STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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 0157 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the physician when there was a significant change in the physical, mental, or psychosocial status of one of seven residents (CR #3) who were reviewed for physician's consults due to a change in condition as evidenced by: -The facility failed to draw CR #3's STAT BMP for 10.5 hours. -The facility failed to consult with CR #3's MD the critical Potassium blood level for 5.25 hours. CR #3 was found unresponsive on [DATE] at 7:11 a.m. and was pronounced dead 26 minutes after transferred to the hospital's emergency room . An IJ was identified on [DATE]. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of pattern and a severity of actual harm due to facility required more time to train staff and monitor the plan of removal for effectiveness. This failure affected one former resident (CR #3) and placed 23 residents on the 200 hallway in the facility at risk for their physicians not being consulted when they had a change in condition which could result in a delay in medical treatment, the development of new or worsening medical conditions, diminished quality of life, hospitalization and death. Findings included: Intake # 4 Record review of the facility face sheet revealed CR# 3 was a [AGE] year old female. She was admitted to the facility on [DATE] with following Diagnoses: [REDACTED]. CR #3 was found unresponsive and was transferred to the hospital on [DATE] and was pronounced dead 26 minutes after arrival to the emergency room . Record review of CR #3's 5 day MDS assessment dated [DATE] revealed CR #3 required limited assistance for bed mobility, transfers, dressing, toileting and personal hygiene. She required supervision for walking in the room, in the corridor, locomotion and eating. CR #3 was always continent of bowel and had an indwelling catheter for urine. Record review of CR #3's electronic and paper records revealed CR #3 did not have a care plan. Record review of CR #3's NP progress notes dated [DATE] revealed in part: . [AGE] year old female readmitted at the hospital for frequent falls. She is here for rehab. Past medical history for hypertension, [MEDICAL CONDITIONS] and acute [MEDICAL CONDITION] .STAT BNP (Pro) (Beta Naturetic Peptide - test to help detect, diagnose, and evaluate the severity of heart failure), BMP (basic metabolic panel, blood work that assess electrolytes and kidney function) and urinalysis. Assessment/Plan: [MEDICAL CONDITION] - BUN (Blood Urea Nitrogen) / Creatinine (test to assess kidney function) high on [DATE]. Will re-check STAT today . Record review of CR #3's physician's telephone orders signed by the NP and dated [DATE] at 9:30 a.m. revealed orders in part: - STAT urinalysis, BMP and Pro BNP . Record review of CR#3's laboratory requisition form dated [DATE] revealed a collection time of 1:52 p.m. for urinalysis and BNP (Beta Naturetic Peptide). Further record review revealed the BMP test, which was also ordered by NP, was omitted in the requisition order. Record review of CR #3's progress/nurses notes revealed in part: -[DATE] at 4:16 p.m. written by LVN C NP into see CR #3 and RP concerned that CR #3 is having kidney issues. Orders to have STAT urinalysis, BNP and Pro BNP .All orders completed . Further record review of CR #3's laboratory requisition form dated [DATE] revealed a collection time of 8:00 p.m. for BMP (basic metabolic panel). Record review of CR #3's laboratory report dated [DATE] at 12:18 a.m. revealed in part: -Potassium level 6.2 mEq/L Reference range (3.5 - 5.3). Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 1:46 a.m. written by LVN A Potassium 6.2. Dr. A informed. Awaiting call back. -[DATE] at 2:30 a.m. by LVN A (CR #3) lying in bed, no complaints of pain or nausea. Oxygen saturation 94% at 3 liters of oxygen. Assisted to restroom with 1 person assistance. Tolerated ambulation well. Dr. (P) paged of Critical Potassium levels of 6.2. Further record review of the progress/nurses notes revealed no further attempts to contact the MD concerning the critical Potassium levels. No vital sign assessments or any further assessments documented during the night shift. Record review of CR #3's progress/nurses notes revealed in part: -[DATE] at 2:14 p.m. written by ADON A Received in report that laboratory reported a critical potassium level and no new orders obtained as of that time. Contacted NP with laboratory results approx. 7:06 a.m. NP returned call at 7:11 a.m. requesting oxygen saturation levels. Reported back to (CR #3's) to check oxygen saturation. Upon entering room (CR #3's) eyes were closed and she was non-responsive to verbal and tactile stimuli. (CR #3) was not breathing, no pulse palpable, skin warm to touch. Code called, CPR initiated and 911 called. Fire department arrived and took over CPR until paramedics arrived. (CR #3) was last observed sleeping in bed at approx. 6:30 A.M. Notified emergency contact at approx. 7:40 a.m. that (CR #3) was observed unresponsive and that she should go to the hospital where (CR #3) was transferred . Record review of CR #3's hospital records from the emergency room revealed in part: Arrival date/time: [DATE] at 8:05 a.m. -At 8:25 a.m. [AGE] years old white female presents to ED via unassigned with complaints of Full (cardiac) arrest. -At 8:25 a.m. preceding the arrest, (CR #3) was found down by nursing home staff. The arrest occurred at the nursing home. The arrest was not witnessed by others. Bystanders at the scene performed CPR. -EMS (emergency medical service) care prior to arrival: Initiation of ACLS (advanced cardiac life support), peripheral IV, was successfully placed. 15 minutes elapsed prior to ACLS. ACLS has been in progress for 45 minutes. ACLS details: initial rhythm was asystole (flat line in electrocardiogram). [MEDICATION NAME] ([MEDICATION NAME]) intravenous 8 doses. Response to therapy: Continued arrest. Arrest was first noted at 7:15 a.m. asystole was presenting rhythm, there may have been PEA (pulseless electrical activity) at one point. --At 8:31 a.m. ED course: (CR #3) has been under CPR for more than 45 minutes with no ROSC (return of spontaneous circulation). While there was not a definitive airway, after 45 minutes of CPR and 9 rounds of [MEDICATION NAME], did not feel like any further attempts at airway wound lead to different outcome other than death. (CR #3) was pronounced. -Diagnosis: [REDACTED]. In an interview on [DATE] at 2:08 p.m. ADON A, stated she was the charge nurse for CR #3 on [DATE] when she was found

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) unresponsive. ADON A then said that she arrived at the facility and started her rounds alone looking at the residents at around 6:30 a.m. and it was at that time she saw CR#3 sleeping. She said LVN B told her CR #3 had a critical potassium level during the night shift and that the MD had not returned the call yet. LVN B also reported that LVN A, who was assigned to CR #3 during the night shift, had gone home earlier on the shift. ADON A then said when LVN B told me that staff had not follow up with the MD regarding the critical potassium levels, I texted the NP and the NP called me within a couple of minutes. I gave her the critical values of potassium for CR #3 and she asked me for CR #3's oxygen saturation levels because CR #3 was having problems with her oxygen on [DATE]. When I went to the room at that moment still with the phone in my hands and the NP on the line, CR #3 was found not breathing, and no vital signs. CPR was started and 911 was called. CR #3 died in route to the hospital. Further interview with ADON A at that time, she stated the night shift tried to call the MD but the MD was not reached. ADON A said facility protocol is that if the MD does not return the calls, we were supposed to call the medical director, but CR #3's MD was the medical director. Facility has another medical director that we were supposed to call if the first medical director does not answer the calls. LVN B said that the other medical director called the facility during the night shift on [DATE] for another resident and that LVN A forgot to mention about the critical potassium values of CR #3. Continued interview the ADON A on [DATE] at 2:20 p.m. said critical laboratory values was a change in condition and the facility staff was supposed to complete a change of condition assessment in the computer where it prompt staff to assess the resident, notify MD and RP. ADON A further said that if for any reason the MD or another medical director was unable to be located, the staff was supposed to notify the DON. She said she did not know if the previous DON was aware of the situation with CR #3. When asked if CR #3 had any assessments previous to being found unresponsive or any vital signs, ADON A then looked at the computed and then said there is none, last vital signs were on [DATE] at 4:42 p.m. In a phone interview on [DATE] at 4:25 p.m. LVN C, stated she was the charge nurse for CR #3 on [DATE] from 6 a.m. to 2:00 p.m. She said she called the NP to notify her that CR #3's oxygen levels were low and the NP called her at the end of her shift and told her to send CR #3 to the hospital. LVN C said she told the 2:00 to 10:00 p.m. shift nurse who was RN D about the order to send CR #3 to the hospital. LVN C said it was around 3:50 p.m. on [DATE] when she got the order from the NP. LVN C continued saying she did not transcribe the order to CR #3's chart because she was going home and she had already talked to RN D about the new orders. LVN C further said she got the orders via a text message and the staff would usually call, page or text the MD or the NP. When asked to see the text message she said she had erased the text message from the NP. Continued phone interview with LVN C at 4:25 P.M. on [DATE], she stated whenever a resident had a change in condition, the staff was to complete a change in condition form in the computer that was like an SBAR when they would write their assessments, MD and RP notifications. She then said that she did not complete that assessment on CR #3. In a phone interview on [DATE] at 4:42 p.m. LVN A, he stated he was the charge nurse for CR #3 from 10:00 p.m. on [DATE] to around 3:00 a.m. on [DATE] and further said I wasn't supposed to even be there on that day and continued saying I did not get any report regarding any change in condition regarding (CR #3). I knew about the critical values of her laboratory results, I paged the MD twice and did not get any response. Then I left at around 3:00 a.m. and gave report to LVN B so she could follow up and pass the information to the day shift. LVN C then said the other medical director called the facility on [DATE] regarding another resident and he did not notify him about CR #3 because he was very busy with this other resident who had a PICC line and then said but I heard that the day shift was able to get hold of the NP. Further interview with LVN A at 4:42 p.m. on [DATE], he stated critical laboratory values was a change in condition and he was supposed to contact the MD or the DON if unable to contact the MD and then said In this place everything is so confusing. I don't even know who the DON is. LVN A then said that he was supposed to check the vital signs of CR #3 but he only checked the oxygen saturation and said RN D didn't really tell me anything about CR #3. We were supposed to do the eINTERAC change of condition documentation in the computer but I can't explain why I did not do it. I don't know why. I should had monitored any cardiac issues, blood pressure and heart rate due to her high potassium levels. I was overwhelmed. In an interview on [DATE] at 5:00 p.m. RN D, stated she was the charge nurse for CR #3 on [DATE] during the 2:00 p.m. to 10:00 p.m. shift and then said during the change of shift report CR #3 was sleepy. When she asked about CR #3's oxygen saturation, the morning shift nurse told her it was around the 80's. The nurse had increased the oxygen to 4 liters, had re-checked the oxygen and the it was in the 89 to 90%. RN D said during her shift, the laboratory collected blood from CR #3 that was ordered during the day shift. RN D said LVN C never told her about any or orders to transfer CR #3 to the hospital. RN D said she spoke with the NP because the NP wanted to know the laboratory results for CR #3 but she had not received any reports from the laboratory and she never knew the NP ordered CR #3 to go to the hospital. Continued interview on [DATE] at 5:15 p.m. RN D, said whenever a resident had a change in condition, there was an eINTERACT form to complete on the computer where the nurse writes the assessments. She said I did not check if someone had completed a change of condition form on CR #3. It should had been completed on the day shift on [DATE]. In a phone interview on [DATE] at 9:15 a.m. LVN B, stated LVN A left the building on [DATE] at around 3:30 a.m. and he told her everything was fine and that CR #3 did not have any issues. LVN B further said LVN A did not mention to her anything about the laboratory values of CR #3 but she knew the laboratory had called at 1:30 a.m. to report critical values because she was the one who got the call and then gave the message to LVN A. LVN B continued saying she also knew LVN A had paged the MD twice and she did not receive any MD calls for the rest of the shift. LVN B then said she did not try calling the MD for CR #3's critical laboratory values and she did not do any vital signs for CR #3 either. In a phone interview on [DATE] at 3:29 p.m. the NP, stated she came to the facility on [DATE] and saw CR #3 and ordered STAT laboratory blood work because when she saw CR #3 she did not look good. The NP stated she did not hear anything about the results of the laboratory blood work for CR #3 after she gave the orders. The NP said the following morning she called the facility to find out if CR #3 was sent to the hospital as she had ordered on [DATE] and to find out about the laboratory results. The NP continued by saying on [DATE] at around 7:00 a.m. she called the facility and spoke to ADON A and asked about CR #3 and how come she did not hear about the laboratory result. She said it was at that moment, ADON A told her CR #3 was still in the facility. The NP then asked ADON A for CR #3's vital signs right away including her oxygen saturation. Further interview at that time the NP, stated she was surprise to find out CR #3 was not in the hospital and requested CR #3's vital signs because she wanted to know how she was doing. It was at that time ADON A told her CR #3 was unresponsive. The NP then said I don't understand why the nurses did not follow the orders and request for the laboratory blood work STAT. I called them the next morning at 7:00 a.m. and inquired about CR #3 status, what if I did not call?. I gave STAT laboratory blood work orders, I expected the results right away. When I did not hear anything during the night shift, I thought CR #3 was sent to hospital but I decided to follow up with the facility the next morning. I even told them, you guys are not following orders . In an interview on [DATE] at 3:52 p.m. the Administrator, stated that STAT laboratory orders needed to be called immediately to the laboratory and the policy was for the laboratory to come and draw the blood within 4 hours and they had 1 to 2 hours to get the results back to the facility. The Administrator then said once the nurse gets the orders, the nurse would enter the order in the computer and then would follow up on the order. She further said the nurse who received the laboratory results was the nurse who would follow up with the MD. The Administrator further said for STAT abnormal laboratory results, the nurses will call the MD right away. If the MD does not answer then one of the medical directors would be called. The facility has 2 medical directors, if one does not answer, then we will call the other medical director. If none of the medical director's answer, then the nurse was to call the DON and the Administrator so we could help in getting a hold of the doctors. Continued interview with the Administrator at that time, she stated whenever a resident had a change in condition, the staff were supposed to complete an eINTERACT form in the computer. She further said the interact form was a tool built in the computer system for changes in condition where it would trigger on what would need to happened. The Administrator further said the interact tool would guide the nurses on calling the MD, the RP and to follow up on assessments. Further interview on [DATE] at 4:00 p.m. the Administrator, stated RN D told her on [DATE] at around 5:45 p.m. CR #3 had some abnormal vitals and that RN D had talked to the MD or the NP. She was told orders were to monitor CR #3's oxygen saturation and if the oxygen dropped, to send CR #3 to the hospital. The Administrator further said CR #3's vitals got better and CR #3 was improving and everything got to looking good. The Administrator then said RN D got the STAT laboratory orders for CR #3 on [DATE] at around 5:45 p.m. then the laboratory called with abnormal values at around 1:00 a.m. They tried to reach the MD, then I am foggy about it. They attempted to call the MD twice. They heard back from the MD 5 minutes

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) before CR #3 coded. Staff gave CR #3 CPR and sent her to hospital. I believed CR#3 was even admitted to ICU before she died . CR #3 had been in the facility for one week. She was here for therapy. Continued interview with the Administrator on [DATE] at 4:09 p.m. she stated that facility staff did not call her on [DATE] when they were unable to contact the MD for CR #3's critical laboratory values but believed the former DON was contacted. In a second interview on [DATE] at 4:45 p.m. with LVN C, she said on [DATE] the NP came to visit CR #3 in the morning and gave STAT laboratory blood work. LVN C said she was not sure how long they have to call the laboratory for STAT orders but she believed they had 4 hours to call the laboratory. LVN C further said she texted the NP on [DATE] regarding CR #3's condition because her oxygen saturations were in the 80's and when she got the text back from the NP, she went and told RN D. LVN C said The nurse who gets the order is the one responsible of inputting the order on the computer system. I did not do it because I was leaving to my home. I should had done it. I should had completed an eINTERACT assessment on CR #3 as well. Further interview with LVN C, she stated the first time she called the laboratory for STAT orders she only called for the urinalysis and the BNP (Beta Naturetic Peptide) because she misread the orders and later during change of shift, she found out together with RN D that she had omitted the STAT orders for BMP (basic metabolic panel) and RN D followed up with it. LVN C further said she did not notify the NP about the mistake in transcribing orders to the laboratory requisition form. In a phone interview on [DATE] at 5:09 p.m. the laboratory, technician stated they received a call from the facility on [DATE] at 12:12 p.m. for STAT order request for urinalysis and the BNP (Beta Naturetic Peptide) for CR #3 and on [DATE] at 5:06 p.m. they received another STAT order request for BMP for CR #3. Record review of http://www.medicinenet.com/[MEDICAL CONDITION]/article.htm: revealed [MEDICAL CONDITION] means an abnormally elevated level of potassium in the blood. The normal potassium level in the blood isCmilliequivalents per liter (mEq/L). Potassium levels between 5.1 mEq/L to 6.0 mEq/L reflect mild [MEDICAL CONDITION]. Potassium levels of 6.1 mEq/L to 7.0 mEq/L are moderate [MEDICAL CONDITION], and levels above 7 mEq/L are severe [MEDICAL CONDITION]. Extremely high levels of potassium in the blood (severe [MEDICAL CONDITION]) can lead to [MEDICAL CONDITION] and death. Record review of the facility's undated Statement of Resident Rights revealed in part: .You have the right to (1) all care necessary for you to have the highest possible level of health . Record review of the facility policy and procedure Change of condition reporting revised ,[DATE] revealed in part: .It is the policy of this facility that all changes in resident condition will be communicated to the physician. Purpose: To clearly define guidelines for timely notification of a change in resident condition. Any sudden or serious change in resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation . If unable to contact attending physician or alternate physician timely, notify Medical Director for follow up to change in resident condition Follow-up. The licensed nurse responsible for the Resident will continue assessment and documentation every shift for at least seventy two (72) hours or until condition has stabilized .Comprehensive Care Plan will be updated/revised accordingly. Record review of the facility policy and procedure Laboratory Services revised ,[DATE] revealed in part: .2- STAT orders are done as soon as possible within facility defined time frames . Record review of the facility policy and procedure Labs, abnormal revised ,[DATE] revealed in part: It is the policy of this facility to inform physician immediately to assist in diagnosing resident appropriately based on the Laboratory results. The RN Supervisor will care plan only the abnormal laboratory results which requires blood levels such as abnormal Potassium that could manifest complications in the short term care plan . Record review of the facility's undated protocol with title Labs revealed in part: It is everyone's responsibility to follow up on all labs in a timely manner. STAT labs: You are expected to get your laboratory results within 4 hours. If you do not receive then in that time. Notify your ED/DON immediately. Once you receive your result notify MD of results. Call responsible party of laboratory results. Document in progress notes the laboratory results, MD and RP notification. The resident will then be in every shift documentation for 72 hours until resolved. If laboratory is abnormal you are required do the following: 1- Notify the MD and RP. Place patient in follow up and chart on patient every shift. If you are unable to reach MD YOU MUST NOTIFY THE ED/DON IMMEDIATELY . An IJ was identified on [DATE] at 4:35 pm and the Administrator and DON were informed at that time. The POR was accepted on [DATE] at 3:38 pm. The POR included: Immediate action: 1- Resident affected by this deficient practiced was discharged to hospital [DATE]. Laboratory audits to determine all residents affected by this deficient practice including: 1.- Laboratory audit performed by Clinical Resources to review all current laboratory orders at facility began on [DATE] with laboratory vendor - ACL laboratory and completed [DATE]. 2.- Medical records designee pulling all orders for laboratory in PCC for all current residents for review, completed [DATE]. 3.-Review of all Telephone Orders by Clinical Resource Nurse to ensure no new orders for laboratory have been missed completed [DATE]. 4.- Clinical Resource Nurse completed audit of laboratory requisition book where laboratory orders are noted by laboratory after laboratory are drawn completed [DATE]. 5.- Charge Nurse designated to check laboratory website to pull results each shift beginning [DATE]. 6.- Any abnormal or critical laboratory to be communicated to physician/designee and RP on [DATE] (no critical laboratory were founds). 7.- DON to notify laboratory vendor to email STAT laboratory and / or abnormal results to DON and ADON's email in addition to calling the facility as part of new process beginning [DATE]. DON and ADON have email access ,[DATE]. 8.- All current resident's charts were audited for potential change of condition on [DATE] by Clinical Resource Nurse. No change of conditions were found. At time of this plan of removal, no other residents identified with laboratory issues. (12:00 p.m.). Education/In-service: 1.- In-service started [DATE] at 5:05 p.m. with licensed nurses including change of condition, using SBAR form, Stop and Watch, notifications, and Resident Behavior and Facility practice related to change of condition. In the event a licensed nurse cannot reach the attending physician, charge nurse will contact either DON or Administrator and Medical Director. The Medical Directors have provided the DON and Administrator with alternate methods to contact them rapidly. In-service started on [DATE] with all licensed nursing staff regarding each Medical Directors preferred methods of communication. 2.- As part of in-service new DON (start date [DATE]) introduced to staff and shared her contact information. 3.- DON and ADON will divide building each taking two hall to follow up daily on any change of condition, new laboratory orders, abnormal laboratory, fall, etcetera starting [DATE]. 4.- Change of Condition log will be utilized and review in daily stand up meeting with leadership IDT starting [DATE]. 5.- Licensed charge nurses were educated on [DATE] to follow up on each change of condition for 72 hours or until condition stable or resolved beginning [DATE]-17. 6.- Medical Directors notified of IJ and associated Plan of Removal. Dr. A was notified via phone on [DATE] at 6:00 p.m. and Dr. B was notified in person on [DATE] at 8:45 a.m. 7.- In-serviced CNA's on reporting change of condition and the Stop and Watch tool on [DATE]. Any staff not available for any in-service will be in-serviced before they are allowed to go on the floor to work a shift. Monitoring: RN corporate nurse resource has been assigned to facility to monitor plan of removal by: 1.- Daily monitoring of laboratory results by charge nurses on each shift beginning [DATE]. 2.- Daily review of change of condition log, and 72 hours follow up. 3.- Ongoing in-service on change of condition, notification, laboratory process. 4.- Daily QA analysis of admissions and readmissions including an updates to plan of care. 5.- QAPI committee to meet review Plan of removal daily until immediacy lifted, then weekly until compliance achieved. Monitoring of the plan: In an interview on [DATE] at 4:05 p.m. LVN C, stated she had been trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs, laboratory reports and said STAT laboratory orders needed to be called to the

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) laboratory immediately. LVN C then said whenever they get laboratory results, staff was supposed to call the MD, and if the MD was not available, to call the Medical Director and if the Medical Director was not available the staff was supposed to call the DON and the Administrator. LVN C continued saying they were supposed to check the fax machine and follow up with the laboratory every one hour on pending laboratory reports. LVN C further said she was also trained on follow MD orders timely and accurately. In an interview on [DATE] at 10:20 a.m. with LVN G and LVN H, both stated they had been trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs, laboratory reports and said STAT laboratory orders needed to be called to the laboratory immediately. LVN G then said whenever they get laboratory results, staff was to call the MD as soon as possible, and if the MD was not available, to call the Medical Director. If the Medical Director was not available the staff was supposed to call the DON and the Administrator. LVN H continued saying training included information on following MD orders. In an interview on [DATE] at 10:30 a.m. LVN E, stated she had been trained on change of condition, assessments, vital signs and documentation including the SBAR tool in the computer system. She also said training included the Stop and Watch form staff would complete to report changes in condition to nurses. LVN E further said training included laboratory orders, follow up and immediate notification to the MD of any critical values. The staff was made aware the chain of notification in case the MD was not able to be contacted that included the DON and Administrator. In an interview on [DATE] at 10:40 a.m. LVN F, stated he had been trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs, laboratory reports. He said STAT laboratory orders needed to be called to the laboratory immediately. LVN F then said whenever they get laboratory results, staff was supposed to call the MD as soon as possible, and if the MD was not available, to call the Medical Director. If the Medical Director was not available the staff was to call the DON and the Administrator. LVN F continued saying training included information on following MD orders. In an interview on [DATE] at 1:00 p.m. CNA I, stated she had been trained on using the Stop and Watch tool to notify to the nurses of any changes in condition of the residents. In an interview on [DATE] at 1:40 p.m. CNA J, stated she was trained on using the Stop and Watch tool for notification on any changes in condition she observed with any of the residents. In an interview on [DATE] at 1:52 p.m. LVN K, stated she had been trained on abnormal laboratory results and immediate MD notification. She said the fax machine was supposed to be checked every one hour. She said if she could not get hold of the MD, she was supposed to call the Medical Director, the DON and the Administrator. She continued saying she was also trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs and documentation including the Stop and Watch tool. In an interview on [DATE] at 2:00 p.m. CNA L and CNA M, both said they attended training regarding changes in condition and notification to the licensed nurse. Both said they were introduced to the Stop and Watch tool to report any changes in condition they observed to any of their residents. In an interview on [DATE] at 2:10 p.m. CNA N, stated she had received training on reporting changes in condition and the completion of the Stop and Watch form they were supposed to give to the nurses for any changes in condition on the residents. In an interview on [DATE] at 2:35 p.m. CNA O, stated she was also trained on using the Stop and Watch tool for notification on any changes in condition she observed with any of the residents. In an interview on [DATE] at 3:05 P.m. LVN P, stated she had been trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs, laboratory reports. She said STAT laboratory orders needed to be called to the laboratory immediately. LVN P then said whenever they get laboratory results, staff was supposed to call the MD as soon as possible, and if the MD was not available, to call the Medical Director. If the Medical Director was not available the staff was supposed to call the DON and the Administrator. LVN P continued saying that training included information on following MD orders. In an interview on [DATE] at 4:20 p.m. CNA Q stated she was also trained on using the Stop and Watch tool for notification on any changes in condition she observed with any of the residents. In an interview on [DATE] at 4:25 p.m. RN R, stated she had been trained on abnormal laboratory results and immediate MD notification. She then said the fax machine w
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the right to be free from neglect for two of seven residents (CR #3 and Resident #1) reviewed for neglect. - The facility failed to draw CR #3's STAT BMP laboratory orders for 10.5 hours. -The facility failed to notify the MD of CR #3's critical Potassium levels for 5.25 hours. -The facility failed to send CR #3 to the hospital for 14 hours after the NP instructed them to do so. -The facility failed to provide assessments and closely monitor the vital signs when CR #3 had a change in her condition. LVN A and LVN B did not assess CR #3's condition and vital signs during the night shift prior to being found unresponsive on [DATE] at 7:11 a.m. CR #3 was pronounced dead 26 minutes after arrival to the emergency room . -The facility failed to provide assessments and closely monitor the vital signs when CR #3 had a change in her condition. LVN A and LVN B did not assess CR #3's condition and vital signs during the night shift prior to being found unresponsive on [DATE] at 7:11 a.m. CR #3 was pronounced dead 26 minutes after arrival to the emergency room . -The facility failed to have adequate trained staff to evacuate Resident #1 from the building in the event of an emergency. She said she felt fearful when she was was forgotten in her room during an actual tornado alert. An IJ was identified on [DATE] and [DATE]. While the IJs were removed on [DATE] the facility remained out of compliance at a scope of pattern and a severity of actual harm due to facility requiring more time to monitor the plan of removal for effectiveness and train staff. These failures affected one former resident (CR#3) who died 26 minutes after arrival to the emergency room and one resident at the facility (Resident #1) and placed the other 87 residents at the facility at risk of not receiving adequate care, fear, injuries, decline in their health condition well-being and death. Findings included: Intakes # 4, # 6 and # 8 CR #3 Record review of the facility face sheet revealed CR# 3 was a [AGE] year old female admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]. CR #3 was found unresponsive and was sent to the hospital on [DATE] and was pronounced dead 26 minutes after arrival to the emergency room . Record review of the 5 day MDS assessment dated [DATE] revealed CR #3 required limited assistance for bed mobility, transfer, dressing, toileting and personal hygiene and supervision for walking in room and in corridor, locomotion and eating. CR #3 was always continent of bowel and had an indwelling catheter for urine. Record review of CR #3's electronic and paper records revealed CR #3 did not have a care plan. Record review of CR #3's NP progress notes dated [DATE] revealed in part: [AGE] year old female readmitted at the hospital for frequent falls. She is here for rehab. Past medical history for hypertension, [MEDICAL CONDITIONS] and acute [MEDICAL CONDITION] .STAT BNP (Pro) (Beta Naturetic Peptide - test to help detect, diagnose, and evaluate the severity of heart failure), BMP (basic metabolic panel, blood work that assess electrolytes and kidney function) and urinalysis. Assessment/Plan: [MEDICAL CONDITION] - BUN (Blood Urea Nitrogen) / Creatinine (test to assess kidney function) high on [DATE]. Will re-check STAT today . Record review of CR #3's physician's telephone orders signed by the NP and dated [DATE] at 9:30 a.m. revealed orders in part: - STAT urinalysis, BMP and Pro BNP . Record review of CR#3's laboratory requisition form dated [DATE] revealed a collection time of 1:52 p.m. for urinalysis and

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	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 4) BNP (Beta Naturetic Peptide). Further record review revealed the BMP test was omitted on the requisition order. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 3:15 p.m. Late entry by LVN C .CR #3 went to therapy and therapist checked oxygen saturation and read 78%. Checked CR #3's oxygen saturation upon returning to room and oxygen saturation read 82%. Immediately placed CR #3 on oxygen at 2 liters. Oxygen continued to rise to 89%. Vital signs blood pressure ,[DATE], pulse 71, temperature 98.4 and respirations 15 - 16 breaths per minute with no labored breathing. Contacted NP with results on low oxygen and informed her that the oxygen was rising and asked if CR #3 could go out to hospital. Informed oncoming nurse . -[DATE] at 4:16 p.m. by LVN C NP into see CR #3 and RP concerned that CR #3 is having kidney issues. Orders to have STAT urinalysis, BNP and Pro BNP .All orders completed . -[DATE] at 4:20 p.m. by LVN C NP called and informed of oxygen saturation . (NP) stated that we could send CR #3 out to hospital. Informed nurse on duty of decision . Record review of CR #3's electronic vital signs record revealed in part: -[DATE] at 4:42 p.m. Blood pressure ,[DATE] and pulse 64 beats per minute. Further record review revealed no further vitals sign assessments for CR #3. Further record review of CR #3's laboratory requisition form dated [DATE] revealed a collection time of 8:00 p.m. for BMP (basic metabolic panel). This was the original STAT ordered lab the NP ordered at 9:30 a.m. that was omitted of the first lab requisition form. Further record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 7:57 p.m. by RN D Given order by NP to increase CR #3's [MEDICATION NAME] to 8 mg by mouth every 4 hours as needed for nausea which was entered into the computer and faxed to pharmacy . Record review of CR #3's electronic MAR indicated [REDACTED] Record review of CR #3's laboratory report dated [DATE] at 12:18 a.m. revealed in part; -Potassium level 6.2 mEq/L Reference range (3.5 - 5.3). Continued record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 1:46 a.m. by LVN A Potassium 6.2. Dr. A informed. Awaiting call back. -[DATE] at 1:49 a.m. by LVN A [MEDICATION NAME] (muscle relaxant) tablet 350 mg. Give 0.5 tablet by mouth every 6 hours as needed for muscle spasm / back pain. CR #3 requested for muscle spasms -[DATE] at 2:30 a.m. by LVN A CR #3 lying in bed, no complaints of pain or nausea. Oxygen saturation 94% at 3 liters of oxygen. Assisted to restroom with 1 person assistance. Tolerated ambulation well. Dr. A paged of Critical Potassium levels of 6.2. -[DATE] at 3:10 a.m. by LVN A [MEDICATION NAME] (muscle relaxant) tablet 350 mg. Give 0.5 tablet by mouth every 6 hours as needed for muscle spasm / back pain effective Further record review of the progress/nurses notes revealed no further attempts to contact the MD for the critical Potassium levels, no vital sign assessments or any further assessments during the night shift. Record review of CR #3's MD orders dated [DATE] revealed in part; -[MEDICATION NAME] tablet 350 mg, give 0.5 tablet by mouth every 6 hours as needed for muscle spasm/back pain. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 2:14 p.m. by ADON A Received in report that laboratory reported a critical potassium level and no new orders obtained as of that time. Contacted NP with laboratory results approx 7:06 a.m. NP returned call at 7:11 a.m. requesting oxygen saturation levels. Reported back to CR #3's to check oxygen saturation. Upon entering room CR #3's eyes were closed and she was non-responsive to verbal and tactile stimuli. CR #3 was not breathing, no pulse palpable, skin warm to touch. Code called, CPR initiated and 911 called. Fire department arrived and took over CPR until paramedics arrived. CR #3 was last observed sleeping in bed at approx 6:30 A.M. Notified emergency contact at approx 7:40 a.m. that CR #3 was observed unresponsive and that she should go to the hospital where CR #3 was transferred . Record review of CR #3's hospital records from the emergency room revealed in part: Arrival date/time: [DATE] at 8:05 a.m. -At 8:25 a.m. [AGE] years old white female presents to ED via unassigned with complaints of Full arrest. -At 8:25 a.m. Preceding the arrest, CR #3 was found down by nursing home staff. The arrest occurred at the nursing home. The arrest was not witnessed by others. Bystanders at the scene performed CPR. -EMS (emergency medical service) care prior to arrival: Initiation of ACLS (advanced cardiac life support), peripheral IV, was successfully placed. 15 minutes elapsed prior to ACLS. ACLS has been in progress for 45 minutes. ACLS details: initial rhythm was asystole (flat line in electrocardiogram). [MEDICATION NAME] ([MEDICATION NAME]) intravenous 8 doses. Response to therapy: Continued arrest. Arrest was first noted at 7:15 a.m. asystole was presenting rhythm, there may have been PEA (pulseless electrical activity) at one point. --At 8:31 a.m. ED course: CR #3 has been under CPR for more than 45 minutes with no ROSC (return of spontaneous circulation). While there was not a definitive airway, after 45 minutes of CPR and 9 rounds of [MEDICATION NAME], did not feel like any further attempts at airway wound lead to different outcome other than death. CR #3 was pronounced. -Diagnosis: [REDACTED]. In an interview on [DATE] at 2:08 p.m. ADON A, stated she was the charge nurse for CR #3 on [DATE] when she was found unresponsive. ADON A said she had arrived at the facility and started her rounds alone looking at the residents at around 6:30 a.m. and it was at that time she saw CR#3 sleeping. She said LVN B told her CR #3 had critical potassium levels during the night shift and that the MD had not returned the call yet. LVN A who was assigned to CR #3 during the night shift, had gone home earlier on the shift. ADON A then said when LVN B told me staff had not follow up with the MD regarding the critical potassium levels, I texted the NP and the NP called me within a couple of minutes. I gave her the critical values of potassium for CR #3 and she asked me for CR #3's oxygen saturation levels because CR #3 was having problems with her oxygen on [DATE]. When I went to the room at that moment still with the phone on my hands and the NP on the line, CR #3 was found not breathing, and no vital signs. CPR was started and 911 was called. CR #3 died in route to the hospital. Further interview with the ADON A at that time, she stated the night shift tried to call the MD but the MD was not reach. ADON A then said facility protocol is that if the MD does not return the calls, we were supposed to call the medical director, but CR #3's MD was the medical director. Facility has another medical director that we were supposed to call if the first medical director does not answer the calls. LVN B said the other medical director called the facility during the night shift on [DATE] for another resident and LVN A forgot to mention about the critical potassium values of CR #3. Continued interview the ADON A on [DATE] at 2:20 p.m. said critical laboratory values was a change in condition and the facility staff was supposed to complete a change of condition assessment in the computer where it prompt staff to assess the resident, notify MD and RP. ADON A further said that if for any reason the MD or another medical director was unable to be located, the staff was supposed to notify the DON. She said she did not know if the previous DON was aware of the situation with CR #3. When asked if CR #3 had any assessments previous to being found unresponsive or any vital signs, ADON A then looked at the computed and then said there is none, last vital signs were on [DATE] at 4:42 p.m. In a phone interview on [DATE] at 4:25 p.m. LVN C, stated she was the charge nurse for CR #3 on [DATE] from 6 a.m. to 2:00 p.m. and said she called the NP to notify her CR #3 oxygen levels were low. The NP called her at the end of her shift and told her to send CR #3 to the hospital. LVN C said she told the 2:00 to 10:00 p.m. shift nurse who was RN D about the order to send CR #3 to the hospital. LVN C said it was around 3:50 p.m. on [DATE] when she got the order. LVN C continued saying she did not transcribe the order to CR #3's chart because she was going home and she had already talked to RN D about the new orders. LVN C further said she got the orders via text message and the staff would usually call, page or text the MD or the NP. When asked to see the text she said that she had erased the text message from the NP. Continued phone interview with LVN C at that time, she stated whenever a resident had a change in condition, the staff was supposed to complete a change in condition form in the computer, like an SBAR, when they would write their assessments, MD and RP notifications . S said she did not complete that assessment on CR #3. In a phone interview on [DATE] at 4:42 p.m. LVN A, he stated he was the charge nurse for CR #3 from 10:00 p.m. on [DATE] to at around 3:00 a.m. on [DATE] and further said I wasn't supposed to even being there on that day and continued saying I did not get any report regarding any change in condition regarding CR #3. I knew about the critical values of her laboratory results, I paged the MD twice and did not get any respond. Then I left at around 3:00 a.m. and gave report to LVN B so she

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) could follow up and pass the information to the day shift. LVN A then said the other medical director called the facility on [DATE] regarding another resident and he did not notify him about CR #3 because he was very busy with this other resident who had a PICC line. He said but I heard that the day shift was able to get hold of the NP. Further interview with LVN A at that time, he stated critical laboratory values was a change in condition and he was supposed to contact the MD or the DON if unable to contact the MD He said In this place everything is so confused, I don't even know who the DON was. LVN A then said he was supposed to check the vital signs of CR #3 but he only checked the oxygen saturation. He said RN D didn't really tell me anything about CR #3. We were supposed to do the eINTERAC change of condition documentation in the computer but I can't explain why I did not do it. I don't know why. I should had monitored any cardiac issues, blood pressure and heart rate due to her high potassium levels. I was overwhelmed. In an interview on [DATE] at 5:00 p.m. RN D, stated she was the charge nurse for CR #3 on [DATE] during the 2:00 p.m. to 10:00 p.m. shift and then said during change of shift report CR #3 was sleepy and she asked about CR #3's oxygen saturation. The morning shift nurse told her it was around the 80's and that she had increased the oxygen to 4 liters and she re-checked the oxygen and it was 89 to 90%. RN D said during her shift, the laboratory collected blood from CR #3 that was ordered during the day shift. RN D said LVN C never told her about the orders to transfer CR #3 to the hospital. RN D continued saying she spoke with the NP because the NP wanted to know the laboratory results for CR #3 but she did not receive any reports from the laboratory. She never knew the NP wanted CR #3 to go to the hospital. When asked about the order to increase [MEDICATION NAME] for CR #3 for nausea and vomiting, RN D stated she did not remember if CR #3 had any nausea that day . Continued interview on [DATE] at 5:15 p.m. with RN D, she said whenever a resident had a change in condition, there was an eINTERACT form to complete on the computer where the nurse writes the assessments and then said I did not check if someone had completed a change of condition form on CR #3. It should had been completed on the day shift on [DATE]. In a phone interview on [DATE] at 9:15 a.m. LVN B, stated LVN A left the building on [DATE] at around 3:30 a.m. He told her everything was fine and that CR #3 did not have any issues. LVN B further said LVN A did not mention to her anything about the laboratory values of CR #3 but that she knew the laboratory had called at 1:30 a.m. to report critical values because she was the one who got the call and gave the message to LVN A. LVN B continued saying she also knew LVN A had paged the MD twice and she did not receive any MD calls for the rest of the shift. LVN B then said she did not try calling the MD for CR #3's critical laboratory values and she did not do any vital signs for CR #3 either. In a phone interview on [DATE] at 3:29 p.m. the NP, stated she came to the facility on [DATE] and saw CR #3 and ordered STAT laboratory blood work because when she saw CR #3 she did not look good. The NP stated she did not hear anything about the results of the laboratory blood work for CR #3 after she gave the orders. The NP then said the following morning she called the facility to find out if CR #3 was sent to the hospital as she had ordered on [DATE] and to find out about the laboratory results. The NP continued saying on [DATE] at around 7:00 a.m. she called the facility and spoke to ADON A and asked about CR #3 and how come she did not hear about the laboratory results. At that moment, ADON A told her CR #3 was still in the facility and the NP asked ADON A for CR #3's vital signs right away including oxygen saturation. Further interview at that time the NP, stated she was surprise to find out CR #3 was not in the hospital and requested CR #3's vital signs because she wanted to know how she was doing and it was at that time ADON A told her CR #3 was unresponsive. The NP then said I don't understand why the nurses did not follow the orders and called for laboratory blood work STAT, if it wasn't that I called them the next morning at 7:00 a.m. and inquired about CR #3 status , what if I did not call?. I gave STAT laboratory blood work orders, I expected the results right away. When I did not hear anything during the night shift, I thought CR #3 was sent to hospital but I decided to follow up with the facility the next morning. I even told them 'you guys are not following orders' . In an interview on [DATE] at 3:52 p.m. with the Administrator, she stated STAT laboratory orders needed to be call immediately to the laboratory and the policy was for the laboratory to come and draw the blood within 4 hours and 1 to 2 hours to get the results back. Administrator then said once the nurse gets the orders, the nurse will enter the order in the computer and then would follow on the order. She further said the nurse who gets the laboratory results is the nurse who will follow up with the MD. Administrator further said for STAT abnormal laboratory results, the nurses will call the MD right away, if the MD does not answer, then the medical director, facility has 2 medical directors, if one does not answer, then we will call the other medical director. If none of the medical directors answer, then the nurse is supposed to call the DON and the Administrator so we can help in getting hold of the doctors. Continued interview with the Administrator, she stated whenever a resident has a change in condition, they are supposed to complete an eINTERACT form in the computer. She further said the interact form was a tool built in the computer system for changes in condition where it will trigger on what will need to happened. The Administrator further said the interact tool would guide the nurses on calling the MD, the RP and to follow up on assessments. Further interview on [DATE] at 4:00 p.m. with the Administrator, she stated RN D told her on [DATE] at around 5:45 p.m. CR #3 had some abnormal vitals and that RN D had talked to the MD or the NP. She was told orders were to monitor CR #3's oxygen saturation and if the oxygen would drop, to send CR #3 to the hospital. The Administrator further said CR #3's vitals got better and CR #3 was improving. Everything got looking good. The Administrator then said RN D got the STAT laboratory orders for CR #3 on [DATE] at around 5:45 p.m. then the laboratory called with abnormal values at around 1:00 a.m. They tried to reach the MD, then I am foggy about it. They attempted to call the MD twice. They heard back from the MD 5 minutes before CR #3 coded. Staff gave CR #3 CPR and sent her to hospital. I believed CR#3 was even admitted to ICU before she died . CR #3 had been in the facility for one week, she was here for therapy. Continued interview with the Administrator on [DATE] at 4:09 p.m. She stated facility staff did not call her on [DATE] when they were unable to contact the MD for CR #3's critical laboratory values but believed the former DON was contacted. In a second interview on [DATE] at 4:45 p.m. LVN C, she said on [DATE] the NP came to visit CR #3 in the morning and gave STAT laboratory blood work. LVN C then said she was not sure how long do they have to call the laboratory for STAT orders but she believed they have 4 hours to call the laboratory. LVN C further said she texted the NP on [DATE] regarding CR #3's condition because her oxygen saturations were on the 80's and when she got the text back from the NP, she went and told RN D. LVN C then said The nurse who gets the order is the one responsible of inputting the order on the computer system. I did not do it because I was leaving to my home. I should had done it. I should had completed an eINTERACT assessment on CR #3 as well. Further interview with LVN C, she stated the first time she called the laboratory for STAT orders she only called for the urinalysis and the BNP (Beta Naturetic Peptide) because she misread the orders. She said later during change of shift, she found out together with RN D she had omitted the STAT orders for BMP (basic metabolic panel) and RN D was to follow up with it. LVN C further said she did not notify the NP about the mistake in transcribing orders to the laboratory requisition form. In a phone interview on [DATE] at 5:09 p.m. with the laboratory, technician stated they received a call from the facility on [DATE] at 12:12 p.m. for STAT order request for urinalysis and the BNP (Beta Naturetic Peptide) for CR #3 and on [DATE] at 5:06 p.m. they received another STAT order request for BMP for CR #3. Resident #1 Record review of the facility face sheet revealed Resident #1 was a [AGE] year old female. She was admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]., unspecified and essential (primary) hypertension. Record review of Resident #1 admission assessment dated [DATE] revealed she was cognitively intact with a BIMS score of 15 out of a possible 15. She required extensive assistance of two or more person for bed mobility, and was total dependent on two or more person physical assist for transfer, locomotion on unit and off unit, dressing, toilet use, personal hygiene and bathing. Resident #1 was always incontinent of bowel and bladder. Further record review revealed a weight of 792 lbs and 64 inches in height. Continued record review revealed Resident #1 was at risk of developing pressure sores and was not on a turning/repositioning program. She received application of non-surgical dressing and ointment/medications other than to feet. Record review of Resident #1's care plan initiated [DATE] revealed in part: -Focus: At risk for an ADL self care performance deficit related to limited mobility, limited ROM. All due to severe [MEDICAL CONDITION] and severe [MEDICAL CONDITION] (swelling that occurs in the arms or legs). Has limited physical movement being total dependent related to disease process, [MEDICAL CONDITION], weakness and limited movement.

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F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 6) -Goal: Resident #1 will be safely assisted with performance with bed mobility, dressing, grooming, toilet/incontinent needs and personal hygiene. She required extensive assist of 5 to 7 staff members. -Interventions: Bed mobility: is totally dependent on staff for repositioning and turning in bed. Requires 5 to 7 staff member to turn and reposition and provided treatment. Further record review revealed no information on her care plan related to the need of an oversize bed with interventions on how to maneuver her oversized bed in the event of an emergency that required evacuation. Record review of facility grievance dated [DATE] revealed in part: .Print individual's name: (Resident #1's) family member. Describe concern using factual terms: On Friday, [DATE], (Resident #1) was cleaned up at 8:00 p.m. so she started to urinate during the night. I asked that she get cleaned up at 10:00 a.m The CNA knew so we waited both me and (Resident #1), we ended up going to sleep so by the time we woke up, it was 5:30 p.m. so I went back with the nurse and told him and the nurse said he will let the 2 to 10:00 p.m. CNA know. Her CNA said she will come after dinner so by the time came (Resident #1) was soaking wet and full of bowel movement to the point that the bed was soaked, the same thing happened Sunday [DATE]th. Informed Administrator . Record review of the facility's In-service education record dated [DATE] with title Resident #1's bed revealed that training was given to only 11 facility staff members. Further record review revealed that 9 staff members were from the 6:00 a.m. to 2:00 p.m. shift, 1 staff member was from the 2:00 p.m. to 10:00 p.m. shift and 1 staff member from the 10:00 p.m. to 6:00 a.m. shift. Record review of Resident #1's social progress notes dated [DATE] at 1:30 p.m. revealed in part: Spoke with Resident #1 and family member and Resident #1 was very upset and frustrated and stated that she does not feel comfortable because during the tornado warning , she (Resident #1) was never brought out to the hallway. She stated that she was told from the Administrator that they would have to break down the bed to get it out of the room. Resident #1 stated that staff just pulled the curtains closed during the storm. Resident #1 stated that the Administrator told her that a tornado would hit the 100 hall first if anything were to happened.(Resident #1 was on the 300 hallway). Resident #1 stated that she found out that by law, all residents were to be pulled out into the hallway .Resident #1 stated that she was told by the Administrator that the facility has the staff and personnel to address her needs. Resident #1 stated that she felt lied to because she sits in her own urine and feces for hours and that the urine and feces go into her wounds. Resident #1 does not understand why it takes so long for the staff to come and clean her up. She stated that she needs to be cleaned up fist to receive physical therapy which she has missed due to not being cleaned in a timely manner. Resident #1 stated that her family member will go up to the front to ask for assistance but it still takes a very long time for the staff to come and clean her up. Resident #1 is very angry and wants something to be done . Further record review of Resident #1's social progress notes dated [DATE] at 2:30 p.m. revealed in part: .Resident #1 stated that she was furious because she felt lied to. She stated that she was last cleaned at 9:00 p.m. on [DATE] and will finally get cleaned up at 2:00 p.m. on [DATE]. Resident #1 stated that she felt that she was lied to by the Administrator prior to being admitted just to get her to the facility to get paid and now that her 20 days are up, she feels like she is overlooked. Resident #1 requested to speak with someone who can ensure that she gets cleaned and the proper care she is entitled to In an interview on [DATE] at 8:58 a.m. with Resident #1 and her family member, she stated she did not feel safe at the facility because there had been a tornado warning few days ago and staff took all residents out to the hallways and she was left in her room. Resident #1 further said staff only closed her curtains. She felt very afraid because she was not evacuated from her room like the other residents. Resident #1 continued saying she was not able to get up or walk on her own. Observation revealed the measurements of the width of Resident #1's bed was 52 inches (from side rail to side rail). The measurements of the width of Resident #1's room door was 44 inches. Further interview at that time with Resident #1 and her family member present, Resident #1 stated facility staff was only providing incontinent care at 9:00 p.m. and 3:00 p.m. and then said I have wounds in my legs and the stool and urine are getting into my wounds. I haven't being cleaned today at all. I don't even know who my aide was. Staff don't come to see me in hours. If I pressed my call light, they will not come until around 11:30 a.m. I am very aware of what's going on, how about the people who are not aware of themselves?. Last night my brief was changed at 9:00 p.m. Normally staff don't change my brief during the night shift. I would like to be cleaned during the night but they don't come, even to check on me. Like now, if I would go and asked them to clean me because I feel that my brief is already soiled, they will say they are busy with breakfast. Every day I don't get care until around 1:30 p.m. or 3:00 p.m. Further interview at that time, Resident #1's family member stated since Resident #1 is in the facility, they haven't cleaned her before 1:00 p.m. Continued interview at on [DATE] at 9:10 a.m. Resident #1 stated my hair was not washed until 21 days after I was admitted to the facility, nobody comes to turn me in bed like they did at the hospital. I get my therapy late because I get cleaned up late. The Administrator told me before coming to the facility they had the staff to care for me. She promised me a lot of things. She told me I was going to be fully taken care of. My family member is the one taking care of me, he would try to help me get cleaned up because the staff is busy. My back hurts, my buttocks hurts. I feel soiled. I can smell myself. In an interview on [DATE] at 11:06 a.m. with Resident #1, she stated nobody had come to her room to check on her and offer to clean her and further said I don't even know who my aide is, since 9:00 p.m. last night that they did incontinent care, nobody has come to check if I need care. In an interview on [DATE] at 11:13 a.m. CNA I, stated she was the aide assigned to care for Resident #1. When asked what time she was going to do care for Resident #1, CNA I stated We need 6 to 7 people to do incontinent care for Resident #1 and the Central Supply person is helping me on gathering all the staff. I can't do it by myself. Observation on [DATE] at 11:40 a.m. during incontinent care to Resident #1 revealed that 6 staff members came to assist with incontinent care. CNA J, CNA W and CNA X supported Resident #1's abdominal fold up while CNA I and CNA Y each held open one leg. Central Supply person (who was also a CNA) cleaned Resident #1's abdominal fold and front perineal area. Further observation at that time revealed that Resident #1's had a rectangular moisture sheet approx 6 inches by 14 inches, under her abdominal area and one between her upper thighs and the moisture sheet that was in between Resident #1's upper thighs was completely soaked and was
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 implement their policy that prohibited neglect for two of seven residents (CR #3 and Resident #1) reviewed for neglect. - The facility failed to draw CR #3's STAT BMP laboratory orders for 10.5 hours. -The facility failed to notify the MD of CR #3's critical Potassium levels for 5.25 hours. -The facility failed to send CR #3 to the hospital for 14 hours after the NP instructed them to do so. -The facility failed to provide assessments and closely monitor the vital signs when CR #3 had a change in her condition. LVN A and LVN B did not assess CR #3's condition and vital signs during the night shift prior to being found unresponsive on [DATE] at 7:11 a.m. CR #3 was pronounced dead 26 minutes after arrival to the emergency room . -The facility failed to have adequate trained staff to evacuate Resident #1 from the building in the event of an emergency. She said she felt fearful when she was was forgotten in her room during an actual tornado alert. -The facility failed to have adequate staffing on the 10:00 p.m.-6:00 a.m. shift to provide Resident #1's incontinent care to protect her wounds causing her emotional distress when she said she smelled herself and felt humiliated. An IJ was identified on [DATE] and [DATE]. While the IJs were removed on [DATE] the facility remained out of compliance at a scope of pattern and a severity of actual harm due to facility requiring more time to monitor the plan of removal for effectiveness and train staff. These failures affected one former resident (CR#3) who died 26 minutes after arrival to the emergency room and one resident at the facility (Resident #1) and placed the other 87 residents at the facility at risk of not receiving adequate care, fear, injuries, decline in their health condition well-being and death.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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 7) Findings included: Intakes # 4, # 6 and # 8 Record review of the facility policy and procedure revised ,[DATE] Abuse prevention and reporting revealed in part: .Neglect: Action or inaction that avoids or prevents physical, mental harm, pain, demonstrates disregard or consequences that may constitute a clear and present danger . Record review of the facility's undated Statement of Resident Rights revealed in part: .You have the right to (1) all care necessary for you to have the highest possible level of health Dignity and respect You have the right to live in safe, decent, and clean conditions, be free from neglect be treated with dignity, consideration and respect Make your own choices regarding personal care . CR #3 Record review of the facility face sheet revealed CR# 3 was a [AGE] year old female admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]. CR #3 was found unresponsive and was sent to the hospital on [DATE] and was pronounced dead 26 minutes after arrival to the emergency room . Record review of the 5 day MDS assessment dated [DATE] revealed CR #3 required limited assistance for bed mobility, transfer, dressing, toileting and personal hygiene and supervision for walking in room and in corridor, locomotion and eating. CR #3 was always continent of bowel and had an indwelling catheter for urine. Record review of CR #3's electronic and paper records revealed CR #3 did not have a care plan. Record review of CR #3's NP progress notes dated [DATE] revealed in part: [AGE] year old female readmitted at the hospital for frequent falls. She is here for rehab. Past medical history for hypertension, [MEDICAL CONDITIONS] and acute [MEDICAL CONDITION] .STAT BNP (Pro) (Beta Naturetic Peptide - test to help detect, diagnose, and evaluate the severity of heart failure), BMP (basic metabolic panel, blood work that assess electrolytes and kidney function) and urinalysis. Assessment/Plan: [MEDICAL CONDITION] - BUN (Blood Urea Nitrogen) / Creatinine (test to assess kidney function) high on [DATE]. Will re-check STAT today . Record review of CR #3's physician's telephone orders signed by the NP and dated [DATE] at 9:30 a.m. revealed orders in part: - STAT urinalysis, BMP and Pro BNP . Record review of CR#3's laboratory requisition form dated [DATE] revealed a collection time of 1:52 p.m. for urinalysis and BNP (Beta Naturetic Peptide). Further record review revealed the BMP test was omitted on the requisition order. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 3:15 p.m. Late entry by LVN C .CR #3 went to therapy and therapist checked oxygen saturation and read 78%. Checked CR #3's oxygen saturation upon returning to room and oxygen saturation read 82%. Immediately placed CR #3 on oxygen at 2 liters. Oxygen continued to rise to 89%. Vital signs blood pressure ,[DATE], pulse 71, temperature 98.4 and respirations 15 - 16 breaths per minute with no labored breathing. Contacted NP with results on low oxygen and informed her that the oxygen was rising and asked if CR #3 could go out to hospital. Informed oncoming nurse . -[DATE] at 4:16 p.m. by LVN C NP into see CR #3 and RP concerned that CR #3 is having kidney issues. Orders to have STAT urinalysis, BNP and Pro BNP .All orders completed . -[DATE] at 4:20 p.m. by LVN C NP called and informed of oxygen saturation . (NP) stated that we could send CR #3 out to hospital. Informed nurse on duty of decision . Record review of CR #3's electronic vital signs record revealed in part: -[DATE] at 4:42 p.m. Blood pressure ,[DATE] and pulse 64 beats per minute. Further record review revealed no further vitals sign assessments for CR #3. Further record review of CR #3's laboratory requisition form dated [DATE] revealed a collection time of 8:00 p.m. for BMP (basic metabolic panel). This was the original STAT ordered lab the NP ordered at 9:30 a.m. that was omitted of the first lab requisition form. Further record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 7:57 p.m. by RN D Given order by NP to increase CR #3's [MEDICATION NAME] to 8 mg by mouth every 4 hours as needed for nausea which was entered into the computer and faxed to pharmacy . Record review of CR #3's electronic MAR indicated [REDACTED] Record review of CR #3's laboratory report dated [DATE] at 12:18 a.m. revealed in part; -Potassium level 6.2 mEq/L Reference range (3.5 - 5.3). Continued record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 1:46 a.m. by LVN A Potassium 6.2. Dr. A informed. Awaiting call back. -[DATE] at 1:49 a.m. by LVN A [MEDICATION NAME] (muscle relaxant) tablet 350 mg. Give 0.5 tablet by mouth every 6 hours as needed for muscle spasm / back pain. CR #3 requested for muscle spasms -[DATE] at 2:30 a.m. by LVN A CR #3 lying in bed, no complaints of pain or nausea. Oxygen saturation 94% at 3 liters of oxygen. Assisted to restroom with 1 person assistance. Tolerated ambulation well. Dr. A paged of Critical Potassium levels of 6.2. -[DATE] at 3:10 a.m. by LVN A [MEDICATION NAME] (muscle relaxant) tablet 350 mg. Give 0.5 tablet by mouth every 6 hours as needed for muscle spasm / back pain effective Further record review of the progress/nurses notes revealed no further attempts to contact the MD for the critical Potassium levels, no vital sign assessments or any further assessments during the night shift. Record review of CR #3's MD orders dated [DATE] revealed in part; -[MEDICATION NAME] tablet 350 mg, give 0.5 tablet by mouth every 6 hours as needed for muscle spasm/back pain. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 2:14 p.m. by ADON A Received in report that laboratory reported a critical potassium level and no new orders obtained as of that time. Contacted NP with laboratory results approx 7:06 a.m. NP returned call at 7:11 a.m. requesting oxygen saturation levels. Reported back to CR #3's to check oxygen saturation. Upon entering room CR #3's eyes were closed and she was non-responsive to verbal and tactile stimuli. CR #3 was not breathing, no pulse palpable, skin warm to touch. Code called, CPR initiated and 911 called. Fire department arrived and took over CPR until paramedics arrived. CR #3 was last observed sleeping in bed at approx 6:30 A.M. Notified emergency contact at approx 7:40 a.m. that CR #3 was observed unresponsive and that she should go to the hospital where CR #3 was transferred . Record review of CR #3's hospital records from the emergency room revealed in part: Arrival date/time: [DATE] at 8:05 a.m. -At 8:25 a.m. [AGE] years old white female presents to ED via unassigned with complaints of Full arrest. -At 8:25 a.m. Preceding the arrest, CR #3 was found down by nursing home staff. The arrest occurred at the nursing home. The arrest was not witnessed by others. Bystanders at the scene performed CPR. -EMS (emergency medical service) care prior to arrival: Initiation of ACLS (advanced cardiac life support), peripheral IV, was successfully placed. 15 minutes elapsed prior to ACLS. ACLS has been in progress for 45 minutes. ACLS details: initial rhythm was asystole (flat line in electrocardiogram). [MEDICATION NAME] ([MEDICATION NAME]) intravenous 8 doses. Response to therapy: Continued arrest. Arrest was first noted at 7:15 a.m. asystole was presenting rhythm, there may have been PEA (pulseless electrical activity) at one point. --At 8:31 a.m. ED course: CR #3 has been under CPR for more than 45 minutes with no ROSC (return of spontaneous circulation). While there was not a definitive airway, after 45 minutes of CPR and 9 rounds of [MEDICATION NAME], did not feel like any further attempts at airway wound lead to different outcome other than death. CR #3 was pronounced. -Diagnosis: [REDACTED]. In an interview on [DATE] at 2:08 p.m. ADON A, stated she was the charge nurse for CR #3 on [DATE] when she was found unresponsive. ADON A said she had arrived at the facility and started her rounds alone looking at the residents at around 6:30 a.m. and it was at that time she saw CR#3 sleeping. She said LVN B told her CR #3 had critical potassium levels during the night shift and that the MD had not returned the call yet. LVN A who was assigned to CR #3 during the night shift, had gone home earlier on the shift. ADON A then said when LVN B told me staff had not follow up with the MD regarding the critical potassium levels, I texted the NP and the NP called me within a couple of minutes. I gave her the critical values of potassium for CR #3 and she asked me for CR #3's oxygen saturation levels because CR #3 was having problems with her

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LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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 8) oxygen on [DATE]. When I went to the room at that moment still with the phone on my hands and the NP on the line, CR #3 was found not breathing, and no vital signs. CPR was started and 911 was called. CR #3 died in route to the hospital. Further interview with the ADON A at that time, she stated the night shift tried to call the MD but the MD was not reach. ADON A then said facility protocol is that if the MD does not return the calls, we were supposed to call the medical director, but CR #3's MD was the medical director. Facility has another medical director that we were supposed to call if the first medical director does not answer the calls. LVN B said the other medical director called the facility during the night shift on [DATE] for another resident and LVN A forgot to mention about the critical potassium values of CR #3. Continued interview the ADON A on [DATE] at 2:20 p.m. said critical laboratory values was a change in condition and the facility staff was supposed to complete a change of condition assessment in the computer where it prompt staff to assess the resident, notify MD and RP. ADON A further said that if for any reason the MD or another medical director was unable to be located, the staff was supposed to notify the DON. She said she did not know if the previous DON was aware of the situation with CR #3. When asked if CR #3 had any assessments previous to being found unresponsive or any vital signs, ADON A then looked at the computed and then said there is none, last vital signs were on [DATE] at 4:42 p.m. In a phone interview on [DATE] at 4:25 p.m. LVN C, stated she was the charge nurse for CR #3 on [DATE] from 6 a.m. to 2:00 p.m. and said she called the NP to notify her CR #3 oxygen levels were low. The NP called her at the end of her shift and told her to send CR #3 to the hospital. LVN C said she told the 2:00 to 10:00 p.m. shift nurse who was RN D about the order to send CR #3 to the hospital. LVN C said it was around 3:50 p.m. on [DATE] when she got the order. LVN C continued saying she did not transcribe the order to CR #3's chart because she was going home and she had already talked to RN D about the new orders. LVN C further said she got the orders via text message and the staff would usually call, page or text the MD or the NP. When asked to see the text she said that she had erased the text message from the NP. Continued phone interview with LVN C at that time, she stated whenever a resident had a change in condition, the staff was supposed to complete a change in condition form in the computer, like an SBAR, when they would write their assessments, MD and RP notifications . S said she did not complete that assessment on CR #3. In a phone interview on [DATE] at 4:42 p.m. LVN A, he stated he was the charge nurse for CR #3 from 10:00 p.m. on [DATE] to at around 3:00 a.m. on [DATE] and further said I wasn't supposed to even being there on that day and continued saying I did not get any report regarding any change in condition regarding CR #3. I knew about the critical values of her laboratory results, I paged the MD twice and did not get any respond. Then I left at around 3:00 a.m. and gave report to LVN B so she could follow up and pass the information to the day shift. LVN A then said the other medical director called the facility on [DATE] regarding another resident and he did not notify him about CR #3 because he was very busy with this other resident who had a PICC line. He said but I heard that the day shift was able to get hold of the NP. Further interview with LVN A at that time, he stated critical laboratory values was a change in condition and he was supposed to contact the MD or the DON if unable to contact the MD He said In this place everything is so confused, I don't even know who the DON was. LVN A then said he was supposed to check the vital signs of CR #3 but he only checked the oxygen saturation. He said RN D didn't really tell me anything about CR #3. We were supposed to do the eINTERAC change of condition documentation in the computer but I can't explain why I did not do it. I don't know why. I should had monitored any cardiac issues, blood pressure and heart rate due to her high potassium levels. I was overwhelmed. In an interview on [DATE] at 5:00 p.m. RN D, stated she was the charge nurse for CR #3 on [DATE] during the 2:00 p.m. to 10:00 p.m. shift and then said during change of shift report CR #3 was sleepy and she asked about CR #3's oxygen saturation. The morning shift nurse told her it was around the 80's and that she had increased the oxygen to 4 liters and she re-checked the oxygen and it was 89 to 90%. RN D said during her shift, the laboratory collected blood from CR #3 that was ordered during the day shift. RN D said LVN C never told her about the orders to transfer CR #3 to the hospital. RN D continued saying she spoke with the NP because the NP wanted to know the laboratory results for CR #3 but she did not receive any reports from the laboratory. She never knew the NP wanted CR #3 to go to the hospital. When asked about the order to increase [MEDICATION NAME] for CR #3 for nausea and vomiting, RN D stated she did not remember if CR #3 had any nausea that day . Continued interview on [DATE] at 5:15 p.m. with RN D, she said whenever a resident had a change in condition, there was an eINTERACT form to complete on the computer where the nurse writes the assessments and then said I did not check if someone had completed a change of condition form on CR #3. It should had been completed on the day shift on [DATE]. In a phone interview on [DATE] at 9:15 a.m. LVN B, stated LVN A left the building on [DATE] at around 3:30 a.m. He told her everything was fine and that CR #3 did not have any issues. LVN B further said LVN A did not mention to her anything about the laboratory values of CR #3 but that she knew the laboratory had called at 1:30 a.m. to report critical values because she was the one who got the call and gave the message to LVN A. LVN B continued saying she also knew LVN A had paged the MD twice and she did not receive any MD calls for the rest of the shift. LVN B then said she did not try calling the MD for CR #3's critical laboratory values and she did not do any vital signs for CR #3 either. In a phone interview on [DATE] at 3:29 p.m. the NP, stated she came to the facility on [DATE] and saw CR #3 and ordered STAT laboratory blood work because when she saw CR #3 she did not look good. The NP stated she did not hear anything about the results of the laboratory blood work for CR #3 after she gave the orders. The NP then said the following morning she called the facility to find out if CR #3 was sent to the hospital as she had ordered on [DATE] and to find out about the laboratory results. The NP continued saying on [DATE] at around 7:00 a.m. she called the facility and spoke to ADON A and asked about CR #3 and how come she did not hear about the laboratory results. At that moment, ADON A told her CR #3 was still in the facility and the NP asked ADON A for CR #3's vital signs right away including oxygen saturation. Further interview at that time the NP, stated she was surprise to find out CR #3 was not in the hospital and requested CR #3's vital signs because she wanted to know how she was doing and it was at that time ADON A told her CR #3 was unresponsive. The NP then said I don't understand why the nurses did not follow the orders and called for laboratory blood work STAT, if it wasn't that I called them the next morning at 7:00 a.m. and inquired about CR #3 status , what if I did not call?. I gave STAT laboratory blood work orders, I expected the results right away. When I did not hear anything during the night shift, I thought CR #3 was sent to hospital but I decided to follow up with the facility the next morning. I even told them 'you guys are not following orders' . In an interview on [DATE] at 3:52 p.m. with the Administrator, she stated STAT laboratory orders needed to be call immediately to the laboratory and the policy was for the laboratory to come and draw the blood within 4 hours and 1 to 2 hours to get the results back. Administrator then said once the nurse gets the orders, the nurse will enter the order in the computer and then would follow on the order. She further said the nurse who gets the laboratory results is the nurse who will follow up with the MD. Administrator further said for STAT abnormal laboratory results, the nurses will call the MD right away, if the MD does not answer, then the medical director, facility has 2 medical directors, if one does not answer, then we will call the other medical director. If none of the medical directors answer, then the nurse is supposed to call the DON and the Administrator so we can help in getting hold of the doctors. Continued interview with the Administrator, she stated whenever a resident has a change in condition, they are supposed to complete an eINTERACT form in the computer. She further said the interact form was a tool built in the computer system for changes in condition where it will trigger on what will need to happened. The Administrator further said the interact tool would guide the nurses on calling the MD, the RP and to follow up on assessments. Further interview on [DATE] at 4:00 p.m. with the Administrator, she stated RN D told her on [DATE] at around 5:45 p.m. CR #3 had some abnormal vitals and that RN D had talked to the MD or the NP. She was told orders were to monitor CR #3's oxygen saturation and if the oxygen would drop, to send CR #3 to the hospital. The Administrator further said CR #3's vitals got better and CR #3 was improving. Everything got looking good. The Administrator then said RN D got the STAT laboratory orders for CR #3 on [DATE] at around 5:45 p.m. then the laboratory called with abnormal values at around 1:00 a.m. They tried to reach the MD, then I am foggy about it. They attempted to call the MD twice. They heard back from the MD 5 minutes before CR #3 coded. Staff gave CR #3 CPR and sent her to hospital. I believed CR#3 was even admitted to ICU before she died . CR #3 had been in the facility for one week, she was here for therapy. Continued interview with the Administrator on [DATE] at 4:09 p.m. She stated facility staff did not call her on [DATE] when they were unable to contact the MD for CR #3's critical laboratory values but believed the former DON was contacted. In a second interview on [DATE] at 4:45 p.m. LVN C, she said on [DATE] the NP came to visit CR #3 in the morning and gave STAT laboratory blood work. LVN C then said she was not sure how long do they have to call the laboratory for STAT orders

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F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 9) but she believed they have 4 hours to call the laboratory. LVN C further said she texted the NP on [DATE] regarding CR #3's condition because her oxygen saturations were on the 80's and when she got the text back from the NP, she went and told RN D. LVN C then said The nurse who gets the order is the one responsible of inputting the order on the computer system. I did not do it because I was leaving to my home. I should had done it. I should had completed an eINTERACT assessment on CR #3 as well. Further interview with LVN C, she stated the first time she called the laboratory for STAT orders she only called for the urinalysis and the BNP (Beta Naturetic Peptide) because she misread the orders. She said later during change of shift, she found out together with RN D she had omitted the STAT orders for BMP (basic metabolic panel) and RN D was to follow up with it. LVN C further said she did not notify the NP about the mistake in transcribing orders to the laboratory requisition form. In a phone interview on [DATE] at 5:09 p.m. with the laboratory, technician stated they received a call from the facility on [DATE] at 12:12 p.m. for STAT order request for urinalysis and the BNP (Beta Naturetic Peptide) for CR #3 and on [DATE] at 5:06 p.m. they received another STAT order request for BMP for CR #3. Resident #1 Record review of the facility face sheet revealed Resident #1 was a [AGE] year old female. She was admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]., unspecified and essential (primary) hypertension. Record review of Resident #1 admission assessment dated [DATE] revealed she was cognitively intact with a BIMS score of 15 out of a possible 15. She required extensive assistance of two or more person for bed mobility, and was total dependent on two or more person physical assist for transfer, locomotion on unit and off unit, dressing, toilet use, personal hygiene and bathing. Resident #1 was always incontinent of bowel and bladder. Further record review revealed a weight of 792 lbs and 64 inches in height. Continued record review revealed Resident #1 was at risk of developing pressure sores and was not on a turning/repositioning program. She received application of non-surgical dressing and ointment/medications other than to feet. Record review of Resident #1's care plan initiated [DATE] revealed in part: -Focus: At risk for an ADL self care performance deficit related to limited mobility, limited ROM. All due to severe [MEDICAL CONDITION] and severe [MEDICAL CONDITION] (swelling that occurs in the arms or legs). Has limited physical movement being total dependent related to disease process, [MEDICAL CONDITION], weakness and limited movement. -Goal: Resident #1 will be safely assisted with performance with bed mobility, dressing, grooming, toilet/incontinent needs and personal hygiene. She required extensive assist of 5 to 7 staff members. -Interventions: Bed mobility: is totally dependent on staff for repositioning and turning in bed. Requires 5 to 7 staff member to turn and reposition and provided treatment. Further record review revealed no information on her care plan related to the need of an oversize bed with interventions on how to maneuver her oversized bed in the event of an emergency that required evacuation. Record review of facility grievance dated [DATE] revealed in part: .Print individual's name: (Resident #1's) family member. Describe concern using factual terms: On Friday, [DATE], (Resident #1) was cleaned up at 8:00 p.m. so she started to urinate during the night. I asked that she get cleaned up at 10:00 a.m The CNA knew so we waited both me and (Resident #1), we ended up going to sleep so by the time we woke up, it was 5:30 p.m. so I went back with the nurse and told him and the nurse said he will let the 2 to 10:00 p.m. CNA know. Her CNA said she will come after dinner so by the time came (Resident #1) was soaking wet and full of bowel movement to the point that the bed was soaked, the same thing happened Sunday [DATE]th. Informed Administrator . Record review of the facility's In-service education record dated [DATE] with title Resident #1's bed revealed that training was given to only 11 facility staff members. Further record review revealed that 9 staff members were from the 6:00 a.m. to 2:00 p.m. shift, 1 staff member was from the 2:00 p.m. to 10:00 p.m. shift and 1 staff member from the 10:00 p.m. to 6:00 a.m. shift. Record review of Resident #1's social progress notes dated [DATE] at 1:30 p.m. revealed in part: Spoke with Resident #1 and family member and Resident #1 was very upset and frustrated and stated that she does not feel comfortable because during the tornado warning , she (Resident #1) was never brought out to the hallway. She stated that she was told from the Administrator that they would have to break down the bed to get it out of the room. Resident #1 stated that staff just pulled the curtains closed during the storm. Resident #1 stated that the Administrator told her that a tornado would hit the 100 hall first if anything were to happened.(Resident #1 was on the 300 hallway). Resident #1 stated that she found out that by law, all residents were to be pulled out into the hallway .Resident #1 stated that she was told by the Administrator that the facility has the staff and personnel to address her needs. Resident #1 stated that she felt lied to because she sits in her own urine and feces for hours and that the urine and feces go into her wounds. Resident #1 does not understand why it takes so long for the staff to come and clean her up. She stated that she needs to be cleaned up fist to receive physical therapy which she has missed due to not being cleaned in a timely manner. Resident #1 stated that her family member will go up to the front to ask for assistance but it still takes a very long time for the staff to come and clean her up. Resident #1 is very angry and wants something to be done . Further record review of Resident #1's social progress notes dated [DATE] at 2:30 p.m. revealed in part: .Resident #1 stated that she was furious because she felt lied to. She stated that she was last cleaned at 9:00 p.m. on [DATE] and will finally get cleaned up at 2:00 p.m. on [DATE]. Resident #1 stated that she felt that she was lied to by the Administrator prior to being admitted just to get her to the facility to get paid and now that her 20 days are up, she feels like she is overlooked. Resident #1 requested to speak with someone who can ensure that she gets cleaned and the proper care she is entitled to In an interview on [DATE] at 8:58 a.m. with Resident #1 and her family member, she stated she did not feel safe at the facility because there had been a tornado warning few days ago and staff took all residents out to the hallways and she was left in her room. Resident #1 further said staff only closed her curtains. She felt very afraid because she was not evacuated from her room like the other residents. Resident #1 continued saying she was not able to get up or walk on her own. Observation revealed the measurements of the width of Resident #1's bed was 52 inches (from side rail to side rail). The measurements of the width of Resident #1's room door was 44 inches. Further interview at that time with Resident #1 and her family member present, Resident #1 stated facility staff was only providing incontinent care at 9:00 p.m. and 3:00 p.m. and then said I have wounds in my legs and the stool and urine are getting into my wounds. I haven't being cleaned today at all. I don't even know who my aide was. Staff don't come to see me in hours. If I pressed my call light, they will not come until around 11:30 a.m. I am very aware of what's going on, how about the people who are not aware of themselves?. Last night my brief was changed at 9:00 p.m. Normally staff don't change my brief during the night shift. I would like to be cleaned during the night but they don't come, even to check on me. Like now, if I would go and asked them to clean me because I feel that my brief is already soiled, they will say they are busy with breakfast. Every day I don't get care until around 1:30 p.m. or 3:00 p.m. Further interview at that time, Resident #1's family member stated since Resident #1 is in the facility, they haven't cleaned her before 1:00 p.m. Continued interview at on [DATE] at 9:10 a.m. Resident #1 stated my hair was not washed until 21 days after I was admitted to the facility, nobody comes to turn me in bed like they did at the hospital. I get my therapy late because I get cleaned up late. The Administrator told me before coming to the facility they had the staff to care for me. She promised me a lot of things. She told me I was going to be fully taken care of. My family member is the one taking care of me, he would try to help me get cleaned up because the staff is busy. My back hurts, my buttocks hurts. I feel soiled. I can smell myself. In an interview on [DATE] at 11:06 a.m. with Resident #1, she stated nobody had come to her room to check on her and offer to clean her and further said I don't even know who my aide is, since 9:00 p.m. last night that they did incontinent care, nobody has come to check if I need care. In an interview on [DATE] at 11:13 a.m. CNA I, stated she was the aide assigned to care for Resident #1. When asked what time she was going to do care for Resident #1, CNA I stated We need 6 to 7 people to do incontinent care for Resident #1 and the Central Supply person is helping me on gathering all the staff. I can't do it by myself. Observation on [DATE] at 11:
F 0241 **Level of harm** - Actual harm **Residents Affected** - Some	**Provide care for residents in a way that keeps or builds each resident's dignity and**

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	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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 0241 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 10) **respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat and care in a manner and in an environment that promoted maintenance or enhanced the quality of life for one of seven residents (Resident #1) reviewed for care provided to promote dignity. -The facility staff failed to provide timely incontinent care, bathing and personal care to Resident #1. Resident #1 did not have a shower for 37 days. She said she smelled herself and felt humiliated. She was angry, frustrated and felt like she was lied to. She was afraid that her wounds would become infected. This affected one resident and placed the other 87 residents at risk for a loss of dignity, low self-esteem and respect in full recognition of his or her individuality. Findings include: Intakes # 6 and # 8 Record review of the facility face sheet revealed Resident #1 was a [AGE] year old female. She was admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]., unspecified and essential (primary) hypertension. Record review of Resident #1 admission assessment dated [DATE] revealed she was cognitively intact with a BIMS score of 15 out of a possible 15. She required extensive assistance of two or more person for bed mobility, and was total dependent on two or more person physical assist for transfer, locomotion on unit and off unit, dressing, toilet use, personal hygiene and bathing. Resident #1 was always incontinent of bowel and bladder. Further record review revealed a weight of 792 lbs and 64 inches in height. Continued record review revealed Resident #1 was at risk of developing pressure sores and was not on a turning/repositioning program. She received application of non-surgical dressing and ointment/medications other than to feet. Record review of Resident #1's care plan initiated 1/6/2017 revealed in part: -Focus: At risk for an ADL self care performance deficit related to limited mobility, limited ROM. All due to severe [MEDICAL CONDITION] and severe [MEDICAL CONDITION] (swelling that occurs in the arms or legs). Has limited physical movement being total dependent related to disease process, [MEDICAL CONDITION], weakness and limited movement. -Goal: Resident #1 will be safely assisted with performance with bed mobility, dressing, grooming, toilet/incontinent needs and personal hygiene. She required extensive assist of 5 to 7 staff members. -Interventions: Bed mobility: is totally dependent on staff for repositioning and turning in bed. Requires 5 to 7 staff member to turn and reposition and provided treatment. Personal hygiene: Requires total assistance with personal hygiene care. Immobility: Requires staff participation (5-7) for incontinent care. Record review of facility grievance dated 1/9/2017 revealed in part: .Print individual's name: (Resident #1's) family member. Describe concern using factual terms: On Friday, January 6, Resident #1 was cleaned up at 8:00 p.m. so she started to urinate during the night. I asked that she get cleaned up at 10:00 a.m The CNA knew so we waited both me and (Resident #1), we ended up going to sleep so by the time we woke up, it was 5:30 p.m. so I went back with the nurse and told him and the nurse said that he will let the 2 to 10:00 p.m. CNA know. Her CNA said she will come after dinner so by the time came Resident #1 was soaking wet and full of bowel movement to the point that the bed was soaked, the same thing happened Sunday January 8th. Informed Administrator . Record review of Resident #1's social progress notes dated 1/18/2017 at 1:30 p.m. revealed in part: Spoke with (Resident #1) and family member and (Resident #1) was very upset and frustrated. She stated that she was told by the Administrator that the facility has the staff and personnel to address her needs. (Resident #1) stated that she felt lied to because she sits in her own urine and feces for hours and that the urine and feces go into her wounds. (Resident #1) does not understand why it takes so long for the staff to come and clean her up. She stated that she needs to be cleaned up first to receive physical therapy which she has missed due to not being cleaned in a timely manner. (Resident #1) stated that her family member will go up to the front to ask for assistance but it still takes a very long time for the staff to come and clean her up. (Resident #1) is very angry and wants something to be done . Further record review of Resident #1's social progress notes dated 1/19/2017 at 2:30 p.m. revealed in part: .(Resident #1) stated that she was furious because she felt lied to. She stated that she was last cleaned at 9:00 p.m. on 1/18/2017 and will finally get cleaned up at 2:00 p.m. on 1/19/2017. (Resident #1) stated that she felt that she was lied to by the Administrator prior to being admitted just to get her to the facility to get paid and now that her 20 days are up, she feels like she is overlooked. (Resident #1) requested to speak with someone who can ensure that she gets cleaned and the proper care she is entitled to In an interview and observation on 1/31/2017 at 8:58 a.m. with Resident #1 and her family member, revealed there was a pervasive smell of urine and stool upon entering her room. Resident #1 stated facility staff was only providing incontinent care at 9:00 p.m. and 3:00 p.m. and then said I have wounds in my legs and the stool and urine are getting into my wounds. I haven't being cleaned today at all. I don't even know who my aide was. Staff don't come to see me in hours. If I press my call light, they will not come until around 11:30 a.m. I am very aware of what's going on, how about the people who are not aware of themselves?. Last night my brief was changed at 9:00 p.m. Normally staff don't change my brief during the night shift. I would like to be cleaned during the night but they don't come, even to check on me. Like now, if I would go and asked them to clean me because I feel that my brief is already soiled, they will say they are busy with breakfast. Every day I don't get care until around 1:30 p.m. or 3:00 p.m. Further interview at that time, Resident #1's family member stated since Resident #1 is in the facility, they haven't cleaned her before 1:00 p.m. Continued interview at on 1/31/2017 at 9:10 p.m. Resident #1 stated my hair was not washed until 21 days after I was admitted to the facility, nobody comes to turn me in bed like they did at the hospital. I get my therapy late because I get cleaned up late. The Administrator told me before coming to the facility that they had the staff to care for me. She promised me a lot of things. She told me I was going to be fully taking care of. My family member is the one taking care of me, he would try to help me get cleaned up because the staff is busy. My back hurts, my buttocks hurts. I feel soiled. I can smell myself. In an interview on 1/31/2017 at 11:06 a.m. with Resident #1, she stated that nobody had come to her room to check on her and offer to clean her and further said I don't even know who my aide is, since 9:00 p.m. last night when they did incontinent care, nobody has come to check if I need care. In an interview on 1/31/2017 at 11:13 a.m. CNA I, stated she was the aide assigned to care for Resident #1. When asked what time she was going to do care for Resident #1, CNA I stated We need 6 to 7 people to do incontinent care for Resident #1 and the Central Supply person is helping me on gathering all the staff. I can't do it by myself. Observation on 1/31/2017 at 11:40 a.m. during incontinent care to Resident #1 revealed that 6 staff members came to assist with incontinent care. CNA J, CNA W and CNA X supported Resident #1's abdominal fold up while CNA I and CNA Y each held open one leg. Central Supply person (who is also a CNA) cleaned Resident #1's abdominal fold and front perineal area. Further observation at that time revealed that Resident #1's had a rectangular moisture sheet approx 6 inches by 14 inches, under her abdominal area and one between her upper thighs and the moisture sheet that was in between Resident #1's upper thighs was completely soaked and was dark brown in color. Continued observation at that time revealed a very strong urine and stool odor in the room. Further observation at that time during incontinent care, while Resident #1 was turned to her side revealed 3 staff were needed to turned Resident #1 to her side and another 3 staff were needed to support Resident #1 on the other side of the bed while she was being turned to her side. Continued observation revealed Resident #1's brief was completely soiled up to the back of the brief. The brief was dark yellow in color and had stool on it. There was stool also on the buttocks of Resident #1. Resident #1 was lying on 2 pads that had a large dark brown colored ring where Resident #1 was lying from the buttocks area to her mid thighs. Under the pads there was a sling (staff used sling to move Resident #1 up in bed) that also had a large circular wet area on the direction where Resident #1 was lying down. While Resident #1 was on her side, she required 3 staff to hold her on her side on the side she was facing, 2 staff to hold Resident #1 on her back while the other staff was providing the incontinent care. Continued observation on 1/31/2017 at 12:23 p.m. at end of incontinent care, Resident #1 was assisted up on her bed. 3 staff

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	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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 0241 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 11) were on one side and 3 other staff were on the other side. Further observation at that time revealed that it took 6 staff members to do incontinent care and took 43 minutes to complete the procedure. In an interview on 2/1/2017 at 10:32 p.m. CNA V, stated she was the aide taking care of Resident #1 and it was her first time in the facility. She further said she was told Resident #1 required 6 people to do incontinent care and the staff from 2:00 p.m. to 10:00 p.m. had just cleaned Resident #1. In an interview on 2/1/2017 at 10:36 p.m. with Resident #1, she stated that she was cleaned only twice during the day, at 2:15 p.m. and 9:00 p.m. In an interview on 2/1/2017 at 11:00 p.m. LVN B, stated there were 3 CNA's and 2 nurses for the night shift at the facility. She further said she was the charge nurse for Resident #1. She said during the night shift, they would only go to Resident #1 room if she put her light on and then said Resident #1 gets her incontinent care during the pm shift when there is more staff. If she had a bowel movement during the night shift and she would want to have incontinent care, it would take all the staff in the facility during the night shift. She stated there were only 5 staff working in the facility at night. In an interview on 2/1/2017 at 11:05 p.m. LVN S, stated she was a full time nurse on the 10:00 p.m. to 6:00 a.m. shift and said if Resident #1 would need any care during the nights shift, they would have to use all the staff present at the facility because it would take 6 to 7 people just to turn Resident #1 in bed. In an interview on 2/1/2017 at 11:13 p.m. CNA U, stated she was a full time CNA working on the night shift. She further said it would take 5 to 6 people to move Resident #1 and if Resident #1 needed incontinent care the 3 aides and the 2 nurses in the facility would have to assist with her care. In an interview on 2/1/2017 at 11:20 p.m. CNA T, stated she was a full time CNA working on the night shift and said I don't think we are equipped for Resident #1. We usually work 3 aides and 2 nurses at the night shift and it takes about 6 people to do incontinent care for her. If we needed to clean her, the whole building of staff would have to go and care for her and it would take 35 to 40 minutes. In an interview on 2/2/2017 at 11:03 a.m. the Administrator, stated the night shift usually works together on helping Resident #1 with her care and further said I was under the impression that Resident #1 had incontinent care every morning at 6:00 a.m. Resident #1 gets care at certain times only because she does not want to be bothered. The Administrator further said she had not heard any concerns related to the care of Resident #1. In an interview on 2/2/2017 at 2:40 p.m. Resident #1, stated she never requested only certain times for care to be provided and she had not refused any care. She stated staff does not check on her during the night time and further said Like this morning, I did not get cleaned until 12:00 p.m. It makes me want to cry. I have a history of getting skin infections. Last night they cleaned me around 9:00 p.m. and I did not get incontinent care again until 12:00 p.m. today. Since 8:00 a.m. I had been waiting for somebody to come but they did not come until 12:00 p.m. I urinated and defecated on myself since early morning. The pad underneath me is always so wet because I urinate and urinate and urinate on it. I cry and get so frustrated because I know I smell. I smell my urine. I have not refused any care. I was told I was going to be bathed every other day and I don't get bathed. In an interview on 2/2/2017 at 3:08 p.m. with Central Supply, stated she was assigned with Resident #1 during the day shift and she was scheduled for a shower. She said she was going to stay over to bathe Resident #1. Central Supply further said she did not give incontinent care to Resident #1 earlier on the shift because Resident #1 was eating breakfast. The Administrator stated on 2/3/2017 at 3:20 p.m. the facility did not have a policy and procedure for staffing. Record review of the facility's undated Statement of Resident Rights revealed in part: .You have the right to (1) all care necessary for you to have the highest possible level of health Dignity and respect You have the right to live in safe, decent, and clean conditions, be free from neglect be treated with dignity, consideration and respect Make your own choices regarding personal care . Record review of the facility policy and procedure Incontinent Care revised 5/2007 revealed in part: It is the policy of this facility to remove urine or feces from skin Further record review revealed no information on how often the facility provided incontinent care to the residents. Record review of the facility policy and procedure ADL, Services to carry out revised 11/2007 revealed in part: It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities .2.- Residents who are unable to carry out activities of daily living will receive necessary services to maintain: grooming, personal hygiene . Record review of the facility policy and procedure Turning rounds revised 11/2007 revealed in part; It is the policy of this facility to 1.- Cleanse, refresh and reposition bedfast residents on a regular basis The CMS form 672 revealed 88 residents in the facility.
F 0282 **Level of harm** - Immediate jeopardy **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 provided care and services according to the comprehensive assessment and physician's orders for one of seven residents on hall 200 (CR #3) who were reviewed for care provided according to physician's orders -The facility failed to order STAT laboratory tests for CR #3. Timely. CR#3's BMP (Basic Metabolic Panel) STAT lab test was not ordered by facility staff for 10 ½ hours after the order was received from the NP (Nurse Practitioner). The resident had a critical Potassium laboratory value. CR #3 was found unresponsive 5.5 hours after the laboratory called the facility with the critical result Potassium level and she was pronounced dead 26 minutes after arrival to the emergency room . -The facility failed to transfer CR #3 to the hospital as ordered by the NP for almost 14 hours. CR #3 was found unresponsive at 7:11 am on [DATE], was transferred to the hospital where she was pronounced dead 26 minutes later. An IJ was identified on [DATE]. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of pattern and a severity of actual harm due to facility requiring more time to monitor the plan of removal for effectiveness. These failures affected one (CR #3) and placed 23 residents at the facility at risk of having a delay in medical intervention or death due to staff not providing care per the physician's orders. Findings Included: Intake # 4 Record review of the facility face sheet revealed CR# 3 was a [AGE] year old female. She was admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]. CR #3 was found unresponsive and was sent to the hospital on [DATE] and was pronounced dead 26 minutes after arrival to the emergency room . Record review of the 5 day MDS assessment dated [DATE] revealed CR #3 required limited assistance for bed mobility, transfer, dressing, toileting and personal hygiene and supervision for walking in room and in corridor, locomotion and eating. CR #3 was always continent of bowel and had an indwelling catheter for urine. Record review of CR #3's electronic and paper records revealed CR #3 did not have a care plan. Record review of CR #3's NP progress notes dated [DATE] revealed in part: [AGE] year old female readmitted at the hospital for frequent falls. She is here for rehab. Past medical history for hypertension, [MEDICAL CONDITIONS] and acute [MEDICAL CONDITION] .STAT BNP (Pro) (Beta Naturetic Peptide - test to help detect, diagnose, and evaluate the severity of heart failure), BMP (basic metabolic panel, blood work that assess electrolytes and kidney function) and urinalysis. Assessment/Plan: [MEDICAL CONDITION] - BUN (Blood Urea Nitrogen) / Creatinine (test to assess kidney function) high on [DATE]. Will re-check STAT today . Record review of CR #3's physician's telephone orders signed by the NP and dated [DATE] at 9:30 a.m. revealed orders in part: - STAT urinalysis, BMP and Pro BNP . Record review of CR#3's laboratory requisition form dated [DATE] revealed a collection time of 1:52 p.m. for urinalysis and BNP (Beta Naturetic Peptide). Further record review revealed that BMP test was omitted on the requisition order. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 3:15 p.m. Late entry by LVN C .CR #3 went to therapy and therapist checked oxygen saturation and read 78%. Checked CR #3's oxygen saturation upon returning to room and oxygen saturation read 82%. Immediately placed CR #3 on oxygen at 2 liters. Oxygen continued to rise to 89%. Vital signs blood pressure ,[DATE], pulse 71, temperature 98.4 and respirations 15 - 16 breaths per minute with no labored breathing. Contacted NP with results on low oxygen and informed her

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F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 12) the oxygen was rising and asked if CR #3 could go out to hospital. Informed oncoming nurse . -[DATE] at 4:16 p.m. by LVN C .NP into see CR #3 and RP concerned that CR #3 is having kidney issues. Orders to have STAT urinalysis, BNP and Pro BNP .All orders completed . -[DATE] at 4:20 p.m. by LVN C NP called and informed of oxygen saturation . (NP) stated that we could send CR #3 out to hospital. Informed nurse on duty of decision . Record review of CR #3's electronic vital signs record revealed in part: -[DATE] at 4:42 p.m. Blood pressure ,[DATE] and pulse 64 beats per minute. Further record review revealed no further vitals sign assessments for CR #3. Further record review of CR #3's laboratory requisition form dated [DATE] revealed a collection time of 8:00 p.m. for BMP (basic metabolic panel). This requisition was for the STAT test ordered at 9:30 am by the NP that had been omitted from the first lab requisition order. Further record review of CR #3's progress/nurses notes revealed in part: -[DATE] at 7:57 p.m. by RN D Given order by NP to increase CR #3's [MEDICATION NAME] to 8 mg by mouth every 4 hours as needed for nausea which was entered into the computer and faxed to pharmacy . Record review of CR #3's electronic MAR indicated [REDACTED] Record review of CR #3's laboratory report dated [DATE] at 12:18 a.m. revealed in part; -Potassium level 6.2 mEq/L Reference range (3.5 - 5.3). Continued record review of CR #3's progress/nurses notes revealed in part: -[DATE] at 1:46 a.m. by LVN A Potassium 6.2. Dr. A informed. Awaiting call back. -[DATE] at 2:30 a.m. by LVN A CR #3 lying in bed, no complaints of pain or nausea. Oxygen saturation 94% at 3 liters of oxygen. Assisted to restroom with 1 person assistance. Tolerated ambulation well. Dr. A paged of Critical Potassium levels of 6.2. Further record review of the progress/nurses notes revealed no further attempts to contact the MD for the critical Potassium levels, no vital sign assessments or any further assessments during the night shift. Record review of CR #3's progress/nurses notes revealed in part: -[DATE] at 2:14 p.m. by ADON A Received in report that laboratory reported a critical potassium level and no new orders obtained as of that time. Contacted NP with laboratory results approx. 7:06 a.m. NP returned call at 7:11 a.m. requesting oxygen saturation levels. Reported back to CR #3's to check oxygen saturation. Upon entering room CR #3's eyes were closed and she was non-responsive to verbal and tactile stimuli. CR #3 was not breathing, no pulse palpable, skin warm to touch. Code called, CPR initiated and 911 called. Fire department arrived and took over CPR until paramedics arrived. CR #3 was last observed sleeping in bed at approx. 6:30 A.M. Notified emergency contact at approx. 7:40 a.m. CR #3 was observed unresponsive and she should go to the hospital where CR #3 was transferred . Record review of CR #3's hospital records from the emergency room revealed in part: Arrival date/time: [DATE] at 8:05 a.m. -At 8:25 a.m. [AGE] years old white female presents to ED via unassigned with complaints of Full (caridac) arrest. -At 8:25 a.m. preceding the arrest, CR #3 was found down by nursing home staff. The arrest occurred at the nursing home. The arrest was not witnessed by others. Bystanders at the scene performed CPR. -EMS (emergency medical service) care prior to arrival: Initiation of ACLS (advanced cardiac life support), peripheral IV, was successfully placed. 15 minutes elapsed prior to ACLS. ACLS has been in progress for 45 minutes. ACLS details: initial rhythm was asystole (flat line in electrocardiogram). [MEDICATION NAME] ([MEDICATION NAME]) intravenous 8 doses. Response to therapy: Continued arrest. Arrest was first noted at 7:15 a.m. asystole was presenting rhythm, there may have been PEA (pulseless electrical activity) at one point. --At 8:31 a.m. ED course: CR #3 has been under CPR for more than 45 minutes with no ROSC (return of spontaneous circulation). While there was not a definitive airway, after 45 minutes of CPR and 9 rounds of [MEDICATION NAME], did not feel like any further attempts at airway wound lead to different outcome other than death. CR #3 was pronounced. -Diagnosis: [REDACTED]. In an interview on [DATE] at 2:08 p.m. ADON A, stated she was the charge nurse for CR #3 on [DATE] when she was found unresponsive. ADON A said she arrived at the facility and started her rounds alone looking at the residents at around 6:30 a.m. and it was at that time she saw CR#3 sleeping. She said LVN B told her CR #3 had critical potassium levels during the night shift and the MD had not returned the call yet. LVN A who was assigned to CR #3 during the night shift, had gone home earlier on the shift. ADON A then said when LVN B told me staff had not follow up with the MD regarding the critical potassium levels, I texted the NP and the NP called me within a couple of minutes. I gave her the critical values of potassium for CR #3 and she asked me for CR #3's oxygen saturation levels because CR #3 was having problems with her oxygen on [DATE]. When I went to the room still with the phone in my hands and the NP on the line, CR #3 was found not breathing and with no vital signs. CPR was started and 911 was called. CR #3 died in route to the hospital. Further interview the ADON A at that time, stated the night shift tried to call the MD but the MD was not reach. ADON A then said facility protocol is that if the MD does not return the calls, we were supposed to call the medical director, but CR #3's MD was the medical director. Facility has another medical director that we were supposed to call if the first medical director does not answer the calls. LVN B said the other medical director called the facility during the night shift on [DATE] for another resident and LVN A forgot to mention about the critical potassium values of CR #3. Continued interview the ADON A on [DATE] at 2:20 p.m. said critical laboratory values was a change in condition and the facility staff was supposed to complete a change of condition assessment in the computer where it prompt staff to assess the resident, notify MD and RP. ADON A further said that if for any reason the MD or another medical director was unable to be located, the staff was supposed to notify the DON. She said she did not know if the previous DON was aware of the situation with CR #3. When asked if CR #3 had any assessments previous to being found unresponsive or any vital signs, ADON A then looked at the computed and then said there is none, last vital signs were on [DATE] at 4:42 p.m. In a phone interview on [DATE] at 4:25 p.m. LVN C, stated she was the charge nurse for CR #3 on [DATE] from 6 a.m. to 2:00 p.m. and she called the NP to notify her CR #3 oxygen levels were low and the NP called her at the end of her shift and told her to send CR #3 to the hospital. LVN C then said she told the 2:00 to 10:00 p.m. shift nurse who was RN D about the order to send CR #3 to the hospital. LVN C then said it was around 3:50 p.m. on [DATE] when she got the order. LVN C continued she did not transcribe the order to CR #3's chart because she was going home and she had already talked to RN D about the new orders. LVN C further said she got the orders via text message and the staff would usually call, page or text the MD or the NP. When asked if text could be reviewed she said that she had erased the text message from the NP. Continued phone interview LVN C, stated whenever a resident had a change in condition, the staff was supposed to complete a change in condition form in the computer that was like an SBAR when they would write their assessments, MD and RP notifications and she did not complete that assessment on CR #3. In a phone interview on [DATE] at 4:42 p.m. LVN A, he stated he was the charge nurse for CR #3 from 10:00 p.m. on [DATE] to at around 3:00 a.m. on [DATE] and further said I wasn't supposed to even being there on that day and I did not get any report regarding any change in condition regarding CR #3. I knew about the critical values of her laboratory results, I paged the MD twice and did not get any respond. Then I left at around 3:00 a.m. and gave report to LVN B so she could follow up and pass the information to the day shift. LVN A said the other medical director called the facility on [DATE] regarding another resident and he did not notify him about CR #3 because he was very busy with this other resident who had a PICC line and said but I heard that the day shift was able to get hold of the NP. Further in the same interview LVN A stated critical laboratory values was a change in condition and he was supposed to contact the MD or the DON if unable to contact the MD and then said In this place everything is so confusing, I don't even know who the DON is. LVN A then said he was supposed to check the vital signs of CR #3 but he only checked the oxygen saturation and said RN D didn't really tell me anything about CR #3. We were supposed to do the eINTERAC change of condition documentation in the computer but I can't explain why I did not do it. I don't know why. I should had monitored any cardiac issues, blood pressure and heart rate due to her high potassium levels. I was overwhelmed. In an interview on [DATE] at 5:00 p.m. RN D, stated she was the charge nurse for CR #3 on [DATE] during the 2:00 p.m. to 10:00 p.m. shift and that during change of shift report CR #3 was sleepy and she asked about CR #3's oxygen saturation and the morning shift nurse told her it was around the 80's. She increased the oxygen to 4 liters and she re-checked the oxygen and was then 89 to 90%. RN D said during her shift, the laboratory collected blood from CR #3 that was ordered during the

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	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) day shift. RN D then said LVN C never told her about the orders to transfer CR #3 to the hospital. RN D continued saying she spoke with the NP because the NP wanted to know the laboratory results for CR #3 but she did not receive any reports from the laboratory and she never knew the NP wanted CR #3 to go to the hospital. When asked about the order to increase [MEDICATION NAME] for CR #3 for nausea and vomiting, RN D stated she did not remember if CR #3 had any nausea that day. Continued interview on [DATE] at 5:15 p.m. RN D, said whenever a resident had a change in condition, there was an eINTERACT form to complete on the computer where the nurse writes the assessments and then said I did not check if someone had completed a change of condition form on CR #3. It should had been completed on the day shift on [DATE]. In a phone interview on [DATE] at 9:15 a.m. LVN B, stated LVN A left the building on [DATE] at around 3:30 a.m. and he told her everything was fine and that CR #3 did not have any issues. LVN B further said LVN A did not mention to her anything about the laboratory values of CR #3 but she knew the laboratory had called at 1:30 a.m. to report critical values because she was the one that got the call and then gave the message to LVN A. LVN B continued saying she also knew LVN A had paged the MD twice and she did not receive any MD calls for the rest of the shift. LVN B said she did not try calling the MD for CR #3's critical laboratory values and she did not do any vital signs for CR #3 either. In a phone interview on [DATE] at 3:29 p.m. the NP, stated she came to the facility on [DATE] and saw CR #3 and ordered STAT laboratory blood work because when she saw CR #3 she did not look good. The NP stated she did not hear anything about the results of the laboratory blood work for CR #3 after she gave the orders. NP then said the following morning she called the facility to find out if CR #3 was sent to the hospital as she had ordered on [DATE] and to find out about the laboratory results. NP continued saying on [DATE] at around 7:00 a.m. she called the facility and spoke to ADON A and asked about CR #3 and how come she did not hear about the laboratory results and at that moment, ADON A told her CR #3 was still in the facility. The NP asked ADON A for CR #3's vital signs right away including oxygen saturation. Further interview at that time the NP, stated she was surprise to find out CR #3 was not in the hospital and requested CR #3's vital signs because she wanted to know how she was doing. ADON A told her CR #3 was unresponsive. NP then said she did not understand why the nurses did not follow the orders and get the laboratory blood work STAT. She stated she gave STAT laboratory blood work orders and expected the results right away. When she did not hear anything during the night shift, she thought CR #3 was sent to hospital but decided to follow up with the facility the next morning. She even told them you guys are not following orders . In an interview on [DATE] at 3:52 p.m. the Administrator, stated STAT laboratory orders needed to be call immediately to the laboratory and the policy was for the laboratory to come draw the blood within 4 hours and within 1 to 2 hours to get the results back. The Administrator then said once the nurse gets the orders, the nurse will enter the order in the computer. Staff then would follow up on the order. She further said the nurse who gets the laboratory results is the nurse who will follow up with the MD. The Administrator further said for STAT abnormal laboratory results, the nurses will call the MD right away. If the MD does not answer, then the medical director, the facility has 2 medical directors, if one does not answer, then we will call the other medical director. If none of the medical director's answer, then the nurse is supposed to call the DON and the Administrator so we can help in getting hold of the doctors. Continued interview with the Administrator at that time, she stated whenever a resident has a change in condition, staff were supposed to complete an eINTERACT form in the computer. She said the interact form was a tool built in the computer system for changes in condition where it triggers on what would need to happen next. Administrator said the interact tool would guide the nurses on calling the MD, the RP and to follow up on assessments. Further interview on [DATE] at 4:00 p.m. the Administrator, stated RN D told her on [DATE] at around 5:45 p.m. CR #3 had some abnormal vitals. RN D had talked to the MD or the NP and she was told orders were to monitor CR #3's oxygen saturation and if the oxygen level drop, to send CR #3 to the hospital. The Administrator said CR #3's vitals got better and CR #3 was improving. Everything got to looking good. The Administrator said RN D got the STAT laboratory orders for CR #3 on [DATE] at around 5:45 p.m. then the laboratory called with abnormal values at around 1:00 a.m. They tried to reach the MD, then I am foggy about it. They attempted to call the MD twice. They heard back from the MD 5 minutes before CR #3 coded. Staff gave CR #3 CPR and sent her to hospital. I believed CR#3 was even admitted to ICU before she died . CR #3 had been in the facility for one week, she was here for therapy. Continued interview with the Administrator on [DATE] at 4:09 p.m. she stated facility staff did not call her on [DATE] when they were unable to contact the MD for CR #3's critical laboratory values but believed the former DON was contacted. In a second interview on [DATE] at 4:45 p.m. LVN C, said on [DATE] the NP came to visit CR #3 in the morning and gave STAT laboratory blood work. LVN C said she was not sure how long they have to call the laboratory for STAT orders but she believed they had 4 hours to call the laboratory. LVN C further said she texted the NP on [DATE] regarding CR #3's condition because her oxygen saturations were on the 80's and when she got the text back from the NP, she went and told RN D. LVN C said the nurse who gets the order is the one responsible of inputting the order in the computer system. She did not do it because she was leaving to go home. She said she should have done it. She should have completed an eINTERACT assessment on CR #3 as well. Further interview with LVN C, she stated the first time she called the laboratory for STAT orders she only called for the urinalysis and the BNP (Beta Naturetic Peptide) because she misread the orders. Later during change of shift, she found out together with RN D she had omitted the STAT orders for BMP (basic metabolic panel) and RN D was to follow up with it. LVN C further said she did not notify the NP about the mistake in transcribing the orders to the laboratory requisition form. In a phone interview on [DATE] at 5:09 p.m. the laboratory, technician stated they received a call from the facility on [DATE] at 12:12 p.m. for STAT order request for urinalysis and the BNP (Beta Naturetic Peptide) for CR #3. On [DATE] at 5:06 p.m. they received another STAT order request for BMP for CR #3. Record review of http://www.medicinenet.com/[MEDICAL CONDITION]/article.htm: revealed [MEDICAL CONDITION] means an abnormally elevated level of potassium in the blood. The normal potassium level in the blood isCmilliequivalents per liter (mEq/L). Potassium levels between 5.1 mEq/L to 6.0 mEq/L reflect mild [MEDICAL CONDITION]. Potassium levels of 6.1 mEq/L to 7.0 mEq/L are moderate [MEDICAL CONDITION], and levels above 7 mEq/L are severe [MEDICAL CONDITION]. Extremely high levels of potassium in the blood (severe [MEDICAL CONDITION]) can lead to [MEDICAL CONDITION] and death. Record review of the facility policy and procedure Change of condition reporting revised ,[DATE] revealed in part: .It is the policy of this facility that all changes in resident condition will be communicated to the physician. Purpose: To clearly define guidelines for timely notification of a change in resident condition. Any sudden or serious change in resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. If unable to contact attending physician or alternate physician timely, notify Medical Director for follow up to change in resident condition Follow-up. The licensed nurse responsible for the Resident will continue assessment and documentation every shift for at least seventy two (72) hours or until condition has stabilized .Comprehensive Care Plan will be updated/revised accordingly. Record review of the facility policy and procedure Laboratory Services revised ,[DATE] revealed in part: .2.- STAT orders are done as soon as possible within facility defined time frames . Record review of the facility policy and procedure Labs, abnormal revised ,[DATE] revealed in part: It is the policy of this facility to inform physician immediately to assist in diagnosing resident appropriately based on the Laboratory results. The RN Supervisor will care plan only the abnormal laboratory results which requires blood levels such as abnormal Potassium that could manifest complications in the short term care plan . Record review of the facility's undated protocol with title Labs revealed in part: It is everyone's responsibility to follow up on all labs in a timely manner. STAT labs.: You are expected to get your laboratory results within 4 hours. If you do not receive then in that time. Notify your ED/DON immediately. Once you receive your result notify MD of results. Call responsible party of laboratory results. Document in progress notes the laboratory results, MD and RP notification. The resident will then be in every shift documentation for 72 hours until resolved. If laboratory is abnormal you are required do the following: 1.- Notify the MD and RP. Place patient in follow up and chart on patient every shift. If you are unable to reach MD YOU MUST NOTIFY THE ED/DON IMMEDIATELY . Record review of the facility's undated Statement of Resident Rights revealed in part: .You have the right to (1) all care necessary for you to have the highest possible level of health . An IJ was identified on [DATE] at 4:35 pm and the Administrator and DON were informed at that time. The POR was accepted on [DATE] at 3:38 pm. The POR included:

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F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 14) Immediate action: 1.- Resident affected by this deficient practiced was discharged to hospital [DATE]. Laboratory audits to determine all residents affected by this deficient practice including: 1.- Laboratory audit performed by Clinical Resources to review all current laboratory orders at facility began on [DATE] with laboratory vendor - ACL laboratory and completed [DATE]. 2.- Medical records designee pulling all orders for laboratory in PCC for all current residents for review, completed [DATE]. 3.-Review of all Telephone Orders by Clinical Resource Nurse to ensure no new orders for laboratory have been missed completed [DATE]. 4.- Clinical Resource Nurse completed audit of laboratory requisition book where laboratory orders are noted by laboratory after laboratory are drawn completed [DATE]. 5.- Charge Nurse designated to check laboratory website to pull results each shift beginning [DATE]. 6.- Any abnormal or critical laboratory to be communicated to physician/designee and RP on [DATE] (no critical laboratory were founds). 7.- DON to notify laboratory vendor to email STAT laboratory and / or abnormal results to DON and ADON's email in addition to calling the facility as part of new process beginning [DATE]. DON and ADON have email access ,[DATE]. 8.- All current resident's charts were audited for potential change of condition on [DATE] by Clinical Resource Nurse. No change of conditions were found. At time of this plan of removal, no other residents identified with laboratory issues. (12:00 p.m.). Education/In-service: 1.- In-service started [DATE] at 5:05 p.m. with licensed nurses including change of condition, using SBAR form, Stop and Watch, notifications, and Resident Behavior and Facility practice related to change of condition. In the event a licensed nurse cannot reach the attending physician, charge nurse will contact either DON or Administrator and Medical Director. The Medical Directors have provided the DON and Administrator with alternate methods to contact them rapidly. In-service started on [DATE] with all licensed nursing staff regarding each Medical Directors preferred methods of communication. 2.- As part of in-service new DON (start date [DATE]) introduced to staff and shared her contact information. 3.- DON and ADON will divide building each taking two hall to follow up daily on any change of condition, new laboratory orders, abnormal laboratory, fall, etcetera starting [DATE]. 4.- Change of Condition log will be utilized and review in daily stand up meeting with leadership IDT starting [DATE]. 5.- Licensed charge nurses were educated on [DATE] to follow up on each change of condition for 72 hours or until condition stable or resolved beginning [DATE]-17. 6.- Medical Directors notified of IJ and associated Plan of Removal. Dr. A was notified via phone on [DATE] at 6:00 p.m. and Dr. B was notified in person on [DATE] at 8:45 a.m. 7.- In-serviced CNA's on reporting change of condition and the Stop and Watch tool on [DATE]. Any staff not available for any in-service will be in-serviced before they are allowed to go on the floor to work a shift. Monitoring: RN corporate nurse resource has been assigned to facility to monitor plan of removal by: 1.- Daily monitoring of laboratory results by charge nurses on each shift beginning [DATE]. 2.- Daily review of change of condition log, and 72 hours follow up. 3.- Ongoing in-service on change of condition, notification, laboratory process. 4.- Daily QA analysis of admissions and readmissions including an updates to plan of care. 5.- QAPI committee to meet review Plan of removal daily until immediacy lifted, then weekly until compliance achieved. Monitoring: In an interview on [DATE] at 4:05 p.m LVN C said she was trained on follow MD orders timely and accurately. In an interview on [DATE] at 10:20 a.m. LVN G and LVN H, both stated they had been trained on following MD orders. In an interview on [DATE] at 10:30 a.m. LVN E, stated she had been trained on following MD orders. In an interview on [DATE] at 10:40 a.m. LVN F, stated he had been trained on following MD orders. In an interview on [DATE] at 1:52 p.m. LVN K, stated she had been trained on following MD orders. In an interview on [DATE] at 3:05 P.m. LVN P, stated she had been trained on following MD orders. In an interview on [DATE] at 4:25 p.m. RN R, stated she had been trained on following MD orders. In a phone interview on [DATE] at 4:30 p.m. LVN A, stated he had been trained on following MD orders. In a phone interview on [DATE] at 4:40 p.m. LVN S, stated she had been trained on following MD orders. Record review of facility In-service Training Attendance record dated [DATE] revealed that nursing staff were educated regarding change in condition assessments, following MD orders and abnormal laboratory reports. Attached was also found the signatures of staff attending the training. The Administrator was informed on [DATE], at 5:20 p.m. the IJ was lowered; however, the facility remained out of compliance at an pattern level and a severity of actual harm that is not an IJ due to facility needing more time to train the staff. The Administrator reported 23 residents resided on hall 200.
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 interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest, practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for one of seven residents on the 200 hall (CR #3) reviewed for care provided. - The facility failed to draw CR #3's STAT BMP laboratory orders for 10.5 hours. -The facility failed to notify the MD of CR #3's critical Potassium levels for 5.25 hours. -The facility failed to send CR #3 to the hospital for 14 hours after the NP instructed them to do so. -The facility failed to provide assessments and closely monitor the vital signs when CR #3 had a change in her condition. LVN A and LVN B did not assess CR #3's condition and vital signs during the night shift prior to being found unresponsive on [DATE] at 7:11 a.m. CR #3 was pronounced dead 26 minutes after arrival to the emergency room . An IJ was identified on [DATE]. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of pattern and a severity of actual harm that is not immediate jeopardy due to facility requiring more time to monitor the plan of removal for effectiveness. This failure affected one former resident (CR#3) who died 26 minutes after arrival to the emergency room and placed 23 other residents at the 200 hall at the facility at risk of not receiving adequate assessments, delay in appropriate medical treatment, the development of new or worsening medical condition, decline in their health condition well-being and death. Findings included: Intake # 4 Record review of the facility face sheet revealed CR# 3 was a [AGE] year old female. She was admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]. CR #3 was found unresponsive and was sent to the hospital on [DATE] and was pronounced dead 26 minutes after arrival to the emergency room . Record review of the 5 day MDS assessment dated [DATE] revealed CR #3 required limited assistance for bed mobility, transfer, dressing, toileting and personal hygiene and supervision for walking in room and in corridor, locomotion and eating. CR #3 was always continent of bowel and had an indwelling catheter for urine. Record review of CR #3's electronic and paper records revealed CR #3 did not have a care plan. Record review of CR #3's NP progress notes dated [DATE] revealed in part: [AGE] year old female readmitted at the hospital for frequent falls. She is here for rehab. Past medical history for hypertension, [MEDICAL CONDITIONS] and acute [MEDICAL CONDITION] .STAT BNP (Pro) (Beta Naturetic Peptide - test to help detect, diagnose, and evaluate the severity of heart failure), BMP (basic metabolic panel, blood work that assess electrolytes and kidney function) and urinalysis. Assessment/Plan: [MEDICAL CONDITION] - BUN (Blood Urea Nitrogen) / Creatinine (test to assess kidney function) high on [DATE]. Will re-check STAT today . Record review of CR #3's physician's telephone orders signed by the NP and dated [DATE] at 9:30 a.m. revealed orders in part: - STAT urinalysis, BMP and Pro BNP .

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 15) Record review of CR#3's laboratory requisition form dated [DATE] revealed a collection time of 1:52 p.m. for urinalysis and BNP (Beta Naturetic Peptide). Further record review revealed the BMP test which was ordered at the same time was omitted in lab requisition order. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 3:15 p.m. Late entry by LVN C .CR #3 went to therapy and therapist checked oxygen saturation and read 78%. Checked CR #3's oxygen saturation upon returning to room and oxygen saturation read 82%. Immediately placed CR #3 on oxygen at 2 liters. Oxygen continued to rise to 89%. Vital signs blood pressure ,[DATE], pulse 71, temperature 98.4 and respirations 15 - 16 breaths per minute with no labored breathing. Contacted NP with results on low oxygen and informed her that the oxygen was rising and asked if CR #3 could go out to hospital. Informed oncoming nurse . -[DATE] at 4:16 p.m. by LVN C NP into see CR #3 and RP concerned that CR #3 is having kidney issues. Orders to have STAT urinalysis, BNP and Pro BNP .All orders completed . -[DATE] at 4:20 p.m. by LVN C NP called and informed of oxygen saturation . (NP) stated that we could send CR #3 out to hospital. Informed nurse on duty of decision . Record review of CR #3's electronic vital signs record revealed in part: -[DATE] at 4:42 p.m. Blood pressure ,[DATE] and pulse 64 beats per minute. Further record review revealed no further vitals sign assessments for CR #3. Further record review of CR #3's laboratory requisition form dated [DATE] revealed a collection time of 8:00 p.m. for BMP (basic metabolic panel). This was the STAT test which was orignally ordered by the NP at 9:30 am, 10 ,[DATE] hours prior. Further record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 7:57 p.m. by RN D Given order by NP to increase CR #3's [MEDICATION NAME] to 8 mg by mouth every 4 hours as needed for nausea which was entered into the computer and faxed to pharmacy . Record review of CR #3's electronic MAR indicated [REDACTED] Record review of CR #3's laboratory report dated [DATE] at 12:18 a.m. revealed in part; -Potassium level 6.2 mEq/L Reference range (3.5 - 5.3). Continued record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 1:46 a.m. by LVN A Potassium 6.2. Dr. A informed. Awaiting call back. -[DATE] at 1:49 a.m. by LVN A [MEDICATION NAME] (muscle relaxant) tablet 350 mg. Give 0.5 tablet by mouth every 6 hours as needed for muscle spasm / back pain. CR #3 requested for muscle spasms -[DATE] at 2:30 a.m. by LVN A CR #3 lying in bed, no complaints of pain or nausea. Oxygen saturation 94% at 3 liters of oxygen. Assisted to restroom with 1 person assistance. Tolerated ambulation well. Dr. A paged of Critical Potassium levels of 6.2. -[DATE] at 3:10 a.m. by LVN A [MEDICATION NAME] (muscle relaxant) tablet 350 mg. Give 0.5 tablet by mouth every 6 hours as needed for muscle spasm / back pain effective (documentation indicated monitoring the effectiveness of the medication) Further record review of the progress/nurses notes revealed no further attempts to contact the MD for the critical Potassium levels, no vital sign assessments or any further assessments during the night shift. Record review of CR #3's MD orders dated [DATE] revealed in part; -[MEDICATION NAME] tablet 350 mg, give 0.5 tablet by mouth every 6 hours as needed for muscle spasm/back pain. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 2:14 p.m. by ADON A Received in report that laboratory reported a critical potassium level and no new orders obtained as of that time. Contacted NP with laboratory results approx 7:06 a.m. NP returned call at 7:11 a.m. requesting oxygen saturation levels. Reported back to CR #3's to check oxygen saturation. Upon entering room CR #3's eyes were closed and she was non-responsive to verbal and tactile stimuli. CR #3 was not breathing, no pulse palpable, skin warm to touch. Code called, CPR initiated and 911 called. Fire department arrived and took over CPR until paramedics arrived. CR #3 was last observed sleeping in bed at approx 6:30 A.M. Notified emergency contact at approx 7:40 a.m. that CR #3 was observed unresponsive and that she should go to the hospital where CR #3 was transferred . Record review of CR #3's hospital records from the emergency room revealed in part: Arrival date/time: [DATE] at 8:05 a.m. -At 8:25 a.m. [AGE] years old white female presents to ED via unassigned with complaints of Full arrest. -At 8:25 a.m. Preceding the arrest, CR #3 was found down by nursing home staff. The arrest occurred at the nursing home. The arrest was not witnessed by others. Bystanders at the scene performed CPR. -EMS (emergency medical service) care prior to arrival: Initiation of ACLS (advanced cardiac life support), peripheral IV, was successfully placed. 15 minutes elapsed prior to ACLS. ACLS has been in progress for 45 minutes. ACLS details: initial rhythm was asystole (flat line in electrocardiogram). [MEDICATION NAME] ([MEDICATION NAME]) intravenous 8 doses. Response to therapy: Continued arrest. Arrest was first noted at 7:15 a.m. asystole was presenting rhythm, there may have been PEA (pulseless electrical activity) at one point. --At 8:31 a.m. ED course: CR #3 has been under CPR for more than 45 minutes with no ROSC (return of spontaneous circulation). While there was not a definitive airway, after 45 minutes of CPR and 9 rounds of [MEDICATION NAME], did not feel like any further attempts at airway wound lead to different outcome other than death. CR #3 was pronounced. -Diagnosis: [REDACTED]. In an interview on [DATE] at 2:08 p.m. ADON A, stated she was the charge nurse for CR #3 on [DATE] when she was found unresponsive. ADON A said she had arrived at the facility and started her rounds alone looking at the residents at around 6:30 a.m. and it was then she saw CR#3 sleeping. She said LVN B told her CR #3 had critical potassium levels during the night shift and the MD had not returned the call yet. LVN A who was assigned to CR #3 during the night shift, had gone home earlier on the shift. ADON A then said when LVN B told me that staff had not follow up with the MD regarding the critical potassium levels, I texted the NP and the NP called me within a couple of minutes. I gave her the critical values of potassium for CR #3 and she asked me for CR #3's oxygen saturation levels because CR #3 was having problems with her oxygen on [DATE]. When I went to the room at that moment still with the phone in my hands and the NP on the line, CR #3 was found not breathing, and no vital signs. CPR was started and 911 was called. CR #3 died in route to the hospital. Further interview with the ADON A at that time, she stated the night shift tried to call the MD but the MD was not reach. ADON A then said facility protocol is that if the MD does not return the calls, we were supposed to call the medical director, but CR #3's MD was the medical director. Facility has another medical director that we were supposed to call if the first medical director does not answer the calls. LVN B said the other medical director called the facility during the night shift on [DATE] for another resident and LVN A forgot to mention about the critical potassium values of CR #3. Continued interview the ADON A on [DATE] at 2:20 p.m. said critical laboratory values was a change in condition and the facility staff was supposed to complete a change of condition assessment in the computer where it prompt staff to assess the resident, notify MD and RP. ADON A further said that if for any reason the MD or another medical director was unable to be located, the staff was supposed to notify the DON. She said she did not know if the previous DON was aware of the situation with CR #3. When asked if CR #3 had any assessments previous to being found unresponsive or any vital signs, ADON A then looked at the computed and then said there is none, last vital signs were on [DATE] at 4:42 p.m. In a phone interview on [DATE] at 4:25 p.m. LVN C, stated she was the charge nurse for CR #3 on [DATE] from 6 a.m. to 2:00 p.m. and said she called the NP to notify her CR #3 oxygen levels were low and the NP called her at the end of her shift and told her to send CR #3 to the hospital. LVN C then said she told the 2:00 to 10:00 p.m. shift nurse who was RN D about the order to send CR #3 to the hospital. LVN C then said it was around 3:50 p.m. on [DATE] when she got the order. LVN C continued saying she did not transcribe the order to CR #3's chart because she was going home and she had already talked to RN D about the new orders. LVN C further said she got the orders via text message and the staff would usually call, page or text the MD or the NP. When asked if the text could be reviewed she said she had erased the text message from the NP. Continued phone interview LVN C at that time, stated whenever a resident had a change in condition, the staff was supposed to complete a change in condition form in the computer, that was like an SBAR where they would write their assessments, MD and RP notifications. She said she did not complete that assessment on CR #3. In a phone interview on [DATE] at 4:42 p.m. LVN A, he stated he was the charge nurse for CR #3 from 10:00 p.m. on [DATE] to at around 3:00 a.m. on [DATE] and further said I wasn't supposed to even being there on that day. He said I did not get any report regarding any change in condition regarding CR #3. I knew about the critical values of her laboratory results, I

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	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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(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 -** Some	(continued... from page 16) paged the MD twice and did not get any response. Then I left at around 3:00 a.m. and gave report to LVN B so she could follow up and pass the information to the day shift. LVN A said the other medical director called the facility on [DATE] regarding another resident and he did not notify him about CR #3 because he was very busy with this other resident who had a PICC line. He said but I heard that the day shift was able to get hold of the NP. Further interview LVN A at that time, he stated critical laboratory values was a change in condition and that he was supposed to contact the MD or the DON if unable to contact the MD. He said In this place everything is so confusing. I don't even know who the DON is. LVN A said he was supposed to check the vital signs of CR #3 but he only checked the oxygen saturation. He said RN D didn't really tell me anything about CR #3. We were supposed to do the eINTERAC change of condition documentation in the computer but I can't explain why I did not do it. I just don't know why. I should had monitored any cardiac issues, blood pressure and heart rate due to her high potassium levels. I was overwhelmed. In an interview on [DATE] at 5:00 p.m. RN D, stated she was the charge nurse for CR #3 on [DATE] during the 2:00 p.m. to 10:00 p.m. shift and then said during change of shift report CR #3 was sleepy and she asked about CR #3's oxygen saturation. The morning shift nurse told her it was around the 80's and she had increased the oxygen to 4 liters and re-checked the oxygen and it was 89 to 90%. RN D then said during her shift, the laboratory collected blood from CR #3 that was ordered during the day shift. RN D then said LVN C never told her about the orders to transfer CR #3 to the hospital. RN D continued saying she spoke with the NP because the NP wanted to know the laboratory results for CR #3 but she did not receive any reports from the laboratory and she never knew the NP wanted CR #3 to go to the hospital. When asked about the order to increase [MEDICATION NAME] for CR #3 for nausea and vomiting, RN D stated she did not remember if CR #3 had any nausea that day . Continued interview on [DATE] at 5:15 p.m. with RN D, she said whenever a resident had a change in condition, there was an eINTERACT form to complete on the computer where the nurse writes the assessments. She said I did not check if someone had completed a change of condition form on CR #3. It should had been completed on the day shift on [DATE]. In a phone interview on [DATE] at 9:15 a.m. LVN B, stated LVN A left the building on [DATE] at around 3:30 a.m. and he told her everything was fine and CR #3 did not have any issues. LVN B further said LVN A did not mention to her anything about the laboratory values of CR #3 but she knew the laboratory had called at 1:30 a.m. to report critical values because she was the one that got the call and then gave the message to LVN A. LVN B continued saying she also knew LVN A had paged the MD twice. She did not receive any MD calls for the rest of the shift. LVN B then said she did not try calling the MD for CR #3's critical laboratory values and she did not do any vital signs for CR #3 either. In a phone interview on [DATE] at 3:29 p.m. the NP, stated she came to the facility on [DATE] and saw CR #3 and ordered STAT laboratory blood work because when she saw CR #3 she did not look good. The NP stated she did not hear anything about the results of the laboratory blood work for CR #3 after she gave the orders. The NP then said the following morning she called the facility to find out if CR #3 was sent to the hospital as she had ordered on [DATE] and to find out about the laboratory results. The NP continued saying on [DATE] at around 7:00 a.m. she called the facility and spoke to ADON A and asked about CR #3 and how come she did not hear about the laboratory results. She said at that moment, ADON A told her CR #3 was still in the facility and the NP asked ADON A for CR #3's vital signs right away including oxygen saturation. Further interview at that time the NP, stated she was surprise to find out CR #3 was not in the hospital and requested CR #3's vital signs because she wanted to know how she was doing. ADON A told her CR #3 was unresponsive. The NP then said I don't understand why the nurses did not follow the orders and call for the laboratory blood work STAT. if it wasn't that I called them the next morning at 7:00 a.m. and inquired about CR #3 status what would have happened? What if I did not call?. I gave STAT laboratory blood work orders, I expected the results right away. When I did not hear anything during the night shift, I thought CR #3 was sent to hospital but I decided to follow up with the facility the next morning. I even told them 'you guys are not following orders' . In an interview on [DATE] at 3:52 p.m. the Administrator, stated STAT laboratory orders needed to be call immediately to the laboratory and the policy was for the laboratory to come and draw the blood within 4 hours and 1 to 2 hours to get the results back. The Administrator then said once the nurse gets the orders, the nurse will enter the order in the computer and then would follow on the order. She further said the nurse who gets the laboratory results is the nurse who will follow up with the MD. The Administrator further said for STAT abnormal laboratory results, the nurses will call the MD right away, if the MD does not answer, then the medical director. The facility has 2 medical directors, if one does not answer, then we will call the other medical director. If none of the medical directors answer, then the nurse is supposed to call the DON and the Administrator so we can help in getting hold of the doctors. Continued interview with the Administrator at that time, she stated whenever a resident has a change in condition, they were supposed to complete an eINTERACT form in the computer. She further said the interact form was a tool built in the computer system for changes in condition where it will trigger on what will need to happened. The Administrator further said the interact tool would guide the nurses on calling the MD, the RP and to follow up on assessments. Further interview on [DATE] at 4:00 p.m. with the Administrator, she stated RN D told her on [DATE] at around 5:45 p.m. CR #3 had some abnormal vitals and RN D had talked to the MD or the NP. She was told the orders were to monitor CR #3's oxygen saturation and if the oxygen would drop, to send CR #3 to the hospital. The Administrator further said CR #3's vitals got better and CR #3 was improving and everything was looking good. The Administrator then said RN D got the STAT laboratory orders for CR #3 on [DATE] at around 5:45 p.m. then the laboratory called with abnormal values at around 1:00 a.m. They tried to reach the MD, then I am foggy about it. They attempted to call the MD twice. They heard back from MD 5 minutes before CR #3 coded. Staff gave CR #3 CPR and sent her to hospital. I believed CR#3 was even admitted to ICU before she died . CR #3 had been in the facility for one week, she was here for therapy. Continued interview with the Administrator on [DATE] at 4:09 p.m. she stated facility staff did not call her on [DATE] when they were unable to contact the MD for CR #3's critical laboratory values but believed the former DON was contacted. In a second interview on [DATE] at 4:45 p.m. LVN C, she said on [DATE] the NP came to visit CR #3 in the morning and gave STAT laboratory blood work. LVN C said she was not sure how long do they had to call the laboratory for STAT orders but she believed they had 4 hours to call the laboratory. LVN C further said she texted the NP on [DATE] regarding CR #3's condition because her oxygen saturations were on the 80's and when she got the text back from the NP, she went and told RN D. LVN C then said The nurse who gets the order is the one responsible of inputting the order on the computer system. I did not do it because I was leaving to my home. I should had done it. I should had completed an eINTERACT assessment on CR #3 as well. Further interview with LVN C, she stated the first time she called the laboratory for STAT orders she only called for the urinalysis and the BNP (Beta Naturetic Peptide) because she misread the orders and later during change of shift, she found out together with RN D she had omitted the STAT orders for BMP (basic metabolic panel) and that RN D was to follow up with it. LVN C further said she did not notify the NP about the mistake in transcribing orders to the laboratory requisition form. In a phone interview on [DATE] at 5:09 p.m. the laboratory, technician stated they received a call from the facility on [DATE] at 12:12 p.m. for STAT order request for urinalysis and the BNP (Beta Naturetic Peptide) for CR #3 and on [DATE] at 5:06 p.m. they received another STAT order request for BMP for CR #3. Record review of http://www.medicinenet.com/[MEDICAL CONDITION]/article.htm: revealed [MEDICAL CONDITION] means an abnormally elevated level of potassium in the blood. The normal potassium level in the blood isCmilliequivalents per liter (mEq/L). Potassium levels between 5.1 mEq/L to 6.0 mEq/L reflect mild [MEDICAL CONDITION]. Potassium levels of 6.1 mEq/L to 7.0 mEq/L are moderate [MEDICAL CONDITION], and levels above 7 mEq/L are severe [MEDICAL CONDITION]. Extremely high levels of potassium in the blood (severe [MEDICAL CONDITION]) can lead to [MEDICAL CONDITION] and death. Record review of the facility policy and procedure Change of condition reporting revised ,[DATE] revealed in part: It is the policy of this facility that all changes in resident condition will be communicated to the physician. Purpose: To clearly define guidelines for timely notification of a change in resident condition. Any sudden or serious change in resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation If unable to contact attending physician or alternate physician timely, notify Medical Director for follow up to change in resident condition Follow-up. The licensed nurse responsible for the Resident will continue assessment and documentation every shift for at least seventy two (72) hours or until condition

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 17) has stabilized .Comprehensive Care Plan will be updated/revised accordingly. Record review of the facility policy and procedure Laboratory Services revised ,[DATE] revealed in part: .2.- STAT orders are done as soon as possible within facility defined time frames . Record review of the facility policy and procedure Labs, abnormal revised ,[DATE] revealed in part: It is the policy of this facility to inform physician immediately to assist in diagnosing resident appropriately based on the Laboratory results. The RN Supervisor will care plan only the abnormal laboratory results which requires blood levels such as abnormal Potassium that could manifest complications in the short term care plan . Record review of the facility's undated protocol with title Labs revealed in part: It is everyone's responsibility to follow up on all labs in a timely manner. STAT labs.: You are expected to get your laboratory results within 4 hours. If you do not receive then in that time. Notify your ED/DON immediately. Once you receive your result notify MD of results. Call responsible party of laboratory results. Document in progress notes the laboratory results, MD and RP notification. The resident will then be in every shift documentation for 72 hours until resolved. If laboratory is abnormal you are required do the following: 1.- Notify the MD and RP. Place patient in follow up and chart on patient every shift. If you are unable to reach MD YOU MUST NOTIFY THE ED/DON IMMEDIATELY . Record review of the facility's undated Statement of Resident Rights revealed in part: .You have the right to (1) all care necessary for you to have the highest possible level of health . An IJ was identified on [DATE] at 4:35 pm and the Administrator and DON were informed at that time. The POR was accepted on [DATE] at 3:38 pm. The POR included: Immediate action: 1.- Resident affected by this deficient practiced was discharged to hospital [DATE]. Laboratory audits to determine all residents affected by this deficient practice including: 1.- Laboratory audit performed by Clinical Resources to review all current laboratory orders at facility began on [DATE] with laboratory vendor - ACL laboratory and completed [DATE]. 2.- Medical records designee pulling all orders for laboratory in PCC for all current residents for review, completed [DATE]. 3.-Review of all Telephone Orders by Clinical Resource Nurse to ensure no new orders for laboratory have been missed completed [DATE]. 4.- Clinical Resource Nurse completed audit of laboratory requisition book where laboratory orders are noted by laboratory after laboratory are drawn completed [DATE]. 5.- Charge Nurse designated to check laboratory website to pull results each shift beginning [DATE]. 6.- Any abnormal or critical laboratory to be communicated to physician/designee and RP on [DATE] (no critical laboratory were founds). 7.- DON to notify laboratory vendor to email STAT laboratory and / or abnormal results to DON and ADON's email in addition to calling the facility as part of new process beginning [DATE]. DON and ADON have email access ,[DATE]. 8.- All current resident's charts were audited for potential change of condition on [DATE] by Clinical Resource Nurse. No change of conditions were found. At time of this plan of removal, no other residents identified with laboratory issues. (12:00 p.m.). Education/In-service: 1.- In-service started [DATE] at 5:05 p.m. with licensed nurses including change of condition, using SBAR form, Stop and Watch, notifications, and Resident Behavior and Facility practice related to change of condition. In the event a licensed nurse cannot reach the attending physician, charge nurse will contact either DON or Administrator and Medical Director. The Medical Directors have provided the DON and Administrator with alternate methods to contact them rapidly. In-service started on [DATE] with all licensed nursing staff regarding each Medical Directors preferred methods of communication. 2.- As part of in-service new DON (start date [DATE]) introduced to staff and shared her contact information. 3.- DON and ADON will divide building each taking two hall to follow up daily on any change of condition, new laboratory orders, abnormal laboratory, fall, etcetera starting [DATE]. 4.- Change of Condition log will be utilized and review in daily stand up meeting with leadership IDT starting [DATE]. 5.- Licensed charge nurses were educated on [DATE] to follow up on each change of condition for 72 hours or until condition stable or resolved beginning [DATE]-17. 6.- Medical Directors notified of IJ and associated Plan of Removal. Dr. A was notified via phone on [DATE] at 6:00 p.m. and Dr. B was notified in person on [DATE] at 8:45 a.m. 7.- In-serviced CNA's on reporting change of condition and the Stop and Watch tool on [DATE]. Any staff not available for any in-service will be in-serviced before they are allowed to go on the floor to work a shift. Monitoring: RN corporate nurse resource has been assigned to facility to monitor plan of removal by: 1.- Daily monitoring of laboratory results by charge nurses on each shift beginning [DATE]. 2.- Daily review of change of condition log, and 72 hours follow up. 3.- Ongoing in-service on change of condition, notification, laboratory process. 4.- Daily QA analysis of admissions and readmissions including an updates to plan of care. 5.- QAPI committee to meet review Plan of removal daily until immediacy lifted, then weekly until compliance achieved. Monitoring: In an interview on [DATE] at 4:05 p.m. LVN C, stated she had been trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs, laboratory reports and said that STAT laboratory orders needed to be called to the laboratory immediately. LVN C then said whenever they get laboratory results, staff was supposed to call the MD, and if the MD was not available, to call the Medical Director and if the Medical Director was not available that the staff was supposed to call the DON and the Administrator. LVN C continued saying staff were supposed to check the fax machine and follow up with the laboratory every one hour on pending laboratory reports. LVN C said she was also trained on follow MD orders timely and accurately. In an interview on [DATE] at 10:20 a.m. with LVN G and LVN H, both stated they had been trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs, laboratory reports and said STAT laboratory orders needed to be called to the laboratory immediately. LVN G then said whenever they get laboratory results, staff was supposed to call the MD as soon as possible, and if the MD was not available, to call the Medical Director and if the Medical Director was not available the staff was supposed to call the DON and the Administrator. LVN H continued saying training included information on following MD orders. In an interview on [DATE] at 10:30 a.m. with LVN E, she stated she had been trained on change of condition, assessments, vital signs and documentation including the SBAR tool in the computer system. She also said training included the Stop and Watch form staff would complete to report changes in condition to nurses. LVN E further said training included laboratory orders, follow up and immediate notification to the MD of any critical values and staff was made aware the chain of notification in case the MD was not able to be contacted that included the DON and Administrator. In an interview on [DATE] at 10:40 a.m. with LVN F, he stated he had been trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs, laboratory reports and said STAT laboratory orders needed to be called to the laboratory immediately. LVN F then said whenever they get laboratory results, staff was supposed to call the MD as soon as possible, and if the MD was not available, to call the Medical Director and if the Medical Director was not available the staff was supposed to call the DON and the Administrator. LVN F continued saying training included information on following MD orders. In an
F 0312 **Level of harm** - Actual harm **Residents Affected** - Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for one of seven residents

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F 0312 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 18) (Resident #1) reviewed for ADL care. -The facility staff failed to provide timely incontinent care to Resident #1 and her brief and underneath pads were heavily saturated with urine and stool. There were multiple dried urine stained circles going from under Resident #1's thighs to under her back where her pad had been saturated in urine and stool and left to dry. She said she could smell herself and felt humiliated. This failure affected one resident and placed an additional 54 residents who were occasionally or frequently incontinent of bladder or bowel at risk for not receiving care and assistance when needed. Findings included: Intakes # 6 and # 8 Record review of the facility face sheet revealed Resident #1 was a [AGE] year old female. She was admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]., unspecified and essential (primary) hypertension. Record review of Resident #1's admission assessment dated [DATE] revealed she was cognitively intact with a BIMS score of 15 out of a possible 15. She required extensive assistance of two or more person for bed mobility, and was total dependent on two or more person physical assist for transfer, locomotion on unit and off unit, dressing, toilet use, personal hygiene and bathing. Resident #1 was always incontinent of bowel and bladder. Further record review revealed a weight of 792 lbs and 64 inches in height. Continued record review revealed Resident #1 was at risk of developing pressure sores and was not on a turning/repositioning program. She received application of non-surgical dressing and ointment/medications other than to feet. Record review of Resident #1's care plan initiated 1/6/2017 revealed in part: -Focus: At risk for an ADL self-care performance deficit related to limited mobility, limited ROM. All due to severe [MEDICAL CONDITION] and severe [MEDICAL CONDITION] (swelling that occurs in the arms or legs). Has limited physical movement being total dependent related to disease process, [MEDICAL CONDITION], weakness and limited movement. -Goal: Resident #1 will be safely assisted with performance with bed mobility, dressing, grooming, toilet/incontinent needs and personal hygiene. She required extensive assist of 5 to 7 staff members. -Interventions: Bed mobility: is totally dependent on staff for repositioning and turning in bed. Requires 5 to 7 staff member to turn and reposition and provided treatment. Personal hygiene: Requires total assistance with personal hygiene care. Immobility: Requires staff participation (5-7) for incontinent care. Record review of facility grievance dated 1/9/2017 revealed in part: .Print individual's name: (Resident #1's) family member. Describe concern using factual terms: On Friday, January 6, (Resident #1) was cleaned up at 8:00 p.m. so she started to urinate during the night. I asked that she get cleaned up at 10:00 a.m The CNA knew so we waited both me and (Resident #1), we ended up going to sleep so by the time we woke up, it was 5:30 p.m. so I went back with the nurse and told him and the nurse said that he will let the 2 to 10:00 p.m. CNA know. Her CNA said she will come after dinner so by the time came Resident 31 was soaking wet and full of bowel movement to the point that the bed was soaked, the same thing happened Sunday January 8th. Informed Administrator . Record review of Resident #1's social progress notes dated 1/18/2017 at 1:30 p.m. revealed in part: Spoke with (Resident #1) and family member and (Resident #1) was very upset and frustrated. She stated that she was told by the Administrator that the facility has the staff and personnel to address her needs. (Resident #1) stated that she felt lied to because she sits in her own urine and feces for hours and that the urine and feces go into her wounds. (Resident #1) does not understand why it takes so long for the staff to come and clean her up. She stated that she needs to be cleaned up first to receive physical therapy which she has missed due to not being cleaned in a timely manner. (Resident #1) stated that her family member will go up to the front to ask for assistance but it still takes a very long time for the staff to come and clean her up. (Resident #1) is very angry and wants something to be done . Further record review of Resident #1's social progress notes dated 1/19/2017 at 2:30 p.m. revealed in part: . (Resident #1) stated that she was furious because she felt lied to. She stated that she was last cleaned at 9:00 p.m. on 1/18/2017 and will finally get cleaned up at 2:00 p.m. on 1/19/2017. (Resident #1) stated that she felt that she was lied to by the Administrator prior to being admitted just to get her to the facility to get paid and now that her 20 days are up, she feels like she is overlooked. (Resident #1) requested to speak with someone who can ensure that she gets cleaned and the proper care she is entitled to In an interview and observation on 1/31/2017 at 8:58 a.m. with Resident #1 and her family member, revealed there was pervasive smell of urine and stool upon entering her room. Resident #1 stated facility staff was only providing incontinent care at 9:00 p.m. and 3:00 p.m. and then said I have wounds in my legs and the stool and urine are getting into my wounds. I haven't being cleaned today at all. I don't even know who my aide was. Staff don't come to see me in hours. If I pressed my call light, they will not come until around 11:30 a.m. I am very aware of what's going on. How about the people who are not aware of themselves? Last night my brief was changed at 9:00 p.m. Normally, staff don't change my brief during the night shift. I would like to be cleaned during the night but they don't come, even to check on me. Like now, if I would go and ask them to clean me because I feel that my brief is already soiled, they would say they were busy with breakfast. Every day I don't get care until around 1:30 p.m. or 3:00 p.m. Further interview at that time, Resident #1's family member stated since (Resident #1) has been in the facility, they haven't cleaned her before 1:00 p.m. Continued interview on 1/31/2017 at 9:10 a.m. Resident #1 stated my hair was not washed until 21 days after I was admitted to the facility. Nobody comes to turn me in bed like they did at the hospital. I get my therapy late because I get cleaned up late. The Administrator told me before coming to the facility that they had the staff to care for me. She promised me a lot of things. She told me I was going to be fully taken care of. My family member is the one taking care of me. He would try to help me get cleaned up because the staff is busy. My back hurts, my buttocks hurts. I feel soiled. I can smell myself. In an interview on 1/31/2017 at 11:06 a.m. with Resident #1, she stated nobody had come to her room to check on her and offer to clean her. She further said I don't even know who my aide is since 9:00 p.m. last night when they did incontinent care. Nobody has come to check to see if I need care. In an interview on 1/31/2017 at 11:13 a.m. CNA I, stated she was the aide assigned to care for Resident #1. When asked what time she was going to do care for Resident #1, CNA I stated We need 6 to 7 people to do incontinent care for Resident #1 and the Central Supply person is helping me on gathering all the staff. I can't do it by myself. Observation on 1/31/2017 at 11:40 a.m. during incontinent care to Resident #1 revealed that 6 staff members came to assist with incontinent care. CNA J, CNA W and CNA X supported Resident #1's abdominal fold up while CNA I and CNA Y each held open one leg. The Central Supply person (who is also a CNA) cleaned Resident #1's abdominal fold and front perineal area. Further observation at that time revealed Resident #1 had a rectangular moisture sheet approx. 6 inches by 14 inches, under her abdominal area and one between her upper thighs. The moisture sheet that was between Resident #1's upper thighs was completely soaked and was dark brown in color. Continued observation at that time revealed a very strong urine and stool odor in the room. Further observation during incontinent care, while Resident #1 was turned to her side, revealed 3 staff were needed to turned Resident #1 to her side and other 3 staff were needed to support Resident #1 on the other side of the bed while she was being turned to her side. Continued observation revealed Resident #1's brief was completely soiled up the back of the brief. The brief was dark yellow in color and had stool on it. There was stool also on the buttocks of Resident #1. Resident #1 was lying on 2 pads that had a large dark brown colored ring where Resident #1 was lying, spreading from the buttocks area to her mid thighs. Under the pads there was a sling (staff used sling to move Resident #1 up in bed) that also had a large circular wet area where Resident #1 was lying. While Resident #1 was on her side, she required 3 staff to hold her on her side and 2 staff to hold Resident #1's back while the other staff was providing the incontinent care. Continued observation on 1/31/2017 at 12:23 p.m. at the end of the incontinent care, Resident #1 was assisted up in her bed. Three staff were on one side and three other staff were on the other side. Further observation at that time revealed it took 6 staff members to provide incontinent care and took 43 minutes to complete the procedure. In an interview on 2/1/2017 at 10:32 p.m. CNA V, stated she was the aide taking care of Resident #1 and it was her first time in the facility. She further said she was told Resident #1 required 6 people to do incontinent care and the staff from 2:00 p.m. to 10:00 p.m. had just cleaned Resident #1. In an interview on 2/1/2017 at 10:36 p.m. with Resident #1, she stated she was cleaned only twice during the day, at 2:15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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 0312 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 19) p.m. and 9:00 p.m. In an interview on 2/1/2017 at 11:00 p.m. LVN B, stated there were 3 CNA's and 2 nurses for the night shift at the facility. She further said she was the charge nurse for Resident #1. She said during the night shift, they would only go to Resident #1 room if she put her light on and then said Resident #1 gets her incontinent care during the pm shift when there is more staff. If she had a bowel movement during the night shift and she would want to have incontinent care, it would take all the staff in the facility. All 5 staff working in the facility would have to do it . In an interview on 2/1/2017 at 11:05 p.m. LVN S, stated she was a full time nurse on the 10:00 p.m. to 6:00 a.m. shift and if Resident #1 would need any care during the nights shift, they would have to use all the staff present at the facility because it would take 6 to 7 people just to turn Resident #1 in bed. In an interview on 2/1/2017 at 11:13 p.m. CNA U, stated she was a full time CNA working on the night shift. She further said it would take 5 to 6 people to move Resident #1 and if Resident #1 needed incontinent care the 3 aides and the 2 nurses in the facility would have to assist with her care. In an interview on 2/1/2017 at 11:20 p.m. CNA T, stated she was a full time CNA working on the night shift and said I don't think we are equipped for Resident #1. We usually work 3 aides and 2 nurses on the night shift and it takes about 6 people to do incontinent care for her. If we needed to clean her, the whole building of staff would have to go and care for her and it would take 35 to 40 minutes. In an interview on 2/2/2017 at 11:03 a.m. the Administrator, stated the night shift usually works together on helping Resident #1 with her care and further said I was under the impression that Resident #1 had incontinent care every morning at 6:00 a.m. Resident #1 gets care at certain times only because she does not want to be bothered. The Administrator further said she had not heard any concerns related to the care of Resident #1. In an interview on 2/2/2017 at 2:40 p.m. Resident #1, stated she never requested only certain times and she had not refused any care or that staff not check on her during the night time. She further said Like this morning, I did not get cleaned until 12:00 p.m. It makes me want to cry. I have a history of getting skin infections. Last night they cleaned me around 9:00 p.m. and I did not get incontinent care again until 12:00 p.m. today. Since 8:00 a.m. I had been waiting for somebody to come but they did not come until 12:00 p.m. I have urinated and defecated on myself since early morning. The pad underneath me is always so wet because I urinate and urinate and urinate on it. I cry and get so frustrated because I know I smell. I smell my urine. I have not refused any care. I was told I was going to be bathed every other day and I don't get baths. In an interview on 2/2/2017 at 3:08 p.m. Central Supply, stated she was assigned with Resident #1 during the day shift and she was scheduled for a shower and said she was going to stay over to bathe Resident #1. Central Supply further said she did not give incontinent care to Resident #1 earlier on the shift because Resident #1 was eating breakfast. The Administrator stated on 2/3/2017 at 3:20 p.m. the facility did not have a policy and procedure for staffing. Record review of the facility's undated Statement of Resident Rights revealed in part: .You have the right to (1) all care necessary for you to have the highest possible level of health . Dignity and respect . You have the right to live in safe, decent, and clean conditions, be free from neglect . be treated with dignity, consideration and respect .Make your own choices regarding personal care . Record review of the facility policy and procedure Incontinent Care revised 5/2007 revealed in part: .It is the policy of this facility to remove urine or feces from skin Further record review revealed no information on how often the facility provided incontinent care to the residents. Record review of the facility policy and procedure ADL, Services to carry out revised 11/2007 revealed in part: .It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities .2.- Residents who are unable to carry out activities of daily living will receive necessary services to maintain: grooming, personal hygiene . Record review of the facility policy and procedure Turning rounds revised 11/2007 revealed in part; .It is the policy of this facility to 1.- Cleanse, refresh and reposition bedfast residents on a regular basis . The CMS form 672 revealed 56 residents who were occasionally or frequently incontinent of bladder or bowel.
F 0353 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**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 staffing to provide nursing related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of one Residents (R #1) reviewed for nursing services. -The facility failed to have sufficient staffing on the 10:00 p.m.-6:00 a.m. shift to provide incontinent care to Resident #1 and to evacuate her from the building in the event of an emergency. Resident #1 was afraid when she was forgotten during and actual tornado alert. Her hair was not washed for 21 dys. She could smell herself and felt humiliated. She was angry, frustrated and felt like she was lied to. She was afraid that her wounds would become infected An IJ was identified on [DATE]. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of pattern and a severity of actual harm that is not immediate jeopardy due to facility requiring more time to train staff and monitor the plan of removal for effectiveness. This failure placed one resident residing in the facility and placed 87 residents at risk for failure to have sufficient staffing to meet the residents care needs. Findings include: Intake # 6 and # 8 Record review of the facility face sheet revealed Resident #1 was a [AGE] year old female admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]., unspecified and essential (primary) hypertension. Record review of Resident #1 admission assessment dated [DATE] revealed she was cognitively intact with a BIMS score of 15 out of a possible 15. She required extensive assistance of two or more person for bed mobility, and was total dependent on two or more person physical assist for transfer, locomotion on unit and off unit, dressing, toilet use, personal hygiene and bathing. Resident #1 was always incontinent of bowel and bladder. Further record review revealed a weight of 792 lbs and 64 inches in height. Continued record review revealed that Resident #1 was at risk of developing pressure sores and was not on a turning/repositioning program. She received application of non-surgical dressing and ointment/medications other than to feet. Record review of Resident #1's care plan initiated [DATE] revealed in part: -Focus: At risk for an ADL self care performance deficit related to limited mobility, limited ROM. All due to severe [MEDICAL CONDITION] and severe [MEDICAL CONDITION] (swelling that occurs in the arms or legs). Has limited physical movement being total dependent related to disease process, [MEDICAL CONDITION], weakness and limited movement. -Goal: Resident #1 will be safely assisted with performance with bed mobility, dressing, grooming, toilet/incontinent needs and personal hygiene. She required extensive assist of 5 to 7 staff members. -Interventions: Bed mobility: is totally dependent on staff for repositioning and turning in bed. Requires 5 to 7 staff member to turn and reposition and provided treatment. Further record review revealed no information on her care plan related to the need of an oversize bed with interventions on how to maneuver her oversized bed in the event of an emergency that required evacuation. Record review of facility grievance dated [DATE] revealed in part: .Print individual's name: Resident #1's family member. Describe concern using factual terms: On Friday, [DATE], Resident #1 was cleaned up at 8:00 p.m. so she started to urinate during the night. I asked that she get cleaned up at 10:00 a.m The CNA knew so we waited both me and Resident #1, we ended up going to sleep so by the time we woke up, it was 5:30 p.m. so I went back with the nurse and told him and the nurse said that he will let the 2 to 10:00 p.m. CNA know. Her CNA said she will come after dinner so by the time came Resident 31 was soaking wet and full of bowel movement to the point that the bed was soaked, the same thing happened Sunday [DATE]th. Informed Administrator . Record review of the facility's In-service education record dated [DATE] with title Resident #1's bed revealed that training

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	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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 0353 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 20) was given to only 11 facility staff members. Further record review revealed that 9 staff members were from the 6:00 a.m. to 2:00 p.m. shift, 1 staff member was from the 2:00 p.m. to 10:00 p.m. shift and 1 staff member from the 10:00 p.m. to 6:00 a.m. shift. Record review of Resident #1's social progress notes dated [DATE] at 1:30 p.m. revealed in part: Spoke with Resident #1 and family member and Resident #1 was very upset and frustrated and stated that she does not feel comfortable because during the tornado warning , she (Resident #1) was never brought out to the hallway. She stated that she was told from the Administrator that they would have to break down the bed to get it out of the room. Resident #1 stated that staff just pulled the curtains closed during the storm. Resident #1 stated that the Administrator told her that a tornado would hit the 100 hall first if anything were to happened.(Resident #1 was on the 300 hallway). Resident #1 stated that she found out that by law, all residents were to be pulled out into the hallway. Resident #1 also was very upset about being told by the Administrator that the facility had the staff to address her needs Resident #1 stated that she was told by the Administrator that the facility has the staff and personnel to address her needs. Resident #1 stated that she felt lied to because she sits in her own urine and feces for hours and that the urine and feces go into her wounds. Resident #1 does not understand why it takes so long for the staff to come and clean her up. She stated that she needs to be cleaned up first to receive physical therapy which she has missed due to not being cleaned in a timely manner. Resident #1 stated that her family member will go up to the front to ask for assistance but it still takes a very long time for the staff to come and clean her up. Resident #1 is very angry and wants something to be done . Further record review of Resident #1's social progress notes dated [DATE] at 2:30 p.m. revealed in part: .Resident #1 stated that she was furious because she felt lied to. She stated that she was last cleaned at 9:00 p.m. on [DATE] and will finally get cleaned up at 2:00 p.m. on [DATE]. Resident #1 stated that she felt that she was lied to by the Administrator prior to being admitted just to get her to the facility to get paid and now that her 20 days are up, she feels like she is overlooked. Resident #1 requested to speak with someone who can ensure that she gets cleaned and the proper care she is entitled to In an interview on [DATE] at 8:58 a.m. with Resident #1 and her family member, she stated that she did not feel safe at the facility because there had been a tornado warning few days ago and that staff took all residents out to the hallways and that she was left in her room. Resident #1 further said that staff only closed her curtains and that she felt very afraid because she was not evacuated from her room like the other residents. Resident #1 continued saying that she was not able to get up or walk on her own. Observation revealed the measurements of the width of Resident #1's bed was 52 inches (from side rail to side rail). The measurements of the width of Resident #1's room door was 44 inches. Further interview at that time with Resident #1 with her family member present, Resident #1 stated that facility staff was only providing incontinent care at 9:00 p.m. and 3:00 p.m. She said I have wounds in my legs and the stool and urine are getting into my wounds. I haven't being cleaned today at all. I don't even know who my aide was. Staff don't come to see me in hours. If I pressed my call light, they will not come until around 11:30 a.m. I am very aware of what's going on, how about the people who are not aware of themselves?. Last night my brief was changed at 9:00 p.m. Normally staff don't change my brief during the night shift. I would like to be cleaned during the night but they don't come, even to check on me. Like now, if I would go and asked them to clean me because I feel that my brief is already soiled, they will say they are busy with breakfast. Every day I don't get care until around 1:30 p.m. or 3:00 p.m. Further interview at that time, Resident #1's family member stated since Resident #1 is in the facility, they haven't cleaned her before 1:00 p.m. Continued interview at on [DATE] at 9:10 a.m. Resident #1 stated my hair was not washed until 21 days after I was admitted to the facility, nobody comes to turn me in bed like they did at the hospital. I get my therapy late because I get cleaned up late. The Administrator told me before coming to the facility that they had the staff to care for me. She promised me a lot of things. She told me I was going to be fully taken care of. My family member is the one taking care of me, he would try to help me get cleaned up because the staff is busy. My back hurts, my buttocks hurts. I feel soiled. I can smell myself. In an interview on [DATE] at 11:06 a.m. with Resident #1, she stated that nobody had come to her room to check on her and offer to clean her and further said I don't even know who my aide is, since 9:00 p.m. last night that they did incontinent care, nobody has come to check if I need care. In an interview on [DATE] at 11:13 a.m. with CNA I, she stated that she was the aide assigned to care for Resident #1. When asked what time she was going to do care for Resident #1, CNA I stated We need 6 to 7 people to do incontinent care for Resident #1 and the Central Supply person is helping me on gathering all the staff. I can't do it by myself. Observation on [DATE] at 11:40 a.m. during incontinent care to Resident #1 revealed that 6 staff members came to assist with incontinent care. CNA J, CNA W and CNA X supported Resident #1's abdominal fold up while CNA I and CNA Y each held open one leg. Central Supply person (who is also a CNA) cleaned Resident #1's abdominal fold and front perineal area. Further observation at that time revealed that Resident #1's had a rectangular moisture sheet approx 6 inches by 14 inches, under her abdominal area and one between her upper thighs and the moisture sheet that was in between Resident #1's upper thighs was completely soaked and was dark brown in color. Continued observation at that time revealed a very strong urine and stool odor in the room. Further observation at that time during incontinent care, while Resident #1 was turned to her side revealed that 3 staff were needed to turned Resident #1 to her side and other 3 staff were needed to support Resident #1 on the other side of the bed while she was being turned to her side. Continued observation revealed that Resident #1's brief was completely soiled up to the back of the brief. The brief was dark yellow in color and had stool on it. There was stool also on the buttocks of Resident #1. Resident #1 was lying on 2 pads that had a large dark brown colored ring where Resident #1 was lying from the buttocks area to her mid thighs. Under the pads there was a sling (staff used sling to move Resident #1 up in bed) that had also a large circular wet area on the direction where Resident #1 was lying down. While Resident #1 was on her side, she required 3 staff to hold her on her side on the side she was facing, 2 staff to hold Resident #1 on her back while the other staff was providing the incontinent care. Continued observation on [DATE] at 12:23 p.m. at end of incontinent care, Resident #1 was assisted up on her bed. 3 staff were on one side and 3 other staff were on the other side. Further observation at that time revealed that it took 6 staff members to do incontinent care and took 43 minutes to complete the procedure. In an interview on [DATE] at 10:32 p.m. with CNA V, she stated that she was the aide taking care of Resident #1 and that it was her first time in the facility. She further said that she was told that Resident #1 required 6 people to do incontinent care and that the staff from 2:00 p.m. to 10:00 p.m. had just cleaned Resident #1. When asked if she was trained on how to evacuate Resident #1 out of her room in case of an emergency, CNA V stated No and then said I worked in another facility, I just came today to help them out. In an interview on [DATE] at 10:36 p.m. with Resident #1, she stated that she was cleaned only twice during the day, at 2:15 p.m. and 9:00 p.m. Resident #1 then said that in order to move her bed out of the room, the side arm rests of the bed needed to come out. She further said that few staff were trained during the day shift when she first got the bed delivered and then said that facility had not done further training on how to operate her bed to the rest of the staff. Further interview with Resident #1, she stated that after the incident of the tornado warning when she was left on her room alone, she said that the Administrator told her that she was left on her room so she would not feel uncomfortable on the hallway. Resident #1 continued saying that some staff told her on the day of the tornado warning that they would come and get her out of the room unless the tornado would really hit the building. At that time, Resident #1 stated If a tornado had really hit the building, I don't think they would had come back to get me, forget it, they would had tried to save themselves. In an interview on [DATE] at 11:00 p.m. with LVN B, she stated that there were 3 CNA's and 2 nurses for the night shift at the facility. She further said that she was the charge nurse for Resident #1. When asked how would she evacuate Resident #1 from her room in case of an emergency, LVN B responded Resident #1's bed would not fit thru the door and to be honest, we don't have the staff. I don't know what would we do, will call 911. We have raised the same question before because it's hard. I have not received any emergency training on Resident #1 and do not know how to maneuver her bed. I would not know what to do. Just call 911. LVN B further stated that there were 3 CNA's and 2 nurses for the night shift at the facility. She further said that she was

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F 0353 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 21) the charge nurse for Resident #1. She then said that during the night shift, they would only go to Resident #1 room unless she put her light on and then said Resident #1 gets her incontinent care during the pm shift when there is more staff. If she had a bowel movement during the night shift and she would want to have incontinent care, it would take all the staff in the facility during the night shift, all the 5 staff working on the facility. In an interview on [DATE] at 11:05 p.m. with LVN S, she stated that she was a full time nurse on the 10:00 p.m. to 6:00 a.m. shift and said that she had not received any training on how to evacuate Resident #1 from her room in case of an emergency and further said In case of a fire, we know the bed can't roll, well with a draw sheet. It takes 6 to 7 people just to turn Resident #1 in bed, we are 5 staff today working in the facility during the night shift, the bed is too big to get thru the door and I am not sure if we can take the bed apart, I don't know what will we do. In an interview on [DATE] at 11:13 p.m. with CNA U, she stated that she was a full time CNA working on the night shift. She further said that she had not received any training on how to evacuate Resident #1 in case of an emergency and then said we would call the fire department and would tell them to hurry up because we would not be able to evacuate her by ourselves. She further said that it would take 5 to 6 people to move Resident #1 and if Resident #1 needed incontinent care the 3 aides and the 2 nurses in the facility would have to assist with her care. In an interview on [DATE] at 11:20 p.m. with CNA T, she stated that she was a full time CNA working on the night shift and said that she had not received any training on how to evacuate Resident #1 out of her room in case of an emergency and further said I have no idea what will we do. The bed might not fit thru the door, it's not enough staff at night to lift her up with a sheet. We would just try to secure her in her room or try to lift her, we are strong. Continued interview with CNA T, she then said I don't think we are equipped for Resident #1, we usually work 3 aides and 2 nurses at the night shift and it takes about 6 people to do care for her. If we needed to clean her, the whole building of staff would have to go and care for her and it would take 35 to 40 minutes. In an interview on [DATE] at 9:38 a.m. with the Administrator, she stated that on the day of the tornado warning, it was around 6:45 a.m. sometime in January, that the facility had to evacuate the residents due to the tornado warning and further said we got the residents to the hallway. Then Resident #1's family member came to me and told me that Resident #1 was very nervous and then I remember that before Resident #1 came to the facility, she told me not to make her feel that she was in a nursing home, so what we did, to not to increase her anxiety, I decided to leave her on her room, we closed her blinds and pulled her curtains. For Resident #1's window to be destroyed by a tornado, the whole front of the building needed to be destroyed. If pressure would built inside the building, we would have to open Resident #1's window or we would have to ask Resident #1 if she would like to come out of the room. Tornado warning did not stop on that day until 8:30 a.m. Further interview with the Administrator at that time, she stated that Resident #1's side rails would have to come out of the bed in order to be able to move the bed out of the room. She then said that the Therapy Director and Central Supply person were trained on how to break the bed down in an emergency situation. Administrator continued saying that she knew Therapy Director and Central Supply person trained some staff but she did not know who and said she was going to get the training records for surveyor. Administrator then said that disaster plan in-services are done annually on the month of April and upon orientation. In an interview on [DATE] at 9:58 a.m. with Central Supply, she stated that she got trained by the bed company representative on how to operate Resident #1's bed but that she did not give any training to anyone else and further said the staff who was here at the facility at that time were trained on how to operate Resident #1's bed. In an interview on [DATE] at 10:05 a.m. with Therapy Director, he stated that the day when Resident #1 had her bed delivered, he was instructed by the bed company representative on how to operate the bed. He then said that there was other staff present but he did not remember who they were or the exact date. Therapy Director continued saying that he did trained some of the CNA's from the day shift, whoever was around, on how to manipulate Resident #1's side rails and what to do in case of a code emergency but he was not sure if nursing had additional training with the rest of the staff on how to maneuver Resident #1's bed. In a second interview on [DATE] at 11:00 a.m. with the Administrator, when asked if the night shift had any training on emergency procedures on Resident #1, how to evacuate her in an emergency, how to maneuver her bed in case of an emergency, the Administrator responded that's what I had been looking for because the training we had was mostly for the day shift, it was supposed to be done but not sure if it was done. It was supposed to happened but I can't find the training records, but in the worst scenario, we will come tonight to train them. When told that nobody from the night shift knew how to operate Resident #1's bed or how to evacuate Resident #1 in case of an emergency, the Administrator said we will come tonight to train them. Further interview with the Administrator, she stated that the night shift usually works together on helping Resident #1 with her care and further said I was under the impression that Resident #1 had incontinent care every morning at 6:00 a.m. Resident #1 gets care at certain times only because she does not want to be bother. Administrator further said that she has not heard any concerns related to the care of Resident #1. In an interview on [DATE] at 2:40 p.m. with Resident #1, she stated that she never requested only certain times and that she has not refused any care or that staff checks on her during the night time and further said Like this morning, I did not get cleaned until 12:00 p.m. It makes me want to cry. I have history of getting skin infections. Last night they cleaned me around 9:00 p.m. and did not get incontinent care until 12:00 p.m. today. Since 8:00 a.m. I had been waiting for somebody to come but they did not come until 12:00 p.m. I urinated and defecated on myself since early morning. The pad underneath me is always so wet because I urinate and urinate and urinate on it. I cry and get so frustrated because I know I smell, I smell my urine. I have not refused any care. I was told I was going to be bathe every other day and I don't. In an interview on [DATE] at 3:08 p.m. with Central Supply, she stated that she was assigned with Resident #1 during the day shift and that she was scheduled for shower and said that she was going to stay over to bathe Resident #1. Central Supply further said that she did not give incontinent care to Resident #1 earlier on the shift because Resident #1 was eating breakfast. The Administrator stated on [DATE] at 3:20 p.m. that the facility did not have a policy and procedure for staffing. Record review of - NWS Houston (@NWSHouston) [DATE] Tornado warnings dotted counties along the Gulf Coast beginning late Tuesday night, reaching and including the metro Houston area during the pre-dawn hours of Wednesday. Record review of the facility's Disaster Risk assessment dated [DATE] revealed that the facility was somewhat likely for the following disasters: Hurricane, tornado/severe storms, flooding, lightning and extreme heat. Record review of the facility's Internal/External disaster plan revised on [DATE] reads in part .Tornado/Severe Storm: If notice is given, take the following steps: 1.- turn on hallway lights, 2.- Close all drapes, blinds, 3.- Evacuate all rooms to the immediate hallways, 4.- Protect all patients 5.- Do not open doors or windows Record review of the facility's document with title Evacuation of Patients in Bari Rehab Beds revealed in part In the event that it should become necessary to evacuate a bed-bound patient in a Bari-Rehab bed, please follow the instructions on how to retract the bed Instruction for expanding/retracting bed deck . emergency hand crank . Side rail instructions .adjusting side rail trouble shooting instructions . Record review of the facility's undated Statement of Resident Rights revealed in part: .You have the right to (1) all care necessary for you to have the highest possible level of health Dignity and respect You have the right to live in safe, decent, and clean conditions, be free from neglect be treated with dignity, consideration and respect Make your own choices regarding personal care . Record review of the facility policy and procedure Incontinent Care revised ,[DATE] revealed in part: It is the policy of this facility to remove urine or feces from skin Further record review revealed no information on how often the facility provided incontinent care to the residents. Record review of the facility policy and procedure ADL, Services to carry out revised ,[DATE] revealed in part: It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities .2.- Residents who are unable to carry out activities of daily living will receive necessary services to maintain: grooming, personal hygiene . Record review of the facility policy and procedure Turning rounds revised ,[DATE] revealed in part; It is the policy of this facility to 1.- Cleanse, refresh and reposition bedfast residents on a regular basis An IJ was identified on [DATE] at 11:56 am and the Administrator, the Clinical Resource Nurse and the Executive Market Director were informed at that time.

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	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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 0353 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 22) The POR was accepted on [DATE] at 4:00 pm. The POR included: Immediate Action: 1.- We are actively seeking to discharge the resident from the bariatric resident from the facility to a facility that can better meet her needs. 2.- On [DATE], we tested and ensured that the bariatric bed can be easily be removed from the room in the event of an emergency evacuation. 3.- Charge nurse will be responsible for directing staff to evacuate such identified patients according to the emergency preparedness plan. Education on the emergency preparedness plan began [DATE]. The process for breaking down the bariatric bed for removal from the room was added to the disaster plan on [DATE]. The process is detailed with the attached guide, and the staff are to follow the normal evacuation procedures, using the set routes and evacuation order, per the disaster plan. 4.- The Director of Therapy or designee will be in-service all staff with return demonstration on the proper procedures on how to breakdown facility's bariatric beds according to manufacturer's instructions, beginning [DATE]. 5.- Staffing coordinator or designee is reviewing schedule with DON or designee every shift to ensure adequate staff to meet resident needs, including emergency situations. 6.-The above training will begin on [DATE] and will continue until all nursing staff have been in-serviced. Staff will not be allowed to resume resident care responsibilities or other duties until trained. 7.- Facility is voluntarily stopping admissions effective [DATE] until substantial compliance is achieved. The Administrator / Designee will ensure that the above training is completed as planned. Two-four staff are required to breakdown and push the bed. Evacuation routes areas listed in the disaster plan. Staff is trained annually and upon orientation on the disaster plan. Then number of staff on the night shift was assessed on [DATE] to ensure adequate staffing in case of an emergency evacuation by the Administrator. Administrator has signed a contract with an agency to ensure that we have two additional staff members on the night shift beginning tonight, [DATE], making it 7 staff members based on the current census. Facility Human Resource designee is actively hiring and orientating new staff members for the 10 to 6 a.m. shift to ensure resident needs are met and that resident safety is ensured in the event of an evacuation route would take 20 to 30 minutes depending upon if the evacuation needs to be to another compartment or out of the building. The building is designed and broken into fire compartments so that a total evacuation would not be needed unless the entire building is engulfed in flames. Beginning [DATE], all new admissions will be screened prior to admission by DON/Designee to determine if they are bed-bound bariatric patients who would need the above procedures. All bariatric patients needing the above procedures will have their care plans updated by [DATE]. As of this time, there are no other bariatric residents requiring special evacuation procedures. DON/Designee will monitor any change in residents' transfer status at weekly Standard of Care meeting beginning [DATE]. All circumstances requiring evacuation as per the Fire and Disaster Manual will trigger the above procedures. Continue to look for alternate placement for patient where needs can be better met. Monitoring: In an interview on [DATE] at 10:20 a.m. with LVN G and LVN H, both stated that they had been trained on the bed operation for Resident #1 and how to evacuate her in case of an emergency. In an interview on [DATE] at 10:30 a.m. with LVN E, she stated that she had been trained on Emergency procedures with Resident #1 and how to maneuver her bed in case of evacuation emergency. In an interview on [DATE] at 10:40 a.m. with LVN F, he stated that he had been trained on How to operate Resident #1's bed, how to remove the side rails in an event of evacuation including for CPR emergencies. In an interview on [DATE] at 1:00 p.m. with CNA I, she stated that she had been trained on Emergency procedures for Resident #1 and how to maneuver her bed including how to remove the side rails in an event of evacuation emergency. She also said that they were trained on how to prepare Resident #1's bed if she needed CPR. In an interview on [DATE] at 1:40 p.m. with CNA J, she stated that she was also trained on emergency procedures for Resident #1's bed. CNA J also said that she felt confident on how to maneuver Resident #1's bed for evacuation and CPR. In an interview on [DATE] at 1:52 p.m. with LVN K, she stated that she had been trained on how to break Resident #1's bed in an event of evacuation to wheeled the bed out of the room and how to deflate her mattress for CPR. In an interview on [DATE] at 2:00 p.m. with CNA L and CNA M, both said that they attended training regarding how to operate Resident #1's bed including how to remove the side rails to make sure the bed can be evacuated out of the room and how to deflate the bed for CPR. In an interview on [DATE] at 2:10 p.m. with CNA N, she stated that she had received training on emergency procedure for Resident #1 and how to maneuver her bed. In an interview on [DATE] at 2:35 p.m. with CNA O, she stated that she was also trained on how to make Resident #1's bed smaller to make it fit thru the door in an event of an emergency. She also said that training included for CPR and how to operate the bed without electricity. In an interview on [DATE] at 3:05 P.m. with LVN P, she stated that she received training on [DATE] on how to maneuver Resident #1's bed and emergency procedures for Resident #1 including evacuation. In an interview on [DATE] at 4:20 p.m. with CNA Q she stated that she was also trained on how to operate Resident #1's bed and what to do in an event of an emergency including evacuation. In an interview on [DATE] at 4:25 p.m. with RN R, she stated that she had been trained on how to break Resident #1's bed in an event of evacuation to wheeled the bed out of the room and how to deflate her mattress for CPR. In a phone interview on [DATE] at 4:30 p.m. with LVN A, he stated that he had been trained on how to maneuver Resident #1's bed, how to move the bed out of the room and other emergency techniques including CPR and what to do with the bed if no electricity. He also said that he was working on the night shift on [DATE] with Resident #1 and that he already knew how to direct the staff in case of an emergency. In a phone interview on [DATE] at 4:40 p.m. with LVN S, she stated that she was trained last night on emergency procedures with Resident #1 including evacuation and how to work Resident #1's bed, including CPR and how to manually operate the bed if no electricity. In an phone interview on [DATE] at 4:58 p.m. with CNA T, she stated that she was also trained on how to operate Resident #1's bed in an event of evacuation. She said that she knew what to do now in an event of an emergency a
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**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 observation, interview and record review, the Administration failed to oversee the facility in a manner that enabled it to use the facility's resources effectively to maintain the highest practicable physical well-being for two of seven residents (CR#3 and Resident #1) reviewed for quality of care. -The Administrator, who was the abuse coordinator, failed to ensure the facility's policies and procedures were implemented for the prohibition of neglect. -The Administrator failed to monitor the system of communication between nurses to follow up with critical laboratory reports and MD notification. --The Administrator failed to supervise and monitor the former DON to ensure she carried out her responsibilities in the areas of assessment and monitoring of medical conditions, such as monitoring of vital signs when a resident had a change in condition including MD notifications and follow up timely with MD orders. -The Administrator failed to monitor that the facility had sufficient staff during the night shift to provide care for Resident #1 who required 6 to 7 staff to provide incontinent care and failed to make sure staff on all shifts were trained on how to evacuate a bariatric resident who had an oversized bed in an event of an emergency. An IJ was identified on [DATE] and [DATE]. While the IJ's were removed on [DATE] the facility remained out of compliance at a scope of widespread and a severity of actual harm due to facility requiring more time to monitor the plan of removal for effectiveness. These failures affected one former resident (CR#3) who died 26 minutes after arrival to the emergency room and one resident at the facility (Resident #1) whose needs were not met due to insufficient staff and placed the other 87 residents at the

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 23) facility at risk of not receiving adequate care, fear, injuries, decline in their health condition well-being, delayed evacutations and death. Findings included: Intakes # 4, # 6 and # 8 In an interview on [DATE] at 11:00 a.m. the DON, stated she was new in the facility. She said her first day of employment was [DATE]. The DON then said she started to meet in person all the nurses in the facility so they knew who she was and to provided them her contact information. In an interview on [DATE] at 11:38 a.m. the Administrator, stated the facility had completed new teams for clinicals because the process previously used was not working. She then said the Clinical Resource Nurse had just trained her on what to look for as an Administrator concerning changes in condition of residents. The Administrator said the facility was implementing a new change of condition log as part of the POR. Further interview with the Administrator at that time, she stated she was aware CR #3 had some abnormal vital signs but she was not aware of any STAT laboratory orders or that the nurses were not able to contact the MD. She then said she was not aware either that the NP had given orders for CR #3 to be sent to the hospital the day before that she was found unconscious. Administrator continued saying that when she learned about CR #3's symptoms on [DATE], she was expecting and assuming that CR #3 was going to be sent to the hospital and it was not until the next day staff told her CR #3 had coded in the facility. Continued interview with the Administrator, she said she was aware staff were trained initially on Resident #1's bed but she was not aware staff from the night shift did not know how to operate Resident #1's bed and was not aware Resident #1 had incontinent care only twice in a 24 hour period. CR #3 Record review of the facility face sheet revealed CR# 3 was a [AGE] year old female admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]. CR #3 was found unresponsive and was sent to the hospital on [DATE] and was pronounced dead 26 minutes after arrival to the emergency room . Record review of CR #3's physician's telephone orders signed by the NP and dated [DATE] at 9:30 a.m. revealed orders in part: - STAT urinalysis, BMP and Pro BNP . Record review of the 5 day MDS assessment dated [DATE] revealed CR #3 required limited assistance for bed mobility, transfer, dressing, toileting and personal hygiene and supervision for walking in room and in corridor, locomotion and eating. CR #3 was always continent of bowel and had an indwelling catheter for urine. Record review of CR #3's electronic and paper records revealed CR #3 did not have a care plan. Record review of CR #3's NP progress notes dated [DATE] revealed in part: XXX[AGE] year old female readmitted at the hospital for frequent falls. She is here for rehab. Past medical history for hypertension, [MEDICAL CONDITIONS] and acute [MEDICAL CONDITION] .STAT BNP (Pro) (Beta Naturetic Peptide - test to help detect, diagnose, and evaluate the severity of heart failure), BMP (basic metabolic panel, blood work that assess electrolytes and kidney function) and urinalysis. Assessment/Plan: [MEDICAL CONDITION] - BUN (Blood Urea Nitrogen) / Creatinine (test to assess kidney function) high on [DATE]. Will re-check STAT today . Record review of CR#3's laboratory requisition form dated [DATE] revealed a collection time of 1:52 p.m. for urinalysis and BNP (Beta Naturetic Peptide). Further record review revealed that BMP test was omitted in requisition order. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 3:15 p.m. Late entry by LVN C .CR #3 went to therapy and therapist checked oxygen saturation and read 78%. Checked CR #3's oxygen saturation upon returning to room and oxygen saturation read 82%. Immediately placed CR #3 on oxygen at 2 liters. Oxygen continued to rise to 89%. Vital signs blood pressure ,[DATE], pulse 71, temperature 98.4 and respirations 15 - 16 breaths per minute with no labored breathing. Contacted NP with results on low oxygen and informed her that the oxygen was rising and asked if CR #3 could go out to hospital. Informed oncoming nurse . -[DATE] at 4:16 p.m. by LVN C NP into see CR #3 and RP concerned that CR #3 is having kidney issues. Orders to have STAT urinalysis, BNP and Pro BNP .All orders completed . -[DATE] at 4:20 p.m. by LVN C NP called and informed of oxygen saturation . (NP) stated that we could send CR #3 out to hospital. Informed nurse on duty of decision . Record review of CR #3's electronic vital signs record revealed in part: -[DATE] at 4:42 p.m. Blood pressure ,[DATE] and pulse 64 beats per minute. Further record review revealed no further vitals sign assessments for CR #3. Further record review of CR #3's laboratory requisition form dated [DATE] revealed a collection time of 8:00 p.m. for BMP (basic metabolic panel). This was the STAT test ordered by the NP at 9:30 a.m. that morning) Record review of CR #3's laboratory report dated [DATE] at 12:18 a.m. revealed in part; -Potassium level 6.2 mEq/L Reference range (3.5 - 5.3). Continued record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 1:46 a.m. by LVN A Potassium 6.2. Dr. A informed. Awaiting call back. -[DATE] at 1:49 a.m. by LVN A [MEDICATION NAME] (muscle relaxant) tablet 350 mg. Give 0.5 tablet by mouth every 6 hours as needed for muscle spasm / back pain. CR #3 requested for muscle spasms -[DATE] at 2:30 a.m. by LVN A CR #3 lying in bed, no complaints of pain or nausea. Oxygen saturation 94% at 3 liters of oxygen. Assisted to restroom with 1 person assistance. Tolerated ambulation well. Dr. A paged of Critical Potassium levels of 6.2. Further record review of the progress/nurses notes revealed no further attempts to contact the MD for the critical Potassium levels, no vital sign assessments or any further assessments during the night shift. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 2:14 p.m. by ADON A Received in report that laboratory reported a critical potassium level and no new orders obtained as of that time. Contacted NP with laboratory results approx. 7:06 a.m. NP returned call at 7:11 a.m. requesting oxygen saturation levels. Reported back to CR #3's to check oxygen saturation. Upon entering room CR #3's eyes were closed and she was non-responsive to verbal and tactile stimuli. CR #3 was not breathing, no pulse palpable, skin warm to touch. Code called, CPR initiated and 911 called. Fire department arrived and took over CPR until paramedics arrived. CR #3 was last observed sleeping in bed at approx 6:30 A.M. Notified emergency contact at approx. 7:40 a.m. that CR #3 was observed unresponsive and that she should go to the hospital where CR #3 was transferred . Record review of CR #3's hospital records from the emergency room revealed in part: Arrival date/time: [DATE] at 8:05 a.m. -At 8:25 a.m. [AGE] years old white female presents to ED via unassigned with complaints of Full arrest. -At 8:25 a.m. preceding the arrest, CR #3 was found down by nursing home staff. The arrest occurred at the nursing home. The arrest was not witnessed by others. Bystanders at the scene performed CPR. -EMS (emergency medical service) care prior to arrival: Initiation of ACLS (advanced cardiac life support), peripheral IV, was successfully placed. 15 minutes elapsed prior to ACLS. ACLS has been in progress for 45 minutes. ACLS details: initial rhythm was asystole (flat line in electrocardiogram). [MEDICATION NAME] ([MEDICATION NAME]) intravenous 8 doses. Response to therapy: Continued arrest. Arrest was first noted at 7:15 a.m. asystole was presenting rhythm, there may have been PEA (pulseless electrical activity) at one point. --At 8:31 a.m. ED course: CR #3 has been under CPR for more than 45 minutes with no ROSC (return of spontaneous circulation). While there was not a definitive airway, after 45 minutes of CPR and 9 rounds of [MEDICATION NAME], did not feel like any further attempts at airway wound lead to different outcome other than death. CR #3 was pronounced. -Diagnosis: [REDACTED]. In an interview on [DATE] at 2:08 p.m. with ADON A, she stated she was the charge nurse for CR #3 on [DATE] when she was found unresponsive. ADON A said she arrived at the facility and started her rounds alone looking at the residents at around 6:30 a.m. and it was at that time she saw CR#3 sleeping. She then said that LVN B told her CR #3 had critical potassium levels during the night shift and the MD had not returned the call yet and LVN A who was assigned to CR #3 during the night shift, had gone home earlier on the shift. ADON A then said when LVN B told me staff had not followed up with the MD regarding the critical potassium levels, I texted the NP and the NP called me within a couple of minutes. I gave her the

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LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 24) critical values of potassium for CR #3 and she asked me for CR #3's oxygen saturation levels because CR #3 was having problems with her oxygen on [DATE]. When I went to the room at that moment still with the phone on my hands and the NP on the line, CR #3 was found not breathing, and no vital signs. CPR was started and 911 was called. CR #3 died in route to the hospital. Further interview with the ADON A at that time, she stated the night shift tried to call the MD but the MD was not reach. ADON A then said facility protocol is that if the MD does not return the calls, we were supposed to call the medical director, but CR #3's MD was the medical director. Facility has another medical director that we were supposed to call if the first medical director does not answer the calls. LVN B said that the other medical director called the facility during the night shift on [DATE] for another resident and that LVN A forgot to mention about the critical potassium values of CR #3. Continued interview the ADON A on [DATE] at 2:20 p.m. said critical laboratory values was a change in condition and the facility staff was supposed to complete a change of condition assessment in the computer where it prompt staff to assess the resident, notify MD and RP. ADON A further said that if for any reason the MD or another medical director was unable to be located, the staff was supposed to notify the DON. She said she did not know if the previous DON was aware of the situation with CR #3. When asked if CR #3 had any assessments previous to being found unresponsive or any vital signs, ADON A then looked at the computed and then said there is none, last vital signs were on [DATE] at 4:42 p.m. In a phone interview on [DATE] at 4:25 p.m. with LVN C, she stated that she was the charge nurse for CR #3 on [DATE] from 6 a.m. to 2:00 p.m. and said she called the NP to notify her CR #3 oxygen levels were low and the NP called her at the end of her shift and told her to send CR #3 to the hospital. LVN C then said she told the 2:00 to 10:00 p.m. shift nurse who was RN D about the order to send CR #3 to the hospital. LVN C said it was around 3:50 p.m. on [DATE] when she got the order. LVN C continued saying she did not transcribe the order to CR #3's chart because she was going home and she had already talked to RN D about the new orders. LVN C further said she got the orders via text message and the staff would usually call, page or text the MD or the NP and then said she had erased the text message from the NP. Continued phone interview with LVN C at that time, she stated whenever a resident had a change in condition, the staff was supposed to complete a change in condition form in the computer that was like an SBAR where they would write their assessments, MD and RP notifications and then said that she did not complete that assessment on CR #3. In a phone interview on [DATE] at 3:29 p.m. the NP, stated she came to the facility on [DATE] and saw CR #3 and ordered STAT laboratory blood work because when she saw CR #3 she did not look good. NP stated she did not hear anything about the results of the laboratory blood work for CR #3 after she gave the orders. NP then said the following morning she called the facility to find out if CR #3 was sent to the hospital as she had ordered on [DATE] and to find out about the laboratory results. NP continued saying on [DATE] at around 7:00 a.m. she called the facility and spoke to ADON A and asked about CR #3 and how come she did not hear about the laboratory results and at that moment, ADON A told her CR #3 was still in the facility and NP asked ADON A for CR #3's vital signs right away including oxygen saturation. Further interview at that time the NP, stated she was surprise to find out that CR #3 was not in the hospital and requested CR #3's vital signs because she wanted to know how she was doing it was at that time that ADON A told her that CR #3 was unresponsive. NP then said I don't understand why the nurses did not follow the orders and called for the laboratory blood work STAT. If it wasn't that I called them the next morning at 7:00 a.m. and inquired about CR #3 status what would have happened? What if I did not call? I gave STAT laboratory blood work orders, I expected the results right away. When I did not hear anything during the night shift, I thought CR #3 was sent to hospital but I decided to follow up with the facility the next morning. I even told them you guys are not following orders' . In an interview on [DATE] at 3:52 p.m. the Administrator, stated STAT laboratory orders needed to be call immediately to the laboratory and the policy was for the laboratory to come and draw the blood within 4 hours and 1 to 2 hours to get the results back. The Administrator then said once the nurse gets the orders, the nurse will enter the order in the computer and then would follow on the order. She further said that the nurse who gets the laboratory results is the nurse who will follow up with the MD. Administrator further said for STAT abnormal laboratory results, the nurses will call the MD right away.If the MD does not answer, then the medical director, the facility has 2 medical directors, if one does not answer, then we will call the other medical director. If none of the medical directors answer, then the nurse is supposed to call the DON and the Administrator so we can help in getting hold of the doctors. Continued interview with the Administrator at that time, she stated whenever a resident has a change in condition, staff are supposed to complete an eINTERACT form in the computer. She further said the interact form was a tool built in the computer system for changes in condition where it will trigger on what will need to happened. Administrator further said the interact tool would guide the nurses on calling the MD, the RP and to follow up on assessments. Resident #1 Record review of the facility face sheet revealed Resident #1 was a [AGE] year old female. She was admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]., unspecified and essential (primary) hypertension. Record review of Resident #1 admission assessment dated [DATE] revealed she was cognitively intact with a BIMS score of 15 out of a possible 15. She required extensive assistance of two or more person for bed mobility, and was total dependent on two or more person physical assist for transfer, locomotion on unit and off unit, dressing, toilet use, personal hygiene and bathing. Resident #1 was always incontinent of bowel and bladder. Further record review revealed a weight of 792 lbs and 64 inches in height. Continued record review revealed Resident #1 was at risk of developing pressure sores and was not on a turning/repositioning program. She received application of non-surgical dressing and ointment/medications other than to feet. Record review of Resident #1's care plan initiated [DATE] revealed in part: -Focus: At risk for an ADL self care performance deficit related to limited mobility, limited ROM. All due to severe [MEDICAL CONDITION] and severe [MEDICAL CONDITION] (swelling that occurs in the arms or legs). Has limited physical movement being total dependent related to disease process, [MEDICAL CONDITION], weakness and limited movement. -Goal: Resident #1 will be safely assisted with performance with bed mobility, dressing, grooming, toilet/incontinent needs and personal hygiene. She required extensive assist of 5 to 7 staff members. -Interventions: Bed mobility: is totally dependent on staff for repositioning and turning in bed. Requires 5 to 7 staff member to turn and reposition and provided treatment. Further record review revealed no information on her care plan related to the need of an oversize bed with interventions on how to maneuver her oversized bed in the event of an emergency that required evacuation. Record review of facility grievance dated [DATE] revealed in part: .Print individual's name: (Resident #1's) family member. Describe concern using factual terms: On Friday, [DATE], (Resident #1) was cleaned up at 8:00 p.m. so she started to urinate during the night. I asked that she get cleaned up at 10:00 a.m The CNA knew so we waited both me and Resident #1, we ended up going to sleep so by the time we woke up, it was 5:30 p.m. so I went back with the nurse and told him and the nurse said that he will let the 2 to 10:00 p.m. CNA know. Her CNA said she will come after dinner so by the time came (Resident #1) was soaking wet and full of bowel movement to the point that the bed was soaked, the same thing happened Sunday [DATE]th. Informed Administrator . Record review of the facility's In-service education record dated [DATE] with title Resident #1's bed revealed that training was given to only 11 facility staff members. Further record review revealed that 9 staff members were from the 6:00 a.m. to 2:00 p.m. shift, 1 staff member was from the 2:00 p.m. to 10:00 p.m. shift and 1 staff member from the 10:00 p.m. to 6:00 a.m. shift. Record review of Resident #1's social progress notes dated [DATE] at 1:30 p.m. revealed in part: Spoke with Resident #1 and family member and Resident #1 was very upset and frustrated and stated that she does not feel comfortable because during the tornado warning , she (Resident #1) was never brought out to the hallway. She stated that she was told from the Administrator that they would have to break down the bed to get it out of the room. Resident #1 stated staff just pulled the curtains closed during the storm. Resident #1 stated the Administrator told her a tornado would hit the 100 hall first if anything were to happened.(Resident #1 was on the 300 hallway). Resident #1 stated she found out that by law, all residents were to be pulled out into the hallway. Resident #1 also was very upset about being told by the Administrator the facility had the staff to address her needs. Resident #1 stated she was told by the Administrator that the facility has the staff and personnel to address her needs. Resident #1 stated she felt lied to because she sits in her own urine and feces

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	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 25) for hours and that the urine and feces go into her wounds. Resident #1 does not understand why it takes so long for the staff to come and clean her up. She stated she needs to be cleaned up first to receive physical therapy which she has missed due to not being cleaned in a timely manner. Resident #1 stated her family member will go up to the front to ask for assistance but it still takes a very long time for the staff to come and clean her up. Resident #1 is very angry and wants something to be done . Further record review of Resident #1's social progress notes dated [DATE] at 2:30 p.m. revealed in part: .Resident #1 stated she was furious because she felt lied to. She stated she was last cleaned at 9:00 p.m. on [DATE] and will finally get cleaned up at 2:00 p.m. on [DATE]. Resident #1 stated she felt she was lied to by the Administrator prior to being admitted just to get her to the facility to get paid and now that her 20 days are up, she feels like she is overlooked. Resident #1 requested to speak with someone who can ensure she gets cleaned and the proper care she is entitled to In an interview on [DATE] at 8:58 a.m. with Resident #1 and her family member, she stated that she did not feel safe at the facility because there had been a tornado warning few days ago and staff took all residents out to the hallways and she was left in her room. Resident #1 further said staff only closed her curtains and she felt very afraid because she was not evacuated from her room like the other residents. Resident #1 continued saying that she was not able to get up or walk on her own. Observation revealed the measurements of the width of Resident #1's bed was 52 inches (from side rail to side rail). The measurements of the width of Resident #1's room door was 44 inches. Continued interview at on [DATE] at 9:10 a.m. Resident #1 stated my hair was not washed until 21 days after I was admitted to the facility, nobody comes to turn me in bed like they did at the hospital. I get my therapy late because I get cleaned up late. The Administrator told me before coming to the facility that they had the staff to care for me. She promised me a lot of things. She told me I was going to be fully taken care of. My family member is the one taking care of me, he would try to help me get cleaned up because the staff is busy. My back hurts, my buttocks hurts. I feel soiled. I can smell myself. In an interview on [DATE] at 11:13 a.m. with CNA I, she stated that she was the aide assigned to care for Resident #1. When asked what time she was going to do care for Resident #1, CNA I stated We need 6 to 7 people to do incontinent care for Resident #1 and the Central Supply person is helping me on gathering all the staff. I can't do it by myself. Observation on [DATE] at 11:40 a.m. during incontinent care to Resident #1 revealed that 6 staff members came to assist with incontinent care. CNA J, CNA W and CNA X supported Resident #1's abdominal fold up while CNA I and CNA Y each held open one leg. Central Supply person (who was also a CNA) cleaned Resident #1's abdominal fold and front perineal area. Further observation at that time revealed that Resident #1's had a rectangular moisture sheet approx 6 inches by 14 inches, under her abdominal area and one between her upper thighs and the moisture sheet that was in between Resident #1's upper thighs was completely soaked and was dark brown in color. Continued observation at that time revealed a very strong urine and stool odor in the room. Further observation at that time during incontinent care, while Resident #1 was turned to her side revealed that 3 staff were needed to turned Resident #1 to her side and other 3 staff were needed to support Resident #1 on the other side of the bed while she was being turned to her side. Continued observation revealed that Resident #1's brief was completely soiled up to the back of the brief. The brief was dark yellow in color and had stool on it. There was stool also on the buttocks of Resident #1. Resident #1 was lying on 2 pads that had a large dark brown colored ring where Resident #1 was lying from the buttocks area to her mid thighs. Under the pads there was a sling (staff used sling to move Resident #1 up in bed) that had also a large circular wet area on the direction where Resident #1 was lying down. While Resident #1 was on her side, she required 3 staff to be holding her on her side on the side she was facing, 2 staff to be holding Resident #1 on her back while the other staff was providing the incontinent care. Continued observation on [DATE] at 12:23 p.m. at end of incontinent care, Resident #1 was assisted up in her bed. 3 staff were on one side and 3 other staff were on the other side. Further observation at that time revealed that it took 6 staff members to do incontinent care and took 43 minutes to complete the procedure. In an interview on [DATE] at 10:32 p.m. with CNA V, she stated that she was the aide taking care of Resident #1 and it was her first time in the facility. She further said she was told that Resident #1 required 6 people to do incontinent care and the staff from 2:00 p.m. to 10:00 p.m. had just cleaned Resident #1. When asked if she was trained on how to evacuate Resident #1 out of her room in case of an emergency, CNA V stated No and then said I worked in another facility, I just came today to help them out. Further interview with Resident #1, she stated that after the incident of the tornado warning when she was left on her room alone, she said the Administrator told her that she was left on her room so she would not feel uncomfortable on the hallway. Resident #1 continued saying that some staff told her on the day of the tornado warning that they would come and get her out of the room unless the tornado would really hit the building. At that time, Resident #1 stated If a tornado had really hit the building, I don't think they would had come back to get me, forget it, they would had tried to save themselves. In an interview on [DATE] at 11:00 p.m. with LVN B, she stated that there were 3 CNA's and 2 nurses for the night shift at the facility. She further said she was the charge nurse for Resident #1. When asked how would she evacuate Resident #1 from her room in case of an emergency, LVN B responded Resident #1's bed would not fit thru the door and to be honest, we don't have the staff. I don't know what we would we do, will call 911. We have raised the same question before because it's hard. I have not received any emergency training on Resident #1 and do not know how to maneuver her bed. I would not know what to do. Just call 911. LVN B further stated that there were 3 CNA's and 2 nurses for the night shift at the facility. She further said she was the charge nurse for Resident #1. She then said that during the night shift, they would only go to Resident #1 room if she put her light on and then said Resident #1 gets her incontinent care during the pm shift when there is more staff. If she had a bowel movement during the night shift and she would want to have incontinent care, it would take all the staff in the facility during the night shift, all the 5 staff working on the facility. In an interview on [DATE] at 11:05 p.m. with LVN S, she stated that she was a full time nurse on the 10:00 p.m. to 6:00 a.m. shift and said she had not received any training on how to evacuate Resident #1 from her room in case of an emergency and further said In case of a fire, we know the bed can't roll, well with a draw sheet. It takes 6 to 7 people just to turn Resident #1 in bed, we are 5 staff today working in the facility during the night shift. The bed is too big to get thru the door and I am not sure if we can take the bed apart, I don't know what will we do. In an interview on [DATE] at 11:13 p.m. with CNA U, she stated that she was a full time CNA working on the night shift. She further said that she had not received any training on how to evacuate Resident #1 in case of an emergency and then said we would call the fire department and would tell them to hurry up because we would not be able to evacuate her by ourselves. She further said that it would take 5 to 6 people to move Resident #1 and if Resident #1 needed incontinent care the 3 aides and the 2 nurses in the facility would have to assist with her care. In an interview on [DATE] at 11:20 p.m. with CNA T, she stated that she was a full time CNA working on the night shift and said that she had not received any training on how to evacuate Resident #1 out of her room in case of an emergency and further said I have no idea what we would do. The bed might not fit thru the door. There is not enough staff at night to lift her up with a sheet. We would just try to secure her in her room or try to lift her, we are strong. Continued interview with CNA T, she then said I don't think we are equipped for Resident #1, we usually work 3 aides and 2 nurses at the night shift and it takes about 6 people to do care for her. If we needed to clean her, the whole building of staff would have to go and care for her and it would take 35 to 40 minutes. In an interview on [DATE] at 9:38 a.m. the Administrator, stated around 6:45 a.m. sometime in January, the facility had to evacuate the residents due to the tornado warning and further said we got the residents to the hallway. Then Resident #1's family member came to me and told me that Resident #1 was very nervous and then I remember before Resident #1 came to the facility, she told me not to make her feel that she was in a nursing home, so what we did, to not to increase her anxiety, I decided to leave her on her room. We closed her blinds and pulled her curtains. For Resident #1's window to be destroyed by a tornado, the whole front of the building needed to be destroyed. If pressure would build inside the building, we would have to open Resident #1's window or we would have to ask Resident #1 if she would like to come out of the room. Tornado warning did not stop on that day until 8:30 a.m. Further interview with the Administrator at that time, she stated Resident #1's side rails would have to come out of the bed

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LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 26) in order to be able to move the bed out of the room. She then said that the Therapy Director and Central Su
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 interview and record review the facility failed to promptly notify the ordering physician or nurse practitioner of laboratory results that fell outside of the clinical reference ranges for one of seven residents reviewed for laboratory results. (CR#3). -The facility failed to consult with CR #3's Physician or Nurse Practitioner when the resident had a critical Potassium laboratory value. CR #3 was found unresponsive 5.5 hours after the laboratory called the facility with a critical result Potassium level and she was pronounced dead 26 minutes after arrival to the emergency room . An IJ was identified on [DATE]. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of pattern and a severity of actual harm due to facility requiring more time to monitor the plan of removal for effectiveness. These failures affected one (CR #3) and placed 88 residents at the facility at risk of having abnormal labs and not having their physician notified, resulting in a delay in medical intervention or death. Findings Included: Intake # 4 Record review of the facility face sheet revealed CR# 3 was a [AGE] year old female. She was admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]. CR #3 was found unresponsive and was sent to the hospital on [DATE] and was pronounced dead 26 minutes after arrival to the emergency room . Record review of the 5 day MDS assessment dated [DATE] revealed CR #3 required limited assistance for bed mobility, transfer, dressing, toileting and personal hygiene and supervision for walking in room and in corridor, locomotion and eating. CR #3 was always continent of bowel and had an indwelling catheter for urine. Record review of CR #3's electronic and paper records revealed CR #3 did not have a care plan. Record review of CR #3's NP progress notes dated [DATE] revealed in part: [AGE] year old female readmitted at the hospital for frequent falls. She is here for rehab. Past medical history for hypertension, [MEDICAL CONDITIONS] and acute [MEDICAL CONDITION] .STAT BNP (Pro) (Beta Naturetic Peptide - test to help detect, diagnose, and evaluate the severity of heart failure), BMP (basic metabolic panel, blood work that assess electrolytes and kidney function) and urinalysis. Assessment/Plan: [MEDICAL CONDITION] - BUN (Blood Urea Nitrogen) / Creatinine (test to assess kidney function) high on [DATE]. Will re-check STAT today . Record review of CR #3's physician's telephone orders signed by the NP and dated [DATE] at 9:30 a.m. revealed orders in part: - STAT urinalysis, BMP and Pro BNP . Record review of CR#3's laboratory requisition form dated [DATE] revealed a collection time of 1:52 p.m. for urinalysis and BNP (Beta Naturetic Peptide). Further record review revealed that BMP test was omitted on the requisition order. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 3:15 p.m. Late entry by LVN C .CR #3 went to therapy and therapist checked oxygen saturation and read 78%. Checked CR #3's oxygen saturation upon returning to room and oxygen saturation read 82%. Immediately placed CR #3 on oxygen at 2 liters. Oxygen continued to rise to 89%. Vital signs blood pressure ,[DATE], pulse 71, temperature 98.4 and respirations 15 - 16 breaths per minute with no labored breathing. Contacted NP with results on low oxygen and informed her the oxygen was rising and asked if CR #3 could go out to hospital. Informed oncoming nurse . -[DATE] at 4:16 p.m. by LVN C NP into see CR #3 and RP concerned that CR #3 is having kidney issues. Orders to have STAT urinalysis, BNP and Pro BNP .All orders completed . -[DATE] at 4:20 p.m. by LVN C NP called and informed of oxygen saturation . (NP) stated that we could send CR #3 out to hospital. Informed nurse on duty of decision . Record review of CR #3's electronic vital signs record revealed in part: -[DATE] at 4:42 p.m. Blood pressure ,[DATE] and pulse 64 beats per minute. Further record review revealed no further vitals sign assessments for CR #3. Further record review of CR #3's laboratory requisition form dated [DATE] revealed a collection time of 8:00 p.m. for BMP (basic metabolic panel). This requisition was for the STAT test ordered at 9:30 am by the NP that had been omitted from the first lab requisition order. Further record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 7:57 p.m. by RN D Given order by NP to increase CR #3's [MEDICATION NAME] to 8 mg by mouth every 4 hours as needed for nausea which was entered into the computer and faxed to pharmacy . Record review of CR #3's electronic MAR indicated [REDACTED] Record review of CR #3's laboratory report dated [DATE] at 12:18 a.m. revealed in part; -Potassium level 6.2 mEq/L Reference range (3.5 - 5.3). Continued record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 1:46 a.m. by LVN A Potassium 6.2. Dr. (P) informed. Awaiting call back. -[DATE] at 1:49 a.m. by LVN A [MEDICATION NAME] (muscle relaxant) tablet 350 mg. Give 0.5 tablet by mouth every 6 hours as needed for muscle spasm / back pain. CR #3 requested for muscle spasms -[DATE] at 2:30 a.m. by LVN A CR #3 lying in bed, no complaints of pain or nausea. Oxygen saturation 94% at 3 liters of oxygen. Assisted to restroom with 1 person assistance. Tolerated ambulation well. Dr. (P) paged of Critical Potassium levels of 6.2. -[DATE] at 3:10 a.m. by LVN A [MEDICATION NAME] (muscle relaxant) tablet 350 mg. Give 0.5 tablet by mouth every 6 hours as needed for muscle spasm / back pain effective (documentation indicated monitoring the effectiveness of the medication) Further record review of the progress/nurses notes revealed no further attempts to contact the MD for the critical Potassium levels, no vital sign assessments or any further assessments during the night shift. Record review of CR #3's MD orders dated [DATE] revealed in part; -[MEDICATION NAME] tablet 350 mg, give 0.5 tablet by mouth every 6 hours as needed for muscle spasm/back pain. Record review of CR #3's progress/nurses notes revealed in part; -[DATE] at 2:14 p.m. by ADON A Received in report that laboratory reported a critical potassium level and no new orders obtained as of that time. Contacted NP with laboratory results approx. 7:06 a.m. NP returned call at 7:11 a.m. requesting oxygen saturation levels. Reported back to CR #3's to check oxygen saturation. Upon entering room CR #3's eyes were closed and she was non-responsive to verbal and tactile stimuli. CR #3 was not breathing, no pulse palpable, skin warm to touch. Code called, CPR initiated and 911 called. Fire department arrived and took over CPR until paramedics arrived. CR #3 was last observed sleeping in bed at approx. 6:30 A.M. Notified emergency contact at approx. 7:40 a.m. CR #3 was observed unresponsive and she should go to the hospital where CR #3 was transferred . Record review of CR #3's hospital records from the emergency room revealed in part: Arrival date/time: [DATE] at 8:05 a.m. -At 8:25 a.m. [AGE] years old white female presents to ED via unassigned with complaints of Full arrest. -At 8:25 a.m. Preceding the arrest, CR #3 was found down by nursing home staff. The arrest occurred at the nursing home. The arrest was not witnessed by others. Bystanders at the scene performed CPR. -EMS (emergency medical service) care prior to arrival: Initiation of ACLS (advanced cardiac life support), peripheral IV, was successfully placed. 15 minutes elapsed prior to ACLS. ACLS has been in progress for 45 minutes. ACLS details: initial rhythm was asystole (flat line in electrocardiogram). [MEDICATION NAME] ([MEDICATION NAME]) intravenous 8 doses. Response to therapy: Continued arrest. Arrest was first noted at 7:15 a.m. asystole was presenting rhythm, there may have been PEA (pulseless electrical activity) at one point. --At 8:31 a.m. ED course: CR #3 has been under CPR for more than 45 minutes with no ROSC (return of spontaneous circulation). While there was not a definitive airway, after 45 minutes of CPR and 9 rounds of [MEDICATION NAME], did not feel like any further attempts at airway wound lead to different outcome other than death. CR #3 was pronounced. -Diagnosis: [REDACTED]. In an interview on [DATE] at 2:08 p.m. ADON A, stated she was the charge nurse for CR #3 on [DATE] when she was found unresponsive. ADON A said she arrived at the facility and started her rounds alone looking at the residents at around 6:30 a.m. and it was at that time she saw CR#3 sleeping. She said LVN B told her CR #3 had critical potassium levels during the

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F 0505 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 27) night shift and the MD had not returned the call yet. LVN A who was assigned to CR #3 during the night shift, had gone home earlier on the shift. ADON A then said when LVN B told me staff had not follow up with the MD regarding the critical potassium levels, I texted the NP and the NP called me within a couple of minutes. I gave her the critical values of potassium for CR #3 and she asked me for CR #3's oxygen saturation levels because CR #3 was having problems with her oxygen on [DATE]. When I went to the room still with the phone in my hands and the NP on the line, CR #3 was found not breathing and with no vital signs. CPR was started and 911 was called. CR #3 died in route to the hospital. Further interview the ADON A at that time, stated the NOC shift tried to call the MD but the MD was not reach. ADON A then said facility protocol is that if the MD does not return the calls, we were supposed to call the medical director, but CR #3's MD was the medical director. Facility has another medical director that we were supposed to call if the first medical director does not answer the calls. LVN B said the other medical director called the facility during the NOC shift on [DATE] for another resident and LVN A forgot to mention about the critical potassium values of CR #3. Continued interview the ADON A on [DATE] at 2:20 p.m. said critical laboratory values was a change in condition and the facility staff was supposed to complete a change of condition assessment in the computer where it prompt staff to assess the resident, notify MD and RP. ADON A further said that if for any reason the MD or another medical director was unable to be located, the staff was supposed to notify the DON. She said she did not know if the previous DON was aware of the situation with CR #3. When asked if CR #3 had any assessments previous to being found unresponsive or any vital signs, ADON A then looked at the computed and then said there is none, last vital signs were on [DATE] at 4:42 p.m. In a phone interview on [DATE] at 4:25 p.m. LVN C, stated she was the charge nurse for CR #3 on [DATE] from 6 a.m. to 2:00 p.m. and she called the NP to notify her CR #3 oxygen levels were low and the NP called her at the end of her shift and told her to send CR #3 to the hospital. LVN C then said she told the 2:00 to 10:00 p.m. shift nurse who was RN D about the order to send CR #3 to the hospital. LVN C then said it was around 3:50 p.m. on [DATE] when she got the order. LVN C continued she did not transcribe the order to CR #3's chart because she was going home and she had already talked to RN D about the new orders. LVN C further said she got the orders via text message and the staff would usually call, page or text the MD or the NP. When asked if text could be reviewed she said that she had erased the text message from the NP. Continued phone interview LVN C, stated whenever a resident had a change in condition, the staff was supposed to complete a change in condition form in the computer that was like an SBAR when they would write their assessments, MD and RP notifications and she did not complete that assessment on CR #3. In a phone interview on [DATE] at 4:42 p.m. LVN A, he stated he was the charge nurse for CR #3 from 10:00 p.m. on [DATE] to at around 3:00 a.m. on [DATE] and further said I wasn't supposed to even being there on that day and I did not get any report regarding any change in condition regarding CR #3. I knew about the critical values of her laboratory results, I paged the MD twice and did not get any respond. Then I left at around 3:00 a.m. and gave report to LVN B so she could follow up and pass the information to the day shift. LVN A said the other medical director called the facility on [DATE] regarding another resident and he did not notify him about CR #3 because he was very busy with this other resident who had a PICC line and said but I heard that the day shift was able to get hold of the NP. Further in the same interview LVN A stated critical laboratory values was a change in condition and he was supposed to contact the MD or the DON if unable to contact the MD and then said In this place everything is so confusing, I don't even know who the DON is. LVN A then said he was supposed to check the vital signs of CR #3 but he only checked the oxygen saturation and said RN D didn't really tell me anything about CR #3. We were supposed to do the eINTERAC change of condition documentation in the computer but I can't explain why I did not do it. I don't know why. I should had monitored any cardiac issues, blood pressure and heart rate due to her high potassium levels. I was overwhelmed. In an interview on [DATE] at 5:00 p.m. RN D, stated she was the charge nurse for CR #3 on [DATE] during the 2:00 p.m. to 10:00 p.m. shift and that during change of shift report CR #3 was sleepy and she asked about CR #3's oxygen saturation and the morning shift nurse told her it was around the 80's. She increased the oxygen to 4 liters and she re-checked the oxygen and was then 89 to 90%. RN D said during her shift, the laboratory collected blood from CR #3 that was ordered during the day shift. RN D then said LVN C never told her about the orders to transfer CR #3 to the hospital. RN D continued saying she spoke with the NP because the NP wanted to know the laboratory results for CR #3 but she did not receive any reports from the laboratory and she never knew the NP wanted CR #3 to go to the hospital. When asked about the order to increase [MEDICATION NAME] for CR #3 for nausea and vomiting, RN D stated she did not remember if CR #3 had any nausea that day. Continued interview on [DATE] at 5:15 p.m. RN D, said whenever a resident had a change in condition, there was an eINTERACT form to complete on the computer where the nurse writes the assessments and then said I did not check if someone had completed a change of condition form on CR #3. It should had been completed on the day shift on [DATE]. In a phone interview on [DATE] at 9:15 a.m. LVN B, stated LVN A left the building on [DATE] at around 3:30 a.m. and he told her everything was fine and that CR #3 did not have any issues. LVN B further said LVN A did not mention to her anything about the laboratory values of CR #3 but she knew the laboratory had called at 1:30 a.m. to report critical values because she was the one that got the call and then gave the message to LVN A. LVN B continued saying she also knew LVN A had paged the MD twice and she did not receive any MD calls for the rest of the shift. LVN B said she did not try calling the MD for CR #3's critical laboratory values and she did not do any vital signs for CR #3 either. In a phone interview on [DATE] at 3:29 p.m. the NP, stated she came to the facility on [DATE] and saw CR #3 and ordered STAT laboratory blood work because when she saw CR #3 she did not look good. The NP stated she did not hear anything about the results of the laboratory blood work for CR #3 after she gave the orders. NP then said the following morning she called the facility to find out if CR #3 was sent to the hospital as she had ordered on [DATE] and to find out about the laboratory results. NP continued saying on [DATE] at around 7:00 a.m. she called the facility and spoke to ADON A and asked about CR #3 and how come she did not hear about the laboratory results and at that moment, ADON A told her CR #3 was still in the facility. The NP asked ADON A for CR #3's vital signs right away including oxygen saturation. Further interview at that time the NP, stated she was surprise to find out CR #3 was not in the hospital and requested CR #3's vital signs because she wanted to know how she was doing. ADON A told her CR #3 was unresponsive. NP then said she did not understand why the nurses did not follow the orders and get the laboratory blood work STAT. She stated she gave STAT laboratory blood work orders and expected the results right away. When she did not hear anything during the NOC shift, she thought CR #3 was sent to hospital but decided to follow up with the facility the next morning. She even told them you guys are not following orders . In an interview on [DATE] at 3:52 p.m. the Administrator, stated STAT laboratory orders needed to be call immediately to the laboratory and the policy was for the laboratory to come draw the blood within 4 hours and within 1 to 2 hours to get the results back. The Administrator then said once the nurse gets the orders, the nurse will enter the order in the computer, Staff would then would follow up on the order. She further said the nurse who gets the laboratory results is the nurse who will follow up with the MD. The Administrator further said for STAT abnormal laboratory results, the nurses will call the MD right away. If the MD does not answer, then the medical director, the facility has 2 medical directors, if one does not answer, then we will call the other medical director. If none of the medical directors answer, then the nurse is supposed to call the DON and the Administrator so we can help in getting hold of the doctors. Continued interview with the Administrator at that time, she stated whenever a resident has a change in condition, staff were upposed to complete an eINTERACT form in the computer. She said the interact form was a tool built in the computer system for changes in condition where it triggers on what would need to happen next. Administrator said the interact tool would guide the nurses on calling the MD, the RP and to follow up on assessments. Further interview on [DATE] at 4:00 p.m. the Administrator, stated RN D told her on [DATE] at around 5:45 p.m. CR #3 had some abnormal vitals. RN D had talked to the MD or the NP and she was told orders were to monitor CR #3's oxygen saturation and if the oxygen level drop, to send CR #3 to the hospital. The Administrator said CR #3's vitals got better and CR #3 was improving. Everything got to looking good. The Administrator said RN D got the STAT laboratory orders for CR #3 on [DATE] at around 5:45 p.m. then the laboratory called with abnormal values at around 1:00 a.m. They tried to reach the MD, then I am foggy about it. They attempted to call the MD twice. They heard back from the MD 5 minutes before CR #3 coded. Staff gave CR #3 CPR and sent her to hospital. I believed CR#3 was even admitted to ICU before she died . CR #3 had been in the facility for one week, she was here for therapy. Continued interview with the Administrator on [DATE] at 4:09 p.m. she stated facility staff did not call her on [DATE] when they were unable to contact the MD for CR #3's critical laboratory values but believed the former DON was contacted. In a second interview on [DATE] at 4:45 p.m. LVN C, said on [DATE] the NP came to visit CR #3 in the morning and gave STAT

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	676251	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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 0505 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 28) laboratory blood work. LVN C said she was not sure how long they have to call the laboratory for STAT orders but she believed they had 4 hours to call the laboratory. LVN C further said she texted the NP on [DATE] regarding CR #3's condition because her oxygen saturations were on the 80's and when she got the text back from the NP, she went and told RN D. LVN C said the nurse who gets the order is the one responsible of inputting the order in the computer system. She did not do it because she was leaving to go home. She said she should have done it. She should have completed an eINTERACT assessment on CR #3 as well. Further interview with LVN C, she stated the first time she called the laboratory for STAT orders she only called for the urinalysis and the BNP (Beta Naturetic Peptide) because she misread the orders. Later during change of shift, she found out together with RN D she had omitted the STAT orders for BMP (basic metabolic panel) and RN D was to follow up with it. LVN C further said she did not notify the NP about the mistake in transcribing the orders to the laboratory requisition form. In a phone interview on [DATE] at 5:09 p.m. the laboratory, technician stated they received a call from the facility on [DATE] at 12:12 p.m. for STAT order request for urinalysis and the BNP (Beta Naturetic Peptide) for CR #3. On [DATE] at 5:06 p.m. they received another STAT order request for BMP for CR #3. Record review of http://www.medicinenet.com/[MEDICAL CONDITION]/article.htm: revealed [MEDICAL CONDITION] means an abnormally elevated level of potassium in the blood. The normal potassium level in the blood isCmilliequivalents per liter (mEq/L). Potassium levels between 5.1 mEq/L to 6.0 mEq/L reflect mild [MEDICAL CONDITION]. Potassium levels of 6.1 mEq/L to 7.0 mEq/L are moderate [MEDICAL CONDITION], and levels above 7 mEq/L are severe [MEDICAL CONDITION]. Extremely high levels of potassium in the blood (severe [MEDICAL CONDITION]) can lead to [MEDICAL CONDITION] and death. Record review of the facility policy and procedure Change of condition reporting revised ,[DATE] revealed in part: It is the policy of this facility that all changes in resident condition will be communicated to the physician. Purpose: To clearly define guidelines for timely notification of a change in resident condition. Any sudden or serious change in resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation If unable to contact attending physician or alternate physician timely, notify Medical Director for follow up to change in resident condition Follow-up. The licensed nurse responsible for the Resident will continue assessment and documentation every shift for at least seventy two (72) hours or until condition has stabilized .Comprehensive Care Plan will be updated/revised accordingly. Record review of the facility policy and procedure Laboratory Services revised ,[DATE] revealed in part: .2.- STAT orders are done as soon as possible within facility defined time frames . Record review of the facility policy and procedure Labs, abnormal revised ,[DATE] revealed in part: It is the policy of this facility to inform physician immediately to assist in diagnosing resident appropriately based on the Laboratory results. The RN Supervisor will care plan only the abnormal laboratory results which requires blood levels such as abnormal Potassium that could manifest complications in the short term care plan . Record review of the facility's undated protocol with title Labs revealed in part: It is everyone's responsibility to follow up on all labs in a timely manner. STAT labs.: You are expected to get your laboratory results within 4 hours. If you do not receive then in that time. Notify your ED/DON immediately. Once you receive your result notify MD of results. Call responsible party of laboratory results. Document in progress notes the laboratory results, MD and RP notification. The resident will then be in every shift documentation for 72 hours until resolved. If laboratory is abnormal you are required do the following: 1.- Notify the MD and RP. Place patient in follow up and chart on patient every shift. If you are unable to reach MD YOU MUST NOTIFY THE ED/DON IMMEDIATELY . Record review of the facility's undated Statement of Resident Rights revealed in part: .You have the right to (1) all care necessary for you to have the highest possible level of health . An IJ was identified on [DATE] at 4:35 pm and the Administrator and DON were informed at that time. The POR was accepted on [DATE] at 3:38 pm. The POR included: Immediate action: 1.- Resident affected by this deficient practiced was discharged to hospital [DATE]. Laboratory audits to determine all residents affected by this deficient practice including: 1.- Laboratory audit performed by Clinical Resources to review all current laboratory orders at facility began on [DATE] with laboratory vendor - ACL laboratory and completed [DATE]. 2.- Medical records designee puling all orders for laboratory in PCC for all current residents for review, completed [DATE]. 3.-Review of all Telephone Orders by Clinical Resource to ensure no new orders for laboratory have been missed completed [DATE]. 4.- Clinical Resource completed audit of laboratory requisition book where laboratory orders are noted by laboratory after laboratory are drawn completed [DATE]. 5.- Charge Nurse designated to check laboratory website to pull results each shift beginning [DATE]. 6.- Any abnormal or critical laboratory to be communicated to physician/designee and RP on [DATE] (no critical laboratory were founds). 7.- DON to notify laboratory vendor to email STAT laboratory and / or abnormal results to DON and ADON's email in addition to calling the facility as part of new process beginning [DATE]. DON and ADON have email access ,[DATE]. 8.- All current resident's charts were audited for potential change of condition on [DATE] by Clinical Resource. No change of conditions were found. At time of this plan of removal, no other residents identified with laboratory issues. (12:00 p.m.). Education/In-service: 1.- In-service started [DATE] at 5:05 p.m. with licensed nurses including change of condition, using SBAR form, Stop and Watch, notifications, and Resident Behavior and Facility practice related to change of condition. In the event a licensed nurse cannot reach the attending physician, charge nurse will contact either DON or Administrator and Medical Director. The Medical Directors have provided the DON and Administrator with alternate methods to contact them rapidly. In-service started on [DATE] with all licensed nursing staff regarding each Medical Directors preferred methods of communication. 2.- As part of in-service new DON (start date [DATE]) introduced to staff and shared her contact information. 3.- DON and ADON will divide building each taking two hall to follow up daily on any change of condition, new laboratory orders, abnormal laboratory, fall, etcetera starting [DATE]. 4.- Change of Condition log will be utilized and review in daily stand up meeting with leadership IDT starting [DATE]. 5.- Licensed charge nurses were educated on [DATE] to follow up on each change of condition for 72 hours or until condition stable or resolved beginning [DATE]-17. 6.- Medical Directors notified of IJ and associated Plan of Removal. Dr. Palacios was notified via phone on [DATE] at 6:00 p.m. and Dr. Hanif was notified in person on [DATE] at 8:45 a.m. 7.- In-serviced CNA's on reporting change of condition and the Stop and Watch tool on [DATE]. Any staff not available for any in-service will be in-serviced before they are allowed to go on the floor to work a shift. Monitoring: RN corporate nurse resource has been assigned to facility to monitor plan of removal by: 1.- Daily monitoring of laboratory results by charge nurses on each shift beginning [DATE]. 2.- Daily review of change of condition log, and 72 hours follow up. 3.- Ongoing in-service on change of condition, notification, laboratory process. 4.- Daily QA analysis of admissions and readmissions including an updates to plan of care. 5.- QAPI committee to meet review Plan of removal daily until immediacy lifted, then weekly until compliance achieved. Monitoring: In an interview on [DATE] at 4:05 p.m. LVN C, stated she had been trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs, laboratory reports and said that STAT laboratory orders needed to be called to the laboratory immediately. LVN C said whenever they get laboratory results, staff was supposed to call the MD, and if the MD was not available, to call the Medical Director. If the Medical Director was not available the staff was supposed to call the DON and the Administrator. LVN C continued saying they were supposed to check the fax machine and follow up with the laboratory every one hour on pending laboratory reports. LVN C further said she was also trained on follow MD orders timely and accurately.

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LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	12921 MISTY WILLOW HOUSTON, TX 77070

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0505 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 29) In an interview on [DATE] at 10:20 a.m. LVN G and LVN H, both stated they had been trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs, laboratory reports and said STAT laboratory orders needed to be called to the laboratory immediately. LVN G said whenever they get laboratory results, staff was supposed to call the MD as soon as possible. If the MD was not available, to call the Medical Director and if the Medical Director was not available the staff was supposed to call the DON and the Administrator. LVN H continued saying training included information on following MD orders. In an interview on [DATE] at 10:30 a.m. LVN E, stated she had been trained on change of condition, assessments, vital signs and documentation including the SBAR tool in the computer system. She also said training included the Stop and Watch form staff would complete to report changes in condition to nurses. LVN E further said training included laboratory orders, follow up and immediate notification to the MD of any critical values and staff was made aware the chain of notification in case the MD was not able to be contacted that included the DON and Administrator. In an interview on [DATE] at 10:40 a.m. LVN F, stated he had been trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs, laboratory reports and said STAT laboratory orders needed to be called to the laboratory immediately. LVN F then said whenever they get laboratory results, staff was supposed to call the MD as soon as possible, and if the MD was not available, to call the Medical Director. If the Medical Director was not available the staff was supposed to call the DON and the Administrator. LVN F continued saying training included information on following MD orders. In an interview on [DATE] at 1:00 p.m. CNA I, stated she had been trained on using the Stop and Watch tool to notify to the nurses any changes in condition of the residents. In an interview on [DATE] at 1:40 p.m. with CNA J, stated she was also trained on using the Stop and Watch tool for notification on any changes in condition she observed with any of the residents. In an interview on [DATE] at 1:52 p.m. LVN K, stated she had been trained on abnormal laboratory results and immediate MD notification. She then said the fax machine was supposed to be checked every one hour. She said if she could not get hold of the MD, she was supposed to call the Medical Director, the DON and the Administrator. She continued saying she was also trained on assessments with change in condition and the eINTERACT tool, assessments, vital signs and documentation including the Stop and Watc
F 0518 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Train all employees on what to do in an emergency, and carry out announced staff drills.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to effectively train all employees on emergency and evacuation procedures in the event of an emergency that required evacuation for one of seven residents (Resident #1) who was reviewed for emergency evacuations. -The facility failed to train employees working on the night shift on how to evacuate Resident #1 from her room. Resident #1 weighed 792 lbs and had an oversized bed which would not fit through the room door unless physically altered. Resident #1 felt scared when she was forgotten and left in her room during an actual tornado alert. An IJ was identified on [DATE]. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of widespread and a severity of no actual harm with potential for more than minimal harm, that is not immediate jeopardy due to facility requiring more time to train staff and monitor the plan of removal for effectiveness. This failure affected one resident at the facility (Resident #1) when she could not be evacuated from her room in case of and emergency situation and placed 87 other residents at risk of injury or death. Findings include: Intake # 6 and # 8 Record review of the facility face sheet revealed Resident #1 was a [AGE] year old female. She was admitted to the facility on [DATE] with following [DIAGNOSES REDACTED]., unspecified and essential (primary) hypertension. Record review of Resident #1 admission assessment dated [DATE] revealed she was cognitively intact with a BIMS score of 15 out of a possible 15. She required extensive assistance of two or more person for bed mobility, and was total dependent on two or more person physical assist for transfer, locomotion on the unit and off the unit, dressing, toilet use, personal hygiene and bathing. Resident #1 was always incontinent of bowel and bladder. Further record review revealed a weight of 792 lbs and 64 inches in height. Record review of Resident #1's care plan initiated [DATE] revealed in part: -Focus: At risk for an ADL self care performance deficit related to limited mobility, limited ROM. All due to severe [MEDICAL CONDITION] and severe [MEDICAL CONDITION] (swelling that occurs in the arms or legs). Has limited physical movement being total dependent related to disease process, [MEDICAL CONDITION], weakness and limited movement. -Goal: Resident #1 will be safely assisted with performance with extensive assist of 5 to 7 staff members. -Interventions: Bed mobility: is totally dependent on staff for repositioning and turning in bed. Requires 5 to 7 staff member to turn and reposition and provided treatment. Further record review revealed no information on her care plan related to the need of an oversize bed with interventions on how to maneuver her oversized bed in the event of an emergency that required evacuation. Record review of the facility's In-service education record dated [DATE] with title Resident #1's bed revealed training was given to only 11 facility staff members. Further record review revealed 9 staff members were from the 6:00 a.m. to 2:00 p.m. shift, 1 staff member was from the 2:00 p.m. to 10:00 p.m. shift and 1 staff member from the 10:00 p.m. to 6:00 a.m. shift. Record review of Resident #1's social progress notes dated [DATE] at 1:30 p.m. revealed in part: Spoke with Resident #1 and her family member and Resident #1 was very upset and frustrated and stated that she does not feel comfortable because during the tornado warning, she (Resident #1) was never brought out to the hallway. She stated she was told from the Administrator they would have to break down the bed to get it out of the room. Resident #1 stated staff just pulled the curtains closed during the storm. Resident #1 stated the Administrator told her a tornado would hit the 100 hall first if anything were to happen. (Resident #1 was on the 300 hallway). Resident #1 stated she found out that by law, all residents were to be pulled out into the hallway. Resident #1 also was very upset about being told by the Administrator the facility had the staff to address her needs. In an interview on [DATE] at 8:58 a.m. with Resident #1, she stated she did not feel safe at the facility because there had been a tornado warning few days ago and staff took all residents out to the hallways and she was left in her room. Resident #1 further said staff only closed her curtains and that she felt very afraid because she was not evacuated from her room like the other residents. Resident #1 continued saying she was not able to get up or walk on her own. Observation revealed the measurements of the width of Resident #1's bed was 52 inches (from side rail to side rail). The measurements of the width of Resident #1's room door was 44 inches. In an interview on [DATE] at 10:32 p.m. with CNA V, she stated that she was the aide taking care of Resident #1 and that it was her first time in the facility. She further said that she was told that Resident #1 required 6 people to do incontinent care and that the staff from 2:00 p.m. to 10:00 p.m. had just cleaned Resident #1. When asked if she was trained on how to evacuate Resident #1 out of her room in case of an emergency, CNA V stated No and then said I worked in another facility, I just came today to help them out. In an interview on [DATE] at 10:36 p.m. with Resident #1, she stated in order to move her bed out of the room, the side arm rests of the bed needed to come off. She further said few staff were trained during the day shift when she first got the bed delivered. She said the facility had not done further training on how to operate her bed to the rest of the staff. Further interview with Resident #1, she stated after the incident of the tornado warning when she was left on her room alone, she said the Administrator told her she was left on her room so she would not feel uncomfortable in the hallway. Resident #1 continued saying some staff told her on the day of the tornado warning they would come and get her out of the room if the tornado would really hit the building. At that time, Resident #1 stated If a tornado had really hit the building, I don't think they would had come back to get me. Forget it. They would had tried to save themselves. In an interview on [DATE] at 11:00 p.m. LVN B, stated there were 3 CNA's and 2 nurses for the night shift at the facility. She further said she was the charge nurse for Resident #1. When asked how she would evacuate Resident #1 from her room in case of an emergency, LVN B responded Resident #1's bed would not fit thru the door and to be honest, we don't have the staff. I don't know what we would do, I would call 911. We have raised the same question before because it's hard. I have not received any emergency training on Resident #1 and do not know how to maneuver her bed. I would not know what to do.

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F 0518 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 30) Just call 911. In an interview on [DATE] at 11:05 p.m. LVN S, stated she was a full time nurse on the 10:00 p.m. to 6:00 a.m. shift and she had not received any training on how to evacuate Resident #1 from her room in case of an emergency. She said in case of a fire, she know the bed did not roll well. She said it took 6 to 7 people just to turn Resident #1 in bed, and they had 5 staff today working in the facility during the night shift. The bed was too big to get thru the door and she was not sure if we can take the bed apart. I don't know what we would do. In an interview on [DATE] at 11:13 p.m. with CNA U, stated at she was a full time CNA working on the night shift. She said she had not received any training on how to evacuate Resident #1 in case of an emergency and we would call the fire department and tell them to hurry up because we would not be able to evacuate her by ourselves. In an interview on [DATE] at 11:20 p.m. CNA T, stated she was a full time CNA working on the night shift and she had not received any training on how to evacuate Resident #1 out of her room in case of an emergency. She said I have no idea what we would do. The bed might not fit thru the door. There is not enough staff at night to lift her up with a sheet. We would just try to secure her in her room or try to lift her. We are strong. Continued interview with CNA T, she said I don't think we are equipped for Resident #1. We usually work 3 aides and 2 nurses at the night shift and it takes about 6 people to do care for her. In an interview on [DATE] at 9:38 a.m. the Administrator, stated around 6:45 a.m. sometime in January, the facility had to evacuate the residents due to the tornado warning and we got the residents to the hallway. Then Resident #1's family member came to me and told me Resident #1 was very nervous. I remembered before Resident #1 came to the facility, she told me not to make her feel like she was in a nursing home, so what we did, as to not to increase her anxiety, I decided to leave her on her room. We closed her blinds and pulled her curtains. For Resident #1's window to be destroyed by a tornado, the whole front of the building needed to be destroyed. If pressure would build inside the building, we would have to open Resident #1's window or we would have to ask Resident #1 if she would like to come out of the room. The tornado warning did not stop on that day until 8:30 a.m. Further interview with the Administrator at that time, she stated Resident #1's side rails would have to come off of the bed in order to be able to move the bed out of the room. She then said the Therapy Director and Central Supply person were trained on how to break the bed down in an emergency situation. The Administrator continued saying she knew theTherapy Director and Central Supply person trained some staff but she did not know who and said she was going to get the training records for the surveyor to review. The Administrator said the disaster plan in-services were done annually oin the month of April and upon new hire orientation. In an interview on [DATE] at 9:58 a.m. with Central Supply, she stated she got trained by the bed company representative on how to operate Resident #1's bed but she did not give any training to anyone else and further said the staff who was here at the facility at that time were trained on how to operate Resident #1's bed. In an interview on [DATE] at 10:05 a.m. the Therapy Director, stated the day when Resident #1 had her bed delivered, they were instructed by the bed company representative on how to operate the bed. He then said there was other staff present but he did not remember who they were or the exact date. The Therapy Director continued saying he did train some of the CNA's from the day shift, whoever was around, on how to manipulate Resident #1's side rails and what to do in case of a code emergency but he was not sure if nursing had additional trainings with the rest of the staff on how to maneuver Resident #1's bed. In a second interview on [DATE] at 11:00 a.m. with the Administrator, when asked if the night shift had any training on emergency procedures on Resident #1. On how to evacuate her in an emergency, how to maneuver her bed in case of an emergency, the Administrator responded that's what I had been looking for because the training we had was mostly for the day shift. It was supposed to be done but not sure if it was done. It was supposed to happen but I can't find the training records, but in the worst scenario, we will come tonight to train them. When informed that nobody from the night shift knew how to operate Resident #1's bed or how to evacuate Resident #1 in case of an emergency, the Administrator said we will come tonight to train them. Record review of - NWS Houston (@NWSHouston) [DATE] Tornado warnings dotted counties along the Gulf Coast beginning late Tuesday night, reaching and including the metro Houston area during the pre-dawn hours of Wednesday. Record review of the facility's Disaster Risk assessment dated [DATE] revealed that the facility was somewhat likely for the following disasters: Hurricane, tornado/severe storms, flooding, lightning and extreme heat. Record review of the facility's Internal/External disaster plan revised on [DATE] reads in part .Tornado/Severe Storm: If notice is given, take the following steps: 1.- turn on hallway lights, 2.- Close all drapes, blinds, 3.- Evacuate all rooms to the immediate hallways, 4.- Protect all patients 5.- Do not open doors or windows Record review of the facility's document with title Evacuation of Patients in Bari Rehab Beds revealed in part In the event that it should become necessary to evacuate a bed-bound patient in a Bari-Rehab bed, please follow the instructions on how to retract the bed Instruction for expanding/retracting bed deck . emergency hand crank . Side rail instructions .adjusting side rail trouble shooting instructions . An IJ was identified on [DATE] at 11:56 a.m. and the Administrator, the Clinical Resource Nurse and the Executive Market Director were informed at that time. The POR was accepted on [DATE] at 4:00 pm. The POR included: Immediate Action: 1.- We are actively seeking to discharge the resident from the bariatric resident from the facility to a facility that can better meet her needs. 2.- On [DATE], we tested and ensured that the bariatric bed can be easily be removed from the room in the event of an emergency evacuation. 3.- Charge nurse will be responsible for directing staff to evacuate such identified patients according to the emergency preparedness plan. Education on the emergency preparedness plan began [DATE]. The process for breaking down the bariatric bed for removal from the room was added to the disaster plan on [DATE]. The process is detailed with the attached guide, and the staff are to follow the normal evacuation procedures, using the set routes and evacuation order, per the disaster plan. 4.- The Director of Therapy or designee will be in-service all staff with return demonstration on the proper procedures on how to breakdown facility's bariatric beds according to manufacturer's instructions, beginning [DATE]. 5.- Staffing coordinator or designee is reviewing schedule with DON or designee every shift to ensure adequate staff to meet resident needs, including emergency situations. 6.-The above training will begin on [DATE] and will continue until all nursing staff have been in-serviced. Staff will not be allowed to resume resident care responsibilities or other duties until trained. 7.- Facility is voluntarily stopping admissions effective [DATE] until substantial compliance is achieved. The Administrator / Designee will ensure the above training is completed as planned. Two-four staff are required to breakdown and push the bed. Evacuation routes areas listed in the disaster plan. Staff is trained annually and upon orientation on the disaster plan. The number of staff on the night shift was assessed on [DATE] to ensure adequate staffing in case of an emergency evacuation by the Administrator. Administrator has signed a contract with an agency to ensure that we have two additional staff members on the night shift beginning tonight, [DATE], making it 7 staff members based on the current census. Facility Human Resource designee is actively hiring and orientating new staff members for the 10 to 6 a.m. shift to ensure resident needs are met and that resident safety is ensured in the event of an evacuation route would take 20 to 30 minutes depending upon if the evacuation needs to be to another compartment or out of the building. The building is designed and broken into fire compartments so that a total evacuation would not be needed unless the entire building is engulfed in flames. Beginning [DATE], all new admissions will be screened prior to admission by DON/Designee to determine if they are bed-bound bariatric patients who would need the above procedures. All bariatric patients needing the above procedures will have their care plans updated by [DATE]. As of this time, there are no other bariatric residents requiring special evacuation procedures. DON/Designee will monitor any change in residents' transfer status at weekly Standard of Care meeting beginning [DATE]. All circumstances requiring evacuation as per the Fire and Disaster Manual will trigger the above procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676251	A. BUILDING _____ B. WING _____	**02/03/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NORTH/	**12921 MISTY WILLOW HOUSTON, TX 77070**

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 0518 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 31) Continue to look for alternate placement for patient where needs can be better met. Monitoring: In an interview on [DATE] at 10:20 a.m. with LVN G and LVN H, both stated they had been trained on the bed operation for Resident #1 and how to evacuate her in case of an emergency. In an interview on [DATE] at 10:30 a.m. LVN E, stated she had been trained on Emergency procedures with Resident #1 and how to maneuver her bed in case of evacuation emergency. In an interview on [DATE] at 10:40 a.m. LVN F, stated he had been trained on how to operate Resident #1's bed, how to remove the side rails in an event of evacuation including for CPR emergencies. In an interview on [DATE] at 1:00 p.m. CNA I, stated she had been trained on Emergency procedures for Resident #1 and how to maneuver her bed including how to remove the side rails in an event of evacuation emergency. She also said they were trained on how to prepare Resident #1's bed if she needed CPR. In an interview on [DATE] at 1:40 p.m. CNA J, stated she was also trained on emergency procedures for Resident #1's bed. CNA J also said she felt confident on how to maneuver Resident #1's bed for evacuation and CPR. In an interview on [DATE] at 1:52 p.m. LVN K, stated she had been trained on how to break Resident #1's bed in an event of evacuation to wheel the bed out of the room and how to deflate her mattress for CPR. In an interview on [DATE] at 2:00 p.m. CNA L and CNA M, both said they attended training regarding how to operate Resident #1's bed including how to remove the side rails to make sure the bed can be evacuated out of the room and how to deflate the bed for CPR. In an interview on [DATE] at 2:10 p.m. CNA N, stated she had received training on emergency procedure for Resident #1 and how to maneuver her bed. In an interview on [DATE] at 2:35 p.m. CNA O, stated she was also trained on how to make Resident #1's bed smaller to make it fit thru the door in an event of an emergency. She also said training included for CPR and how to operate the bed without electricity. In an interview on [DATE] at 3:05 P.m. LVN P, stated she received training on [DATE] on how to maneuver Resident #1's bed and emergency procedures for Resident #1 including evacuation. In an interview on [DATE] at 4:20 p.m. CNA Q stated she was also trained on how to operate Resident #1's bed and what to do in an event of an emergency including evacuation. In an interview on [DATE] at 4:25 p.m. RN R, stated she had been trained on how to break down Resident #1's bed in an event of evacuation to wheel the bed out of the room and how to deflate her mattress for CPR. In a phone interview on [DATE] at 4:30 p.m. LVN A, stated he had been trained on how to maneuver Resident #1's bed, how to move the bed out of the room and other emergency techniques including CPR and what to do with the bed if no electricity. He also said he was working on the night shift on [DATE] with Resident #1 and he already knew how to direct the staff in case of an emergency. In a phone interview on [DATE] at 4:40 p.m. LVN S, stated she was trained last night on emergency procedures with Resident #1 including evacuation and how to work Resident #1's bed, including CPR and how to manually operate the bed if no electricity. In a phone interview on [DATE] at 4:58 p.m. CNA T, stated she was also trained on how to operate Resident #1's bed in an event of evacuation. She said she knew what to do now in an event of an emergency and how to evacuate Resident #1. In an interview on [DATE] at 5:03 p.m. CNA U, stated she was trained on emergency procedures with Resident #1 and she was working with Resident #1 on the night shift as well (was working double on [DATE]) and she felt confident on how to evacuate and help Resident #1 in an event of an emergency. CNA U then said training included how to operate Resident #1's bed and how to evacuate her out of the room during any emergency. Further record review of facility In-service Training Attendance record dated [DATE] revealed nursing staff were educated regarding how to operate Resident #1's bed, how to remove the side rails in an event of evacuation and CPR emergencies. Training also included other emergencies such as no electricity and how to manually operate Resident #1's bed. Training included returned demonstration. Attached were the signatures of staff attending the trainings. The Administrator was informed on [DATE], at 5:20 p.m. the IJ was lowered; however, the facility remained out of compliance at a scope of widespread and a severity of no actual harm with potential for more than minimal harm, that is not immediate jeopardy due to facility needing more time to train the staff. Administrator said there was only one resident in the facility who required a bariatric bed.