STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	C 06/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

(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 For the complaint investigation, conducted June 16-24, 2014, the sample included (5) five current residents for review.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Facility failed to notify family members of 1 of 1 sampled residents-Resident #1. Charge nurses will be re-educated on 7/23/14 to "Notification Policy". All resident's residing in facility have the potential to be affected. Charge nurses will be re-educated on 7/23/14, during general orientation and PRN to facility "Notification Policy". Resident Care Managers will bring Accident/Incident reports from prior day or weekend to Interdisciplinary Team Meeting (IDT) daily during the week for review and to assure documentation of notification of: resident / physician / and (or) resident's legal guardian occurred timely. IDT meeting minutes were revised on 7/21/14 to include review and notification of family and physician occurred for Accidents/Incidents. DNS or designee will audit four Accident / Incident Reports weekly X 1 month starting 8/4/14, then monthly X 6 months, then quarterly for documentation of timely notification of family and physician to assure compliance. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Date of Completion:	8/4/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dennis Goebel | TITLE: Administrator | (X6) DATE: 8-5-14

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...llowing 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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on information provided to the Division and record review, the facility failed to notify family members for 1 of 1 sampled resident (Resident #1) who experienced an unresponsive episode during a stand lift (aide) transfer. Failure to notify the family members does not allow them the opportunity to provide input and/or consent to the resident's treatment plan. Findings include: Information provided to the Division indicated the facility failed to notify family members when Resident #1 "slipped out of a lift." Resident #1's medical record, reviewed on all days of survey, identified diagnoses including diabetes, atrial fibrillation and coronary athrosclerosis. The accident/incident report identified, ". . . Time of incident: 12:00 p.m. ? . . . was transfering [sic] [Resident #1] from his reclyiner [sic] to his wheelchair with easy stand [lift] and all of a sudden her [sic] started shaking a little. then he just went limp and let go. so I had to quickly grap [sic] him and get him in his chair [be]cause he was almost out of the sling . . ." The progress note, dated 04/11/14 at 12:45 a.m. [sic], identified, "Staff reporting that resident had unresponsive episode while the [sic] were transferring him with stand aide at 11:15 [a.m.] Resident went limp when he was standing. . . ." Resident #1's medical record lacked evidence	F 157		

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F 157	Continued From page 2 facility staff informed family of this unresponsive episode.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225	Facility failed to thoroughly investigate an injury of unknown origin of 1 of 1 sampled residents - Resident #1. Nursing staff will be re-educated on 7/23/14, upon hire, during general orientation, and annually on the following: Report injuries of unknown source to the administrator or designated representative for investigation and appropriate action, in accordance to State law. All residents have the potential to be affected. Nursing staff will be re-educated on 7/23/14, upon hire, during general orientation, and annually on the following: Report injuries of unknown source to the administrator or designated representative for investigation and appropriate action, in accordance to State law. Resident Care Managers will review treatment sheets and Accident/ Incident Reports to assure cause for new skin issues has been investigated and a cause determined starting 7/21/14. DNS or designee will audit 4 residents treatment sheets and their Accident/Incident Reports (to assure cause of injury was investigated and determined) weekly X 1 month starting 8/4/14 for compliance, then monthly X 6 months, then quarterly. Areas of concern will be addressed immediately and reviewed in Quality	

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F 225	Continued From page 3 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on information provided to the Division, record review, and staff interview, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #1). Failure to investigate an injury of unknown origin places all residents at risk of abuse and neglect. Findings include: Information (including photographs) provided to the Division indicated the facility failed to determine the cause of Resident #1's right arm which showed lateral, dark purple bruising from the midpoint of the humerus (upper arm) to the proximal phalanx of the hand (lower fingers). The width of the bruising is unknown, as the medial portion of the arm was not visible in the photographs. Resident #1's medical record, reviewed on all days of survey, identified diagnoses including atrial fibrillation, coronary athrosclerosis, chronic airway obstruction, and ecchymosis. The physician's orders identified the following: * 01/02/14, Coumadin (Warfarin) 4 milligrams (mg) once a day on Sunday, Monday, Wednesday, and Friday * 01/02/14, Coumadin 6 mg once a day Tuesday, Thursday, and Saturday * 03/13/14, Prednisone 10 mg once a day every other day	F 225	Assurance Meeting monthly. Date of Completion:	8/4/14

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F 225	Continued From page 4 The progress notes identified: * 04/13/14 at 11:13 p.m., "Right arm has swelling, redness and painful to touch. [The nurse failed to identify the resident's right arm as bruised or characteristics of the affected area.] Skin warm and dry. Resident able to move fingers freely and CN [charge nurse] is able to lift up right arm and side to side and resident does grimace when arm is held. Per S.O. [standing order] ice applied for 20 minutes and elevated with PRN [as needed] pain medication given. MD [medical doctor] Faxed. Will advise Day CN to notify family in AM and has [sic] resident be seen in clinic." * 04/14/14 at 10:39 a.m., ". . . Also swelling and bruising, dark purple/red in color to RFA [right forearm]. C/o [complains of] pain when arm is moved. CN updated and aware of this. CN will call MD," at 2:00 p.m., "Call to [physician] at 8:00 a.m. to report condition of res [resident's] arm and unresponsive episodes. MD ordered res to go to ER [emergency room] . . ." The [Hospital] "Patient Visit Information," dated 04/14/14, identified, ". . . Elevate right hand and arm as much as possible. . . . x-rays of the right ribs have been done and there is no evidence for fracture. . . ." Resident #1's medical record failed to identify the possiblity of a rib injury prior to being transferred to the emergency room. The "Skin Issue Investigation Report," dated 04/14/14, identified, ". . . Bruise - swollen (R) [right] arm wrist [and] above elbow red [and] purple . . . Results of investigation - possible/probable cause: . . . RFA swollen [and] bruised - ? . . ." The "Non-Pressure Skin Condition Reports"	F 225		

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F 225	Continued From page 5 identified the following: * 04/22/14, "Bruise to Rt [right] arm cont's [continues] from shoulder to fingers. C/o pain when arm is moved. Swelling down." This was the first entry identifying the bruise on Resident #1's right arm. * 04/24/14, "Bruise (R) arm (entire arm) conts. Fading some. Swelling way down." This was the only other entry identified regarding the bruise on Resident #1's right arm. Although staff identified Resident #1's right arm as swollen and showing signs of redness on 04/13/14, they failed to identify the bruise that extended from "the wrist to above the elbow" or the possibility of a rib injury prior to Resident #1 being transferred to the emergency room. They also failed to thoroughly investigate the possible/probable cause of the arm/rib injuries.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279	Facility failed to develop a comprehensive care plan for 1 of 1 sampled residents - Resident #2 who discharged from facility on 6/25/14. Residents on continuous oxygen have the potential to be affected. Those residents (requiring continuous oxygen) will have a Respiratory Care Plan put in place by 7/30/14. Licensed Nurses will be re-educated regarding developing a comprehensive care plan for those residents on continuous oxygen on 7/23/14. DNS or designee will review 4 resident Care Plans (of those residents with orders for continuous oxygen) weekly X 1 month, then monthly X 6 months, then quarterly starting 8/4/14 . Areas	

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F 279	Continued From page 6 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to develop a comprehensive care plan for 1 of 1 sampled resident (Resident #2) that included measureable objectives and timeframes to meet the resident's medical and nursing needs. Specifically, the facility failed to implement a respiratory care plan for Resident #2 identifying his need for continuous oxygen and addressing his increased anxiety/fear related to running low/out of oxygen. The findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included bronchus/lung neoplasm and chronic airway obstruction. The quarterly Minimum Data Set (MDS), dated 06/12/14, identified intact cognition. The facility also identified Resident #2 as interviewable. The physician order, dated 06/05/14, identified, "O2 [oxygen] at 4-6 L [liters]/NC [nasal canula] continous to maintain sat [saturation] > [greater than] 90%." Observation of the noon meal on 06/16/14, showed Resident #2 eating in his room following tray set-up. He wore a nasal canula and received oxygen via a concentrator.	F 279	of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Date of Completion:	8/4/14

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F 279	Continued From page 7 During an interview on 06/16/14 at 4:00 p.m., Resident #2 stated he "ran short of oxygen more than once." He expressed being "scared to eat in the dining room" and being "scared to go to church." He further stated, "I want to be near the concentrator." During an interview on 06/16/14 at 2:55 p.m., a supervisory staff member of Public Transit (#1) confirmed transit staff have returned to the facility due to Resident #2's tank running low/out of oxygen. During an interview on 06/23/14 at 11:00 a.m., an administrative staff member (#4) confirmed tanks were taken to both the hospital and clinic for Resident #2. He stated, "Sometimes the CNAs forget to fill them [oxygen tanks] and we have to run one over there. He [Resident #2] panics. He even uses a concentrator in the dining room, [be]cause he's scared he'll run out [of oxygen]." Resident #2's medical record lacked a care plan addressing his need for continuous oxygen, and his increased anxiety/fear of staff failing to administer the oxygen as prescribed by his physician. Failure to develop a care plan does not ensure staff will provide care and services consistent with Resident #4's needs and/or as prescribed by his physician. See F328.	F 279		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	Facility failed to assess the appropriateness of the continued use of a stand lift (aide) for 1 of 1 sampled residents. Resident #1 who experienced a fall during a transfer. Resident was changed to a total body lift on 4/14/14 and has remained a	

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F 323	Continued From page 8 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on information provided to the Division, record review, and staff interview, the facility failed to assess the appropriateness of the continued use of a stand lift (aide) for 1 of 1 sampled resident (Resident #1) who experienced a fall during a transfer. Failure to investigate the first fall, reassess the appropriateness of the stand lift, and implement alternative interventions resulted in Resident #1 being transferred with the stand lift for three additional days and experiencing additional unresponsive episodes during transfers in the stand lift.. Findings include: Information provided to the Division indicated the facility failed to notify family members when Resident #1 "slipped out of a lift." Resident #1's medical record, reviewed on all days of survey, identified diagnoses including diabetes, atrial fibrillation and coronary athrosclerosis. The quarterly Minimal Data Set (MDS), dated 03/11/14, identified severely impaired cognitive skills and extensive assistance of one person required for transfers. The daily living needs sheet, dated 01/24/12, further identified, ". . . Transfers . . . Sit to stand . . . Harness sizes: Medium . . . Number to operate	F 323	a total body lift. Orders were obtained from MD on 7/15/14 for Occupational / Physical Therapy to evaluate for transfers. Licensed Nurses were re-educated on 7/23/14 that when a resident has a change of condition with a stand lift transfer the resident is to be changed to a full body lift transfer until resident can be re-evaluated for transfers by Therapy and/ or the Resident Care Manager. Nursing staff were also re-educated on 7/23/14 that anytime a resident has a change in plane during a transfer it is to be considered a fall and must be reported to the charge nurse immediately for proper assessment, intervention, family notification and documentation. Residents who require a stand lift to transfer have the potential to be affected. Licensed Nurses will be re-educated on 7/23/14 that when a resident has a change of condition with a stand lift transfer the resident is to be changed to a full body lift transfer until resident can be re-evaluated for transfers by Therapy and/ or the Resident Care Manager. Nursing staff were also re-educated on 7/23/14 that anytime a resident has a change in plane during a transfer it is to be considered a fall and must be reported to the charge nurse immediately for proper assessment, intervention, family notification and documentation. Residents who require a stand lift to transfer will be assessed quarterly with the MDS assessment and if there is a change in their transfer ability at any time they will be re-evaluated by the Resident	

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F 323	Continued From page 9 lift: 1-2 . . ." The accident/incident report regarding the certified nursing assistant (CNA)'s back injury, dated 04/11/14, identified, ". . . Time of incident: 12:00 p.m. ? . . . was transfering [sic] [Resident #1] from his reclyiner [sic] to his wheelchair with easy stand [lift] and all of a sudden her [sic] started shaking a little. then he just went limp and let go. so I had to quickly grap [sic] him and get him in his chair [be]cause he was almost out of the sling . . . Describe Type/Extent of Injury: hurt my back . . . Describe in detail the action that will or has been taken to prevent a recurrence: . . . Educated aide to use lowering technique if possible using hip and leg to lower resident to floor and/or use hip and leg to rest resident's weight until help comes." The progress notes, dated 04/11/14, identified: * 12:45 a.m. [sic], "Staff reporting that resident had unresponsive episode while the [sic] were transferring him with stand aide at 11:15. Resident went limp when he was standing. . . ." * 6:48 p.m., "Staff reported that resident had another unresponsive episode while transferring. Symptoms were same as earlier. . . ." During an interview on 06/17/14 at 9:39 a.m., a certified nursing assistant (#5) indicated Resident #1 experienced additional unresponsive episodes while being transferred the weekend of April 11-13, 2014. The progress note, dated 04/14/14, identified: *7:44 a.m., "[As per nursing staff] Resident will be changed to a hoyer lift x 2 assist due to recent unresponsive spells in the stand lift. Will reassess as appropriate."	F 323	Care Manager and/or therapy. DNS or designee will audit 4 residents weekly starting 8/4/14 (who have had a fall and will check for appropriateness of transfer method being used) X 1 month, then monthly X 6 months, then quarterly in accordance to MDS assessment schedule. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Date of Completion:	8/4/14

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F 323	Continued From page 10 * 2:00 p.m., "Call to [physician] at 8:00 a.m. to report condition of res [resident's] arm and unresponsive episodes. MD [medical doctor] ordered res to go to ER [emergency room]. . . ." * 3:28 p.m., "Res returned from ER . . . Have been using stand aid to transfer res and will now use hoyer r/t res weakness. . . ." The current care plan failed to address Resident #1's transfer needs, including the use of a Hoyer lift with two persons assisting. The facility failed to provide evidence they investigated Resident #1's falls from the stand lift on 04/11/14 at 11:15 a.m. and 6:48 p.m. During an interview the morning of 06/14/14, when asked why Resident #1's falls from the stand lift were not investigated, an administrative staff member (#7) stated, "We didn't consider it a fall, since he was strapped into the lift." This contradicts the CNA's statement "I had to quickly grap [sic] him and get him in his chair [be]cause he was almost out of the sling." This also failed to account for the CNA's back injury secondary to bearing Resident #1's weight. The facility failed to: * Investigate Resident #1's falls from the stand lift on 04/11/14 at 11:15 a.m. and 6:48 p.m. * Care plan Resident #1's transfer needs, ensuring staff are aware he required a Hoyer lift with two persons assisting. * Ensure staff used the appropriate mechanical lift from April 11-14, 2014, thereby reducing the risk of additional falls with/without injury during transfers.	F 323		
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328	Facility failed to ensure proper respiratory care for 1 of 1 sampled	

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F 328 SS=G	Continued From page 11 NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on information provided to the Division, observation, record review, resident interview, and staff interview, the facility failed to ensure proper respiratory care for 1 of 1 sampled resident (Resident #2) with orders for continuous oxygen. Failure to administer oxygen as ordered resulted in Resident #2 experiencing significant anxiety/fear after he ran out of oxygen on more than one occasion both in and out of the facility. Findings include: Information provided to the Division indicated the facility failed to ensure the availability of continuous oxygen for Resident #2 within and when outside the facility. Review of Resident #2's medical record occurred on all days of survey. Diagnoses included bronchus/lung neoplasm and chronic airway obstruction. The quarterly Minimum Data Set (MDS), dated 06/12/14, identified intact cognition.	F 328	residents - Resident #2 who discharged from the facility on 6/25/14. Residents on continuous oxygen have the potential to be affected. Oxygen Audit was completed on 7/15/14 and residents requiring continuous oxygen were identified. "Oxygen Policy" was updated on 7/18/14 to include recommended fill times for portable Helios tanks and topping off tanks before resident goes out of facility for an activity or appointment. Oxygen concentrator was placed in the chapel on 6/24/14 for resident use in the event a resident wishes to use it. Signs were posted at nurses station on each unit with recommended Helios fill times on 7/18/14. Nursing staff will be re-educated 7/23/14 on: 1) Updated "Oxygen Policy" to include recommended fill times for portable Helios tanks and topping off tanks before resident goes out of facility for an activity or appointment. 2) Oxygen concentrator is located in the chapel in the event a resident wishes to use it. 3) Signs are posted at the nurses station on each unit with recommended Helios fill times. DNS or designee will audit four nursing units 5 days each week X 1 month, then weekly X 6 months, then quarterly starting 8/4/14 (during one of the specified "fill" times) to assure compliance. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Date of Completion:	8/4/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	C 06/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 328	Continued From page 12 The facility also identified Resident #2 as interviewable. The physician's order, dated 06/05/14, identified, "O2 [oxygen] at 4-6 L [liters]/NC [nasal canula] continous to maintain sat [saturation] > [greater than] 90%." Observation of the noon meal on 06/16/14, showed Resident #2 eating in his room following tray set-up. He wore a nasal canula and received oxygen via a concentrator. During an interview on 06/16/14 at 4:00 p.m., when asked if staff ensured he received continous oxygen throughout the day, Resident #2 stated he "ran short of oxygen more than once." He expressed being "scared to eat in the dining room" and being "scared to go to church." He further stated, "I want to be near the concentrator." He reported, "Once they [the CNAs] took me down there [chapel on first floor], and I told them I couldn't get my oxygen. They left me down there. They finally brought me back to my room, hooked me up to the concentrator, and left. I checked myself [with an oxygen saturation monitor], they [saturation level] were down to 80 [percent]." When asked if staff ensured he received continous oxygen when outside the facility, Resident #2 stated, "They [CNAs] said the tanks were full. We had to come back in [to the facility] for full tanks. Last week at [Clinic], I ran out of oxygen. We called, and they brought a tank." During an interview on 06/16/14 at 2:55 p.m., when asked if any Public Transit staff member had returned to the facility to obtain oxygen for Resident #2, a supervisory staff member of	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 328	Continued From page 13 Public Transit (#1) confirmed transit staff have returned to the facility due to Resident #2's tank running low/out of oxygen. During an interview on 06/16/14 at 3:40 p.m., when asked who is responsible for ensuring oxygen availability, a managerial staff member (#2) stated the "nurses and CNAs make sure the oxygen tanks are full." During an interview on 06/16/14 at 4:20 p.m., when asked who is responsible for ensuring oxygen availability, a second managerial staff member (#3) confirmed "CNAs prep [prepare] the tanks." When asked who is responsible for ensuring oxygen availability outside the facility, the managerial staff member (#3) stated, "Maintenance takes tanks to the hospital and clinic if needed." She further stated, "[Resident #2] was struggling with Helios [portable liquid oxygen tanks]. The more oxygen he needed, the worse they worked." During an interview on 06/23/14 at 11:00 a.m., when asked if any Maintenance staff member had transported oxygen tanks to the hospital/clinic for Resident #2, an administrative maintenance staff member (#4) confirmed tanks were taken to both the hospital and clinic for Resident #2. He stated, "Sometimes the CNAs forget to fill them [oxygen tanks] and we have to run one over there." He further stated, "He [Resident #2] panics. He even uses a concentrator in the dining room, [be]cause he's scared he'll run out [of oxygen]." Resident #2's current care plan failed to address his need for continuous oxygen, and his increased anxiety/fear of staff failing to administer	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 328	Continued From page 14 the oxygen as prescribed by his physician. The facility failed to: * care plan Resident #2's oxygen usage, ensuring all staff were aware of his need for 4-6 liters of continous oxygen via nasal canula to maintain saturation levels greater than 90%, * ensure the availability of continuous oxygen for Resident #2 within and when outside the facility, * address Resident #2's increased anxiety/fear of not being able to breathe following his previous experiences of his oxygen tanks running low/out of oxygen.	F 328		