A complaint investigation survey was conducted 01/13/20 - 01/14/20. There were 50 allegations investigated and 4 were substantiated. Event ID# LKNR11.

**F 695**

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 observations, nurse practitioner (NP) interview, staff interviews, and record review, the facility failed to provide oxygen therapy per physician order for 1 of 3 residents reviewed for respiratory care (Resident #8).

Findings included:

Resident #8 admitted to the facility on 8/6/2019. Diagnoses included chronic obstructive pulmonary disease (COPD) and chronic pulmonary embolism.

Resident #8's quarterly Minimum Data Set (MDS) dated 11/22/2019 revealed she had moderate cognitive impairments. She was coded as receiving oxygen therapy.

Resident #8 had a plan of care in place, with...
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 695</td>
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<td>Oxygen at 2 liters continuous via nasal cannula</td>
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Most recent revision dated 11/3/2019, related to alteration in respiratory status due to COPD. Interventions were inclusive of administering oxygen as needed per physician order.

Resident #8's January 2020 physician's orders revealed the following:

**Oxygen at 2 liters continuous via nasal cannula**

An observation was completed on 1/13/2020 at 2:21 PM of Resident #8. Resident #8 was observed in the east day room without her oxygen in place. The portable oxygen tank was observed to the back of her wheelchair in a black sling. No tubing was applied via nasal cannula to her nares. Her portable oxygen tank was observed to be set at 3 liters. The portable oxygen tank was turned off. Resident #8 did not appear in any distress.

An observation and interview was attempted with Nurse #1 on 1/13/2020 at 2:25 PM. She was not available at that time.

An observation and interview was completed on 1/13/2020 at 2:32 PM with the Unit Manager (UM). The UM reviewed the electronic medication administration record (eMAR) which revealed Resident #8 had an order in place for oxygen 2 liters continuous via nasal cannula. Resident #8 was observed by the UM which revealed her oxygen was not applied to her nares via nasal cannula. Continued observation revealed the portable oxygen tank to be set at 3 liters and turned off. The UM verbalized the portable oxygen tank setting should have been on 2 liters, per the physician order, and turned on. The UM communicated Resident #8 would not be...
## SUMMARY STATEMENT OF DEFICIENCIES

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<td>able to manipulate the portable oxygen tank settings, just the removal or placement of her nasal cannula. An oxygen saturation reading was obtained from Resident #8, by the UM, which revealed 80% on room air. Resident #8 did not appear in any distress. The UM took Resident #8 to the nurse's station and reapplied her portable oxygen via nasal cannula to her nares. The setting was observed at 2 liters continuous.</td>
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An interview was completed on 1/13/2020 at 2:35 PM with Nurse #1. Nurse #1 stated she last visualized Resident #8 in her wheelchair around 10:15 AM with her portable oxygen applied to her nares via nasal cannula. Resident #8 was on her way to the Beauty Shop. Nurse #1 explained she recalled Resident #8's portable oxygen tank being set at 2 liters continuously. She further verbalized Resident #8's oxygen saturation for the morning was 98% with in-room oxygen applied via nasal cannula. This was taken prior to Nurse #1 administering Resident #8's morning inhalations. Nurse #1 communicated if something were wrong with a resident while getting their hair done, the beautician would notify staff immediately. Nurse #1 expressed the beautician did not notify her of any concerns related to Resident #8. Nurse #1 was not certain when Resident #8 departed from the Beauty Shop or why Resident #8's portable tank was turned off.

An interview was completed on 1/13/2020 at 2:52 PM with the Nurse Practitioner (NP). The NP stated Resident #8's oxygen should not be turned off. Her oxygen should remain in place continuously as ordered. She further verbalized Resident #8 had a history of chronic lung disease.
A follow up observation of Resident #8 was completed on 1/13/2020 at 2:58 PM. She was observed sitting in her wheelchair with her portable oxygen set at 2 liters with the nasal cannula applied to her nares. She was not in distress. Her oxygen saturation was obtained by the UM and the reading was 94%.

An additional observation was completed on 1/14/2020 at 8:40 AM of Resident #8 in her room. The observation revealed Resident #8's in-room oxygen concentrator was set on 3 liters. Resident #8 did not appear in distress.

An interview and observation was completed on 1/14/2020 at 8:47 AM with Nurse #1. She stated Resident #8's in-room concentrator should be set on 2 liters. The observation revealed Resident #8's in-room oxygen concentrator set on 3 liters. Nurse #1 explained nurse aides were not responsible for manipulating in-room oxygen settings. She continued to explain hall nurses were responsible for monitoring and completing that task. Nurse #1 verbalized when she started her shift, she would spot check her residents and speak to them. Nurse #1 continued to explain when she administered medication, she would complete a more thorough assessment of the resident and any devices. Nurse #1 placed the in-room oxygen concentrator at the ordered setting of 2 liters.

An interview was completed with the Director of Nursing (DON) on 1/14/2020 at 8:55 AM. He stated staff should have assisted Resident #8 out of the Beauty Shop when she was done with her service. He further explained staff would have seen Resident #8's oxygen was not in place and could have reapplied her oxygen and checked
**PELICAN HEALTH AT CHARLOTTE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2616 EAST 5TH STREET  
CHARLOTTE, NC  28204

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<td>her oxygen saturation level. The DON expressed in-room oxygen concentrators should be checked on rounds and during report by nursing staff. Anything over 2 liters should be questioned by nursing staff and orders verified to ensure the setting was correct. The DON verbalized Resident #8 should have had her oxygen in place per the physician's order and been properly saturated.</td>
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