Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000939	A. BUILDING: ______ B. WING ______	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANAGAN REHABILITATION & HCC	**201 EAST FALCON HIGHWAY FLANAGAN, IL 61740**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2360524/IL168932	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610a) 300.1035a) 300.1210b) 300.1210c) 300.1210d)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment.	S9999		

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Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

These requirement was not met as evidenced by:

Based on interview and record review, the facility failed to treat residents with respect, dignity and provide care in a manner that promotes quality of life by not allowing a resident to have a say in medical treatment for one of four residents (R3) reviewed for respiratory care in the sample of six. This failure resulted in R3 being fearful of staff and experiencing ongoing psychosocial harm of R3; which resulted in R3 being sent to the Emergency Room for an anxiety attack.

Findings Include:

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R3's MDS (Minimum Data Set) dated 12/24/24 documents R3 is alert and oriented.

R3's January 2023 Physician Orders document the following orders: oxygen at 2-5 L (liters) per NC (Nasal Cannula) or vented mask, and BiPAP (BiLevel Positive Airway Pressure) with 6 LPM (liters per minute) oxygen bled into it.

R3's ongoing diagnoses list includes the following diagnoses: COPD (Chronic Obstructive Pulmonary Disease), Chronic Respiratory Failure with Hypoxia, Dependence on Respirator or Ventilator, Dyspnea,

On 1/22/24 at 7:30 pm, R3 was lying awake in bed with oxygen running at 4.5 L/NC. R3 stated since getting the new BiPAP machine on 1/19/24, R3 has "only had it on once because you can't find anyone to put it on you correctly". R3 explained, "something is not right with it, and it makes my oxygen levels drop." R3 also stated over the weekend, R3 was short of breath and had called for the nurse, V6 Agency RN (Registered Nurse) to give R3 a breathing treatment. R3 stated when V6 entered R3's room, V6 "cranked" R3's oxygen level up to 10 L/NC, then started to check my oxygen level., and was hitting R3 on the back. R3 reports telling V6 to turn the oxygen down but V6 did not do it. R3 stated R3 ended up having to call V5 CNA (Certified Nursing Assistant) into the room and V5 positioned R3 so that R3 could turn the oxygen down by R3's self. R3 stated R3 ended up in the ER (Emergency Room) that day, which R3 believes was 1/20/24. R3 stated "this has actually happened twice now". Because of V6's actions, "I (R3) don't want him (V6) in my room or taking care of me without someone else in here to be a witness, he (V6) scares me (R3)." While R3 was

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S9999	Continued From page 3 talking about this incident, R3 started getting real anxious, shaking and R3's breathing increased, including use of accessory muscles. On 1/22/24 at 8:05 pm, V5 CNA stated V5 has a big concern with V6 and explained V6 has turned R3's, along with other resident's, oxygen up to 10 L several times over the past week. "Whenever a resident calls and says they can't breathe, that is what (V6) does." V5 stated, it really stressed R3 out and last week on Thursday, 1/18/24, V17 CNA and V5 were doing our last rounds around 9:15 pm when R3 said R3 couldn't breathe. V5 checked R3's oxygen level and it was in the 50%. V5 reports yelling for V6 Agency RN to come check R3 and V6 immediately turned R3's oxygen up to 10 L/NC. R3 told V6 to stop at least 10-15 times and said, "I've told you before that I (R3) don't like that" but V6 wouldn't turn it down. V6 started yelling at R3, telling R3 "I'm the nurse and you (R3) are going to die". V5 reports that V14 CNA was approximately 100 feet away, and overheard V6 yelling at R3 so V14 came down the hall to see what was going on. V5 stated at that point V5 left the room to report an abuse allegation. After the phone call and on the way back to R3's room, V6 was outside of R3's room throwing things and kicking the medication cart. V6 then came back into R3's room and shoved an inhaler in R3's mouth. R3 told V6 "I don't want that; I need a nebulizer" but V6 instructed R3 to open R3's mouth. R3 was sitting up on the side of the bed at this point and V6 started hitting R3 on the back 4-5 times, "like you would a baby". R3 instructed V6 to stop because V6 was hurting R3 but he continued to do it a couple more times. V5 stated, "I'm not sure if that is abuse or not but to me(V5), when you ask to stop being touched and someone continues to do it, that is a problem in my eyes!" V5 stated another incident happened	S9999		

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on 1/20/24. V5 explained R3 was in respiratory distress with an oxygen level in the 70's and V6 did the same thing and turned the oxygen up to 10 L. R3 was fearful, V6 was not listening to R3. At that point on 1/20/23, R3 was sent to the hospital. V5 reports that R3 asked V5 not to let V6 touch R3 because R3 was not comfortable with how V6 treated R3. V6 made R3 do the inhaler, and nebulizer before V6 would even call to send R3 to the hospital, even though R3 kept requesting to be sent. V5 exclaimed, "all I know is I'm very concerned about resident safety due to having a nurse that is doing questionable things".

On 1/22/24 at 8:56 pm, V13 CNA stated R3 told V13 that R3 "felt unsafe" with V6 due to V6 turning R3's oxygen up to 10 L and then walking away, on 1/20/24. V13 explained, it's been over 24 hours now and R3 still feels unsafe and is requesting a CNA in the room with R3 whenever V6 is in there. V13 stated R3 told V13 that V6 "was shoving pills down (R3's) throat, inhaler in (R3's) mouth when (R3) wasn't wanting the stuff".

On 1/22/24 at 9:34 pm, V14 CNA confirmed V5's above statement of events. V14 also stated R3 reported to V14, that on a different night, R3 was having breathing trouble and had requested a nebulizer but instead V6 turned up R3's oxygen, then told R3, "I (V6) told you (R3); you were going to be okay." V14 stated R3 has told V14 that R3 "don't like or trust (V6)" and has requested a CNA be with R3 anytime V6 has to go into R3's room.

On 1/23/24 at 1:24 pm, V6 stated V6 has had a couple incidents with R3 where R3 was having breathing issues and refusing care/treatment. V6 explained, when an oxygen level is in the 50's, "without treatment (R3) will die and (R3) wasn't wanting anything other than a nebulizer but I (V6)

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did both the nebulizer and inhaler, turned up (R3's) oxygen and then (R3) was fine." V6 explained V6 was "frustrated". V6 stated after the first incident on 1/18/24, V6 was told "the customer is always right and to basically do what they ask so a couple of days later, (R3) was short of breath again and (R3's) {oxygen} levels were again in the 50's" and she was wanting to go to the hospital so V6 sent R3 to the hospital after giving R3 an inhaler, nebulizer and increasing R3's oxygen to 10 L.

R3's Hospital History and Physical dated 1/20/24 by V27 Hospital Physician documents R3 has a history of COPD is on 3-4 L oxygen at baseline, presents with a chief complaint of feeling short of breath. R3 reports a new male nurse was putting R3's CPAP on and "cranked it up to 10L" which was very uncomfortable for R3, causing R3 to feel more short of breath however this has since improved. R3 received two breathing treatments per EMS (Emergency Medical Services) in route to the hospital as well as Solu-Medrol {Steroid} 125 mg (milligrams). R3 reports R3 is now breathing at R3's baseline. R3 was not having any of this breathing distress prior to improper management of the CPAP. R3 is upset at this male nurse for cranking up the CPAP to a very high setting, which caused R3 to feel like R3 could not breathe. "Symptoms have resolved and the episode was likely related to anxiety after inappropriate CPAP use."

The facility's Residents' Rights for People In Long Term Care Facilities dated November 2018 documents; you have a right to make your own decisions, your facility must treat you with dignity and respect and must care for you in a manner that promotes quality of life, you have the right to request, refuse, and/or discontinue any treatment.

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300.1210d)5)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's

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plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour,

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seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to notify the physician of a pressure ulcer to obtain an appropriate wound treatment, assess and document the pressure ulcer, notify the resident representative of a pressure ulcer and prevent cross contamination of the wound during a treatment for one of three residents (R2) reviewed for wounds in the sample list of six. This failure resulted in R2's MASD (Moisture Associated Skin Damage) progressing to an unstageable pressure ulcer.

Findings Include:

R2's ongoing diagnoses listing documents R2 has TBI (Traumatic Brain Injury), Morbid Obesity, and Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease affecting Right Dominant Side.

On 1/22/23 at 11:22 am, V10 (R2's POA (Power of Attorney) stated R2 was at the hospital on 1/21/23 and the nurse there said R2 has an open area on R2's buttocks. V10 also stated the nurse reported R2 also has another "big" area that is ready to break open. V10 stated V10 had never been notified by the facility that R2 had any wounds.

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R2's Hospital Notes dated 1/22/24 at 1:01 am document R2 has a 1 cm (centimeter) open sore to the coccyx, and a reddened area below the coccyx that is not yet open.

The facility's ongoing Weekly Wound Tracking Form documents on 1/3/24 and 1/10/24, R2 had MASD to the buttocks but does not document any characteristics of the area.

Wound Assessment and Plan Notes by V11 Wound NP (Nurse Practitioner) for R2 document the following:
1/3/24 -Initial visit for MASD to buttocks with onset date of 1/3/24. Peri wound Macerated with Minimal exudate. Treatment Order: cleanse area, pat dry well. Apply an Antifungal powder and a zinc barrier Cream 20% or greater apply every shift and PRN (as needed). This area has a fungal appearance to it with redness, scalloped edges and satellite lesions noted.
1/10/24 - discontinuing the Antifungal powder, new treatment is for zinc barrier cream 20% or greater every shift and PRN.

Neither of the Wound Assessment and Plan Notes include measurements of the MASD area.

On 1/22/24 at 2:55 pm, V4 and V7 BOM (Business Office Manager)/CNA (Certified Nursing Assistant) entered R2's room to complete the ordered treatment. R2 was rolled to the side and upon removing R2's brief, R2's entire buttocks was caked in a thick white substance with a flaky appearance. V4 attempted to cleanse the area with Normal Saline but the substance would not come off. V4 then had to use a washcloth with soap and warm water to remove the substance and stated, "it looks like someone put zinc and Nystatin {Antifungal} on (R2). V4

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explained, R2 "use to have an order for that but now we are just to use zinc". After the substance was cleansed off, R2 had three different open areas to the buttocks area that V4 measured. The left buttocks had a 0.5 cm by 0.7 and approximately. 0.1 cm deep open area. The wound bed was not visible as it was covered in yellow slough (unstageable). V4 stated "that was not there last week so it must have just developed over the last couple of days". R2 also had an area to the left inner buttocks measuring 6.5 cm by 0.6 cm that V4 stated is a self inflicted scratch, that was scabbed over. On the right buttocks, R2 had a 7.2 cm by 4.4 cm superficial open area, in the middle of larger reddened/discolored area, with a beefy red wound base. V4 applied the zinc ointment, which was pink in color, with V4's gloved finger to all three open areas, without changing gloves or performing hand hygiene between wounds. V4 stated V11 will be at the facility on 1/24/24, and that R2's treatment will need changed as zinc is not an appropriate treatment for an unstageable pressure ulcer. At this time, V4 stated the facility don't measure wounds generally, we just go by what the wound provider documents. V4 stated V4 does not know if we are supposed to or not explaining, "I'm the only facility nurse and we have no DON", so there is no guidance.
As of 1/24/24, R2's Progress Notes do not document V10 was notified of the MASD on 1/3/24 or any changes to R2's skin condition since then. These notes also do not document that V11 Wound NP (Nurse Practitioner) was notified of the MASD progressing to an unstageable pressure ulcer or to get a new treatment order.

On 1/24/24 at 1:00 pm, V25 MDS (Minimum Data Set)/Care Plan Coordinator stated when a

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resident develops a wound or the condition of the wound deteriorates, the staff should be calling the physician to obtain a new treatment order, not wait until they are in the facility. V25 also stated wounds should be monitored and documented on at least once a week and families should be notified of a new and/or worsening wound.

The facility's Decubitus Care/Pressure Areas Policy dated May 2007 documents this policy is to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified. Upon notification of skin breakdown, a newly acquired skin condition report will be completed and forwarded to the Director of Nursing. The pressure area will be assessed and documented on the Treatment Administration Record. Documentation should include size, stage, site, depth, drainage, color, odor, and treatment (upon obtaining from the physician). Notify the physician for treatment orders. Documentation of the pressure area must occur upon identification and at least once each week on the TAR (Treatment Administration Record). Re-evaluate the treatment for response at least every two to four weeks. Most pressure areas will respond to treatment in this amount of time. If no improvement is seen, contact the physician for a new treatment order.

The facility's Dressing Change Policy dated July 2007 documents to apply topical medication per physician's order using an applicator, tongue blade, cotton ball or gauze square.

The facility's Notification for Change in Resident Condition or Status documents to promptly notify the appropriate individuals including but not limited to the physician and resident guardian if

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there is a significant change in the resident's physical/emotional/mental condition and the need to alter the resident's medical treatment.

(B)

3 of 3

300.610a)
300.1035a)
300.1210b)
300.1210c)
300.1210d)2)
300.1210d)3)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1035 Life-Sustaining Treatments

a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment.

Section 300.1210 General Requirements for

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Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow physician orders for respiratory care including oxygen, BiPAP and C-PAP usage, change oxygen tubing and humidifier bottles as ordered and document resident complaisance/non-compliance of

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respiratory care for four of four residents (R1, R2, R3, R4) reviewed for respiratory care in the sample list of six. This failure resulted in psychosocial harm of R3. R3 was sent to the hospital after having a panic attack and remains fearful of facility staff's action related to R3's respiratory care.

Findings Include:

1. R3's January 2023 Physician Orders document the following orders: oxygen at 2-5 L (liters) per NC (Nasal Cannula) or vented mask, change oxygen tubing and humidifier once a week (scheduled for Sundays), and BiPAP (BiLevel Positive Airway Pressure) with 6 LPM (liters per minute) oxygen bled into it.

R3's ongoing diagnoses list includes the following diagnoses: COPD (Chronic Obstructive Pulmonary Disease), Chronic Respiratory Failure with Hypoxia, Dependence on Respirator or Ventilator, and Dyspnea.

R3's MDS (Minimum Data Set) dated 12/24/24 documents R3 is alert and oriented.

On 1/22/24 at 8:50 am, R3 is asleep in bed wearing oxygen but not the BiPAP. Oxygen is running at 3.5 L/NC and the BiPAP machine is sitting on the overbed table. The oxygen tubing and humidifier bottle are not dated.

On 1/22/24 at 7:30 pm, R3 was lying awake in bed with oxygen running at 4.5 L/NC. R3 stated since getting the new BiPAP machine on 1/19/24, R3 has "only had it on once because you can't find anyone to put it on you correctly". R3 explained, "something is not right with it, and it makes my oxygen levels drop." R3 also stated

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over the weekend, V6 Agency RN (Registered Nurse) cranked R3's oxygen level up to 10 L/NC because R3 was short of breath. R3 reports R3 told V6 to turn the amount of oxygen down but V6 wouldn't. R3 stated, R3 ended up going to the Emergency Room because of this. R3 started getting real anxious; shaking and increased respirations with the use of accessory muscles when talking about the incident. R3 stated this has happened twice now and because of V6's actions, R3 does not want V6 in R3's room or taking care of R3 "without someone else in here to be a witness, he (V6) scares me (R3)."

R3's January 2023 MAR/TAR (Medication Administration Record/Treatment Administration Record) does not document that R3's oxygen tubing or humidifier were changed as ordered on 1/7/24 and 1/14/24. This MAR/TAR also documents R3 has used the BiPAP daily other than 1/14/24 and 1/19/24, it is signed out as refused.

On 1/23/24 at 1:24 pm, V6 confirmed R3 had breathing problems on 1/20/24 and V6 turned R3's oxygen up to 10L/NC and sent R3 to the hospital per R3's request.

R3's Hospital History and Physical dated 1/20/24 by V27 Hospital Physician documents R3 has a history of COPD is on 3-4 L oxygen at baseline, presents with a chief complaint of feeling short of breath. R3 reports a new male nurse was putting R3's CPAP on and "cranked it up to 10L" which was very uncomfortable for R3, causing R3 to feel more short of breath however this has since improved. R3 received two breathing treatments per EMS (Emergency Medical Services) in route to the hospital as well as Solu-Medrol {Steroid} 125 mg (milligrams). R3 reports R3 is now

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breathing at R3's baseline. R3 was not having any of this breathing distress prior to improper management of the CPAP. R3 is upset at this male nurse for cranking up the CPAP to a very high setting, which caused R3 to feel like R3 could not breathe. "Symptoms have resolved and the episode was likely related to anxiety after inappropriate CPAP use."

2. R2's ongoing diagnoses listing documents R2 has TBI (Traumatic Brain Injury), Morbid Obesity, Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease affecting Right Dominant Side, Acute and Chronic Respiratory Failure with Hypoxia, and Sleep Apnea.

R2's January 2023 Physician Orders document the following orders: BI-PAP wear while sleeping as resident tolerates/allows. Maintain BI-PAP pressures at 20/10 cm (centimeters) H_2O (water) and maintain E-PAP (Expiratory Positive Airway Pressure) Rate at 14. Bleed oxygen in at 3L oxygen per minute, oxygen at 2-6 L/minute, document when resident refuses the BiPAP and change oxygen tubing and humidifier weekly (scheduled for Sundays).

On 1/22/24 at 8:30 am, R2 was sitting up in bed wearing oxygen running at 3 L/NC. The tubing and humidifier were not dated.

The facility's ongoing Grievance Log documents grievances by V10 (R2's POA (Power of Attorney)) on 1/4/24 and 1/10/24 for the facility not applying R2's BiPAP when R2 is sleeping.

R2's January 2024 MAR/TAR does not document that the oxygen tubing or humidifier were changed on 1/7/24 or 1/14/24. This MAR/TAR

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does not document if R2 wore or refused R2's BiPAP on 1/2/24, 1/3/24, 1/14/24 and documents it was refused only on 1/15/24, 1/16/24 and 1/17/24.

On 1/22/24 at 11:22 am, V10 stated the facility is not putting R2's machine on R2 at night and when R2 is sleeping. V10 explained, the facility will ask R2 to put it on when R2 is awake, which R2 will not do but that V10 has instructed the facility staff on several occasions to put it on R2 after R2 falls asleep. V10 stated the facility is telling V10 they put it on R2 but V10 has never seen it on R2, even though V10 comes to the facility, at all hours of the day/night. "I (V10) fear for (R2's) life because it is nothing but lies. They aren't caring for (R2) as they should." V10 also stated on 1/21/24 around 12:00 am, V10 came to the facility to check on R2 because V10 and R2 had been talking on the phone and R2 was "very short of breath". Upon arriving, V10 observed R2's oxygen being unplugged, therefore R2 was not getting any oxygen. R2 was "very short of breath" and R2's oxygen level "was in the 70's". V10 stated that once V6 Agency RN (Registered Nurse) plugged the oxygen in again, R2's oxygen levels began to raise back into the 90's%. V10 explained that during the time without oxygen, R2 "was so out of it, (R2) couldn't even tell me (V10) that (R2) wasn't getting oxygen".

On 1/22/24 at 4:22 pm, V6 stated R2 is supposed to wear oxygen all the time. V6 confirmed on 1/21/24, R2's oxygen tubing had come disconnect from concentrator so R2 was not getting oxygen. V6 does not know how long R2 had been without the oxygen.

On 1/22/24 at 9:15 pm and 10:40 pm, R2 was asleep in bed with oxygen running at 4L/NC but

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S9999	Continued From page 18 was not wearing the ordered BiPAP. On 1/23/24 at 12:20 pm, 12:45 pm, 1:18 pm, 1:51 pm and 2:08 pm, R2 was asleep in bed without the ordered BiPAP in place. On 1/23/24 at 1:24 pm, V6 confirmed V6 works the night shift on Sunday's when the oxygen tubing and humidifiers are to be changed. V6 stated V6 has never done that but should have, V6 "was just too busy." On 1/24/24 at 8:51 am, V10 stated V10 arrived at the facility at 2:15 pm on 1/23/24. V10 explained R2 was asleep in bed at that time without the BiPAP in place. 3. R4's MDS (Minimum Data Set) dated 1/10/24 documents R4 is alert and oriented. R4's ongoing diagnoses listing contains the following diagnoses: Unspecified Asthma with Exacerbation, Acute Respiratory Failure with Hypoxia, Cerebral Palsy, and COPD (Chronic Obstructive Pulmonary Disease). R4's January 2024 Physician Orders document an order for oxygen at 2-5 L/NC as needed to keep SPO2 levels above 90% and to change the oxygen tubing and humidifier bottles weekly (scheduled for Sundays). R4's January 2024 MAR/TAR does not document that the oxygen tubing or humidifier bottle was changed on 1/7/24 and 1/14/24. On 1/22/24 at 8:50 am, R4 was lying in bed with oxygen running at 5L/NC. The tubing and humidifier bottle were not dated.	S9999		

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On 1/22/24 at 9:45 am, R4 was sitting up in the wheelchair by the Nurses Station wearing oxygen at 3L/NC. At this time, R4 stated R4 uses oxygen at 3L/NC. When questioned about the oxygen being at 5L/NC earlier this morning, R4 stated "that is what happens when V6 Agency RN (Registered Nurse) works. "(V6) always turns it way up, saying it will help me (R4). (V6) had it turned up to 10 at one point and I (R4) told him he had to turn it down." R4 explained, R4 has COPD so having oxygen that high doesn't help, "it hurts me". R4 said V6 did that a could of days ago too.

On 1/22/24 at 4:35 pm, V6 stated when someone has COPD, they aren't supposed to have high oxygen levels but over V6's 30 years of being a nurse and practicing, V6 has found that if you bump up the oxygen when someone is having difficulty breathing and give them some breathing treatments then bring the oxygen back down it helps them. V6 stated R4 was having difficulty breathing so V6 bumped R4's oxygen level up. V6 does not recall how high V6 turned it up to, but "it could have been up to 10 L".

On 1/23/24 at 1:24 pm, V6 confirmed V6 works the night shift on Sunday's when the oxygen tubing and humidifiers are to be changed. V6 stated V6 has never done that but should have.

4. R1's January 2024 Physician Orders document an order for Oxygen at 2 L per nasal cannula to maintain oxygen level above 90%, change oxygen tubing and humidifier bottle weekly (scheduled on Sundays), and CPAP nightly as resident tolerates/allows. Bleed oxygen in at 2 LPM.

On 1/22/24 at 8:30 am, R1 was lying in bed with

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an oxygen concentrator next to the bed. The concentrator was hooked up to the CPAP machine. There was no water in the undated humidifier bottle and the oxygen tubing was not dated. R1 stated R1 uses the CPAP machine every night but doesn't need to use oxygen during the day anymore.

R1's January 2024 MAR/TAR does not document the ordered CPAP was worn on 1/2/24 and 1/14/24 or a reason why it wasn't. This MAR/TAR also does not document that the oxygen tubing and humidifier changed were changed on 1/7/24 and 1/14/24.

On 1/23/24 at 1:24 pm, V6 confirmed V6 works the night shift on Sunday's when the oxygen tubing and humidifiers are to be changed. V6 stated V6 has never done that but should have.

The facility's Oxygen Therapy Policy dated March 2019 documents oxygen is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress. Oxygen may be used provided there is a written order by the physician. The order must state liter flow per minute, mask or cannula, and the time frame to be used. Oxygen tubing/mask/cannula are to be changed weekly. If humidification is indicated, document changes and cleaning of them on the treatment sheet at the time of the occurrence.

The facility's undated Nursing Documentation Guidelines documents when a treatment is refused, the staff needs to document: the date and time the treatment was attempted, the residents response and reason for refusal, name of the person attempting to administer the treatment, document that the resident was informed of the purpose of the treatment and the

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S9999	Continued From page 21 consequences of not receiving the treatment, all pertinent observations, and the date and time the physician was notified, as well as the physicians response. (B)	S9999		