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

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

**LEVEL OF HARM - IMMEDIATE JEOPARDY**

**Residents Affected - Few**

A nurse note, dated 10/05/16, documented at 2:00 p.m. licensed practical nurse (LPN) #1 entered the resident's room and 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. The policy documented the resident was alert and oriented times three. The note documented the resident required extensive to limited assistance for ADLs. A nurse note, dated 09/18/16, documented the resident was experiencing respiratory distress with an oxygen saturation of 55%. The resident was in respiratory distress 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. The resident was experiencing respiratory distress with an oxygen saturation of 55%. The resident was in respiratory distress 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 policy for [MEDICAL CONDITION] and [MEDICAL CONDITION] related to limited mobility, shortness of breath (SOB), and impaired balance. The care plan documented the resident had [MEDICAL CONDITION].

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.

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 resident experiencing respiratory distress.

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Residents Affected - Few

(continued... from page 1)

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 but the resident had to wait for the physician to call her back with an order. She also stated she 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 extra [MEDICATION NAME] for his increased blood pressure, and to call the physician with the results of the Xray. The LPN stated the resident was not concerned with having low oxygen saturations with [MEDICAL CONDITION]. The LPN stated the physician had ordered not to be concerned and just keep monitoring the resident. The LPN stated the resident had been seen by the physician at [MEDICATION NAME] earlier that day. The LPN stated the resident was still having trouble breathing and the LPN stated she had tried to contact the physician and the family and no one had returned her call.

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 he 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 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 05/03/17 at 10:05 a.m., the quality assurance nurse was interviewed. The quality assurance nurse had 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.