STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676422	A. BUILDING _____ B. WING _____	04/25/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALOMINO PLACE	3160 GUS THOMASSON ROAD MESQUITE, TX 75150

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review; it was determined the facility failed to ensure each resident received nebulizer treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 9 residents reviewed for neglect. LVN A failed to monitor and assess Resident #1, who had [MEDICAL CONDITION], during and after a breathing treatment and failed to put his oxygen, which he needed at 5 LPM, back on him for approximately three hours. The resident was unattended and experienced respiratory distress, became unresponsive, and subsequently expired in the facility. An Immediate Jeopardy was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy, and a scope of isolated because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. This failure could affect the 9 residents receiving nebulizer treatments by placing them at risk for respiratory distress, lack of medical treatment, improper medical treatment, and death. Findings included: Review of Resident #1's face sheet, dated [DATE] reflected a [AGE] year-old male, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He had an advance directive for do not resuscitate. Review of Resident #1's MDS assessment dated [DATE] reflected he had moderately impaired cognition with no behaviors. He needed assistance of one to two staff with his activities of daily living (ADLs). The resident had shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring), shortness of breath or trouble breathing when sitting at rest, and shortness of breath or trouble breathing when lying flat. Resident #1 was always continent if urine and occasionally incontinent of bowel. Review of Resident #1's Care Plan Report with a date range of [DATE] to [DATE] reflected, resident has potential for ineffective airway exchange and infection related to [DIAGNOSES REDACTED].Administer [MEDICATION NAME][MEDICATION NAME], aerosol treatments, nebulizers, and oxygen as ordered and monitor status, administer medications as ordered and monitor for side effects for [MEDICAL CONDITION] . The Care plan revealed Resident #1 required hospice as evidenced by terminal illness of [MEDICAL CONDITION]. Interventions are monitor for signs and symptoms of increased pain, discomfort-give medication and treatments, monitor for relief Review of Provider Progress Soap (subjective, objective, assessment, and plan) Note dated [DATE] revealed the chief complaint was shortness of breath without relief from present medical regimen. History of present illness was end stage lung disease of [MEDICAL CONDITION] with severe anxiety not responsive to present dosage of medication. Overall assessment and plan revealed conference with resident and resident's family who requested hospice for end of life care. Provider Progress Soap Note dated [DATE] overall assessment and plan revealed that resident had hypoxic [MEDICAL CONDITION] (failure to maintain adequate blood oxygen level) with oxygen dependence. Review of Resident #1's (MONTH) (YEAR) Physician order [REDACTED]. - Keep saturation at or greater than 91%, monitor with pulse oximetry; by shift; order date [DATE] - Oxygen 5L/min with humidification; order date [DATE] (Providers Progress Note dated [DATE] reflected continue with oxygen OER (Oxygen Enhancement Ratio) NC (nasal cannula) but maintain saturation at goal of ,[DATE]%). - [MEDICATION NAME]-[MEDICATION NAME] 0.5mg-3mg (2.5mg base)/3mL nebulization solution (1 vial) ampul (sealed glass bottle with premeasured medication) for nebulization (ml) inhalation; as needed every four hours; physical monitor - breath sounds/Pulse/ Pulse Oximetry/Respiration; order date [DATE] - Incruse Ellipta 62.5 mcg/actuation powder for inhalation (1 puff) with inhalation device; one time daily; order date [DATE] - [MEDICATION NAME] (anti-[MEDICAL CONDITION]) 10 mg 1 tablet once daily; order date [DATE] - Post respiratory nebulizer treatment: physical monitor - minutes for treatment/pulse/pulse oximetry/respiration; as needed, order date [DATE] Review of the Nurses' Notes for Resident #1 revealed the following: - On [DATE] at 9:39 PM: Resident is admitted to hospice care service today, with . No new medication and all previous medication remain as ordered. Breathing treatment given as ordered, as needed every 4 hours. Resident continued to request for treatment more than ordered. Responsible party notified. Resident is not in acute distress at this time. Entered by LVN D. - On [DATE] at 3:30 AM: Resident noted unresponsive and no pulse by the side of his bed. Hospice nurse made aware, called placed to resident's daughter (name) and call placed to MD (Medical Doctor), nursing awaits call back. Note was entered by LVN A. - On ,[DATE] at 4:48 AM: Resident family and Hospice nurse at bedside. Note was entered by LVN A Telephone interview with LVN A on [DATE] at 11:07 AM revealed that she gave Resident #1 a PRN breathing treatment during the morning of [DATE] (she could not recall exactly what time) and did not remember if she used a mask or mouthpiece. She stated that the resident had both. LVN A stated that Resident #1 requested the breathing treatment. She stated this happened a long time ago and she did not remember everything that happened that day. LVN A stated she assessed the resident before she provided the treatment. She stated she removed Resident #1's nasal cannula (device used to deliver supplemental oxygen or airflow to a patient or person in need of respiratory help), to administer the breathing treatment. She revealed she stayed in the resident's room during the nebulizer treatment, but lights in the hall were going off close by and across the hall from the resident's room so she left to answer them. LVN A stated she could not remember exactly how long she was gone but returned after the treatment was done. She said when she returned to Resident #1's room, she found him unresponsive. She stated she repositioned him back into bed and placed his oxygen back on him, and no pulse was found. LVN A stated she then left the room to get help with resident. LVN A revealed the aide got the other nurse working in hall that morning. She stated she reassessed the resident when she returned to resident's room and no pulse was found. LVN A revealed she found Resident #1 with his legs off the bed with the head of bed elevated and his head over towards the side rails. She revealed she then contacted hospice, the doctor and family. She stated she only gave him the one treatment that night. LVN A stated she was aware that resident had an electronic monitoring sign posted outside his room but was not sure it was recording. When revealed to LVN the length of time the video showed she was gone, LVNA stated she did not think she was gone that long. Review of Resident #1's (MONTH) (YEAR) MAR indicated [REDACTED].

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Observation on [DATE] at 1:30 PM of the motioned activated in room video surveillance recording for the morning of [DATE] between the time of 12:27 AM to 3:35 PM (approximately 3 hours timeframe) provided by Resident #1's family revealed the following: - At 12:27 AM Resident #1 sitting on the side of the bed with the head of the bed elevated and the bedside table in front of him. There were several items on the bedside table obstructing complete view of the resident. His television was on. A female staff entered Resident #1's room and asked him what he needed. It was unclear what the resident said due to television noises. She stated the nurse? Okay and left room. - At 12:29 AM A female staff returned to his room, applied gloves and gathered trash off his bedside table and picked up the trash can and left the room. She returned a short time later and put the trash can back and walked to the bathroom. As she walked towards the restroom, she told Resident #1 she got your breathing treatment and then LVN A entered the room. LVNA applied gloves, retrieved the nebulizer mask from the bed and applied the medication to the mask portal. At 12:31 AM, she removed the resident's nasal cannula and applied the breathing treatment mask over the resident's nose and mouth. She then turned on the nebulizer and mist came from the mask. - At 12:33 AM, LVN A was still in the room, moving things around and making sure the nebulizer treatment was going. She then walked out the door. - At 1:25 AM Resident #1 was lying his head on his bedside table in front of him. He had a difficult time lifting his head off the table. The table slid to the side as the resident pushed off it. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered the room during this video. - At 1:30 AM the resident was still sitting on the bedside, with arms on table and head hanging over arms. The strap from the nebulizer mask was on his cheeks and around toward the back of his head. He was moving his head from the bedside table to lean towards the bed, appeared to be saying help several times but hard to hear clearly over the television sounds. He was not wearing his nasal cannula, so he was not receiving oxygen at 5 LPM No staff entered his room during this video. Length of this video was 3:09 minutes. - At 1:34 AM Resident #1 was more upright, the nebulizer mask was on his face. He was leaning into the bedside table and rocking the table slightly. A box with items in it fell off the bedside table and hit the floor with a noticeable noise. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. - At 1:49 AM Resident #1 was still wearing his nebulizer mask. He sat up and then leaned/fell back on his bed, lying across the bed. He was able to sit back up after a few moments. He then fell back across his bed again. His breaths were short and deep. His whole chest moved with each breath taken. He sat back up and leaned over the bedside table again. His head appeared to slip off the table and could can be seen hanging between his legs under the table. He lifted his head and then dropped it again between his legs several times. At one point, he sat upright and tried to say something, or took open mouth breaths (sounds unclear). He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered his room, video length is 3:06 minutes. - At 1:52 AM, 1:59 AM and 2:03 AM: Resident #1 slumped over his bedside table and leaning toward the head of bed. He was moving his head around during these videos. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered his room during any of these videos. - At 2:07 AM Resident #1 said help me and help several times. At 1:31 minutes into the video, he hit his bedside table with his fist several times. At the end of the video, he leaned over his legs with his right arm on the bedside table. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered the room during this video. Video length was 2:32 minutes. - At 3:35 AM Resident #1 slumped over his legs on the side of the bedside table. His back showed no signs of movement. LVN A entered his room applying gloves and there was another female staff with her in the doorway. LVN A moved the bedside table aside and called out sir. She lifted his right arm, and there was no response from the Resident #1. The female staff stood to the side observing the nurse. LVN A rolled the resident's head onto his bed and picked up the oxygen tubing. She applied the nasal cannula to him. LVN A asked the female staff to get someone (words unclear as to what was said exactly, due to music playing in the background). After applying oxygen to the resident, LVN A moved his legs onto the bed and left the room. A male staff member entered the room, looked at the resident and left. LVN A and the female staff returned to Resident #1's room as the male staff left. LVN A lowered the head of bed slightly and the female staff picked up items from the resident's bed and floor around the side of the bed closest to the restroom. LVN A and the female staff member left the room at 2:32 minutes into the video, approximately 3:37 AM. - At 3:38 AM LVN A and the female staff returned to Resident #1's room with a male staff. The male staff and LVN A went to each side of the resident's bed. The female staff picked items off the floor and placed the resident's urinal in front of the camera blocking the view. The female staff pulled at the bed sheets and picked up items. Unable to see what the other staff were doing with the resident. Staff talked amongst themselves, but the conversation was unclear due to television noise. - At 3:44 AM, 3:45 AM, 3:49 AM, 3:53 AM, 3:58 AM, 4:01 AM and 4:06 AM: The camera was blocked by the urinal. Staff could be seen coming and going from lower corners of the video. The staff conversation was unclear. - At 4:09 AM Staff removed the urinal from in front of the camera and left the resident's room. Resident #1was lying in bed with sheets covering him and the room was straightened. - At 4:20 AM Resident #1's family entered his room with LVN A and female staff. Interview on [DATE] at 10:34 AM with the Interim DON revealed LVN A was terminated due to failure to document the resident's assessment into the Medical Assessment Records (MARs) for the treatment provided. LVN A was terminated on [DATE]. She stated nursing staff should stay with a resident during a nebulizer treatment to monitor the resident. The Interim DON stated that facility policy did not state that staff had to stay in the room with the resident, but facility trained staff to stay and monitor the resident before, during and after treatment. Review of LVN A personnel file revealed Employee Coaching and Counseling Records that reflected the following: On [DATE] revealed violation of substandard work and suspended for failure to document with employee remarks stating breathing tx (treatment) was given to my patient and I wasn't sure for how long, and it was a PRN tx given to him. Approximately ,[DATE] min. There were lights going off on the hall and across from him. Nurse went to answer and came back noted resident removed mask and was not responding. On [DATE] revealed LVN A's remarks reflected, It was an emergency situation and I was coming back to document every care provided to this patient. A message for was left for Resident #1's Hospice nurse on [DATE] at 2:17 PM but no return call was received. A message was left for Resident #1's primary care provider on [DATE] at 9:53 AM but no return call was received. Review of Resident #1's Record of Death, undated revealed Resident #1 expired on [DATE] at 3:35 AM with LVN A present at time of death. The physician was notified on [DATE] at 3:40 AM. Remarks on record revealed hospice nurse was at facility and did all the notifications. Review of the facility's current policy and procedure on Nebulizer Treatment, dated [DATE] and provided by the Interim DON on [DATE] at 2:20 PM reflected: - Administer therapy until medication is depleted, treatment require a minimum of 15 minutes. (Drug.com website: https://www.drugs.com/dosage/[MEDICATION NAME].html revealed usual adult dose for [MEDICAL CONDITION] - Acute . Nebulizer inhalation solution: -2.5 mg three or four times a day by nebulization, over approximately 5 to 15 minutes) - Monitor patient for side effects of treatment (a) Nervousness, (b) [MEDICATION NAME], (c) Hypoventilation/Hyperventilation, (d) Infection, (e) [MEDICAL CONDITION]/>- Monitor heart rate, respiratory rate, and breath sounds before, during and after treatment - Instruct the patient to take slow deep breaths - When treatment is completed instruct the patient to take deep breath and cough, observing the nature of the cough and any sputum produced . - Document treatment in patient's chart . - Documentation: Date and time of treatment, type of treatment ., equipment used for the treatment, duration of the treatment, breath sounds before and after treatment, heart rate and respiratory rate before, during and after treatment . Review of the facility's current policy and procedure on Abuse Protocol, dated (MONTH) (YEAR) reflected: 1. The patient/resident has the right to be free from Abuse, neglect, mistreatment of [REDACTED].

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F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) 7. The following definition are provided to assist out Facility's staff members in recognizing incidents of Patient/Resident Abuse: l. 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 treatment protocol and appropriate monitoring with licensed nursing staff. - The DON and ADON are conducting competency testing, in-servicing and skills checks related to facility nebulizer treatment protocol related to training provided by Registered Respiratory Therapist with licensed nursing staff. The training included appropriate monitoring of nebulizer treatment which revealed monitoring for side effects such as nervousness, [MEDICATION NAME], hypoventilation/hyperventilation, infection and [MEDICAL CONDITION] Process also included monitor heart rate, respiratory rate, and breath sounds before during and after treatment. - All current orders of residents receiving nebulizer treatments have been assessed for physical monitors such as heart rate, respiratory rate, breath sounds and O2 saturation. Review of Personnel Status Form for LVN A revealed a termination date of [DATE] for failure to document accordingly. LVN A's last day worked was [DATE]. Administrator signed form on [DATE]. Interview with the facility's Medical Director on [DATE] at 2:53 PM revealed the facility made him aware of the IJ on the evening of [DATE] at 8:30 PM. He stated that he was not the primary care provider for Resident #1 and was unfamiliar with his care situation. The Medical Director stated that the IJ most likely occurred because the nurse had provided a nebulizer treatment and did not return to assess the resident. Medical Director revealed that the IJ could have been avoided by retraining the staff and monitoring and assessing the residents. During an interview on [DATE] at 3:46 PM, the Administrator revealed I think it (IJ) occurred because we weren't following policies and procedure of nebulizer treatments. The Administrator revealed that to prevent the reoccurrence of the IJ the facility had done extensive training. She stated she had a Registered Respiratory Therapist come and provide comprehensive training on nebulizer treatments and had staff do return demonstrations. The Administrator revealed they reviewed the facility's policies and procedures to make sure everyone understood what was expected. Interview with the Interim DON on [DATE] at 4:48 PM revealed the IJ occurred because of the nurse's actions and the facility was unaware of the situation. She stated the facility was providing in-services to all nurses to prevent a reoccurrence. She stated no nurse would be working the floor without taking the training for nebulizer treatments. The Interim DON revealed the training could be provided by the respiratory therapist, DON or ADON (managers). She stated the Respiratory Therapist would also do quarterly assessments with staff. She revealed she would prefer that the nurse not leave a resident during the nebulizer treatment. She stated there are two nurses were on a unit at all times. During interview with Unit Manager on [DATE] at 10:12 AM revealed the IJ occurred due to staff's carelessness. The Unit Manager stated that to prevent the reoccurrence of the incident, the facility was conducting in-services, talking to staff about skills, covering check off lists by reviewing treatment process and reviewing protocols that staff needed to follow 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 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 2:00 PM; Unit 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; LVNs F and G who worked the 10:00 PM to 6:00 AM shift; and LVN I who worked as needed, revealed that nursing staff received nebulizer training from Respiratory therapist and return demonstration was required for all nursing staff. Staff stated that pulse, respiratory rate, lung sounds, and oxygen saturation needed to be assessed before, during and after each nebulizer treatment. Staff revealed that residents need to be monitored for side effects such as nervousness, [MEDICATION NAME] and [MEDICAL CONDITION] Nursing staff stated that residents need to be observed throughout entire treatment process. On [DATE] the IJ was removed. On [DATE] at 3:52 PM the Administrator, Regional Nurse Consultant, Interim DON and Unit Manager were informed the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not an IJ and a scope of isolated because the facility was continuing to in-service staff and monitor the effectiveness of the Plan of Removal. The Interim DON provided a list on [DATE] of 9 residents who received nebulizer treatments.
F 0607 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement written policies and procedures to prohibit and prevent abuse and neglect for 1 (Resident #1) of 10 residents reviewed for abuse. LVN A failed to monitor and assess Resident #1, who had [MEDICAL CONDITION], during and after a breathing treatment and failed to put his oxygen, which he needed at 5 LPM, back on him for approximately three hours. The resident was unattended and experienced respiratory distress, became unresponsive, and subsequently expired in the facility. An Immediate Jeopardy was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy, and a scope of isolated because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. This failure could affect the 9 residents receiving nebulizer treatments by placing them at risk for respiratory distress, lack of medical treatment, improper medical treatment, and death. Findings included: Review of the facility's current policy and procedure on Nebulizer Treatment, dated [DATE] and provided by the Interim DON on [DATE] at 2:20 PM reflected: - Administer therapy until medication is depleted, treatment require a minimum of 15 minutes. (Drug.com website: https://www.drugs.com/dosage/[MEDICATION NAME].html revealed usual adult dose for [MEDICAL CONDITION] - Acute . Nebulizer inhalation solution: -2.5 mg three or four times a day by nebulization, over approximately 5 to 15 minutes) - Monitor patient for side effects of treatment (a) Nervousness, (b) [MEDICATION NAME], (c) Hypoventilation/Hyperventilation, (d) Infection, (e) [MEDICAL CONDITION]/>- Monitor heart rate, respiratory rate, and breath sounds before, during and after treatment - Instruct the patient to take slow deep breaths - When treatment is completed instruct the patient to take deep breath and cough, observing the nature of the cough and any sputum produced . - Document treatment in patient's chart . - Documentation: Date and time of treatment, type of treatment ., equipment used for the treatment, duration of the treatment, breath sounds before and after treatment, heart rate and respiratory rate before, during and after treatment . Review of the facility's current policy and procedure on Abuse Protocol, dated (MONTH) (YEAR) reflected: 1. The patient/resident has the right to be free from Abuse, neglect, mistreatment of [REDACTED]. 7. The following definition are provided to assist out Facility's staff members in recognizing incidents of Patient/Resident Abuse: l. 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] with [DIAGNOSES REDACTED]. He had an advance directive for do not resuscitate.

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) Review of Resident #1's MDS assessment dated [DATE] reflected he had moderately impaired cognition with no behaviors. He needed assistance of one to two staff with his activities of daily living (ADLs). The resident had shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring), shortness of breath or trouble breathing when sitting at rest, and shortness of breath or trouble breathing when lying flat. Resident #1 was always continent if urine and occasionally incontinent of bowel. Review of Resident #1's Care Plan Report with a date range of [DATE] to [DATE] reflected, resident has potential for ineffective airway exchange and infection related to [DIAGNOSES REDACTED].Administer [MEDICATION NAME][MEDICATION NAME], aerosol treatments, nebulizers, and oxygen as ordered and monitor status, administer medications as ordered and monitor for side effects for [MEDICAL CONDITION] . The Care plan revealed Resident #1 required hospice as evidenced by terminal illness of [MEDICAL CONDITION]. Interventions are monitor for signs and symptoms of increased pain, discomfort-give medication and treatments, monitor for relief Review of Provider Progress Soap (subjective, objective, assessment, and plan) Note dated [DATE] revealed the chief complaint was shortness of breath without relief from present medical regimen. History of present illness was end stage lung disease of [MEDICAL CONDITION] with severe anxiety not responsive to present dosage of medication. Overall assessment and plan revealed conference with resident and resident's family who requested hospice for end of life care. Provider Progress Soap Note dated [DATE] overall assessment and plan revealed that resident had hypoxic [MEDICAL CONDITION] (failure to maintain adequate blood oxygen level) with oxygen dependence. Review of Resident #1's (MONTH) (YEAR) Physician order [REDACTED]. -- Keep saturation at or greater than 91%, monitor with pulse oximetry; by shift; order date [DATE] -- Oxygen 5L/min with humidification; order date [DATE] (Providers Progress Note dated [DATE] reflected continue with oxygen OER (Oxygen Enhancement Ratio) NC (nasal cannula) but maintain saturation at goal of ,[DATE]%). -- [MEDICATION NAME]-[MEDICATION NAME] 0.5mg-3mg (2.5mg base)/3mL nebulization solution (1 vial) ampul (sealed glass bottle with premeasured medication) for nebulization (ml) inhalation; as needed every four hours; physical monitor - breath sounds/Pulse/ Pulse Oximetry/Respiration; order date [DATE] -- Incruse Ellipta 62.5 mcg/actuation powder for inhalation (1 puff) with inhalation device; one time daily; order date [DATE] -- [MEDICATION NAME] (anti-[MEDICAL CONDITION]) 10 mg 1 tablet once daily; order date [DATE] -- Post respiratory nebulizer treatment: physical monitor - minutes for treatment/pulse/pulse oximetry/respiration; as needed, order date [DATE] Review of the Nurses' Notes for Resident #1 revealed the following: -- On [DATE] at 9:39 PM: Resident is admitted to hospice care service today, with . No new medication and all previous medication remain as ordered. Breathing treatment given as ordered, as needed every 4 hours. Resident continued to request for treatment more than ordered. Responsible party notified. Resident is not in acute distress at this time. Entered by LVN D. -- On [DATE] at 3:30 AM: Resident noted unresponsive and no pulse by the side of his bed. Hospice nurse made aware, called placed to resident's daughter (name) and call placed to MD (Medical Doctor), nursing awaits call back. Note was entered by LVN A. -- On ,[DATE] at 4:48 AM: Resident family and Hospice nurse at bedside. Note was entered by LVN A Telephone interview with LVN A on [DATE] at 11:07 AM revealed that she gave Resident #1 a PRN breathing treatment during the morning of [DATE] (she could not recall exactly what time) and did not remember if she used a mask or mouthpiece. She stated that the resident had both. LVN A stated that Resident #1 requested the breathing treatment. She stated this happened a long time ago and she did not remember everything that happened that day. LVN A stated she assessed the resident before she provided the treatment. She stated she removed Resident #1's nasal cannula (device used to deliver supplemental oxygen or airflow to a patient or person in need of respiratory help), to administer the breathing treatment. She revealed she stayed in the resident's room during the nebulizer treatment, but lights in the hall were going off close by and across the hall from the resident's room so she left to answer them. LVN A stated she could not remember exactly how long she was gone but returned after the treatment was done. She said when she returned to Resident #1's room, she found him unresponsive. She stated she repositioned him back into bed and placed his oxygen back on him, and no pulse was found. LVN A stated she then left the room to get help with resident. LVN A revealed the aide got the other nurse working in hall that morning. She stated she reassessed the resident when she returned to resident's room and no pulse was found. LVN A revealed she found Resident #1 with his legs off the bed with the head of bed elevated and his head over towards the side rails. She revealed she then contacted hospice, the doctor and family. She stated she only gave him the one treatment that night. LVN A stated she was aware that resident had an electronic monitoring sign posted outside his room but was not sure it was recording. When revealed to LVN the length of time the video showed she was gone, LVNA stated she did not think she was gone that long. Review of Resident #1's (MONTH) (YEAR) MAR indicated [REDACTED]. Observation on [DATE] at 1:30 PM of the motioned activated in room video surveillance recording for the morning of [DATE] between the time of 12:27 AM to 3:35 PM (approximately 3 hours timeframe) provided by Resident #1's family revealed the following: -- At 12:27 AM Resident #1 sitting on the side of the bed with the head of the bed elevated and the bedside table in front of him. There were several items on the bedside table obstructing complete view of the resident. His television was on. A female staff entered Resident #1's room and asked him what he needed. It was unclear what the resident said due to television noises. She stated the nurse? Okay and left room. -- At 12:29 AM A female staff returned to his room, applied gloves and gathered trash off his bedside table and picked up the trash can and left the room. She returned a short time later and put the trash can back and walked to the bathroom. As she walked towards the restroom, she told Resident #1 she got your breathing treatment and then LVN A entered the room. LVNA applied gloves, retrieved the nebulizer mask from the bed and applied the medication to the mask portal. At 12:31 AM, she removed the resident's nasal cannula and applied the breathing treatment mask over the resident's nose and mouth. She then turned on the nebulizer and mist came from the mask. -- At 12:33 AM, LVN A was still in the room, moving things around and making sure the nebulizer treatment was going. She then walked out the door. -- At 1:25 AM Resident #1 was lying his head on his bedside table in front of him. He had a difficult time lifting his head off the table. The table slid to the side as the resident pushed off it. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered the room during this video. -- At 1:30 AM the resident was still sitting on the bedside, with arms on table and head hanging over arms. The strap from the nebulizer mask was on his cheeks and around toward the back of his head. He was moving his head from the bedside table to lean towards the bed, appeared to be saying help several times but hard to hear clearly over the television sounds. He was not wearing his nasal cannula, so he was not receiving oxygen at 5 LPM No staff entered his room during this video. Length of this video was 3:09 minutes. -- At 1:34 AM Resident #1 was more upright, the nebulizer mask was on his face. He was leaning into the bedside table and rocking the table slightly. A box with items in it fell off the bedside table and hit the floor with a noticeable noise. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. -- At 1:49 AM Resident #1 was still wearing his nebulizer mask. He sat up and then leaned/fell back on his bed, lying across the bed. He was able to sit back up after a few moments. He then fell back across his bed again. His breaths were short and deep. His whole chest moved with each breath taken. He sat back up and leaned over the bedside table again. His head appeared to slip off the table and could can be seen hanging between his legs under the table. He lifted his head and then dropped it again between his legs several times. At one point, he sat upright and tried to say something, or took open mouth breaths (sounds unclear). He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered his room, video length is 3:06 minutes. -- At 1:52 AM, 1:59 AM and 2:03 AM: Resident #1 slumped over his bedside table and leaning toward the head of bed. He was moving his head around during these videos. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered his room during any of these videos. -- At 2:07 AM Resident #1 said help me and help several times. At 1:31 minutes into the video, he hit his bedside table with

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) his fist several times. At the end of the video, he leaned over his legs with his right arm on the bedside table. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered the room during this video. Video length was 2:32 minutes. -- At 3:35 AM Resident #1 slumped over his legs on the side of the bedside table. His back showed no signs of movement. LVN A entered his room applying gloves and there was another female staff with her in the doorway. LVN A moved the bedside table aside and called out sir. She lifted his right arm, and there was no response from the Resident #1. The female staff stood to the side observing the nurse. LVN A rolled the resident's head onto his bed and picked up the oxygen tubing. She applied the nasal cannula to him. LVN A asked the female staff to get someone (words unclear as to what was said exactly, due to music playing in the background). After applying oxygen to the resident, LVN A moved his legs onto the bed and left the room. A male staff member entered the room, looked at the resident and left. LVN A and the female staff returned to Resident #1's room as the male staff left. LVN A lowered the head of bed slightly and the female staff picked up items from the resident's bed and floor around the side of the bed closest to the restroom. LVN A and the female staff member left the room at 2:32 minutes into the video, approximately 3:37 AM. -- At 3:38 AM LVN A and the female staff returned to Resident #1's room with a male staff. The male staff and LVN A went to each side of the resident's bed. The female staff picked items off the floor and placed the resident's urinal in front of the camera blocking the view. The female staff pulled at the bed sheets and picked up items. Unable to see what the other staff were doing with the resident. Staff talked amongst themselves, but the conversation was unclear due to television noise. -- At 3:44 AM, 3:45 AM, 3:49 AM, 3:53 AM, 3:58 AM, 4:01 AM and 4:06 AM: The camera was blocked by the urinal. Staff could be seen coming and going from lower corners of the video. The staff conversation was unclear. -- At 4:09 AM Staff removed the urinal from in front of the camera and left the resident's room. Resident #1was lying in bed with sheets covering him and the room was straightened. -- At 4:20 AM Resident #1's family entered his room with LVN A and female staff. Interview on [DATE] at 10:34 AM with the Interim DON revealed LVN A was terminated due to failure to document the resident's assessment into the Medical Assessment Records (MARs) for the treatment provided. LVN A was terminated on [DATE]. She stated nursing staff should stay with a resident during a nebulizer treatment to monitor the resident. The Interim DON stated that facility policy did not state that staff had to stay in the room with the resident, but facility trained staff to stay and monitor the resident before, during and after treatment. Review of LVN A personnel file revealed Employee Coaching and Counseling Records that reflected the following: On [DATE] revealed Violation of Substandard Work and Suspended for failure to document with employee remarks stating breathing tx (treatment) was given to my patient and I wasn't sure for how long, and it was a PRN tx given to him. Approximately ,[DATE] min. There were lights going off on the hall and across from him. Nurse went to answer and came back noted resident removed mask and was not responding. On [DATE] revealed LVN A's remarks reflected, It was an emergency situation and I was coming back to document every care provided to this patient. A message for was left for Resident #1's Hospice nurse on [DATE] at 2:17 PM but no return call was received. A message was left for Resident #1's primary care provider on [DATE] at 9:53 AM but no return call was received. Review of Resident #1's Record of Death, undated revealed Resident #1 expired on [DATE] at 3:35 AM with LVN A present at time of death. The physician was notified on [DATE] at 3:40 AM. Remarks on record revealed hospice nurse was at facility and did all the notifications. 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 treatment protocol and appropriate monitoring with licensed nursing staff. -- The DON and ADON are conducting competency testing, in-servicing and skills checks related to facility nebulizer treatment protocol related to training provided by Registered Respiratory Therapist with licensed nursing staff. The training included appropriate monitoring of nebulizer treatment which revealed monitoring for side effects such as nervousness, [MEDICATION NAME], hypoventilation/hyperventilation, infection and [MEDICAL CONDITION] Process also included monitor heart rate, respiratory rate, and breath sounds before during and after treatment. -- All current orders of residents receiving nebulizer treatments have been assessed for physical monitors such as heart rate, respiratory rate, breath sounds and O2 saturation. Review of Personnel Status Form for LVN A revealed a termination date of [DATE] for failure to document accordingly. LVN A's last day worked was [DATE]. Administrator signed form on [DATE]. Interview with the facility's Medical Director on [DATE] at 2:53 PM revealed the facility made him aware of the IJ on the evening of [DATE] at 8:30 PM. He stated that he was not the primary care provider for Resident #1 and was unfamiliar with his care situation. The Medical Director stated that the IJ most likely occurred because the nurse had provided a nebulizer treatment and did not return to assess the resident. Medical Director revealed that the IJ could have been avoided by retraining the staff and monitoring and assessing the residents. During an interview on [DATE] at 3:46 PM, the Administrator revealed I think it (IJ) occurred because we weren't following policies and procedure of nebulizer treatments. The Administrator revealed that to prevent the reoccurrence of the IJ the facility had done extensive training. She stated she had a Registered Respiratory Therapist come and provide comprehensive training on nebulizer treatments and had staff do return demonstrations. The Administrator revealed they reviewed the facility's policies and procedures to make sure everyone understood what was expected. Interview with the Interim DON on [DATE] at 4:48 PM revealed the IJ occurred because of the nurse's actions and the facility was unaware of the situation. She stated the facility was providing in-services to all nurses to prevent a reoccurrence. She stated no nurse would be working the floor without taking the training for nebulizer treatments. The Interim DON revealed the training could be provided by the respiratory therapist, DON or ADON (managers). She stated the Respiratory Therapist would also do quarterly assessments with staff. She revealed she would prefer that the nurse not leave a resident during the nebulizer treatment. She stated there are two nurses were on a unit at all times. During interview with Unit Manager on [DATE] at 10:12 AM revealed the IJ occurred due to staff's carelessness. The Unit Manager stated that to prevent the reoccurrence of the incident, the facility was conducting in-services, talking to staff about skills, covering check off lists by reviewing treatment process and reviewing protocols that staff needed to follow 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 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 2:00 PM; Unit 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; LVNs F and G who worked the 10:00 PM to 6:00 AM shift; and LVN I who worked as needed, revealed that nursing staff received nebulizer training from Respiratory therapist and return demonstration was required for all nursing staff. Staff stated that pulse, respiratory rate, lung sounds, and oxygen saturation needed to be assessed before, during and after each nebulizer treatment. Staff revealed that residents need to be monitored for side effects such as nervousness, [MEDICATION NAME] and [MEDICAL CONDITION] Nursing staff stated that residents need to be observed throughout entire treatment process. On [DATE] the IJ was removed. On [DATE] at 3:52 PM the Administrator, Regional Nurse Consultant, Interim DON and Unit Manager were informed the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not an IJ and a scope of isolated because the facility was continuing to in-service staff and monitor the effectiveness of the Plan of Removal. The Interim DON provided a list on [DATE] of 9 residents who received nebulizer treatments.

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F 0607 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 5)
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #1) of 10 residents reviewed for care and treatment. LVN A failed to monitor and assess Resident #1, who had [MEDICAL CONDITION], during and after a breathing treatment and failed to put his oxygen, which he needed at 5 LPM, back on him for approximately three hours. The resident was unattended and experienced respiratory distress, became unresponsive, and subsequently expired in the facility. An Immediate Jeopardy was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy, and a scope of isolated because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. This failure could affect the 9 residents receiving nebulizer treatments by placing them at risk for respiratory distress, lack of medical treatment, improper medical treatment, and death. Findings included: Review of Resident #1's face sheet, dated [DATE] reflected a [AGE] year-old male, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He had an advance directive for do not resuscitate. Review of Resident #1's MDS assessment dated [DATE] reflected he had moderately impaired cognition with no behaviors. He needed assistance of one to two staff with his activities of daily living (ADLs). The resident had shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring), shortness of breath or trouble breathing when sitting at rest, and shortness of breath or trouble breathing when lying flat. Resident #1 was always continent if urine and occasionally incontinent of bowel. Review of Resident #1's Care Plan Report with a date range of [DATE] to [DATE] reflected, resident has potential for ineffective airway exchange and infection related to [DIAGNOSES REDACTED].Administer [MEDICATION NAME][MEDICATION NAME], aerosol treatments, nebulizers, and oxygen as ordered and monitor status, administer medications as ordered and monitor for side effects for [MEDICAL CONDITION] . The Care plan revealed Resident #1 required hospice as evidenced by terminal illness of [MEDICAL CONDITION]. Interventions are monitor for signs and symptoms of increased pain, discomfort-give medication and treatments, monitor for relief Review of Provider Progress Soap (subjective, objective, assessment, and plan) Note dated [DATE] revealed the chief complaint was shortness of breath without relief from present medical regimen. History of present illness was end stage lung disease of [MEDICAL CONDITION] with severe anxiety not responsive to present dosage of medication. Overall assessment and plan revealed conference with resident and resident's family who requested hospice for end of life care. Provider Progress Soap Note dated [DATE] overall assessment and plan revealed that resident had hypoxic [MEDICAL CONDITION] (failure to maintain adequate blood oxygen level) with oxygen dependence. Review of Resident #1's (MONTH) (YEAR) Physician order [REDACTED]. -- Keep saturation at or greater than 91%, monitor with pulse oximetry; by shift; order date [DATE] -- Oxygen 5L/min with humidification; order date [DATE] (Providers Progress Note dated [DATE] reflected continue with oxygen OER (Oxygen Enhancement Ratio) NC (nasal cannula) but maintain saturation at goal of ,[DATE]%). -- [MEDICATION NAME]-[MEDICATION NAME] 0.5mg-3mg (2.5mg base)/3mL nebulization solution (1 vial) ampul (sealed glass bottle with premeasured medication) for nebulization (ml) inhalation; as needed every four hours; physical monitor - breath sounds/Pulse/ Pulse Oximetry/Respiration; order date [DATE] -- Incruse Ellipta 62.5 mcg/actuation powder for inhalation (1 puff) with inhalation device; one time daily; order date [DATE] -- [MEDICATION NAME] (anti-[MEDICAL CONDITION]) 10 mg 1 tablet once daily; order date [DATE] -- Post respiratory nebulizer treatment: physical monitor - minutes for treatment/pulse/pulse oximetry/respiration; as needed, order date [DATE] Review of the Nurses' Notes for Resident #1 revealed the following: -- On [DATE] at 9:39 PM: Resident is admitted to hospice care service today, with . No new medication and all previous medication remain as ordered. Breathing treatment given as ordered, as needed every 4 hours. Resident continued to request for treatment more than ordered. Responsible party notified. Resident is not in acute distress at this time. Entered by LVN D. -- On [DATE] at 3:30 AM: Resident noted unresponsive and no pulse by the side of his bed. Hospice nurse made aware, called placed to resident's daughter (name) and call placed to MD (Medical Doctor), nursing awaits call back. Note was entered by LVN A. -- On ,[DATE] at 4:48 AM: Resident family and Hospice nurse at bedside. Note was entered by LVN A Telephone interview with LVN A on [DATE] at 11:07 AM revealed that she gave Resident #1 a PRN breathing treatment during the morning of [DATE] (she could not recall exactly what time) and did not remember if she used a mask or mouthpiece. She stated that the resident had both. LVN A stated that Resident #1 requested the breathing treatment. She stated this happened a long time ago and she did not remember everything that happened that day. LVN A stated she assessed the resident before she provided the treatment. She stated she removed Resident #1's nasal cannula (device used to deliver supplemental oxygen or airflow to a patient or person in need of respiratory help), to administer the breathing treatment. She revealed she stayed in the resident's room during the nebulizer treatment, but lights in the hall were going off close by and across the hall from the resident's room so she left to answer them. LVN A stated she could not remember exactly how long she was gone but returned after the treatment was done. She said when she returned to Resident #1's room, she found him unresponsive. She stated she repositioned him back into bed and placed his oxygen back on him, and no pulse was found. LVN A stated she then left the room to get help with resident. LVN A revealed the aide got the other nurse working in hall that morning. She stated she reassessed the resident when she returned to resident's room and no pulse was found. LVN A revealed she found Resident #1 with his legs off the bed with the head of bed elevated and his head over towards the side rails. She revealed she then contacted hospice, the doctor and family. She stated she only gave him the one treatment that night. LVN A stated she was aware that resident had an electronic monitoring sign posted outside his room but was not sure it was recording. When revealed to LVN the length of time the video showed she was gone, LVNA stated she did not think she was gone that long. Review of Resident #1's (MONTH) (YEAR) MAR indicated [REDACTED]. Observation on [DATE] at 1:30 PM of the motioned activated in room video surveillance recording for the morning of [DATE] between the time of 12:27 AM to 3:35 PM (approximately 3 hours timeframe) provided by Resident #1's family revealed the following: -- At 12:27 AM Resident #1 sitting on the side of the bed with the head of the bed elevated and the bedside table in front of him. There were several items on the bedside table obstructing complete view of the resident. His television was on. A female staff entered Resident #1's room and asked him what he needed. It was unclear what the resident said due to television noises. She stated the nurse? Okay and left room. -- At 12:29 AM A female staff returned to his room, applied gloves and gathered trash off his bedside table and picked up the trash can and left the room. She returned a short time later and put the trash can back and walked to the bathroom. As she walked towards the restroom, she told Resident #1 she got your breathing treatment and then LVN A entered the room. LVNA applied gloves, retrieved the nebulizer mask from the bed and applied the medication to the mask portal. At 12:31 AM, she removed the resident's nasal cannula and applied the breathing treatment mask over the resident's nose and mouth. She then turned on the nebulizer and mist came from the mask. -- At 12:33 AM, LVN A was still in the room, moving things around and making sure the nebulizer treatment was going. She then walked out the door. -- At 1:25 AM Resident #1 was lying his head on his bedside table in front of him. He had a difficult time lifting his head off the table. The table slid to the side as the resident pushed off it. He was not wearing his nasal cannula, so he was

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) not receiving oxygen at 5LPM. No staff entered the room during this video. -- At 1:30 AM the resident was still sitting on the bedside, with arms on table and head hanging over arms. The strap from the nebulizer mask was on his cheeks and around toward the back of his head. He was moving his head from the bedside table to lean towards the bed, appeared to be saying help several times but hard to hear clearly over the television sounds. He was not wearing his nasal cannula, so he was not receiving oxygen at 5 LPM No staff entered his room during this video. Length of this video was 3:09 minutes. -- At 1:34 AM Resident #1 was more upright, the nebulizer mask was on his face. He was leaning into the bedside table and rocking the table slightly. A box with items in it fell off the bedside table and hit the floor with a noticeable noise. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. -- At 1:49 AM Resident #1 was still wearing his nebulizer mask. He sat up and then leaned/fell back on his bed, lying across the bed. He was able to sit back up after a few moments. He then fell back across his bed again. His breaths were short and deep. His whole chest moved with each breath taken. He sat back up and leaned over the bedside table again. His head appeared to slip off the table and could can be seen hanging between his legs under the table. He lifted his head and then dropped it again between his legs several times. At one point, he sat upright and tried to say something, or took open mouth breaths (sounds unclear). He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered his room, video length is 3:06 minutes. - - At 1:52 AM, 1:59 AM and 2:03 AM: Resident #1 slumped over his bedside table and leaning toward the head of bed. He was moving his head around during these videos. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered his room during any of these videos. -- At 2:07 AM Resident #1 said help me and help several times. At 1:31 minutes into the video, he hit his bedside table with his fist several times. At the end of the video, he leaned over his legs with his right arm on the bedside table. He was not wearing his nasal cannula, so he was not receiving oxygen at 5LPM. No staff entered the room during this video. Video length was 2:32 minutes. -- At 3:35 AM Resident #1 slumped over his legs on the side of the bedside table. His back showed no signs of movement. LVN A entered his room applying gloves and there was another female staff with her in the doorway. LVN A moved the bedside table aside and called out sir. She lifted his right arm, and there was no response from the Resident #1. The female staff stood to the side observing the nurse. 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Interview on [DATE] at 10:34 AM with the Interim DON revealed LVN A was terminated due to failure to document the resident's assessment into the Medical Assessment Records (MARs) for the treatment provided. LVN A was terminated on [DATE]. She stated nursing staff should stay with a resident during a nebulizer treatment to monitor the resident. The Interim DON stated that facility policy did not state that staff had to stay in the room with the resident, but facility trained staff to stay and monitor the resident before, during and after treatment. Review of LVN A personnel file revealed Employee Coaching and Counseling Records that reflected the following: On [DATE] revealed violation of substandard work and suspended for failure to document with employee remarks stating breathing tx (treatment) was given to my patient and I wasn't sure for how long, and it was a PRN tx given to him. Approximately ,[DATE] min. There were lights going off on the hall and across from him. Nurse went to answer and came back noted resident removed mask and was not responding. On [DATE] revealed LVN A's remarks reflected, It was an emergency situation and I was coming back to document every care provided to this patient. A message for was left for Resident #1's Hospice nurse on [DATE] at 2:17 PM but no return call was received. A message was left for Resident #1's primary care provider on [DATE] at 9:53 AM but no return call was received. Review of Resident #1's Record of Death, undated revealed Resident #1 expired on [DATE] at 3:35 AM with LVN A present at time of death. The physician was notified on [DATE] at 3:40 AM. Remarks on record revealed hospice nurse was at facility and did all the notifications. Review of the facility's current policy and procedure on Nebulizer Treatment, dated [DATE] and provided by the Interim DON on [DATE] at 2:20 PM reflected: - Administer therapy until medication is depleted, treatment require a minimum of 15 minutes. (Drug.com website: https://www.drugs.com/dosage/[MEDICATION NAME].html revealed usual adult dose for [MEDICAL CONDITION] - Acute . Nebulizer inhalation solution: -2.5 mg three or four times a day by nebulization, over approximately 5 to 15 minutes) - Monitor patient for side effects of treatment (a) Nervousness, (b) [MEDICATION NAME], (c) Hypoventilation/Hyperventilation, (d) Infection, (e) [MEDICAL CONDITION]/>- Monitor heart rate, respiratory rate, and breath sounds before, during and after treatment - Instruct the patient to take slow deep breaths - When treatment is completed instruct the patient to take deep breath and cough, observing the nature of the cough and any sputum produced . - Document treatment in patient's chart . - Documentation: Date and time of treatment, type of treatment ., equipment used for the treatment, duration of the treatment, breath sounds before and after treatment, heart rate and respiratory rate before, during and after treatment . 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 treatment protocol and appropriate monitoring with licensed nursing staff. -- The DON and ADON are conducting competency testing, in-servicing and skills checks related to facility nebulizer treatment protocol related to training provided by Registered Respiratory Therapist with licensed nursing staff. The training included appropriate monitoring of nebulizer treatment which revealed monitoring for side effects such as nervousness, [MEDICATION NAME], hypoventilation/hyperventilation, infection and [MEDICAL CONDITION] Process also included monitor heart rate, respiratory rate, and breath sounds before during and after treatment. -- All current orders of residents receiving nebulizer treatments have been assessed for physical monitors such as heart rate, respiratory rate, breath sounds and O2 saturation. Review of Personnel Status Form for LVN A revealed a termination date of [DATE] for failure to document accordingly. LVN A's last day worked was [DATE]. Administrator signed form on [DATE]. Interview with the facility's Medical Director on [DATE] at 2:53 PM revealed the facility made him aware of the IJ on the evening of [DATE] at 8:30 PM. He stated that he was not the primary care provider for Resident #1 and was unfamiliar with his care situation. The Medical Director stated that the IJ most likely occurred because the nurse had provided a nebulizer treatment and did not return to assess the resident. Medical Director revealed that the IJ could have been avoided by retraining the staff and monitoring and assessing the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676422	A. BUILDING _____ B. WING _____	04/25/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALOMINO PLACE	3160 GUS THOMASSON ROAD MESQUITE, TX 75150

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 7) During an interview on [DATE] at 3:46 PM, the Administrator revealed I think it (IJ) occurred because we weren't following policies and procedure of nebulizer treatments. The Administrator revealed that to prevent the reoccurrence of the IJ the facility had done extensive training. She stated she had a Registered Respiratory Therapist come and provide comprehensive training on nebulizer treatments and had staff do return demonstrations. The Administrator revealed they reviewed the facility's policies and procedures to make sure everyone understood what was expected. Interview with the Interim DON on [DATE] at 4:48 PM revealed the IJ occurred because of the nurse's actions and the facility was unaware of the situation. She stated the facility was providing in-services to all nurses to prevent a reoccurrence. She stated no nurse would be working the floor without taking the training for nebulizer treatments. The Interim DON revealed the training could be provided by the respiratory therapist, DON or ADON (managers). She stated the Respiratory Therapist would also do quarterly assessments with staff. She revealed she would prefer that the nurse not leave a resident during the nebulizer treatment. She stated there are two nurses were on a unit at all times. During interview with Unit Manager on [DATE] at 10:12 AM revealed the IJ occurred due to staff's carelessness. The Unit Manager stated that to prevent the reoccurrence of the incident, the facility was conducting in-services, talking to staff about skills, covering check off lists by reviewing treatment process and reviewing protocols that staff needed to follow 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 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 2:00 PM; Unit 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; LVNs F and G who worked the 10:00 PM to 6:00 AM shift; and LVN I who worked as needed, revealed that nursing staff received nebulizer training from Respiratory therapist and return demonstration was required for all nursing staff. Staff stated that pulse, respiratory rate, lung sounds, and oxygen saturation needed to be assessed before, during and after each nebulizer treatment. Staff revealed that residents need to be monitored for side effects such as nervousness, [MEDICATION NAME] and [MEDICAL CONDITION] Nursing staff stated that residents need to be observed throughout entire treatment process. On [DATE] the IJ was removed. On [DATE] at 3:52 PM the Administrator, Regional Nurse Consultant, Interim DON and Unit Manager were informed the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not an IJ and a scope of isolated because the facility was continuing to in-service staff and monitor the effectiveness of the Plan of Removal. The Interim DON provided a list on [DATE] of 9 residents who received nebulizer treatments.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on interview and record review, the facility failed to designate a registered nurse to serve as the director of nursing on a full-time basis. The facility failed to have an RN Director of Nurses (DON) for more than one month. This failure could affect all 86 residents by placing them at risk for not receiving necessary care and services. Findings included: On 04/04/18, 04/20/18 and 04/24/18 the Administrator provided a Key Personnel list which revealed the Interim DON was an LVN/GN (graduate nurse). The interim DON was a Licensed Vocational Nurse that recently graduated and is due to test for her Registered Nurse license. On 04/23/18 at 6:30 PM, RN D called the Interim DON and handed the telephone to the surveyor. She identified herself and confirmed she was the DON. An interview with the Administrator, Regional Consultant E and Regional Consultant F on 04/24/18 at 11:39 AM revealed the previous DON left the facility over 30 days ago. The Administrator stated the Interim DON was a graduate nurse waiting to test and that the Unit Manager, RN was the acting DON for the facility. Regional Consultant E stated that the Unit Manager, RN was the DON and the Interim DON was the ADON. When asked why the Interim DON was on the Key Personnel list received from the facility on 04/20/18 and on 04/24/18 as the Interim, DON and the Unit Manager, RN had no identifier by her name. Regional Consultant E responded he was not aware that the Interim DON was on the list as the Interim DON. The Administrator stated that they got a little ahead of themselves and that they are going to offer the Interim DON the DON position as soon as she tests. Stated the Interim DON was waiting until after the annual survey to take some time off and get ready for the test. The Administrator stated Unit Manager, RN was being paid an additional stipend for acting as the DON. Review of the Interim DON's employee file revealed she was a Licensed Vocational Nurse. A document in her file revealed an email from HR (Human Resources)/Payroll Coordinator to Regional Consultant E on 04/04/18 at 12:13 PM reflected I need your approval for (Interim DON) off cycle pay increase. She was promoted to Interim DON on 03/05/18 when (previous DON) left. Regional Consultant E's reply at 1:12 PM reflected this transaction was approved. On 04/24/18 at 12:00 PM the Administrator provided a written document dated 04/02/18 which indicated that Unit Manager, RN was an Interim DON with a start date of 04/02/18. The Administrator stated at that time that the previous DON left the facility and facility was actively looking for new DON. The Administrator revealed when they realized that it was not getting the position filled soon enough, they gave Unit Manager, RN the Interim DON position. The Administrator stated the facility had not handled the situation of the DON change well and had not presented it to the staff effectively. The Unit Manager RN was present during this interview but did not comment. On 04/25/18 at 3:13 PM interview with Administrator revealed that facility does not have policy and procedure for DON requirements. Stated facility follows guidelines provided by the state. The facility's 04/20/18 Census provided by the Administrator documented a census of 86 residents.