STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105690	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND PINES REHABILITATION CENTER	**1111 S HIGHLAND AVE CLEARWATER, FL 33756**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and photographic evidence, the facility failed to ensure adequate respiratory services consistent with professional standards of practice were provided for two residents (#4 and #5) of two residents reviewed for respiratory care services. Resident #4 and #5 were observed to have oxygen tanks with the gauge indicator in the lower portion of the red zone and close to empty. Resident #4 was in receipt of 2 LPM (liters per minute) instead of the physician ordered 3 LPM. Resident #5 was in receipt of oxygen with no physician order for [REDACTED].#4 on the secured unit in the common dining area. Resident #4 was in a wheelchair with an oxygen (O2) tank on the back of the wheelchair, and a nasal cannula was in position in her nose. Resident #4's O2 tank gauge needle was observed to be in the lower portion of the red zone for the level of the O2 in the O2 tank. The red zone was observed to have the words, REFILL. Resident #4's O2 flow rate was observed to be at 2. An observation at 4:20 p.m. was conducted of Resident #5 on the secured unit. Resident #5 was sitting in the common dining area at a table with two other residents and Staff D, Certified Nursing Assistant (CNA). Resident #5 was observed to have an O2 tank on the back of his wheelchair and a nasal cannula in position in his nose. The O2 tank gauge needle was observed to be in the lower portion of the red zone which indicated the level of O2 in the tank. The red zone was observed to have the words, REFILL. Resident #5's O2 flow rate was observed to be at 2. An interview was conducted at approximately 4:25 p.m. with Staff C, CNA. She reported that her shift was 11:00 a.m. to 7:00 p.m. Staff C, CNA was asked who was responsible for checking the residents' oxygen tanks, she reported that she did. She stated that she checks when she comes in to see if it is on 2 L (liters), and if the tank is full or not. She was asked, when would there be a concern about the amount of O2 in the tank. She said, When it is almost to the red. She also reported that there were no flow sheets to mark down that she checks the oxygen, but, that she does. An interview at 4:27 p.m. was conducted with Staff A, Agency Licensed Practical Nurse (LPN). She was interviewed about the residents on the secured unit with oxygen. She stated that two residents were on oxygen; (Resident #4) is at 3L; (Resident #5) is at 2L. She stated that she watched the tank and that she did not know the facility's protocol. She stated that she checked at the beginning of the shift, middle of the shift and at the end and added that the tanks really do not run out too fast. Staff A confirmed that she did not document when she checks the oxygen. She said not necessarily; don't really document. She stated that she checked the tanks when she did rounds with the other nurse. She stated that she changes the tank herself when it is getting low. Staff A confirmed that low would be when it is getting toward the red. An attempt was made to interview both Resident #4 and Resident #5 and no response was provided by either resident to questions asked. An observation at 4:30 p.m. was conducted of Staff C, CNA, changing Resident #4's O2 tank in the common dining area. She confirmed that the tank was low and that is why she was changing it. She confirmed that she also changed Resident #5's tank. Both Resident 4's and Resident #5's tank were observed to be in the lower portion of the red zone on the gauge. (Photographic Evidence Obtained) Staff C, CNA further stated that the O2 goes fast in the tanks. The Director of Nursing (DON) was interviewed at 5:31 p.m. A review of Resident #4's clinical chart was conducted with the DON, she stated that for Resident #4, the file reflected an oxygen order for 3LPM (Liters per Minute). The DON stated that oxygen is a medication, and it should be checked by the nurse. For the nurse, it is on the TAR (Treatment Administration Record). She stated that the CNA Kardex for this resident was not populated with information related to oxygen use for this resident. During this interview a review of Resident #5's clinical chart was conducted. During the review of Resident #5's care plan, the DON confirmed that the care plan had no oxygen therapy focus area on it. The DON confirmed that, yes, there was supposed to be a care plan for the oxygen use. Further review of Resident #5's chart revealed no physician order for [REDACTED]. During this interview at 5:46 p.m., the DON stated that staff are taught to check the level and that her expectation is the nurse checks the O2. She stated that they are to check when they come in. The DON confirmed that agency staff are informed of the expectation by a packet that they are given and expected to review. She stated that they review it and sign off that it was reviewed. An observation at 6:00 p.m. was conducted of Resident #4 and #5 with the DON. The DON confirmed that both residents were in receipt of oxygen via nasal cannula at a rate of 2LPM. The DON stated that when the gauge is close to the red zone the tanks should be changed. The DON confirmed if the level was at the bottom of the red that the resident has a chance of running out of oxygen. A review of Resident #4's Admission Record, documented an admission of 05/2016, with a readmission of 07/22/20. [DIAGNOSES REDACTED]. A review of Resident #4's care plan revealed: Focus: Oxygen: The resident has Oxygen Therapy r/t (related to) Dx (diagnosis) [MEDICAL CONDITION], initiated 05/24/16, revised 04/17/17. Goal: Will have no untreated s/s (signs/symptoms) of SOB (shortness of breath) through next review. Interventions included: Special Equipment: Oxygen, initiated 05/24/16; Administer Oxygen as ordered. (Refer to current POS/MAR for current order), initiated 05/24/16. Focus: [MEDICAL CONDITION]/[MEDICAL CONDITION]: The resident has [MEDICAL CONDITION]/[MEDICAL CONDITION] r/t Smoking, initiated 04/17/17. Goal: The resident will display optimal breathing pattern daily through review date. Interventions included: Give oxygen therapy as ordered by the physician, initiated 04/17/17. A review of Resident #4's Treatment Administration Record for 08/2020 reflected the following physician order: 07/28/20 thru discontinuation date of 08/07/20: Oxygen at 2 LPM (liters per minute) via nasal cannula continuous for [MEDICAL CONDITION], every shift for [MEDICAL CONDITION]. 08/07/20, ongoing: Oxygen at 3 LPM via nasal cannula continuous for [MEDICAL CONDITION], every shift for [MEDICAL CONDITION]. Review of nursing documentation reflected that nurses documented every shift the administration of the oxygen. A review of physician orders for 08/2020, reflected a physician order, start date of 08/08/20, Oxygen at 3 LPM via nasal cannula, continuous for [MEDICAL CONDITION], every shift for [MEDICAL CONDITION]. A review of Resident #5's Admission Record, documented an admission of 06/19/20. [DIAGNOSES REDACTED]. During a review of Resident #5's care plan, conducted at 5:31 p.m. with the DON, she confirmed no oxygen care plan was available for Resident #5. A review of Resident #5's MAR (Medication Administration Record) and TAR (Treatment Administration Record) for 08/2020, reflected no listing for a physician order for [REDACTED].#4's and #5's care plan. She stated that she had the care plan updated with a new focus area related to oxygen for Resident #5. In addition, she provided a new order from the physician for Resident #5, dated 08/27/20 at 18:23 (6:23 p.m.): Oxygen at 2 LPM via nasal cannula continuously for sob every shift for Shortness of Breath. A review of the facility's Oxygen Administration and Therapeutics policy and procedure, 2.1.1, dated May 2020, for Oxygen Administration, documented the following policy: The facility requires that a physician order be obtained prior to the administration of oxygen. In an emergency, oxygen may be administered as per physician-approved center protocol. The goals of oxygen therapy are as follows: Treat or prevent hypoxemia; Decrease the work of breathing; Decrease [MEDICAL CONDITION] work. All order for oxygen therapy must include: Liter flow or concentration; Mode of delivery; Duration of use (PRN (as needed), continuously, etc.); Specific weaning criteria (when applicable). Equipment May include but is not limited to: Oxygen source-cylinder, liquid oxygen vessel, flowmeter (if wall source).; Delivery device-nasal cannula, (low flow) mask, simple oxygen mask, non-rebreathing mask, etc.; . Procedure: 1. Verify physician's order. 2. Gather equipment and supplies as applicable. 3. Maintain standard Precautions. 4. Identify resident/patient, . 5. Observe procedure for mode-specific oxygen administration .

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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