

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/04/2024
NAME OF PROVIDER OR SUPPLIER  Juniper Village at Lincoln Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 855 E Basse Rd San Antonio, TX 78209	

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 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34469</p> <p>Based on observation, interview and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 6 residents (Resident #1) reviewed for respiratory care, in that:</p> <ol style="list-style-type: none"> <li>1. The facility failed to monitor Resident #1 to ensure she was connected to continuous oxygen in accordance with her physician's order.</li> <li>2. The facility failed to accurately document Resident #1's oxygen saturation levels when they were discovered to be in the 60s as a result of not being connected to continuous oxygen in accordance with her physician's order.</li> <li>3. The facility failed to accurately document Resident #1's change of condition in her progress notes upon discovering Resident #1 was not connected to continuous oxygen in accordance with her physician's order.</li> <li>4. The facility failed to ensure Resident #1 was connected to an oxygen concentrator with a functioning humidifier upon being transferred to a different location within the facility.</li> </ol> <p>These failures resulted in the identification of an Immediate Jeopardy (IJ) on [DATE] at 4:45 p.m. While the IJ was removed on [DATE] at 4:02 p.m., the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm due to the facility's need to monitor and evaluate the effectiveness of the plan of removal and corrective actions.</p> <p>These failures could place residents at risk of respiratory complications, injury to vital organs, or death.</p> <p>Findings included:</p> <p>Record review of a document titled, Monthly Grievance Log, for ,d+[DATE], stated, Date of Grievance [DATE], (Resident #1) - PT connected to empty e-cylinder .</p> <p>Record review of Resident #1's electronic face sheet revealed Resident #1 was admitted [DATE] and was [AGE] years old at the time of admission and died on [DATE]. Resident #1's diagnoses included: altered mental status, muscle weakness, depression, post covid-19 condition (unspecified), acute respiratory failure with hypoxia.</p> <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 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's electronic chart revealed no care plan or MDS.</p> <p>Record review of Resident #1's physician orders stated, O2: Oxygen at 5 liters per nasal cannula every shift for Dyspnea/Shortness of Breath - Start [DATE].</p> <p>Record review of Resident #1's February 2024 TAR stated, Oxygen at 5 liters per nasal cannula every shift for Dyspnea/SOB (Order date [DATE] at 1:01 PM)</p> <p>Record review of Resident #1's physician orders stated, Check Oxygen Saturation Q2 hours. (Start Date [DATE] at 6:00 PM - End Date [DATE])</p> <p>Record review of Resident #1's electronic chart, section, Weights and Vitals, revealed the following oxygen saturation readings and times (note: Oxygen saturation level of 67% that occurred on [DATE] at 1:45 PM was not recorded. Additionally, label, Room Air was inaccurately labeled).</p> <p>[DATE] @ 12:14 PM - 96% (Oxygen Via Nasal Cannula)</p> <p>[DATE] @ 12:20 AM - 95% (Room Air)</p> <p>[DATE] @ 2:27 PM - 83% (Oxygen via Mask)</p> <p>[DATE] @ 5:58 PM - 93% (Oxygen via Mask)</p> <p>[DATE] @ 12:12 AM - 91% (Room Air)</p> <p>[DATE] @ 2:13 AM - 92% (High Flow Oxygen)</p> <p>[DATE] @ 5:26 AM - 91% (High Flow Oxygen)</p> <p>[DATE] @ 6:41 AM - 90 % (Room Air)</p> <p>[DATE] @ 2:49 PM - 93% (Oxygen Nasal Cannula)</p> <p>[DATE] @ 5:51 PM - 96% (Oxygen Via Mask)</p> <p>[DATE] @ 5:52 PM - 96 % (Oxygen Via Mask)</p> <p>Record review of Resident #1's MAR/TAR (page 12 and 13 of 28) for February 2024, stated, Check oxygen saturation Q 2 hours. Every 2 hours - Order Date- [DATE] at 4:15 PM -D/C Date - [DATE] at 1:34 PM. Further review revealed missed Oxygen Saturation level recording the following dates and shifts:</p> <p>12:00 AM on [DATE] and [DATE],</p> <p>2:00 AM [DATE], [DATE], [DATE]</p> <p>4:00 AM [DATE], [DATE], [DATE]</p> <p>6:00 AM [DATE], [DATE], [DATE]</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of a written statement, dated [DATE] written by LVN D (2:00 PM to 10:00 PM on [DATE]) stated, .This nurse did apply portable o2 tank to (Resident #1) @ 4 liters. This was around 3:30 PM. LVN D's statement indicated Resident #1's hospice nurse had assisted Resident #1 from her wheel chair to her bed which resulted in a skin tare at around 4pm and was assessed and treated at 4:15 PM by RN F. LVN D further stated she reconnected Resident #1 to her oxygen concentrator .@ 4 liters ., and that she, .did leave O2 tank in room for future use . (Note, Resident #1's order was for 5 liters - see Resident #1's order in above record review).</p> <p>Record review of a written statement, dated [DATE], authored by LVN B, stated, .On [DATE] the sitter for (Resident #1) in room [resident's room] approached my workstation at 1345 stating that she had not been able to get (Resident #1) to wake up or talk the whole day. I went to [resident's room], (Resident #1) was lying in bed head of bed was slightly elevated. She had an oxygen cannula in place, but her breathing appeared more labored than it had earlier in the shift. During my morning shift the oxygen saturation was 93% and (Resident #1) appeared comfortable. Upon checking her oxygen, it was in the upper 60s- lower 70's. I realized that she was not on her concentrator and looked at the E cylinder her cannula was connected to and saw that it was empty. I changed her cannula to the concentrator, the sitter assisted me with repositioning her in the bed and I raised the head of the bed. I increased the liters per minute of oxygen from 5 to 6. Her saturation improved only to ,d+[DATE]%. I was instructing the sitter to please communicate soon ER when she observed a change in the resident when she told me that she told the girl who brought her tray at lunch. I requested in the future she come get me or the other nurse or a director rather than relaying the information through the CNA's .</p> <p>Record review of written statement, dated [DATE], Author, LVN E (10:00 PM - 6:00 AM for shift [DATE]-[DATE]), stated, . I do not recall if (Resident #1) was using a concentrator or O2 tank.</p> <p>Record review of a Resident #1's Hospice Documentation (regarding [DATE] incident), Author, HRN A, received via email on [DATE], page 18 of 22, stated, .Facility Nurse (LVN B) notified this RN that (Resident #1) had been lethargic the whole morning and when staff took pts vitals, they notified the pt oxygen saturation was in the 60%. Facility nurse (LVN B) noticed the pts NC was connected to a oxygen tank that was empty. They placed the NC tubing to oxygen concentrator and pts oxygen saturation increased to 85% at 6 LPM. Upon RN assessment, pt lung sounds are diminished to all lobes. Pt has RR 35. Lorazepam .5 mg .[sic]</p> <p>Telephone interview on [DATE] at 1:16 PM, Hospice RN (HRN A) stated she was familiar with Resident #1 as she was her Hospice Case Manager. HRN A said she was informed by the Resident #1's caretaker, Caretaker A, that Resident #1's nurse forgot to reconnect Resident #1 to her oxygen concentrator after Resident #1 returned to her bedroom following a tour of the facility while utilizing an e-cylinder as her oxygen source. HRN A said Caretaker A told her Resident #1 was still discovered to be connected to her oxygen e-cylinder, which was empty, the following afternoon ([DATE]) after approximately 21 hours had passed and that her oxygen . HRN A said the Resident #1 was receiving ,d+[DATE] liters of continuous oxygen which would have caused her oxygen tank to run out of oxygen within ,d+[DATE] hours. HRN A said Caretaker A informed her Resident #1 was lethargic the next day and her oxygen saturation was in the 60s. HRN A said she saw Resident #1 the day before and then again the day after she was without her oxygen and observed her to have a major decline in that she was very talkative and eating popcorn on [DATE] and then bedbound and lethargic when she saw her on [DATE]. HRN A was asked if Resident #1 was hospitalized as a result but responded that she was not as she was already on hospice services and being treated with comfort measures.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 2:50 PM, RN C stated the only interaction she had with Resident #1 was when she discovered Resident #1 deceased in her bed. RN C was asked if she had knowledge of Resident #1 being without oxygen and said she heard LVN C mention Resident #1 had gone without her oxygen for an extended period of time which resulted in a change of condition and responded that she had heard various staff say Resident #1 had been connected to an empty oxygen e-cylinder overnight which resulted in a major change of condition.</p> <p>Telephone interview on [DATE] at 3:04 PM, Care Manager B said he was very familiar with Resident #1 and would see her weekly. Care Manager B stated he was made aware Resident #1 was disconnected from her oxygen for an extended period of time and, .experienced a major decline as a result up until her death. Care Manager B said he went to the DON regarding this incident and was told the DON and the Administrator were investigating the incident but would not divulge any additional information.</p> <p>Telephone interview on [DATE] at 10:43 AM, Caretaker A stated she and CGRN B were with Resident #1 when she admitted to the facility on [DATE] and said Resident #1 had a caretaker with her 24 hours per day. Caretaker A said she and CGRN B elected to show the Resident #1 around the facility via wheelchair and said facility staff removed her from her oxygen concentrator and placed her on a portable oxygen tank affixed to her wheelchair so that she could tour the facility while remaining on continuous oxygen. The Caretaker A said that she, the CGRN B, and Resident #1 returned to her room approximately an hour later and said CGRN B notified staff Resident #1 needed to be placed back on her oxygen concentrator. Caretaker A said she left the facility around 5:00 PM or 5:30 PM that evening when relieved by the overnight Caretaker and then returned to the facility around 8:00 AM on [DATE]. Caretaker A said that at around 1:00 PM, she asked LVN B why Resident #1 was not connected to her oxygen concentrator as she had the same oxygen tank next to her from the day before. Caretaker A said at that point LVN B indicated that an oversight had occurred in that they were unaware, and then proceeded to connect Resident #1 back onto her oxygen concentrator. Caretaker A said Resident #1 had a significant change in condition from one day to another in that Resident #1, was eating popcorn and able to change her own clothing one day to almost being in a damn coma the next. Caretaker A explained that there was another similar incident several days later when staff moved Resident #1 to a private room and connected her to an oxygen concentrator that was broken. Caretaker A said that she noticed the oxygen concentrator was not functioning the way her previous oxygen concentrator had functioned, specifically, the humidifier reservoir had no condensation, and alerted LVN B who then agreed Resident #1's oxygen condenser was not adequately functioning and said, 'How strange, that never happens.' Caretaker A said that on that occasion, Resident #1 had gone at least 20 minutes without oxygen. Caretaker A confirmed during this interview that she never connected or disconnected Resident #1 to her oxygen concentrator or oxygen cylinder. Caretaker A stated she had no clinical background or licensure and that she and Resident #1's other caretakers were primarily tasked with keeping Resident #1 company as she had not immediate family in the area. Caretaker A stated she had known and worked with Resident #1 for multiple years and were very close.</p> <p>Telephone interview on [DATE] at 11:27 AM, Hospice Director of Clinical Services (HD), said HRN A observed Resident #1 at the facility on [DATE] at 11:00 AM and again on [DATE] at approximately 5:05 PM, because Resident #1 had a change in condition. During this interview, HD reviewed her agency's documentation and which she said stated Resident #1 was discovered to be attached to an empty oxygen tank and her oxygen saturation was in the 60s. HD further stated Resident #1 was subsequently placed on her oxygen concentrator which brought her oxygen saturation levels up to the 80s.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 1:35 PM, the DON revealed she was aware Resident #1 was discovered connected to an empty oxygen e-cylinder on the afternoon of [DATE]. The DON also confirmed that Caretaker A informed nursing staff Resident #1 was in distress at around 1:35 PM on [DATE] and was assessed to have an oxygen saturation in the upper 60s. The DON said she was unsure how long Resident #1 could have gone without being connected to continuous oxygen but said LVN D wrote a statement saying she had connected the resident to her oxygen concentrator on the evening of [DATE] during her shift. The DON confirmed Resident #1's care takers were unlicensed said indicated they should have been responsible for ensuring Resident #1 was having her needs being medically met. The DON opined that perhaps Resident #1's caretaker could have removed her from her oxygen concentrator and connected her to an empty tank to take her out on her wheelchair again but agreed there were no witnesses of such activities. The DON agreed that it was ultimately the facility's responsibility to ensure Resident #1 was receiving adequate medical care even if she had paid caretakers, 24 hours a day. The DON was asked why staff did not document Resident #1's oxygen saturation on [DATE] when it was in the 60s percentage range but did not have an answer and agreed that it should have been documented. The DON indicated Resident #1 must have been ok until the time she was discovered to be hypoxic in that Resident #1's caretaker had not bring any concerns to her staff until then. The DON was asked why Resident #1's oxygen saturation levels were only documented at 12:20 AM (95%) and again after Resident #1's oxygen saturation was brought back up on [DATE] at 2:27 PM (83%),but did not include the readings in the 60s and responded that she was unsure. The DON was asked if she had reported this incident to HHS and responded that she had not. When asked why, the DON said that she conducted an investigation with inconclusive findings and that there had been no harm. At this time, this investigator confirmed with the DON that Resident #1 was documented to have had a change of condition and was hypoxic, with oxygen saturation levels in the 60s, as a result of not being attached to continuous oxygen per her physician's orders.</p> <p>Interview on [DATE] at 3:10 PM, LVN D stated she was on the 2pm-10pm shift on [DATE] and said she was providing care for Resident #1. LVN D said Resident #1 was attached to a portable oxygen cylinder that evening and that she had placed Resident #1 back on her oxygen concentrator but was unsure why the oncoming staff could not recall Resident #1 being attached to the oxygen concentrator per their written statements. LVN D was asked which staff relieved her on the evening of [DATE] but responded that she could not recall. LVN D was asked once more if that staff was LVN E and responded that yes, it was LVN E. When asked if LVN E still worked at the facility LVN D responded that he did not as she hadn't seen him for a while. LVN D was asked how she knew for certain that she had attached Resident #1 to her oxygen concentrator and responded that she had wheeled it into her room, and connected Resident #1 to the oxygen concentrator and then took her vitals according to her physician's orders, which included her oxygen saturation levels as she did near the end of every shift (Note: Resident #1 had already been connected to her oxygen concentrator in her room prior to being connected to the e-cylinder). LVN D was asked when and where the documentation would have occurred and responded that it would have been documented in Resident #1's electronic chart under weights and vitals at around 9:45 PM on [DATE]. LVN D was shown the Resident #1's electronic chart and confirmed the Resident #1's oxygen saturation levels were not documented at or around that time but were only documented once on [DATE] at 12:14 PM (96 % @ 5 L/Min). LVN D then insisted on checking Resident #1's electronic chart via her own computer access and again could not locate where she had documented Resident #1's oxygen saturation levels. LVN D said Resident #1 had a caretaker in her room at the time of her shift, Caretaker A and then another Caretaker, Caretaker B when she left her shift that evening. LVN D was asked once more if there may have been an oversight on her part, specific to reattaching Resident #1 back to her oxygen concentrator and responded that it might have been possible in that she was very busy that day and a lot was going on.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview and record review on [DATE] at 3:03 PM, LVN B stated she checked on Resident #1 during her morning rounds on [DATE] between 7:00 AM and 8:00 AM. She stated the resident was a bit sleepier than normal but said she measured the Resident #1's oxygen saturation and that it was 93%. LVN B was asked why she did not document Resident #1's oxygen saturation at that time responded that she did not as she would typically document by exception. LVN B was asked if she Resident #1 was connected to her oxygen concentrator at that time but said she could not recall. LVN B said she then checked on Resident #1 once more around lunch time and said the resident was still sleeping. LVN B said she was alerted by Caretaker A at around 1:30 PM that Resident #1 could not be awoken and was not eating. LVN B said at that time she noticed Resident #1 was still connected to an empty oxygen e-cylinder as opposed to her oxygen concentrator so she said she then attached Resident #1 to her oxygen concentrator and was able to bring her oxygen saturation up to the 80s. LVN B was asked why she did not notice Resident #1 was not connected to her oxygen concentrator during her morning round, she responded that she was likely preoccupied and distracted as another resident in the hall was requesting her attention. LVN B was asked why she hadn't documented Resident #1's oxygen saturation when it was in the 60s at the time of that observation but did not have an answer. LVN B was asked if there was ever a time Resident #1's oxygen concentrator was not functioning adequately, LVN B denied knowledge of this incident. When asked once more, LVN B confirmed that several days later, Resident #1 had moved to a private room and said Caretaker A brought to her attention that the humidifier on the oxygen concentrator was not working so LVN B said she replaced Resident #1s oxygen concentrator at that time because she wanted to ensure the tension Caretaker A was experiencing was diffused given the recent trauma Resident #1 had experienced and wanted to make her happy. LVN B said Resident #1's oxygen saturation levels went back up to the 90s once she connected Resident #1 to the new oxygen concentrator. LVN B was asked once more why Resident #1's oxygen saturation levels were not documented to be in the 60s on [DATE] upon discovery and then reviewed Resident #1's progress notes with this investigator. During this record review, LVN B confirmed Resident #1's progress note for [DATE] at 7:55 AM, .SpO2 is ,d+[DATE]%, was documented on the wrong date and said, that's strange, it doesn't even say it is a late entry.</p> <p>Telephone interview on [DATE] at 4:40 PM, CGRN B stated she and Caretaker A asked facility staff on [DATE] if they could place Resident #1 on a portable oxygen cylinder so she could tour the facility with them. CGRN B said after this occurred, she and Caretaker A took Resident #1 on a tour of the facility and enjoyed some popcorn with her. She said Resident #1 was talkative and in good spirits. CGRN B said that up returning Resident #1 to her bed an hour later, Resident #1 attempted to self-transfer at which time CGRN B indicated Resident #1 looked as though she could fall so CGRN B said she attempted to assist Resident #1 by catching her and pivoting her to her bed but said Resident #1 caught her foot on a footrest located on her wheelchair and sustained a cut which required treatment by the facility's wound care nurse. After the treatment, CGRN B said she informed LVN D that Resident #1 needed to be placed back onto her oxygen condenser and said the wound care nurse, RN F, was present when she said this. CGRN B said upon leaving, she told another nurse at the nurse's station that Resident #1 still had not been transferred to her oxygen condenser and was told that staff would soon reattach Resident #1 to her oxygen condenser. CGRN B said she was informed the following day that Resident #1 had a change of condition after LVN B discovered Resident #1 was still connected to the portable oxygen cylinder and had never been reconnected to her oxygen condenser. CGRN B said several days later Resident #1 had a room change and was connected to a non-functioning oxygen concentrator and again experienced a drop in her oxygen saturation levels until Caretaker A brought it to LVN B's attention and was issued a functioning oxygen concentrator. CGRN B confirmed during this interview that she never connected or disconnected Resident #1 to her oxygen concentrator or oxygen cylinder and that it was not policy for her nor other staff within her agency to do so.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/04/2024
NAME OF PROVIDER OR SUPPLIER  Juniper Village at Lincoln Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  855 E Basse Rd San Antonio, TX 78209	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview and record review on [DATE] at 3:10 PM, LVN B confirmed Resident #1's electronic TAR for February [DATE] did not reflect Resident #1's oxygen saturation levels every two hours per her physician's order.</p> <p>Attempted telephone interview on [DATE] at 2:48 PM, with LVN E. The call went directly to voicemail and voice message was left requesting a returned telephone call.</p> <p>Interview on [DATE] at 3:05 PM, the DON was asked why only 10 staff were listed as having received in-servicing regarding this incident. The DON responded that, some staff are PRN, and that only staff directly involved with the incident had been in-serviced but she would work on getting all other staff in-serviced.</p> <p>Interview on [DATE] at 12:17 PM, RN F stated Resident #1 sustained a large skin tear to her left lower extremity on the afternoon of [DATE] when her Hospice RN attempted to assist her to her bed which resulted in Resident #1 catching her foot on the footrest leading to the wound. RN F stated she treated Resident #1's wound at that time and then again treated Resident #1's wound shortly after lunchtime on [DATE]. RN F said she was concerned because Resident #1 was unable to be aroused and slept through her wound treatment at that time. RN F said she was told by Resident #1's caretaker, Caretaker A, that Resident #1 had slept through both breakfast and lunch. RN F said she asked if Resident #1 had been placed on any new medications that would have caused her to be so unresponsive but was told that she had not. RN F said she then approached LVN B and said soon after it was determined Resident #1 was connected to an empty oxygen cylinder which caused her oxygen saturation to be so low. RN F was asked if she had checked to see if Resident #1 was connected to her oxygen concentrator at the time, she was treating the resident's wound and responded that she had not as she was preoccupied with the wound treatment.</p> <p>Telephone interview on [DATE] at 1:30 PM, the facility's Medical Director and Resident #1's physician stated an individual requires supplemental oxygen if and when that person's oxygen saturation levels drop below 90%. Resident #1's physician stated that if an individual experiences hypoxia it can lead to damage of vital organs in that they require oxygen to adequately function.</p> <p>Review of an article title Hypoxia by The Cleveland Clinic, <a href="https://my.clevelandclinic.org/health/diseases/23063-hypoxia">https://my.clevelandclinic.org/health/diseases/23063-hypoxia</a>, and was accessed on [DATE] indicated, Hypoxia is low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin. Many chronic heart and lung conditions can put you at risk for hypoxia. Hypoxia can be life-threatening. If you are experiencing symptoms of hypoxia, call 911 or go to the nearest ER. The treatment for hypoxia depends on the underlying cause. The cause might be a one-time event, or it could be an ongoing condition.</p> <p>The Administrator was notified of an IJ on [DATE] at 4:45 PM and was given a copy of the IJ template and a Plan of Removal (POR) was requested.</p> <p>The Plan of Removal was accepted on [DATE] at 4:02 PM and included the following:</p> <p>[DATE], Plan of Removal F695</p> <p>All residents have been assessed to ensure respiratory needs are in place. A facility-wide audit was completed by Regional Nurse on [DATE] and identified all residents in need of oxygen.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Juniper Village at Lincoln Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  855 E Basse Rd San Antonio, TX 78209	
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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident's responsible party, Residents care management provider Hospice Agency A and primary physician were notified February 21, 2024.</p> <p>A facility wide audit of residents in need of oxygen concentrators, e-tanks, etc. have been assessed to ensure respiratory needs are in place. There were no residents identified to have an issue with oxygen devices on [DATE].</p> <p>In-service training that includes checking the levels of the e-tanks, the source of O2, O2 saturation rates and method of O2 delivery began [DATE] with all licensed staff. CNA's will be in-service on the basic principles of O2, able identify e-cylinder levels, and notify charge nurse immediately if there are any in discrepancies. The Administrator, all will ensure all in-serviced prior to working shift going forward.</p> <p>Monitoring will be completed by all residents on O2 that have O2 saturation, method of oxygen delivery, source of O2 delivery, and liters per minute will be added to their physicians' orders and documented on the MAR/TAR q shift by the licensed nurse. DON and/or designee will conduct routine checks on MARs/TARs daily to ensure compliance. Each shift, the charge nurse will visually check the source (i.e. E-Cylinder) of O2 delivery and document on the MAR/TAR daily.</p> <p>Facility will ensure that ensure that staff receive any in-service training to address the issues prior to the start of their next shift if a staff member is unavailable due to leave, FMLA, new hire, or agency by attending required in-servicing on ensuring that respiratory care is provided consistent with professional standards of practice. This will be via required new hire orientation before working their first shift, required in-servicing via Relias Training have been assigned to those that may be out FMLA, leave, agency, etc.</p> <p>Going forward, the facility will intervene as needed through daily rounds conducted by The Director of Nursing or designee; daily standups meeting conducted by the Administrator or designee; and reviewed by Quality Assurance Committee conducted on [DATE], monthly or as needed for the next 3 months and/or as needed.</p> <p>The verification of the Plan of Removal was completed as follow:</p> <p>Record review of a typed statement dated [DATE] and signed by the Corporate RN revealed he had reviewed/assessed all residents at the facility for respiratory needs. His statement indicated he reviewed oxygen orders in the electronic medical records for oxygen route, amount, source and method. His statement also indicated all residents on oxygen had the appropriate orders written and respiratory equipment available.</p> <p>Record review of the electronic medical records revealed 14 residents with orders for oxygen.</p> <p>During observations</p>		