part) in these findings.

Based on record review and interview, the facility failed to ensure the communication of complete and accurate assessment information and the facility's failure to provide the prescribed oxygen therapy when consulting with the Hospice Registered Nurse, the Hospice Physician, and the attending Physician's on-call Advanced Practitioner Nurse (APN) regarding the resident's respiratory distress for 1 (Resident #4) of 5 (Residents #1 through #5) case mix residents who had Physician orders for supplemental oxygen administration. The failed practice resulted in immediate jeopardy, which caused or could have caused serious injury, harm, impairment or death to Resident #4 and had the potential to affect 29 residents who received supplemental oxygen (13 continuous and 16 PRN [as needed]), as listed by the facility and received from the Director of Nursing on 9/27/07 at 4:14 p.m. The facility was notified of the immediate jeopardy condition on 9/27/07 at 2:55 p.m. The findings are:

Resident #4 had diagnoses of Reactive Airway Disease, Wheezing, Shortness of Breath, Mild Congestive Failure, Cerebrovascular Disease, Organic Brain Syndrome and Dementia with Psychosis. The Minimum Data Set dated 7/26/07 documented the resident had severe impairment in cognitive skills for daily decision-making, had an inability to make self understood, had total dependence on staff for the performance of activities of daily living and had received no oxygen therapy within the last 14 days. The Plan of Care updated 7/25/07 documented a problem of, "at risk for alteration in respiratory function

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F 157	Continued From page 2 related to Reactive Airway Disease" with approaches to: "assess for s & s (signs and symptoms) of respiratory distress: shallow respirations, dyspnea, diminished breath sounds, confusion, cyanotic color and restlessness.... elevate HOB (head of bed) 30 degrees to facilitate breathing....O2 (oxygen) per physician order-assess effectiveness and record." The Physician's Orders dated 8/9/07 documented, "O2 (oxygen) at 2 L (liters) via n/c (nasal cannula) dx (diagnosis) Reactive Airway Disease" and "Oxygen at 2 LPM (liters per minute) can be off at meal time dx SOB (shortness of breath)." a. The Nurse's Notes dated 9/16/07 at 10:00 p.m. documented, "VS (vital signs) 90/50, P (pulse) 132, Resp (respirations) 44, Temp (temperature) 95.6 and Pulse ox (oximeter) 68%. R (Resident) up in Gerichair. Went into room R hands were blue, lower extremities cold to touch. R was making a gurgling sound as if she couldn't swallow. Called [Advanced Nurse Practitioner], notified family. [Son] stated do not send to ER (Emergency Room). Notified hospice [Hospice Registered Nurse] received TO (telephone order) per [Hospice Registered Nurse] per [Hospice Physician] for 1. Diazepam Inj (injection) IM (intramuscular) 5 mg (milligram) q (every) 4 hours PRN (as needed), 2. ii (two) Lortab 5/500 mg to = (equal) 10/1000 mg (milligram) q 4 hours PRN if R is in pain." The Physician's Orders dated 9/16/07 documented, "Diazepam Injection 5 mg (milligrams) = (equals) 1 ml (milliliter) IM (intramuscular) PRN (as needed) q (every) 4 hours dx pain."	F 157		

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F 157	Continued From page 3 The Medication Record dated 9/16/07 (3-11 shift) documented the administration of one dose of "Diazepam Injection IM PRN q 4 hours, 5 mg = 1 ml, dx pain." The reverse side of the Medication Record documented "9/16/07, 2200 (10:00 p.m.), [initials of Licensed Practical Nurse (LPN) #1]" with medication documented as "Diazepam 5 mg = 1 ml," the reason for administration was documented as "pain" and the result was documented as "effective." b. LPN #1 documented the following witness statement on 9/20/07 at no time noted, "This nurse took report, started medication dispensing at 7:10 p.m. Gave medicines to R (residents) in the day room and hall around nursing station. Went to the middle hall rooms gave those meds (medications) then went into [Resident #4's] room gave her roommate's meds. At 7:30 p.m. picked up her hand to check her pulse noticed her fingers were blue. Pulse was 132, resp (respirations) was 44. Put eye drops in her eyes. Stepped out into hall called for other nurse. She came in to help me c (with) resident. We checked her legs and feet also starting to model. Resident had nasal cannula in nose. Looked to see if hooked to wall unit, was not. Checked O2 (oxygen) tank behind her gerichair that resident was sitting in. The tank was on empty. Unhooked the tubing from tank, hooked to wall unit. Checked pulse ox was 68%. Left resident's room at 8:10 p.m. After checking pulse ox again still 68%. Went to nurse's desk called [Attending Physician's] nurse on call [Advanced Practice Nurse]. Gave her R vitals was told to call [Resident #4's] son to see if he wanted to send her to ER (Emergency Room). He said no. He ask me to call hospice to see if they would send	F 157		

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F 157	Continued From page 4 someone over. I said I would. At 8:30 p.m. called hospice gave the on call nurse vitals [Hospice Nurse]. She said to make resident comfortable. Went in checked vitals again at 8:40 p.m. Pulse ox 76%, respirations 36 and pulse 134 while on 2 L O2 via nasal cannula. Asked CNA's (Certified Nursing Assistant) to help watch resident while I finished med pass. [LPN #3] came back around 9:00 p.m. Told her about resident. She went into resident's room, came back out said she was going to try a updraft. I stated I don't know. [Advanced Nurse Practitioner] didn't say give her an updraft. [LPN #3] said it might bring her pulse ox back up and she has updrafts PRN. I said I will try it then she said I can, I'm still clocked in. She took the updraft med, went into resident's room. She came back said it didn't work. I finished med pass at 9:10 p.m. went to Nurses Station. [LPN #3] was sitting at desk finishing her charting. She said she called [Resident #4's] son and asked if he wanted [Resident #4] to be sent to ER. He said no but he would like someone to sit with her until hospice arrived. [LPN #3] told me [CNA #1] was in room c resident. I said o.k. [LPN #3] left around 9:30-9:45 p.m. The hospice nurse called with some Dr. (doctor) orders for Lortab 5/500 ii via rectum and Diazepam 5 mg IM injection. I called [Advanced Practice Nurse] verified these orders. She told me to give her the Diazepam to help c her heart rate but to wait on the Lortab to see if the Diazepam helped. 10:30 p.m. gave the Diazepam. Resident in bed at this time. Had a CNA help me roll her to one side for the injection at about 10:50 p.m. Resident's breathing became one breath, wait 1 min (minute) then breathe. Called other nurse in listened to heart still beating 100 bpm (beats per minute). R closed eyes then stopped breathing at 11:10 p.m. Listen for heart beat heard no sound. Took vitals,	F 157		

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F 157	Continued From page 5 was unable to obtain at this time. 11:15 p.m. called [Advanced Practice Nurse] left message, 11:20 p.m. called [Resident #4's son], 11:30 p.m. coroner, 11:35 DON (Director of Nursing) left message, 11:40-11:45 called Administrator. Called DON at 10:00 p.m. to see if I needed to chart in the chart about the O2 tank being empty she said no. [CNA #1] was sent home at 10:30-10:40 p.m." c. On 9/27/07 at 1:25 p.m., LPN #1 stated, "I called [APN-Advanced Practice Nurse], I did not tell her about the oxygen being off. I gave her the vital signs and told her [Resident #4] was turning blue. I told her what the Hospice Nurse had got ordered. She said to hold the Lortab and go ahead and give her 5 mg Valium. The APN was on call for [Attending Physician]. I was told by the nurse on duty that we don't tell about the oxygen because I should call the DON (Director of Nursing) first to let her know. Later I called the DON and she told me not to chart about the oxygen tank being empty. She said not to tell the doctor or family that it would be up to them, administration, whether they would tell. Later when I talked to the Administrator, I forgot to tell her about the oxygen." 1) On 9/27/07 at 12:45 p.m., the Advanced Practice Nurse stated that she was notified on 9/16/07 regarding the resident's change of condition. She stated that she was given "vital signs, no pulse ox and was told that the resident was uncomfortable. I was not told her oxygen had been off and that was probably the reason for her immediate change of condition. I probably would not have approved the Valium if I had been aware of her lack of oxygen." She further stated that "I was not informed until today" of the failure	F 157		

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F 157	Continued From page 6 to administer oxygen prior to her change of condition. 2) On 9/27/07 at 1:06 p.m., the Hospice Registered Nurse stated, "I was called regarding [Resident #4's] change of condition [on 9/16/07]. I called [Hospice Physician] who gave me orders. I called and gave the orders to the nurse at the nursing home. I was not informed of her pulse ox and that [Resident #4] had been without oxygen until they called me today. [Hospice Physician] does not know either. He or even I would have said to leave her on the oxygen for one hour then reassess. The other orders would not have been given." 3) On 9/27/07 at 2:10 p.m., the interim Administrator stated, "I spoke with [Attending Physician] about 30 minutes ago. I asked him if he had been notified on 9/16/07 that [Resident #4] had been oxygen deprived. He said 'no', he had not. He said he spoke with her son a few days later and he made him aware." d. The Immediate Jeopardy was removed and the scope/severity lowered to "G" on 9/28/07 at 8:45 a.m. when the facility implemented the following Plan of Removal: "Plan of removal" "09/27/07" "1. All residents with orders for oxygen therapy were assessed by Respiratory Therapy beginning on 9/21/07 at 8 pm by [specific name], Registered Respiratory Therapist and completed on 09/23/07 at 2:10 pm by [specific name], Certified Respiratory Therapist. The residents with oxygen	F 157		

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therapy orders will continue to be monitored twice a day, morning and evening on a daily basis by the Respiratory Therapy Department. Any changes will be reported to the charge nurse of that respective resident. The Respiratory Therapy Department will monitor and record resident's respiratory status at each assessment.

The Licensed Practical Nurse will monitor and assess for proper application, flow rate and amount of oxygen in the E cylinder if applicable. The Licensed Practical Nurse will record the oxygen status on all residents on oxygen therapy before and after each meal, shift change, evening medication pass, and every four hours during the night.

Before the shift begins, all professional nursing staff will be in-serviced starting 9/27/07 at 3pm and continuing until all professional incoming staff has been in-serviced. In-services will be completed by 09/28/07 at 11:55pm. All professional staff will be in-serviced on the Resident Transport with Oxygen policy, Notification Of Change In Resident's Condition policy, assessment and monitoring of residents, and the correct information to report to physician.

Non-licensed staff will be in-serviced on the Resident Transport with Oxygen policy with emphasize on their responsibilities. (Example: notifying the Licensed Practical Nurse before and after transport.).

The Licensed Practical Nurse will round on each resident at the beginning of shift and routinely monitor throughout the shift for any negative change in condition. (Example: vital signs, oxygen levels, physical changes, respiratory

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F 157	Continued From page 8 status, mental status, psychosocial needs, therapy need, abnormal labs, or results of any diagnostic testing affecting the care of the resident). 2. During routine assessment by the Respiratory Therapy Department any change in condition or concerns regarding the resident will be reported to the Licensed Practical Nurse responsible for that resident."	F 157		
F 309 SS=J	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Complaint #12938 was substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure the provision of oxygen therapy to prevent respiratory distress; the communication of complete and accurate assessment information and the facility's failure to provide the prescribed oxygen therapy when consulting with the Hospice Registered Nurse, the Hospice Physician, and the attending Physician's on-call Advanced Practitioner Nurse (APN) regarding the resident's respiratory distress; and an ongoing assessment of the resident's condition after discovering the resident in distress for 1 (Resident #4) of 5 (Residents #1 through #5)	F 309		

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F 309	Continued From page 9 case mix residents who had Physician orders for supplemental oxygen administration. This failed practice resulted in immediate jeopardy, which caused or could have caused serious injury, harm, impairment or death to Resident #4 and had the potential to affect 29 residents who received supplemental oxygen (13 continuous and 16 PRN [as needed]), as listed by the facility and received from the Director of Nursing on 9/27/07 at 4:14 p.m. The facility was notified of the immediate jeopardy condition on 9/27/07 at 2:55 p.m. The findings are: 1. Resident #4 had diagnoses of Reactive Airway Disease, Wheezing, Shortness of Breath, Mild Congestive Failure, Cerebrovascular Disease, Organic Brain Syndrome and Dementia with Psychosis. The Minimum Data Set dated 7/26/07 documented the resident had severe impairment in cognitive skills for daily decision-making, had an inability to make self understood, had total dependence on staff for the performance of activities of daily living and had received no oxygen therapy within the last 14 days. The Plan of Care updated 7/25/07 documented a problem of, "at risk for alteration in respiratory function related to Reactive Airway Disease" with approaches that included, "assess for s & s (signs and symptoms) of respiratory distress: shallow respirations, dyspnea, diminished breath sounds, confusion, cyanotic color and restlessness." The interventions also included "elevate HOB (head of bed) 30 degrees to facilitate breathing" and "O2 (oxygen) per physician order-assess effectiveness and record." a. The Physician's Orders dated 8/9/07 documented, "O2 (oxygen) at 2 L (liters) via n/c (nasal cannula) dx (diagnosis) Reactive Airway	F 309		

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F 309	Continued From page 10 Disease" and "Oxygen at 2 LPM (liters per minute) can be off at meal time dx SOB (shortness of breath)." b. The Physician's Orders dated 9/14/07 documented, "Refer to Hospice Home Care for evaluation." c. The Oxygen Compliance form dated 9/16/07 at 5:00 p.m. documented, "1000" as the amount of oxygen in E tank. d. LPN #1 documented the following witness statement dated 9/20/07 at no time noted regarding Resident #4's condition on her shift, "This nurse took report, started medication dispensing at 7:10 p.m. Gave medicines to R (residents) in the day room and hall around nursing station. Went to the middle hall rooms gave those meds (medications) then went into [Resident #4's] room gave her roommate's meds. At 7:30 p.m. picked up her hand to check her pulse noticed her fingers were blue. Pulse was 132, resp (respirations) was 44. Put eye drops in her eyes. Stepped out into hall called for other nurse. She came in to help me c (with) resident. We checked her legs and feet also starting to model. Resident had nasal cannula in nose. Looked to see if hooked to wall unit, was not. Checked O2 (oxygen) tank behind her gerichair that resident was sitting in. The tank was on empty. Unhooked the tubing from tank, hooked to wall unit. Checked pulse ox was 68%. Left resident's room at 8:10 p.m. After checking pulse ox again still 68%. Went to nurse's desk called [Attending Physician's] nurse on call [Advanced Practice Nurse]. Gave her R vitals was told to call [Resident #4's] son to see if he wanted to send her to ER (Emergency Room). He said no.	F 309		

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F 309	Continued From page 11 He ask me to call hospice to see if they would send someone over. I said I would. At 8:30 p.m. called hospice gave the on call nurse vitals [Hospice Nurse]. She said to make resident comfortable. Went in checked vitals again at 8:40 p.m. Pulse ox 76%, respirations 36 and pulse 134 while on 2 L O2 via nasal cannula. Asked CNA's (Certified Nursing Assistant's) to help watch resident while I finished med pass. [LPN #3] came back around 9:00 p.m. Told her about resident. She went into resident's room, came back out said she was going to try a updraft. I stated I don't know. [Advanced Nurse Practitioner] didn't say give her an updraft. [LPN #3] said it might bring her pulse ox back up and she has updrafts PRN. I said I will try it then she said I can, I'm still clocked in. She took the updraft med, went into resident's room. She came back said it didn't work. I finished med pass at 9:10 p.m. went to Nurses Station. [LPN #3] was sitting at desk finishing her charting. She said she called [Resident #4's] son and asked if he wanted [Resident #4] to be sent to ER. He said no but he would like someone to sit with her until hospice arrived. [LPN #3] told me [CNA #1] was in room c resident. I said o.k. [LPN #3] left around 9:30-9:45 p.m. The hospice nurse called with some Dr. orders for Lortab 5/500 ii via rectum and Diazepam 5 mg IM injection. I called [Advanced Practice Nurse] verified these orders. She told me to give her the Diazepam to help c her heart rate but to wait on the Lortab to see if the Diazepam helped. 10:30 p.m. gave the Diazepam.Resident in bed at this time. Had a CNA help me roll her to one side for the injection at about 10:50 p.m. Resident's breathing became one breath, wait 1 min (minute) then breathe. Called other nurse in listened to heart still beating 100 bpm (beats per minute). R closed eyes then	F 309		

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stopped breathing at 11:10 p.m. Listen for heart beat heard no sound. Took vitals, was unable to obtain at this time. 11:15 p.m. called [Advanced Practice Nurse] left message, 11:20 p.m. called [Resident #4's son], 11:30 p.m. coroner, 11:35 DON left message, 11:40-11:45 called Administrator. Called DON at 10:00 p.m. to see if I needed to chart in the chart about the O2 tank being empty she said no. [CNA #1] was sent home at 10:30-10:40 p.m."

1) LPN #2 documented on a witness form dated 9/20/07 at 11:25 a.m., "[LPN #1] asked me to come to [Resident #4's] room at approx (approximately) 7:30 p.m. She stated that the resident didn't look good and was having trouble breathing. When I got in the room the resident's respirations were slightly labored and shallow. I asked [LPN #1] if she had checked resident's O2 sats (saturation). She had not, so we did at that time. It was approx 68%. I noticed she was not hooked up to O2 on the wall. I asked [LPN #1] to check O2 in the E tank. The E tank was empty. Myself and [LPN #1] hooked resident back up to the wall O2. Resident's respirations were still slightly labored and shallow. I then went back to my side while [LPN #1] made phone calls with [LPN #3]."

2) LPN #3 documented on a witness form dated 9/18/07 at 4:20 p.m., "At around 1600-1630 (4:00 p.m. to 4:30 p.m.) this nurse checked resident's O2 portable tank. It was sitting at 1000 PSI (pounds per square inch). This nurse charted it and passed evening meds. Resident was taken to dining room for supper. [LPN #1] came in around 1800 (6:00 p.m.) This nurse gave report and did count. Around 1915 (7:15 p.m.) I had to go pick-up my son. This nurse arrived back

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around 2000 (8:00 p.m.). [LPN #1] was down the hall passing meds. She motioned me to come to resident, that is when she told me that resident's pulse ox 66% and acted like she was choking. She stated that portable tank was empty and resident not hooked up to wall unit. She hooked resident to wall unit. This nurse then immediately gave resident updraft and attempted to suction. [LPN #1] called MD (medical doctor) and son. This nurse notified hospice."

e. The Nurse's Notes dated 9/16/07 at 10:00 p.m. documented, "VS (vital signs) 90/50, P (pulse) 132, Resp (respirations) 44, Temp (temperature) 95.6 and Pulse ox (oximeter) 68%. R (Resident) up in Gerichair. Went into room R hands were blue, lower extremities cold to touch. R was making a gurgling sound as if she couldn't swallow. Called [Advanced Nurse Practitioner], notified family. [Son] stated do not send to ER (Emergency Room). Notified hospice [Hospice Registered Nurse] received TO (telephone order) per [Hospice Registered Nurse] per [Hospice Physician] for 1. Diazepam Inj (injection) IM (intramuscular) 5 mg (milligram) q (every) 4 hours PRN (as needed), 2. ii (two) Lortab 5/500 mg to = (equal) 10/1000 mg (milligram) q 4 hours PRN if R is in pain."

1) The Physician's Orders dated 9/16/07 documented, "Diazepam Injection 5 mg (milligrams) = (equals) 1 ml (milliliter) IM (intramuscular) PRN (as needed) q (every) 4 hours dx pain."

2) The Medication Record dated 9/16/07 (3-11 shift) documented the administration of one dose of "Diazepam Injection IM PRN q 4 hours, 5 mg = 1 ml, dx pain." The reverse side of the

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Medication Record documented "9/16/07, 2200 (10:00 p.m.), [initials of Licensed Practical Nurse (LPN) #1]" with medication documented as "Diazepam 5 mg = 1 ml," the reason for administration was documented as "pain" and the result was documented as "effective."

3) There was no documentation in the Nurses Notes of the resident's distress (discovered at 7:30 p.m.) or an assessment of the resident's condition until 10 p.m. The fact that the resident went for an undetermined time without receiving oxygen therapy was not documented in the 9/16/07 Nurses Notes.

4) On 9/27/07 at 8:40 a.m., the Director of Nursing stated that she told LPN #1 on 9/16/07 "to chart the resident's condition when found, everything that had been done, everything but the E cylinder was empty. I guess I was thinking from a legal standpoint."

f. On 9/27/07 at 1:25 p.m., LPN #1 stated, "I called [APN-Advanced Practice Nurse], I did not tell her about the oxygen being off. I gave her the vital signs and told her [Resident #4] was turning blue. I told her what the Hospice Nurse had got ordered. She said to hold the Lortab and go ahead and give her 5 mg Valium. The APN was on call for [Attending Physician]. I was told by the nurse on duty that we don't tell about the oxygen because I should call the DON (Director of Nursing) first to let her know. Later I called the DON and she told me not to chart about the oxygen tank being empty. She said not to tell the doctor or family that it would be up to them, administration, whether they would tell. Later when I talked to the Administrator, I forgot to tell her about the oxygen."

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1) On 9/27/07 at 12:45 p.m., the Advanced Practice Nurse stated that she was notified on 9/16/07 regarding the resident's change of condition. She stated that she was given "vital signs, no pulse ox and was told that the resident was uncomfortable. I was not told her oxygen had been off and that was probably the reason for her immediate change of condition. I probably would not have approved the Valium if I had been aware of her lack of oxygen." She further stated that "I was not informed until today" of the failure to administer oxygen prior to her change of condition.

2) On 9/27/07 at 1:06 p.m., the Hospice Registered Nurse stated, "I was called regarding [Resident #4's] change of condition [on 9/16/07]. I called [Hospice Physician] who gave me orders. I called and gave the orders to the nurse at the nursing home. I was not informed of her pulse ox and that [Resident #4] had been without oxygen until they called me today. [Hospice Physician] does not know either. He or even I would have said to leave her on the oxygen for one hour then reassess. The other orders would not have been given."

3) On 9/27/07 at 2:10 p.m., the interim Administrator stated, "I spoke with [Attending Physician] about 30 minutes ago. I asked him if he had been notified on 9/16/07 that [Resident #4] had been oxygen deprived. He said 'no', he had not. He said he spoke with her son a few days later and he made him aware."

g. The Nurse's Notes dated 9/16/07 at 11:10 p.m. documented, "Checked on R unable to abate VS at this time." The Nurse's Notes at

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F 309	Continued From page 16 11:20 p.m. documented, "Notified Coroner." The 11:10 p.m. entry in the Nurses Notes was the next entry after the 10:00 p.m. entry, there was no other documented assessment of the resident's condition between 10 p.m. and 11:10 p.m. 1) LPN #1 was asked to describe the monitoring and assessment of the resident from the time of oxygen deprivation discovery until her death. The LPN stated, "I didn't chart it but I assessed her around 7:30 p.m., that's charted at 2200 [10:00 p.m.]. The next assessment was about 8:30 p.m. I took the vital signs, I didn't chart. At 9:30 I took vital signs, they were the same. I didn't chart it. The only things I did wrong was not charting and not telling the Doctor about the oxygen." 2) CNA #1 documented on a witness form dated 9/19/07 at 1:30 p.m., "[LPN #1] told me that [Resident #4] had been taken to her room and left on her bottle of oxygen and that it was empty and did I know who took her to her room. I did not. After [LPN #3] came in she asked me to assist her with [Resident #4]. She attempted to suction her and did not get anything and asked me to stay with her while she went to call [Director of Nursing]. I stayed in her room and monitored her vitals until about 10:30 when [LPN #1] told me I could go home. We did change her from the cannula to a mask which seemed to make it easier for her to breathe." On 9/27/07 at 2:00 p.m., CNA #1 stated, "I stayed in the room [on 9/16/07] from 8:15 p.m. until 10:30 p.m. because [LPN #3], one of the LPN's, asked me to. She was the first shift nurse and was going home. During this period [LPN #3] tried to suction [Resident #4] once and checked her pulse ox once. No one assessed her vital	F 309		

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signs, listened to her chest or anything other than looked at her pulse ox once [LPN #3]. I was told to sit with her, not told to do vital signs or anything else. At 10:30 p.m., I was told I could leave."

h. On 9/27/07 at 8:40 a.m., the Director of Nursing stated that no in-services had been presented to the staff since 9/16/07 regarding oxygen administration, physician orders, assessments and physician notification or monitoring of residents post change of condition.

i. The Immediate Jeopardy was removed and the scope/severity lowered to "G" on 9/28/07 at 8:45 a.m. when the facility implemented the following Plan of Removal:

"Plan of removal"

"09/27/07"

"1. All residents with orders for oxygen therapy were assessed by Respiratory Therapy beginning on 9/21/07 at 8 pm by [specific name], Registered Respiratory Therapist and completed on 09/23/07 at 2:10 pm by [specific name], Certified Respiratory Therapist. The residents with oxygen therapy orders will continue to be monitored twice a day, morning and evening on a daily basis by the Respiratory Therapy Department. Any changes will be reported to the charge nurse of that respective resident. The Respiratory Therapy Department will monitor and record resident's respiratory status at each assessment.

The Licensed Practical Nurse will monitor and assess for proper application, flow rate and amount of oxygen in the E cylinder if applicable. The Licensed Practical Nurse will record the

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F 309	Continued From page 18 oxygen status on all residents on oxygen therapy before and after each meal, shift change, evening medication pass, and every four hours during the night. Before the shift begins, all professional nursing staff will be in-serviced starting 9/27/07 at 3pm and continuing until all professional incoming staff has been in-serviced. In-services will be completed by 09/28/07 at 11:55pm. All professional staff will be in-serviced on the Resident Transport with Oxygen policy, Notification Of Change In Resident ' s Condition policy, assessment and monitoring of residents, and the correct information to report to physician. Non-licensed staff will be in-serviced on the Resident Transport with Oxygen policy with emphasize on their responsibilities. (Example: notifying the Licensed Practical Nurse before and after transport.). The Licensed Practical Nurse will round on each resident at the beginning of shift and routinely monitor throughout the shift for any negative change in condition. (Example: vital signs, oxygen levels, physical changes, respiratory status, mental status, psychosocial needs, therapy need, abnormal labs, or results of any diagnostic testing affecting the care of the resident). 2. During routine assessment by the Respiratory Therapy Department any change in condition or concerns regarding the resident will be reported to the Licensed Practical Nurse responsible for that resident."	F 309		