STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675460	A. BUILDING _____ B. WING _____	07/01/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK HIGHLANDS NURSING & REHABILITATION CENTER	711 LUCAS ST ATHENS, TX 75751

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 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement their policies and procedures to prohibit neglect for 2 of 10 residents reviewed for neglect. (Residents #1 and #3) 1. Resident #1 had a significant change in his condition and experienced respiratory distress for over a week. The facility did not recognize progressive symptoms or assess Resident #1 when he had a decline in condition and experienced respiratory distress. The facility did not consult with the physician regarding the resident ' s continuous decline and of an abnormal chest x-ray. Resident #1 continued to decline and died 5 days after his condition began to deteriorate and the abnormal x-ray was obtained. 2. The facility did not: * ensure Resident #3 did not receive medications, to which she was allergic. She received 5 doses. * perform blood sugar checks as ordered by the physician. * perform neurological assessments as ordered following a fall. Resident #3 died 2 hours after the reported fall. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]; 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. This failure could place the census of 91 residents at risk for serious injury or possible death. Findings included: 1. Physician orders [REDACTED].#1, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. A care plan dated [DATE] indicated Resident #1's baseline respirations were 20 breaths a minute and oxygen saturation level was 97%. According to the website, http://www.medguidance.com/thread/Oxygen-Saturation-Levels, accessed [DATE], oxygen saturation levels, they are referring to the extent of haemoglobin that is saturated with oxygen and .normal oxygen saturation level is between 95% to 100% . Nursing notes dated [DATE] at 3:00 p.m., indicated Resident #1 wandered out the door and was found walking on a sidewalk by the facility. Resident #1 was escorted back in the building and assisted to his wheelchair. The notes indicated Resident #1 said he was walking out of the facility. Nursing notes dated [DATE] at 8:29 a.m., indicated Resident #1 ambulated down the hall and attempted to elope out the back door. He was assisted back to his wheelchair by staff. Resident #1 said he was going home. Nursing notes dated [DATE] at 4:05 a.m., indicated Resident #1's oxygen saturation level was 96% (his baseline was 97%). Nursing notes dated [DATE] at 9:22 a.m., indicated Resident #1 demanded staff to push him down the hall in his wheelchair to be let out of the facility. [MEDICATION NAME] (anti-anxiety medication) was administered to Resident #1. An oxygen saturation level log for Resident #1 indicated his oxygen saturation levels included the following: (Baseline 97%) *[DATE] - 93%, *[DATE] - 94%. The log did not indicate if the resident's respiratory status was assessed or if the physician was consulted. Nursing notes dated [DATE] at 1:45 p.m., indicated Resident #1 said he called for assistance for a long time, but nobody came to his room. He said he needed to go to the bathroom. Resident #1 was assisted back to his room and he was getting short of breath. Oxygen was placed on the resident and he received a breathing treatment with good results. Nursing notes dated [DATE] at 7:00 p.m., indicated Resident #1 was not able to support himself in a seated position. Resident #1 was becoming increasingly lethargic and agitated. He developed a productive cough and was short of breath at rest. The notes did not indicate if the nurse assessed the resident or consulted with the physician. Nursing notes dated [DATE] at 6:40 p.m., indicated Resident #1 had labored respirations, he was short of breath, and was mouth breathing. He did not eat breakfast or lunch. The notes did not indicate if the physician was consulted or if the nurse applied oxygen for respiratory support. Nursing notes dated [DATE] at 1:57 p.m., indicated Resident #1 was noted to have difficulty breathing, was coughing, and was wheezing. The notes did not indicate if the physician was consulted or if the nurse applied oxygen for respiratory support or any other intervention. Nursing notes dated [DATE] at 2:01 p.m., indicated the on call doctor was notified of Resident #1' s condition and a STAT (immediate) chest x-ray was ordered. During a telephone interview on [DATE] at 9:01 a.m., LVN A said she worked on [DATE] and was covering for LVN B (who was responsible for Resident #1) while LVN B was at lunch. She said Resident #1 was having difficulty breathing and did not look good. She said she called the on call doctor who ordered a chest x-ray. She said there was no follow up on the x-ray even though she told LVN B that she ordered the chest x-ray. LVN A said when she left on Sunday, she did not come back until the next Saturday and Resident #1 was deceased when she returned the following Saturday ([DATE]). During an interview on [DATE] at 11:30 a.m., LVN C said on [DATE], she went into Resident #1's room with LVN A. She said Resident #1 was pale and was having difficulty breathing. She said she thought he had a change of condition and that was why LVN A ordered the chest x-ray. LVN C thought Resident #1 would be sent out to the hospital for further evaluation. She said she did not know if anything else was done for Resident #1. During an interview on [DATE] at 2:57 p.m., LVN B said LVN A covered her shift while she went to lunch and ordered a chest x-ray for Resident #1. She said when she came back from lunch, LVN A told her she needed to check on Resident #1 and follow up on the chest x-ray. She said she went into Resident #1's room and he was breathing like he always did. LVN B said she did not assess Resident #1. She said normally x-ray results were faxed, but she did not receive Resident #1's chest x-ray results and she did not call the x-ray company to get the results. She said she told the oncoming nurse that the resident had a chest x-ray and wrote it on the 24 hour report for [DATE], but it was not transferred to the 24 hour report for [DATE]. A STAT (immediate) chest x-ray result dated [DATE] for Resident #1 indicated he had pneumonia in both of his lungs and the word ALERT was written across the results. During a telephone interview on [DATE] at 1:20 p.m., the on call doctor's nurse said the facility did not call the on call doctor to notify him of the x-ray results. A 24-hour report sheet dated [DATE] indicated Resident #1 received a chest x-ray and was short of breath. The [DATE] 24-hour report did not contain any other information regarding Resident #1.

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) During an interview on [DATE] at 1:30 p.m., the DON said Resident #1's physician was not notified of results of the chest x-ray. She said normal procedure would be to fax the doctor with the results, but the fax machine was not working properly on [DATE]. She said LVN B told her Resident #1 was agitated on [DATE]. She said she was not aware that Resident #1 had pneumonia. Nursing notes dated [DATE] at 11:20 a.m., indicated the NP was notified of Resident #1's declining strength and poor food intake. The NP said to make him an appointment with his primary doctor to talk about hospice. The notes did not indicate if the NP was notified of the resident's x-ray results. Nursing notes dated [DATE] at 5:52 a.m., indicated Resident #1 occasionally yelled out for help. Resident #1 became easily short of breath and had increased weakness with mobility. Nursing notes dated [DATE] at 10:55 p.m., indicated Resident #1 continued to decline. Resident #1 did not eat or drink fluids the entire day. His oxygen saturation levels were 88%-90% (his baseline was 97%). Nursing notes dated [DATE] at 5:40 a.m., indicated Resident #1 continued to decline and his skin was pale and warm. Resident #1's respirations were shallow and he was short of breath. Resident #1's oxygen saturation levels remained between 86%-90% (his baseline was 97%). He required maximum assistance of 2 staff with ADLs and mobility. Nursing notes dated [DATE] at 7:10 a.m., indicated Resident #1 was not doing good at all. Resident #1's oxygen saturation was 89% and his respirations were 32 breaths a minute, and were rapid and shallow. Resident #1 moaned a little to a sternal rub (his baseline was 20 breaths a minute and 97% oxygen saturation level). Nursing notes dated [DATE] at 9:46 a.m., indicated Resident #1 received a new order for [MEDICATION NAME] for comfort measures. Nursing notes dated [DATE] at 2:30 p.m., indicated Resident #1 was lying in bed with his eyes and mouth open, and responded to sternal rub only. Resident #1's oxygen saturation level was 91% (his baseline was 97%) and [MEDICATION NAME] was given to Resident #1 for comfort measures. An oxygen saturation level log for Resident #1 indicated his oxygen saturation levels from [DATE] through [DATE] and [DATE]-[DATE] were between 95%-98%. Nursing notes dated [DATE] at 12:20 a.m., indicated Resident #1 was grimacing and had shortness of breath with shallow respirations. Resident #1's oxygen saturation level was 78% (his baseline was 97%) and his skin was hot to touch. He had occasional apnea episodes (not breathing) [MEDICATION NAME] up to 10 seconds. [MEDICATION NAME] was administered to Resident #1 for comfort. Nursing notes dated [DATE] at 1:00 a.m., indicated Resident #1 was resting quietly with shallow respirations. Resident #1 had mottling to all 4 extremities and his skin was hot to touch. Resident #1 was unresponsive to touch or verbal stimuli. Nursing notes dated [DATE] at 1:45 a.m., indicated Resident #1 was pronounced dead by an RN. During an interview on [DATE] at 2:10 p.m., CNA D said Resident #1 had a rapid decline in the last week of his life. She said his breathing and his appearance were dramatically worse. During a telephone interview on [DATE] at 11:17 a.m., Resident #1'ss primary physician's nurse said they were not notified of Resident #1's pneumonia. She said the only communication they received about Resident #1 was a fax on [DATE] about the resident expiring. During a telephone interview on [DATE] at 12:33 p.m., the NP said she did not know Resident #1 had expired. She said the facility called her the previous week to notify her of Resident #1's decline in health, but the facility did not notify her that he had pneumonia. She said if the facility would have notified her of Resident #1's pneumonia, she would have ordered him an antibiotic. During an interview on [DATE] at 3:45 p.m., the administrator said he knew Resident #1 had pneumonia, but did not know any more details. During an interview on [DATE] at 3:50 p.m., the corporate nurse said she knew a chest x-ray was ordered for Resident #1 and the physician was not notified of the results of the chest x-ray. 2. Physician orders [REDACTED].#3, [AGE] years old, was admitted on [DATE] and was a Do Not Resuscitate status (DNR). Her [DIAGNOSES REDACTED]. The final orders also indicated she expired in the facility on [DATE]. Nursing notes dated [DATE] at 11:11 a.m., indicated Resident #3 had a reddened, open area to her left lower leg and the doctor was notified. A new order for the antibiotic [MEDICATION NAME] was received. Physician orders [REDACTED].#3 was ordered [MEDICATION NAME] (antibiotic) 300 mg to be given by mouth three times a day for a wound infection. A computerized MAR for [DATE] indicated Resident #3 was allergic to [MEDICATION NAME], fish, iodine, [MEDICATION NAME], and [MEDICATION NAME]. Nursing notes dated [DATE] at 2:00 p.m., indicated Resident #3 was ordered [MEDICATION NAME] 300 mg, three times a day. The notes indicated prior to the administration of the first oral dose of the [MEDICATION NAME], Resident #3 said intravenous [MEDICATION NAME] made her skin itch. The initial dose of [MEDICATION NAME] was given. A hand-written MAR for [DATE], that included the order for [MEDICATION NAME] 300 mg, three times a day, did not include Resident #3's allergies [REDACTED]. An incident report dated [DATE] indicated at 5:30 a.m., Resident #3 attempted to get out of bed to use the bathroom, lost her balance, and sat on the floor. The incident report indicated Resident #3 did not have any injuries; her vital signs were within normal limits. A neurological record dated [DATE] indicated 30 minute neurological checks were initiated at 6:00 a.m., Vital signs were documented as the same as the incident report. The 6:00 a.m. neurological check indicated Resident #3 was drowsy, opened her eyes to speech, and she flexed all four of her extremities abnormally. No further neurological checks were documented. A MAR for [DATE] indicated Resident #3's blood sugar was to be checked at 6:30 a.m. There was no entry for Resident #3's blood sugar on [DATE]. Nursing notes dated [DATE] at 7:15 a.m., indicated Resident #3 was lying on her bed with her eyes closed. Resident #3's lips were purple and mottling was noted to her right arm and hand. Resident #3 was unresponsive with no blood pressure and no pulse. The Abuse/Neglect Policy revised [DATE], indicated neglect was the failure to provide goods and services necessary to avoid physical harm. Facility supervisors would immediately correct and intervene in reported or identified situations in which neglect was at risk for occurring. Immediate Jeopardy was a situation in which the provider ' s non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death of a resident. The Changes in Resident Condition Policy revised [DATE], indicated the resident, the attending physician, and family member would be notified when changes in condition occurred. Communication with the interdisciplinary team and caregivers was also important to ensure that consistency and continuity were maintained. Changes in condition were communicated from shift to shift though the 24 hour report. The administrator was notified on [DATE] at 4:19 p.m., an Immediate Jeopardy situation was identified due to the above failures. The facility's revised Plan of Removal was accepted on [DATE] at 7:18 p.m. and included: 1. Nurses will be re-educated on MD/Family notification of change in resident condition. 2. Nurses will be re-educated on documentation in resident charts on changes in condition. 3. Nurses will be re-educated on resident assessments as it relates to changes in condition. 4. Nurses will be re-educated to notify physician by telephone when receiving abnormal diagnostic results, and documenting response in medical record, and follow-through with orders when indicated. 5. Nursing administrative staff will review resident charts to ensure previously ordered diagnostic tests have been followed-through with MD notification. 6.Nurses will be re-educated on process of ordering diagnostic testing to included orders, MD & family notification, documentation, and following-up with results or inability to obtain testing. 7. Educate nurses on physical assessments. 8. Educate nurses to follow-up at beginning of shift on all pending diagnostic tests from pervious shift, and calling if they haven ' t received results. Target completion date will be ,[DATE]/ or prior to the start of the next scheduled shift. (sic)

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 2) On [DATE] the surveyors confirmed the POR was implemented sufficiently to remove the Immediate Jeopardy by: Two RNs, 3 LVNs, and 1 LVN (ADON) were in-serviced on MD/family notification of change in resident condition, documentation in resident charts and change in condition, resident assessments, notifying physicians by phone of abnormal diagnostic results, and following up on results. Ten residents' charts were reviewed for ordered, pending diagnostic testing, and MD notification of results. All were correct and complete. On [DATE] at 2:20 p.m., the administrator, corporate nurse, DON, and ADON were informed the Immediate Jeopardy 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. The resident roster dated [DATE] indicated there were 91 residents in the facility.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement their written policies and procedures to prohibit neglect for 2 of10 residents reviewed for neglect. (Residents #1 and #3) 1. Resident #1 had a significant change in his condition and experienced respiratory distress for over a week. The facility did not recognize progressive symptoms or assess Resident #1 when he had a decline in condition and experienced respiratory distress. The facility did not consult with the physician regarding the resident ' s continuous decline and of an abnormal chest x-ray. Resident #1 continued to decline and died 5 days after his condition began to deteriorate and the abnormal x-ray was obtained. 2. The facility did not: * ensure Resident #3 did not receive medications, to which she was allergic. She received 5 doses. * perform blood sugar checks as ordered by the physician. * perform neurological assessments as ordered following a fall. Resident #3 died 2 hours after the reported fall. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]; 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. This failure could place the census of 91 residents at risk for serious injury or possible death. Findings included: The Abuse/Neglect Policy revised [DATE], indicated neglect was the failure to provide goods and services necessary to avoid physical harm. Facility supervisors would immediately correct and intervene in reported or identified situations in which neglect was at risk for occurring. Immediate Jeopardy was a situation in which the provider ' s non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death of a resident. 1. Physician orders [REDACTED].#1, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. A care plan dated [DATE] indicated Resident #1's baseline respirations were 20 breaths a minute and oxygen saturation level was 97%. According to the website, http://www.medguidance.com/thread/Oxygen-Saturation-Levels, accessed [DATE], oxygen saturation levels, they are referring to the extent of haemoglobin that is saturated with oxygen and .normal oxygen saturation level is between 95% to 100% . Nursing notes dated [DATE] at 3:00 p.m., indicated Resident #1 wandered out the door and was found walking on a sidewalk by the facility. Resident #1 was escorted back in the building and assisted to his wheelchair. The notes indicated Resident #1 said he was walking out of the facility. Nursing notes dated [DATE] at 8:29 a.m., indicated Resident #1 ambulated down the hall and attempted to elope out the back door. He was assisted back to his wheelchair by staff. Resident #1 said he was going home. Nursing notes dated [DATE] at 4:05 a.m., indicated Resident #1's oxygen saturation level was 96% (his baseline was 97%). Nursing notes dated [DATE] at 9:22 a.m., indicated Resident #1 demanded staff to push him down the hall in his wheelchair to be let out of the facility. [MEDICATION NAME] (anti-anxiety medication) was administered to Resident #1. An oxygen saturation level log for Resident #1 indicated his oxygen saturation levels included the following: (Baseline 97%) *[DATE] - 93%, *[DATE] - 94%. The log did not indicate if the resident's respiratory status was assessed or if the physician was consulted. Nursing notes dated [DATE] at 1:45 p.m., indicated Resident #1 said he called for assistance for a long time, but nobody came to his room. He said he needed to go to the bathroom. Resident #1 was assisted back to his room and he was getting short of breath. Oxygen was placed on the resident and he received a breathing treatment with good results. Nursing notes dated [DATE] at 7:00 p.m., indicated Resident #1 was not able to support himself in a seated position. Resident #1 was becoming increasingly lethargic and agitated. He developed a productive cough and was short of breath at rest. The notes did not indicate if the nurse assessed the resident or consulted with the physician. Nursing notes dated [DATE] at 6:40 p.m., indicated Resident #1 had labored respirations, he was short of breath, and was mouth breathing. He did not eat breakfast or lunch. The notes did not indicate if the physician was consulted or if the nurse applied oxygen for respiratory support. Nursing notes dated [DATE] at 1:57 p.m., indicated Resident #1 was noted to have difficulty breathing, was coughing, and was wheezing. The notes did not indicate if the physician was consulted or if the nurse applied oxygen for respiratory support or any other intervention. Nursing notes dated [DATE] at 2:01 p.m., indicated the on call doctor was notified of Resident #1's condition and a STAT (immediate) chest x-ray was ordered. During a telephone interview on [DATE] at 9:01 a.m., LVN A said she worked on [DATE] and was covering for LVN B (who was responsible for Resident #1) while LVN B was at lunch. She said Resident #1 was having difficulty breathing and did not look good. She said she called the on call doctor who ordered a chest x-ray. She said there was no follow up on the x-ray even though she told LVN B that she ordered the chest x-ray. LVN A said when she left on Sunday, she did not come back until the next Saturday and Resident #1 was deceased when she returned the following Saturday ([DATE]). During an interview on [DATE] at 11:30 a.m., LVN C said on [DATE], she went into Resident #1's room with LVN A. She said Resident #1 was pale and was having difficulty breathing. She said she thought he had a change of condition and that was why LVN A ordered the chest x-ray. LVN C thought Resident #1 would be sent out to the hospital for further evaluation. She said she did not know if anything else was done for Resident #1. During an interview on [DATE] at 2:57 p.m., LVN B said LVN A covered her shift while she went to lunch and ordered a chest x-ray for Resident #1. She said when she came back from lunch, LVN A told her she needed to check on Resident #1 and follow up on the chest x-ray. She said she went into Resident #1's room and he was breathing like he always did. LVN B said she did not assess Resident #1. She said normally x-ray results were faxed, but she did not receive Resident #1's chest x-ray results and she did not call the x-ray company to get the results. She said she told the oncoming nurse that the resident had a chest x-ray and wrote it on the 24 hour report for [DATE], but it was not transferred to the 24 hour report for [DATE]. A STAT (immediate) chest x-ray result dated [DATE] for Resident #1 indicated he had pneumonia in both of his lungs and the word ALERT was written across the results. During a telephone interview on [DATE] at 1:20 p.m., the on call doctor's nurse said the facility did not call the on call doctor to notify him of the x-ray results. A 24-hour report sheet dated [DATE] indicated Resident #1 received a chest x-ray and was short of breath. The [DATE] 24-hour report did not contain any other information regarding Resident #1. During an interview on [DATE] at 1:30 p.m., the DON said Resident #1's physician was not notified of results of the chest x-ray. She said normal procedure would be to fax the doctor with the results, but the fax machine was not working properly

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) on [DATE]. She said LVN B told her Resident #1 was agitated on [DATE]. She said she was not aware that Resident #1 had pneumonia. Nursing notes dated [DATE] at 11:20 a.m., indicated the NP was notified of Resident #1's declining strength and poor food intake. The NP said to make him an appointment with his primary doctor to talk about hospice. The notes did not indicate if the NP was notified of the resident's x-ray results. Nursing notes dated [DATE] at 5:52 a.m., indicated Resident #1 occasionally yelled out for help. Resident #1 became easily short of breath and had increased weakness with mobility. Nursing notes dated [DATE] at 10:55 p.m., indicated Resident #1 continued to decline. Resident #1 did not eat or drink fluids the entire day. His oxygen saturation levels were 88%-90% (his baseline was 97%). Nursing notes dated [DATE] at 5:40 a.m., indicated Resident #1 continued to decline and his skin was pale and warm. Resident #1's respirations were shallow and he was short of breath. Resident #1's oxygen saturation levels remained between 86%-90% (his baseline was 97%). He required maximum assistance of 2 staff with ADLs and mobility. Nursing notes dated [DATE] at 7:10 a.m., indicated Resident #1 was not doing good at all. Resident #1's oxygen saturation was 89% and his respirations were 32 breaths a minute, and were rapid and shallow. Resident #1 moaned a little to a sternal rub (his baseline was 20 breaths a minute and 97% oxygen saturation level). Nursing notes dated [DATE] at 9:46 a.m., indicated Resident #1 received a new order for [MEDICATION NAME] for comfort measures. Nursing notes dated [DATE] at 2:30 p.m., indicated Resident #1 was lying in bed with his eyes and mouth open, and responded to sternal rub only. Resident #1's oxygen saturation level was 91% (his baseline was 97%) and [MEDICATION NAME] was given to Resident #1 for comfort measures. An oxygen saturation level log for Resident #1 indicated his oxygen saturation levels from [DATE] through [DATE] and [DATE]-[DATE] were between 95%-98%. Nursing notes dated [DATE] at 12:20 a.m., indicated Resident #1 was grimacing and had shortness of breath with shallow respirations. Resident #1's oxygen saturation level was 78% (his baseline was 97%) and his skin was hot to touch. He had occasional apnea episodes (not breathing) [MEDICATION NAME] up to 10 seconds. [MEDICATION NAME] was administered to Resident #1 for comfort. Nursing notes dated [DATE] at 1:00 a.m., indicated Resident #1 was resting quietly with shallow respirations. Resident #1 had mottling to all 4 extremities and his skin was hot to touch. Resident #1 was unresponsive to touch or verbal stimuli. Nursing notes dated [DATE] at 1:45 a.m., indicated Resident #1 was pronounced dead by an RN. During an interview on [DATE] at 2:10 p.m., CNA D said Resident #1 had a rapid decline in the last week of his life. She said his breathing and his appearance were dramatically worse. During a telephone interview on [DATE] at 11:17 a.m., Resident #1's primary physician's nurse said they were not notified of Resident #1's pneumonia. She said the only communication they received about Resident #1 was a fax on [DATE] about the resident expiring. During a telephone interview on [DATE] at 12:33 p.m., the NP said she did not know Resident #1 had expired. She said the facility called her the previous week to notify her of Resident #1's decline in health, but the facility did not notify her that he had pneumonia. She said if the facility would have notified her of Resident #1's pneumonia, she would have ordered him an antibiotic. During an interview on [DATE] at 3:45 p.m., the administrator said he knew Resident #1 had pneumonia, but did not know any more details. During an interview on [DATE] at 3:50 p.m., the corporate nurse said she knew a chest x-ray was ordered for Resident #1 and the physician was not notified of the results of the chest x-ray. 2. Physician orders [REDACTED].#3, [AGE] years old, was admitted on [DATE] and was a Do Not Resuscitate status (DNR). Her [DIAGNOSES REDACTED]. The final orders also indicated she expired in the facility on [DATE]. Nursing notes dated [DATE] at 11:11 a.m., indicated Resident #3 had a reddened, open area to her left lower leg and the doctor was notified. A new order for the antibiotic [MEDICATION NAME] was received. Physician orders [REDACTED].#3 was ordered [MEDICATION NAME] (antibiotic) 300 mg to be given by mouth three times a day for a wound infection. A computerized MAR for [DATE] indicated Resident #3 was allergic to [MEDICATION NAME], fish, iodine, [MEDICATION NAME], and [MEDICATION NAME]. Nursing notes dated [DATE] at 2:00 p.m., indicated Resident #3 was ordered [MEDICATION NAME] 300 mg, orally three times a day. The notes indicated prior to administration of the [MEDICATION NAME], Resident #3 said intravenous [MEDICATION NAME] made her skin itch. The initial dose of [MEDICATION NAME] was given. A hand-written MAR for [DATE], that included the order for [MEDICATION NAME] 300 mg, three times a day, did not include Resident #3's allergies [REDACTED]. An incident report dated [DATE] indicated at 5:30 a.m., Resident #3 attempted to get out of bed to use the bathroom, lost her balance, and sat on the floor. The incident report indicated Resident #3 did not have any injuries; her vital signs were within normal limits. A neurological record dated [DATE] indicated 30 minute neurological checks were initiated at 6:00 a.m., Vital signs were documented as the same as the incident report. The 6:00 a.m. neurological check indicated Resident #3 was drowsy, opened her eyes to speech, and she flexed all four of her extremities abnormally. No further neurological checks were documented. A MAR for [DATE] indicated Resident #3's blood sugar was to be checked at 6:30 a.m. There was no entry for Resident #3's blood sugar on [DATE]. Nursing notes dated [DATE] at 7:15 a.m., indicated Resident #3 was lying on her bed with her eyes closed. Resident #3's lips were purple and mottling was noted to her right arm and hand. Resident #3 was unresponsive with no blood pressure and no pulse. The Changes in Resident Condition Policy revised [DATE], indicated the resident, the attending physician, and family member would be notified when changes in condition occurred. Communication with the interdisciplinary team and caregivers was also important to ensure that consistency and continuity were maintained. Changes in condition were communicated from shift to shift though the 24 hour report. The administrator was notified on [DATE] at 4:19 p.m., an Immediate Jeopardy situation was identified due to the above failures. The facility's revised Plan of Removal was accepted on [DATE] at 7:18 p.m. and included: 1. Nurses will be re-educated on MD/Family notification of change in resident condition. 2. Nurses will be re-educated on documentation in resident charts on changes in condition. 3. Nurses will be re-educated on resident assessments as it relates to changes in condition. 4. Nurses will be re-educated to notify physician by telephone when receiving abnormal diagnostic results, and documenting response in medical record, and follow-through with orders when indicated. 5. Nursing administrative staff will review resident charts to ensure previously ordered diagnostic tests have been followed-through with MD notification. 6.Nurses will be re-educated on process of ordering diagnostic testing to included orders, MD & family notification, documentation, and following-up with results or inability to obtain testing. 7. Educate nurses on physical assessments. 8. Educate nurses to follow-up at beginning of shift on all pending diagnostic tests from pervious shift, and calling if they haven ' t received results. Target completion date will be ,[DATE]/ or prior to the start of the next scheduled shift. (sic) On [DATE] the surveyors confirmed the POR was implemented sufficiently to remove the Immediate Jeopardy by: Two RNs, 3 LVNs, and 1 LVN (ADON) were in-serviced on MD/family notification of change in resident condition, documentation in resident charts and change in condition, resident assessments, notifying physicians by phone of abnormal diagnostic results, and following up on results. Ten residents' charts were reviewed for ordered, pending diagnostic testing, and MD notification of results. All were correct and complete. On [DATE] at 2:20 p.m., the administrator, corporate nurse, DON, and ADON were informed the Immediate Jeopardy was removed;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675460	A. BUILDING _____ B. WING _____	07/01/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK HIGHLANDS NURSING & REHABILITATION CENTER	711 LUCAS ST ATHENS, TX 75751

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 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 4) 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. The resident roster dated [DATE] indicated there were 91 residents in the facility.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**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 care and services in accordance with the comprehensive assessment to maintain the highest practicable well-being for 2 of 10 residents reviewed for assessments. Residents #1 and #3) 1. Resident #1 had a significant change in his condition and experienced respiratory distress for over a week. The facility did not recognize progressive symptoms or assess Resident #1 when he had a decline in condition and experienced respiratory distress. The facility did not consult with the physician regarding the resident ' s continuous decline and of an abnormal chest x-ray. Resident #1 continued to decline and died 5 days after his condition began to deteriorate and the abnormal x-ray was obtained. 2. The facility did not: * ensure Resident #3 did not receive medications, to which she was allergic. She received 5 doses. * perform blood sugar checks as ordered by the physician. * perform neurological assessments as ordered following a fall. Resident #3 died 2 hours after the reported fall. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]; 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. This failure could place the census of 91 residents at risk for serious injury or possible death. Findings included: 1. Physician orders [REDACTED].#1, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. A care plan dated [DATE] indicated Resident #1's baseline respirations were 20 breaths a minute and oxygen saturation level was 97%. According to the website, http://www.medguidance.com/thread/Oxygen-Saturation-Levels, accessed [DATE], oxygen saturation levels, they are referring to the extent of haemoglobin that is saturated with oxygen and .normal oxygen saturation level is between 95% to 100% . Nursing notes dated [DATE] at 3:00 p.m., indicated Resident #1 wandered out the door and was found walking on a sidewalk by the facility. Resident #1 was escorted back in the building and assisted to his wheelchair. The notes indicated Resident #1 said he was walking out of the facility. Nursing notes dated [DATE] at 8:29 a.m., indicated Resident #1 ambulated down the hall and attempted to elope out the back door. He was assisted back to his wheelchair by staff. Resident #1 said he was going home. Nursing notes dated [DATE] at 4:05 a.m., indicated Resident #1's oxygen saturation level was 96% (his baseline was 97%). Nursing notes dated [DATE] at 9:22 a.m., indicated Resident #1 demanded staff to push him down the hall in his wheelchair to be let out of the facility. [MEDICATION NAME] (anti-anxiety medication) was administered to Resident #1. An oxygen saturation level log for Resident #1 indicated his oxygen saturation levels included the following: (Baseline 97%) *[DATE] - 93%, *[DATE] - 94%. The log did not indicate if the resident's respiratory status was assessed or if the physician was consulted. Nursing notes dated [DATE] at 1:45 p.m., indicated Resident #1 said he called for assistance for a long time, but nobody came to his room. He said he needed to go to the bathroom. Resident #1 was assisted back to his room and he was getting short of breath. Oxygen was placed on the resident and he received a breathing treatment with good results. Nursing notes dated [DATE] at 7:00 p.m., indicated Resident #1 was not able to support himself in a seated position. Resident #1 was becoming increasingly lethargic and agitated. He developed a productive cough and was short of breath at rest. The notes did not indicate if the nurse assessed the resident or consulted with the physician. Nursing notes dated [DATE] at 6:40 p.m., indicated Resident #1 had labored respirations, he was short of breath, and was mouth breathing. He did not eat breakfast or lunch. The notes did not indicate if the physician was consulted or if the nurse applied oxygen for respiratory support. Nursing notes dated [DATE] at 1:57 p.m., indicated Resident #1 was noted to have difficulty breathing, was coughing, and was wheezing. The notes did not indicate if the physician was consulted or if the nurse applied oxygen for respiratory support or any other intervention. Nursing notes dated [DATE] at 2:01 p.m., indicated the on call doctor was notified of Resident #1's condition and a STAT (immediate) chest x-ray was ordered. During a telephone interview on [DATE] at 9:01 a.m., LVN A said she worked on [DATE] and was covering for LVN B (who was responsible for Resident #1) while LVN B was at lunch. She said Resident #1 was having difficulty breathing and did not look good. She said she called the on call doctor who ordered a chest x-ray. She said there was no follow up on the x-ray even though she told LVN B that she ordered the chest x-ray. LVN A said when she left on Sunday, she did not come back until the next Saturday and Resident #1 was deceased when she returned the following Saturday ([DATE]). During an interview on [DATE] at 11:30 a.m., LVN C said on [DATE], she went into Resident #1's room with LVN A. She said Resident #1 was pale and was having difficulty breathing. She said she thought he had a change of condition and that was why LVN A ordered the chest x-ray. LVN C thought Resident #1 would be sent out to the hospital for further evaluation. She said she did not know if anything else was done for Resident #1. During an interview on [DATE] at 2:57 p.m., LVN B said LVN A covered her shift while she went to lunch and ordered a chest x-ray for Resident #1. She said when she came back from lunch, LVN A told her she needed to check on Resident #1 and follow up on the chest x-ray. She said she went into Resident #1's room and he was breathing like he always did. LVN B said she did not assess Resident #1. She said normally x-ray results were faxed, but she did not receive Resident #1's chest x-ray results and she did not call the x-ray company to get the results. She said she told the oncoming nurse that the resident had a chest x-ray and wrote it on the 24 hour report for [DATE], but it was not transferred to the 24 hour report for [DATE]. A STAT (immediate) chest x-ray result dated [DATE] for Resident #1 indicated he had pneumonia in both of his lungs and the word ALERT was written across the results. During a telephone interview on [DATE] at 1:20 p.m., the on call doctor's nurse said the facility did not call the on call doctor to notify him of the x-ray results. A 24-hour report sheet dated [DATE] indicated Resident #1 received a chest x-ray and was short of breath. The [DATE] 24-hour report did not contain any other information regarding Resident #1. During an interview on [DATE] at 1:30 p.m., the DON said Resident #1's physician was not notified of results of the chest x-ray. She said normal procedure would be to fax the doctor with the results, but the fax machine was not working properly on [DATE]. She said LVN B told her Resident #1 was agitated on [DATE]. She said she was not aware that Resident #1 had pneumonia. Nursing notes dated [DATE] at 11:20 a.m., indicated the NP was notified of Resident #1' s declining strength and poor food intake. The NP said to make him an appointment with his primary doctor to talk about hospice. The notes did not indicate if the NP was notified of the resident's x-ray results. Nursing notes dated [DATE] at 5:52 a.m., indicated Resident #1 occasionally yelled out for help. Resident #1 became easily short of breath and had increased weakness with mobility. Nursing notes dated [DATE] at 10:55 p.m., indicated Resident #1 continued to decline. Resident #1 did not eat or drink fluids the entire day. His oxygen saturation levels were 88%-90% (his baseline was 97%). Nursing notes dated [DATE] at 5:40 a.m., indicated Resident #1 continued to decline and his skin was pale and warm. Resident #1's respirations were shallow and he was short of breath. Resident #1's oxygen saturation levels remained between 86%-90% (his baseline was 97%). He required maximum assistance of 2 staff with ADLs and mobility. Nursing notes dated [DATE] at 7:10 a.m., indicated Resident #1 was not doing good at all. Resident #1's oxygen saturation was 89% and his respirations were 32 breaths a minute, and were rapid and shallow. Resident #1 moaned a little to a sternal

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	675460	A. BUILDING _____ B. WING _____	07/01/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK HIGHLANDS NURSING & REHABILITATION CENTER	711 LUCAS ST ATHENS, TX 75751

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 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 5) rub (his baseline was 20 breaths a minute and 97% oxygen saturation level). Nursing notes dated [DATE] at 9:46 a.m., indicated Resident #1 received a new order for [MEDICATION NAME] for comfort measures. Nursing notes dated [DATE] at 2:30 p.m., indicated Resident #1 was lying in bed with his eyes and mouth open, and responded to sternal rub only. Resident #1's oxygen saturation level was 91% (his baseline was 97%) and [MEDICATION NAME] was given to Resident #1 for comfort measures. An oxygen saturation level log for Resident #1 indicated his oxygen saturation levels from [DATE] through [DATE] and [DATE]-[DATE] were between 95%-98%. Nursing notes dated [DATE] at 12:20 a.m., indicated Resident #1 was grimacing and had shortness of breath with shallow respirations. Resident #1's oxygen saturation level was 78% (his baseline was 97%) and his skin was hot to touch. He had occasional apnea episodes (not breathing) [MEDICATION NAME] up to 10 seconds. [MEDICATION NAME] was administered to Resident #1 for comfort. Nursing notes dated [DATE] at 1:00 a.m., indicated Resident #1 was resting quietly with shallow respirations. Resident #1 had mottling to all 4 extremities and his skin was hot to touch. Resident #1 was unresponsive to touch or verbal stimuli. Nursing notes dated [DATE] at 1:45 a.m., indicated Resident #1 was pronounced dead by an RN. During an interview on [DATE] at 2:10 p.m., CNA D said Resident #1 had a rapid decline in the last week of his life. She said his breathing and his appearance were dramatically worse. During a telephone interview on [DATE] at 11:17 a.m., Resident #1 's primary physician's nurse said they were not notified of Resident #1's pneumonia. She said the only communication they received about Resident #1 was a fax on [DATE] about the resident expiring. During a telephone interview on [DATE] at 12:33 p.m., the NP said she did not know Resident #1 had expired. She said the facility called her the previous week to notify her of Resident #1's decline in health, but the facility did not notify her that he had pneumonia. She said if the facility would have notified her of Resident #1's pneumonia, she would have ordered him an antibiotic. During an interview on [DATE] at 3:45 p.m., the administrator said he knew Resident #1 had pneumonia, but did not know any more details. During an interview on [DATE] at 3:50 p.m., the corporate nurse said she knew a chest x-ray was ordered for Resident #1 and the physician was not notified of the results of the chest x-ray. 2. Physician orders [REDACTED].#3, [AGE] years old, was admitted on [DATE] and was a Do Not Resuscitate status (DNR). Her [DIAGNOSES REDACTED]. The final orders also indicated she expired in the facility on [DATE]. Nursing notes dated [DATE] at 11:11 a.m., indicated Resident #3 had a reddened, open area to her left lower leg and the doctor was notified. A new order for the antibiotic [MEDICATION NAME] was received. Physician orders [REDACTED].#3 was ordered [MEDICATION NAME] (antibiotic) 300 mg to be given by mouth three times a day for a wound infection. A computerized MAR for [DATE] indicated Resident #3 was allergic to [MEDICATION NAME], fish, iodine, [MEDICATION NAME], and [MEDICATION NAME]. Nursing notes dated [DATE] at 2:00 p.m., indicated Resident #3 was ordered [MEDICATION NAME] 300 mg, orally three times a day. The notes indicated prior to the administration of [MEDICATION NAME], Resident #3 said intravenous [MEDICATION NAME] made her skin itch. The initial dose of [MEDICATION NAME] was given. A hand-written MAR for [DATE], that included the order for [MEDICATION NAME] 300 mg, three times a day, did not include Resident #3's allergies [REDACTED]. An incident report dated [DATE] indicated at 5:30 a.m., Resident #3 attempted to get out of bed to use the bathroom, lost her balance, and sat on the floor. The incident report indicated Resident #3 did not have any injuries; her vital signs were within normal limits. A neurological record dated [DATE] indicated 30 minute neurological checks were initiated at 6:00 a.m., Vital signs were documented as the same as the incident report. The 6:00 a.m. neurological check indicated Resident #3 was drowsy, opened her eyes to speech, and she flexed all four of her extremities abnormally. No further neurological checks were documented. A MAR for [DATE] indicated Resident #3's blood sugar was to be checked at 6:30 a.m. There was no entry for Resident #3's blood sugar on [DATE]. Nursing notes dated [DATE] at 7:15 a.m., indicated Resident #3 was lying on her bed with her eyes closed. Resident #3 ' s lips were purple and mottling was noted to her right arm and hand. Resident #3 was unresponsive with no blood pressure and no pulse. The Changes in Resident Condition Policy revised [DATE], indicated the resident, the attending physician, and family member would be notified when changes in condition occurred. Communication with the interdisciplinary team and caregivers was also important to ensure that consistency and continuity were maintained. Changes in condition were communicated from shift to shift though the 24 hour report. The administrator was notified on [DATE] at 4:19 p.m., an Immediate Jeopardy situation was identified due to the above failures. The facility's revised Plan of Removal was accepted on [DATE] at 7:18 p.m. and included: 1. Nurses will be re-educated on MD/Family notification of change in resident condition. 2. Nurses will be re-educated on documentation in resident charts on changes in condition. 3. Nurses will be re-educated on resident assessments as it relates to changes in condition. 4. Nurses will be re-educated to notify physician by telephone when receiving abnormal diagnostic results, and documenting response in medical record, and follow-through with orders when indicated. 5. Nursing administrative staff will review resident charts to ensure previously ordered diagnostic tests have been followed-through with MD notification. 6.Nurses will be re-educated on process of ordering diagnostic testing to included orders, MD & family notification, documentation, and following-up with results or inability to obtain testing. 7. Educate nurses on physical assessments. 8. Educate nurses to follow-up at beginning of shift on all pending diagnostic tests from pervious shift, and calling if they haven ' t received results. Target completion date will be ,[DATE]/ or prior to the start of the next scheduled shift. (sic) On [DATE] the surveyors confirmed the POR was implemented sufficiently to remove the Immediate Jeopardy by: Two RNs, 3 LVNs, and 1 LVN (ADON) were in-serviced on MD/family notification of change in resident condition, documentation in resident charts and change in condition, resident assessments, notifying physicians by phone of abnormal diagnostic results, and following up on results. Ten residents' charts were reviewed for ordered, pending diagnostic testing, and MD notification of results. All were correct and complete. On [DATE] at 2:20 p.m., the administrator, corporate nurse, DON, and ADON were informed the Immediate Jeopardy 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. The resident roster dated [DATE] indicated there were 91 residents in the facility.
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the drug regimen was free from unnecessary medications for 2 of 10 residents reviewed for [MEDICAL CONDITION] medications. (Resident #1 and #5) 1. Resident #1 received [MEDICATION NAME] 25 mg (atypical antipsychotic medication) and [MEDICATION NAME] sprinkles 250 mg (antipsychotic used to treat [MEDICAL CONDITION] and [MEDICAL CONDITION]). 2. Resident #5 received [MEDICATION NAME] sprinkles 250 mg (antipsychotic used to treat [MEDICAL CONDITION] and [MEDICAL

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	675460	A. BUILDING _____ B. WING _____	**07/01/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK HIGHLANDS NURSING & REHABILITATION CENTER	**711 LUCAS ST ATHENS, TX 75751**

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 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) CONDITION]) and [MEDICATION NAME] 30 mg (hypnotic used to treat [MEDICAL CONDITION]). The facility did not ensure Resident #1 and #5 had adequate indications for the antipsychotic and hypnotic medication use and did not monitor the resident's behavior while receiving the antipsychotic and hypnotic medications. This failure could place 15 residents who received antipsychotic medications at risk for over sedation, weight loss, and decreased quality of life. Findings included: 1. Physician orders [REDACTED].#1 was [AGE] years old, admitted on [DATE], with diagnoses included dementia, [MEDICAL CONDITION], cognitive communication deficit, and history of falling. On [DATE] Resident #1 received new orders for [MEDICATION NAME] 25 mg at bedtime for dementia and [MEDICATION NAME] sprinkles 125 mg twice a day for behaviors. On [DATE] Resident #1 received a new order to increase [MEDICATION NAME] sprinkles to 250 mg twice a day. The orders indicated the resident expired in the facility on [DATE]. A PASRR Level 1 Screening dated [DATE] indicated Resident #1 showed no evidence of mental illness. A psychotherapy progress note dated [DATE] indicated Resident #1 was anxious and sad. The note indicated it was reported by staff that Resident #1 wandered and was irritable with staff and other residents. The most recent care plan dated [DATE] indicated Resident #1 did not indicate Resident #1 received [MEDICAL CONDITION] medications. A psychological assessment dated [DATE] indicated Resident #1 had abnormal sleep patterns, anxiety, dementia, confusion, restlessness, and wandering. There were no diagnoses of [MEDICAL CONDITION] or [MEDICAL CONDITION]. During an interview on [DATE] at 12:37 p.m., RN E said Resident #1's medications were increased on [DATE] because he became more agitated and more anxious. She said his [MEDICATION NAME] sprinkles were increased from 125 mg twice a day to 250 mg twice a day. A MAR for [DATE], indicated Resident #1 received [MEDICATION NAME] nightly from [DATE] to [DATE]. He received [MEDICATION NAME] sprinkles 125 mg twice a day from [DATE] to [DATE]. He received [MEDICATION NAME] sprinkles 250 twice a day from [DATE] to [DATE]. Resident #1 received [MEDICATION NAME] 0.5 mg on [DATE], [DATE], [DATE], [DATE], [DATE], twice on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], twice on [DATE], and [DATE]. Nursing notes dated [DATE] at 10:15 p.m., indicated Resident #1 received [MEDICATION NAME] 25 mg and [MEDICATION NAME] 0.5 mg (anti-anxiety medication) for restlessness and anxiety due to propelling himself around the facility and asking staff to turn on the lights in the hall, straighten his bed, and the time. The notes indicate Resident #1 repeatedly called out nurse. Resident #1 allowed staff to help him to bed approximately 1 hour after medications were given. 2.Physician orders [REDACTED].#5 was [AGE] years old and admitted on [DATE]. His diagnoses included dementia and anxiety. Resident #5 received an order for [REDACTED].#5 received an order for [REDACTED]. A MAR indicated [REDACTED]. Resident #5 received [MEDICATION NAME] sprinkles 500 mg nightly on [DATE], [DATE], and [DATE]. Resident #5 received [MEDICATION NAME] 30 mg on [DATE] and [DATE]. According to the Food and Drug Administration (www.fda.gov <http://www.fda.gov>), accessed [DATE], [MEDICATION NAME] was used to treat [MEDICAL CONDITION] and [MEDICAL CONDITION] disorder. [MEDICATION NAME] sprinkles were used to treat [MEDICAL CONDITION] disorder and [MEDICAL CONDITION]. [MEDICATION NAME] was used to treat [MEDICAL CONDITION] and can lead to dependence. According to the National Alliance for Mental Illness (www.nami.org <http://www.nami.org>), accessed [DATE], both first generation (typical) and second generation (atypical) antipsychotics were associated with an increased risk of mortality in elderly patients when used for dementia related [MEDICAL CONDITION]. Although there were multiple causes of death in studies, most deaths appeared to be due to cardiovascular causes (e.g. sudden cardiac death) or infection (e.g. pneumonia). Antipsychotics were not indicated for the treatment of [REDACTED]. The CMS 672 dated [DATE] indicated 15 residents received antipsychotic medications.

F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient staff to provide nursing and related services maintain the highest practical physical, mental and psychosocial well-being for 3 of 10 residents reviewed for care and services. (Resident #2, #4, and #5) The facility did not provide sufficient staff on the secure unit to ensure the residents were safe and care was provided. 1. Resident #2 made attempts to leave the facility, 2. Resident #s 2 and 5 had a physical altercation, and 3. Resident #4 was left in bed unattended. These failures could place 18 residents who resided on the secure unit at risk of not receiving care and services to meet their needs and increased risk of injury. Findings included: 1. Physician orders [REDACTED].#2 was [AGE] years old and admitted on [DATE]. His [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #2 sometimes understood others and usually made his needs known. He required extensive assistance with personal hygiene and limited assistance with eating and dressing. He exhibited inattention and disorganized thinking. A care plan dated 06/23/16 indicated Resident #2 was at risk for injury related to his wandering and could make attempts to leave the facility. He was at risk for falls and required frequent monitoring. An incident report dated 05/11/16 indicated Resident #2 had an unwitnessed fall, hitting his side and arm on the window seal. He received a skin tear to his right forearm. X-rays were ordered and results were negative. Nursing notes dated 05/11/16 at 11:37 a.m., indicated staff heard a loud noise and found Resident #2 in his room holding his right side. Resident #2 said when he stood up; he slipped and hit his arm and ribs on the window seal. Nursing notes dated 05/19/16 at 2:32 p.m., indicated Resident #2 was pacing the hallways and said he would leave as soon as the doors opened or when someone came through the door. Resident #2 stood in front of the door waiting for the door to open. Resident #2 was unable to be redirected and was argumentative with staff. During an interview on 06/29/16 at 4:37 p.m., RN G said since Resident #2's wife recently passed away, he had attempted to elope from his window in his room. She said if 2 CNAs were scheduled on the secure unit, one would be pulled to another area of the facility. She said the scheduled showed 2 CNAs per shift on the secure unit, but a note would be attached to the schedule ordering 1 CNA to work another hall, leaving 1 CNA and 1 nurse on the unit. She said it was not safe for the residents to only have 1 CNA and 1 nurse on the secure unit. She said CNAs were expected to shower 5 residents per shift and she helped the CNA shower residents who were a 2 person assist. RN G said she and the CNA could be in the shower room for half an hour, leaving the rest of the residents unattended. RN G said 6 of the residents on the secure unit were combative with staff and other residents. She said from the shower room, she often heard commotion and yelling from the residents and just hoped they were safe. RN G said after dinner, the residents began to exhibit signs of sundowners syndrome and wanted out of the facility. She said the secure unit was short staffed for about 2 months. She said the secure unit did not have a medication aide, so the nurses passed the medications. RN G said the facility hired agency nurses and CNAs during the last state survey, but after the survey was completed, the facility got rid of the agency staff. Staffing schedules dated 06/15/16 on the secure unit, indicated one nurse and two CNAs for the 6:00 a.m. to 2:00 p.m. shift, one nurse and one CNA for the 2:00 p.m. to 10:00 p.m. shift, and one nurse and one CNA for the 10:00 p.m. to 6:00 a.m. shift. An incident report dated 06/15/16 indicated Resident #2 eloped from him room through the window and was found in the parking lot. Resident #2 did not receive injuries from the elopement. Staffing schedules dated 06/16/16 on the secure unit, indicated one nurse two CNAs for the 6:00 a.m. to 2:00 p.m. shift, one nurse and two CNAs for the 2:00 p.m. to 10:00 p.m. shift, and one nurse and one CNA for the 10:00 p.m. to 6:00 a.m. shift. Staffing schedules dated 06/17/16 on the secure unit, indicated one nurse and two CNAs for the 6:00 a.m. to 2:00 p.m. shift, one nurse and one CNA for the 2:00 p.m. to 10:00 p.m. shift, and one nurse and one CNA for the 10:00 p.m. to 6:00 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675460	A. BUILDING _____ B. WING _____	07/01/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK HIGHLANDS NURSING & REHABILITATION CENTER	711 LUCAS ST ATHENS, TX 75751

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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F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) shift. Nursing notes dated 06/24/16 at 1:35 p.m. indicated Resident #2 opened his window in his room and attempted to elope. Resident #2 yelled at staff, pulled on doors, and was unable to be redirected at times. During an interview on 06/29/16 at 11:30 a.m., LVN C said Resident #2 probably eloped more than what was documented in incident reports and nursing notes. She said usually one nurse and one CNA was on the secure unit, even though the schedule indicated 2 CNAs were on the schedule. She said 6 residents were combative and there was not enough staff on the unit for care for all the residents. She said there were 19 residents on the unit, but one resident went out to a behavioral hospital leaving 18 residents. She said providing care to the residents was the most important and sometimes documentation did not get completed. She said the nurse administered all the medications and assisted the CNAs with 2 person assist residents. She said residents were left unattended for up to 30 minutes at a time. 2.Physician orders [REDACTED].#5 was [AGE] years old and admitted on [DATE]. His [DIAGNOSES REDACTED]. An incident report dated 06/26/16 indicated Resident #2 saw Resident #5 attacking CNA D in the shower room. Resident #2 began swinging his fist at Resident #5 so he would release CNA D. During an interview on 06/30/16 at 2:10 p.m., CNA D said on 06/26/16, she was shaving Resident #2 ' s face when Resident #5 came into the shower room without her knowledge. She said Resident #5 put her in a headlock and took her to the ground. CNA D said Resident #2 began kicking and swinging at Resident #5 and Resident #5 began kicking and swinging back at Resident #2. She said she got free and was able to get Resident #2 out of the shower room. She called for help, but she was the only aide on the unit and the nurse on the unit was in a resident ' s room down the hall. She said it was a safety issue only having one CNA on the unit because 6 residents were combative. She said the schedule showed 2 CNAs were scheduled on the secure unit, but one would be pulled to work on another hall. She said each shift was expected to shower at least 5 residents and some of the residents were 2 person assist. She said when she and the nurse were giving showers; the residents were left unattended for up to 30 minutes for each shower. She said several residents were on 30 minute checks, but they did not have the staff to provide that service. During an interview on 06/30/16 at 2:40 p.m., CNA H said it was rare to have 2 CNAs on the secure unit. She said if 2 CNAs were scheduled on the unit, one would have to work on another hall. She said residents were left unattended if she needed the nurse to help in the shower room or in a resident ' s room. She said it was not safe for the residents because there were some residents that were combative. Staffing schedules dated 06/27/16 on the secure unit, indicated one nurse and two CNAs for the 6:00 a.m. to 2:00 p.m. shift, one nurse and two CNAs for the 2:00 p.m. to 10:00 p.m. shift, and one nurse and one CNA for the 10:00 p.m. to 6:00 a.m. shift. Staffing schedules dated 06/28/16 on the secure unit, indicated one nurse and two CNAs for the 6:00 a.m. to 2:00 p.m. shift, one nurse and two CNAs for the 2:00 p.m. to 10:00 p.m. shift, and one nurse and one CNA for the 10:00 p.m. to 6:00 a.m. shift. 3. Physician orders [REDACTED].#4 was [AGE] years old and admitted on [DATE]. His [DIAGNOSES REDACTED]. A care plan dated 02/16/16 indicated Resident #4 had impulsive behavior and was violently aggressive towards others and received antipsychotic medications. He required extensive 2 person assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #2 required total assistance with bathing. He was incontinent of bowel and bladder. He was at risk for falls and had a history of [REDACTED]. An MDS dated [DATE] indicated Resident #4 rarely understood others and rarely made his needs known. He required 2 person assistance with bed mobility, transfers, dressing, eating, bathing, toilet use, and person hygiene. During an interview on 06/29/16 at 12:00 p.m., Resident #4's wife said about a week ago, her husband was left in bed for over 12 hours with no care provided. She said the secure unit did not have enough CNAs to care for all the residents on the unit. She said Resident #4 required 2 staff to move him, and that left the other residents unattended. During an interview on 06/29/16 at 1:05 p.m., the DON said day shift staff notified her last week that Resident #4 was put to bed around 6:00 p.m. and was left there until the day shift got him up the next morning after 6:00 a.m. She said she notified the family. During an interview on 06/30/16 at 2:40 p.m., CNA H said Resident #4 required total assistance with bathing and his showers took 30 minutes. She said whenever she and the nurse were in the shower room with Resident #4; the other residents were left alone. During an interview on 06/29/16 at 12:32 p.m., CNA J said he often worked as the only CNA on the secure unit. He said he was told that the secure unit only had 18 residents and the halls had over 30 residents, so the halls needed the CNA more than the secure unit. He said working with only 2 staff on the secure unit was not safe for anybody on the unit. During an observation on 06/30/16 at 4:45 p.m., RN G, CNA J, and CNA D were in residents' rooms, leaving 16 residents roaming the secure unit unsupervised. The resident roster dated 06/29/16 indicated 18 residents resided on the secure unit.
F 0505 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Quickly tell the resident's doctor the results of lab tests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promptly notify the physician of abnormal x-ray results for 1 or 10 residents reviewed for laboratory/x-ray services. (Resident #1) The facility did not notify the physician of Resident #1's chest x-ray that indicated Resident #1 had pneumonia in both of his lungs. He died 5 days after the x-ray when his respiratory status continued to deteriorate. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]; 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. This failure could place the census of 91 residents at risk for serious injury or possible death. Findings included: Physician orders [REDACTED].#1, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. A care plan dated [DATE] indicated Resident #1's baseline respirations were 20 breaths a minute and oxygen saturation level was 97%. According to the website, http://www.medguidance.com/thread/Oxygen-Saturation-Levels, accessed [DATE], oxygen saturation levels, they are referring to the extent of haemoglobin that is saturated with oxygen and .normal oxygen saturation level is between 95% to 100% . Nursing notes dated [DATE] at 3:00 p.m., indicated Resident #1 wandered out the door and was found walking on a sidewalk by the facility. Resident #1 was escorted back in the building and assisted to his wheelchair. The notes indicated Resident #1 said he was walking out of the facility. Nursing notes dated [DATE] at 8:29 a.m., indicated Resident #1 ambulated down the hall and attempted to elope out the back door. He was assisted back to his wheelchair by staff. Resident #1 said he was going home. Nursing notes dated [DATE] at 4:05 a.m., indicated Resident #1 ' s oxygen saturation level was 96% (his baseline was 97%). Nursing notes dated [DATE] at 9:22 a.m., indicated Resident #1 demanded staff to push him down the hall in his wheelchair to be let out of the facility. [MEDICATION NAME] (anti-anxiety medication) was administered to Resident #1. An oxygen saturation level log for Resident #1 indicated his oxygen saturation levels included the following: (Baseline 97%) *[DATE] - 93%, *[DATE] - 94%. The log did not indicate if the resident's respiratory status was assessed or if the physician was consulted. Nursing notes dated [DATE] at 1:45 p.m., indicated Resident #1 said he called for assistance for a long time, but nobody came to his room. He said he needed to go to the bathroom. Resident #1 was assisted back to his room and he was getting short of breath. Oxygen was placed on the resident and he received a breathing treatment with good results. Nursing notes dated [DATE] at 7:00 p.m., indicated Resident #1 was not able to support himself in a seated position. Resident #1 was becoming increasingly lethargic and agitated. He developed a productive cough and was short of breath at rest. The notes did not indicate if the nurse assessed the resident or consulted with the physician. Nursing notes dated [DATE] at 6:40 p.m., indicated Resident #1 had labored respirations, he was short of breath, and was mouth breathing. He did not eat breakfast or lunch. The notes did not indicate if the physician was consulted or if the

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	675460	A. BUILDING _____ B. WING _____	07/01/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK HIGHLANDS NURSING & REHABILITATION CENTER	711 LUCAS ST ATHENS, TX 75751

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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F 0505 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 8) nurse applied oxygen for respiratory support. Nursing notes dated [DATE] at 1:57 p.m., indicated Resident #1 was noted to have difficulty breathing, was coughing, and was wheezing. The notes did not indicate if the physician was consulted or if the nurse applied oxygen for respiratory support or any other intervention. Nursing notes dated [DATE] at 2:01 p.m., indicated the on call doctor was notified of Resident #1's condition and a STAT (immediate) chest x-ray was ordered. During a telephone interview on [DATE] at 9:01 a.m., LVN A said she worked on [DATE] and was covering for LVN B (who was responsible for Resident #1) while LVN B was at lunch. She said Resident #1 was having difficulty breathing and did not look good. She said she called the on call doctor who ordered a chest x-ray. She said there was no follow up on the x-ray even though she told LVN B that she ordered the chest x-ray. LVN A said when she left on Sunday, she did not come back until the next Saturday and Resident #1 was deceased when she returned the following Saturday ([DATE]). During an interview on [DATE] at 11:30 a.m., LVN C said on [DATE], she went into Resident #1's room with LVN A. She said Resident #1 was pale and was having difficulty breathing. She said she thought he had a change of condition and that was why LVN A ordered the chest x-ray. LVN C thought Resident #1 would be sent out to the hospital for further evaluation. She said she did not know if anything else was done for Resident #1. During an interview on [DATE] at 2:57 p.m., LVN B said LVN A covered her shift while she went to lunch and ordered a chest x-ray for Resident #1. She said when she came back from lunch, LVN A told her she needed to check on Resident #1 and follow up on the chest x-ray. She said she went into Resident #1's room and he was breathing like he always did. LVN B said she did not assess Resident #1. She said normally x-ray results were faxed, but she did not receive Resident #1's chest x-ray results and she did not call the x-ray company to get the results. She said she told the oncoming nurse that the resident had a chest x-ray and wrote it on the 24 hour report for [DATE], but it was not transferred to the 24 hour report for [DATE]. A STAT (immediate) chest x-ray result dated [DATE] for Resident #1 indicated he had pneumonia in both of his lungs and the word ALERT was written across the results. During a telephone interview on [DATE] at 1:20 p.m., the on call doctor's nurse said the facility did not call the on call doctor to notify him of the x-ray results. A 24-hour report sheet dated [DATE] indicated Resident #1 received a chest x-ray and was short of breath. The [DATE] 24-hour report did not contain any other information regarding Resident #1. During an interview on [DATE] at 1:30 p.m., the DON said Resident #1's physician was not notified of results of the chest x-ray. She said normal procedure would be to fax the doctor with the results, but the fax machine was not working properly on [DATE]. She said LVN B told her Resident #1 was agitated on [DATE]. She said she was not aware that Resident #1 had pneumonia. Nursing notes dated [DATE] at 11:20 a.m., indicated the NP was notified of Resident #1's declining strength and poor food intake. The NP said to make him an appointment with his primary doctor to talk about hospice. The notes did not indicate if the NP was notified of the resident's x-ray results. Nursing notes dated [DATE] at 5:52 a.m., indicated Resident #1 occasionally yelled out for help. Resident #1 became easily short of breath and had increased weakness with mobility. Nursing notes dated [DATE] at 10:55 p.m., indicated Resident #1 continued to decline. Resident #1 did not eat or drink fluids the entire day. His oxygen saturation levels were 88%-90% (his baseline was 97%). Nursing notes dated [DATE] at 5:40 a.m., indicated Resident #1 continued to decline and his skin was pale and warm. Resident #1's respirations were shallow and he was short of breath. Resident #1's oxygen saturation levels remained between 86%-90% (his baseline was 97%). He required maximum assistance of 2 staff with ADLs and mobility. Nursing notes dated [DATE] at 7:10 a.m., indicated Resident #1 was not doing good at all. Resident #1's oxygen saturation was 89% and his respirations were 32 breaths a minute, and were rapid and shallow. Resident #1 moaned a little to a sternal rub (his baseline was 20 breaths a minute and 97% oxygen saturation level). Nursing notes dated [DATE] at 9:46 a.m., indicated Resident #1 received a new order for [MEDICATION NAME] for comfort measures. Nursing notes dated [DATE] at 2:30 p.m., indicated Resident #1 was lying in bed with his eyes and mouth open, and responded to sternal rub only. Resident #1's oxygen saturation level was 91% (his baseline was 97%) and [MEDICATION NAME] was given to Resident #1 for comfort measures. An oxygen saturation level log for Resident #1 indicated his oxygen saturation levels from [DATE] through [DATE] and [DATE]-[DATE] were between 95%-98%. Nursing notes dated [DATE] at 12:20 a.m., indicated Resident #1 was grimacing and had shortness of breath with shallow respirations. Resident #1's oxygen saturation level was 78% (his baseline was 97%) and his skin was hot to touch. He had occasional apnea episodes (not breathing) [MEDICATION NAME] up to 10 seconds. [MEDICATION NAME] was administered to Resident #1 for comfort. Nursing notes dated [DATE] at 1:00 a.m., indicated Resident #1 was resting quietly with shallow respirations. Resident #1 had mottling to all 4 extremities and his skin was hot to touch. Resident #1 was unresponsive to touch or verbal stimuli. Nursing notes dated [DATE] at 1:45 a.m., indicated Resident #1 was pronounced dead by an RN. During an interview on [DATE] at 2:10 p.m., CNA D said Resident #1 had a rapid decline in the last week of his life. She said his breathing and his appearance were dramatically worse. During a telephone interview on [DATE] at 11:17 a.m., Resident #1's primary physician's nurse said they were not notified of Resident #1's pneumonia. She said the only communication they received about Resident #1 was a fax on [DATE] about the resident expiring. During a telephone interview on [DATE] at 12:33 p.m., the NP said she did not know Resident #1 had expired. She said the facility called her the previous week to notify her of Resident #1's decline in health, but the facility did not notify her that he had pneumonia. She said if the facility would have notified her of Resident #1's pneumonia, she would have ordered him an antibiotic. During an interview on [DATE] at 3:45 p.m., the administrator said he knew Resident #1 had pneumonia, but did not know any more details. During an interview on [DATE] at 3:50 p.m., the corporate nurse said she knew a chest x-ray was ordered for Resident #1 and the physician was not notified of the results of the chest x-ray. The Changes in Resident Condition Policy revised [DATE], indicated the resident, the attending physician, and family member would be notified when changes in condition occurred. Communication with the interdisciplinary team and caregivers was also important to ensure that consistency and continuity were maintained. Changes in condition were communicated from shift to shift though the 24 hour report. The administrator was notified on [DATE] at 4:19 p.m., an Immediate Jeopardy situation was identified due to the above failures. The facility ' s revised Plan of Removal was accepted on [DATE] at 7:18 p.m. and included: 1. Nurses will be re-educated on MD/Family notification of change in resident condition. 2. Nurses will be re-educated on documentation in resident charts on changes in condition. 3. Nurses will be re-educated on resident assessments as it relates to changes in condition. 4. Nurses will be re-educated to notify physician by telephone when receiving abnormal diagnostic results, and documenting response in medical record, and follow-through with orders when indicated. 5. Nursing administrative staff will review resident charts to ensure previously ordered diagnostic tests have been followed-through with MD notification. 6.Nurses will be re-educated on process of ordering diagnostic testing to included orders, MD & family notification, documentation, and following-up with results or inability to obtain testing. 7. Educate nurses on physical assessments. 8. Educate nurses to follow-up at beginning of shift on all pending diagnostic tests from pervious shift, and calling if they haven ' t received results. Target completion date will be ,[DATE]/ or prior to the start of the next scheduled shift. (sic) On [DATE] the surveyors confirmed the POR was implemented sufficiently to remove the Immediate Jeopardy by:

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	675460	A. BUILDING _____ B. WING _____	**07/01/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK HIGHLANDS NURSING & REHABILITATION CENTER	**711 LUCAS ST ATHENS, TX 75751**

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F 0505 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 9) Two RNs, 3 LVNs, and 1 LVN (ADON) were in-serviced on MD/family notification of change in resident condition, documentation in resident charts and change in condition, resident assessments, notifying physicians by phone of abnormal diagnostic results, and following up on results. Ten residents' charts were reviewed for ordered, pending diagnostic testing, and MD notification of results. All were correct and complete. On [DATE] at 2:20 p.m., the administrator, corporate nurse, DON, and ADON were informed the Immediate Jeopardy 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. The resident roster dated [DATE] indicated there were 91 residents in the facility.