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	345296	A. BUILDING _____ B. WING _____	C 06/06/2025

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation survey was conducted from 06/02/25 through 06/04//25. Additional interviews were obtained offsite on 06/05/25 and 06/06/25, therefore the exit date was changed to 06/06/25. Event ID #HKXG11. The following intake was investigated NC00230702. One (1) of the 3 allegations resulted in a deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 641		6/20/25

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

Electronically Signed | 06/18/2025

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F 641	Continued From page 1 §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code an admission Minimum Data Set (MDS) assessment for the use of oxygen for 1 of 3 residents (Resident #1) reviewed for respiratory care. The findings included: Resident #1 was admitted to the facility on 05/07/25 with diagnoses that included atrial fibrillation, coronary artery disease and pneumonia. Review of Resident #1's admission physician orders initiated on 05/07/25 for continuous oxygen at 2 liters per minute. Review of Resident #1's baseline care plan dated 05/07/25 indicated oxygen therapy at 2 liters per minute. Review of Resident #1's Medication Administration Record (MAR) for 05/2025 indicated Resident #1 received continuous oxygen and the order was set up for all three shifts (7:00 AM-3:00 PM, 3:00 PM-11:00 PM, 11:00 PM-7:00 AM). The MAR was signed off as being done for all three shifts. Review of the admission Minimum Data Set assessment dated 05/14/25 revealed Resident #1 was cognitively intact and did not receive oxygen therapy. An interview was conducted with the MDS Nurse	F 641	The facility failed to accurately code the MDS assessment for oxygen use for Resident #1. The assessment was immediately amended and resubmitted. All current residents and new admission residents have the potential to be affected by the deficient practice. An audit was completed on 6/4/25 by the Director of Clinical Reimbursement Consultant to ensure all residents with oxygen are coded correctly on the MDS . No new concerns were found. An ad hoc QAPI was held on 6/17/25 to discuss the deficient practice and implement a plan of correction. MDS Coordinator #1 and #2 were educated on 6/4/25 by the Regional Clinical Reimbursement Consultant to ensure residents oxygen is accurately coded. The RAI manual was reviewed with the coordinators. MDS Coordinators will not be allowed to work until the education is completed. The Regional Clinical Reimbursement Consultant will educate all new hires before they can begin work, the Administrator will ensure this is completed. The DON or designee will complete audits of the facility MDS assessments to ensure MDS O2 assessments continue to be coded accurately, weekly for 4 weeks and monthly for 2 months to ensure continued compliance. The DON or designee will submit the findings to the Quality Assurance Performance Improvement	

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F 641	Continued From page 2 on 06/04/25 at 8:30 AM. The MDS Nurse reviewed Resident #1's admission MDS dated 05/14/25 and acknowledged she did not code the MDS for oxygen therapy. The MDS Nurse stated it was an oversight on her part probably due to the facility being in the middle of changing to a different electronic health record system and she just missed it. During an interview with the Director of Nursing (DON) on 06/04/25 at 9:15 AM the DON indicated that if Resident #1 had an order for continuous oxygen therapy when the MDS was completed then it was her expectation that the MDS be coded for oxygen therapy.	F 641	(QAPI) committee monthly meeting for 3 months for review to ensure the facility's continued compliance. The date of compliance is 6/20/25	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, Admission Clerk, Emergency Room (ER) Nurse, ER Physician, and Nurse Practitioner (NP) interviews, the facility failed to implement continuous oxygen as ordered during transport to the ER. This practice affected 1 of 3 residents (Resident #1) reviewed for respiratory care. The findings included:	F 695	The facility failed to implement continuous oxygen for Resident #1 as ordered during transport to the Emergency Room. On 6/5/25 the Director of Nursing (DON) educated Nurse #1 and Nurse Aide #1 (NA) to ensure education on the proper implementation of continuous oxygen therapy orders to guarantee residents	6/20/25

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F 695	Continued From page 3 Resident #1 was admitted to the facility on 05/07/25 with diagnoses that included coronary artery disease (CAD) and pneumonia. Review of Resident #1's physician orders initiated on 05/07/25 for continuous oxygen at 2 liters per minute. Review of Resident #1's baseline care plan dated 05/07/25 indicated oxygen therapy at 2 liters per minute. Review of Resident #1's Medication Administration Record (MAR) for 05/2025 indicated Resident #1 received continuous oxygen and the order was set up for all three shifts (7:00 AM-3:00 PM, 3:00 PM-11:00 PM, 11:00 PM-7:00 AM). The MAR was signed off as being completed for all three shifts. Review of the admission Minimum Data Set assessment dated 05/14/25 revealed Resident #1 was cognitively intact and did not receive oxygen therapy. Review of Resident #1's progress notes written by Nurse #1 dated 05/16/25 at 1:17 PM revealed Resident #1 continued on an antibiotic for the treatment of a urinary tract infection (UTI). The Resident was very lethargic and had been asleep most of the morning. She took scheduled medications this morning but fell back asleep. NP has ordered her to be seen in the ER for follow up. Resident left facility via wheelchair by facility transport. Report given to ER Nurse at hospital. Son notified. An interview was conducted with Nurse #1 on	F 695	receive prescribed oxygen as directed. The DON also provided education when sending a resident out of the building, who is on continuous oxygen to ensure it is in place at the time of discharge. All residents who have orders for continuous oxygen are at risk for deficient practice. On 6/5/25 the DON and the Staff Development Coordinator (SDC) completed an audit of all residents in the building with physician orders for continuous oxygen to ensure they were wearing their oxygen. No other residents were observed without their oxygen. An ad hoc QAPI meeting was held on 6/17/25 to discuss the complaint survey and the deficient practice. A plan of correction with monitoring tools was developed and implemented. On 6/5/25 the DON and SDC nurse provided in-service training to ensure all licensed nursing staff, Medication Aides, and NAs on the proper implementation of continuous oxygen therapy orders to guarantee residents receive prescribed oxygen as directed. Education was also provided when sending a resident out of the building, who is on continuous oxygen to ensure it is in place at the time of discharge. On 6/5/25 the DON implemented the following procedure: " The nurse, Medication Aide, and Nurse Aide (NA) will assess all residents with continuous oxygen orders at the start of each shift to ensure the oxygen is in place. If it is not, they will either prompt the resident to reapply it or assist them	

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F 695	Continued From page 4 06/02/25 at 10:50 AM who explained that she worked with Resident #1 on 05/16/25. Nurse #1 stated she assessed Resident #1 as having difficulty staying awake and when she called the ER to report her coming to the ER, she informed them that she was having increased confusion and was being treated for a UTI. Nurse #1 stated she could not remember if Resident #1 had continuous oxygen because she rarely took care of her, but she did not recall her having any respiratory distress. An interview was conducted with the Nurse Practitioner (NP) on 06/02/25 at 12:30 PM. The NP explained that Resident #1 was admitted to the facility on 05/07/25 with a prior diagnosis of pneumonia in 04/2025, which included initiating the use of continuous oxygen. The NP stated that the pneumonia had been resolved by the Resident's admission to the facility on 05/07/25. The NP continued to explain that during the admission she developed a urinary tract infection and was started on an oral antibiotic on 05/13/25. A couple days later the NP found that Resident #1 was a "little confused", and refusing her medications so the NP changed the antibiotic to one that could be given intramuscularly and ordered for the nursing staff to push fluids 05/15/25 on Resident #1. The NP continued to explain that the next day on 05/16/25 he found that Resident #1 was not eating or drinking and was more confused, so he ordered the nursing staff to take Resident #1 to the ER because he did not think it was an EMS (emergency medical service) call. The NP stated he felt like Resident #1 could sit in a wheelchair for the transport. The NP stated he could not remember if Resident #1 was on continuous oxygen, but he could report that she was not having any respiratory distress	F 695	directly if the resident is unable. • If the resident refuses to wear the physician ordered continuous oxygen the NA or Medication Aide will report this to the nurse, and the nurse will discuss the issue with the resident. If they still refuse, the nurse will notify the physician. On 6/5/2025, administrator informed DON she would be responsible for adding above education to the new hire orientation education. She will ensure no new nursing staff work until education has been completed. The DON or designee will monitor 3 random residents who are currently receiving continuous oxygen therapy to ensure that it is in use. Monitoring will be completed weekly x 3 weeks and monthly x 2 months on various days and various shifts. Reports will be presented to the monthly QA committee by the DON or designee to ensure corrective action is initiated as appropriate. The date of compliance is 6/20/25	

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F 695	Continued From page 5	F 695		

when he assessed her 05/16/25. The NP stated if Resident #1 had an order for continuous oxygen, then he expected her to be wearing oxygen when she was taken to the ER but reiterated that respiratory distress was not why he was sending the Resident to the ER.

A review of Resident #1's medical record revealed vital signs charted by Nurse Aide #2 at 1:45 PM on 05/16/25 were vital signs on 05/16/25 which were Temperature 98.7, Pulse 93, Respirations 14, Blood Pressure 158/95 and Oxygen Saturation of 95%.

An interview was conducted with Nurse Aide (NA) #2 on 06/05/25 at 12:15 PM who explained that she took Resident #1's vital signs on 05/16/25 close to lunch time which were 98.7, 93, 14, 158/95 and oxygen saturation of 95%. The NA continued to explain that Resident #1 was not having trouble breathing nor was she unresponsive. NA #2 reported she could not remember if Resident #1 was wearing oxygen. She stated the Resident was confused and refusing to eat or drink. NA #2 stated Resident #1 was still in her bed when she obtained her vital signs, but she knew that she was going to be transferred to the hospital, but she was not responsible for getting the Resident ready to go to the hospital.

During an interview with Nurse #2 on 06/02/25 at 11:30 AM the Nurse explained that she tried to assess Resident #1 on the morning of 05/16/25 but the Resident was confused and was not able to complete an assessment. The Nurse continued to explain that Resident #1 did allow her to give Resident #1 the IM injection of antibiotic to treat her UTI. Nurse #2 stated Resident #1 did have an

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order for continuous oxygen, but she would often remove it which had to be replaced by staff. The Nurse stated she did not see Resident #1 go to the ER that day on 05/16/25 so she could not say if she had the oxygen on or not.

An interview was conducted with Nurse Aide (NA) #1 on 06/02/25 at 1:55 PM. The NA confirmed that she worked with Resident #1 on 05/16/25 from 7:00 AM - 3:00 PM. NA #1 explained that she was instructed to get the Resident ready to go to the ER so she made sure Resident #1 was checked and changed and left her in the bed so that she could be transferred onto the stretcher. The NA stated she could not remember if Resident #1 was wearing her oxygen, but she felt sure that if she had oxygen, it would have been taken with her to the ER.

During an interview with Nurse Aide (NA) #3 on 06/02/25 at 11:25 AM the NA explained that she was assigned to take care of Resident #1 on 05/16/25 from 7:00 AM - 3:00 PM but did not get her ready to go to the ER. The NA continued to explain that Resident #1 had continuous oxygen but would often remove it and the oxygen would have to be replaced.

During an interview with the facility Transportation Aide on 06/02/25 at 11:00 AM, the Transportation Aide explained that she was asked to take Resident #1 to the ER and when she went to get the Resident she was sitting at the nursing desk in a wheelchair ready to go to the ER. The Transportation Aide reported Resident #1 was alert and made eye contact with her after she arrived at the ER and understood her when she told Resident #1 that her son would be at the ER soon to be with her. The Transportation Aide

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stated she could not remember if the Resident was wearing oxygen. The Transportation Aide explained that she could load the residents up in the van and drive them down the hill to the ER faster than the EMS could get to the facility to transport them to the ER.

An interview was conducted with the Hospital Admission Clerk on 06/03/25 at 1:55 PM who explained that on 05/16/25 Resident #1 was brought to the ER in a wheelchair by a nursing home staff member. The Admission Clerk continued to explain that she could tell that the nursing home staff was in a hurry so she told the nursing home staff that she could go, and she would keep an eye on Resident #1. The Admissions Clerk stated she went to stand by Resident #1's wheelchair and it was "just a quick second" before the ER Nurse came to get the Resident. The Admission Clerk reported the whole time Resident #1 was at her desk, she was in a sleep-like state, and she did not wake up to speak with either the nursing home staff member or herself. She stated she could not recall whether the Resident was wearing oxygen.

Review of a written statement by the ER Nurse dated and signed on 06/02/25 revealed on 05/16/25 this Nurse went out to the waiting room to get Resident #1 who had the chief complaint of unresponsiveness. Per registration the Resident had been brought down from the nursing home via private vehicle and a nursing home staff member had brought the Resident in a wheelchair, gave her information to registration and left the Resident in the waiting room by herself. Resident #1 was brought to room 3 and with assistance, the Resident was placed on the bed. The ER Nurse attempted to get the Resident

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to respond to both verbal and painful stimuli, but Resident #1 would not respond. Vital signs were obtained, and the Resident was hypoxic with an oxygen saturation of 81% on room air. Upon review of Resident #1's medication list, it was discovered that the Resident normally wore oxygen at all times. The patient was not on any oxygen when she arrived at the ER.

Review of Resident #1's Emergency Room Initial Notes dated 05/16/25 indicated Resident #1 was from nursing home and was leaning to the right and unresponsive. A worker (from the nursing home) called on the phone to let us know that she was coming. The Resident's oxygen saturation level at 1:43 PM on 05/16/25 was 81% on room air and at 1:45 PM the Resident's oxygen saturation level on oxygen was 94% after 4 liters of oxygen was applied. Resident #1 was given a dose of IV (intravenous) antibiotic and IV fluids of normal saline while in the ER. Per the ER notes Resident #1's electrolytes were normal, her ABG (Arterial Blood Gas) was normal with a pH of 7.46, slightly low oxygen at 78, and slightly high pCO2 of 30.6. The physician did think this was the cause of her symptoms. It was thought that this may be due to her antidepressant and holding this may help her be more awake and alert and able to eat and drink appropriately.

Further review of the ER progress notes dated 05/16/25 indicated Resident #1 was sent back to the nursing home with diagnoses of dehydration and altered mental status at 9:24 PM on 05/16/25 with no new orders.

An interview was conducted with the ER Physician on 06/03/25 at 4:30 PM. The ER Physician evaluated the Resident and stated she

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was basically "obtunded." Her oxygen saturation level was low (81%) and when they applied oxygen her oxygen level immediately returned to a normal level (94%). The ER Physician stated that when they reviewed Resident #1's nursing home orders it was discovered that the Resident had an order for continuous oxygen which she did not have when she was brought to the ER. When the ER Physician was asked what the negative outcome could have been from a low oxygen saturation level, the ER Physician explained that the Resident did not have a negative outcome, but she could have died if the oxygen level dropped to a certain level which was different for everyone. She explained that once a person's oxygen level was at a certain level it was like falling off a cliff, you can't stop it meaning they will quickly decline. The ER Physician stated that did not happen to Resident #1 because after they applied oxygen to the Resident her oxygen level went back up to a normal level. The ER Physician reported she checked Resident #1 out by obtaining blood work, urine and CT scan and could not find anything that would cause the Resident to be obtunded except for being hypoxic (low oxygen levels) and poly pharmacy (concurrent use of multiple medications). She stated after they gave Resident #1 some IV fluids she started coming around back to her baseline and a little later in the shift she was discharged to back to the nursing home.

Interviews were conducted with the Director of Nursing (DON) on 06/02/25 at 2:35 PM and 06/04/25 at 9:15 AM. The DON explained that it was normal for the Transportation Aide to take the residents down to the ER instead of transporting them via EMS if they were able to sit upright in a wheelchair and it was her

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F 695	Continued From page 10 understanding that Resident #1 was able to sit in her wheelchair. The DON stated the Transportation Aide could load the residents up in the van, drive them down the hill to the ER faster than the EMS could come to the facility, load them up and transport them to the ER. The DON stated that if Resident #1 had an order for continuous oxygen, then it was her expectation that the oxygen would be sent with Resident #1 to the ER.	F 695		