STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065427	A. BUILDING _____ B. WING _____	04/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTER AT PARK WEST LLC, THE	3727 PARKER BLVD PUEBLO, CO 81008

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 observations, record review and interviews, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents ' goals and preferences for one (#1) of three residents reviewed for [MED]gen therapy out of 21 sample residents. Specifically, the facility failed to ensure [MED]gen was administered according to physician orders [REDACTED]. The facility's failure to ensure [MED]gen was administered to Resident #1 according to physician's orders [REDACTED]. Findings include: I. Resident #1 A. Resident status Resident #1, [AGE], was admitted on [DATE] and discharged to the hospital on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. There was no minimum data set completed because of the resident ' s immediate discharge from the facility. B. Record review The care plan dated [DATE] identified a respiratory risk related to [MEDICAL CONDITION]. Interventions included to administer [MED]gen as ordered and as needed, and to monitor vital signs as ordered and as needed. The progress note dated [DATE] written at 2:06 p.m. by licensed practical nurse (LPN) #2 included, Patient's wife reports that [MED]gen (02) was not plugged into wall unit, (the) patient became minimally responsive. The nurse practitioner (NP) notified, returned orders to send to emergency room (ER) via ambulance service. Patient transferred. The progress note did not identify the blood [MED]gen level. The change of condition form dated [DATE] at 12:05 p.m. included, change of condition identified: altered mental status; signs and symptoms: answering slowly any questions posed from staff or spouse. Vital signs: blood sugar 212, blood pressure 129/83, pulse 80, [MED]gen level 95% at 4.5 liters per minute. Patient's response to change: unable to answer. NP in to see patient at 11:50 a.m. Care plan completion and intervention: sent to emergency room for evaluation and treatment as required, The March 2020 electronic Medication Administration Record [REDACTED]. Okay for therapy to titrate every shift for shortness of breath (SOB). The eMAR for the date of [DATE] for the night shift documented 3 liters per minute with an [MED]gen level of 95%. The eMAR for the date of [DATE] day shift was not completed. II. Hospital records A. Emergency department physician documentation The emergency department physician documentation dated [DATE] at 1:07 p.m. included, Patient is minimally responsive and wife at bedside provides history. Daughter saw the patient this morning at 8:00 a.m. and related to patient's wife that he was wearing a nasal cannula and seemed a little confused, although this was not abnormal in the last several weeks as he had periodic hallucinations. Wife saw the patient at 10:30 a.m. this morning and states he appeared very pale and was 'gasping for air'. His nasal cannula was in place but not attached to the [MED]gen. The [MED]gen was attached instead to a nearby face mask. The emergency department course doctor note included, I suspect that the altered mental status was secondary to hypoxemia from being off of his baseline of four liters of [MED]gen as being back on [MED]gen has slowly shown improvement. B. History and physical report The history and physical report dated [DATE] at 5:10 p.m. included, Patient was lethargic today after he did not have his [MED]gen placed after he had gotten up to go to the bathroom for a bowel movement with assistance. Patient even noted that he remembered the [MED]gen not being on told the certified nurse aide (CNA) at the facility but he was told that the [MED]gen would 'start up soon and he would feel it then.' Patient was increasingly lethargic at the facility and sent out to our facility for further evaluation. Wife states that he is improving in his mental status now that his [MED]gen is on. C. Hospitalist progress note The hospitalist progress note dated [DATE] at 8:05 a.m. included, readmitted this time for acute on chronic hypoxic [MEDICAL CONDITION] with transient alteration in mental status. The progress note dated [DATE] at 6:59 p.m. included, Patient is overall much improved. III. Interviews CNA #1 was interviewed on [DATE]3/2020 at 12:00 p.m. He said he took [MED]gen levels as part of routine vital signs. He said if the [MED]gen levels were low, below 90% he would encourage the resident to take slow deep breaths. He said if the breathing did not help, he would notify the nurse for further evaluation. LPN #1 was interviewed on [DATE]3/2020 at 11:45 a.m. She said [MED]gen was a medication. She said if the [MED]gen levels were low, she would check the orders and if there was a titration order, she would titrate the [MED]gen up to try to get to an acceptable level. She said if there were any unusual findings she was to report it to the charge nurse. Registered nurse (RN) #1 was interviewed on [DATE]3/2020 at 12:10 p.m. She said if she received a report of a low [MED]gen level, she would reassess the [MED]gen level. She said if the [MED]gen level was still low, she would increase the [MED]gen level slowly going by the titration physician orders. She said if she was not able to increase the [MED]gen level after titration, she would notify the provider and ask for further orders. The director of nursing (DON) was interviewed on [DATE]3/2020 at 12:15 p.m. She said she wanted the aides to report a low [MED]gen right away to a nurse for an assessment. She said if the nurse discovered a less than ideal assessment, she would want the nurse to listen to breath sounds, titrate [MED]gen as ordered and notify the provider. She said she would expect the nurse to document all the [MED]gen levels discovered and recovered. She said Resident #1 was in the facility for only a short amount of time, and was sent to the emergency department for a change of condition. She said he had a change in his responsiveness. The nurse practitioner (NP) was interviewed on [DATE]3/2020 at 3:27 p.m. She said the family wanted him sent out immediately. She said it was the normal practice for her group to send any resident to the emergency department if the family wished it. She said she wrote the orders because the family wanted him sent out. The DON was interviewed on [DATE]4/2020 at 1:25 p.m. She said Resident #1 was sent out due to altered mentation. She said she did not know why there was not documentation of the [MED]gen level in the MAR indicated [REDACTED]. She said to send a resident out to the emergency department was a decision by the NP. She said she did not know if the [MED]gen was connected or not. She said the facility did not do an investigation. IV. Facility follow-up The DON supplied the following information on [DATE]6/2020 at 3:30 p.m.: Staff interviews: CNA Went into patient ' s room that morning on [DATE] at approx. 6:30-7am. CNA removed continuous positive airway pressure ([MEDICAL CONDITION]) and applied O2 via nasal cannula. At appox(imately) 7:30-8am Patients breakfast was there. Patient was alert and conversing with CNA. Around 8:30am, approximately the CNA went back to get the patient ' s tray. The patient and the CNA had a conversation about his past work experience. CNA never witnessed the O2 not being plugged in or the wife making a statement about plugging the [MED]gen back in. CNA did recall a conversation with the patient ' s wife about there being a family member who was [MED]gen deprived. On [DATE] Nurse had been to take the patient blood sugar. Nurse noted the patient was receiving [MED]gen via nasal cannula and the [MED]gen was attached to the wall. Patients breakfast tray was delivered. Patient verbalized he wanted to wait to eat breakfast. Wife had come to visit. It was reported to the nurse by the CNA that the patient was not acting right. He was more confused but answering questions. Nurse does not recall the O2 sat being below 90%. Medication nurse on [DATE] was to administer medication to the patient at approx. 8:30 a.m. Nasal cannula was in place, with tubing attached to [MED]gen. Physician medical group was notified. NP had assessed patient on 5 liters with an O2 sat of 90%. Even though I could not substantiate that, the patients [MED]gen was not connected to the wall as reported by the wife, staff was educated on documentation, and [MED]gen. The documented education provided to the facility staff was dated April 15-17 2020.

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.