DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:7/25/2018 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 04/25/2018
NAME OF PROVIDER OF SU	676422 PPL IER	STREET ADDRES	SS, CITY, STATE, ZIP
PALOMINO PLACE		3160 GUS THOM MESQUITE, TX 1	ASSON ROAD
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state surve	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE PI MATION)	RECEDED BY FULL REGULATORY
F 0600		pes of abuse such as physical, mental, sexual abus	е,
Level of harm - Immediate jeopardy	Based on interview and record rev	'S HAVE BEEN EDITED TO PROTECT CONFIDE view; it was determined the facility failed to ensure ea	ch resident received nebulizer
Jeopardy Residents Affected - Few	treatment and care in accordance neglect. LVN A failed to monitor and asse failed to put his oxygen, which ha and experienced respiratory distr An Immediate Jeopardy was ident at a severity level of actual harm continuing to in-service staff and This failure could affect the 9 resi lack of medical treatment, improp Findings included: Review of Resident #1's face shee [DIAGNOSES REDACTED]. Ho Review of Resident #1's MDS ass needed assistance of one to two s trouble breathing with exertion (c sitting at rest, and shortness of br and occasionally incontinent of b Review of Resident #1's Care Plat ineffective airway exchange and NAME][MEDICATION NAME] aerosol treatments, nebulizers, an side effects for [MEDICAL CON of [MEDICAL CONDITION]. In treatments, monitor for relief Review of Provider Progress Soag complaint was shortness of breat lung disease of [MEDICAL CON and plan revealed conference wit Provider Progress Soap Note date CONDITION] (failure to maintain adequate blor Review of Resident #1's (MONT + Keep saturation at or greater tha - Oxygen 5L/min with humidific: OER (Oxygen Enhancement Rati - [MEDICATION NAME]-[MEI] glass bottle with premeasured medication) fo sounds/Pulse/Pulse Oximetry/Re - Incruse Ellipta 62.5 mcg/actuati [DATE] - [MEDICATION NAME] (anti- Post respiratory nebulizer treatm needed, order date [DATE] Review of the Nurses' Notes for R - On [DATE] at 9:39 PM: Reside medication remain as ordered. Br - On [DATE] at 9:39 PM: Reside medication remain as ordered. ID. - On [DATE] at 9:39 PM: Reside medication remain as ordered. ID. - On [DATE] at 9:39 PM: Reside medication remain as ordered. ID. - On [DATE] at 4:48 AM: Resid felephone interview with LVN A morning of [DATE] (she could n stated that the resident's daughter (nan LVN A. - On, [DATE] at 4:48 AM: Resid felephone interview with LVN A morning of inflow to a patient or she stayed in the resident's room gone but returned after the treatment oxygen or airflow to a patient or she stayed in the resident's room gone but returned after the treat	with professional standards of practice for 1 (Resider ss Resident #1, who had [MEDICAL CONDITION], e needed at 5 LPM, back on him for approximately th ses, became unresponsive, and subsequently expired i fied on [DATE]. While the IJ was removed on [DAT that is not immediate jeopardy, and a scope of isolate was monitoring the effectiveness of the Plan of Reme dents receiving nebulizer treatments by placing them ber medical treatment, and death. t, dated [DATE] reflected a [AGE] year-old male, add had an advance directive for do not resuscitate. essment dated [DATE] reflected he had moderately in taff with his activities of daily living (ADLs). The res .g. walking, bathing, transferring), shortness of breath tath or trouble breathing when lying flat. Resident #1 owel. doxygen as ordered and monitor status, administer m DITION]. The Care plan revealed Resident #1 requi- terventions are monitor for signs and symptoms of in o (subjective, objective, assessment, and plan) Note da without relief from present medical regimen. Histor (DITION] with severe anxiety not responsive to prese h resident and resident's family who requested hospic d [DATE] overall assessment and plan revealed that r od oxygen level) with oxygen dependence. f) (YEAR) Physician order [REDACTED]. n 91%, monitor with pulse oximetry; by shift; order or tion; order date [DATE] (Providers Progress Note da o) NC (nasal cannula) but maintain saturation at goal DICATION NAME] 0.5mg-3mg (2.5mg base)/3mL nor r nebulization (ml) inhalation; as needed every four h	tt #1) of 9 residents reviewed for during and after a breathing treatment and ree hours. The resident was unattended in the facility. [E], the facility remained out of compliance d because the facility was oval. at risk for respiratory distress, mitted to the facility on [DATE] with mpaired cognition with no behaviors. He ident had shortness of breath or n or trouble breathing when was always continent if urine ected, resident has potential for minister [MEDICATION addications as ordered and monitor for red hospice as evidenced by terminal illness creased pain, discomfort-give medication and ated [DATE] revealed the chief y of present illness was end stage int dosage of medication. Overall assessment e for end of life care. esident had hypoxic [MEDICAL date [DATE] revealed the chief y of, [DATE]? ebulization solution (1 vial) ampul (sealed ours; physical monitor - breath ice; one time daily; order date y; order date [DATE] bulse oximetry/respiration; as o new medication and all previous h hours. Resident continued to request stress at this time. Entered by LVN bed. Hospice nurse made aware, called awaits call back. Note was entered by thered by LVN A dent #1 a PRN breathing treatment during the he used a mask or mouthpiece. She g treatment. She stated this . LVN A stated she assessed the resident (device used to deliver supplemental oreathing treatment. She revealed vere going off close by and across ot remember exactly how long she was tt #1's room, she found him ck on him, and no pulse was found. LVN the other nurse working in hall that
	she found Resident #1 with his le revealed she then contacted hospi A stated she was aware that resid recording. When revealed to LVP gone that long.	gs off the bed with the head of bed elevated and his h ce, the doctor and family. She stated she only gave hi ent had an electronic monitoring sign posted outside l N the length of time the video showed she was gone, I	ead over towards the side rails. She im the one treatment that night. LVN his room but was not sure it was
		I) (YEAR) MAR indicated [REDACTED].	
LABORATORY DIRECTOR'S REPRESENTATIVE'S SIGNA		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.

FORM CMS-2567(02-99) Previous Versions Obsolete

CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:7/25/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 676422	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/25/2018
NAME OF PROVIDER OF SU PALOMINO PLACE			DDRESS, CITY, STATE, ZIP FHOMASSON ROAD
For information on the nursing	home's plan to correct this deficien	MESQUIT: cy, please contact the nursing home or the state	E, TX 75150
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I	DEFICIENCIES (EACH DEFICIENCY MUST	Γ BE PRECEDED BY FULL REGULATORY
F 0600	OR LSC IDENTIFYING INFORM (continued from page 1)	MATION)	
Level of harm - Immediate jeopardy	between the time of 12:27 AM to following:	3:35 PM (approximately 3 hours timeframe) p	
	 following: At 12:27 AM Resident #1 sittin, of him. There were several items A female staff entered Resident # television noises. She stated the r - At 12:29 AM A female staff ret the trash can and left the room. S she walked towards the restroom, LVNA applied gloves, retrieved 1 she removed the resident's nasal of then turned on the nebulizer and to - At 1:25 AM Resident #1 was ly off the table. The table slid to the not receiving oxygen at 5LPM. N - At 1:30 AM the resident was still then walked out the door. At 1:33 AM, LVNA was still then walked out the door. At 1:30 AM the resident was still then walked out the door. At 1:30 AM the resident was still then to receiving oxygen at 5LPM. N - At 1:30 AM the resident was still the nebulizer mask was on his ch to lean towards the bed, appeared was not wearing his nasal cannul. Length of this video was 3:09 mi - At 1:34 AM Resident #1 was m rocking the table slightly. A box 'was not wearing his nasal cannul. At 1:49 AM Resident #1 was stit the bed. He was able to sit back u deep. His whole chest moved wit appeared to slip off the table and dropped it again between his legs mouth breaths (sounds unclear). I entered his room, video length is - At 1:52 AM, 1:59 AM and 2:03 moving his head around during th No staff entered his room during the stood to the side observing the na applied the nasal cannula, so length was 2:32 minutes. At 3:35 AM Resident #1 slump A entered his room applying glov table aside and called out sir. She stode to the side observing the na applied the nasal cannula to him. due to music playing in the backs the room. A male staff member e Resident #1's room as the male st the resident 's bed. Th tha camera blocking the view. Th staff were doing with the resident noise. At 3:34 AM LVN A and the fer each side of the resident 's bed. Th the cames age for was left for Resident #1's famil Interview on [DATE] at 10:34 AM assessment into the Medical Asses stated nursing staff should st	g on the side of the bed with the head of the be on the bedside table obstructing complete view l's room and asked him what he needed. It was nurse? Okay and left room. urned to his room, applied gloves and gathered he returned a short time later and put the trash , she told Resident #1 she got your breathing tr the nebulizer mask. from the bed and applied th annula and applied the breathing treatment ma mist came from the mask. in the room, moving things around and making ing his head on his bedside table in front of hit side as the resident pushed off it. He was not vo o staff entered the room during this video. Il sitting on the bedside, with arms on table an eeks and around toward the back of his head. I to be saying help several times but hard to heir a, so he was not receiving oxygen at 5 LPM No nutes. ore upright, the nebulizer mask was on his face with items in it fell off the bedside table and hi a, so he was not receiving oxygen at 5LPM. Ill wearing his nebulizer mask. He sat up and the gaveral times. At one point, he sat upright and leader breath taken. He sat back up and leaned could can be seen hanging between his legs un several times. At one point, he sat upright and le was not wearing his nasal cannula, so he was 306 minutes. A M: Resident #1 slumped over his bedside ta tese videos. He was not wearing his nasal cannula, so he was 306 minutes. IVN A sked the female staff to get someone ground). After applying oxygen at 5LPM. No stat ed over his legs on the side of the bedside table rest and there was another female staff with her lifted his right arm, and there was no response tres. LVN A rolled the resident's head onto his right flattled amongst themselves, but the con 4, 3:53 AM, 3:58 AM, 4:01 AM and 4:06 AM: et corners of the video. The staff conversation urnal from in front of the camera and left the r room was straightened. Y entered his room with LVN A and female staff with the Interim DON revealed LVN A was ssment Records (MARs) for the treatment pro is tak tatff had to stay in the roon wi	de devated and the bedside table in front w of the resident. His television was on. a unclear what the resident said due to I trash off his bedside table and picked up can back and walked to the bathroom. As reatment and then LVN A entered the room. he medication to the mask portal. At 12:31 AM, ask over the resident's nose and mouth. She g sure the nebulizer treatment was going. She m. He had a difficult time lifting his head wearing his nasal cannula, so he was d head hanging over arms. The strap from the was moving his head from the bedside table ar clearly over the television sounds. He o staff entered his room during this video. e. He was leaning into the bedside table and the floor with a noticeable noise. He hen leaned/fell back on his bed, lying across ss his bed again. His breaths were short and lover the bedside table again. His head due the table. He lifted his head and then 1 tried to say something, or took open as not receiving oxygen at 5LPM. No staff ble and leaning toward the head of bed. He was ula, so he was not receiving oxygen at 5LPM. into the video, he hit his bedside table with ght arm on the bedside table. He was if entered the room during this video. Video e. His back showed no signs of movement. LVN in the doorway. LVN A moved the bedside e from the Resident #1. The female staff bed and picked up the oxygen tubing. She (words unclear as to what was said exactly, LVN A moved his legs onto the bed and left 1. LVN A and the female staff member left the a male staff. The male staff member left the sounclear. esident's room. Resident # lwas lying i
	treatment, breath sounds before a Review of the facility's current po	chart . f treatment, type of treatment ., equipment use nd after treatment, heart rate and respiratory ra licy and procedure on Abuse Protocol, dated () t to be free from Abuse, neglect, mistreatmeni	te before, during and after treatment . MONTH) (YEAR) reflected:

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NAME OF PROVIDER OF SU PALOMINO PLACE	Y, STATE, ZIP N ROAD			
For information on the nursing	home's plan to correct this deficien	MESQUITE, TX 75150 cy, please contact the nursing home or the state survey agend	cy.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST BE PRECED	ED BY FULL REGULATORY	
F 0600	(continued from page 2)			
Level of harm - Immediate	7. The following definition are pro Abuse:	ovided to assist out Facility's staff members in recognizing in	cidents of Patient/Resident	
jeopardy Residents Affected - Few	 1. Neglect is the failure of the facility, it's employees or service providers to provide goods and services to a Patient/Resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. An Immediate Jeopardy was identified on [DATE] at 7:12 PM. The administrator was notified by telephone because she was not in the facility at the time Immediate Jeopardy was identified and a Plan of Removal was requested at that time. The Plan of Removal was accepted on [DATE] at 12:04 PM and reflected the following steps be taken to remove the immediacy: Registered Respiratory Therapist is conducting respiratory in-services and skills checks related to facility nebulizer 			
	 The DOÑ and ADON are condu- treatment protocol related to train training included appropriate mon nervousness, [MEDICATION N/ included monitor heart rate, respiratory rat 	e monitoring with licensed nursing staff. icting competency testing, in-servicing and skills checks rela ing provided by Registered Respiratory Therapist with licen nitoring of nebulizer treatment which revealed monitoring fo NME], hypoventilation/hyperventilation, infection and [MEE e, and breath sounds before during and after treatment.	sed nursing staff. The r side effects such as DICAL CONDITION] Process also	
	rate, respiratory rate, breath sound Review of Personnel Status Form last day worked was [DATE]. Ad Interview with the facility's Medic evening of [DATE] at 8:30 PM. I- his care situation. The Medical D treatment and did not return to as retraining the staff and monitorin During an interview on [DATE] a policies and procedure of nebuliz	for LVN A revealed a termination date of [DATE] for failur ministrator signed form on [DATE]. cal Director on [DATE] at 2:53 PM revealed the facility mad He stated that he was not the primary care provider for Resid irector stated that the IJ most likely occurred because the nu sess the resident. Medical Director revealed that the IJ could	e to document accordingly. LVN A's e him aware of the IJ on the ent #1 and was unfamiliar with rse had provided a nebulizer have been avoided by I because we weren't following reoccurrence of the IJ the	
	training on nebulizer treatments a facility's policies and procedures Interview with the Interim DON of was unaware of the situation. She She stated no nurse would be woo revealed the training could be pro Therapist would also do quarterly during the nebulizer treatment. SI During interview with Unit Manag Manager stated that to prevent the	Ind had staff do return demonstrations. The Administrator re- to make sure everyone understood what was expected. In [DATE] at 4:48 PM revealed the IJ occurred because of the stated the facility was providing in-services to all nurses to king the floor without taking the training for nebulizer treatrivided by the respiratory therapist, DON or ADON (manager vasessments with staff. She revealed she would prefer that the e stated there are two nurses were on a unit at all times. ger on [DATE] at 10:12 AM revealed the IJ occurred due to e reoccurrence of the incident, the facility was conducting in sts by reviewing treatment process and reviewing protocols is	vealed they reviewed the e nurse's actions and the facility prevent a reoccurrence. nents. The Interim DON 's). She stated the Respiratory he nurse not leave a resident staff's carelessness. The Unit -services, talking to staff	
	in different situations. Observations on [DATE] at 12:31 PM and 12:55PM and [DATE] at 11:52 AM and 12:10 PM of four nebulizer treatments performed by four different nurses from different halls throughout facility revealed the nurses followed policies and procedures for			
	nebulizer treatments and documentation of treatments. All residents tolerated the procedures well with no adverse reactions. Interviews on [DATE] from between 10:00 AM and 1:30 PM with five Residents #2, #5, #6, #7, and #8 revealed they received nebulizer treatments in the facility. All the residents interviewed felt had no concerns regarding the nebulizer treatments			
Interviewed in the racinty. An the residents interviewed for had no concerns regarding the nounzer dealing they received. Interviews on [DATE] at 12:45 PM through [DATE] at 3:27 PM with LVNs B, C, and H who worked 6:00 AM to 2: Manager D, LVN L, and the ADON who worked on the day shift; LVNs E, J and K who worked 2:00 PM to 10:00 PM; LVN				
	Respiratory therapist and return d rate, lung sounds, and oxygen sat revealed that residents need to be CONDITION] Nursing staff state On [DATE] the IJ was removed. O Manager were informed the IJ wa level of actual harm that is not an monitor the effectiveness of the F	nd LVN I who worked as needed, revealed that nursing staff temonstration was required for all nursing staff. Staff stated t uration needed to be assessed before, during and after each n monitored for side effects such as nervousness, [MEDICAT d that residents need to be observed throughout entire treatm On [DATE] at 3:52 PM the Administrator, Regional Nurse C is removed. While the IJ was removed, the facility remained IJ and a scope of isolated because the facility was continuin lan of Removal. on [DATE] of 9 residents who received nebulizer treatments.	hat pulse, respiratory lebulizer treatment. Staff ION NAME] and [MEDICAL ent process. 'onsultant, Interim DON and Unit out of compliance at a severity g to in-service staff and	
F 0607 Level of harm - Immediate	Develop and implement policies **NOTE- TERMS IN BRACKET	and procedures to prevent abuse, neglect, and theft. 'S HAVE BEEN EDITED TO PROTECT CONFIDENTIAL and record review, the facility failed to implement written po	JITY**	
jeopardy Residents Affected - Few	LVN A failed to monitor and asse failed to put his oxygen, which h and experienced respiratory distr An Immediate Jeopardy was ident at a severity level of actual harm continuing to in-service staff and	glect for 1 (Resident #1) of 10 residents reviewed for abuse, ss Resident #1, who had [MEDICAL CONDITION], during e needed at 5 LPM, back on him for approximately three hou ess, became unresponsive, and subsequently expired in the fa ified on [DATE]. While the IJ was removed on [DATE], the that is not immediate jeopardy, and a scope of isolated becau was monitoring the effectiveness of the Plan of Removal. dents receiving nebulizer treatments by placing them at risk per medical treatment, and death.	and after a breathing treatment and rs. The resident was unattended actility. facility remained out of compliance use the facility was	
	on [DATE] at 2:20 PM reflected: - Administer therapy until medica https://www.drugs.com/dosage/[N Nebulizer	licy and procedure on Nebulizer Treatment, dated [DATE] a tion is depleted, treatment require a minimum of 15 minutes. MEDICATION NAME].html revealed usual adult dose for [] or four times a day by nebulization, over approximately 5 to	. (Drug.com website: MEDICAL CONDITION] - Acute .	
	 Monitor patient for side effects of Hypoventilation/Hyperventilation breath sounds before, during and Instruct the patient to take slow of When treatment is completed insist sputum produced. 	of treatment (a) Nervousness, (b) [MEDICATION NAME], (a, (d) Infection, (e) [MEDICAL CONDITION]/>- Monitor h after treatment leep breaths struct the patient to take deep breath and cough, observing th	c) eart rate, respiratory rate, and	
	treatment, breath sounds before a Review of the facility's current po 1. The patient/resident has the rigl 7. The following definition are pro Abuse:	f treatment, type of treatment ., equipment used for the treatm nd after treatment, heart rate and respiratory rate before, duri licy and procedure on Abuse Protocol, dated (MONTH) (YE at to be free from Abuse, neglect, mistreatment of [REDACT ovided to assist out Facility's staff members in recognizing in	ing and after treatment . (AR) reflected: (ED]. icidents of Patient/Resident	
 Neglect is the failure of the facility, it's employees or service providers to provide goods and services to a Patient/Resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of Resident #1's face sheet, dated [DATE] reflected a [AGE] year-old male, admitted to the facility on [DATE] wit [DIAGNOSES REDACTED]. He had an advance directive for do not resuscitate. 			l distress.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1011

Facility ID: 676422

If continuation sheet Page 3 of 8

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:7/25/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 676422	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	FION	(X3) DATE SURVEY COMPLETED 04/25/2018
NAME OF PROVIDER OF SU PALOMINO PLACE			STREET ADDRESS, CITY, STA 3160 GUS THOMASSON ROA MESQUITE, TX 75150	,
	home's plan to correct this deficient			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED BY	FULL REGULATORY
F 0607 Level of harm - Immediate jeopardy	trouble breathing with exertion (e	taff with his activities of daily live e.g. walking, bathing, transferring)	ing (ADLs). The resident had sho	tness of breath or eathing when
	 needed assistance of one to two strouble breathing with exertion (e sitting at rest, and shortness of br and occasionally incontinent of b Review of Resident #1's Care Plan ineffective airway exchange and i NAME][MEDICATION NAME], aerosol treatments, nebulizers, an is de effects for [MEDICAL CON of [MEDICAL CONDITION]. In treatments, monitor for relief Review of Provider Progress Soap complaint was shortness of breatlung disease of [MEDICAL CON on and plan revealed conference with Provider Progress Soap Note date CONDITION] (failure to maintain adequate bloc Review of Resident #1's (MONTF Keep saturation at or greater the - Oxygen SL/min with humidific: OER (Oxygen Enhancement Rati [MEDICATION NAME]-[MEI] glass bottle with premeasured medication) for sounds/Pulse/ Pulse Oximetry/Re Incruse Ellipta 62.5 mcg/actuati [DATE] - [MEDICATION NAME] (anti-Post respiratory nebulizer treatm needed, order date [DATE] Review of the Nurses' Notes for R - On [DATE] at 3:30 AM: Reside medication remain as ordered. D. - On [DATE] at 3:30 AM: Reside placed to resident's daughter (nan LVN A. - On [DATE] at 3:30 AM: Reside placed to resident's daughter (nan turns of [DATE] (she could no stated that the resident had both. J happened a long time ago and she before she provided the treatment oxygen or airflow to a patient or she stayed in the resident's room a gone but returned after the treatment oxygen or airflow to a patient or she stated she then contacted hospir A stated she then contacted hospir A stated she than contacted hospir A stated she than level at 1:30 PM. A t 12:27 AM Resident #1 with his le revealed she then contacted hospir A stated she than level A. - At 12:27 AM Resident #1 with yis between the time of 12:27 AM to following: - At 12:25 AM Resident #1 with yis le nevealed she	taff with his activities of daily livi- .eg. walking, bathing, transferring, eath or trouble breathing when lyi owel. n Report with a date range of [DA infection related to [DIAGNOSES, , d oxygen as ordered and monitor IDITION]. The Care plan reveale terventions are monitor for signs o (subjective, objective, assessment h without relief from present medi IDITION] with severe anxiety not h resident and resident's family with a resident and resident's family with d [DATE] overall assessment and od oxygen level) with oxygen dep H) (YEAR) Physician order [RED an 91%, monitor with pulse oxima ation; order date [DATE] (Provide to) NC (nasal cannula) but mainta DICATION NAME] 0.5mg-3mg (r nebulization (ml) inhalation; as is spiration; order date [DATE] ion powder for inhalation (1 puff) [MEDICAL CONDITION]) 10 m nent: physical monitor - minutes f Resident #1 revealed the following ent is admitted to hospice care serre reathing treatment given as ordere Responsible party notified. Reside ent noted unresponsive and no pul ne) and call placed to MD (Medic lent family and Hospice nurse at b on [DATE] at 11:07 AM revealed to recall exactly what time) and di LVN A stated that Resident #1 revealed in recal with the head of be so she left to answer them. LVN <i>A</i> tent was done. She said when she estitoned him back into bed and pl uring the nebulizer treatment, bu so she left to answer them. LVN <i>A</i> read the resident when she returned gs off the bed with the head of be sito, et doctor and family. She sta ent had an electronic monitoring s N the length of time the video shor 4) (YEAR) MAR indicated [RED M of the motioned activated in ro 3:35 PM (approximately 3 hours g on the side of the bed with the feat on the side of the bed with the feat on the side of the reord uring th is trame from the mask. in the room, moving things arount ing his head on his bedside table obstructing c 1's room and asked him what he n uring his head on his bedside table what is side as the resident pushed off it. to be staff entered the room during th	ing (ADLs). The resident had shor, , shortness of breath or trouble br ing flat. Resident #1 was always c TE] to [DATE] reflected, residem S REDACTED]. Administer [MEE status, administer medications as d Resident #1 required hospice as and symptoms of increased pain, d it, and plan) Note dated [DATE] r ical regimen. History of present ill responsive to present dosage of r ho requested hospice for end of lift plan revealed that resident had hy endence. ACTED]. try; by shift; order date [DATE] r in saturation at goal of ,[DATE]% (2.5mg base)/3mL nebulization so needed every four hours; physical with inhalation device; one time of a 1 tablet once daily; order date [for treatment/pulse/pulse oximetry g; vice today, with . No new medicat d, as needed every 4 hours. Reside ent is not in acute distress at this ti lse by the side of his bed. Hospice al Doctor), nursing awaits call bac edside. Note was entered by LVN d that she gave Resident #1 a PRN id not remember if she used a mas quested the breathing treatment. S thappened that day. LVN A state t #15 nasal cannula (device used 1), to administer the breathing treat t thappened that day. LVN A stated t she so we gone, LVNA stated se ACTED]. om video surveillance recording f timeframe) provided by Resident the side of this head over towa ted she only gave him the one treation on pulse wit to resident's room and no pulse wit to resident's room and no pulse wit to resident serve the resident. His eeded. It was unclear what the res and gathered trash off his bedside put the trash can back and whenk V reatment mask over the resident. His eeded. It was unclear what the res and gathered trash off his bedside put the trash can back and difficult the was not wearing his nasal can	tness of breath or eathing when ontinent if urine has potential for ICATION ordered and monitor for evidenced by terminal illness discomfort-give medication and evealed the chief ness was end stage nedication. Overall assessment e care. poxic [MEDICAL effected continue with oxygen). lution (1 vial) ampul (sealed monitor - breath laily; order date DATE] /respiration; as ion and all previous ent continued to request me. Entered by LVN nurse made aware, called k. Note was entered by A breathing treatment during the k or mouthpiece. She he stated this d she assessed the resident o deliver supplemental ment. She revealed close by and across xactly how long she was e found him no pulse was found. LVN is working in hall that as found. LVN A revealed rds the side rails. She timent that night. LVN as not sure it was he did not think she was or the morning of [DATE] #1's family revealed the diside table in front television was on. ident said due to to the bathroom. As N A entered the room. hask portal. At 12:31 AM, is nose and mouth. She reatment was going. She time lifting his head nula, so he was arms. The strap from ad from the bedside table evision sounds. He
	Length of this video was 3:09 mir At 1:34 AM Resident #1 was m rocking the table slightly. A box v was not wearing his nasal cannul: At 1:49 AM Resident #1 was st the bed. He was able to si back u deep. His whole chest moved wit appeared to slip off the table and dropped it again between his legs mouth breaths (sounds unclear). I entered his room, video length is At 1:52 AM, 1:59 AM and 2:03 moving his head around during th No staff entered his room during	nutes. iore upright, the nebulizer mask w with items in it fell off the bedsidd a, so he was not receiving oxygen ill wearing his nebulizer mask. Hu pafter a few moments. He then feh h each breath taken. He sat back u could can be seen hanging between several times. At one point, he sa He was not wearing his nasal canr 3:06 minutes. AM: Resident #1 slumped over h nese videos. He was not wearing hay of these videos.	as on his face. He was leaning int e table and hit the floor with a not	o the bedside table and ceable noise. He on his bed, lying across oreaths were short and le again. His head d his head and then g, or took open en at 5LPM. No staff rd the head of bed. He was ceiving oxygen at 5LPM.

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:7/25/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 676422	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/25/2018
NAME OF PROVIDER OF SU PALOMINO PLACE	PPLIER	STREET ADDRESS, CITY, 3160 GUS THOMASSON 1	
For information on the nursing	home's plan to correct this deficient	MESQUITE, TX 75150 cy, please contact the nursing home or the state survey agency.	
(X4) ID PREFIX TAG	home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0607	(continued from page 4)	of the video, he leaned over his leas with his right arm on the he	adside table. He was
Level of harm - Immediate	not wearing his nasal cannula, so	he was not receiving oxygen at 5LPM. No staff entered the roo	
	his fist several times. At the end of not wearing his nasal cannula, so length was 2:32 minutes. At 3:35 AM Resident #1 slump A entered his room applying glow table aside and called out sir. She stood to the side observing the nu applied the nasal cannula to him. due to music playing in the backg the room. A male staff member of Resident #1's room as the male st the resident's bed and floor aroun room at 2:32 minutes into the vid At 3:38 AM LVN A and the fer each side of the resident's bed. Th the camera blocking the view. Th staff were doing with the resident noise. At 3:44 AM, 3:45 AM, 3:49 AM seen coming and going from low At 4:20 AM Resident #1's famil Interview on [DATE] at 10:34 AM assessment into the Medical Asse stated fursing staff should stay w stated that facility policy did not s to stay and monitor the resident b Review of LVN A personnel file r On [DATE] revealed Violation of breathing tx (treatment) was give: Approximately .[DATE] min. Th noted resident removed mask and On [DATE] revealed LVN A's rer provided to this patient. A message for was left for Resident # Review of Resident #1's Record o time of death. The physician was and did all the notifications. An Immediate Jeopardy was ident in the facility at the time Immedia The Plan of Removal was accepte Registered Respiratory Therapis treatment protocol related to train training included appropriat The DON and ADON are condu treatment protocol related to train training include approprised for evening of [DATE] at 8:30 PM. F his care situation. The Medical D treatment and did not return to as retraining the staff and monitorin; During an interview on [DATE] at 8:30 PM. F his care situation. The Medical D treatment and did not return to as facility's policies and procedures of nevelad the training could be pro riverapist would also do quarterly during the nebulizer treatments af acility's policies and procedures of nebulizer treatments of Mocuumer reactions. Interviews on [DATE] at 12:31 PW Manager D, LVN L, and the ADON who w	ed over his legs on the side of the bedside table. His back show es and there was another female staff with her in the doorway. lifted his right arm, and there was no response from the Reside rse. LVN A rolled the resident's head onto his bed and picked u LVN A asked the female staff to get someone (words unclear a round). After applying oxygen to the resident, LVN A moved I netred the room, looked at the resident and left. LVN A and the faff left. LVN A lowered the head of bed slightly and the female d the side of the bed closest to the restroom. LVN A and the fer eo, approximately 3:37 AM. nale staff returned to Resident #1's room with a male staff. The is female staff picked items off the floor and placed the residen e female staff picked items off the floor and placed the residen e female staff picked items off the floor and placed the residen e reorners of the video. The staff conversation was unclear. rinal from in front of the camera and left the resident's room. Is room was straightened. y entered his room with LVN A and female staff. 4 with the Interim DON revealed LVN A was terminated due to sament Records (MARs) for the treatment provided. LVN A w ith a resident during an ebulizer treatment to monitor the reside fore, during and after treatment. evealed Employee Coaching and Counseling Records that refte Substandard Work and Suspended for failure to document with in to my patient and I wasn't sure for how long, and it was a PRI ere were lights going off on the hall and across from him. Nurs was not responding. narks reflected, It was an emergency situation and I was comin nt #1's Hospice nurse on [DATE] at 2:17 PM but no return call 1's primary care provider on [DATE] at 2:3 AM but no return f Death, undated revealed Resident #1 expired on [DATE] at 3:40 AM. Remarks on record revealed F ified on [DATE] at 3:40 AM. Remarks on record revealed F ified on [DATE] at 3:40 AM. Remarks on record revealed F ified on [DATE] at 3:40 AM. Remarks on record revealed F ified on [DATE] at 3:40 PM and reflected the f	m during this video. Video ed no signs of movement. LVN LVN A moved the bedside int #1. The female staff p the oxygen tubing. She is to what was said exactly, inis legs onto the bed and left female staff returned to e staff picked up items from male staff and LVN A went to t's urinal in front of able to see what the other clear due to television is blocked by the urinal. Staff could be Resident #1 was lying in bed o failure to document the resident's as terminated on [DATE]. She nt. The Interim DON dity trained staff exted the following: nemployee remarks stating N tx given to him. e went to answer and came back g back to document every care was received. call was received. call was received. 35 AM with LVN A present at hospice nurse was at facility y telephone because she was not ed at that time. taken to remove the immediacy: to facility nebulizer d to no adverse d and provide comprehensive d d they reviewed the d they reviewed the d they reviewed the d to no adverse and #8 revealed they received he nebulizer treatments performed d s and procedures for l with no adverse and #8 revealed they received he nebulizer treatments orked 6:00 AM to 2:00 PM; Unit d to 10:
	monitor the effectiveness of the P	IJ and a scope of isolated because the facility was continuing t lan of Removal. on [DATE] of 9 residents who received nebulizer treatments.	5 m-service staff and

Previous Versions Obsolete

Page 5 of 8

NO. 0938-0391 ATE SURVEY LETED 2018 P . REGULATORY . REGULATORY entered care nent. eathing treatment and it was unattended
REGULATORY respiratory entered care nent. athing treatment and it was unattended
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ned out of compliance
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on [DATE] with
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when t if urine
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ced by terminal illnes fort-give medication a
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MEDICAL
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d continue with 5). (1 vial) ampul (sealed
r - breath
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ation; as
l all previous
inued to request tered by LVN
made aware, called was entered by
ing treatment during t
outhpiece. She d this
ssessed the resident er supplemental
he revealed and across
now long she was
se was found. LVN
1. LVN A revealed side rails. She hat night. LVN
sure it was not think she was
norning of [DATE]
nily revealed the
able in front on was on. iid due to
and picked up
bathroom. As tered the room.
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nt was going. She
fting his head he was

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1011

Facility ID: 676422

If continuation sheet Page 6 of 8

ENTERS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:7/25/2018 FORM APPROVED
TATEMENT OF DEFICIENCIES ND PLAN OF ORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 04/25/2018
ME OF PROVIDER OF SU	676422 IPPLIER	STREET AD	DRESS, CITY, STATE, ZIP
LOMINO PLACE		3160 GUS TI MESQUITE	HOMASSON ROAD , TX 75150
	home's plan to correct this deficien	cy, please contact the nursing home or the state	
X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST MATION)	BE PRECEDED BY FULL REGULATORY
F 0684 Level of harm - Immediate jeopardy Residents Affected - Few	At 1:30 AM the resident was st the nebulizer mask was on his ch to lean towards the bed, appeared was not wearing his nasal cannul: Length of this video was 3:09 min At 1:34 AM Resident #1 was n rocking the table slightly. A box was not wearing his nasal cannul: At 1:49 AM Resident #1 was si across the bed. He was able to sit short and deep. His whole chest n	o staff entered the room during this video. ill sitting on the bedside, with arms on table and seks and around toward the back of his head. Hi to be saying help several times but hard to hear a, so he was not receiving oxygen at 5 LPM No nutes. hore upright, the nebulizer mask was on his face with items in it fell off the bedside table and hit a, so he was not receiving oxygen at 5LPM. Ill wearing his nebulizer mask. He sat up and th back up after a few moments. He then fell back noved with each breath taken. He sat back up at and could can be seen hanging between his leg	e was moving his head from the bedside table c clearly over the television sounds. He staff entered his room during this video. e. He was leaning into the bedside table and the floor with a noticeable noise. He nen leaned/fell back on his bed, lying a caross his bed again. His breaths were d leaned over the bedside table again. His
	then dropped it again between his mouth breaths (sounds unclear). I entered his room, video length is - At 1:52 AM, 1:59 AM and 2:0 moving his head around during th No staff entered his room during - At 2:07 AM Resident #1 said h with his fist several times. At the was not wearing his nasal cannuli Video length was 2:32 minutes. - At 3:35 AM Resident #1 slump A entered his room applying glov table aside and called out sir. She stood to the side observing the nu applied the nasal cannula to him. due to music playing in the backg the room. A male staff member c Resident #1's room as the male st the resident's bed and floor aroun room at 2:32 minutes into the vid - At 3:38 AM LVN A and the fe each side of the resident's bed. Tf the camera blocking the view. Th	legs several times. At one point, he sat upright le was not wearing his nasal cannula, so he was 3:06 minutes. B AM: Resident #1 slumped over his bedside tal ese videos. He was not wearing his nasal cannu any of these videos. elp me and help several times. At 1:31 minutes end of the video, he leaned over his legs with h a, so he was not receiving oxygen at 5LPM. No wed over his legs on the side of the bedside table es and there was another female staff with her i lifted his right arm, and there was no response rse. LVN A rolled the resident's head onto his b LVN A asked the female staff to get someone (round). After applying oxygen to the resident, I ntered the room, looked at the resident and left. aft left. LVN A lowered the head of bed slightly the side of the bed closest to the restroom. LV	and tried to say something, or took open s not receiving oxygen at 5LPM. No staff ble and leaning toward the head of bed. He was la, so he was not receiving oxygen at 5LPM. into the video, he hit his bedside table is right arm on the bedside table. He staff entered the room during this video. . His back showed no signs of movement. LVN n the doorway. LVN A moved the bedside from the Resident #1. The female staff bed and picked up the oxygen tubing. She words unclear as to what was said exactly, LVN A moved his legs onto the bed and left LVN A and the female staff returned to y and the female staff member left the an and estaff. The male staff and LVN A went to aced the resident #1 in front of ed up items. Unable to see what the other
	At 4:09 AM Staff removed the bed with sheets covering him and At 4:20 AM Resident #1's fami Interview on [DATE] at 10:34 AM assessment into the Medical Asses stated nursing staff should stay w stated that facility policy did not to stay and monitor the resident b Review of LVN A personnel file t On [DATE] revealed violation of breathing tx (treatment) was give Approximately ,[DATE] min. Th noted resident removed mask and On [DATE] revealed LVN A's rer provided to this patient. A message for was left for Resident A message for was left for Resident # Review of Resident #1's Record o time of death. The physician was and did all the notifications. Review of the facility's current po on [DATE] at 2:20 PM reflected: - Administer therapy until medica	ly entered his room with LVN A and female sta f with the Interim DON revealed LVN A was tt soment Records (MARs) for the treatment prov- ith a resident during a nebulizer treatment to mo- state that staff had to stay in the room with the r- efore, during and after treatment. evealed Employee Coaching and Counseling R substandard work and suspended for failure to co- n to my patient and I wasn't sure for how long, a ere were lights going off on the hall and across- was not responding. narks reflected, It was an emergency situation a nt #1's Hospice nurse on [DATE] at 2:17 PM bu 1's primary care provider on [DATE] at 9:53 Al f Death, undated revealed Resident #1 expired co- notified on [DATE] at 3:40 AM. Remarks on re- licy and procedure on Nebulizer Treatment, dation tion is depleted, treatment require a minimum o	esident's room. Resident #1was lying in aff. erminated due to failure to document the resident's ided. LVN A was terminated on [DATE]. She onitor the resident. The Interim DON esident, but facility trained staff ecords that reflected the following: locument with employee remarks stating and it was a PRN tx given to him. from him. Nurse went to answer and came back and I was coming back to document every care at no return call was received. M but
	 Monitor patient for side effects of Hypoventilation/Hyperventilation breath sounds before, during and Instruct the patient to take slow of When treatment is completed insight sputum produced . Document treatment in patient's Documentation: Date and time of treatment, breath sounds before a An Immediate Jeopardy was ident in the facility at the time Immedia The Plan of Removal was accepte Registered Respiratory Therapi treatment protocol and appropriat The DON and ADON are cond treatment protocol related to train training included appropriate mon nervousness, [MEDICATION N/ included monitor heart rate, respiratory ratt All current orders of residents 1 rate, respiratory rate, breath soum Review of Personnel Status Form last day worked was [DATE]. Ad Interview with the facility's Media evening of [DATE] at 8:30 PM. H 	leep breaths truct the patient to take deep breath and cough, chart . f treatment, type of treatment ., equipment used nd after treatment, heart rate and respiratory rati ified on [DATE] at 7:12 PM. The administrator tte Jeopardy was identified and a Plan of Remo' on [DATE] at 12:04 PM and reflected the foll st is conducting respiratory in-services and skil e monitoring with licensed nursing staff. ucting competency testing, in-servicing and ski ing provided by Registered Respiratory Therap nitoring of nebulizer treatment which revealed n AME], hypoventilation/hyperventilation, infecti- e, and breath sounds before during and after trea- receiving nebulizer treatments have been assess is and O2 saturation.	IN NAME], (c) >- Monitor heart rate, respiratory rate, and observing the nature of the cough and any for the treatment, duration of the e before, during and after treatment . was notified by telephone because she was not val was requested at that time. owing steps be taken to remove the immediacy: ls checks related to facility nebulizer lls checks related to facility nebulizer ist with licensed nursing staff. The nonitoring for side effects such as on and [MEDICAL CONDITION] Process also atment. ed for physical monitors such as heart IFE] for failure to document accordingly. LVN A's e facility made him aware of the IJ on the der for Resident #1 and was unfamiliar with cause the nurse had provided a nebulizer

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE &			PRINTED:7/25/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 676422	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/25/2018
NAME OF PROVIDER OF SU		STREET ADDRI	ESS, CITY, STATE, ZIP
PALOMINO PLACE		3160 GUS THO MESQUITE, TX	MASSON ROAD
For information on the nursing	home's plan to correct this deficient	cy, please contact the nursing home or the state surv	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	EFICIENCIES (EACH DEFICIENCY MUST BE	PRECEDED BY FULL REGULATORY
F 0684	(continued from page 7)		
Level of harm - Immediate jeopardy	policies and procedure of nebulize facility had done extensive training training on nebulizer treatments a	1 3:46 PM, the Administrator revealed I think it (IJ) er treatments. The Administrator revealed that to pr g. She stated she had a Registered Respiratory The nd had staff do return demonstrations. The Administration of the Administration o	revent the reoccurrence of the IJ the rapist come and provide comprehensive strator revealed they reviewed the
Residents Affected - Few	Interview with the Interim DON o was unaware of the situation. She She stated no nurse would be wor revealed the training could be pro Therapist would also do quarterly during the nebulizer treatment. Sh During interview with Unit Manag Manager stated that to prevent the about skills, covering check off li in different situations. Observations on [DATE] at 12:31 by four different nurses from differen nebulizer treatments and documen reactions. Interviews on [DATE] from betwo nebulizer treatments in the facility they received. Interviews on [DATE] at 12:45 PM Manager D, LVN L, and the ADON who w worked the 10:00 PM to 6:00 AM shift; an Respiratory therapist and return d rate, lung sounds, and oxygen sati revealed that residents need to be CONDITION] Nursing staff state On [DATE] the JJ was removed. C	to make sure everyone understood what was expect n [DATE] at 4:48 PM revealed the IJ occurred beca stated the facility was providing in-services to all r king the floor without taking the training for nebuli vided by the respiratory therapist, DON or ADON assessments with staff. She revealed she would pre the stated there are two nurses were on a unit at all ti ger on [DATE] at 10:12 AM revealed the IJ occurred reoccurrence of the incident, the facility was cond sts by reviewing treatment process and reviewing p PM and 12:55PM and [DATE] at 11:52 AM and 12 and thalls throughout facility revealed the nurses follo tation of treatments. All residents tolerated the pro teen 10:00 AM and 1:30 PM with five Residents #2, . All the residents interviewed felt had no concerns <i>A</i> through [DATE] at 3:27 PM with LVNs B, C, an worked on the day shift; LVNs E, J and K who work and LVN I who worked as needed, revealed that nur emonstration was required for all nursing staff. Staf uration needed to be assessed before, during and aff monitored for side effects such as nervousness, [M d that residents need to be observed throughout ent DATE] at 3:52 PM the Administrator, Regional s removed. While the IJ was removed, the facility r	ause of the nurse's actions and the facility nurses to prevent a reoccurrence. Izer treatments. The Interim DON (managers). She stated the Respiratory effer that the nurse not leave a resident mes. ed due to staff's carelessness. The Unit ucting in-services, talking to staff rotocols that staff needed to follow 2:10 PM of four nebulizer treatments performed owed policies and procedures for ccedures well with no adverse #5, #6, #7, and #8 revealed they received s regarding the nebulizer treatments d H who worked 6:00 AM to 2:00 PM; Unit ted 2:00 PM to 10:00 PM; LVNs F and G who sing staff received nebulizer training from ff stated that pulse, respiratory ter each nebulizer treatment. Staff EDICATION NAME] and [MEDICAL ire treatment process. I Nurse Consultant, Interim DON and Unit
F 0727 Level of harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty director of nurses on a full time Based on interview and record rev nursing on a full-time basis. The facility failed to have an RN I This failure could affect all 86 resi Findings included: On 04/04/18, 04/20/18 and 04/24/ LVN/GN (graduate nurse). The ir Registered Nurse license. On 04/23/18 at 6:30 PM, RN D ca confirmed she was the DON. An interview with the Administrat previous DON left the facility ovc test and that the Unit Manager, RI RN was the DON and the Interim from the facility on 04/20/18 and on 04 Regional Consultant E responded stated that they got a little ahead c as she tests. Stated the Interim DO test. The Administrator stated Un Review of the Interim DON's emp email from HR (Human Resource approval for (Interim DON) off c Regional Consultant E's reply at I 0n 04/24/18 at 12:00 PM the Adm was an Interim DON with a start facility and facility was actively I getting the position filled soon en facility had not handled the situat Manager RN was present during t On 04/25/18 at 3:13 PM interview	an [DATE] of 9 residents who received nebulizer transmissionbours a day; and select a registered nurse to l	be the se to serve as the director of essary care and services. which revealed the Interim DON was an recently graduated and is due to test for her the surveyor. She identified herself and tF on 04/24/18 at 11:39 AM revealed the n DON was a graduate nurse waiting to nsultant E stated that the Unit Manager, n DON was on the Key Personnel list received RN had no identifier by her name. hist as the Interim DON. The Administrator terim DON the DON position as soon some time off and get ready for the d for acting as the DON. Nurse. A document in her file revealed an 104/04/18 at 12:13 PM reflected I need your DN on 03/05/18 when (previous DON) left.