STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	C 03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

(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) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/7/22 through 3/8/22, a standard abbreviated investigation survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5236085C (MN81298), with deficiencies cited at (F580). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		4/4/22

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

Electronically Signed | 04/04/2022

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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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 580	R1 discharged and did not return to the	

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F 580	Continued From page 2 facility failed to ensure a resident's medical provider was notified in a timely manner of a change in condition for 1 of 1 resident (R1) related to a change in vital signs, poor appetitie, insulin refusals and deterioraring respiratory status. The facility's failure resulted in actual harm for R1 whose treatment was delayed despite requiring an increase in oxygen from 2 liters (L) to 6 L since hospital discharge and an elevated temperature of 100.5 degrees. R1 required hospitalization related to a low oxygen saturation level of 54% even with the use of 6 L of oxygen. Findings include: R1's diagnoses obtained from the hospital Discharge Summary dated 12/17/20, included: fracture of unspecified part of left clavicle, primary subsequent encounter for fracture with routine healing, chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease with heart failure chronic diastolic (congestive) heart failure, chronic atrial fibrillation, abnormalities of gait and mobility and weakness. Review of R1's nurse's notes revealed the following: -Admission Note dated 12/17/20, at 9:40 p.m. indicated R1 was admitted to the facility for rehabilitation from the hospital where he had been treated for gastrointestinal (GI) bleeding and left clavicle fracture secondary to resident reporting he "felt a pop" while transferring into his wheelchair and had experienced left shoulder/clavicle pain. The note indicated R1 was alert and orientated, but had some memory loss/forgetfulness. The note also indicated R1's lung sounds were somewhat diminished in	F 580	facility An audit was completed of all current residents for any changes of conditions that were not yet reported to resident's physician or resident representative. Facility policy for Change in Condition reviewed and remains appropriate. Staff education provided to all licensed nurses in regards to policy and procedures for notification of changes to physicians and resident representative's. Two audits per week of all residents will be conducted weekly to review residents with a change in condition to ensure appropriate notifications were completed. Compliance date April 4th, 2022	

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bilateral bases and some crackles were noted to right lower lobe. R1 had shortness of breath with minimal exertion, was unable to tolerate lying in bed, and had reported he felt too short of breath even with head of bed elevated at 90 degrees. Further the note indicated R1 reported he preferred to sit/sleep in his recliner at night and wore continuous oxygen at 2 liters (L) via nasal cannula. The resident's oxygen saturation was identified as 92%.

-Progress Note dated 12/18/20, at 10:54 a.m. indicated R1 had a temperature of 99.3 this AM (morning) with resident also de-sating (blood oxygen levels dropping) to 76-77% on 2 L of oxygen, with respirations at 24 per minute. The note also indicated the resident complained of "mild" congestion that started "about 2 days ago" and was complaining of feeling light headed while at rest in wheelchair. Resident also stated he felt more fatigued and weaker in comparison to yesterday. Resident had some conflicting reports; told therapy he was experiencing shortness of breathe (SOB) at night and did not get any adequate sleep and told writer that he had a good night of sleep and denied SOB. Lung sounds diminished. Binex swab was negative for Covid. The note indicated St. Luke's Community Care (SLCC) was updated and orders were obtained to check labs which included complete blood count (CBC) with differential, comprehensive metabolic panel (CMP- is a test that measures 14 different substances in your blood), B-type natriuretic peptide (BNP- blood test measures the levels of the BNP hormone in your blood which can indicate heart failure), daily weights are to be obtained every morning, chest x-ray and oxygen orders changed to state "maintain oxygen [02] between 88-92%, document liter flow." The note

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further indicated R1's oxygen had been increased from 2 LPM to 5 LPM to get the oxygen saturations up to 88-89% . There was no documentation/order for the oxygen liter flow being bumped above 4 liters according to the nurse practitioner.

-Progress Note dated 12/18/20, at 1:52 p.m. indicated, "Chest X-ray came back with the following impression: Peripheral airspace opacities in both lungs are concerning for atypical infectious process such as COVID-19 pneumonia. The heart size and pulmonary vascularity appear stable. The right hemidiaphragm remains elevated. The lateral view is nondiagnostic. Results faxed to SLCC. Lab results still pending. Infection nurse and nurse manager updated. Copy of results placed in resident's chart."

-Progress Note dated 12/18/20, at 5:22 p.m. indicated labs had been drawn and the tests that were elevated (high) included: BNP 196.0 with normal levels (0.0-100.0 K/ul); carbon dioxide (C02) 38 with normal level (23-32 mmol/L); glucose 112 (60-99 mg/dL); blood urea nitrogen 27 (a test that reveals how well one's kidneys are working with normal levels 8-23 mg/dL); WBC 12.3 (a blood test to measure the number of white blood cells in the blood. WBC's help fight infections with normal level 4.0-10.0 K/uL) and Neutrophils 8.95 (a type of white blood cell that act as the immune system's first line of defense. Having a high percentage of neutrophils in the blood is a sign that a person's body has an infection with normal levels 1.56-6.13 K/uL). The noted further indicated Family member (FM)-A was updated, a copy of results were placed in resident's chart, the rounding nurse practitioner

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(NP) was updated, and an order for CBC and BMP to be rechecked on Monday was obtained.

During further review of R1's medical record it was revealed the medical record lacked who the rounding NP was who provided the orders to repeat the labs on 12/21/20. There was also no record of the order as a telephone order or verbal order written in R1's medical record for re-checking the labs. In addition, the medical record lacked documentation from the rounding physician/NP of why other treatments were not initiated despite R1 having elevated white blood cell count at 12.3 with normal levels (3.8-10.6) and Neutrophil's 8.95 with normal levels (1.8-7.8) despite this being abnormal compared to the last labs obtained prior to discharge from the hospital the day prior, 12/17/20, when results of 9.4 for WBC and 6.1 Neutrophil's (both normal lab values) were identified.

-Progress Note dated 12/18/20, at 9:59 p.m. indicated "Resident is alert and orientated, can use call light and verbalize needs. Resident had no complaints of pain. Resident had complaints of increased SOB when getting ready for bed, oxygen saturation was at 87% on 5 L, Resident was situated into his recliner and told to take deep breathes through his nose, oxygen was turned up to 6 L and nurse observed him taking deep breaths, resident is now sating at 92% on 6 L. Resident's blood sugars were 169 and 110."

-Admission Note dated 12/19/20, at 1:50 a.m. indicated "Resident is able to make needs known, uses call light appropriately. Resident complains of SOB, oxygen on at 6 L, oxygen saturation at 91%, sitting in recliner as it is easier to for resident to breath. Resident had temp of 100.3

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this NOC [night] shift. Residents blood sugar was 110 at bedtime [HS], had HS snack. Resident had chest x-ray done today, still awaiting results. COVID swab done, still awaiting results." The progress note lacked evidence the physician/provider had been contacted about the elevated temperature as this was the first time following the abnormal x-ray and chest x-ray with pending labs on 12/21/20.

-New Admit Note dated 12/19/20, at 3:04 p.m. indicated "Resident ate poorly this day shift. Held insulin due to BS [blood suger] only 74 in am and poor appetite. Res refused noon insulin. Ate only about 1/3 of lunch. BS was 282 before lunch, res still did not want the insulin. Next nurse notified. Res sats were in the low 90's on 6 L high flow O2. Some SOB noted at times, especially when lying in bed to change. Res could not tolerate this, was put back in reclining chair, but sitting upright all shift. Staff able to calm res SOB down by talking him thru deep slow breathing exercises. Afebrile for day shift. Tolerated dressing change. Small yellowing drainage on removed dressing. Wrapped right lower extremity after dressing change and wrapped Kerlix on left lower extremity. Lung sounds [LS] are dim [diminished] with some wheezing noted in upper lobes." The note lacked evidence the physician/provider had been updated on staff holding the insulin as ordered, poor appetite and resident noted "wheezing in upper lobes."

-Admission/Medicare Note dated 12/19/20, at 11:35 p.m. indicated "Resident's lung sounds remain diminished in bilateral bases. He has shortness of breath with minimal exertion and is unable to tolerate lying in bed, as he reports he feels too short of breath--even with head of bed

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elevated 90 degrees. He prefers to sit/sleep in recliner. Oxygen sats are 92% on 6 L via NC [nasal cannula]. No cough noted. Resident remains afebrile. Denied chest pain. Left shoulder/clavicle and left lower extremity/stump pain effectively managed with scheduled Gabapentin and prn [as needed] Tylenol. Resident resting comfortably in recliner at this time."

-Admission Note dated 12/20/20, at 3:10 a.m. indicated "Resident able to make needs known, uses call light appropriately. Resident complains of SOB, on 6 L oxygen, sitting in recliner due to [d/t] easier to breath sitting up. Temp [temperature] 100.5. Resident wanted blood sugar [BS] checked d/t feeling low, blood sugars 112 at 0120 [1:20 a.m.] with snack given after checking, rechecked at 0245 [2:45 a.m.]with blood sugar of 234 [2:34 a.m.], feels a little better. No PRN [as needed] medication given. No scheduled medications given. Resident remains on enhanced precautions awaiting Covid testing results." The noted lacked evidence of the physician/provider being updated of the continued SOB and elevated temperature. In addition, the note did not indicate the oxygen saturation level R1 was at with the 6 liters of oxygen.

-New Admit Note dated 12/20/20, at 1:56 p.m. indicated "Res SOB [short of breath]at times. Sats in the 88-90% range on 6 L of O2 [oxygen]. Res appetite poor, insulin held. Granddaughter called for update and stated res has had some history [hx] of bowel obstructions. Res had 2 loose large stools this shift. Granddaughter insisted loose stool could mean an obstruction for him. Abd [abdomen] non-tender, hard. BS [bowel sounds]are active. Res was asked about

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pain/discomfort, res stated his shoulder was uncomfortable, but not that bad. Gave PRN Tylenol. Granddaughter stated res has a hard time telling people of how much pain he is in. Res does state at times he has a hard time breathing. Some anxiety noted with resident. Granddaughter would like res tested further for bacterial pneumonia and possible bowel obstruction. Res is stable, informed granddaughter we are waiting Covid test results. Will update RN case manager and pass on to St Lukes Community Care for f/u [follow up]." The medical record lacked documentation of a physician/provider being updated of the loose stools, insulin being held and R1's responsible party requesting R1 to be tested further related to the issues R1 was experiencing. In addition, the medical record lacked evidence of the nurse manager and SLCC being updated to follow up on the concerns.

-Admission/Medicare Note dated 12/20/20, at 11:40 p.m. indicated "Resident is a diabetic and his blood sugars this shift were 265 prior to dinner. Resident ate less than 25% of dinner, stating he had no appetite. Writer held scheduled 45 units of Novolog secondary to poor intake. At HS, resident's blood sugar was 456. He reported he did not eat anything since dinner. Writer administered the 45 units of Novolog previously held, along with 80 units of scheduled Lantus. At 2230 resident's blood sugar was 118. He was provided an HS snack of milk and Lorna Dune diabetic friendly cookies. Resident's lung sounds remain diminished in bilateral bases. He has shortness of breath with minimal exertion and is unable to tolerate lying in bed, as he reports he feels too short of breath--even with head of bed elevated 90 degrees. He prefers to sit/sleep in recliner. Oxygen sats are 93% on high flow

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oxygen of 6 L via NC. No cough noted. Resident remains afebrile. Denied chest pain. Left shoulder/clavicle and left lower extremity/stump pain effectively managed with scheduled Gabapentin and PRN Tylenol. Resident resting comfortably in recliner at this time." The medical noted lacked evidence of the provider/physician being updated of staff holding the scheduled insulin at 4:30 p.m. then administering it at HS together with scheduled Lantus (long acting insulin) and R1's continued report of feeling "too short of breath" plus the diminished lung sounds.

-Shift Note dated 12/21/20, at 3:37 a.m. indicated "Beginning midnight resident's O2 dropped between 88 to 54 on 6 L free airflow. O2 sat went back up to 90 with help of deep breathing. O2 sat continued going up and down through the night till 3 am. Unable to keep sat above 88, stayed 74." Writer called on-call St Lukes Community Care physician who gave verbal order to send R1 to emergency room (ER). Nurse at ER was updated with resident's condition. Family member was notified, and resident consent to going to ER. The medical record lacked documentation of the provider/physician being notified timely when the oxygen saturation levels were dropping between 88% to 54% beginning at midnight so the physician could make the decision to continue monitoring R1 at the facility or send R1 to the hospital. The nurse waited until 3:00 a.m. which was 3 hours later and although R1's oxygen saturations went back to 90% with deep breathing, R1's oxygen level continued to go up and down through the night. In addition, the medical record lacked documentation of what the oxygen levels were through out the time frame from when the level stayed at 74% upon which the nurse called the on-call physician who gave

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order to send R1 to ER. The note also lacked R1's temperature at the time of the assessment prior to transferring R1 to the hospital.

During review of the physician orders the following was revealed:
-12/18/20, order for O2 to keep sats between 88-92%. Document liter flow every shift.
-12/18/20, check temperature, blood pressure (BP), pulse, respirations and O2 sats once daily. Special Instructions: Report Temperature over 100 to registered nurse [RN]."

During review of the hospital Internal Med Progress Note dated 12/23/20, the note indicated R1's admitting diagnoses included COPD exacerbation, congestive heart failure exacerbation, acute hypercapnia (elevated carbon dioxide level), respiratory failure, acute and chronic diastolic congestive heart failure and acute respiratory failure with hypoxia. The note indicated a CT scan of the chest had been completed with the following results "Extensive ground glass [finding on CT (computerized tomography) scan that indicates a partial filling of air spaces in the lungs], interstitial and airspace opacities were seen throughout the bilateral hemithoraces likely representing pulmonary edema versus multifocal with associated small basilar effusions and compressive atelectasis." In addition, the note indicated R1 had blood gas showing acute respiratory acidosis with arterial blood gas (ABG- test measures the oxygen and carbon dioxide levels in your blood) with carbon dioxide level of 82 with normal levels (35-45 mmHg); WBC 13.5 K/ul with normal (4.0-10.0 K/ul) and due to R1 showing signs of respiratory distress R1 was started on Lasix (water pill), BiPap (a type of ventilator machine used to treat

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chronic conditions that affect your breathing), Solumedrol (used to treat many different inflammatory conditions including exacerbations) and two antibiotics Azithromycin and Rocephin).

During interview on 3/7/22, at 12:39 p.m. RN-A clinical coordinator stated she recalled R1 coming from the hospital and seemed medically complex and did not feel it was a safe discharge from the hospital. RN-A stated she had tried to work with the other nurse to make sure R1 got all the orders he needed to get good care. RN-A stated after going through her documentation, the chest x-ray was inconclusive and she had brought it up to the provider and had updated the responsible party. RN-A then stated without reviewing the medical record and from the little she could remember R1 had been tested for Covid-19 and the result ended up testing negative. RN-A stated after she had received the results for the x-ray and the labs she had documented them in the progress note and she had contacted the provider about R1 along the way as she wanted R1 to be managed. When asked where she would document which provider she had contacted she stated it would have been the resident notes. RN-A also stated she also would have communicated with the supervisor RN-B, nurse on the cart or would have documented in the 24 hour board. RN-A stated usually the process was if a resident oxygen level they were receiving needed to be bumped, or there was a change in condition, or a significant lab result typically the expectation was "we contact the on-call so we know how to proceed moving forward. I know when I was working with him I was keeping close contact with the providers I don't recall who I spoke with."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

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F 580	Continued From page 12 During interview on 3/7/22, at 1:34 p.m. licensed practical nurse (LPN)-A reviewed both her progress note for 12/19/20 at 3:04 p.m. and 12/20/20, at 1:56 p.m. and verified R1 had been on 6 liters of oxygen and had still continued to complain of being short of breath. LPN-A stated during both times she had worked with R1, she had found R1 was on 6 liters of oxygen and that was what R1 had for the shift. LPN-A stated from her recollection, R1 "was very sick and had a lot of things wrong." When asked about the charting and who she had spoken to or updated regarding R1's responsible party concerns on 12/20/20, at 1:56 p.m. progress note, LPN-A stated after reading the note she had spoken to R1's responsible party because the responsible party was insisting about the loose stools and had questioned if R1 had a bowel obstruction. LPN-A also stated she had assessed R1, and had passed the responsible party concern to the RN manager and RN-B. When asked where she would have documented who she had communicated about R1's responsible party concerns, LPN-A stated she would have called the on-call, put a "SBAR" Situation, Background, Assessment and Recommendation note in the provider binder for the provider to review when in the building next or could have done both. LPN-A acknowledged the medical record lacked documentation of her following up with the responsible party concerns to review the course for treatment. LPN-A further acknowledged it was the weekend and since the nurse manager was not in the building she could have sent an e-mail. During interview on 3/7/22, at 4:49 p.m. primary facility nurse practitioner (NP) stated he had not seen R1 as the resident was admitted on 12/17/20, which was a Thursday and R1 was sent	F 580		

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to the hospital 12/21/20, before he could do the first visit with R1. The NP reviewed the lab result for 12/18/20, and acknowledged R1 had an elevated WBC count. NP stated although the 12/18/20, results were elevated for WBC count and the Neutrophils, it was hard to draw a conclusion if R1 had an infection because someone had to look at the previous labs results to compare the trends. The NP stated going by the nursing note about the provider being updated of the lab results on 12/18/20, it appeared at 5:22 p.m. he would have been off work that time and the facility nurse would have called the on-call at those hours. The NP acknowledged he did not have any documentation of seeing R1 or regarding the nurse update of the lab results and the chest x-ray. The NP reviewed R1's hospital lab results dated 12/17/20, and acknowledged R1 had within normal WBC count and Neutrophils which was different from the labs on 12/18/20. The NP reviewed the staff nursing notes and stated according to the notes, R1 had appeared to have gotten worse as the night went on from 12/18/20, and was going a different direction compared to the hospital labs. When asked if the nurses were supposed to call the on-call about R1's elevated temperatures, SOB, loose stools, responsible party concerns about treatment, insulin being held and the lung sounds, the NP stated someone had to review the whole picture including the chest x-ray, code status if R1 had any specific measures and the lab results. The NP stated since R1 was on 2 liters of oxygen from the hospital and continued to need more, normally staff were to run the oxygen flow rate at 1-4 liters, the nurses should have known to call the on-call with a change of condition when they had increased the oxygen to over 4 liters. "The question is the nursing judgement we are only as

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good as our notes. Someone's judgement must have felt he was not deteriorating. When did he tip when someone should have been notified." When asked about the chest x-ray indicating the result was: "Peripheral airspace opacities in both lungs are concerning for atypical infectious process such as COVID-19 pneumonia" the NP stated it was hard to answer the question about what atypical meant because this question would have to be asked of the person who read the x-ray. The NP stated atypical infectious process in simple terms "would be like walking pneumonia, they did not say consolidation it's like more of a fog like look mycoplasma. It's hard to know with atypical because it was not showing fluid lines so I think that's the challenge. It will be difficult to be able to tell from the x-ray if it's viral pneumonia. It's hard to put judgement into this."

During interview on 3/7/20, at 3:37 p.m. the interim director of nursing (DON) stated the chest x-ray results from 12/18/20, were faxed to the NP and the rounding NP had also been updated of the lab results and had given orders to re-check CBC and BMP on Monday 12/21/20, which were both seen by RN-A. The interim DON stated R1 was "very sick" when he was admitted to the facility. The interim DON acknowledged the medical record lacked documentation of the nurses notifying the provider/physician through the weekend when R1 had elevated temperatures, insulin was held, when the responsible party had concerns with R1's condition and the decreased oxygen saturation levels leading up to being sent to the hospital. The interim DON stated, "I see there was no documentation of the nurses doing a follow up during the day. Myself, I have gone over the notes and looked at them. He was not eating and

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they were not giving him his insulin and this is in the notes." The interim DON acknowledged the nurses had opportunities to notify the physician between the course of the 3 days when the resident required the increased oxygen level, as the standing house was 1-4 liters, when R1 had a temperature and stated that was the reason why RN-C was no longer working at the facility.

During interview on 3/7/22, at 5:28 p.m. when asked about her documentation regarding R1's diminished lung sounds, RN-B stated she had reviewed the chest x-ray and the lab results which had been faxed to SLCC and in her opinion nothing had changed with R1's lung sounds from admission. RN-B stated R1 continued to have the intolerance to lying in bed from admit. RN-B stated to her R1 looked like he had improved compared to when he had admitted to the facility because at admission time "he was compensated and I felt we needed to keep a close eye on him we had been keeping the primary informed I felt with the labs and x-ray being done. I was not there during the night shift when he was sent in to judge what he was like. RN-B stated, "During my shift, when we notice people are not at their baseline we follow the care plan and the treatment orders and if we feel a resident has had a change in condition we would notify the doctor." RN-B also stated, "If family came back and was questioning the treatment plan, basically I would do an assessment and update the RN coordinator, she is right there able to be in contact with the provider and would update them. We would e-mail the care coordinator and update St Luke's Community Care on the weekends on-call and tell them what is going on and would find out what they want us to do." RN-B then stated, "I train the nurses to do a SBAR

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F 580	Continued From page 16 [Situation- Background -Assessment - Recommendation] and tell them if something is urgent they need to call the on-call or you can fax a SBAR to the provider during the business hours." When asked where the SBARs completed for residents were kept, RN-B stated some of the providers will sign off on the SBARs as orders and others will write it in the orders as there is no regulation of where really they can document the orders. RN-B further stated, "The nurses are supposed to write notes of what is going on with the residents during their shifts." RN-B reviewed R1's notes leading up to being sent to the hospital and acknowledged there was no documentation of what the resident condition was before the nurse notified the physician who ordered R1 to be sent to the hospital. During interview with the medical director (MD) on 3/8/22, 8:18 a.m. when asked about the chest X-ray results, "Peripheral airspace opacities in both lungs are concerning for atypical infectious process such as COVID-19 pneumonia." The facility MD stated atypical mycoplasma pneumonia like Covid could be either bacterial or viral however, in R1's chest x-ray, it would have been bacterial pneumonia but the result did not come out and say that. The MD stated he was aware of R1's incident however, acknowledged he had not reviewed R1's medical record. The MD stated the issue was R1 had tests completed and the staff were aware of the x-ray results and the labs and the rounding nurse practitioner had ordered the labs to be repeated in 3 days adding, "I would say someone should have had a nurse practitioner or someone on call to have weighed in on it given the fact he was continuing to have the sats going down even with the increased oxygen and the other things including the	F 580		

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F 580	Continued From page 17 temperature. The nurses are to notify the provider on call to see if there was need to alter the course of treatment." The MD further stated there was just a lot of things which made the issue complex including the medical history and being the weekend which should not be an excuse. "They should have called the on-call." The facility undated Change in Condition policy directed the following: "Purpose: To provide care and services based upon the current needs of the resident under the direction of the attending provider. To inform resident/resident representative and attending provider when a significant change in resident condition occurs. Policy: When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative Procedure Licensed nursing associate: 1. Assess significant change in the resident's condition noted through direct observation, interview or report for other staff. 2. Obtain a set of vital signs and repeat as needed or ordered. 3. Open Matrix Event and conduct a symptom review and assessment, as condition warrants. 4. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If unable to contact the physician, contact the Medical Director, as appropriate.	F 580		

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F 580	Continued From page 18 5. Notify the appropriate members of the IDT (interdisciplinary) team. 6. Notify the resident/resident representative. 7. Document symptom(s), assessment, observations, resident/resident representative, and medical provider notification. 8. Monitor and provide treatment as ordered by the attending provider. 9. Update the care plan as appropriate..."	F 580		