Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Number **6283**			**Report Date** **September 28, 2016**
Facility Name **Riceville Family Care and Therapy Center**		**Survey Dates** **August 31, 2016 and September 13, 2016**	
Facility Address **915 Woodland Ave**			
City **Riceville, IA. 50466**	**HL**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.19(2)g **58.20(1)**	**58.19(2) *Medication and treatment.*** ***g.* Administration of oxygen (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II)** **481—58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:** **58.20(1) Direct the implementation of the physician's orders; (I, II)** **DESCRIPTION:** Based on clinical record review, staff and physician interviews, the facility failed to ensure staff were educated and demonstrated proper use of e-tank oxygen administration to ensure delivery of oxygen as ordered for one of two residents reviewed with orders for continuous oxygen. The facility identified a census of 25 residents. Findings include: The Minimum Data Set (MDS) assessment with a reference date of 8/15/16 for Resident #1 identified the resident had diagnoses that included heart failure, hypertension, diabetes mellitus, a cerebrovascular accident (CVA), a cardiac pacemaker and depression. The MDS assessment documented the resident had Brief Interview for Mental Status (BIMS) score of 9 out of 15, which meant the resident had moderate cognitive impairments. The resident had fluctuating inattention, and relied on staff to assist with locomotion on and off the unit. The resident had shortness of breath (SOB) with exertion, when sitting at res, and when lying flat. The Care Plan revised 7/20/16 documented the resident	**I**	**$8000.00** **Held In Suspension**	**Upon Receipt**

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	had impaired physical mobility, weakness, a risk for falls manifested by a fall history at home. The resident had completed occupational therapy after a pacemaker placement. The Care plan identified Resident #1 had dyspnea with exertion and a need for oxygen (O2). The care plan approaches included the following: a. O2 at 3 liters (L) per nasal cannula (n/c) except with transfers, ambulation and showers. b. O2 at 2-4 L per n/c as needed (PRN). A Riceville Family Care Center and Therapy Center Order Listing form signed by a physician 8/8/16, indicated the resident as on O2 at 2 L per n/c and 2-4 L per n/c PRN SOB. A Medication Administration Record (MAR) dated 8/1/16 to 8/31/16, documented the resident with a order for O2 at 2 L per n/c. May have off for transport, ambulation and showers (dated 8/8/16) and O2 at 2-4 L per n/c PRN for SOB. A Long Term Medical Supply Oxygen Tank Log form, indicated a portable e-tank #609408 as signed out to the resident on 8/17/16. Nurses' Progress Notes, written by Staff B (nurse), dated 8/18/16 at 9:30 a.m., documented the Housekeeper (Staff A) informed Staff B prior to taking the O2 concentrator to the resident's room, the resident looked as if she was not breathing. Upon entering the resident's room, Staff B found the resident's head tilted back seated in the wheelchair. The resident's skin was pale, his/her lips were pale in color, with the resident's mouth open and limbs flaccid. The housekeeper and a CNA [Staff C] were in the room and the Housekeeper was asked to get the DON. Resident #1 had O2 nasal			

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	cannula in nares and hooked up to portable O2 tank [e-tank]. Staff switched O2 from portable O2 [e-tank] to the O2 concentrator at this time. The resident had a faint pulse palpated. Staff B, the DON and another nurse continued to monitor the resident for several minutes, only detecting a faint apical/radial pulse. Staff B held the resident's head up strait and DON sent staff to notify resident's family. Staff transferred the resident into his/her bed with a Hoyer lift and O2 on via nasal cannula in bilateral nostrils. After resident positioned in bed and there was no apical pulse or respiration, staff pronounced the resident as deceased at 9:50 p.m. The oxygen concentrator was then shut off and tubing removed from bilateral nares. The nurses' progress note dated 8/18/16 at 10:00 a.m. to 10:05 a.m. documented the resident's family and physician alerted of the resident's death. During an interview 9/9/16 at 1:25 p.m., a Physician confirmed he would have expected staff to maintain a functioning oxygen system and the resident not having oxygen could have contributed to his/her death. A Death Record signed by a physician 8/19/16, documented the resident's principal cause of death as critical aortic stenosis. The facility investigation included the following: On 8/18/16, Staff B's (nurse) written statement documented the housekeeper [Staff A] took the resident's O2 concentrator to his/her room and reported the resident appeared asleep but barely breathing. Upon entering the room, she [Staff B] found the resident sitting in the wheelchair facing towards the closet door,			

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	and his/her skin was pale. Resident #1's lips were pale in color and limbs flaccid. The O2 was on via nasal cannula in bilateral nares. Staff B attempted to awaken Resident #1 and then checked the resident's pulse. Staff B asked the DON to come to the resident's room. Staff B documented she checked the portable O2 tank [e-tank] but only glanced at it and did not remember if it was empty or not. Staff B did not recall saying it was empty or not. Staff B reported she began doing an assessment right away prior to telling the housekeeper to get the DON. Staff B documented later in the afternoon of 8/18/16, the DON called her into her office and showed her Resident #1's O2 tank [e-tank] was over half full; and the tank had been checked out 8/18/16. After looking at the O2 tank and the sign out sheet, Staff B documented she [should] not have said, “the tank was empty.” A written statement from the housekeeper [Staff A] on 8/18/16, documented at 9:30 a.m., she noticed Resident #1's concentrator (oxygen) was still by his/her spot at the table and took it to his/her room. When she arrived at the room, she thought the resident was asleep, then noticed he/she was doing small gasps for air and his/her face had a grayish tint. She immediately obtained the charge nurse [Staff B] and told her what she had seen. As staff B was checking Resident #1, she stated the oxygen tank located on the resident’s wheelchair was empty. Staff B asked her to get the DON and she ran down the hallway. A short while later Staff C asked her “when are they supposed to check the oxygen tanks?” Review of a typed statement (not dated) from the			

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	Director of Nursing (DON), included the following documentation. At the time of the resident's death the housekeeper [Staff A] reported she thought the oxygen tank [e-tank] had been empty because she thought she heard the nurse [Staff B] state that information. Upon investigation nurse [Staff B] reported she did not remember telling anyone the oxygen tank [e-tank] was empty. The CNA [Staff C] that transported the resident down to her room after breakfast states she turned the oxygen tank [e-tank] on. Upon further investigation the DON noted that the oxygen tank [e-tank] was over half way full and functioned without any problems. A full tank would last approximately 5.41 hours and a full tank at 4 Liters would last 2.5 hours. A brand new oxygen tank was pulled for Resident #1 on 8/17/16 and the resident had a concentrator that she used the majority of time. During an interview 9/8/16 at 1 p.m., Staff A, housekeeper stated after break she noticed an O2 concentrator in the dining room, knew it had been the resident's so she took it to his/her room. When she entered the resident's room she thought the resident had been sleeping in the wheelchair because he/she had been leaning down in the chair with his/her head tilted back and mouth open. The staff member thought the resident had been breathing at that time but looked gray in color and could not see the resident's chest moving. She went to get Staff B, Licensed Practical Nurse (LPN) who returned to the resident's room with the staff member and Staff C, CNA. Staff B checked to see if the resident had been breathing as Staff C went around and looked at the e-tank and confirmed it as empty. Staff B checked the e-tank and confirmed it as			

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	empty as well. At that point Staff A had been directed to exit the resident's room. During an interview 9/7/16 at 1:53 p.m., Staff B (nurse) indicated following break at 9:30 a.m. she had been at the nurse's station and observed Staff A take the resident's oxygen concentrator to his/her room. Staff A returned to the nurse's station and reported to her the resident did not look good, appeared sleeping and had been barely breathing. Staff B went to the room and found the resident slouched down in the wheelchair, head back, mouth open and eyes closed. The staff member looked at the e-tank and thought it had been empty but never checked to see if there had been air flow. The first thing the staff member did was rub the resident's chest for a response but received no reaction. The staff member requested Staff A get the DON as she assessed for pulses which were faint but present. When the DON arrived with Staff G, LPN they were able to feel a faint pulse as well. The staff members changed the resident from the e-tank to the concentrator and transferred the resident via a Hoyer sling device from the wheelchair to the bed. When the staff positioned the resident for comfort they were no longer able to palpate a pulse at which time the resident had been pronounced deceased. The staff member also confirmed there had been an incident on 8/11/16 where the resident had been in the activity room when someone assisting with activities reported the resident's oxygen as off and they did not think the resident looked very good. When Staff D brought the resident to the nurse's station staff already had the resident connected to oxygen and the resident had been in no respiratory distress. During an interview 9/9/16 at 12 p.m., Staff B confirmed when the e-tank had been shut off the needle registered in the refill section of the gauge which looked like the tank had been empty and that had been her observation			

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	in the resident's room the morning of the incident. During an interview 9/8/16 at 2:25 p.m., Staff C, reported working since March of 2016 as a CNA. Regarding the incident that occurred on 8/18/16, Staff C indicated at 9:10 to 9:30 a.m. she changed the resident from the O2 concentrator to the portable e-tank, and shut the concentrator off, unplug and unhook the tubing connected to the E-tank and turned the dial to 5 liters. She could hear the O2 flow but did not check to see how much O2 had been in the e-tank. She confirmed she heard air come out of the resident's tank but did not see how much oxygen was in the tank. Staff C reported the whole trip down to the resident's room, the resident was in good spirits and she had no troubles. Staff C left the room, Resident #1 was still on the E-tank and she gave Resident #1 his/her call light. Staff C left to answer an alarm and was gone about 10-15 minutes and observed Staff A running out of the resident's room when she returned. She observed the resident still positioned in the wheelchair but with his/her head tilted back as if sleeping. She called the resident's name, tapped on the shoulders and kept repeating his/her name with no response. The nurse, Staff B came to Resident #1's room and completed vitals and said he/she felt a faint heart beat and said, "Oh my God, there's no oxygen in the tank". Staff C never looked at the E-tank but heard oxygen coming out when Staff B said the E-tank was empty. The DON then came to Resident #1's room and at that point Staff C had been asked to leave the resident's room. Staff C said she had no clinical training on oxygen E-tanks in CNA school or when she was orientated at the facility. Staff C stated she does not even know where the E-tanks are stored and she knows nothing about the key device to turn on the machine, until the surveyor showed her (when the surveyor demonstrated proper usage.) Staff C stated she was suspended over the situation and the Administrator stated we take these things			

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	seriously. Staff C reported she did not check the E-tank, and she never looked to see if full or empty. Staff C reported she did not even know what the red line meant. Staff C reported she would not know how to check them. Staff C reported she was familiar with the concentrators, but not with the E-tanks. Staff C reported at the In-services, the nurse is now doing the change from concentrators to e-tanks. Staff C said nurses' checks oxygen to make sure everything is connected correctly. Staff C indicated she had no clinical training on how to manage e-tanks. Additionally she reported she knew nothing about the key device that turned on the e-tank. During an interview 9/8/16 at 3:53 p.m., the DON confirmed she never checked the e-tank when the resident had been found unresponsive and failed to listen to the oxygen/air flow. During an interview 9/8/16 at 3:17 p.m., Staff G confirmed she never checked the e-tank when the resident had been found unresponsive and never heard any oxygen/air flow. During an interview 9/9/16 at 12:20 p.m., Staff G, LPN confirmed when an e-tank had been shut off it registered empty. During an interview 9/8/16 at approximately 2:15 p.m., Staff D, CNA confirmed there had been times she failed to put on another resident's oxygen on (Resident #2). The staff member also confirmed there had been an incident in the activity room where the oxygen tubing for Resident #1 had not been placed and/or had fallen off the concentrator. By the time she arrived Staff E, CNA placed the resident back on the oxygen but the resident had still been a little SOB. The staff member recalled the resident's pulse oximetry at 90%. During an interview 9/8/16 at 4 p.m., Staff D indicated			

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	she did not remember having been trained on how to manage an e-tank. During an interview 9/8/16 at approximately 12:15 p.m., a community member confirmed on 8/11/16 he/she assisted the facility with community coffee in the facilities activity room when a CNA brought the resident to the activity, plugged in the oxygen concentrator and left. The resident attended the activity for approximately 45 minutes when the community member noticed he/she did not look very good. The resident appeared to look like he/she was in respiratory distress. The community member noticed the oxygen tubing had been disconnected from the humidifier and there had been a pool of water on the floor. The resident's son had been present and they connected him/her to the e-tank and staff took the resident out of the activity room. The facility reported Resident #1 as the only resident using a portable oxygen tank (e-tank). During an interview 9/9/16 at 12:25 p.m., the DON confirmed if the e-tank had been shut off it registered empty. When questioned if it would have been reasonable to say if Staff B looked at the tank and it had been on the refill section the tank could have been shut off, the DON stated “I do not know”. The DON reported she did not look at the e-tank until after the resident had passed away and left the building. At which time the Administrator and her checked the e-tank, turned the device on and could not hear any oxygen/air flow. They then called their Corporate Nurse, she came to the facility that same day, the dial still showed 1/2 full, she turned the E-tank to 2-3 Liters and said she could hear oxygen flowing and she never adjusted the gauge. The DON also confirmed the agency staff who worked at the facility had not been educated/in-serviced on how to change a resident from an oxygen concentrator to an e-tank and vice-versa.			

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	During an interview 9/8/16 at 4:05 p.m., Staff E indicated she did not think she had been trained/orientated on how to manage an e-tank prior to this incident. During an interview 9/9/16 at 11:35 a.m., Staff E confirmed prior to the incident CNA'S changed residents from oxygen concentrator to e-tanks and vice versa. During an interview 9/8/16 at 4:25 p.m., Staff H, CNA with Nurse finder's agency. This was her 3rd time working at the facility. She did not know the facilities expectations with portable E-tanks. During an interview 9/9/16 at 11:45 a.m., Staff F confirmed prior to the incident CNA'S changed residents from oxygen concentrator to e-tanks and back again. On 9/8/16 at 4 p.m. - Staff D, CNA was asked if staff had been orientated on how to use an E-tank (portable oxygen tanks) and responded, when a situation came up, she just learned it. Staff D reported she did not remember being trained on E-tanks. The investigation determined the facility did not have a policy to guide staff on the procedure to change a resident from a concentrator to a portable oxygen tank [e-tank]. **FACILITY RESPONSE:**			

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