STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676045	A. BUILDING _____ B. WING _____	08/15/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRENTWOOD TERRACE HEALTHCARE AND REHABILITATION	2885 STILLHOUSE ROAD PARIS, TX 75460

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 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure care and services were provided in accordance with the written plan of care for 1 of 6 residents reviewed for following physician orders. (Resident #1) Resident #1 was admitted on [DATE] at 5:26 p.m., and was not administered his medication as ordered by the physician. This failure could place the census of 90 residents at risk for complications due to not receiving their ordered medication. Findings included: Physician orders [REDACTED].#1 was [AGE] years old and admitted [DATE] with [DIAGNOSES REDACTED]. Resident #1 was admitted to hospice services. An initial admission assessment dated [DATE] noted Resident # 1 was a total care resident. He had a [MEDICAL CONDITION] and was incontinent of urine. The assessment included he had no family, he was alert but not oriented and was thin and frail. The assessment included Resident #1's vital signs were: blood pressure 122/74, pulse 86, respirations 22, and oxygen saturation was at 91 percent. The assessment did not indicate his code status. The assessment was completed on 08/12/14 at 5:26 p.m. The assessment was completed by RN B. The August 2014 MAR indicated [REDACTED] 8:00 p.m. - [MEDICATION NAME] 10 mlligram (mg) 8:00 p.m.- [MEDICATION NAME] 20 mg 8:00 p.m. - [MEDICATION NAME] 0.25 mg 8:00 p.m.- [MEDICATION NAME] 5 mg There was no evidence Resident #1 received his medications according to his MAR. During an interview on 08/14/14 at 2:00 p.m., RN B said she documented the assessment she performed on Resident #1 at 5:26 p.m. She said she looked in on him at 9:00 p.m. but did not document it. RN B said she forgot to give Resident #1 his medication and added, I was wrong. During an interview on 08/14/14 at 9:15 a.m., the DON said Resident #1 was admitted on [DATE] on the evening shift. The DON said he was found unresponsive and LVN A did not know he was a full code. The DON said the charge nurses were responsible for placing a red or green sheet on the front of a new resident's record when the social worker was not available. She also said the charge nurses were responsible for the initial care plan and administering ordered medications. The DON said NA D failed to provide care for Resident #1 on the night shift on 08/13/14. The DON said the nurse had not checked on the new resident even though he should have been checked every two hours. The DON said CNAs checked on Resident #1; however, there was no documentation that any staff checked Resident #1 or provided any care after his initial assessment at 5:26 p.m. A resident list dated 08/15/14 provided by the administrator noted a census of 80.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services to maintain the highest practicable well-being in accordance with the comprehensive assessment and plan of care for 1 of 6 residents reviewed for code status. (Resident #1) Resident #1 was admitted to the facility on [DATE] at 5:26 p.m. An admission assessment was done at that time and no other staff assessed or provided medication or care for Resident #1 until 12:50 a.m. at which time he was unresponsive (approximately 7.5 hours later). Resident #1 was a full code and cardiopulmonary resuscitation (CPR) was not immediately initiated. When CPR was initiated, resuscitative measures were unsuccessful and Resident # 1 expired in the facility. The facility did not have a system in place to immediately determine residents' code status or to ensure temporary care plans were developed to ensure necessary care for new admissions. Resident #1 was not checked every 2 hours per protocol. Resident #1 did not receive medications as ordered. The CNAs were not made aware of necessary care to provide for new residents. This failure created an Immediate Jeopardy situation identified on [DATE] at 11:20 a.m. The Immediate Jeopardy was removed on [DATE] at 4:40 p.m. The facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place the 8 new residents who required timely and ongoing assessments as well as staff knowledge of code status at risk for not receiving necessary care or death. Findings included: Physician orders [REDACTED].#1 was [AGE] years old and admitted [DATE] with [DIAGNOSES REDACTED]. Resident #1 was admitted to the facility for hospice services. An initial admission assessment completed by RN B dated [DATE] at 5:26 p.m. noted Resident #1 was a total care resident. He had a [MEDICAL CONDITION] and was incontinent of urine. The assessment included he had no family; he was alert but not oriented and was thin and frail. Resident #1's vital signs were: blood pressure ,[DATE], pulse 86, respirations 22, and oxygen saturation was at 91 percent. The assessment did not indicate his code status. Nursing notes for Resident #1 included the following documentation: *[DATE] at 5:28 p.m., the resident was admitted with skin issues, he had three pressure areas to his back that were Stage 1, they were covered. He also had a Stage II pressure ulcer to his coccyx and a crusty skin tear that was healing on his left elbow. There was no other documentation in the nursing notes until 12:50 a.m. *[DATE] at 12:50 a.m., LVN A entered Resident #1's room to obtain his vital signs. The resident was found to be not breathing, no respirations, and no pulse. The hospice RN was notified and informed LVN A Resident #1 was a full code. CPR was then initiated and emergency medical services EMS was notified, CPR was continued until EMS arrived and took over. CPR was continued by EMS until orders were obtained from the medical director to stop CPR, Resident # 1 was pronounced dead at 1:25 a.m. The [DATE] MAR indicated [REDACTED] 8:00 p.m. - [MEDICATION NAME] 10 milligram (mg) 8:00 p.m. - [MEDICATION NAME] 20 mg 8:00 p.m. - [MEDICATION NAME] 0.25 mg 8:00 p.m. - [MEDICATION NAME] 5 mg There was no documentation Resident #1 received any of these medications. During an interview on [DATE] at 11:25 a.m. the hospice nurse said Resident #1 was admitted on [DATE] at approximately 5:30 p.m. She said she wrote physician orders [REDACTED]. She said the do not resuscitate (DNR) would be faxed the next morning to his responsible party. The hospice nurse said she got a call around 12:50 a.m. from LVN A that the resident was not breathing. The hospice nurse said she informed LVN A Resident #1 was still a full code and she responded, are you kidding me? During an interview on [DATE] at 2:00 p.m., RN B said she assessed Resident #1 on admission at 5:26 p.m. and looked in on him at 9:00 p.m., but did not document anything more at that time. She said it was understood that you check on residents every two hours. RN B said she forgot to give Resident #1's medications. She said, I was wrong. RN B said she told the oncoming shift nurse, LVN A that Resident #1 was on hospice, but was a full code. She said she did not write the information on the 24 hour report. RN B said the social worker was responsible for putting the code status information in the charts. During an interview on [DATE] at 2:05 p.m., NA D said she was assigned to Resident #1 and she worked a double shift, but did not lay eyes on Resident #1 during the 2 p.m.-10 p.m. and 10 p.m.-6 a.m. shifts on [DATE] or [DATE]. During an interview on [DATE] at 4:10 p.m., EMS E said they received a call from the facility, and upon arrival at 1:00 a.m. they found LVN A doing chest compressions. He said he and another paramedic took over the code and pronounced Resident #1 dead at 1:25 a.m. EMS E said he estimated the resident had been dead from one to three hours because he had some lividity (gravitational pooling of blood that occurs within 30 minutes of the heart stopping) and was a little stiff. During an interview on [DATE] at 5:20 p.m., LVN A said she reported to work on [DATE] at around 9:45 p.m. and was told about a new admission. She said the evening shift nurse RN B told her

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) Resident #1 was a hospice resident, but not that he was a full code. LVN A said it was understood residents should be checked on every two hours but she did not lay eyes on Resident #1 until 12:50 a.m. on [DATE] and he was not breathing. She said she ran down the hall and called the hospice nurse who informed her he was a full code. She said she had another staff call 911 while she started CPR on the resident. LVN A said EMS arrived and took over CPR without success and Resident #1 was pronounced dead on [DATE] at 1:25 a.m. During an interview on [DATE] at 9:15 a.m., the DON said Resident #1 was admitted on [DATE] on the evening shift. The DON said he was found unresponsive and LVN A did not know he was a full code. The DON said the charge nurses were responsible for placing a red or green sheet on the front of a new resident's record when the social worker was not available. She also said the charge nurses were responsible for the initial care plan and administering ordered medications. The DON said NA D failed to provide care for Resident #1 on the night shift on [DATE]. The DON said the nurse had not checked on the new resident even though he should have been checked every two hours. The DON said CNAs checked on Resident #1; however, there was no documentation that any staff checked Resident #1 after his initial assessment at 5:26 p.m. During an interview on [DATE] at 10:30 a.m., CNA C said he passed ice around 10:45 p.m. and Resident #1 was in his room in bed. He said the resident appeared asleep, was breathing slowing, and his eyes were twitching. CNA C said he did not know Resident #1's code status. He said there was no communication between nurses and CNAs regarding assistance with ADLS, code status, or anything pertaining to the resident care issues. He said he did not provide any care for Resident #1. An ADL assistance record dated [DATE] had no documentation regarding care provided for Resident #1. An undated care plan was found in Resident #1's record; however, the care plan was blank. During an interview on [DATE] at 9:12 a.m., the administrator she said she was unaware of a resident expiring in the facility on [DATE]. The administrator and DON were notified on [DATE] at 11:20 a.m. that an Immediate Jeopardy situation was identified due to the above failures. The facility's Plan of Removal (POR) was accepted on [DATE] at 3:07 p.m. and included: The POR included: 1). Role of the charge nurse on new admits regarding verifying code status and communicating to the next shift. Placing the new admit code status on the 24 hour report. Flagging the chart, shift to shift communication regarding plan of care. 2). The charge nurse each shift will be responsible for conducting a shift huddle to inform staff of after-hours admit and their current code status. 3). During regular working hours the social services director will be responsible for communication of code status of new admissions. 4). Assessing, monitoring and documenting clinical condition and status: 1. During their shift and communicating the changes to oncoming nurse. 2. Nurses will make rounds on new admits every 2 hours and/or as based on current clinical condition. 3. Clinical documentation based on resident clinical status. 4. Role of nurse during emergency and implementing immediate interventions as indicated based on resident clinical status. 5. Center conducted 100 % audit of current advance directives. All staff will be educated on code status identifier based on name color code on the door of their rooms. On [DATE] the surveyors confirmed the POR had been implemented sufficiently to remove the Immediate Jeopardy by: 8 CNAs were interviewed and said the resident's code status was going to be placed on the resident's doors using a green or red sticker. The CNAs said red means DNR and green means full code. The CNAs also said they were to check new admissions as well as other residents every two hours and more often depending on the resident's condition. They said they would report any changes to the charge nurses immediately. 8 nurses were interviewed and said they would verify code status of new residents and communicate to the next shift by using the 24 hour report. They also said they would make rounds every two hours and/or more often as based on current clinical condition. All licensed nursing personnel were in-serviced by 3:00 p.m. on [DATE]. On [DATE] at 4:40 p.m., the administrator and DON were informed the IJ was removed; however, the facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. A list dated [DATE] provided by the administrator on [DATE] noted eight residents were admitted during [DATE].
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the administrator and director of nurses (DON) failed to ensure the facility's resources were managed effectively and efficiently to attain or maintain the highest practicable physical, mental and psycho-social well-being for 1 of 6 residents reviewed for advance directives (Resident #1) The administrator and DON did not monitor and supervise care and services to ensure the following for Resident #1: *obtain and verify code status for new admissions after business hours, and communicate to staff, and *charge nurse to assess and monitor new admissions every 2 hours and document in resident's clinical record as needed. Resident #1 was admitted to the facility on [DATE] at 5:26 p.m., an admission assessment was done at that time and no other staff saw Resident # 1 until 12:50 a.m. at which time he was unresponsive (approximately 7.5 hours later). Resident #1 was a full code and cardio [MEDICAL CONDITION] resuscitation (CPR) was not immediately initiated. The facility did not have a system in place to determine residents' code status or to ensure temporary care plans were developed to ensure necessary care for new admissions. Resuscitative measures were unsuccessful and Resident #1 expired in the facility. This failure created an Immediate Jeopardy situation was identified on [DATE] at 11:20 a.m. The Immediate Jeopardy was removed on [DATE] at 4:40 p.m. The facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place the census of 8 newly admitted residents at risk of not receiving necessary care or death. Findings included: During an interview on [DATE] at 12:43 p.m. the administrator said staff should use best nursing practice to ensure residents' needs were met. The administrator said she had a system for monitoring staff to ensure competency and she monitored the DON by attending morning meetings and talking with residents. The administrator said the Immediate Jeopardy occurred because the staff failed to do their job. She said she was not aware of the situation until the following day. The administrator said she investigated and corrective measures were completed. During an interview on [DATE] at the DON said there had not been an in-service for do not resuscitate (DNR) status and when and where to post. She said she ensured nurses were competent by watching skills and performing check offs annually. The DON said the IJ occurred because LVN A did not assess Resident #1 and RN B did an admission assessment but did not communicate the resident's code status in writing. Physician orders [REDACTED].#1 was [AGE] years old and admitted [DATE] with [DIAGNOSES REDACTED]. Resident #1 was admitted to the facility for hospice services. An initial admission assessment completed by RN B dated [DATE] at 5:26 p.m. noted Resident #1 was a total care resident. He had a [MEDICAL CONDITION] and was incontinent of urine. The assessment included he had no family; he was alert but not oriented and was thin and frail. Resident #1's vital signs were: blood pressure ,[DATE], pulse 86, respirations 22, and oxygen saturation was at 91 percent. The assessment did not indicate his code status. Nursing notes for Resident #1 included the following documentation: *[DATE] at 5:28 p.m., the resident was admitted with skin issues, he had three pressure areas to his back that were Stage 1, they were covered. He also had a Stage II pressure ulcer to his coccyx and a crusty skin tear that was healing on his left elbow. There was no other documentation in the nursing notes until 12:50 a.m. *[DATE] at 12:50 a.m., LVN A entered Resident #1's room to obtain his vital signs. The resident was found to be not breathing, no respirations, and no pulse. The hospice RN was notified and informed LVN A Resident #1 was a full code. CPR was then initiated and emergency medical services EMS was notified, CPR was continued until EMS arrived and took over. CPR was continued by EMS until orders were obtained from the medical director to stop CPR, Resident # 1 was pronounced dead at 1:25 a.m. The [DATE] MAR indicated [REDACTED] 8:00 p.m. - [MEDICATION NAME] 10 milligram (mg) 8:00 p.m. - [MEDICATION NAME] 20 mg 8:00 p.m. - [MEDICATION NAME] 0.25 mg 8:00 p.m. - [MEDICATION NAME] 5 mg There was no documentation Resident #1 received any of these medications. During an interview on [DATE] at 11:25 a.m. the hospice nurse said Resident #1 was admitted on [DATE] at approximately 5:30 p.m. She said she wrote physician orders [REDACTED]. She said the do not resuscitate (DNR) would be faxed the next morning to his responsible party. The hospice nurse said she got a call around 12:50 a.m. from LVN A that the resident was not breathing. The hospice nurse said she informed LVN A Resident #1 was still a full code and she responded, are you kidding me? During an interview on [DATE] at 2:00 p.m., RN B said she assessed Resident #1 on admission at 5:26 p.m. and looked in on him at 9:00 p.m., but did not document anything more at that time. She said it was understood that you check on residents every two hours. RN B said she forgot to give Resident #1's medications. She said, I was wrong. RN B said she told the oncoming shift nurse, LVN A that Resident #1 was on hospice, but was a full code. She said she did not write the information on the 24 hour report. RN B said the social worker was responsible for putting the code status information in the charts. During an interview on [DATE] at 2:05 p.m., NA D said she was assigned to Resident #1 and she worked a double shift, but did not lay eyes on Resident #1 during the 2 p.m.-10 p.m. and 10 p.m.-6 a.m. shifts on [DATE] or [DATE]. During an interview on [DATE] at 4:10 p.m., EMS E said they received a call from the facility, and upon arrival at 1:00 a.m. they found LVN A doing chest compressions. He said he and another paramedic took over the code and pronounced Resident #1 dead at 1:25 a.m. EMS E said he estimated the

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) resident had been dead from one to three hours because he had some lividity (gravitational pooling of blood that occurs within 30 minutes of the heart stopping) and was a little stiff. During an interview on [DATE] at 5:20 p.m., LVN A said she reported to work on [DATE] at around 9:45 p.m. and was told about a new admission. She said the evening shift nurse RN B told her Resident #1 was a hospice resident, but not that he was a full code. LVN A said it was understood residents should be checked on every two hours but she did not lay eyes on Resident #1 until 12:50 a.m. on [DATE] and he was not breathing. She said she ran down the hall and called the hospice nurse who informed her he was a full code. She said she had another staff call 911 while she started CPR on the resident. LVN A said EMS arrived and took over CPR without success and Resident #1 was pronounced dead on [DATE] at 1:25 a.m. During an interview on [DATE] at 9:15 a.m., the DON said Resident #1 was admitted on [DATE] on the evening shift. The DON said he was found unresponsive and LVN A did not know he was a full code. The DON said the charge nurses were responsible for placing a red or green sheet on the front of a new resident's record when the social worker was not available. She also said the charge nurses were responsible for the initial care plan and administering ordered medications. The DON said NA D failed to provide care for Resident #1 on the night shift on [DATE]. The DON said the nurse had not checked on the new resident even though he should have been checked every two hours. The DON said CNAs checked on Resident #1; however, there was no documentation that any staff checked Resident #1 after his initial assessment at 5:26 p.m. During an interview on [DATE] at 10:30 a.m., CNA C said he passed ice around 10:45 p.m. and Resident #1 was in his room in bed. He said the resident appeared asleep, was breathing slowing, and his eyes were twitching. CNA C said he did not know Resident #1's code status. He said there was no communication between nurses and CNAs regarding assistance with ADLS, code status, or anything pertaining to the resident care issues. He said he did not provide any care for Resident #1. An ADL assistance record dated [DATE] had no documentation regarding care provided for Resident #1. An undated care plan was found in Resident #1's record; however, the care plan was blank. During an interview on [DATE] at 9:12 a.m., the administrator she said she was unaware of a resident expiring in the facility on [DATE]. The administrator and DON were notified on [DATE] at 11:20 a.m. that an Immediate Jeopardy situation was identified due to the above failures. The facility's Plan of Removal (POR) was accepted on [DATE] at 3:07 p.m. and included: The POR included: 1). Role of the charge nurse on new admits regarding verifying code status and communicating to the next shift. Placing the new admit code status on the 24 hour report. Flagging the chart, shift to shift communication regarding plan of care. 2). The charge nurse each shift will be responsible for conducting a shift huddle to inform staff of after-hours admit and their current code status. 3). During regular working hours the social services director will be responsible for communication of code status of new admissions. 4). Assessing, monitoring and documenting clinical condition and status: 1. During their shift and communicating the changes to oncoming nurse. 2. Nurses will make rounds on new admits every 2 hours and/or as based on current clinical condition. 3. Clinical documentation based on resident clinical status. 4. Role of nurse during emergency and implementing immediate interventions as indicated based on resident clinical status. 5. Center conducted 100 % audit of current advance directives. All staff will be educated on code status identifier based on name color code on the door of their rooms. On [DATE] the surveyors confirmed the POR had been implemented sufficiently to remove the Immediate Jeopardy by: 8 CNAs were interviewed and said the resident's code status was going to be placed on the resident's doors using a green or red sticker. The CNAs said red means DNR and green means full code. The CNAs also said they were to check new admissions as well as other residents every two hours and more often depending on the resident's condition. They said they would report any changes to the charge nurses immediately. 8 nurses were interviewed and said they would verify code status of new residents and communicate to the next shift by using the 24 hour report. They also said they would make rounds every two hours and/or more often as based on current clinical condition. All licensed nursing personnel were in-serviced by 3:00 p.m. on [DATE]. On [DATE] at 4:40 p.m., the administrator and DON were informed the IJ was removed; however, the facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. A list dated [DATE] provided by the administrator on [DATE] noted eight residents were admitted during [DATE].