STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035250	A. BUILDING _____ B. WING _____	12/16/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUEL CAMPUS OF CARE	**11301 NORTH 99TH AVENUE PEORIA, AZ 85345**

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

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F 0658 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on staff interviews, record reviews, review of medical sources and review of policies and procedures, the facility failed to ensure that services provided to one resident (#3) for a change in condition that included mental status change and respiratory distress met professional standards of quality. The deficient practice resulted in a delay in emergency medical treatment and oxygen was incorrectly provided to the resident who was experiencing respiratory distress. Findings include: Resident #3 was admitted on (MONTH) 4, 2019 with [DIAGNOSES REDACTED]. An Admission Nursing Data Collection dated (MONTH) 5, 2019 included the resident had [MEDICAL CONDITION], history of [MEDICAL CONDITION], congestion and wheezing, had lung sounds that were clear bilaterally but were diminished bilaterally in the lower lobes, had shortness of breath or trouble breathing with exertion, and when lying flat. The assessment included that the resident's respiratory rate was 18, and O2 (Oxygen) sat's (Saturation) was 98%, and that the resident used oxygen via nasal cannula at 2 L (Liters). A comprehensive plan of care for altered respiratory status and difficulty breathing related to [MEDICAL CONDITION] was initiated on (MONTH) 5, 2019 (revised on (MONTH) 13, 2019). The plan of care included a goal that the resident will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate and pattern, and included multiple interventions, including to administer medication/puffers as ordered, and monitor for effectiveness and side effects, and monitor/document/report abnormal breathing patterns to the MD (medical doctor). Review of the comprehensive plan of care, revealed an incomplete focused plan that read The resident has altered cardiovascular status related to Dx which was initiated on (MONTH) 5, 2019, (revised on (MONTH) 11, 2019). The plan of care had a goal which included the resident will be free from cardiac problems. The plan of care included two interventions, the first of which read Assess for shortness of breath and cyanosis every (specify). The second intervention which had been revised on (MONTH) 12, 2019 read OXYGEN SETTINGS: O2 via (SPECIFY: nasal prongs/mask) @ (Specify) L (Specify Freq) Humidified (Specify). Continued review of the comprehensive plan of care for altered cardiovascular status revealed the following missing details: -The actual [DIAGNOSES REDACTED]. -The plan of care did not include how often to assess the resident for shortness of breath and cyanosis. -The plan of care did not include whether to use nasal prongs or a mask, how much oxygen to administer, how frequently the resident was to receive oxygen, or whether the oxygen was to be humidified. Review of the clinical record revealed a flow record titled O2 sat's Summary, which included entries for (MONTH) 1, 3, 4, 6, 7, 8, 9, 10, and 11, 2019. The entries included that the resident's O2 saturation's ranged 94% to 99% and the resident received oxygen via nasal cannula. An admission MDS (Minimum Data Set) assessment dated (MONTH) 11, 2019 included that the resident had a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident was cognitively intact, used a walker or wheelchair, and received oxygen therapy. Continued review of the O2 sat's Summary flow record revealed entries dated (MONTH) 15, 16, 17, 18, 2019 and (MONTH) 3, 2019 which all included that the resident continued to receive oxygen via nasal cannula and the O2 saturation's ranged 94% to 99%. An entry dated (MONTH) 4, 2019 included the resident's O2 sat. was 94% on room air, and an entry dated (MONTH) 12, 2019 included the O2 sat was 96% on room air. Entries dated (MONTH) 18, 19, and 21, 2019 included the O2 saturations ranged 95% to 97% and that the resident was receiving oxygen via nasal cannula. A Daily Skilled Nurses Note dated (MONTH) 21, 2019 at 2:46 p.m. included that the resident's respiratory rate was 18, oxygen was in use via nasal cannula at 3 L, and the O2 sat. on room air was 93(%). Review of Daily Skilled Nurses Notes dated (MONTH) 22, 2019, revealed two notes, one note at 3:37 p.m. included that the respiratory rate was 18, the resident was receiving 2 L O2, and the sat. on room air was 97(%). A note at 11:49 p.m. included that the respiratory rate was 18, the resident had shortness of breath on exertion, shortness of breath when lying flat, non-productive cough, oxygen was in use via nasal Cannula at 3 L, and the sat. on room air was 97(%). Review of the clinical record did not reveal any additional documentation that the physician had been notified of the resident's shortness of breath on exertion, when lying flat or a non-productive cough, or that the resident was receiving O2 at 3 L, via nasal cannula. A Daily skilled not dated (MONTH) 23, 2019 at 1:48 p.m. included the respiratory rate was 18, and the resident had shortness of breath on exertion, and was receiving 3 L O2, and the sat. on room air was 93(%). Review of the clinical record did not reveal any additional documentation that the physician had been notified of the resident's shortness of breath on exertion, or that the resident was receiving O2 at 3 L, via nasal cannula. An NP (Nurse Practitioner) note dated (MONTH) 23, 2019 at 2:53 p.m. included statements that the resident denied SOB (Shortness of Breath), there was no current exacerbation of [MEDICAL CONDITION], and the resident had chronic hypoxic [MEDICAL CONDITION], and had been on 4 L of oxygen via nasal cannula at home. Continued review of the NP note dated (MONTH) 23, 2019 did not reveal any additional information that he resident had been receiving oxygen therapy in the facility, or that the resident had been experiencing any shortness of breath or non-productive cough. Review of the physician's orders from (MONTH) 5, 2019, through (MONTH) 23, 2019 did not reveal any physician's orders for the resident to receive oxygen therapy. A Health Status Note dated (MONTH) 23, 2019 at 9:49 p.m. included that the resident had appeared to be more difficult to awaken, and appeared more lethargic. The nurse checked vital signs, and the O2 sat's. were 89% on 3 L of O2 via nasal cannula. The nasal cannula was replaced with a non-rebreather mask, and the sat's improved to 93%. the NP was called and an order was received to send the resident to the hospital for evaluation and treatment of [REDACTED]. The resident was transported via (medical transport) ambulance. Review of the clinical record revealed a notation (flagged in red letters) that an eInteract Transfer form V 4.1 had not been completed for the resident's discharge to the hospital on (MONTH) 23, 2019 at 9:49 p.m. and was overdue. A hospital emergency room report dated (MONTH) 23, 2019 at 9:28 p.m. included that the resident had arrived at the hospital with a complaint from EMS (Emergency Medical Service)that she had been found to have altered level of consciousness, 911 was not called, and when transport EMS picked the resident up from the facility her blood pressure was 70/35, and the facility did not provide any history to the EMS. The report included that upon arrival, the resident was moaning and not speaking, had eyes open but not tracking with her eyes and not following commands to speak. The report included a statement that read The degree at present is severe. A hospital History and Physical Pertinent Report dated (MONTH) 24, 2019 at 3:34 a.m. included that the resident had been

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

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F 0658 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) intubated in the emergency department, a chest X-Ray had been performed followed by a CT scan which showed the resident had a 15% left lung pneumothorax, and a chest tube was inserted. An interview was conducted on (MONTH) 12, 2019 at 12:05 p.m. with an LPN (Licensed Practical Nurse/staff #132) who stated that if a resident had a change in condition such as a change in mental status and decreased O2 sat's, depending on the resident's condition, she would notify the physician, place the resident on oxygen, with a re-breather mask and call 911. The LPN stated that when a non-rebreather mask is used on a resident, the O2 needed for the non-rebreather mask is 15 [MI] The LPN stated that an oxygen tank must be used because the oxygen tank can deliver 15 L of O2, and an oxygen concentrator cannot deliver 15 [MI] The LPN stated that the facility had a written nursing protocol to provide oxygen and increase the oxygen until the resident's sat's are 90%. The LPN stated she did not know where the facility protocol for oxygen administration was located. The LPN stated that all pertinent medical records are to be sent to the hospital with the resident. An interview was conducted on (MONTH) 16, 2019 at 1:35 p.m. with the Director of Nursing (staff #244) who stated that when there is a medical emergency, the nurse is to call 911, and if the resident's condition is not an emergency, the nurse will call medical transportation (to send the resident to the hospital). However, whether 911 or medical transportation is called depends on the resident's condition. The Director stated that the nurse may not have called 911 because the resident's condition had stabilized. However, the director stated she did not know for sure why the nurse did not call 911 for the resident. The Director stated that the nurse should have completed the eInteract Transfer Form. The Director stated that the nurse should have used 10 L to 15 L of O2 when using a non-rebreather mask and that she was unable to locate the nursing protocol for the use of oxygen mentioned by staff #132 and stated I don't know what she was talking about. An interview was conducted on (MONTH) 16, 2019 at 3:10 p.m. with an RN (Registered Nurse/staff #211) who stated that (on (MONTH) 23, 2019) she had observed that the resident #3 had started having breathing problems while sitting up in a wheelchair. the RN stated that the resident was receiving oxygen from an oxygen tank while sitting in the wheelchair, and that the resident was moved to her bed, and placed a non-rebreather mask at a flow rate of 3 [MI] The RN stated that when the non-breather mask was applied, she removed the resident from the oxygen tank and attached the oxygen tubing to an oxygen concentrator, and the flow rate remained at 3 [MI] The RN stated that the resident's breathing was very diminished with heavy wheezing. The RN stated she notified the physician, and obtained an order to send the resident to the hospital, and she called an ambulance company which arrived 20 minutes later. When asked why an oxygen concentrator was used instead of an oxygen tank which could deliver oxygen at a higher rate, the RN stated that with a non-rebreather mask you can give oxygen at a rate of up to 12 L, and the resident's O2 sat's improved using a concentrator so there was no need for a higher concentration of oxygen. When asked why the nurse did not call 911 to have the resident sent to the hospital emergency department, rather than a medical transport ambulance which took 20 minutes to arrive, the RN stated she had already called the ambulance and that the resident wasn't critical, she was definitely in respiratory distress and had severe wheezing. A policy and procedure titled Transfer or Discharge Emergency, included a statement that emergency transfers or discharges may be necessary to protect the health and/or well being of the resident(s). The policy included that should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, the facility will call 911 and notify the receiving facility that the transfer is being made, prepare a transfer form to send with the resident, assist in obtaining transportation. A policy and procedure titled Pulse Oxymetry (Assessing Oxygen Saturation) included a statement that the purpose of the procedure is to monitor arterial blood oxygen saturation (SaO2) without the use of invasive devices. The policy included to review the physician's orders or facility protocol for pulse oxymetry. A policy and procedure titled Oxygen Administration included a statement that the purpose of the procedure is to provide safe guidelines for oxygen administration. The policy included to verify that there is a physician's order for the procedure, to review the physician's orders or facility protocol for oxygen administration, and to review the resident's care plan to assess for any special needs of the resident. An American Red Cross fact Sheet titled Administering Emergency Oxygen included a stated that emergency oxygen can be given for many breathing and cardiac emergencies. The fact sheet listed instructions for the use of multiple oxygen delivery devices including the non-rebreather mask. The fact sheet included that the non-rebreather mask is a face mask with an attached oxygen reservoir bag and one-way valve between the mask and bag, the victim inhales oxygen from the bag, and exhaled air escapes through valves on the side of the mask. The fact sheet included that the flow rate for the non-rebreather mask is 10-15 LPM (Liters Per Minute) and is suitable for breathing victims only.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on resident and staff interviews, record reviews and review of policies and procedures, the facility failed to ensure that one resident (#1) with aggressive behaviors was provided adequate supervision to prevent the resident from behaving in a physically aggressive towards another resident (#2). The deficient practice could result in the resident behaving aggressively towards other residents. Findings include: -Resident #1 was admitted on (MONTH) 14, (YEAR) with [DIAGNOSES REDACTED]. A comprehensive plan of care revised on (MONTH) 8, 2019 included that the resident had a behavior problem of sexual aggression (including grabbing), and sexually inappropriate behavior and physical aggression (including hitting) related to dementia with behaviors. the stated goal of the plan of care included that the resident will not harm himself or others. The plan of care listed multiple interventions including the following: -Intervene as necessary to protect the rights and safety of others. -Approach in a calm manner. -Divert attention and remove the resident from the situation. -The resident may become physically aggressive towards peers when the resident feels criticized when being redirected, so redirect the resident to what he is able to do. Continued review of the comprehensive plan of care included that the resident was at risk for side effect related to the use of [MEDICAL CONDITION] medications and included that he received anxiolyitic and antidepressant medications for the management and treatment of [REDACTED]. Interventions also included to monitor and record behaviors exhibited including verbal agitation, sexual aggression, tearfulness, verbalizations of distress and physical aggression. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 5, 2019 included that the resident had a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident was cognitively intact. The assessment included that the resident exhibited no behavioral symptoms, used a wheelchair for locomotion on the unit with supervision and one person physical assistance, had no limitation in his functional range of motion, and had [DIAGNOSES REDACTED]. The assessment also included that the resident received antidepressant and antipsychotic medication. A monthly summary dated (MONTH) 13, 2019 included that the resident was alert and oriented to person, was always able to understand others and to be understood, and displayed moods that included being sad, anxious and agitated. The summary included that the resident was also confused and wandered and has very limited recall, and required supervision and redirection often. The summary included that behaviors that the resident displayed included sexual inappropriate behaviors, verbal aggression and grabbing staff and wandering behaviors. The summary also included that the resident was alert and used a wheelchair, will grab staff inappropriately, can be very difficult to redirect and aggressive at times. A nurses note dated (MONTH) 16, 2019 included that the resident had been moved to a different room to prevent wandering behavior and because he was incompatible with another resident he shared an adjacent bathroom with. The note included that the resident continued to need orientation to the location of his new room, and to not wander into other resident's rooms. Review of behavioral monitoring documented in the MAR (Medication Administration Record) for (MONTH) 1, through (MONTH) 24, 2019 did not reveal any documented episodes of physical aggression on any shift. However, multiple episodes of physical aggression on multiple shifts were documented on (MONTH) 25, 27, 28, 29, and 30, 2019. Review of behavioral monitoring for December, 2019 revealed that multiple episodes of physical aggression occurred on

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) multiple shifts on (MONTH) 1, 2, 3, and 4, 2019. Review of the clinical record revealed the following: -There was no additional documentation that described the resident's physically aggressive behaviors. -There was no documented evidence that the resident's psychiatrist, attending physician or NP (Nurse Practitioner) had been notified of the sudden increase of the resident's physically aggressive behaviors. -There was no documented evidence that any additional behavioral assessing had been provided to determine the cause of the resident's sudden increase in physically aggressive behaviors. -There were no additional interventions added to the resident's plan of care in (MONTH) 2019 that addressed the sudden increase in resident's physically aggressive behaviors. An NP note dated (MONTH) 4, 2019 included that the resident had chronic dementia which was stable, was being followed by a psychiatrist for intermittent aggressive and sexual behaviors, and that the resident remained in a safe environment as evidenced by no falls and no unsupervised wandering. Continued review of behavioral monitoring for December, 2019 revealed that two episodes of physical aggression occurred on the day shift on (MONTH) 6, 2019. A Health Status Note dated (MONTH) 6, 2019 at 5:22 p.m. included that resident #1 had been found in another resident's room trying to hit her on the chest, the (other) resident was screaming and staff ran into the room and redirected resident #1 out of the room to his (own) room. There was no injury noted and resident (#2) was assured she is safe. A nurses note dated (MONTH) 6, 2019 at 6:46 p.m. included that resident #1 had been transferred to a different unit. -Resident #2 was admitted on (MONTH) 3, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 14, 2019 included that the resident had a BIMS score of 10, which indicated that the resident had moderately impaired cognition. The assessment included that he resident required extensive assistance with bed mobility with one person physical assistance, had functional limitation in range of motion on one side of both upper and lower extremities and used a wheelchair. A Health Status Note dated (MONTH) 6, 2019 at 5:56 p.m. included that the resident (#2) was lying in her bed in her room and another resident went into her room and was trying to hit her on the chest with both hands. The note included that the resident was screaming for help and staff ran into the room and got the other) resident away from her and redirected the resident to his room. The note included that the resident was assessed for injury and none was noted. -Resident #4 was admitted on (MONTH) 27, 2019 with [DIAGNOSES REDACTED]. An admission MDS assessment dated (MONTH) 4, 2019 included that the resident had a BIMS score of 15, which indicated that the resident was cognitively intact, had verbal behaviors directed at others. The assessment included that the resident used a wheelchair for locomotion on the unit with supervision and no physical help from others and had no functional limitation in range of motion. -Resident #5 was admitted on (MONTH) 7, 2019 with [DIAGNOSES REDACTED]. An Admission MDS assessment dated (MONTH) 20, 2019 included that the resident had a BIMS of 14, which indicated that the resident was cognitively intact. The assessment included the the resident used a wheelchair for locomotion on the unit with set-up help, and had functional limitation in range of motion on both sides of his lower extremities. A facility investigative report dated (MONTH) 12, 2019 included that on (MONTH) 6, 2019 at 1;30 p.m. a CNA (Certified Nursing Assistant/staff #161) observed resident #1 enter the room of resident #2, and before she could get to the room, she heard resident #2 screaming. The resport included that when she entered the room, she observed resident #1 seated the bedside of resident #2, next to her bed and he was bouncing his hands on the chest of resident #2 in the same manner as if he was doing chest compressions. A synopsis of the facility investigation dated (MONTH) 10, 2019 included that when staff #161 observed resident #1 seated at the bedside of resident #2, next to her bed and he was bouncing his hands on the chest of resident #2, she immediately removed resident #1 from the room of resident #2, and remained with resident #1 until he was moved to another unit. The synopsis included a statement that the Behavioral Health Program Manager (staff #79) reported that earlier in the week Prior to the incident on (MONTH) 6, 2019), he had contacted the psychiatrist for resident #1 to ask him to reassess the resident and possibly increase the resident's medication, which would result in his increases being controlled, and on the evening of the incident, the psychiatrist increased the dosages of two of the resident's medications. During an interview conducted on (MONTH) 12, 2019 at 1:50 p.m. with resident #4, he stated that earlier on the day that the incident happened between resident #1 and #2, resident #1 had entered his room and got into his bed. He yelled for staff and resident #1 was removed from his bed. Resident #4 stated that resident #1 frequently entered other resident's rooms, and stated he kept coming in here and trying to get in my bed. An interview was conducted on (MONTH) 13, 2019 at 1:30 p.m. with staff #161, who stated that when the incident happened (on (MONTH) 6, 2019) the staff were in the dining room after the residents ate lunch, clearing the lunch trays and she heard yelling coming from the room of resident #2. Staff #161 stated that she ran to the room and when she entered, she observed the female resident (#2) laying on her bed, fully clothed, resident #1 was sitting in a wheelchair at the bedside bouncing up and down repeatedly with his open hands on the chest of resident #2, and an aggressive manner, and not in a sexual manner. Staff #161 stated that she immediately separated the resident's, removed resident #1 from the room and remained with resident #1 until he was moved to another unit. When asked if resident #1 had been observed wandering into other resident's rooms prior to the incident, she stated all the time he goes into other rooms. Staff #161 stated that prior to the incident, resident #1 was not receiving any additional behavioral supervision for his intrusive wandering behavior, just the regular, every two hours check. During an interview conducted on (MONTH) 13, 2019 at 1:50 p.m. with resident #5, he stated that resident #1 went into other resident's rooms a lot and all the time. Resident #5 stated that although resident #1 did not behave aggressively towards him, he frequently would find resident #1 in his room, and watching his television in his room, tell resident #1 to get out! and resident #1 would leave the room. Resident #5 stated that when the incident occurred (on (MONTH) 6, 2019) there were no staff in the resident hallway outside of the rooms, and that all of the staff were in the dining room. An interview was conducted on (MONTH) 13, 2019 at 2:35 p.m. with staff #79, who stated that when the nurses document the frequency of a resident's behaviors in the MAR, they should do a behavioral note in the clinical record, and a behavioral assessment. Staff #79 stated that he reviews daily the behavioral notes and assessments, and that is how he knows there is an increase or change in a resident's behaviors, and he will notify the psychiatrist for direction or changes in a resident's medications. Staff #79 stated he had reviewed the record for resident #1 and did not see any notes or additional assessments that would have told him that there had been an increase in the resident's aggressive behaviors in (MONTH) and early (MONTH) 2019. Staff #79 stated that there had been a definite increase in the resident's behaviors and the nurses could have notified the physician that there was an increase in the resident's behaviors and they did not. A policy and procedure titled Behavioral Care Services included a statement that the facility will provide and residents will receive behavioral care services as needed to attain or maintain the highest practicable physical, mental and psychosocial well being in accordance with the comprehensive assessment and plan of care. The policy included that behavioral care services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care, and that residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. The policy also included that staff are scheduled in sufficient numbers to manage resident needs throughout the day, evening and night.