

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/07/2025
NAME OF PROVIDER OR SUPPLIER  North Bay Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  300 Douglas Street Petaluma, CA 94952	
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)		
<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>31424</p> <p>Based on interview and record review, the facility failed to ensure 1 of 2 sampled residents (Resident 1), who had a history of COPD (chronic obstructive pulmonary disease; a chronic lung disease causing difficulty in breathing) and cancer in her lungs received care consistent with nursing professional standards of quality and the resident's individualized nursing care plan (document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes). Resident 1 experienced a medical emergency (a serious and sudden situation that requires immediate medical attention to prevent serious injury, disability, or death) on the morning of 3/23/25 that included respiratory distress (difficulty breathing associated with inadequate oxygenation) and critical hypoxia (low level of oxygen in the blood), but licensed nursing staff:</p> <ol style="list-style-type: none"> <li>1) Did not physically assess Resident 1 by listening to her lung sounds (using a stethoscope [medical instrument used to detect sounds produced in the body] to assess airflow through the respiratory tract/lungs) or by assessing her use of accessory muscles (use of neck or intercostal [between the ribs] muscles when breathing is an indication of respiratory distress);</li> <li>2) Did not administer oxygen (medical treatment that provides extra oxygen to the body when the lungs cannot oxygenate the blood sufficiently) to meet her needs; licensed staff attempted to titrate (adjust) the oxygen down while she had critical hypoxia;</li> <li>3) Did not administer Albuterol (a rescue medication that opens the airways and can ease breathing) as ordered by her physician;</li> <li>4) Did not document Resident 1's oxygen saturation levels (percent of oxygen in a person's blood; normal range is approximately 95% - 100%) throughout her medical emergency;</li> <li>5) Did not ensure Resident 1 was promptly transferred to the hospital when her emergent condition was discovered on 3/23/25 at approximately 10:30 a.m.; the ambulance company was contacted at 11:20 a.m. (reflecting a timespan of approximately 50 minutes);</li> <li>6) Did not document contacting Resident 1's physician immediately upon discovery of her critical condition; nursing staff documented they contacted Physician F at 11:20 a.m., approximately 50 minutes after her hypoxia was discovered; and,</li> <li>7) Did not document nursing interventions implemented to treat Resident 1's emergency.</li> </ol> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>These failures:</p> <ol style="list-style-type: none"> <li>1) Impaired Physician F from knowing the extent of Resident 1's condition and ordering medication to treat her declining respiratory status;</li> <li>2) Potentially exacerbated (to make worse or more severe) Resident 1's critical hypoxia by decreasing her oxygen administration, when she required additional oxygen administration;</li> <li>3) Potentially contributed to Resident 1's respiratory distress by failing to administer medication (Albuterol) designed to treat COPD and the resulting hypoxia; and,</li> <li>4) Delayed Resident 1's transportation to the Emergency Department, thereby delaying life-saving respiratory treatments (Resident 1's was ultimately admitted to the Intensive Care Unit - specialty unit providing round-the-clock monitoring and treatment for critically ill patients).</li> </ol> <p>Findings:</p> <p>During a telephone interview on 4/1/25 at 12:46 p.m., Registered Nurse C (RN C), who worked at Hospital E, stated a nurse from the facility called report (nurse to nurse communication regarding important patient health status details) to her on the morning of 3/23/25, prior to Resident 1's hospital transfer. RN C stated the facility nurse told her Resident 1's oxygen saturation was 78% and she was struggling (to breathe), but the facility nurse was weaning (decreasing) Resident 1 off her oxygen. RN C stated she instructed the facility nurse to go back to the patient and increase her oxygen, because she needed the oxygen. RN C stated she was concerned because the facility nurse lacked knowledge of how to treat hypoxia. RN C stated if a patient had hypoxia, you give them oxygen; if 5 liters (of oxygen) is not working, she stated you put on a mask (oxygen is measured in liters [L] per minute and delivered via mask or nasal cannula [small plastic tube, which fits into the person 's nostrils for providing supplemental oxygen]).</p> <p>During the same telephone interview on 4/1/25 at 12:46 p.m., RN C stated Emergency Responders (ER's) determined Resident 1's physical status required Code 3 transport (driving using lights and sirens) and they administered an Albuterol treatment in route to the hospital. RN C stated Code 3 transportation was utilized with someone who was dying. RN C stated Resident 1 was critical upon arrival to the Emergency Department (ED) and she was classified as an ESI 2 (Emergency Severity Index; high risk of deterioration; ESI 1 is the most urgent/ESI 5 is the least urgent) and she was close to coding (code blue; an emergent situation when a patient's breathing or heart has stopped). RN C stated Resident 1 was also struggling (to breathe), unable to speak, and weak as a noodle when she arrived and was subsequently transferred to the Intensive Care Unit. RN C stated Resident 1's hypoxia (at the facility) contributed to her respiratory distress and bumped her into a more critical presentation in the ED and came close to killing her.</p> <p>Online review of the Cleveland Clinic's website indicated, .Hypoxia is when the tissues of your body don't have enough oxygen .Hypoxia can be life-threatening .prolonged hypoxia can cause organ damage. Brain and heart damage are particularly dangerous and can lead to death . (<a href="https://my.clevelandclinic.org/health/diseases/23063-hypoxia">https://my.clevelandclinic.org/health/diseases/23063-hypoxia</a>)</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Ambulance Trip Sheet (ER's documentation of Resident 1's care), dated 3/23/2025 at 11:21 a. m., indicated on 3/23/25, the facility called for an ambulance at 11:20 a.m. and the emergency responders arrived at approximately 11:27 a.m. (seven minutes later). The ER's documented upon their arrival at the facility, Resident 1's respiratory rate was increased (a sign of respiratory distress), her breathing was labored (abnormal breathing; increased effort to breathe; may include use of accessory muscles), and her oxygen saturation was 74%. The ER's also documented Resident 1 had decreased tidal volume (the amount of air inhaled or exhaled during a normal breath ), had retractions (indicating use of accessory muscles) around her neck area, her lung sounds were diminished in the bases (reduced air flow in the lower part of the lungs) and she had mild wheezing (high-pitched sound caused by narrowed airways).</p> <p>Continued review of the Ambulance Trip Sheet, dated 3/23/2025 at 11:21 a.m., indicated on 3/23/2025 at approximately 11:29 a.m., the ER's gave Resident 1 a respiratory treatment with Albuterol and placed her on 6 liters of oxygen; they documented Resident 1's response to their interventions was improved. At approximately 11:42 a.m., prior to arrival at Hospital 3, the ER's documented Resident 1's breathing was still labored but her oxygen saturation had increased to 92%.</p> <p>Oxygen saturation is measured by a pulse oximetry devise at the bedside. According to the National Library of Medicine, pulse oximetry is a quick, non-invasive technique to measure/monitor oxygen saturation in the blood. Normal pulse oximeter readings (oxygen saturation) range from 95% to 100%. Hypoxemia (hypoxia) is an oxygen saturation of less than 90%. Critical findings prompting intervention for most patients would be oxygen saturation in the mid to high 80%. [<a href="https://www.ncbi.nlm.nih.gov/books/NBK470348/">https://www.ncbi.nlm.nih.gov/books/NBK470348/</a>]</p> <p>During an interview on 4/3/2025 at 1:58 p.m., RN A stated she worked on 3/23/25 but did not remember Resident 1 being sent out to Hospital 3. RN A described the process she would follow if a resident had SOB (shortness of breath): RN A stated she would check the resident's vital signs (temperature, heart rate, blood pressure and respirations/breathing), check the oxygen saturation, listen to the lungs, look at medication (for possible administration), and call the physician. She stated the physician may order labs (laboratory blood work; draw the resident's blood to run tests) and order a chest X-ray (medical imaging of the lungs and heart). RN A stated if a resident's oxygen saturation was below 90%, she would increase the oxygen up to the maximum (ordered by the physician) and would call the physician. She stated if the saturation was in the 80's or 70's (percentile), she would send the resident out (to the hospital) by calling 911 (request for emergency assistance; emergency responders). RN A stated if a resident's saturation was 68%, that would be a very critical situation and she would send the resident to the hospital ASAP (as soon as possible).</p> <p>During an interview on 4/3/2025 at 3:13 p.m., Licensed Nurse B (LN B) stated she would follow the following process if her resident had SOB: check the oxygen saturation, if it was below 90% she would start oxygen and notify the physician; she would elevate the head of the bed, give medication via the nebulizer (medical equipment that administers medication directly and quickly to the lungs via mist) and check the saturation level again; if there was no improvement, she would call 911. LN B stated normal oxygen saturation levels were between 92% - 96%. LN B stated if a residents oxygen saturation was in the 60's or 70's (percentile), they were at risk of dying and she would call 911.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/7/2025 at 1:58 p.m., RN D stated on the morning of 3/23/25 at approximately 10:30 a.m., Resident 1's daughter came out of the room and told her something was wrong with her mother. RN D stated she checked Resident 1's vital signs, her oxygen saturation was 68%, and she was short of breath. RN D stated she turned Resident 1's oxygen up to 5 L (via nasal cannula) and her oxygen saturation increased to 88%. RN D stated she instructed a nursing assistant to stay with the resident while she called Physician F. When questioned if these interventions were documented in Resident 1's medical record, RN D confirmed that she had not documented them. RN D stated she had not listened to Resident lungs during the morning of 3/23/25. When asked why she had not assessed her lung sounds, RN D stated she did not think of it.</p> <p>Review of facility policy titled, Oxygen Administration subtitled, Assessment (revised 10/2010) indicated, . while the resident is receiving oxygen therapy, assess for the following: .5. Lung sounds . Under subtitle, Documentation, the policy indicated, After completing the oxygen . adjustment (dose change), the following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed . 3. The rate of the oxygen flow, route (delivery method, nasal tubing or mask), and rationale. 4. The frequency and duration of the treatment . 6. All assessment data obtained before, during, and after the procedure .</p> <p>Review of facility Registered Nurse job description (dated 08/2015) indicated, . A. Safety discussions: . 17. Reports change of condition to physician . in timely manner . Under subtitle, A. Provision of Nursing Care, the document indicated, 1. Performs nursing care consistent with resident needs . Under subtitle, B. Demonstrates Knowledge and Understanding of Physical Evaluations, the document indicated, 1. Respiratory a. Breath Sounds .</p> <p>During the same interview on 4/7/2025 at 1:58 p.m. RN D reviewed Resident 1's MAR (medication administration report; daily record used by a licensed nurse to document medications and treatments given to a resident), dated March 2025, and confirmed she had a physician order for PRN (as needed) Albuterol inhaler (handheld device that delivers a measured amount of medication as a mist the patient can inhale). RN D confirmed Albuterol was not documented as given on 3/23/25. When asked why she had not given Resident 1 Albuterol, RN D stated Resident 1 was too weak to take it (inhalers require a person to inhale deeply and hold their breath). RN D confirmed Resident 1 had a medication nebulizer (device that converts liquid medication into a mist the patient can inhale easily) at her bedside for administration of other respiratory (lung) medication. When asked if she could have gotten an Albuterol vial (liquid form of the medication to be used with a nebulizer and mask) from the E-kit (emergency kit; facility supply of emergency medication) and given Resident 1 a dose via the nebulizer (does not require deep inhalation or breath-holding), RN D stated she did not know if Albuterol was in the E-kit.</p> <p>Review of Resident 1's MAR (dated March, 2025) revealed a physician order, dated 2/27/2025 at 2:19 p.m., that indicated, ProAir .Inhalation Aerosol Solution . (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for COPD .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During the same interview on 4/7/2025 at 1:58 p.m. RN D reviewed Resident 1's SBAR (situation, background, assessment, recommendation; a communication tool used by healthcare workers when there is a change of condition in the resident), dated 3/23/2025 at 3 p.m., and stated it indicated Resident 1's oxygen saturation was 78%. RN D stated the reading of 78% occurred at approximately 11:20 a.m., prior to Resident 1's hospital transfer. RN D was asked if she had attempted to wean Resident 1 to a lower level of oxygen administration and she stated, yes. When asked why she tried to lower the amount of oxygen administered, RN D stated she was not sure why she had done that.</p> <p>Review of Resident 1's SBAR, dated 3/23/25 at 3 p.m., indicated RN D documented the following: .Resident reported difficulty breathing as well as chest congestion . This started on: 03/23/2025 (no time documented) . RN D documented she increased the oxygen from 3L (the increased amount was not identified). RN D documented Resident 1's oxygen saturation was 78% at 11:30 p.m. and, The problem is respiratory due to COPD . She appears with shortness of breath . The SBAR indicated RN D called Physician F one time at 11:20 a.m., prior to her hospital transfer. RN D documented, . Updated MD at 1120. O sat (oxygen saturation) was 78 on NC (nasal cannula) at 4 L SBAR indicated RN D called an RN at Hospital E and gave her report at 11:24 a.m.</p> <p>Review of Resident 1's MAR (dated March, 2025) revealed a physician order that indicated, Titrate (adjust) oxygen from 2L-4L (2 to 4 liters) to maintain (oxygen) saturation of &gt; (greater than) 90% every shift . RN D documented on the MAR that Resident 1's oxygen saturation during the day shift of 3/23/25 was 78%; no specific time was indicated.</p> <p>Review of Resident 1's RN D's nursing progress notes (nurse's documentation of resident care), dated 3/23/25 at 11:30 a.m. indicated, Resident (1) sent to (Hospital E) via 911 (emergency responders).</p> <p>During an interview on 4/7/25 at 2:07 p.m., the DON (Director of Nursing) stated an oxygen saturation of 68% was considered low-low and the nurse should assess the resident's vital signs, increase the oxygen dose level, to increase the oxygen saturation, listen to lung sounds and give a breathing treatment if a PRN medication was ordered. The DON stated if the resident did not improve, the physician should be called (notified). When the DON was asked if a nurse should attempt to wean a hypoxic resident's oxygen administration down, the DON stated, that doesn't make sense. The DON asked why would a nurse wean oxygen down when staff were trying to increase their oxygen (saturation) level.</p> <p>During the same interview and concurrent medical record review on 4/7/25 at 2:07 p.m., the DON stated he advised nursing staff to document their interventions. The DON reviewed Resident 1's SBAR and nurse progress notes from the incident on 3/23/25; he confirmed neither contained documentation that Resident 1's oxygen saturation was 68%, RN D turned up the oxygen to 5L and the resident's saturation increased to 88%, or that RN D listened to Resident 1's lung sounds. When asked about emergency supplies of Albuterol, the DON confirmed Albuterol for nebulizer administration were located in the E-kits.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/7/2025 at 3:15 p.m., Physician F was asked if Resident 1's oxygen saturation level from 68% to 78% was a medical emergency and she stated, yes. She stated staff needed to get the resident to the hospital. Physician F stated a saturation of 68% could indicate the resident was going to crash (code blue; an emergent situation when a patient's breathing or heart has stopped). She stated staff should keep the resident talking (to keep them awake) and not leave them alone. She stated staff should listen to the lungs; if the resident was wheezing, she would use that information to decide on a medication to treat them. Physician F stated she could have ordered oral Prednisone (anti-inflammatory medication) that could be given under the tongue and Albuterol; she stated these medications would give the Emergency doctors a head start (on treatment).</p> <p>Review of Resident 1'a physician notes from Hospital E titled, Admission History &amp; Physical , dated 3/23/25 at 11:57 a.m., indicated, . presenting (came to the hospital) from (the facility) for shortness of breath, patient found to be labored (difficulty breathing), with low oxygen saturation . Today in the ED (emergency department) found to have . respiratory failure (condition were a person does not have enough oxygen or too much carbon dioxide [chemical compound in the blood] in their body), started on Bipap (treatment that uses mild air pressure to keep the airways open), also given . abx (antibiotics to fight infection) . CT (computed tomography scan; imaging that produces detailed images of the inside of the body) shows diffuse (spread out) metastatic disease/infiltrate (cancer that spread to the lungs) . Under the subtitle of Assessment/plan, the physician note indicated . Admit to ICU .</p> <p>Review of Resident 1's physician progress note from Hospital E, dated 3/24/2025 at 9:46 a.m. indicated after coming to the hospital, Resident 1 was, .eventually intubated (a tube is inserted through the windpipe and into the lungs; medical procedure that helps patients who cannot breathe on their own) [on] 3/23/ (2025) .</p> <p>Review of Resident 1's physician's notes from Hospital E titled, Hospitalist Discharge Summary (dated 3/28/2025) indicated, . decision was made for patient (Resident 1) to transition to hospice on discharge .</p> <p>Review of Resident 1's Nursing Care Plan dated 2/27/25 indicated Resident 1 had, .altered respiratory status/difficulty breathing r/t (related to) COPD, metastatic . cancer (cancer that spread to her lungs) . The nursing interventions identified in the care plan indicated, Administer medication/puffers (Albuterol) as ordered. Monitor for effectiveness . Monitor for s/sx (signs and symptoms) of respiratory distress and report to MD (physician) . Decreased Pulse oximetry .cough . Accessory muscle usage . Monitor/document/report abnormal breathing .use of accessory muscles .Oxygen settings: (oxygen) via nasal prongs (nasal cannula)/mask 2-4L/min (2 to 4 liters per minute) .</p> <p>Review of facility job description titled, Charge Nurse subtitled, Charting and Documentation (undated), the document indicated, . Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well and the resident's response to the care . Under subtitle, Care Plan and Assessment Functions, the document indicated, Review care plans daily to ensure that appropriate care is being rendered . Review resident care plans for appropriate resident goals, problems, approaches and revisions .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled, Change in a Resident's Condition or State (revised 2/2021) indicated, Our facility promptly notifies the . attending physician . of changes in the resident's medical .condition and/or status . Under subtitle, Policy Interpretation and Implementation, the policy indicated, . 2. A significant change of condition is a major decline . in the residents status . 3. Prior to notifying the physician . the nurse will make detailed observations and gather relevant and pertinent information for the provider (physician) .</p> <p>Review of facility policy titled, Transfer of Discharge, Facility-Initiated, subtitled, Documentation of Facility-Initiated Transfer or Discharge (dated 10/2022) indicated, When a resident is transferred or discharged from the facility, the following information is documented in the medical record: . a.(1) If the resident is being transferred or discharged because his or her needs cannot be met . documentation will include: a. the specific resident needs that cannot be met; b) this facility's attempt to meet those needs; . f. A summary of the resident's overall medical, physical, and mental condition .</p> <p>Review of facility document titled, Competency (demonstration of appropriate knowledge/skills) Validation Checklist (undated) for licensed nurses indicated, Respiratory Assessment . Observe respiratory rate, pattern, work of breathing . Auscultate (listen via stethoscope) anterior (front), lateral (side) and posterior (back) chest comparing one side to the other; .Ability to determine the following Breath sounds: 1. Wheezing - .usually a sign that something is making your airways narrow or keeping air from flowing through them. Two of the most common causes of wheezing are lung disease . COPD .lung cancer .</p> <p>Online review of the National Library of Medicine indicated the brain is the most sensitive organ, and visual, cognitive, and electroencephalographic (EEG - recording of the spontaneous electrical activity of the brain) changes develop when the oxygen saturation is less than 80% to 85%. (<a href="https://www.ncbi.nlm.nih.gov/books/NBK525974/">https://www.ncbi.nlm.nih.gov/books/NBK525974/</a>)</p>		