STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26218 Based on record review and interviews, the facility failed to ensure that all alleged violations involving abuse, neglect, and including injuries of unknown source are reported immediately, but not later than 2 hours after the allegation is made, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for add extent reviewed for abuse and neglect for 1 of 3, (CR #1) residents reviewed for reporting of alleged violations. The facility failed to notify the State Agency when CR #1, who was tracheostomy/ventilator dependent, was found non-responsive on [DATE] with circuitry for the ventilator disconnected. This failure affected one deceased resident, for which an investigation by the State Agency was not initiated within the required time parameters and placed other residents of abuse, neglect or victims of unknown injuries at risk of the abuse or neglect not being addressed in a timely manner or not at all. Findings Include: Record review of CR#1's clinical records including the face sheet, progress notes, nursing notes, assessments and MDS, revealed the [AGE] year-old female resident was readmitted to the facility on [DATE] and expired at the facility on [DATE]. The record review of the entire clinical chart, revealed CR #1 had the following diagnoses: acute respiratory failure, chronic respiratory failure with hypoxia, persistent vegetative state, The review further revealed CR #1 was completely oxygen dependent on her ventilator and was dependent on renal dialysis. CR #1 did not have the use of her arms and was dependent on staff for all her needs. Record review of CR #1's significant change MDS dated [DATE] revealed that she required extensive assistance and was a total assist with bed mobility and transfers. CR #1 was also ventilator dependent for oxygen . Additionally, a BIMS score could not be obtained as the resident had no expressive language capacity. Record review of care plans dated [DATE] revealed CR # 1 was care planned for hemodialysis, use of a ventilator and for her tracheostomy. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone Interview on [DATE] at 3:47 PM LPN N stated on [DATE], CR #1 returned from dialysis around 11:30 PM to 12:00 PM. She said CR #1 was in the Geri chair when she checked upon return to her room from dialysis. CR #1's respirations and breath sounds were normal, her vital signs were normal and the ventilator circuitry was intact. LPN N said the RT told her CR #1 had difficulty breathing but LPN N did not agree. She said the RT gave her breathing treatments and it took maybe ,d+[DATE]mins to complete the treatment. LPN N said she returned after breathing treatment was completed. CR #1 was not in any distress and her vital signs were WNL. LPN N said she returned in about one hour at change of shift. She said she gave CR #1 meds at 2:00 or 2:15 PM. She said CR #1 was looking good and ventilator tubing was connected to CR #1. CR #1 was put to bed by the aids around 1:45 PM. LPN N returned to check on CR #1 at around 3:00 PM and she was not in any distress. She knew CR #1 was connected to the ventilator because the machine was not alarming. At 3:30 PM, LPN N went to the nurse station to chart. She said she saw the RT lady was doing her rounds then the RT came out to the hall and said to call a code. In an interview on [DATE] at 5:00 PM RT G said she saw CR #1 when she returned from dialysis and she was in a was in a neuro chair (Geri chair) and not in the bed. She said CR #1 was in mild distress. RT G gave her a breathing treatment and suctioned a moderate amount of pale colored secretions. There was nothing outstanding about the secretions. RT G noticed the ventilator circuit/tubing from the resident's trach was twisted and she untwisted it. The ventilator was on CR #1's left side and she wanted the circuit to be more in a straight line. After procedure CR #1 settled. She said the nurse came in the room after end of suctioning. RT G returned around 4:00 PM to do a check. The machine was alarming, the resident was in bed. The circuit was disconnected at the junction where the 5-inch flex tubing connects to the HME (heat and moisture exchange device). The circuit was laying across CR #1's chest. RT G re-connected the circuit and pressed reset button on ventilator. Then checked for a pulse and there was none. RT G then called for help and began CPR using the Ambu bag. In an Interview on [DATE] at 1:43 PM with CNA S, stated she heard RT G yell outside of CR #1's room and told her to call a code around 4:00 PM. The DON and all the nurses came. Everyone performed CPR. 911 arrived in 10 minutes. CPR was 20 minutes tops. CNA S stated she did the post-mortem care. In an interview on [DATE] at 10:15 AM with the Director of Respiratory Services revealed that it was quite difficult to separate the circuitry at the junction of the Heat Mechanism Exchange. He brought sample circuitry with him and demonstrated how one has to forcefully twist the tubing in order to separate the tubing. In an interview on [DATE] at 1:09 PM, the Director of Respiratory Services stated based on CR #1's diagnosis and history she could not breathe without the ventilator compared to other residents. It would not take long for CR #1 to stop breathing. CR #1 would desaturate (low blood oxygen concentration) rapidly. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the RDO, (Regional Director of Operations), revealed she was not aware of the incident when it occurred. She reported she learned from the CEO of the Corporation on [DATE] that he had been notified by text of the departures of the previous RDO, the DON, (Director of Nursing) and ADON, (Assistant Director of Nursing) all who had suddenly resigned. As the Administrative staff were no longer employed at the facility she came to the facility to oversee day to day operations. When she learned of the incident upon her arrival at the facility, she and other corporate staff initiated an investigation on [DATE], which included an immediate QUAPI meeting as part of their investigation. The investigation resulted in findings not being able to be determined. She stated she was focused on ensuring the investigation was initiated and carried out and consequently they overlooked their obligations of notifying the State Agency. She stated she understood the facility should have reported the incident to the State Agency and that it was overlooked. Record review of the facility's policy Abuse, Neglect and Exploitation. The document read in part, .Reporting Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the RDO state agency, adult protective services and to all other agencies (e.g. law enforcement when applicable) within specified time frames: a. Immediately, but not later than 2 hours after the allegation is, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26218 Based on record review and interview, the facility failed to ensure residents received respiratory treatment and care in accordance with professional standards of practice for 2 of 15 residents (CR#1 and CR #2) reviewed for respiratory, tracheostomy care and suctioning as evidenced by: The facility failed to ensure that the ventilator circuit for CR#1's ventilator, remained intact and connected. The facility failed to ensure CR #2's oxygen saturation rates were monitored during ventilator checks. These failures placed facility residents who are dependent on ventilators at risk of hypoxemia, hospitalization , and death. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was lowered on [DATE], the facility remained out of compliance at a scope of a pattern and severity of actual harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures placed facility residents receiving respiratory treatment and care at risk of harm including death. Findings include: Findings include: CR #1 Record review of CR #1's face sheet revealed the [AGE] year-old female resident was readmitted to the facility on [DATE] and expired at the facility on [DATE]. Record review of CR #1's face sheet had the following diagnoses: acute respiratory failure, chronic respiratory failure with hypoxia, persistent vegetative state, diabetes, dysphagia, aphasia, and gastronomy . The review further revealed CR #1 was completely oxygen dependent on her ventilator and was dependent on renal dialysis. The review further revealed CR #1 did not have the use of her arms and was dependent on staff for all her needs. Record review of CR#1's significant change MDS dated [DATE] revealed she required extensive assistance and was a total assist with bed mobility and transfers. Additionally, a BIMS score could not be obtained as the resident had no expressive language capacity. The MDS also revealed CR #1 was ventilator dependent. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of care plans dated [DATE] revealed CR # 1 was care planned for hemodialysis, use of a ventilator and for her tracheostomy. Interventions included mechanical ventilation .keep SP 02 sat > 92% . observe document respiratory rate, depth and quality. Check and document q shift as ordered. Suction as necessary. In a telephone Interview on [DATE] at 3:47 PM LPN N stated on [DATE], CR #1 returned from dialysis around 11:30 PM to 12:00 PM. She said CR #1 was in the Geri chair when she checked upon return to her room from dialysis. CR #1's respirations and breath sounds were normal; her vital signs were normal, and the ventilator circuitry was intact. LPN N said the RT G told her CR #1 had difficulty breathing but LPN N did not agree. She said RT G gave her breathing treatments and it took maybe ,d+[DATE]mins to complete the treatment. LPN N said she returned after breathing treatment was completed. CR #1 was not in any distress and her vital signs were WNL. LPN N said she returned in about one hour at change of shift. She said she gave CR #1 meds at 2:00 or 2:15 PM. She said CR #1 was looking good and ventilator tubing was connected to CR #1. CR #1 was put to bed by the aids around 1:45 PM. She told the CNAs to do this. LPN N returned to check on CR #1 at around 3:00 PM and she was not in any distress. She knew CR #1 was connected to the ventilator because the machine was not alarming. At 3:30 PM, LPN N went to the nurse station to chart. She said she saw the RT lady was doing her rounds then the RT came out to the hall and said to call a code. In an Interview on [DATE] at 1:43 PM with CNA S, she stated she had worked at the facility for 2 years and worked on [DATE]. On [DATE] , at approximately 4:00 PM, CNA S stated she heard RT G yell outside of CR #1's room. RT G at that time instructed CNAS to call the code. The DON and all the nurses came. Everyone performed CPR. 911 arrived in 10 minutes. She stated CPR was approximately 20 minutes in duration. CNA S stated she did the post-mortem care. CNA S stated she had worked with CR #1 before and described her as unable to self-turn, had a colostomy bag, was on dialysis, was an amputee and never responded to anything. She stated she had never seen CR #1 in distress. Most of the time she was asleep and never saw her awake. She did not have contractures and had never seen CR #1 with a gag reflex when turning or changing. The only way to knew she needed suctioning was hearing the gurgling sounds. In an interview on [DATE] at 5:00 PM RT G said she saw CR #1 when she returned from dialysis and she was in a neuro chair (Geri chair) and not in the bed. She said CR #1 was in mild distress. RT G gave her a breathing treatment and suctioned a moderate amount of pale colored secretions. There was nothing outstanding about the secretions. RT G noticed the ventilator circuit/tubing from the resident's trach was twisted and she untwisted it. The ventilator was on CR #1's left side and she wanted the circuit to be more in a straight line. After procedure CR #1 settled. She said the nurse came in the room after end of suctioning. RT G returned around 4:00 PM to do a check. The machine was alarming, the resident was in bed. The circuit was disconnected at the junction where the 5-inch flex tubing connects to the HME (heat and moisture exchange device). The circuit was laying across CR #1's chest. RT G re-connected the circuit and pressed reset button on ventilator. Then checked for a pulse and there was none. RT G then called for help and began CPR using the Ambu bag (bag valve mask used for manual resuscitation). (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 9:40 AM, RT G said she did vent checks on [DATE] at 11:40 AM for CR #1 and at 1:10 PM (as documented on the flow sheet). She said CR #1 was still in the Geri chair at the time. She thinks CR #1 was in distress at the time because the circuit was twisted, and this was when she straightened it out and left CR #1 in stable condition. When she returned at 4:00 PM the back of the ventilator was facing the door, when usually the front of ventilator faces the door, alarms were audible, circuit was laying across her chest as if the ventilator was to her right side. The ventilator was on her left side. She stated CR #1 was not mobile and not able to move or use her hands. In a telephone interview on [DATE] at 10:49 AM, LPN N stated CR#1 was bedfast and not mobile. She stated she was aphasic and could not speak. LPN N said on [DATE] at 12:30 PM CR #1's ventilator was on her right side and that everything was on her right side. CR #1 was not in any distress; she was alert and did not notice any contractures. In an interview on [DATE] at 1:05 PM, CNA GG stated she had been at the facility for 3 months and worked 6:00 AM to 2:00 PM shift. She said she was at work when CR #1 passed away. She came in after 2:00 PM. CNA HH did rounds with CNA GG around 2:00 PM. CNA HH told her that CR #1's brief had been changed. CNA GG said during 2:00 PM rounds she observed CR #1 in bed, snoring and the ventilator was on the resident's left side (she did not provide care at this time). The concentrator and TF pump were also on the left side. The ventilator was in a diagonal position and the circuit tubing was draped over CR #1's left side towards the ventilator. The Geri chair was well away from the CR #1, the bed was in low position and the HOB was raised. In a telephone interview on [DATE] a confidential employee , who had been working with residents, stated, nurses were not trained for tracheostomies and ventilators and were uncomfortable working with them. There were issues with the RT department as well due to lack of training. The nurses were under the impression that all they needed to do was call the RT if needed. On [DATE] CR #1 was non-responsive, and they initiated a code blue. In a telephone interview on [DATE] at 7:20 PM, the Transporter who worked from [DATE] to [DATE]. CR #1's dialysis ended on [DATE] at 10:30 AM. CR #1 was transported back to her room by the transporter and a CNA. CR #1 was in the Geri chair, ventilator and oxygen concentrator was transported. The machines were plugged into wall outlets. The trach tubing remained connected before staff left the room. CR #1 was doing fine and was snoring. In an interview on [DATE] at 3:54 PM, CNA HH stated on [DATE] at 12:05 PM she and another CNA transferred CR #1 from chair to bed. By 2:00 PM CNA HH and second CNA did rounds and performed incontinent care for CR #1. CR #1 was turned towards the door, propping to left side using a wedge pillow. According to CNAHH, CR #1 appeared to be fine and in no distress. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 10:00 AM, the Treatment Nurse said she had worked at the facility for 90 days. She stated CR #1 was in bed and she cleaned CR #1's wounds on [DATE]. CR #1 had wounds to sacrum, elbow, left and right stumps and friction wounds to thigh/buttocks. She said she worked on the wounds before 2:00 PM. She said the WCT was assisting with the care. She said CR #1 was a hard turn, heavy, dead weight requiring 2 staff members one on each side of the bed. She said CR #1 has always been almost comatose, her arms were flaccid and could not move her own body. She said she had never seen CR #1 flinch. She said CR #1 did not have contractures, never moved her arms and never had facial grimaces. CR #1's eyes were open, and she was breathing fine. When turned to her right side, the treatment nurse was able to see all of CR #1's wounds. After care, CR #1 was turned towards the door and propped with a wedge pillow placed to upper back. The vent circuit was intact. The ventilator was on her left side with front of vent facing the door. In an interview [DATE] at 10:15 PM with the Director of Respiratory Services revealed it was quite difficult to separate the circuitry at the junction of the Heat Mechanism Exchange (HME). He demonstrated how one had to forcefully twist the circuitry in order to separate the tubing from the HME. In an interview on [DATE] at 1:09 PM, the Director of Respiratory Services stated based on CR #1's diagnosis and history she could not breathe without the ventilator compared to other residents. It would not take long for CR #1 to stop breathing. He compared CR #1 to a more stable resident who was alert that he was using as an example. He said CR #1 would desaturate (low blood oxygen concentration) rapidly if off the ventilator. In a telephone interview on [DATE] at 2:20 PM with CR #1's physician, he stated he believed CR #1 could have disconnected the vent tubing by herself by moving around in bed. The physician was reminded of the fact that CR #1 was unable to move her arms and had one leg amputated. He stated, you would be surprised what these patients can do. He further stated he will get with the facility to utilize medications for residents on vents/trachs to prevent further incidents. Record review of progress notes written by RT G on [DATE], read, Patient summary: Patient on AC-PC 35, RR 18, Peep 5, 8L 02. Shiley 6 trach in place, trach care done. Neb Txs done x2. Suctioned for moderate, thick secretions. SAT 100%, HR 96, RR 23. Emergency equipment set up at bedside. Patient in NAD will continue to monitor. Record review of progress notes written by RT G on [DATE], read, Respiratory Note addendum: 1600[4PM] came into patient's room to perform vent check-found patient in bed disconnected from vent with vent alarming. Vent re-connected, patient assessed no pulse found. Code called and CPR initiated 1603[4:03PM]. EMS pronounced patient @ 1652[4:52PM]. Record review of CR #1's Ventilator Flow Sheet revealed CR #1 was checked by RT G on [DATE] at 6:30 AM, 10:30 AM, 11:40 AM and 1:10 PM. At these times the SpO2 was between 100% and 99% and oxygen was at 6 L/min. The next time RT G did rounds was 4:00 PM when she found resident disconnected from ventilator and without a pulse. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's progress note written by LPN N, effective date [DATE] at 11:51 AM and created on [DATE] at 9:12 PM read in part: During rounds upon arrival resident was in dialysis. At 11:30 AM Resident returned from dialysis awake, alert in Geri chair well connected with vent with all setting intact .oxygen 99%. Schedule medications administered via G tube tolerated well. RT was observed in resident room doing trach care suctioning. Per RT statement resident was having difficulty breathing, breathing treatment was administer per RT. In 15mins breathing treatment was in progress, no s/s of distress noted. 1:45PM, , d+[DATE]pm CNAs were observed putting residents back to bed while making their final round from room to room. 2 PM change of shift was done on coming CNA was observed walking from one hall to another checking residents. At 3:00 PM resident was observed in bed resting no signs of distress noted. At 4:03 PM a code was called for room [ROOM NUMBER]. Upon arrival to room [ROOM NUMBER] RT, DON and unit manager were performing CPR, 911 arrived in room and took over. At 4:52 PM 911 personnel pronounce resident dead. MD made aware family notified too. CR #2 Record review of CR #2's admission record revealed a [AGE] year-old male, admitted on [DATE]. The diagnoses included metabolic encephalopathy (disease affecting brain structure or function), traumatic brain injury, cerebral vascular disease, pleural effusion (excessive fluid surrounding the lungs), cognitive communication deficit, quadriplegia, end stage renal disease, dependence on dialysis, tracheostomy status and dependence on respiratory ventilator. Record review of CR #2's admission MDS dated [DATE] revealed he rarely or never made himself understood and rarely or never understood others. His cognitive skills for daily decision making were severely impaired. He required total assistance with two-person assist for bed mobility, transfers between surfaces, dressing and toilet use. He required total assistance with one person assist for eating and personal hygiene. Section O (special treatments, procedures, and programs) of the MDS revealed he was receiving oxygen therapy, suctioning, tracheostomy care and invasive mechanical ventilator while not a resident and while a resident. Record review of CR #2's care plan revealed Focus: Difficulty in understanding and making self-understood: date initiated [DATE]. Goal - CR #2's basic needs will be anticipated and met on a daily basis through the review date. Intervention - Anticipate and meet resident's needs. Responsible staff: nursing supervision and respiratory services. Focus - CR #2 has a tracheostomy and is at risk for potential complications such as weight loss, increased secretions, congestion, infection, and respiratory distress: date initiated [DATE]. Goal - CR #2 will have clear airways with adequate ventilation through the next review date. Interventions included in part: - provide oxygen, humidity, tracheostomy care, and tubing changes as indicated by physician's orders .Monitor and document respiratory rate, depth, and quality every shift or as ordered by the physician. Responsible staff: nursing supervisor and respiratory services. Record review of CR #2's physician orders revealed a verbal order for Midodrine 10mg give via PEG-tube every 6 hours as needed for hypotension, order date: [DATE]. (no BP parameters were included). Metoprolol Tartrate Tablet, give 12.5mg via G-Tube every 12 hours for HTN, hold if BP <110 or HR <60. A physician order revealed in part, Mechanical Ventilation every shift .titrate Oxygen to keep SpO2 (peripheral capillary oxygen saturation) greater than 92%, order date [DATE]. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #2's physician's visit note dated [DATE] read in part: .CR #2 was also seen and examined today to address concerns for abnormal chest x-ray results. Patient lab results show some abnormalities .Will continue to monitor closely due to changes in acuity of chronic diseases .chest x-ray results - pneumonia . In an interview on [DATE] at 10:49 AM, LPN N stated CR #2 had gone to in-house dialysis, returned without receiving dialysis because BP was too low. LPN N administered the Midodrine (on [DATE] at 8:00 AM. There were no BP parameters for the Midodrine in the physician orders). On [DATE] at 6:45PM LPN N said she reported to the oncoming nurse (RN C) about CR #2's change in condition. LPN N said report was given to RN C or another nurse (no longer working at the facility). LPN N returned the next day on [DATE] at 6:45 AM the day CR #2 expired. She said a CNA (whose name she did not recall) and RT A were in CR #2's room. RT A had begun CPR. CR #2 was connected to the ventilator. LPN N said during report from night shift, RN C did not mention any vital sign results during the night. LPN N said the nurses were responsible for checking BPs and round in the morning starting with checking vital signs. She said around 3:00 PM she would round again and check her resident's vital signs as this was her routine - and expectation of duties of the night nurse Record review of CR #2's MAR/TAR revealed that RN C did not work with CR #2 on [DATE] at 7:00 PM to [DATE] at 7:00 AM instead it was LPN Q who had signed the MAR/TAR with her initials confirming that she worked on [DATE] at 7:00 PM to [DATE] at 7:00 AM. In a telephone interview on [DATE] at 10:42 AM, LPN Q said she started working at the facility on, [DATE] and always works nights 7p - 7a shift. She said honestly, she could not remember taking care of CR #2 on [DATE] to [DATE]. She said she did not remember a time when any nurse told her about a resident who had a change in condition and had hypotension. LPN Q stated her duties were as follows: she said at the start of her shift she always made rounds and visually checked the residents. She said the electronic chart had alert pop ups, an alert signal, that notified her if vital signs are scheduled and that was how she knew to check. If vital signs are not scheduled and she sees a reason to, then she will take a set of vitals as she would need this information before contacting the doctor. She said she gets her information from verbal report with the day shift nurse and from the 24-hour report. She does her audits using the 24-hour report to see if there was anything missed during the verbal report. The 24-hour report will have what the previous nurse did and if there were any new physician orders. She said if she were ever told about a resident who was on a ventilator with cold extremities and the RT was unable to obtain a SpO2, that would be an alert for her indicating a change in condition for the resident. In an interview on [DATE] at 2:15 PM CNA X stated she found CR #2 non-responsive when she came on duty. RT A came when she called for help. They found CR #2 connected to the ventilator. When she came on duty the night shift did not provide any report regarding his condition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 11:35 AM, RT A said she had been working at the facility since 2017. She said on [DATE] she was able to get a pulse on CR #2 and his respirations were 24, but unable to obtain a SpO2. RT A said she did cover CR #2's hands with a blanket to help warm them up. She said she believed she told the nurse that she was unable to obtain a SpO2 on CR #2. She said CR #2 was non-responsive and had been this way since he had been in and out of the hospital maybe ,d+[DATE] times. RT A said it was normal practice to leave the resident if an SpO2 cannot be obtained, then return later. She said she suctioned CR #2, checked the ventilator settings, palpated for a heart rate at the antecubital (inner front surface of the forearm at the elbow) at obtained a pulse of 74 beats per minute. She said she explained to LPN G that there were no other changes. RT A said she tried to look at the rest of CR #2's body, his arms were cool, and hands were cold. She said he was covered with bed linen and typically RTs work with only the top part of a resident's body. She said she thinks his torso was neither hot nor cold, she could not remember. RT A said the nurse came and could not find a BP and this was when she knew there was a change in the resident's condition. In an interview on [DATE] at 11:45 AM, LPN G said she did not work with CR #2 on [DATE] because she did not work on the weekend. In an interview on [DATE] at 11:36 AM, the Director of Respiratory Services said he expects the RTs should tell the nurse and let them know that they were unable to obtain an oxygen saturation rate. If a resident was in any type of distress, we would want the nurse to call the MD. There may be a minute when you cannot obtain an oxygen saturation but there may be no apparent change in condition as well. He said he would try to get a second reading, tell the nurse, and see what the physician would want to do next or call the pulmonary director. If it was one of my therapists, I would tell them to address with the nurse. If unable to obtain an oxygen saturation twice in a row, the first thing to do would be to try and warm up the hands by putting them under cover. We do not have a P&P for care of ventilator residents, whatever the facility has was what we have. He said he was unfamiliar with CR #2. In an interview on [DATE] at 5:45 PM, RT G said she started working at the facility 70 days ago and she barely remembers working with CR #2. She said with a low BP she would not be able to get an oxygen saturation rate. Clinically, you can't get a saturation rate with low BPs. She said if still unable to obtain oxygen saturation, then she would probably suggest to the nurse that the resident should be sent out. In an interview on [DATE] at 12:50 PM, the interim DON said she started working at the facility on [DATE]. She said if the RT or the Nurse were unable to obtain an oxygen saturation rate for a resident on a ventilator and it's so low, they can't get a reading she expected they would need to contact the MD immediately for orders and let the MD say what to do next. She said they could try to warm up the fingers or try to get oxygen saturation on the toes. They can do an overall assessment, checking to see if the resident is turning blue or was pale and assess the pulse rate as well as obtaining a full set of vital signs to get a whole picture. They can also check capillary refill. Record review of change in condition form dated [DATE] at 8:04 AM, written by LPN N revealed CR #2 didn't get dialysis due to low BP of ,d+[DATE]. PRN Midodrine 10mg was administered. The physician was notified, and the recommendations were to monitor blood pressure, transfer out if blood pressure continued to be low. Blood pressures recheck was ,d+[DATE] (no time noted), no distress noted on assessment and MD made aware. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #2's progress note written by RT G on [DATE] at 2:09 PM read in part: .Patient Summary: .9L O2. Shiley 8 trach in place, trach care done. Neb tx done x 1. Suctioned for moderate, thick secretions .Patient returned early from dialysis due to low BP. Could not obtain SATs on patient initially. When SATs were able to be obtained resident was ,d+[DATE]%, HR 67, RR 22. NAD (no apparent distress) noted. Will continue to monitor. Record review of CR #2's ventilator flow sheet entry by RT N revealed on [DATE] at 7:35 PM CR #2's SpO2 was 95%, at 10:45 PM it was 97%, on [DATE] at 1:15 AM it was 97%, at 5:30 AM it was 97% and at 6:50 AM RT A wrote too cold. The oxygen flow rate remained unchanged at 9L/min during all the checks. RT A wrote a note on the flow sheet. It read in part: Unable to measure pulse ox too cold/poor circulation due to shunt in both arms. 9:15 AM nurse called RT to resident room. No pulse, no BP, no respirations, CPR started . Record review of CR #2's MAR/TAR for [DATE] revealed on [DATE], Metoprolol 12.5 mg was ordered to be given at 6:00 AM. There were no indications Metoprolol was either given or held and there were no BP results documented. There was no indication that Midodrine was given as needed for hypotension. Record review of CR #2's progress note written by RT A on [DATE] at 7:30 AM read in part: .resident remained on a ventilator. Unable to measure pulse oximetry due to cold extremities, HR 70, RR 24. Treatment given as ordered. Will continue to monitor resident. Record review of CR #2's progress note written by RT A on [DATE] at 8:45 AM read in part: .Unable to measure O2 sat, due to hands being too cool, poor circulation in fingers, and dialysis shunts. Heart rate 70, RR 24. Treatment given as ordered. Will continue to monitor resident. Will continue to attempt to measure O2 Sat. Record review of CR #2's progress note written by LPN N on [DATE] at 9:10 AM read in part .at 9:15 AM this writer was called to resident room by the CNA to come quickly and assess resident, upon arrival resident was observed with no pulse no blood pressure. Code blue was called, CPR initiated, 911 called. 911 arrived and took over resident was pronounced at 9:29 AM . Record review of facility policy titled Tracheostomy Care dated [DATE] read in part: .Policy: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences . Record review of the facility's undated policy entitled, Oxygen Administration, read in part .4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system. B. When to administer, such as continuous or intermittent and/or when to discontinue. C. Equipment setting for the prescribed blood flow rates. D. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. E. Monitoring for complications associated with the use of oxygen . Record review of facility policy titled Notification of Changes dated [DATE] read in part: .Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification; .2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility's Resident Admission Agreement, revised on [DATE] read in part: .Upon such admission, the Resident and Resident Representative herby consent to such routine care and treatment as may be provided by the Facility, .or ordered by the Resident's attending physician (the Attending Physician) in accordance with the Resident's plan of care . An I.J. (Immediate Jeopardy) was identified on [DATE]. There was no Administrator for the building at this time. Consequently, the Regional Director of Operations who had been filling in as Administrator was notified of IJ on [DATE] at 4:49pm. IJ template was provided at this time and plan of removal was requested. Plan of Removal was accepted on [DATE] after several revision and read in part: All residents' (with ventilators and tracheostomy) tubing/circuit were changed on [DATE]. On [DATE], the QAPI committee reviewed the policy related to ventilator checks. Residents with Ventilators and Tracheostomy will be rounded at least every two (2) hours. The RT's and the nurses will identify the residents who will need additional checks and/or more frequent ventilator checks/rounds and the indication and specific intervention will be incorporated into the residents' plans of care. The nurses and the RT's will be provided with training by the RDO (regional director of operations) /designee related to the policy, the expectations related to ventilator checks/rounds and responsibility related to the alarms. The training will be completed on or before [DATE]. In between ventilator checks and/or rounds, the RT's and nurses will respond to the alarms and assess the need for immediate intervention and/or need for additional assessment. The RT's office was relocated into the ventilator unit to further enhance accessibility. The facility will override the default settings for alarm volume setting for all mechanical ventilators; all ventilators' volume settings will all be set to the maximum level. These actions are in place as of [DATE]. On [DATE], the QAPI committee reviewed the policy related to obtaining oxygen saturation. The responsibility of the RT and nurse includes completing further assessment and if necessary, notifying the attending physician if unable to obtain oxygen saturation during assessments/checks. The nurses and the RT's will be provided with training by the RDO (regional director of operations)/designee related to the policy and the staff (RT's and nurses) responsibility related to oxygen saturation checks. The training will be completed on or before [DATE]. The RT's and nurses will not assume any job responsibilities until training has been received by them. The orientation program, which includes but not limited to training related to, 1) CPAP/BIPAP, 2) Oxygen Management, 3) suctioning, 4) Pulse Oximetry, 5) Tracheostomy care, 6) Nebulizer, 7) Tracheostomy tube change, 8) ventilator management, 9) Trilogy EVO and 10) Trilogy 100, for RT's was reviewed by the QAPI team on [DATE]. Revision was made to include further assessment if unable to obtain oxygen saturation and to notify the attending physician if deemed necessary. The director of respiratory therapy will provide the RT's with training related to the revision. The training will be completed on or before [DATE]. The RT's will not assume any job responsibilities until training has been received by them. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Skill competency testing related to ventilator checks and pulse oximeter readings will be completed for all RT's. The competency validation tests will be completed by the director of respiratory therapists and will be completed on or before [DATE]. The RT's will not assume any job responsibilities until training has been received by them. The RT's and nurses will complete a minimum of every two-hour ventilator checks to ensure that ventilation equipment remains connected and intact. The RT's and nurses will identify the residents who will need additional ventilator checks for any identified clinical reason. Any specific and more frequent rounds/ventilator checks will be incorporated into the residents' plans of care. The RT's and nurses will be provided with training by the RDO/designee related to this process. The training will be completed on or before [DATE]. The RT's and nurses will not assume any job responsibilities until training has been received by them. On [DATE], the QAPI committee reviewed the policy related to change of condition and communication between staff, between staff and physician and between shifts when a resident has a change of condition. The nurses and RT's will receive training related to the policy and their responsibilities to communicate about resident's change of condition and communication of identified changes of condition to the attending physician. The training will be conducted b [TRUNCATED]

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26218 Based on record review and interview, the facility failed to ensure residents who require dialysis services, receive services consistent with professional standards of practice, the person-centered care plan and the resident's goals and preferences for 1 of 3 (CR #3) residents, reviewed for dialysis. The facility failed to ensure that CR #3 was dialyzed 3 times per week as ordered by her physician. The facility failed to consult the physician when CR #3 refused dialysis on [DATE]. CR #3 went 5 days without dialysis. The facility failed to ensure staff obtained pre dialysis blood pressure readings for CR #3 prior to her being transported to dialysis. The facility failed to administer CR#3's Procardia prescribed for hypertension at 6:00 AM on [DATE], at 6:00 AM on [DATE], at 6:00 PM on [DATE] and on [DATE] at 6:00 AM. The facility failed to administer CR#3's ordered Clonidine patch for hypertension on [DATE] at 8:00 AM. The facility failed to ensure pre dialysis communication forms for CR #3's off-site dialysis were completed and accurate on [DATE] and on [DATE]. On [DATE], the dialysis sheet from the facility to the dialysis center was incomplete and read, BP 108 while the transportation services recorded CR#3's blood pressure prior to her arrival at the dialysis center as ,d+[DATE] and ,d+[DATE]. The facility failed to monitor CR #3's dialysis site to ensure dialysis catheter and failed to assess site on [DATE] in order to identify change in catheter status and signs of infections. On [DATE], the dialysis center found CR #3 upon arrival at the center, less than 10 minutes from the facility by car/ambulance, to have a dirty dressing with visibly dried blood and with the cuff of the sub- clavian catheter (hemodialysis catheter inserted into the chest wall) visible indicating a malfunction. The dialysis center could not perform dialysis and transferred CR #3 to the hospital where she was placed on hospice and later expired. Immediate Jeopardy was identified on [DATE]. While the IJ was lowered on [DATE] at 10:43 AM, the facility remained out of compliance at a scope of a pattern and severity of actual harm that is not immediate jeopardy as the facility requiring more time to monitor the Plan of removal for effectiveness. These failures placed facility residents receiving dialysis services at risk of harm including death. Findings include: CR #3 (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #3's face sheet revealed [AGE] year-old female resident was readmitted to the facility on [DATE] and effectively discharged on [DATE] at which time she was transferred to the hospital from her off-site dialysis center. Record review of CR #3's face sheet revealed the following diagnoses: end stage renal disease, dependence on renal dialysis, type 2 diabetes without complications, hypertensive heart disease with heart failure, congestive heart failure, gastro-esophageal reflux disease without esophagitis and was profoundly deaf and non-verbal with no capacity for receptive or expressive language. The review revealed CR #3 used sign language or written notes to communicate her needs. Record review of CR #3's physician current orders dated [DATE] revealed Clonidine patch weekly 0.1 mg/24 HR apply 1 patch transdermally one time every 7 day(s) for HTN and remove per schedule. Record review of CR #3's physician orders with start date of [DATE], revealed Procardia XL Tablet Extended Release 24-hour 60 MG (Nifedipine ER Osmotic Release). (Give 1 tablet by mouth every 12 hours for HTN Hold for SBP less than 110 and HR less than 60, Further review of Physician orders revealed no order to hold Procardia at any time. Record review of CR #3 's dialysis orders dated [DATE] read, Dialysis: Check dialysis site every shift; Dialysis: May go to dialysis on MWF . Dialysis: palpitate AV shunt-check for Bruit and Thrill every shift Dialysis: Vital signs post dialysis .Vital signs post dialysis. However, CR #3 did not have an arm shunt but had hemodialysis chest catheter. Record review of CR #3 dialysis orders revealed physician orders to check her hemodialysis chest catheter it every shift. Record review of CR #3's care plan revealed a care-plan for hypertension and administration of anti-hypertensive medications, obtain blood pressure readings per MD order and notify MD if abnormal. CR #3 was also care-planned for dialysis services. The care plan was last reviewed on [DATE]. Record review of CR #3's care plan for hypertension read, Focus. has hypertension (HTN) r/t CHF Date initiated [DATE] Revision on ,d+[DATE] 2021 Goal .will remain free of complications related to hypertension through review date .Target Date [DATE] Interventions Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (a form of low BP that occurs when standing up from sitting or lying down position) and increased heart rate (Tachycardia) and effectiveness .Monitor document/report PRN any s/s of malignant hypertension: headache, visual problems, confusion, orientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing (Dyspnea). Record review of CR #3's care plan for dialysis services read, Focus .needs dialysis r/t renal failure Date initiated [DATE] Revision on [DATE] Goal .will have no s/s of complications from dialysis through the review date. Interventions: Palpate AV shunt-check for Bruit and Thrill per MD's orders Date initiated: [DATE]. Revision on: [DATE] Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis (.M-W-F 6am). Monitor labs and report to doctor as needed. Monitor VITAL SIGNS per MD's orders. Notify MD of significant abnormalities. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Focus .needs dialysis r/t renal failure Date initiated: [DATE] Revision CR #3 was dialyzed on [DATE], [DATE] and on [DATE]. CR #3 refused dialysis on [DATE]XXX[DATE]. (The section for Goal had no documentation.) The section for Interventions read, Monitor/document/report PRN any s/s of infection to access site: Redness, Swelling, warmth or drainage. Monitor/document/report PRN for s/s of renal insufficiency, changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Monitor/document/report PRN for s/s of the following: Bleeding, Hemorrhage, Bacteremia, Septic shock. Record review of CR #3's progress note dated [DATE] at 10:51 AM and written by a former DON read, in part: [DATE] .Received phone call from .outpatient dialysis, reports going to send resident to hospital due to uncontrolled high blood pressure attempted to control with Clonidine unsuccessful ,d+[DATE]. Caller expressed being upset that the resident has high blood pressure most of the time . Record review of CR #3 nursing note dated [DATE] read, [DATE] 18:40 [6:50PM] Health Status Note Resident arrived back from the hospital. Blood pressure checked on arrival to facility and it was high , d+[DATE], Scheduled medications administered BP check 1 hour and B/P went down to ,d+[DATE] . Record review of CR #3's hospital records dated [DATE] revealed she was admitted for hypertension post dialysis. On [DATE] at 11:21 AM CR #3's BP in ER was ,d+[DATE], pulse 76. On [DATE] at 2:22 PM, BP was ,d+[DATE] and CR #3 was discharged to the facility the same day. Record review of CR #3's hospital records dated on [DATE] at 8:46 AM CR #3 was admitted for ESRD. Per hospital records she was admitted due to positive Covid results and need for dialysis. Per records CR #3Patient stated she was unsure why she was there. Per records CR #3 was evaluated and did not meet criteria for emergent dialysis at the time. CR #3 was discharged to the facility on [DATE] at 1:16 PM the same day. Record review of the top portion of the document entitled, Dialysis Communication Form Pre-Dialysis Information dated [DATE] and completed by the facility, read shunt location status chest right Vital signs BP 108. There was no further blood pressure written on the form and it is unknow whether the reading was systolic or diastolic. The review revealed no documentation of any assessment of the catheter site having been assessed prior to being sent to the dialysis center. Record review of nursing notes for CR #3 revealed the schedule for CR #3's dialysis was changed to Tuesday, Thursday, Saturday once Covid was diagnosed on [DATE], as the dialysis center provides dialysis services to Covid positive residents on those days. Record review of Nursing note from the facility for CR #3 dated [DATE] read, [DATE] 08:26 Resident left the facility via .to hospital pending dialysis. Resident is Covid positive and asymptomatic in stable condition . Nursing notes further read, [DATE] 13:42 Resident was transferred post dialysis in stable condition . Record review of nursing notes for CR #3 revealed that the schedule for CR #3's dialysis was changed to Tuesday, Thursday, Saturday once Covid was diagnosed on [DATE], as the dialysis center provides dialysis services to Covid positive residents on those days. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #3's dialysis treatment log dated [DATE] revealed, treatment initiated at 9:38 AM. Pre-treatment BP was ,d+[DATE], pulse 70. Clonidine 0.2 mg was given orally at 10:05 AM. Treatment was terminated early per NP at 12:16 PM due to high BP. Post treatment BP was ,d+[DATE]. Dialysis notes further revealed CR #3 stated the nursing home did not give her BP medication. Post treatment data collection & assessment revealed NP was aware of patient BP, instructed dialysis to communicate with nursing home to give BP medication. Nursing home phone lines down. Verbal communication sent via EMS. Record review of CR#3's Dialysis Communication Form Pre-Dialysis Information dated [DATE] and completed by the facility, read shunt location status chest right Vital signs BP 108. There was no further blood pressure written on the form and it is unknow whether the reading was systolic or diastolic. The review revealed no documentation of any assessment of the catheter site having been assessed prior to being sent to the dialysis center. The section of the form completed by the dialysis center entitled, Dialysis Center Information, read, Patient CVC bloody upon arrival cuff or catheter visible sent to hospital. Record review of CR#3's transportation log sheets for [DATE] revealed transportation was on-site at the facility at 6:51 AM and arrived at dialysis at 7:15 AM. The narrative notes read in part: .patient was transferred to EMS stretcher, placed on a semi-Fowler position, covered with blanket and pillow to her back due to pain to lower back and trunk . Vitals were (no times were noted) ,d+[DATE] and ,d+[DATE]. When dialysis called for transport to return, they were still on site at 7:15 AM. Vital signs were (no times were noted) ,d+[DATE] and ,d+[DATE]. CR #3 was alert and oriented x 2. A head-to-toe assessment was done. CR #3 was covered with blanket and pillow to her back due to pain to lower back and trunk. At 7:21 AM transportation arrived at the hospital. Interview on [DATE] at 9:50 AM the Transportation EMT said on [DATE], CR #3 was transported to dialysis. He was the attendant who monitored CR #3's BPs several times on the trip. (EMT did not say if he checked BP prior to leaving the facility. The transportation log sheet did not indicate the time BPs were checked). He said he notified Dialysis of her elevated BPs upon arrival. He said he did not notice anything unusual about CR #3 that day other than elevated BPs. (BPs were documented on the transportation log sheet dated [DATE]) Interview on [DATE] at 12:50 PM the outpatient dialysis nurse stated CR #3 was a regular dialysis patient. CR #3's dialysis schedule was Monday, Wednesday and Friday. When CR #3 tested Covid positive she had to switch to Tuesday, Thursday, and Saturday, the Covid positive patient schedule. She dialyzed on [DATE], skipped Monday [DATE] (due to Covid status, was rescheduled for [DATE]), missed [DATE](CR #3 refused), dialyzed [DATE], facility was closed on Saturday [DATE], she dialyzed on Sunday [DATE]. On [DATE], upon arrival to dialysis, CR #3's BP was elevated. The systolic BP was above 200. Since CR #3 did not get started on dialysis, the dialysis machine did not record the BP result. The CVC was partially out of the chest and the inner CVC cuff was exposed. The dressing over the catheter exit site had old-dried blood. CR #3 was sent immediately to the Hospital via primary transport. The dialysis NP and nursing facility was notified. Record review of hospital records dated [DATE] for CR #3 read in part, Presentation Chief complaint R chest catheter malfunction. Stated complaint HYPERTENSION, DIALYSIS CATHETER OUT The review also revealed CR #3 was diagnosed with sepsis and Covid pneumonia. The prognosis was shared with family and she was placed on hospice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the document entitled, Progress and POC Follow-Up Notes Report dated [DATE] for CR #3 read in part, UPON ARRIVAL TO UNIT, CVC CUFF VISIBLE ALONG WITH OLD BLOODY DRAINAGE TO DRESSING. PATIENT SENT TO HOSPITAL VIA PRIMARY TRANSPORTATION, NP AND NURSING HOME NOTIFIED PER CHARGE NURSE Record review of a second document entitled, Progress and POC Follow-Up Notes also dated [DATE], read in part, .sub reason for admission stroke .Pt condition declining family decided to put patient in Hospice Services, per daughter. The Summary Review further revealed CR #3 passed away per family on [DATE]. On [DATE] at 12:20 PM, a telephone call was made to LPN Z. No call back was received by exit. In a telephone interview on [DATE] at 8:00 PM LPN Q stated she works night shift 7:00 PM to 7:00 AM and she did not know if she administered Procardia to CR #3 on [DATE] at 6:00 AM. LPN Q stated she did not remember what time CR #3 was picked up by transportation on [DATE], it was early. Night shift is usually the ones who send the resident out. LPN Q said CR #3 might have had a dialysis access on the right chest and she could not remember what it looked like the morning of [DATE]. She said to get CR #3 ready for dialysis she wound get paperwork, get her snack, we do vital signs and weight. This is documented on communication paper and CR #3 brings it back then the information we get from dialysis nurse we document in PCC (electronic health records) and then paper gets filed. When asked what she meant when she wrote BP 108 on the Dialysis Communication Sheet for CR #3 on [DATE], LPN Q said systolic over diastolic, this is how we write it. It should have two numbers. LPN Q said it was too long ago and did not remember what the BP was. In a telephone interview on [DATE] at 4:45PM CNA G stated he works worked 6:00 AM to 2:00 PM shift. CR #3 did a lot of ADLs herself and needed little help with dressing; she wore Pjs or gown at night. CNA G when asked what CR#3's dialysis access looked like stated he did not remember seeing CR #3's dialysis access on [DATE] day shift. CNA G said he could not comment on the status of the hemodialysis catheter. On the morning of [DATE], CNA G said CR #3 would have left for dialysis by the time he started his shift at 6:00 AM and would not have had the opportunity to assess the status of the hemodialysis catheter. In a telephone interview on [DATE] at 5:05PM, CNA T stated she said she did work with CR #3 [DATE] to [DATE] [DATE] to [DATE] on the night shift. She was in the covid unit. She recalls she helped CR #3 to the bathroom a lot; she went frequently that night and CNA T did notify her nurse of her concern. She did not remember which nurse. That night CR #3 complained of feeling cold, was weak, did not want to remove her clothes. She just wanted to be covered up. CNA T said she did not remember seeing her dialysis access. She thought she had an AV fistula; she did not recall seeing a dialysis catheter in her chest. She said CR #3 always left early in the mornings for dialysis. CNA T said before she was in covid unit, CR #3 would communicate and would want to brush her hair, brush her teeth and do more. When in covid unit she did not want to do any of that, and she was always cold. In an interview on [DATE] at 12:21 PM, LPN T stated she worked 7:00 AM to 7:00 PM shift. On [DATE], night shift sent CR #3 out to dialysis before she started her shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 12:50 PM the outpatient dialysis nurse stated CR #3 was a regular dialysis patient. CR #3's dialysis schedule was Monday, Wednesday and Friday. When CR #3 tested Covid positive she had to switch to Tuesday, Thursday, and Saturday Covid positive patient schedule. She dialyzed on [DATE], skipped [DATE], missed [DATE], dialyzed [DATE], facility was closed on Saturday [DATE], she dialyzed on Sunday [DATE]. On [DATE], upon arrival to dialysis, CR #3's BP was elevated. The systolic BP was above 200. Since CR #3 did not get started on dialysis, the dialysis machine did not record the BP result. The CVC was partially out of the chest and the inner CVC cuff was exposed. The dressing over the catheter exit site had old-dried blood. CR #3 was sent immediately to the Hospital via primary transport. The dialysis NP and nursing facility was notified. Interview on [DATE] at 9:50 AM the Transportation EMT said on [DATE], CR #3 was transported to dialysis. He was the attendant who monitored CR #3's BPs several times on the trip. He said he notified Dialysis of her elevated BPs. He said he did not notice anything unusual about CR #3 that day other than elevated BPs. In a telephone interview on [DATE] at 1:45 PM, the MD said it was possible he was notified of CR #3's missed dialysis treatment on [DATE]. If he was notified, he said he would first ask for the reason why. He said the risks of not dialyzing would be fluid overload, electrolyte changes and possible death. In a telephone interview on [DATE] at 2:00 PM, the NP said she did not recall if she was notified that CR #3 went to theER on [DATE]. The only time she can recall being notified was when CR #3 went toER on [DATE]. She did not remember if she was notified of CR #3 missing dialysis on [DATE]. She said if dialysis was missed the MD/NP should always be notified. She would first find out why the resident refused and would instruct the nurses to monitor BPs. The risks of missing dialysis treatments would be fluid overload and it could be a life threatening. In an interview on [DATE] at 1:00 PM, the LPN Manager stated she ordered CR #3's Clonidine patch from the pharmacy on [DATE]. She said the computer was connected to pharmacy and this is how the order was placed. She said she passed it on to the oncoming nurse. She said it would have shown up on the 24-hour report (for nurses to see that it was ordered) had she clicked the 24-hour report box in the computer, but she did not do this. She said the risks of not getting Clonidine would be problems with BP. She gave CR #3 Procardia XL on [DATE] at 6:00 PM per MAR. She said she did check CR #3's BP, but it did not pop up on vitals taken. She said it depends on how orders are entered in the system. If the add button is not selected, then special tasks such as check BP with each administration will not appear as a prompt. She said if she didn't get the Clonidine patch, she would call the MD to get instructions. LPN Manager did not say why she did not do call the MD when CR #3 did not receive the Clonidine patch. In an interview on [DATE] at 10:00 AM, LPN U stated regarding CR #3's Clonidine patch, she did not remember receiving report about Clonidine patch and it had not arrived yet on [DATE] for CR #3. She was not aware the Clonidine patch was ordered. Normally if a medication was not there, we would contact the pharmacy then notify MD. It would be the nurse's responsibility to get the medication here and pass on the information. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 1:59 PM the ADON stated CR #3 did not receive Procardia on [DATE] at 6:00 AM and does not know why it was not given as there were no records. She said on [DATE] at 6:00 PM and [DATE] at 6:00 AM, the Procardia doses were not given and does not know why they were not given. The ADON said if there was an administration note regarding Procardia when it was due, the note would populate in the Progress notes. The ADON said she did not find Administration notes for the Procardia on those dates and times. In an interview on [DATE] at 10:19 AM the RDO said she could not find CR #3's Dialysis Communication Sheets for [DATE] and [DATE]. In an interview on [DATE] at 12:50PM, the Interim DON who started on [DATE] stated if a medication was ordered it automatically goes to the pharmacy the system. She expects the nurses to make sure it is was received and f/u; check to see if it is was in the E-kit. I expect them to give each other report; also, they should write it in the 24-hour report. The 5 rights for medication administration included if a med was skipped for some reason. The medical practitioner was in charge of audits and would match with the MAR and will then run the report, also make sure nurses were caring out the orders. In an interview on [DATE] at 12:35 PM the ADON said she has been at the facility since [DATE]. She said if the nurse sends a resident to the ER, she expects they would complete a change in condition form, write a basic nurse note: SBAR format. Transfer out and make the notifications (MD, DON, RP). There will always be a doctor order. The nurse would present the information to the MD based on change of condition. BP results should be documented in system. When the medication is selected the system will ask for supplemental documentation. If BPs are not checked along with BP medication as ordered there would be standard risks and we shouldn't give if not within parameters. If BP meds ordered for hypertension was missed the resident can be in a crisis and heart issues or stroke issues. She said the nurses understand what the risks are. Typically, the DON reviews the orders listing report. It is always the nurse responsibility to make sure orders are followed. If there's an issue the nurse is to follow up, contact the pharmacy and check on delivery status. In an interview on [DATE] at 9:25 AM, the RDO said they did not have a policy and procedure for Resident Assessment. Record review of CR #3's dialysis treatment log dated [DATE] revealed, treatment initiated at 9:38 AM. Pre-treatment BP was ,d+[DATE], pulse 70. Clonidine 0.2 mg was given orally at 10:05 AM. Treatment was terminated early per NP at 12:16 PM due to high BP. Post treatment BP was ,d+[DATE]. Dialysis notes revealed CR #3 stated the nursing home did not give her BP medication. Post treatment data collection & assessment revealed NP was aware of patient BP, instructed dialysis to communicate with nursing home to give BP medication. Nursing home phone lines down. Verbal communication sent via EMS. Record review of CR #3's progress notes revealed between [DATE] at 4:47 AM and [DATE] 1at 10:39 AM there were no administration notes regarding Procardia. Record review of CR #3's MAR/TAR dated [DATE] through [DATE] revealed weekly Clonidine patch was removed on [DATE] at 7:59 AM by LPN Manager and not replaced at 8:00 AM by LPN Manager. Procardia XL 60 mg was due and not checked as administered on the following: [DATE] at 6:00 AM, [DATE] at 6:00 PM and [DATE] at 6:00 AM. (continued on next page)

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	455815	A. Building B. Wing	02/16/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #3's progress note revealed an order administration note written by LPN Manager with the effective date [DATE] at 3:09 PM. It read: Clonidine Patch Weekly 0.1 mg/24 hour, apply 1 patch transdermally one time a day every 7 days for HTN and remove per schedule. Awaiting delivery. Record review of CR #3's Blood Pressure Summary revealed on [DATE] at 5:35 PM the BP was ,d+[DATE], on [DATE] at 6:51 AM the BP was ,d+[DATE]. There were no other BP results recorded after [DATE] at 6:51 AM. Record review of CR #3's progress note revealed on [DATE] at 9:14 PM, LPN Z wrote a comprehensive skilled nursing note including vital signs: BP ,d+[DATE], pulse 76, RR 18, Temp 97.6, O2 97% and pain level of ,d+[DATE] (hurts a little bit) of abdomen. Review of clinical records revealed there were no notes regarding any communication with out-patient dialysis unit for the elevated BPs during dialysis on [DATE]. Record review of the transportation log sheets for [DATE] revealed transportation was on-site at the facility at 6:51 AM and arrived at dialysis at 7:15 AM. The Narrative notes read in part: .patient was transferred to EMS stretcher, placed on a semi-Fowler position, covered with blanket and pillow to her back due to pain to lower back and trunk . Vitals were (no times were noted) ,d+[DATE] and ,d+[DATE]. When dialysis called for transport to return, they were still on site at 7:15 AM. Vital signs were (no times were noted) ,d+[DATE] and , d+[DATE]. CR #3 was alert and oriented x 2. A head-to-toe assessment was done. CR #3 was covered with blanket and pillow to her back due to pain to lower back and trunk. At 7:21 AM transportation arrived at the hospital. Record review of CR #3's progress note written by the Registered Dietician on [DATE] at 4:06 PM read in part: .reply from renal RD. [DATE] labs .K 5.1 .Hgb 10. 1 L (low) .No concerns with labs at this time . Record review of CR #3's hospital records dated [DATE] revealed she was admitted for hypertension post dialysis. BP in ER was ,d+[DATE], pulse 76. CR #3 was discharged the same day. On [DATE] CR #3 was admitted for ESRD. Per hospital records she was admitted due to positive Covid results and need for dialysis. Patient stated she was unsure why she was there. Per records CR #3 was evaluated and did not meet criteria for emergent dialysis at the time. CR #3 was discharged the same day. Record review of the top portion of the document entitled, Dialysis Communication Form Pre-Dialysis Information dated [DATE] and completed by the facility, read shunt location status chest right Vital signs BP 108. There was no further blood pressure written on the form and it is unknow whether the reading was systolic or diastolic. The review revealed no documentation of any assessment of the catheter site having been assessed prior to being sent to the dialysis center. The section of the form completed by the dialysis center entitled, Dialysis Center Information, read, Patient CVC bloody upon arrival cuff or catheter visible sent to hospital. Review of the document entitled, Progress and POC Follow-Up Notes Report dated [DATE] for CR #3 read in part, UPON ARRIVAL TO UNIT, CVC CUFF VISIBLE ALONG WITH OLD BLOODY DRAINAGE TO DRESSING. PATIENT SENT TO HOSPITAL VIA PRIMARY TRANSPORTATION, NP AND NURSING HOME NOTIFIED PER CHARGE NURSE (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a second document entitled, Progress and POC Follow-Up Notes also dated [DATE], read in part, .sub reason for admission stroke .Pt condition declining family decided to put patient in Hospice Services, per daughter. The Summary Review further revealed CR #3 passed away per family on [DATE]. Record review of two facility in-service reports dated [DATE] and [DATE] titled Dialysis Communication revealed topics included dialysis policy and procedures must be followed; proper communication; follow MD and Nephrologist orders; change of condition; vital signs; lab results. In-services were conducted by the NP Clinical Specialist as well as the DON at the time. The review revealed nursing staff signatures on sign in sheets. The review revealed a QAPI Committee meeting was conducted [DATE] specifically to address the Dialysis IJ. Record review of hospital records dated [DATE] for CR #3 read in part, Presentation Chief complaint R chest catheter malfunction. Stated complaint HYPERTENSION, DIALYSIS CATHETER OUT . The review also revealed CR #3 was diagnosed with sepsis and Covid pneumonia. The prognosis was shared with family and she was placed on hospice. Record review of the facility policy and procedure titled Hemodialysis, Copyright 2020 The Compliance Store, LLC and date implemented on [DATE] revealed in part: .Compliance Guidelines: .2. The facility will coordinate and collaborate with the dialysis facility to assure that: a. The resident's needs related to dialysis treatments are met, b. The provision of the dialysis treatments and care of the resident meets current standards of practice for the safe administration of the dialysis treatments; c. Documentation requirements are met to assure that treatments are provided as ordered by [TRUNCATED]

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on observations, interviews, and record reviews, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of two residents (CR #3 and Resident #1) reviewed for pharmacy services as evidenced by: The facility failed to ensure Resident #1's medications were separately administered via G-tube. The facility failed to ensure all of CR #3's medications were administered as ordered by the physician resulting in multiple omitted doses of two medications. This failure could place residents at risk of not receiving medications as ordered by their physicians and exacerbations of their medical conditions. Findings included: CR #3 Record review of CR #3s face sheet revealed the [AGE] year-old female resident was readmitted to the facility on [DATE] and effectively discharged on [DATE] at which time she was transferred to the hospital from her off-site dialysis center. The review revealed CR #3 had the following diagnoses: end stage renal disease, dependence on renal dialysis, hypertensive heart disease with heart failure, congestive heart failure. Record review of CR #3's physician orders revealed the following orders: Clonidine patch weekly 0.1 mg/24 HR apply 1 patch trans-dermally one time every 7 day(s) for HTN and remove per schedule. The clonidine was ordered on 10/16/21 and was a current order. Procardia XL Tablet Extended Release 24-hour 60 MG (Nifedipine ER Osmotic Release. Give 1 tablet by mouth every 12 hours for HTN Hold for SBP less than 110 and HR less than 60, order start date 11/25/21. There was no physician order to hold Procardia at any time. Record review of CR #3's care plan for hypertension read, Focus has hypertension (HTN) r/t CHF Date initiated 10/18/2021 Revision on 10/18 2021 Goal .will remain free of complications related to hypertension through review date .Target Date 01/16/2022 Interventions Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate (Tachycardia) and effectiveness .Monitor document/report PRN any s/s of malignant hypertension: headache, visual problems, confusion, orientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing (Dyspnea) Date initiated: 10/18/2021. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Review of CR #3's care plan for dialysis services read, Focus .needs dialysis r/t renal failure Date initiated 9/22/2021 Revision on 9/23/2021 Goal .will have no s/s of complications from dialysis through the review date. Interventions Dialysis: Palpate AV shunt-check for Bruit and Thrill per MD's orders Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis (.M-W-F 6am) Monitor labs and report to doctor as needed. Monitor VITAL SIGNS per MD's orders. Notify MD of significant abnormalities. Focus .needs dialysis r/t renal failure D CR #3 was dialyzed on 12/24/21, 12/30/21 and on 1/2/22. CR #3 refused dialysis on 12/28/21.09/23/2021 Interventions read, Monitor/document/report PRN any s/s of infection to access site: Redness, Swelling, warmth or drainage. Monitor/document/report PRN for s/s of renal insufficiency, changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Monitor/document/report PRN for s/s of the following: Bleeding, Hemorrhage, Bacteremia, Septic shock. Record review of CR #3's MAR/TAR dated 1/1/2022 through 1/31/2022 revealed weekly Clonidine patch was removed on 01/01/2022 at 7:59 AM by LPN Manager and was not replaced at 8:00 AM by LPN Manager. Procardia XL 60 mg was due and not checked as administered on the following: 01/01/22 at 6:00 AM, 01/02/22 at 6:00 PM and 01/04/22 at 6:00 AM. Record review of CR #3's progress notes revealed between 01/01/22 4:47 AM and 01/04/22 10:39 AM there were no administration notes regarding Procardia. Record review of CR #3's progress note revealed an order administration note written by LPN Manager with the effective date 01/01/2022 at 3:09 PM. It read: Clonidine Patch Weekly 0.1 mg/24 hour, apply 1 patch trans-dermally one time a day every 7 days for HTN and remove per schedule. Awaiting delivery. In a telephone interview on 2/09/22 at 8:00 PM LPN Q stated she works night shift 7:00 PM to 7:00 AM and she did not know if she administered Procardia to CR #3 on 01/04/21 at 6:00 AM. In an interview on 02/03/22 at 1:00 PM, the LPN Manager stated she ordered CR #3's Clonidine patch from the pharmacy on 01/01/22. She said the computer was connected to pharmacy. She said she passed it on to the on-coming nurse. It would have shown up on the 24-hour report had she clicked the 24-hour report box in the computer. She said the risks of not getting Clonidine would be problems with BP. She gave CR #3 Procardia XL on 01/01/22 at 6:00 PM per MAR. She said if she didn't get the Clonidine patch, she would call the MD to get instructions. LPN Manager did not say why she did not do this. In an interview on 02/08/22 at 10:00 AM, LPN U stated regarding CR #3's Clonidine patch, she did not remember receiving report that Clonidine patch had not arrived yet on 01/01/22 for CR #3. Normally if medication was not there, they would contact the pharmacy then notify MD. It would be the nurse's responsibility to get the medication here and pass son the information. Record review of Pharmacy Delivery Manifest revealed on 12/25/21 at 3:19 PM, one Clonidine patch for CR #3 was delivered to the facility. In an interview on 02/08/22 at 11:20AM, the Pharmacist said the last time a Clonidine Patch for CR #3 was sent to the facility was on 12/25/21 and it was one patch. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	In an interview on 02/10/22 at 1:59 PM the ADON stated CR #3 did not receive Procardia on 01/01/22 at 6:00 AM and does not know why it was not given as there were no records. On 01/02/22 at 6:00 PM and 01/04/22 at 6:00 AM, the Procardia doses were not given and does not know why they were not given. The ADON said if there was an administration note regarding Procardia when it was due, the note would populate in the Progress notes. The ADON said she did not find Administration notes for the Procardia on those dates and times. In an interview on 02/08/22 at 12:50PM the Interim DON who started on 02/01/22 stated if a med was ordered it automatically goes to the pharmacy the system. She expects the nurses to make sure it was received and f/u; check to see if it is in the E-kit. She expected them to give each other report. Also, they should write it in the 24-hour report. The 5 rights for medication administration included if a med was skipped for some reason. The medical practitioner was in charge of audits and would match with the MAR and will then run the report, also make sure nurses were caring out the orders. In an interview on 02/10/22 at 12:35 PM the ADON said if BP medications ordered for hypertension was missed the resident can be in a crisis and heart issues or stroke issues. She said the nurses understand what the risks are. Typically, the DON reviews the orders listing report. It is always the nurse responsibility to make sure orders are followed. If there's an issue the nurse is to follow up, contact the pharmacy and check on delivery status. Resident #1 Record review of Resident #1's admission record revealed a [AGE] year-old-female admitted on [DATE] with diagnoses to include tracheostomy status, gastrostomy status, anxiety/depressive disorder, psychotic disorder, respiratory failure, and aphonia (inability to speak due to damage to larynx). Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS score of 13 indicating she was cognitively intact. She required extensive assistance with two person assist for bed mobility. She was totally dependent on staff for intake of nourishment and toilet use. She required extensive assistance with one person assist for transfers, dressing and personal hygiene. The swallowing/nutritional status section of the MDS indicated she had a feeding tube while she was not a resident as well as while she was a resident. The special treatments section of the MDS indicated she required oxygen therapy, suctioning, tracheostomy care, invasive and non-invasive mechanical ventilator tube while she was not a resident as well as while she was a resident. Record review of Resident #1's care plan, last reviewed on 12/07/21 revealed care plans for requiring tube feedings r/t to difficulty swallowing; tracheostomy status and ventilator dependent r/t respiratory failure; ADL self-care deficit r/t confusion and limited mobility; communication deficit r/t aphonia. Record review of Resident #1's active physician orders as of 02/08/2022 revealed an order for the following: Loratadine 10 mg give 1 tablet one time a day for allergy symptoms; Famotidine 20 20 mg give 1 tablet via PEG-Tube two times a day for acid indigestion. Levetiracetam 1000 mg tablet via PEG-Tube two times a day for seizures: start date 07/16/21. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	Levetiracetam Solution 1000 mg/ml give 10 ml two times a day start date: 02/08/2021. Midodrine HCL 10 mg tablet give 1 tablet via PEG-Tube two times a day for hypotension. Pyridostigmine Bromide 60 mg tablet give 1 tablet via PEG-Tube 3 times a day for myasthenia gravis. Docusate Sodium tablet 100 mg via PEG-Tube one time a day for constipation. Enoxaparin 30 mg/0.3 ml inject 30 mg subcutaneously one time a day for blood thinner. Record review of Resident #3's MAR/TAR for February 2022 revealed the following medications were administered on 02/08/2022 at 9:00 AM by LPN AA: Loratadine 10 mg tablet Levetiracetam Solution 1000 mg/ml give 10 ml, Midodrine HCL 10 mg tablet, Pyridostigmine Bromide 60 mg tablet, Docusate Sodium tablet 100 mg Enoxaparin 30 mg/0.3ml injectable. Observation and interview on 02/08/22 at 8:45 AM, LPN AA prepare Resident #1's medications. LPN AA combined the tablets into one plastic pouch and crushed. She went to the sink and added 90 ml of warm water to drinking cup, added the crushed tablets and stirred. She paused the TF pump and disconnected tubing from PEG-Tube. Resident #1 was alert and sitting up in bed with the head of bed raised behind her. Towel was placed under PEG-Tube, LPN AA checked placement by injecting 20-30 cc of air via syringe, placed bell of stethoscope over abdomen near PEG listened with stethoscope; then aspirated; minimal formula was aspirated, and formula was pushed back into PEG-Tube. She attached syringe without plunger and poured 20-30 cc warm water. Water was not moving via gravity after unclamping the PEG-Tube. She then milked the tubing, gently pushed 20-30 cc air via syringe and instilled via gravity 20-30 cc of warm water. She poured dissolved meds into barrel of syringe and allowed to infuse via gravity. She flushed with 20-30cc water; administered the liquid Levetiracetam (Keppra) then flushed with 30 cc water and reconnected TF restarting the TF pump. She Administered Enoxaparin injection to Resident #1's right abdomen. LPN AA said she had been doing this for [AGE] years and had always combined crushed tablets because she knows which medications should not be combined. She did not know what the facility's policy and procedure was for administration of medications via PEG-Tube. In an interview on 02/08/2022 at 11:00 AM, LPN AA checked Resident #1's order in the computer for Keppra and said the liquid form was what was in the cart. She searched and said there was no Keppra in tablet form for Resident #1. She said she would get the order changed from tablet to liquid form. An interview was not attempted with Resident #1 regarding the administration of the combined crushed medications via PEG-Tube in order to avoid unnecessary distress to the resident. Resident #1's diagnoses included anxiety, depressive and psychotic disorder. (continued on next page)

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	455815	A. Building B. Wing	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	In an interview on 02/08/2022 at 12:50PM the Interim DON said most of the medications they do not mix them together and there should be flush in between the medicines even the liquid medications. She said that was done to make sure there was no interaction between medications and to make sure the resident gets the full dose. In an interview on 02/08/22 at 2:00 PM, the RDO said she heard about LPN AA mixing the medications and administering via PEG-Tube for Resident #1 and the Keppra given was the wrong form (liquid vs tablet). The RDO shook her head when asked what should have occurred. RDO did not verbally answer the question. The RDO said the plan was to conduct Ad-Hoc QAPI on medication administration via PEG-Tube and to write a medication error report including for the liquid Keppra and for follow up on orders. Record review of facility incident report for Resident #1 dated 02/08/22 at 3:38 PM and prepared by LPN AA read: Nursing Description: This writer administered Keppra liquid that was not in the cart instead of Keppra tablet that was on the EMAR. This writer also gave all the tablets crush together and staff was in-serviced. NP called and notified. Have orders to change tablet to liquid per PEG Tube. Resident #1's RP was notified. No injuries observed at time of incident. Record review of facility policy and procedure for Medication Administration via Enteral Tube dated 2021 read in part: It is the policy of this facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practices. Policy Explanation and Compliance Guidelines: .6. Each medication will be administered separately, not combined or added to an enteral feeding formula . Record review of facility's policy and procedure for Medication Reordering, dated 2021 read in part: It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident Policy Explanation and Compliance Guidelines: 1. The facility will utilize a systematic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident. 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting 4. The facility will consider factors indicating errors in medication administration, including, but not limited to the following: a. Medication administration not in accordance with the prescriber's order. Examples include, but not limited to: i. Incorrect dose, rout of administration, dosage form, time of administration; ii. Medication omission; iii. Incorrect medication .6. Medication administration observations will be conducted periodically to evaluate facility medication administration practices. 7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right mediation, dose, route and time of administration . (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's policy and procedure for Medications Errors, dated 2021 read in part: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Definitions: Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order or accepted professional standards and principles which apply to professionals providing services Policy Explanation and Compliance Guidelines: 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders. b. Per manufacturer's specifications regarding the preparation, and administration of the drug or biological. c. In accordance with accepted standards and principles which apply to professionals providing services 5. Medication timing errors will be determined by utilizing the facility's policy relating to dosing schedules. 6. Medication administration observations will be conducted periodically to evaluate facility medication administration practices 8. If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible .