STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555744	A. BUILDING _____ B. WING _____	**03/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIENA SKILLED NURSING AND REHABILITATION CENTER	**11600 EDUCATION STREET AUBURN, CA 95603**

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 interview and record review, the facility failed to ensure 1 of 3 residents (Resident 1) received oxygen (O2) therapy per the physician order when: 1. Licensed Nurses (LN) titrated (increase or decrease gradually) oxygen delivery without a physician order; 2. Care plan for oxygen therapy was inconsistent with the physician orders; and, 3. There was no policy and procedure for LNs to titrate oxygen to maintain percentage of oxygen saturation (sats, or SpO2: the percentile of oxygen-bound to hemoglobin relative to total hemoglobin in the blood, normal range 95%-100%) levels. This failure had the potential for Resident 1 to receive too much or too little oxygen that could lead to respiratory distress. Findings: Resident 1 was a short term resident in the facility with [DIAGNOSES REDACTED]. 1. Review of the clinical record, January, 2020 TAR (Treatment Administration Record), indicated upon Resident 1's readmission, the resident had the physician orders for O2 as follows: 1/31/20: Oxygen at 2 L via nasal cannula continuously every shift 1/31/20: Oxygen at 2 L via nasal cannula continuously as needed The above physician orders did not include or specify set parameters for Licensed Nurses (LN) to titrate administered oxygen or percentage of oxygen saturation levels for Resident 1. Review of the clinical record, Progress Notes, Skilled charting and eInteract Transfer Form V5, indicated LNs titrated O2 administration as follows; 2/1/20: Progress Notes indicated, pt (Resident 1) had an episode of SOB (shortness of breath) after .I turned up his O2 initially to 5 L after 15 minutes .turned it (O2) down .his SpO2 stays above 90%. 2/1/20: Skilled charting, indicated, Amount of O2 and Route 4 L via NC, 2/7/20: Skilled charting, indicated, O2 sats: 91% .Room Air . 2/10/20: Progress Notes indicated, . increased from 2 L to 3 L due to O2 reading the high 80's . 2/13/20: eInteract Transfer Form V5 indicated, O2 sats: 91% .Room Air . Review of the facility 10/10 policies and procedures, Oxygen Administration, stipulated to provide safe oxygen administration, the facility was to Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review of the clinical record, January 2020 TAR, indicated Resident 1 had physician orders for O2 as follows: 1/4/20: Oxygen at 3 L (liters) via nasal cannula (NC, a plastic tube that delivers supplemental oxygen to the nostrils) continuously every shift 1/4/20: Oxygen at 3 L via nasal cannula continuously as needed Review of the care plan, dated 1/6/20 for [MEDICAL CONDITION], indicated, Give oxygen therapy as ordered by the physician. Review of the care plan, dated 1/6/20 for chronic [MEDICAL CONDITION], indicated the goal for Resident 1 was not to have complications related to poor oxygen absorption. The implementations to attain the goal included, Oxygen Setting: (Resident 1) has O2 via nasal prongs @ 2 L continuously. This care plan did not indicate the resident's baseline O2 saturation level or the O2 administration parameters to maintain the therapeutic O2 level. 3. The facility 10/10 policies and procedure, Oxygen Administration, was reviewed. The policy did not address the oxygen titration in response to O2 saturation level or actions to take for LNs to respond to a resident's O2 level below 90%. However, the policy stipulated to follow the physician order or the facility protocol, Review the physician's orders or facility protocol for oxygen administration. In an interview on 2/24/20 at 3:42 p.m., the Director of Nursing (DON) stated the oxygen administration needed the physician orders and should have given as ordered. In a telephone interview on 3/11/20 at 3:41 p.m., the DON verified Resident 1 received titrated O2. The DON stated when the resident had O2 at 2 L continuous order, it was not necessary to have O2 at 2 L continuous as needed order. The DON verified the physician's order did not indicate the O2 titration parameters or the resident's O2 saturation level. The DON acknowledged the care plan did not indicate O2 titration or the resident's O2 saturation therapeutic level. The DON confirmed, via email on 3/17/20, there was no other facility protocol regarding O2 administration other than the 10/10 policy and procedure provided.

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