STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38530 Based on interview and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 6 residents (CR #1) reviewed for quality of care. 1. The facility failed to timely identify CR #1's change in condition of lethargy, impaired communication and motor functions. 2. The facility failed to timely assess, notify CR #1's physician, and provide interventions to CR #1 who began to have an increased altered mental state, lethargy and physical impairments. 3. The facility failed to timely address CR #1's increase in seizure activity. An Immediate Jeopardy (IJ) situation was identified on 11/3/21. While the IJ was removed on 11/06/2021 at 4:30PM, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of not receiving timely care, health complications, serious illness or death. Findings include: Record review of CR #1's facesheet revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged to the hospital on 9/26/21. Her diagnoses included: obstructive hydrocephalus (fluid buildup in the brain), congenital hydrocephalus (present at birth), convulsions(uncontrollable muscle contractions) , anemia (low red blood cell count), anxiety disorder, major depressive disorder, hypertension (high blood pressure), osteoarthritis (joint disease), visual hallucinations (perception of having seen, heard, touched, taste, or smell something that is not real). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's quarterly MDS, dated [DATE], revealed a BIMS score of 3 out of 15, which indicated severe impaired cognition. The MDS indicated CR #1 had unclear speech and usually made herself understood and usually understood others. She required one-person limited assist with eating and had no impairment of upper extremities. The MDS revealed diagnoses of seizure disorder or epilepsy (uncontrollable muscle movements of the body), anxiety disorder (worry and fear) , depression (sadness), obstructive hydrocephalus (fluid buildup in the brain) , and congenital hydrocephalus(present at birth). The MDS also indicated antianxiety medication was received 2 days with the last 7 days of the MDS. Record review of CR #1's, undated, care plan revealed she required assistance with all of her ADL's due to cognitive deficits and limited mobility. Her intervention included in part, .eating CR #1 is able to eat her meals once setup by staff. Cut foods, open packages, etc. Provide cueing when CR #1 gets off task. Provide a divided plate with meals. 9/16/21 [CR #1] was limited assist of one staff in the lookback 9/4/21 - 9/10/21 . Further review of the care plan revealed CR #1 had the potential to be verbally aggressive (curses at staff, and at other residents) related to poor impulse control. Per CR #1's mother, verbal outburst generally precedes seizure activity. At times, CR #1 will hallucinate or yell out. Her interventions included: Administer medications as ordered. Monito/document for side effects and effectiveness, Monitor behaviors (every shift). Document observed behavior and attempted interventions, provide positive feedback for good behavior. Emphasize the positive aspects of compliance, when CR #1 becomes agitated, attempt to intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk away, and approach later. Record review of CR #1's, undated, care plan revealed CR #1 used anti-anxiety medication (diazepam) PRN related to anxiety disorder, seizures. She's at risk for adverse effects. Her interventions included: Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness. As needed, Educate family/caregivers about risks, benefits and the side effects. Observe for any adverse reactions to anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Observe for target behavior symptoms (inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. Reassure resident. Record review of CR #1's physician orders, dated 10/3/17, revealed an order for Aptiom Tablet (Eslicarbazepine Acetate) Give 800 mg by mouth one time a day related to convulsions. Record review of CR #1's physician orders, dated 8/1/18, revealed an order for Diazepam tablet 10 mg by mouth every 6 hours as needed for seizures. Record review of CR #1's physician orders, dated 11/20/18, revealed an order for Vimpat Tablet 200 mg (Lacosamide) Give 1 tablet by mouth two times a day for seizures. Record review of CR #1's physician orders, dated 3/25/20, revealed an order for Fycompa Tablet 2 mg (Perampanel) Give 4 tablets by mouth at bedtime related to convulsions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's physician orders, dated 4/27/21, revealed an order for Neurologist consult one time only for seizures for 1 day. Record review of CR #1's physician orders, dated 4/30/21, revealed an order for Dilantin Capsule 100 mg Phenytoin Sodium Extended) Give 100 mg by mouth every 8 hours for seizures. Record review of CR #1's May 2021 MAR revealed Aptiom Tablet (Eslicarbazepine Acetate) 800 mg was administered by mouth one time a day related to convulsions 5/1/21 - 5/31/21. Record review of CR #1's May 2021 MAR revealed Vimpat Tablet 200 mg (Lacosamide)1 tablet was administered by mouth two times a day for seizures 5/1/21 - 5/31/21. Record review of CR #1's May 2021 MAR revealed Fycompa Tablet 2 mg (Perampanel) 4 tablets was not administered by mouth at bedtime related to convulsions on 5/1/21 - 5/7/21, 5/10/21 - 5/14/21, and 5/17/21 - 5/19/21 due to medication being unavailable. Further review of the MAR revealed the medication was administered on 5/8/21, 5/9/21, 5/15/21, 5/16/21, and 5/20/21 - 5/31/21. The MAR revealed 15 doses were missed of the medication due to unavailability. Record review of CR #1's May 2021 MAR revealed Dilantin Capsule 100 mg (Phenytoin Sodium Extended) 100 mg was administered by mouth every 8 hours for seizures 5/1/21 - 5/31/21. Record review of CR #1's May 2021 MAR revealed Diazepam tablet 10 mg by mouth every 6 hours as needed for seizures was administered 3 times on 5/18/21, 5/21/21, and 5/31/21. Administration was noted to be effective. Record review of CR #1's progress notes, dated 5/18/21, at 1:42 PM revealed Diazepam was administered prior to ambulance transport. Record review of CR #1's Neurology consult, dated 5/18/21, revealed in part, .history of hydrocephalus status post ventricular shunt placement for which she had on revision as well as history of seizures for which she is currently on Dilantin 300 mg a day, Vimpat 200 mg twice a day, Aptiom 800 mg once a day and Fycompa 8 mg a day. For her acute headache she has been taking Diazepam 10 mg. She has been experiencing about one seizure a month . Mental status: today she is awake and smiling. She is able to follow simple commands . She moves upper extremities against gravity Further review of the consult progress note revealed in part, .Her seizures have been relatively well - controlled. I have asked that she continue with her current regimen of medications including Vimpat 200 mg twice a day, Aptiom 800 mg a day, Fycompa 8 mg a day, and Dilantin 300 mg a day. She may also use Diazepam; however, I will switch her to the intranasal 10 mg/0.1 mL for her acute headaches Record review of CR #1's progress notes, dated 5/21/21 at 12:28 PM, revealed Diazepam was given, resident noted jerking, loud outburst of yelling and screaming. Record review of CR #1's progress notes, dated 5/31/21 at 9:31 PM, revealed resident was given Diazepam for seizure at exactly 9:18 PM by mouth. Vital signs were taken (temp 98.6, BP 142/66, pulse 74, O2 96). Will continue to monitor. Record review of CR #1's progress notes, dated 5/31/21 at 10:14 PM, revealed Resident RP notified of the mild seizure episode. Resident is stable and resting now. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's June 2021 MAR revealed medications for seizures and convulsion (Aptiom, Vimpat, Fycompa, and Dilantin) were administered 6/1/21 - 6/30/21 as ordered. Record review of CR #1's June 2021 MAR revealed Diazepam tablet 10 mg by mouth every 6 hours as needed for seizures was administered 2 times on 6/11/21 and 6/24/21. Record review of CR #1's progress notes, dated 6/11/21 - 6/24/21, revealed no documentation regarding seizure activity despite Diazepam being administered. Record review of CR #1's July 2021 MAR revealed medications for seizures and convulsion (Aptiom, Vimpat, Fycompa, and Dilantin) were administered 7/1/21 - 7/31/21 as ordered. Record review of CR #1's July 2021 MAR revealed Diazepam tablet 10 mg by mouth every 6 hours as needed for seizures was administered 7 times on 7/5/21, 7/9/21, 7/14/21, 7/29/21, 7/30/21 and 7/31/21. Record review of CR #1's progress notes, dated 7/5/21- 7/14/21, revealed no documentation regarding seizures despite Diazepam being administered. Record review of CR #1's progress notes, dated 7/18/21 at 6:03 PM, revealed the Diazepam was administered as needed for seizures and noted, patient having a little seizure activity Record review of CR #1's progress notes, dated 7/18/21 at 9:56 PM, revealed Patient had a little seizure activity today, seizure pill Dilantin, Vimpat, and Diazepam was administered. Within 10 minutes patient was calm, vital signs are within limit. Patient was monitored closely. Patient was sleeping as the shift ended, next nurse will continue to monitor. Record review of CR #1's progress notes, dated 7/20/21 at 10:25 AM, revealed resident was alert and able to verbalize needs to staff and resident had not exhibited any shouting, yelling, cursing or jerking movements. Record review of CR #1's progress notes, dated 7/27/21 at 9:21 PM, revealed, patients mother stated patient had a short episode of seizing, but none was witnessed by nurse. Will continue to monitor. Record review of CR #1's progress notes, dated 7/29/21 - 7/31/21, revealed no documentation regarding seizure activity despite Diazepam being administered. Record review of CR #1's progress notes, dated 7/29/21 at 1:21 PM, revealed CR #1 was diagnosed with a UTI with ESBL and MDR. CR #1 was started on Augmentin 875/125 twice daily for 14 days. Record review of CR #1's August 2021 MAR revealed medications for seizures and convulsion (Aptiom, Vimpat, Fycompa, and Dilantin) were administered 8/1/21 - 8/31/21 as ordered. Record review of CR #1's August 2021 MAR revealed Diazepam tablet 10 mg by mouth every 6 hours as needed for seizures was administered 12 times on 8/2/21, 8/4/21, 8/5/21 (twice), 8/6/21, 8/10/21, 8/15/21, 8/17/21, 8/18/21, 8/28/21, 8/30/21, and 8/31/21. Administrations were listed as effective. Record review of CR #1's progress notes, dated 8/2/21, revealed no documentation of seizure activity despite Diazepam being administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's NP A progress notes, dated 8/3/21, revealed in part, .No seizure episode . congenital hydrocephalus/seizure disorder - supportive care, Vimpat, Aptiom, Dilantin, and Fycompa, Neuro Follow-up as recommended, seizure precautions, Diazepam PRN . Record review of CR #1's progress note, dated 8/4/21 at 2:07 PM, revealed PRN Diazepam was given for seizure and noted, given for behaviors, cursing and screaming. Record review of CR #1's progress notes, dated 8/5/21 - 8/6/21, revealed no documentation of seizure activity despite Diazepam being administered. Record review of CR #1's progress note, dated 8/9/21 at 10:24 AM, revealed in part, .Resident exhibiting pre-seizure behavior yelling and cursing. Resident given PRN Diazepam Record review of CR #1's August 2021 MAR revealed no documentation Diazepam administration on 8/9/21. Record review of CR #1's physician progress note, dated 8/9/21, revealed CR #1 was seen for follow - up. He noted in part, .No seizures lately/no pain issues, up and feeling herself, complained of body aches no fever, mild cough Record review of CR #1's progress notes, dated 8/10/21 - 8/17/21, revealed no documentation of seizure activity despite Diazepam being administered. Record review of CR #1's NP A progress notes, dated 8/13/21 at 9:30 AM, revealed she was seen for generalized pain and experienced chronic back pain which was discussed with mother over the phone. Further review of note revealed in part, .seizure controlled on medications Record review of CR #1's progress notes, dated 8/18/21 at 11:45 AM, revealed PRN Diazepam for seizures was given and noted, Resident having verbal outburst screaming shut up. Record review of CR #1's progress notes, dated 8/28/21 at 5:20 PM, revealed PRN diazepam was given for seizures and notes, resident observed twitching during care, Diazepam tablet 10 mg PO PRN given, resident tolerated well. Record review of CR #1's progress notes, dated 8/30/21 - 8/31/21, revealed no documentation of seizure activity despite Diazepam being administered. Record review of CR #1's September 2021 MAR revealed medications for seizures and convulsion (Aptiom, Vimpat, Fycompa, and Dilantin) were administered 9/1/21 - 9/26/21 as ordered. Record review of CR #1's September 2021 MAR revealed Diazepam tablet 10 mg by mouth every 6 hours as needed for seizures was administered 12 times on 9/1/21 - 9/4/21, 9/6/21, 9/11/21, 9/12/21, 9/16/21, 9/19/21 (twice), 9/20/21, and 9/22/21. Administrations were listed as effective. Record review of CR #1's progress notes, dated 9/1/21 - 9/6/21, revealed no documentation of seizure activity despite Diazepam being administered for seizures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's 24-hour report, dated 9/1/21 - 9/7/21, revealed she had 0 seizure activity despite Diazepam being administered for seizures. Record review of CR #1's physician progress notes, dated 9/7/21, revealed CR #1 was seen for a follow-up and revealed in part, No seizures lately .seizure in control phenytoin (seizure medication) level 11.5 Record review of CR #1's progress notes, dated 9/8/21 at 5:42 AM, revealed in part, .up through the shift . No seizure activity noted this shift . Record review of CR #1's 24-hour report, dated 9/8/21, revealed she was awake and talkative until 3 AM during night shift. Record review of CR #1's progress notes, dated 9/9/21 at 5:55 AM revealed in part, .remained awake through shift. at intervals. No seizure activity noted . Record review of CR #1's 24-hour report, dated 9/10/21, revealed she was up all-night .No distress. Vital signs were stable. Record review of CR #1's 24-hour report, dated 9/11/21 - 9/15/21, revealed she had 0 seizure activity despite Diazepam being administered for seizures. 9/12/21 during night shift it was noted she was up all night. Record review of CR #1's progress notes, dated 9/11/21 - 9/15/21, revealed no documentation regarding seizure activity or change in condition. Record review of CR #1's Medication Regimen Review, dated 9/16/21, revealed in part, Patient has order for diazepam 10 mg q6hr for seizures. Please ensure this medication in only being administered when the patient is having a seizure, not for anxiety or other indication. Record review of CR #1's 24-hour report, dated 9/16/21, revealed CR #1 was given PRN Diazepam during the day shift otherwise no further documentation regarding seizures. Record review of CR #1's 24-hour report, dated 9/18/21, evening shift noted, monitor patient for drowsiness, mother asked that NP be notified. ADON notified, patient is to go to dining room for all 3 meals. Record review of CR #1's 24-hour report, dated 9/19/21, night shift noted, stable, monitor patient for drowsiness, patient is to go to dining room for all 3 meals. No documentation of seizure activity despite Diazepam being administered twice for seizure activity. Record review of CR #1's 24-hour report, dated 9/20/21, revealed she was stable with no seizure activity documented despite Diazepam being administered for seizure activity. Record review of CR #1's 24-hour report, dated 9/22/21, revealed she was given Diazepam at 8 AM but did not eat lunch, ate less than 25%. No further documentation regarding seizure activity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's progress notes, dated 9/23/2021 at 12:28 PM, written by Social Worker revealed, Data: IDT has observed a change/decline in her cognition and communication and upper extremity range of motion. Action: ST/OT to screen for evaluation and treatment. continues to visit with resident twice weekly. Record review of CR #1's progress notes, dated 9/23/2021 at 1:42 PM written by LVN B, revealed, Resident constantly yelling .take me shopping. Record review of CR #1's 24-hour report, dated 9/23/21, revealed she was up talking to herself throughout the night. Record review of CR #1's physician orders, dated 9/24/21, revealed an order for CBC, CMP, C&S STAT for UTI were entered by LVN B. Record review of CR #1's 24-hour report, dated 9/24/21, revealed labs were ordered, and UA was collected. Record review of CR #1's progress notes, dated 9/24/21, revealed no documentation of change in condition or why STAT lab were ordered. Record review of CR #1's CBC (Complete Blood Cell Count) with Differential/Platelet, CMP and UA was a routine order and the CBC, CMP was collected on 9/25/21 at 12:00 AM, received on 9/26/21 and reported on 9/27/21. The Urinalysis was not performed due specimen not at refrigerated temperature. Record review of CR #1's progress notes, dated 9/25/21, at 1:38 PM revealed CR #1 was resting in bed with eyes opened, her respirations were even and unlabored and she required total care with ADL's. Her lung sounds were clear, no SOB/distress noted. Her vital signs were stable. 10 PM - 6 AM shift had collected a urine sample and stored it in refrigerator. The writer (LVN A) noted she contacted the lab company to check on pick up time but current closed. Oncoming nurse to follow - up. Record review of CR #1's 24-hour report, dated 9/25/21, revealed in part, .facial edema to left side, lab results pending . abscess to left face. Record review of CR #1's 24 hours reports for the month of September 2021 revealed report from 9/26/21 was not provided. Record review of CR #1's progress notes, dated 9/26/21 at 12:08 PM written by LVN A, revealed CR #1 had a change in condition of altered mental status. An Evaluation was completed which revealed her blood pressure was 118/68, pulse was 74, respiration was 18, temperature (tympanic - ear) was 98.2, and O2 was 96%. Physical assessment revealed she had altered level of consciousness and needed more assistance with ADLs, general weakness, and decreased mobility. Further review of the assessment revealed in part, Writer was in the dining room assisting residents with lunch meals, Writer informed by a staff member resident was assisted with meals, and unable to eat her lunch, resident holds food in her mouth. Writer observed resting on bed with eyes opened, respiration even and unlabored. Resident skin to bilateral hands cold, resident unable to respond by name calling or touch. Lung sounds increased bilateral breath sounds to anterior right upper lobe abdomen soft, non-tender, bowel sound active in 4 quadrants . NP on-call (NP B) was informed of resident condition, new order received to transfer resident to hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's progress notes, dated 9/26/21 at 1:58 PM, revealed NP on call (NP B) ordered to transfer CR #1 to the hospital for altered mental state. Record review of CR #1's hospital records, dated 9/26/21, revealed she entered the emergency room at 1:14 PM and her triage started at 1:20 PM for altered mental status and nursing home reported she was last seen at her baseline last night. She ate 50% of her breakfast and none of her lunch which is not normal for her. History of hydrocephalus and normally alert and oriented x1. Records noted she had an altered mental status since 10 AM and her baseline was usually conversive, but staff told EMS she had been less responsive than usual and altered. She was noted to not be eating or drinking as much as she usually did, nor is she talking. EMS measured her blood glucose to be in 150s. Resident temperature during triage was noted to be 87.3 degrees and pulse of 44 bpm. CR #1 reasons for admission were: Hypothermia, lethargy, altered mental status, and abnormal LFTS (Liver Function Test), she started warming blankets and was admitted to the IMU (intermediate care unit). Record review of the hospital history and physical, dated 9/26/21, revealed in part, .Majority of history is obtained from the mother who is sitting at bedside. At baseline, the patient is alert, very talkative, friendly to everyone in the facility, likes to listen to music, wheelchair bound, requires assistance with ADL's apart from feeding. Mother and Father both visit daily. Mother reports that for the last two weeks she has been having frequent 'staring spells' that she believes are seizures and says they are occurring 'back to back' in the of their conversations . For the last 24 to 48 hours, her mental status became progressively worse to where she became completely unresponsive except to pain Interview on 9/29/21 at 4:35 PM, CR #1's visitor said she hadn't seen CR #1 since July 2021 prior to her visit on 9/26/21. The visitor said she arrived at the facility on 9/26/21 and found CR #1 in her room and she looked completely different than the last time she saw her. The visitor said CR #1 laid in bed and her eyes were blood shot red and fixated. The visitor said CR #1 was unable to communicate on 9/26/21 and said CR #1 was usually very talkative and friendly. The visitor described her condition as being unresponsive. The visitor said she found LVN A in the hallway and asked her how long CR #1 had been in her current condition. The visitor said LVN A told her it was only her second day back to work and she was told by the previous nurse (name unknown), CR #1's change in condition happened a week ago. The visitor said she told LVN A to call the physician and send CR #1 out to the hospital. CR #1 said LVN A then called the physician and got orders to transfer CR #1 out. The visitor said she immediately called CR #1's RP and told her about CR #1's condition and she agreed she wanted her transferred to the hospital and reported she was on her way there. The visitor said she was very upset and felt it was neglectful the facility let CR #1 sit in the facility all week with the changes CR #1 experienced. The visitor said she was close with CR #1's RP and was also upset because the RP had been telling the facility CR #1's seizures had increased, and she had silent seizures. The visitor said the RP had visited CR #1 the last week she was in the facility and noticed she was different as well and was told by the facility to make CR #1 a neurologist appointment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 9/29/21 at 5:07 PM, CR #1's RP said CR #1 had passed away in the hospital on 9/27/21 and she was in the process of making her funeral arrangement. The RP said she told the facility CR #1's seizures had increased, and she had them more frequently but at the care plan meeting they told her they had not observed CR #1 having any seizures. The RP said she would walk into the facility and ask the nurses if CR #1 had any seizures and they would tell her no, then she would walk into the CR #1's room and find her in the middle of having a seizure. The RP said the seizure activity she reported wasn't like a grand mal seizure and said it was more of a, silent seizure. She said she would walk in and CR #1 would not be talking, her eyes would be locked in, and she would be gritting her teeth. The RP said CR #1 would typically yell out and say bad words before she would seize but the silent seizures were different, and she was not doing her usual seizure behavior. The RP said she was told to make CR #1 a Neurologist appointment for the seizures she observed. The RP said she did make the appointment for 9/28/21 but CR #1 was transferred to the hospital and passed away before the appointment. The RP said she would visit CR #1 every day and had noticed physical changes in her the last week she was in the facility and said when she asked the staff about it they said they did not know what was causing it. The RP said she noticed CR #1's color was darker, and her gums were darker as well the last few days she was in the facility. The RP said CR #1 stopped eating as much of her food at first, then CR #1 transitioned to not being able to feed herself the week prior to her passing away. The RP said she visited CR #1 on 9/25/21 and CR #1 was unable to hold her head up or eat at all, the RP said she was only able to get CR #1 to drink a small can of coke. The RP said on 9/25/21 CR #1 could not communicate clearly or move her arms like she previously could. The RP said she did not feel the facility addressed CR #1's increased seizure activity like they should have. The RP said when CR #1 got to the hospital on 9/26/21, they did an EEG (a test that detects abnormalities in your brain waves, or in the electrical activity of your brain) and it showed CR #1 had seizures repeatedly throughout the night. Phone interview on 10/6/21 at 5:00 PM, LVN A said she remembered transferring CR #1 out to the hospital on 9/26/21 because she became unstable. LVN A said she could not recall how she was unstable without her notes in front of her but said she thought CR #1 was unable to eat her lunch which was what prompted her to call the NP. LVN A said she had just returned to work on 9/25/21 and the CNA's and nurses reported to her CR #1 needed more assistance than usual. LVN A said, previously CR #1 was able to feed herself and communicate well. LVN A said she remembered CR #1 had a visitor on 9/26/21 and she told the visitor CR #1 was transferred to the hospital but could not recall anything else that was said. Interview on 11/1/21 at 2:30 PM, the Social Worker said on 9/23/21 they had their weekly IDT meeting and CR #1 was recognized to have experienced a change. The Social Worker said CR #1 was noticed to be more tired than usual, required more assistance, and had a change in her communication. The Social Worker said she thought the physician was notified and said the previous DON would have been the person to notify the physician. The Social Worker said the previous DON no longer worked at the facility and she would be the person to know what the physician said in response to the reported change on 9/23/21. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/1/21 at 2:40 PM, the Administrator said the previous DON no longer worked at the facility and she was unable to assist the facility with any questions they had. The Administrator said he knew the DON had notified the physician but was not sure of the date. The Administrator said he saw in the records STAT labs were ordered for CR #1 on 9/24/21 and agreed he saw no further documentation as to why the labs were ordered but said it must have been from the nurses notifying the physician of CR #1's change in condition. The Administrator said there should be documentation from the nurses. Phone interview on 11/1/21 at 2:50 PM, CR #1's Community Support Trainer said she visited with CR #1 twice a week on Tuesday's and Wednesday's. The Community Support Trainer said she had in her records she last saw CR #1 on Wednesday (9/22/21) and she recalled CR #1's health had gone down quite a bit. The Community Support Trainer said CR #1 had slurred speech and was not able to communicate clearly like she usually could. She said CR #1's appearance looked like she was sick and said her eyes and nose were running. She said CR #1's was very lethargic, and her coordination was off. The Community Support Trainer described activity CR #1 would complete using alphabets and letters and said on 9/22/21 CR #1 was unable to complete the activity because she was unable to properly use her hands to pick up the letters and numbers. The Community Support Trainer said she did not recall talking about the changes she observed with facility staff. Interview on 11/1/21 at 2:58 PM, CNA B said CR #1 started sleeping a lot before she transferred to the hospital on 9/26/21. CNA B said she could not recall when CR #1's change started, but said it was within the last week she was at the facility and said maybe guessed it was the last 3 or 4 days she worked with her. CNA B said CR #1 was previously not like that and was more alert and talkative and did not require assistance with eating. CNA B said the last few days she worked with CR #1 she did not communicate well, needed assistance with eating, and did not eat as much. CNA B said CR #1 started yelling out people's names as well and she did not do that before. CNA B said when she first observed the changes, she told the nurses but was not sure what the nurses did after she told them. CNA B said she recalled she tried to feed CR #1 and she was unable to eat and said the food was just falling out of her mouth when she tried to feed her. CNA B said she told the nurse about CR #1 not being able to eat and was not sure what happened after. CNA B was not sure of the date when CR #1 was unable to eat. Phone interview on 11/1/21 at 3:35 PM, LVN B said she recalled CR #1 was sleeping a lot, more than usual and she would be up all night. LVN B said CR #1 would usually sleep through the night and not be so sleepy and tired during the day. LVN B said she recalled CR #1's left side of her face was swollen and thought she could have had an abscess. LVN B said she notified the NP of CR #1's change and the NP ordered STAT labs to see if she had a UTI. LVN B said she recalled CR #1's RP reported CR #1 had silent seizures. LVN B said CR #1 would typically yell out and start cursing and that was how they knew she was about to have a seizure. LVN B said she had not observed the silent seizures but CR #1's RP said CR #1 had a Neurologist appointment on 9/28/21 to get her checked for her seizures but CR #1 transferred to the hospital before the appointment date. LVN B said the changes happened with CR #1 over the last few days she was at the facility, but she could not recall specific dates when it started or when she notified the NP. LVN B said when she last worked CR #1's lab results had not resulted yet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	11/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/1/21 at 4:15 PM, NP A said she usually saw CR #1, but she was out on leave at the end of September when CR #1 experienced her change in condition. NP A said there were several different NP's who helped cover her service and said she was not sure who the facility could have communicated with regarding CR #1's change in condition. Interview on 11/1/21 at 5:15 PM, NP B said she recalled being contacted about CR #1 not eating and being unable to swallow any food. The staff reported CR #1 was not alert and they transferred her to the hospital. NP B denied being previously notified of any changes regarding CR #1 or giving lab orders for her. NP B said CR #1's usual NP (NP A) was out on leave and there were several different NP's who rotated to cover her service and was not sure who the facility could have spoken to. NP B said typically when she was on-call and not familiar with a resident, if a minor change of condition was reported she would order labs and if it was something acute she would always transfer to the hospital because treating in house and getting labs could take a while. Interv [TRUNCATED]