STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. BUILDING _____ B. WING _____	05/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE SPRINGS, A GRACE LIVING CENTER COMMUNITY	5800 WEST OKMULGEE MUSKOGEE, OK 74401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/02/17 an Immediate Jeopardy (IJ) was determined to exist due to the facility's failure to assess, monitor, and intervene for resident #1 who was experiencing respiratory distress. The resident was in respiratory distress for five hours before being transported to the hospital. A hospital record, dated 10/05/16, documented at 7:32 p.m. the resident was pulseless. The record documented the resident's time of death was 7:36 p.m. The IJ situation was verified with the Oklahoma State Department of Health. On 05/02/17 at 5:01 p.m., the administrator (ADM) and the director of nurses (DON) were notified of the IJ situation regarding the resident not being transported to the hospital when experiencing respiratory distress. On 05/02/17 at 6:47 p.m., the plan of removal was accepted for the Immediate Jeopardy pertaining to [MEDICAL CONDITION]. The Plan of Removal for Immediate Jeopardy documented: All nurses will be inserviced on the respiratory distress policy and procedure. They will also be inserviced to notify the physician of a patient's status and to document. If unable to reach the physician, call the director of nurses (DON). If the resident's condition worsens call emergency management services association (EMSA) for transport to the hospital. Residents receiving oxygen will be assessed to ensure no respiratory distress noted. The facility policy for [MEDICAL CONDITION] will be updated to include: the nurse will remain with the resident when experiencing [MEDICAL CONDITION], the nurse will have staff call the physician, and bring needed items to the nurse. This will be done by midnight 05/02/17. On 05/02/17 the nurse staff who were present in the facility were inserviced on the facility policy for respiratory distress. The nurse staff who were not in the facility were contacted via the telephone. On 05/02/17 at 7:51 p.m., the last resident on oxygen therapy was assessed for respiratory distress. On 05/02/17 at 08:16 p.m., the facility inservice sheet documented the last nurse had been inserviced regarding respiratory distress. On 05/03/17 interviews were conducted with staff regarding inservices for education pertaining to content for Immediate Jeopardy removal. The staff stated an inservice was provided the previous evening in the facility and some staff stated they had been inserviced via the telephone. The staff was able to verbalize understanding of information provided in the inservice pertaining to the plan of removal. On 05/02/17 at 8:16 p.m., the IJ was removed when all components of the plan of removal had been completed. The deficiency remained at a isolated level of actual harm. Based on interview and record review, it was determined the facility failed to provide necessary care and services for one (#1) of five residents reviewed for highest levels of well-being. The facility failed to assess, monitor, and intervene for a resident experiencing respiratory distress. The resident was experiencing respiratory distress with an oxygen saturation of 55%. The resident was in respiratory distress for five hours prior to being transported to the hospital. A hospital record, dated 10/05/16, documented at 7:32 p.m. the resident was pulseless. The record documented the resident's time of death was 7:36 p.m. The facility identified 25 residents who received oxygen therapy resided in the facility. Findings: The facility policy for respiratory distress documented the staff would rapidly assess the resident's respiratory status, lung sounds, and vital signs. The policy documented the resident would be positioned to facilitate breathing and the respiratory therapist would be notified when possible. The policy documented the staff would stay with the resident and have another staff member notify the physician. The policy documented the staff would apply a pulse oximeter and obtain a baseline reading. The policy documented the staff would apply a non-rebreather mask at five to 15 liters per minute providing 100% oxygen. The policy documented the staff would notify the physician of the resident's status for further orders. The policy documented the staff would assess for worsening signs of the resident's condition. The policy documented the staff would call EMSA for transport to the hospital. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission assessment, dated 11/19/15, documented the resident was independent for daily decision making. The assessment documented the resident required extensive to limited assistance for ADLs. The care plan, updated 04/20/16, documented the resident had an activity of daily living (ADL) self care performance deficit related to limited mobility, shortness of breath (SOB), and impaired balance. The care plan documented the resident had altered cardiovascular status related to a history of [MEDICAL CONDITION] infarction and [MEDICAL CONDITION] The care plan documented the resident had hypertension. The care plan documented the resident had [MEDICAL CONDITION] and [MEDICAL CONDITION] and was on oxygen therapy. The care plan documented the resident had a history of [REDACTED]. The care plan documented the resident was a full code and if the resident was found in respiratory distress emergency services would be activated immediately. The care plan documented the resident wished to be resuscitated and would receive all available emergency services and aggressive treatments. The quarterly assessment, dated 07/15/16, documented the resident was severly impaired for daily decision making. The assessment documented the resident required extensive to total assistance for ADLs. A physician order, dated 08/02/16, documented the resident was a full code. A physician order, dated 09/16/16, documented an order for [REDACTED]. A nurse note, dated 10/03/16, documented the resident was alert and oriented times three. The note documented the resident's vital signs were within normal limits and wheezes were present in the upper lobes of the resident's lungs upon auscultation. The note documented the resident's oxygen saturation was 97%. No nurse assessment was performed on 10/04/16 related to the resident's respiratory status. A nurse note, dated 10/05/16, documented at 2:00 p.m. licensed practical nurse (LPN) #1 entered the resident's room and found the resident in respiratory distress. The note documented the resident's vital signs were as follows: blood pressure 199/119, respirations 16 and labored, pulse 89, oxygen saturation 55% on 3 liters of oxygen. The note documented the resident's head of the bed was elevated, a breathing treatment was administered, and the physician was contacted. (The note did not document the time the nurse attempted to contact the physician.) The note documented a new order for a STAT chest Xray and a one time dose of [MEDICATION NAME] for the resident's blood pressure. The note documented to continue the breathing treatment and notify the physician of the Xray results. (The note did not document the time the Xray was ordered.) The note documented the feeding tube was disconnected and the medication was administered as ordered. (The note did not document the time the medication was administered to the resident.) The note documented PK Xray arrived at approximately 5:30 p.m. The note documented the results of the Xray were obtained at 6:00 p.m. and no acute pathology was found. (The note did not document if the physician had been contacted with the Xray results.) The note documented the

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. BUILDING _____ B. WING _____	05/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE SPRINGS, A GRACE LIVING CENTER COMMUNITY	5800 WEST OKMULGEE MUSKOGEE, OK 74401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) resident's oxygen saturation was reassessed at 78% on three liters of oxygen. (The note did not document the time the assessment was performed.) The note documented at 7:00 p.m. staff asked for assistance to change the resident's linens and stated the resident had thick mucous coming from his mouth. The note documented upon entrance to the resident's room the nurse observed the resident in acute respiratory distress. The note documented the resident was turned to his left side to prevent aspiration and the resident's vital signs were obtained as follows: blood pressure 85/53, respirations 12, pulse 70, oxygen saturation 54%. The note documented the nurse called an ambulance to transport the resident to the hospital. (The note did not document the time the ambulance was called.) The note documented an attempt was made to contact the physician and family related to a change in the resident's condition. (The note did not document the time the nurse attempted to contact the physician and family.) The note documented the DON was notified. (The note did not document the time the DON was contacted.) The note documented the hospital called at 9:00 p.m. to report the resident had passed away while in the emergency room . (The note did not document the time the resident passed away.) The Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The facility could not provide an order for [REDACTED]. The emergency management services (EMS) dispatch record, dated 10/05/16, documented at 7:18 p.m. upon arrival to the nursing facility the resident's mental status was altered, the resident was experiencing SOB, [MEDICAL CONDITION], and [MEDICAL CONDITION]. The narrative documented the nurse reported the resident had been experiencing SOB the day before with low oxygen saturation. The narrative documented the nurse had ordered an Xray of the patient's chest and it came back clear. The nurse stated when she arrived at work that day, the resident was again experiencing SOB and low oxygen saturation. The narrative documented upon the resident's initial assessment the resident was unresponsive which was not normal for the resident. The narrative documented the resident's lungs had coarse rhonci bilaterally in the upper lobes. The narrative documented there was a delay on the scene related to getting paperwork from the nurse. The narrative documented the resident was put on four liters of oxygen and the initial pulse oximetry was less than 50%. The resident was intubated and stayed in asystole during transport. The hospital record, dated 10/05/16, documented the resident presented to the emergency department from the nursing home after [MEDICAL CONDITION]. The record documented the resident had been SOB all day and the previous night with oxygen saturations in the 50's and improved to 70 after a breathing treatment. The record documented the resident had an oxygen saturation in the 50's all day and upon arrival to the emergency room the resident was agonal (gasping respirations) and the resident's oxygen saturation was in the 30's. The record documented the resident arrested prior to transport to the emergency department. The record documented the resident was intubated during compressions and the patient was given [MEDICATION NAME]. The record documented the resident was still in asystole ([MEDICAL CONDITION]) upon arrival to the emergency department. The record documented at 7:32 p.m. the resident was pulseless. The record documented the resident's time of death was 7:36 p.m. On 05/02/17 at 12:45 p.m., LPN #1 was interviewed. The LPN stated the resident had been having issues with his oxygen saturation the day before he passed away. The LPN stated the resident was more communicative than normal that day and had asked for a butterfinger. The LPN stated she had tried to contact the physician when the resident started having respiratory distress and had to wait for the physician to call her back with an order. The LPN stated she always had trouble making contact with the physician. The LPN stated she received a verbal order from the physician for a chest Xray, to give the resident an extra [MEDICATION NAME] for his increased blood pressure, and to call the physician with the results of the Xray. The LPN stated the physician was not concerned with a resident having low oxygen saturations with [MEDICAL CONDITION]. The LPN stated the physician stated not to be concerned and just keep monitoring the resident. The LPN stated about an hour after she gave the resident the extra [MEDICATION NAME] his oxygen saturations began to fall. The LPN stated she thought she had to wait for the chest Xray and an order from the physician before the resident could be transported to the hospital. The LPN stated the CNA came to ask for help to change the resident's linens and stated the resident was vomiting. The LPN stated when she entered the room the resident was sweating and vomiting. The LPN stated she turned the resident on his left side to keep him from aspirating, took the resident's vitals, and called the ambulance to transport the resident to the hospital. On 05/02/17 at 1:20 p.m., certified nurse aide (CNA) #1 was interviewed. The CNA stated she arrived to work at 2:00 p.m. and was instructed by the nurse to keep a good eye on the resident. The CNA stated she went in to check on the resident and he was really sweaty and his clothes and bedding were saturated. The CNA stated she had never had a resident act like that before and it really scared her. The CNA stated she asked another CNA for assistance to change the resident's bedding. The CNA stated the resident was really loose and couldn't hold his head up. The CNA stated the resident looked really scary. The CNA stated she notified the nurse. The CNA stated the nurse took the resident's vital signs and they were low. The CNA stated the nurse was on the phone and whoever she was talking to wouldn't let her send the resident to the hospital. The CNA stated foam was coming out of the resident's mouth. The CNA stated the nurse said she had everything under control and that was when she sent the resident to the hospital. On 05/02/17 at 2:30 p.m., the physician was interviewed. The physician was asked if he could tell me about the events leading up to the resident's discharge from the facility. The physician stated October was a long time ago, he would have to review the resident's records, and it may be a week before he could get back with me. On 05/02/17 at 2:35 p.m., CNA #2 was interviewed. The CNA stated he was asked to help another CNA change the resident's linens. The CNA stated he remembered they had to hold the resident's head up to help him breathe. On 05/02/17 at 2:40 p.m., LPN #2 was interviewed. The LPN stated she was working the day of the incident with the resident. The LPN stated the resident's nurse could not get in touch with the physician for an order but had kept trying. The LPN stated the physician had ordered another [MEDICATION NAME] for the resident. The LPN stated the resident's nurse was very frustrated because the physician wouldn't give her orders to do anything. On 05/02/17 at 3:08 p.m., the physician called back to speak with the surveyor. The physician stated the facility had given him some information about the resident. The physician stated, If you have read the nurse note, that's about all I can tell you. The physician stated he gave the nurse an order for [REDACTED]. The physician stated obviously with oxygen saturations of 55%, he wouldn't have wanted the resident to lay there that long without an Xray. On 05/02/17 at 4:15 p.m., the DON was interviewed. The DON stated she was not working at the facility when the incident happened with the resident. The DON was asked if she had problems contacting the physician. The DON stated she didn't usually have a problem making contact with the physician. The DON was asked if the facility had recognized respiratory distress as a problem in their quality assurance (QA) meetings. The DON stated she had just been made aware of QA meetings and one was scheduled for the following week. The DON stated no QA meetings had been performed in 2017. The DON stated respiratory distress had not been recognized as a problem in their morning stand up meetings. The DON was asked how new staff was trained when coming to the facility. The DON stated she had implemented training for new staff as follows: new staff would be put with the most experienced nurse at the facility for two to three days for computer and point click care training. The DON stated the regional nurse also worked with the staff one on one for computer training. The DON stated the new nursing staff would shadow a nurse on the hall for two to three days and once they were comfortable they would run the shift. On 05/03/17 at 10:05 a.m., the quality assurance nurse was asked if the facility had recognized respiratory distress as a problem in the QA meetings. The QA nurse reviewed the meeting notes for 2016 and stated respiratory distress had not been recognized during the QA process.