| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375146 | A. Building<br>B. Wing | 08/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Broadway Care & Rehab Center | 1622 East Broadway<br>Muskogee, OK 74403 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0569<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.<br><br>25225<br><br>Based on interview and record review, it was determined the facility failed to notify eight (#3, #21, #30, #31, #35, #40, #41, and #58) of 25 residents or representatives, whose payer source was Medicaid, when their resource balances were within $200 of the amount allowed for each resident. The facility identified 40 residents as having Medicaid as a payer source.<br><br>Findings:<br><br>Review of residents' trust fund account balances, effective 08/16/21, revealed the following:<br><br>~ resident #21 had a balance of $6,303.66;<br><br>~ resident #41 had a balance of $5,076.32;<br><br>~ resident #3 had a balance of $4,309.46;<br><br>~ resident #31 had a balance of $5,937.16;<br><br>~ resident #35 had a balance of $7,082.60;<br><br>~ resident #58 had a balance of $5,677.27;<br><br>~ resident #30 had a balance of $6,806.55; and<br><br>~ resident #40 had a balance of $4,370.99.<br><br>On 08/16/21 at 12:45 p.m., the business office manager stated all the residents had Medicaid as their payer source. She stated the residents had all received stimulus checks, and those credits had increased the balances of their trust accounts.<br><br>When deducting the amounts of the credits for the stimulus checks, it was noted the residents had the following balances:<br><br>~ resident #21 - $4303.66;<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0569<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | ~ resident #41 - $3076.32;<br><br>~ resident #3 - $2309.46;<br><br>~ resident #31 - $3937.16;<br><br>~ resident #35 - $5082.60;<br><br>~ resident #58 - $4277.27;<br><br>~ resident #30 - $4806.55; and<br><br>~ resident #40 - $2970.99.<br><br>These amounts were still over the $2000.00 resource limit allowed by Medicaid, and there was no documentation to show the residents or their representatives had been notified the accounts were within $200 of reaching the resource limit.<br><br>On 08/16/21 at 1:03 p.m., the business office manager was asked what the resource limit was for a resident receiving Medicaid services as a payer source. She stated, I hear it is $2000, but I keep hearing they are being lenient on it. She was asked why the account balances were greater than $2000 for each resident, even after deducting for the stimulus checks. She stated, We don't have anything to spend the money on. She stated many of the residents already had burial arrangements taken care of, and the facility had not identified anything the residents needed, or they said they did not want anything. The business office manager stated she was not aware the residents could lose Medicaid as their payer source if they exceeded their resource limit.<br><br>On 08/16/21 at 12:55 p.m., the administrator stated she was not aware of any leniency or that the account balances were so high. |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225<br><br>On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist when the facility failed to notify the physician when a resident had a significant change in condition.<br><br>Resident #68 was admitted to the facility on [DATE] with diagnoses that included a history of deep vein thrombosis, atrial fibrillation, atrial flutter, multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, and acute intraoperative massive pulmonary embolism. On [DATE], [DATE], and [DATE], the resident exhibited signs of symptoms of a change in her respiratory status. Staff did not notify the physician when the resident showed signs of a change in her respiratory status. On [DATE], the resident was found unresponsive. Cardiopulmonary resuscitation was started but was unsuccessful. The resident expired on [DATE].<br><br>At 11:46 a.m., the Oklahoma State Department of Health verified the existence of the IJ situation.<br><br>At 11:49 a.m., the administration, director of nursing, and corporate administrator were notified of the IJ situation related to the facility's failure to notify the physician of a significant change in condition.<br><br>On [DATE] at 3:57 p.m., an acceptable plan of removal was provided. The plan of removal documented,<br><br>. 1. All residents in the facility who currently have oxygen will be reassessed by a Licensed Nurse to ensure that the oxygen liter flow being delivered matches the physician order for oxygen administration. Pulse Ox [pulse oximetry] will be obtained for all residents currently receiving oxygen. All findings will be documented in their medical record. [Physician name withheld] will be notified of any abnormal findings . "<br><br>2. In-services will be initiated immediately for all Licensed Nurses concerning respiratory assessment. These in-services will be continued/conducted for Licensed Nurses as they report to work for their shifts to ensure all Licensed Staff receive training. This will include:<br><br>~ Symptoms of low O2 sats [oxygen saturation] and high O2 sats,<br><br>~ Following treatment orders for breathing treatments such as nebulizers which will include checking MD order for the treatment and documentation on the MARS/TARS [medication administration sheets/treatment administration sheets] after the treatment is administered.<br><br>~ Ensuring all oxygen flow is delivered per physician order<br><br>~ Notifying the physician for any abnormal pulse ox reading, changes in mental status complaints of SOB [shortness of breath], cough, and abnormal lung sounds .<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 3. In-service will be initiated immediately for all Licensed Nurses concerning notification of physician for any resident change in condition. This will include any new resident complaints, any subtle changes in resident's ADL [activities of daily living] abilities, subtle changes in resident's level of consciousness or cognition, changes in vital signs, increased SOB, etc. This in-service will also include notification of physician if any medication is not available for administration - Nurse may not 'hold' a medication without a physician order .<br><br>4. In-service will be initiated immediately for all Licensed Nurses concerning addressing O2 flow rates .<br><br>5. Pharmacy will conduct medication audit for all residents in the facility to ensure that all ordered medications are present for administration. These audits will be initiated this afternoon .<br><br>6. Direct Care Nursing staff to be in-serviced immediately concerning notification to Charge Nurse any changes noted in a resident's condition. This will include any resident complaint of discomfort, changes in resident's ability to perform ADLs, changes in resident's cognition, changes in resident's level of alertness, changes in resident's communication, noted increased weakness or balance issues .<br><br>7. Direct Care staff will be questioned upon completion of the above in-service, if they have any resident that has had changes in condition. Any resident noted will be reassessed by a Licensed Nurse with the assessment documented in the resident's medical record and notification of the changes, if noted, to the physician .<br><br>8. Nurse Managers will check the Oxygen Administration for all residents receiving oxygen daily x the next week to ensure that the oxygen flow rates are being administered according to physician orders .<br><br>9. Facility has posted the INTERACT Care Path for symptoms of SOB and the INTERACT Care Path for Acute Mental Status Change .<br><br>10. Any employee who was unable to come to facility for in service will be taken off of the schedule until they can be in services .<br><br>The immediate jeopardy was removed on [DATE] at 10:20 p.m. when all components of the plan of removal were carried out. The deficient practice remained at a pattern of actual harm.<br><br>Based on interview and record review, it was determined the facility failed to notify the physician of a significant change in condition for one (#68) of 24 sampled residents reviewed for change in condition after the resident exhibited signs of a change in respiratory status. This had the potential to affect 64 of 64 residents who resided at the facility.<br><br>Findings:<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A hospital history and physical report for resident #68, dated [DATE] and located in the facility's scanned documents, documented, . PMH [past medical history] of . atrial fibrillation previously on Eliquis who presents . with CC [chief complaint] of numbness and tingling to her left lower leg . intermittent numbness and tingling to left lower leg and occasionally similar symptoms to the right lower leg and bilateral wrists. Her symptoms have been progressive. Over the last month, she has had more constant numbness and tingling to the left lower leg and foot. She now reports a cold feeling to the limb. She had not previously sought medical attention after losing her job and health insurance . No chest pain or shortness of breath . palpitation intermittently. She stopped taking her Eliquis about 3 to 5 days ago after running out of medication .<br><br>Hospital discharge documentation, dated [DATE] and located in the facility's scanned documents, documented, . Your Diagnosis[:] Atrial Flutter, physical deconditioning, right leg deep vein thrombosis (DVT) . multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, acute intraoperative massive pulmonary embolism - s/p [status post] catheter direct TPA [tissue plasminogen activator, used to dissolve blood clots] thrombolysis, subacute thrombotic occlusion of the left iliac artery and left femoral-popliteal trifurcation vessels, acute kidney injury, anemia, hypertension, hypertension, hypokalemia,, moderate aortic regurgitation, ventricular septal defect, multiple fractures of ribs .<br><br>Home needs: oxygen; 'Contact physician for: increased swelling, chest pain' 'Contact physician for: increased shortness of breath . '<br><br>Education: .<br><br>Atrial Flutter . get help right away if you have: . shortness of breath .<br><br>Peripheral Vascular Disease . get help right away if: . you have chest pain or trouble breathing .<br><br>Deep Vein Thrombosis . get help right away if: . you have . shortness of breath .<br><br>Cardiogenic shock . what are the signs or symptoms . shallow, quick breathing, or shortness of breath . Get help right away if you: . Have shortness of breath .<br><br>Discharge physician orders documented the resident was to receive Apixaban (Eliquis, an anticoagulant) 5 milligrams (mgs) twice daily for the prevention of blood clots.<br><br>Resident #68 was admitted to the facility on [DATE] with diagnoses that included atrial flutter, chronic embolism, and deep vein thrombosis.<br><br>A medication administration note, dated [DATE] at 8:23 p.m., documented, . waiting on pharmacy .<br><br>A medication administration note, dated [DATE] at 9:10 a.m., documented, . Apixaban Tablet 5 MG Give 1 tablet by mouth two times a day related to chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity .<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A medication administration note, dated [DATE] at 9:44 a.m., documented, . Pharmacy notified that medication Apixaban has not made it to facility, pharmacist stated the medication needed insurance approval and he would be sending a form over to the facility to fill out. Apixaban Tablet 5 MG placed on hold until paperwork can be submitted to insurance .<br><br>Review of facility medication administration records revealed the resident did not receive Eliquis, as ordered by the physician from admission on [DATE] until 8:00 p.m. on [DATE]. There was no documentation to show the physician was notified the resident did not receive the ordered medication.<br><br>The resident's care plan, dated [DATE], documented the resident had a problem related to an imbalance between oxygen supply and demand. The goal was the resident would maintain blood pressure, pulse, and respirations within prescribed limits during activity through the review date. Interventions included to administer medications as prescribed; assess for signs and symptoms of activity intolerance such as statements of fatigue and weakness, exertional dyspnea, and chest pain; and to report decreased activity tolerance to the physician.<br><br>An admission assessment, dated [DATE], documented the resident was moderately impaired in cognitive skills for daily decision making; required limited assistance for most activities of daily living; had diagnoses that included blood clots and heart failure; and was receiving oxygen therapy. The assessment documented the resident was not receiving an anticoagulant medication.<br><br>A progress note, dated [DATE] at 4:34 p.m., documented, . Resident arrived in facility . No acute distress or discomfort noted . One person limited assist is required for transfers and ambulation due to general weakness. Continent of bowel and bladder with occasional episodes of incontinence requiring extensive assist. Staff strive to keep call light and fluids within easy reach.<br><br>A progress note, dated [DATE] at 1:40 a.m., documented, . respirations unlabored via nasal cannula, in place and patent .<br><br>A health status note, dated [DATE] at 7:13 a.m., documented, . Respirations are even and unlabored, clear to auscultation . Resident uses oxygen via nasal cannula, respirations unlabored . O2 at 2LPM [two liters per minute] via nasal cannula . for Shortness of Breath related to acute respiratory failure with hypoxia .<br><br>A health status note, dated [DATE] at 7:45 a.m., documented, . respirations easy on room air 02 off for awhile giving nose a rest continues with good 02 Sat on room air .<br><br>A health status note, dated [DATE] at 9:57 a.m., documented, . Respiration with ease 02 flowing at 2LPM via NC. [nasal cannula] .<br><br>A health status note, dated [DATE] at 11:40 a.m., documented, . focused assessment r/t [related to] resident requesting breathing treatment. no orders for breathing treatment. [physician name withheld] office notified with a request of breathing treatments .<br><br>Review of the resident's clinical record revealed no documentation the resident's respiratory status was assessed and monitored. There was no documentation the physician's office was notified of the resident's request for a breathing treatment. There was no documentation an order was received for a breathing treatment or that one was provided.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A health status note, dated [DATE] at 1:48 p.m., documented, . focused assessment r/t resident continues to tell staff she can't breath, 02 sat [blood oxygen level] 99%. 02 bumped up to 3L/NC. resident setting on side of bed leaning forward, nurse spoke with resident about trying to relax and breath in through her nose out through her mouth .<br><br>Review of the resident's clinical documentation reveals no documentation the resident's physician was notified after the resident complained of being unable to breath on [DATE]. There was no documentation the facility notified the physician of the increase in the oxygen flow rate. There was no documentation of any previous reports that the resident was unable to breath.<br><br>A health status note, dated [DATE] at 11:10 a.m., documented, . focused assessment r/t residents breathing pattern. Resident is breathing with her mouth open and her oxygen in her mouth. Residents O2 sat 94 on 3L .<br><br>Review of the resident's clinical record revealed no documentation the resident's physician was notified of the resident's decreased blood oxygenation level and continued difficulties with breathing on [DATE].<br><br>A health status note, dated [DATE] at 1:49 a.m., documented, . [12:50 a.m.] entered resident room and noted resident wasn't breathing. Resident assisted to floor with assist of 3 staff CPR [cardiopulmonary resuscitation] started nurse from back nurses station called EMS [Emergency Medical Services]. EMS here at 1 am CPR stopped at that time. EMT's [emergency medical technicians] received order to stop CPR at that time .<br><br>On [DATE] at 9:59 a.m., licensed practical nurse (LPN) #5, who was the resident's nurse, was asked what the resident's admitting diagnoses were. She stated atypical atrial flutter, chronic embolism of the deep veins of the lower extremities, hypertension, anemia, heart failure at one time, acute kidney failure, and acute respiratory failure with hypoxia. LPN #5 was asked what things were monitored for with these diagnoses. She stated, Pulse ox [blood saturation level], breathing, color of the skin, if diaphoretic.<br><br>LPN #5 was asked what the facility did when the resident requested a breathing treatment on [DATE]. She stated, I guess I should have followed up with that. She stated she had notified the physician, received an order, and then started with the breathing treatment he had ordered. She was asked where the order was documented. She reviewed the clinical record and stated, I don't see it do I. I don't see one. She stated there was no documentation a breathing treatment had been given.<br><br>LPN #5 was asked what the facility did after the resident complained of being unable to breath on [DATE]. She stated, I made sure the head of the bed was raised and repositioned her. She stated, With mouth breathing, I put the oxygen in her mouth and turned it up to make sure she was breathing it in. She stated the resident's blood oxygen saturation levels were in the middle 90's. She stated, I didn't do very good charting. LPN #5 was asked if she notified the physician. She stated, I always fax him. She was asked where it was documented the physician was notified of the resident's complaint of being unable to breath and that she had turned the oxygen flow rate up. She stated, Should be in the chart.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | LPN #5 was asked if the physician was notified on [DATE] and how he was notified. She stated, We have to fax him every time. She was asked if she faxed him on this date. She shook her head in a yes motion and stated it should be on the chart. LPN #5 was asked if there was any other place the information might be documented. She stated, Everything I would have charted would be in this area right here [pointed at the progress note section of the electronic medical record]. Other than me doing it, it it's not charted, it's not done.<br><br>On [DATE] at 10:18 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were asked where the physician's order was for a breathing treatment on [DATE]. They reviewed the clinical record, and the ADON stated, I don't see an order. The DON stated, I don't either. They were asked where the documentation was the resident received a breathing treatment. The ADON stated, I don't see it on any MAR [medication administration sheet].<br><br>The DON and ADON were asked what the staff did when the resident began to have complaints of being unable to breath on [DATE]. The ADON stated, It looks like they did the deep breathing and breathing through her mouth for that day. They were asked where it was documented the physician was notified. They reviewed the clinical record, and the ADON stated, I did not see any in the notes.<br><br>The DON and ADON were asked how the staff assessed and monitor the resident on [DATE] after she was noted to have a change in her breathing pattern, breathing with her mouth open, and her oxygen in her mouth. The ADON stated, I don't see any assessments.<br><br>The DON and ADON were asked how the physician was notified of the resident's continued difficulties with breathing on [DATE]. The ADON stated the staff would have notified him via fax. She was asked where that information was. She stated it should be on the chart. The surveyor informed her there was no documentation the physician was notified. They were asked why the staff did not notify the physician. The ADON stated, I can't answer that. I'm not the nurse.<br><br>On [DATE] at 11:09 a.m., the resident's physician was asked if the facility had notified him the resident had missed dosage of Eliquis from admission on [DATE] until 8:00 p.m. on [DATE]. He stated he did not recall it, but they may have. He stated sometimes they had trouble getting insurance companies to pay for Eliquis. He was asked what the dangers were of a resident not receiving their Eliquis. He stated they could certainly have a pulmonary embolis or stroke. He stated he would normally place a resident on Lovenox (an anticoagulant) until a resident was able to get their Eliquis.<br><br>The physician was asked what the staff should have been monitoring the resident for. He stated oxygen levels, normal vitals signs, and respiratory status. He was asked if the facility notified him on [DATE] when the resident stated she was have difficulty breathing. He stated he could remember being called on her, but he could not state what days or for what reason. He was asked if staff had notified him they had increased her oxygen flow rate. He stated he did not specifically remember the conversation. He was asked if the facility notified him on [DATE] when the resident continued to have difficulties breathing. He stated he did not remember. He was asked what his expectation was if a resident began to have a change in condition or began to show signs and symptoms of distress. He stated he expected to be notified. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225<br><br>On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist when the facility failed to assess and monitor a resident with a significant change in condition.<br><br>Resident #68 was admitted to the facility on [DATE] with diagnoses that included a history of deep vein thrombosis, atrial fibrillation, atrial flutter, multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, and acute intraoperative massive pulmonary embolism. On [DATE], [DATE], and [DATE], the resident exhibited signs of symptoms of a change in her respiratory status. Staff did not assess for the cause of the change in respiratory status. The staff did not monitor the resident after showing signs of a change in condition. On [DATE], the resident was found unresponsive. Cardiopulmonary resuscitation was started but was unsuccessful. The resident expired on [DATE].<br><br>At 11:46 a.m., the Oklahoma State Department of Health verified the existence of the IJ situation.<br><br>At 11:49 a.m., the administration, director of nursing, and corporate administrator were notified of the IJ situation related to the facility's failure to assess and monitor the resident.<br><br>On [DATE] at 3:57 p.m., an acceptable plan of removal was provided. The plan of removal documented,<br><br>. 1. All residents in the facility who currently have oxygen will be reassessed by a Licensed Nurse to ensure that the oxygen liter flow being delivered matches the physician order for oxygen administration. Pulse Ox [pulse oximetry] will be obtained for all residents currently receiving oxygen. All findings will be documented in their medical record. [Physician name withheld] will be notified of any abnormal findings . "<br><br>2. In-services will be initiated immediately for all Licensed Nurses concerning respiratory assessment. These in-services will be continued/conducted for Licensed Nurses as they report to work for their shifts to ensure all Licensed Staff receive training. This will include:<br><br>~ Symptoms of low O2 sats [oxygen saturation] and high O2 sats,<br><br>~ Following treatment orders for breathing treatments such as nebulizers which will include checking MD order for the treatment and documentation on the MARS/TARS [medication administration sheets/treatment administration sheets] after the treatment is administered.<br><br>~ Ensuring all oxygen flow is delivered per physician order<br><br>~ Notifying the physician for any abnormal pulse ox reading, changes in mental status complaints of SOB [shortness of breath], cough, and abnormal lung sounds .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 3. In-service will be initiated immediately for all Licensed Nurses concerning notification of physician for any resident change in condition. This will include any new resident complaints, any subtle changes in resident's ADL [activities of daily living] abilities, subtle changes in resident's level of consciousness or cognition, changes in vital signs, increased SOB, etc. This in-service will also include notification of physician if any medication is not available for administration - Nurse may not 'hold' a medication without a physician order .<br><br>4. In-service will be initiated immediately for all Licensed Nurses concerning addressing O2 flow rates .<br><br>5. Pharmacy will conduct medication audit for all residents in the facility to ensure that all ordered medications are present for administration. These audits will be initiated this afternoon .<br><br>6. Direct Care Nursing staff to be in-serviced immediately concerning notification to Charge Nurse any changes noted in a resident's condition. This will include any resident complaint of discomfort, changes in resident's ability to perform ADLs, changes in resident's cognition, changes in resident's level of alertness, changes in resident's communication, noted increased weakness or balance issues .<br><br>7. Direct Care staff will be questioned upon completion of the above in-service, if they have any resident that has had changes in condition. Any resident noted will be reassessed by a Licensed Nurse with the assessment documented in the resident's medical record and notification of the changes, if noted, to the physician .<br><br>8. Nurse Managers will check the Oxygen Administration for all residents receiving oxygen daily x the next week to ensure that the oxygen flow rates are being administered according to physician orders .<br><br>9. Facility has posted the INTERACT Care Path for symptoms of SOB and the INTERACT Care Path for Acute Mental Status Change .<br><br>10. Any employee who was unable to come to facility for in service will be taken off of the schedule until they can be in services .<br><br>The immediate jeopardy was removed on [DATE] at 10:20 p.m. when all components of the plan of removal were carried out. The deficient practice remained at a pattern of actual harm.<br><br>Based on interview and record review, it was determined the facility failed to assess and monitor one (#68) of 24 sampled residents reviewed for change in condition after the resident exhibited signs of a change in respiratory status. This had the potential to affect 64 of 64 residents who resided at the facility.<br><br>Findings:<br><br>(continued on next page) |

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| | 375146 | A. Building<br>B. Wing | 08/17/2021 |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A hospital history and physical report for resident #68, dated [DATE] and located in the facility's scanned documents, documented, . PMH [past medical history] of . atrial fibrillation previously on Eliquis who presents . with CC [chief complaint] of numbness and tingling to her left lower leg . intermittent numbness and tingling to left lower leg and occasionally similar symptoms to the right lower leg and bilateral wrists. Her symptoms have been progressive. Over the last month, she has had more constant numbness and tingling to the left lower leg and foot. She now reports a cold feeling to the limb. She had not previously sought medical attention after losing her job and health insurance . No chest pain or shortness of breath . palpitation intermittently. She stopped taking her Eliquis about 3 to 5 days ago after running out of medication .<br><br>Hospital discharge documentation, dated [DATE] and located in the facility's scanned documents, documented, . Your Diagnosis[:] Atrial Flutter, physical deconditioning, right leg deep vein thrombosis (DVT) . multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, acute intraoperative massive pulmonary embolism - s/p [status post] catheter direct TPA [tissue plasminogen activator, used to dissolve blood clots] thrombolysis, subacute thrombotic occlusion of the left iliac artery and left femoral-popliteal trifurcation vessels, acute kidney injury, anemia, hypertension, hypertension, hypokalemia,, moderate aortic regurgitation, ventricular septal defect, multiple fractures of ribs .<br><br>Home needs: oxygen; 'Contact physician for: increased swelling, chest pain' 'Contact physician for: increased shortness of breath . '<br><br>Education: .<br><br>Atrial Flutter . get help right away if you have: . shortness of breath .<br><br>Peripheral Vascular Disease . get help right away if: . you have chest pain or trouble breathing .<br><br>Deep Vein Thrombosis . get help right away if: . you have . shortness of breath .<br><br>Cardiogenic shock . what are the signs or symptoms . shallow, quick breathing, or shortness of breath . Get help right away if you: . Have shortness of breath .<br><br>Discharge physician orders documented the resident was to receive Apixaban (Eliquis, an anticoagulant) 5 milligrams (mgs) twice daily for the prevention of blood clots.<br><br>Resident #68 was admitted to the facility on [DATE] with diagnoses that included atrial flutter, chronic embolism, and deep vein thrombosis.<br><br>A medication administration note, dated [DATE] at 8:23 p.m., documented, . waiting on pharmacy .<br><br>A medication administration note, dated [DATE] at 9:10 a.m., documented, . Apixaban Tablet 5 MG Give 1 tablet by mouth two times a day related to chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A medication administration note, dated [DATE] at 9:44 a.m., documented, . Pharmacy notified that medication Apixaban has not made it to facility, pharmacist stated the medication needed insurance approval and he would be sending a form over to the facility to fill out. Apixaban Tablet 5 MG placed on hold until paperwork can be submitted to insurance .<br><br>Review of facility medication administration records revealed the resident did not receive Eliquis, as ordered by the physician from admission on [DATE] until 8:00 p.m. on [DATE].<br><br>The resident's care plan, dated [DATE], documented the resident had a problem related to an imbalance between oxygen supply and demand. The goal was the resident would maintain blood pressure, pulse, and respirations within prescribed limits during activity through the review date. Interventions included to administer medications as prescribed; assess for signs and symptoms of activity intolerance such as statements of fatigue and weakness, exertional dyspnea, and chest pain; and to report decreased activity tolerance to the physician.<br><br>An admission assessment, dated [DATE], documented the resident was moderately impaired in cognitive skills for daily decision making; required limited assistance for most activities of daily living; had diagnoses that included blood clots and heart failure; and was receiving oxygen therapy. The assessment documented the resident was not receiving an anticoagulant medication.<br><br>A progress note, dated [DATE] at 4:34 p.m., documented, . Resident arrived in facility . No acute distress or discomfort noted . One person limited assist is required for transfers and ambulation due to general weakness. Continent of bowel and bladder with occasional episodes of incontinence requiring extensive assist. Staff strive to keep call light and fluids within easy reach.<br><br>A progress note, dated [DATE] at 1:40 a.m., documented, . respirations unlabored via nasal cannula, in place and patent .<br><br>A health status note, dated [DATE] at 7:13 a.m., documented, . Respirations are even and unlabored, clear to auscultation . Resident uses oxygen via nasal cannula, respirations unlabored . O2 at 2LPM [two liters per minute] via nasal cannula . for Shortness of Breath related to acute respiratory failure with hypoxia .<br><br>A health status note, dated [DATE] at 7:45 a.m., documented, . respirations easy on room air 02 off for awhile giving nose a rest continues with good 02 Sat on room air .<br><br>A health status note, dated [DATE] at 9:57 a.m., documented, . Respiration with ease 02 flowing at 2LPM via NC. [nasal cannula] .<br><br>A health status note, dated [DATE] at 11:40 a.m., documented, . focused assessment r/t [related to] resident requesting breathing treatment. no orders for breathing treatment. [physician name withheld] office notified with a request of breathing treatments .<br><br>Review of the resident's clinical record revealed no documentation the resident's respiratory status was assessed and monitored. There was no documentation the physician's office was notified of the resident's request for a breathing treatment. There was no documentation an order was received for a breathing treatment or that one was provided.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A health status note, dated [DATE] at 1:48 p.m., documented, . focused assessment r/t resident continues to tell staff she can't breath, 02 sat 99%. 02 bumped up to 3L/NC. resident setting on side of bed leaning forward, nurse spoke with resident about trying to relax and breath in through her nose out through her mouth .<br><br>Review of the resident's clinical documentation reveals no documentation the resident's physician was notified after the resident complained of being unable to breath on [DATE]. There was no documentation the facility assessed and monitored the resident for a change in condition except checking her blood oxygen level. There was no documentation the facility notified the physician of the increase in the oxygen flow rate. There was no documentation of any previous reports that the resident was unable to breath.<br><br>A health status note, dated [DATE] at 11:10 a.m., documented, . focused assessment r/t residents breathing pattern. Resident is breathing with her mouth open and her oxygen in her mouth. Residents O2 sat 94 on 3L .<br><br>Review of the resident's clinical record revealed no documentation the resident's physician was notified of the resident's decreased blood oxygenation level and continued difficulties with breathing on [DATE]. There was no documentation the facility assessed and monitored the resident for a change in condition except for checking her blood oxygen level.<br><br>A health status note, dated [DATE] at 1:49 a.m., documented, . [12:50 a.m.] entered resident room and noted resident wasn't breathing. Resident assisted to floor with assist of 3 staff CPR [cardiopulmonary resuscitation] started nurse from back nurses station called EMS [Emergency Medical Services]. EMS here at 1 am CPR stopped at that time. EMT's [emergency medical technicians] received order to stop CPR at that time .<br><br>On [DATE] at 9:59 a.m., licensed practical nurse (LPN) #5, who was the resident's nurse, was asked what the resident's admitting diagnoses were. She stated atypical atrial flutter, chronic embolism of the deep veins of the lower extremities, hypertension, anemia, heart failure at one time, acute kidney failure, and acute respiratory failure with hypoxia. LPN #5 was asked what things were monitored for with these diagnoses. She stated, Pulse ox [blood saturation level], breathing, color of the skin, if diaphoretic.<br><br>LPN #5 was asked what the facility did when the resident requested a breathing treatment on [DATE]. She stated, I guess I should have followed up with that. She stated she had notified the physician, received an order, and then started with the breathing treatment he had ordered. She was asked where the order was documented. She reviewed the clinical record and stated, I don't see it do I. I don't see one. She stated there was no documentation a breathing treatment had been given.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | LPN #5 was asked what the facility did after the resident complained of being unable to breath on [DATE]. She stated, I made sure the head of the bed was raised and repositioned her. She stated, With mouth breathing, I put the oxygen in her mouth and turned it up to make sure she was breathing it in. She stated the resident's blood oxygen saturation levels were in the middle 90's. She stated, I didn't do very good charting. LPN #5 was asked if she notified the physician. She stated, I always fax him. She was asked where it was documented the physician was notified of the resident's complaint of being unable to breath and that she had turned the oxygen flow rate up. She stated, Should be in the chart. LPN #5 was asked how the resident was assessed and monitored following the change in condition. She stated, I just kept watching her, making sure she did not turn blue, that her O2 sats were in the 90s. She stated she tried to do some relaxing with the resident and tried to get her to breath through her mouth and not her nose.<br><br>LPN #5 was asked how the resident was assessed and monitored on [DATE] after she was noted to have a change in her breathing pattern and continued with mouth breathing and using the oxygen nasal cannula in her mouth and where it was documented. She stated, Clearly, it's not there. She was asked if the physician was notified on [DATE] and how he was notified. She stated, We have to fax him every time. She was asked if she faxed him on this date. She shook her head in a yes motion and stated it should be on the chart. LPN #5 was asked what the facility did after the resident continued to have a change in her breathing patterns on [DATE]. She stated, She [the resident] wouldn't let me send her to the hospital. I just kept monitoring her O2 sats. She was asked where that was documented. She stated, I didn't chart that either. LPN #5 was asked if there was any other place the information might be documented. She stated, Everything I would have charted would be in this area right here [pointed at the progress note section of the electronic medical record]. Other than me doing it, it it's not charted, it's not done.<br><br>On [DATE] at 10:18 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were asked where the physician's order was for a breathing treatment on [DATE]. They reviewed the clinical record, and the ADON stated, I don't see an order. The DON stated, I don't either. They were asked where the documentation was the resident received a breathing treatment. The ADON stated, I don't see it on any MAR [medication administration sheet].<br><br>The DON and ADON were asked what the staff did when the resident began to have complaints of being unable to breath on [DATE]. The ADON stated, It looks like they did the deep breathing and breathing through her mouth for that day. They were asked where it was documented the physician was notified. They reviewed the clinical record, and the ADON stated, I did not see any in the notes. They were asked where it was documented the staff assessed and monitored the resident after complaining of being unable to breathe. The ADON stated, I don't see that.<br><br>The DON and ADON were asked how the staff assessed and monitor the resident on [DATE] after she was noted to have a change in her breathing pattern, breathing with her mouth open, and her oxygen in her mouth. The ADON stated, I don't see any assessments.<br><br>They were asked what the resident's diagnoses were. The ADON stated atypical atrial flutter, chronic embolism of DVT (deep vein thrombosis), hypertension, anemia, hyperlipidemia, heart failure, atrial fibrillation, acute kidney failure, rib fractures, respiratory failure with hypoxia. They were asked what the staff should have been monitoring for in relation to the resident's diagnoses. The ADON stated, All the respiratory stuff, shortness of breath, fluid overload.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The DON and ADON were asked how often the resident's oxygen saturation levels were monitored. They reviewed the clinical record and stated the levels were being checked once to twice daily through [DATE]. The ADON stated when a resident was admitted on Intermediate Care, their levels were usually charted for 72 hours and then stopped, but if there was a change in condition, staff should chart on them for that length of care again. They were asked if the resident was exhibiting signs of a condition change. The ADON stated, Yes, she was with the breathing problems. They were asked what happened to the resident. The ADON stated, She expired after she coded.<br><br>The DON and ADON were asked how the physician was notified of the resident's continued difficulties with breathing. The ADON stated the staff would have notified him via fax. She was asked where that information was. She stated it should be on the chart. The surveyor informed her there was no documentation the physician was notified. They were asked why the staff did not notify the physician. The ADON stated, I can't answer that. I'm not the nurse. They were asked why the staff did not assess and monitor the resident after she began to have difficulties breathing. The ADON stated, I can't answer that either. I don't know what else to say other than they didn't do it.<br><br>The DON and ADON were asked how they ensured the nursing staff was competent to care for the residents with cardiac issues. They stated competency checks were done yearly. They were asked if the staff was assessed for competency related to cardiac and respiratory concerns. The ADON stated it was added into their evaluations. They were asked if, in their professional opinion, the staff acted with competency with the resident's care. The ADON stated, I don't think they did. The DON stated, I have to agree with that.<br><br>On [DATE] at 11:09 a.m., the resident's physician was asked if the facility had notified him the resident had missed dosage of Eliquis from admission on [DATE] until 8:00 p.m. on [DATE]. He stated he did not recall it, but they may have. He stated sometimes they had trouble getting insurance companies to pay for Eliquis. He was asked what the dangers were of a resident not receiving their Eliquis. He stated they could certainly have a pulmonary embolis or stroke. He stated he would normally place a resident on Lovenox (an anticoagulant) until a resident was able to get their Eliquis.<br><br>The physician was asked what the staff should have been monitoring the resident for. He stated oxygen levels, normal vitals signs, and respiratory status. He was asked if the facility notified him on [DATE] when the resident stated she was have difficulty breathing. He stated he could remember being called on her, but he could not state what days or for what reason. He was asked if staff had notified him they had increased her oxygen flow rate. He stated he did not specifically remember the conversation. He was asked if the facility notified him on [DATE] when the resident continued to have difficulties breathing. He stated he did not remember. He was asked what his expectation was if a resident began to have a change in condition or began to show signs and symptoms of distress. He stated he expected to be notified. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>38495<br><br>Based on observation and interview, it was determined the facility failed to ensure the facility's emergency suction machine was in a safe operating condition. This had the potential to affect 64 of 64 residents who resided at the facility.<br><br>Findings:<br><br>The facility's policy and procedure regarding emergency medical equipment, dated March 2019, documented, . Emergency Medical Equipment/Cart . will include suction machine . Emergency cart will be stored in a central location so it can be accessed quickly by staff in the event of an emergency . The Emergency cat will be checked daily by Licensed Staff daily to ensure equipment is clean and available for immediate use. (Suction machine clean/oxygen cylinder set up etc) .<br><br>On 08/16/21 at 9:45 a.m., the crash cart was observed on D hall in the supply closet. The suction machine was observed sitting on the top of the crash cart. The dial on the machine was broken and there was no top to the suction canister. Licensed practical nurse (#3) was asked if the suction machine worked. She stated she did not know.<br><br>On 08/16/21 at 12:59 p.m., the assistant director of nursing (ADON) looked at the crash cart. The ADON stated, Oh yeah, that's broke. The suction machine dial is broken and missing the cap to the suction bottle. She was asked what the staff would do if they had an emergency and needed the suction machine. The ADON stated the staff would probably get another suction machine. She stated she could get another suction machine for it now. The ADON tried to open the storage closet, but it was locked. The ADON asked the nurse working that hall to open the storage closet door. The nurse did not have a key to open the door. She stated if there was an emergency, they would have had to get a suction machine from another hall.<br><br>On 08/16/21 at 1:12 p.m., LPN #2 brought a different suction machine from another hall for the crash cart.<br><br>On 08/17/21 at 12:03 p.m., the administrator stated the crash cart should be inspected every shift. She stated she thought there was a check off list in the drawer of the cart. |