STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676155	A. Building B. Wing	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Courtyards at Pasadena	4048 Red Bluff Road Pasadena, TX 77503

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 to resident health or safety 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** 35963 Based on interview, and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for 1 of 5 residents (CR# 1) reviewed for quality of care. The facility failed to implement CR#1's physician order to increase Lactulose from 20g (30ml) to 40g (60ml) for 12 hours after a critical lab level ammonia level of 165 (normal range 15 - 45 u/dL) was obtained from the lab company. The facility failed to ensure LVN A reported CR#1's critical lab level and medication change during the change of shift to the oncoming nurse for implementation resulting in the resident not receiving ordered medication .CR#1 was found unresponsive 16 hours later. The facility failed to ensure RN B immediately called 911 emergency services when CR#1 was found unresponsive and without a blood pressure reading but instead called the physician and non-emergency EMS resulting in a delay in emergency care and intervention for CR#1 whose Ammonia level increased from 165 (at the facility) to 179 (at the hospital) with altered mental status. An Immediate Jeopardy (IJ) situation was identified on 9/2/21. While the IJ was removed on 9/3/21, the facility remained out of compliance at a scope of isolated and severity of actual harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for delayed medical intervention, decline in health and death. Findings include: Record review of CR#1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] and was transferred to the emergency roiagnom on [DATE] at 4:50am. His diagnoses included Pneumonia, Myocardial Infarction (heart attack), Cirrhosis of the Liver, Iron Deficiency Anemia, Gastroesophageal reflux disease, Muscle Wasting and Atrophy, Edema (swelling), Dementia without behaviors and Dysphagia (difficulty swallowing). Record review of CR#1's admission Minimum Data Set (MDS), dated [DATE], revealed CR#1 had a Brief Interview for Mental Status (BIMS) of 5, which indicated cognitive impairment. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's nursing note written by RN B, dated 8/24/2021 at 12:00 AM, read, Admission labs: CBC, BMP ordered for next lab routine date 8/24/21 and then weekly on Mondays thereafter via online, requisitions printed and placed in lab book. Record Review of CR#1's nursing note written by RN B, dated 8/24/2021 at 10:13 AM, read in part, . Resident is AAOx3-4 with episodes of confusion and forgetfulness. Resident is able to make needs known to the staff, requires assistance x1 with ADLs . Record review of CR#1's nursing note, dated 8/24/21 at 3:14 PM read, The Doctor visited resident and gave orders for CBC, CMP and Ammonia level to be drawn every Thursday due to confusion. Requisition for ordered labs were completed and placed in the lab book. Record review of CR#1's lab report, dated 8/25/21 read, Critical Value, RRB (received-read back), LVN A on 8/25/2021 at 11:40 AM . which revealed CR#1's ammonia level of 165. Record review of CR#1's nursing note written by RN B, dated 8/26/21 at 4:35 AM, read, Upon rounding citizen was hard to arouse, non-responsive to verbal or tactile stimulation. Would only open eyes for a second and wound not verbally respond to writer. Resp even and unlabored. Unable to obtain BP, Spo2 at 95% on RA. Temp 97.5. Call placed to the doctor and gave order to send citizen to ER ASAP. After reviewing labs, Ammonia level noted to be critically high at 165. Non-emergency 911 contacted at this time. EMS en route. Record review of CR#1's nursing note written by RN B, dated 8/26/21 at 4:50 AM, read in part, EMS in facility at this time to transport citizen to ER. Citizen stable upon departure but still non-responsive per baseline . Record review of CR#1's medication administration record (MAR) revealed an order for Lactulose solution 20 gram/30 mL; amount to administer: 30 mL; oral, with a start date of 8/24/21 and a discontinue date of 8/25/21. CR#1 received the 30 ml of lactulose on 8/24/21 at 1:00 PM, 5:00 PM and 9:00 PM and on 8/25/21 at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM. Record review of CR#1's MAR revealed an order for Lactulose solution 20 gram/30 mL; amount to administer: 40 mL; oral, with a start date of 8/26/21 and discontinue date 8/27/21. Record review of the August 2021 mediation administration record revealed CR#1 did not receive the increased lactulose order. CR#1 received 30 mL of lactulose. Record review of the nursing 24-hour report, dated 8/25/21 for 6a-6p shift, indicated CR#1 was stable with no new orders checked. Record review of CR#1's Prescription Fax Order, dated 8/26/21 at 8:59 AM, revealed the order for Lactulose 40 mL four times daily was ordered on 8/26/21 and the order for 30 mL of Lactulose four times daily was discontinued on 8/25/21 at 11:48 AM due to a change in order. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN D on 8/31/21 at 9:50 AM, LVN D stated when new admissions are admitted the facility completes a head to toe assessment, check vitals and writes communication for new diets and orders. The MD is notified and a COVID test is completed and if they're positive, they notify the DON and Administrator. She stated when labs were drawn and were critical, the lab would call the facility and would also fax the results. LVN D stated the nurse would pull labs from the lab system and would notify the MD. If the labs were critical, they would call the MD to get any orders or see what the MD wanted to do. If labs were abnormal, sometimes the resident would be sent out to the hospital if the MD ordered to do so, it depended on what was going on with the resident. In an interview with CR#1's Responsible Party (RP) on 8/31/21 at 10:28 AM CR#1's RP stated CR#1 was in the hospital. She stated CR#1 was not given the proper medication, which he needed due to cirrhosis of the liver. She stated when she brought CR#1 to the facility, she went over his medication with a nurse and handed them the list of medications and dosages he received at home. CR#1's RP stated CR#1 had to have a blood transfusion at the hospital due to not getting his iron medication. She stated CR#1's liver was leaking blood and he would have a procedure in the hospital today (8/31/21) to drain the fluid from his stomach. In an interview on 8/31/21 at 2:50 PM with the Director of Nursing (DON), she stated when a critical lab was called in from the lab, the lab tech would speak to the nurse on duty for the specific resident. The DON stated if the nurse received a critical lab, they would contact the physician immediately to inform them of the critical lab. She stated if the physician made an order change, the nurse was to put the order in the system at that time and read the order back to the physician to ensure accuracy. The DON stated the nurse would also inform the family of the critical lab. She stated if the physician wanted to send the resident to the hospital, they would give an order to send the resident to the hospital. In an interview on 8/31/21 at 2:51 PM with LVN A, she stated at change of shift, the nurses were to give report to the oncoming nurse to discuss any changes with the residents, such as change in condition, new orders, medication changes or lab reports. LVN A stated she would relay any critical lab values to the oncoming nurse. LVN A stated for residents with critical labs, she would call the doctor and discuss the labs and document any changes in the order and would notify the family. She stated she would chart the conversation in her nursing notes. LVN A stated whenever a critical lab was reported from the lab, the lab would call the facility before the fax came through and the nurses would place it in folders for the doctor to review. LVN A stated she received a call for critical labs for CR#1, which stated his ammonia level was 165. She stated she called the doctor and the doctor asked about the Lactulose. LVN A stated the current Lactulose order was for 30 ml. She stated the doctor increased the order to 40 ml, four times a day and to repeat his CBC/BMP on 8/26/21. LVN A stated while putting in the new order from the doctor, she got another call from lab which stated CR#1 had a critical HGB level. She stated the doctor informed her to continue to monitor the resident and changes would be made as needed. LVN A stated she administered the 40 ml of lactulose to CR#1. LVN A stated at change of shift, she notified the nurse of CR#1's critical lab value. LVN A said she dropped the ball and forgot to document the changes in her notes regarding the critical lab value and her conversation with the doctor regarding CR#1. She stated when she was leaving for the day, CR#1 was responsive before she left the facility around 9 pm. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 8/31/21 at 3:32 PM with the doctor, she stated she received the call on 8/25/21 from LVN A informing her of CR#1's critical ammonia level. The doctor stated she gave the order to change CR#1's Lactulose from 20g (30ml) every four hours to 40 grams (60ml) every six hours. The doctor stated she wanted CR#1's medication change to start the same day she gave the order. The doctor stated she wanted to try the increase in Lactulose and monitor the resident with the increase in medication. The doctor stated had she not wanted the order to increase the same day and monitor for any changes, she would have given the order to send the resident to the emergency room right away. The doctor stated increasing the lactulose dose as ordered would have lowered the ammonia level. In an interview on 8/31/21 at 6:33 PM with RN B, she stated CR#1 was alert and able to make his needs known. She stated CR#1 was able to take his medications and knew what medication he was taking. RN B stated when she went to assess him at 4:30 AM, he was unresponsive. She stated she tried to arouse him, he only opened his eye for a second and then closed his eyes again. She stated he was not able to verbalize anything, which was different from his baseline. RN B stated she attempted to get his vitals but couldn't get his blood pressure, due to her blood pressure cuff not working. She stated she did not remember if she attempted to get his heart rate, but he was breathing at 95% on room air. RN B stated she called the doctor and told her about her assessment and the change in the resident. She called the doctor first due to him having a pulse and his breathing was unlabored and due to her assessment. RN B stated once she received the order from the doctor to send CR#1 to the hospital, she called the Police department, non-emergency line. RN B stated she called non-emergency due to her assessing the resident and him opening his eyes, she knew he was still alive, but not responding normally. RN B stated it took EMS 15-20 minutes to arrive to facility. RN B stated when she saw CR#1's critical lab, he was already on his way to the hospital. RN B stated she was not aware his ammonia level was high. She stated when she got report from LVN A, she did not let her know his labs were critical. She stated LVN A gave report for CR#1 and LVN A told her he had labs drawn but didn't mention his labs were critical. RN B stated on 8/26/21 during report, she informed LVN A she had to send CR#1 out to the hospital. RN B stated LVN A then told her the doctor increased CR#1's lactulose order. RN B stated she was not aware of this change in the order and continued to give the normal 30 ml of lactulose. RN B stated when she gave report to the oncoming nurse, she would give them a report sheet and would tell the nurse about any new changes for each resident, such as medication changes, change in condition, behaviors, labs and any family dynamics. RN B stated she would also document the changes in the residents nursing notes. In an interview on 8/31/21 at 7:10 PM with Hospital RN L, she stated CR#1 was stable. She stated CR#1 was still confused and remained on the telemetry unit. Hospital RN L stated the doctors were still monitoring his labs and his ammonia levels. In an interview on 9/2/21 at 8:30 AM with Hospital RN M, she stated CR#1 admitted with a diagnosis of Altered Mental Status (AMS), Anemia, Pneumonia and Sepsis. She stated on 8/30/21 CR#1 had a paracentesis, which is a needle placed in the body cavity to remove fluid, to remove 1.7 L of fluid off his stomach. She stated his ammonia level was still elevated (from 165 to 179 u/dl) which was being monitored by the doctor. She stated she had no current discharge date for CR#1 and would continue monitoring him. In an interview on 9/2/21 at 11:35 AM with the Administrator, she stated an investigation began on 8/31/21 at 8 AM. She stated LVN A was suspended pending the investigation. She stated LVN A has not returned any of the phone calls regarding the investigation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 9/2/21 at 12:23 PM with the DON stated she was made aware CR#1 was sent out at 4:30AM on 8/26/21 due to a change in condition, but at the time was not aware it was non-emergency EMS. The DON stated nursing should call 911 if a resident is nonresponsive to avoid a delay in medical treatment. The DON stated upon her investigation, she found that at 8am the lab called to inform LVN A of the critical lab. She stated LVN A called and informed the doctor of the critical lab and was directed to increase the lactulose. She stated per LVN A, 40 ml of lactulose was given to CR#1, but she forgot to put the order on CR#1's MAR. The DON stated she called the doctor and confirmed she did speak with LVN A but gave the order for 40 g of lactulose to be increased on 8/25/21 and not the next day and also not 40 ml of lactulose. In an interview on 9/3/21 at 11:47 AM with the Administrator, she stated she was not sure why LVN A didn't ask for assistance for getting orders in and writing orders timely. She stated nothing like this has happened before and she expected the licensed nurses to be able to communicate with each other and get orders from the medical doctor and placed in the system timely to ensure the resident were properly cared for in emergency situations. She stated she knows the IJ came about due to lack of communication and documentation. She stated the DON and ADON would continue to train all staff and new employees on the protocols of the facility. The Administrator stated training and in-servicing would continue regarding change in condition, shift change and giving report, critical labs and medication management. She stated management would continue doing audits and observations for a month. The Administrator stated she had not heard from LVN A, despite many attempts. Record review of information on Ammonia Levels retrieved from https://medlineplus.gov/lab-tests/ammonia-levels/ on 09/13/2021 revealed This test measures the level of ammonia in your blood. Ammonia is a waste product made by your body during the digestion of protein. Normally, ammonia is processed in the liver, where it is changed into another waste product called urea. Urea is passed through the body in urine. Signs and symptoms of high ammonia level include: confusion, excessive sleepiness, disorientation- the condition of being confused about time, place, and/or your surroundings, mood swings , hand tremors. If your body can't process or eliminate ammonia, it builds up in the bloodstream. High ammonia levels in the blood can lead to serious health problems, including brain damage, coma, and even death. High ammonia levels in the blood are most often caused by liver disease. Other causes include kidney failure and genetic disorders. Record review of the facility 24 Hour Report Policy dated 7/1/2016 read in part, The nursing staff will complete a 24-Hour Report on each unit/floor, each shift, 7 days per week. The 24-hour report will include, among other things, any status change, changes in resident conditions, appropriated notification and the verification of documentation of any changes .6. The licensed nurse will fill in the narrative section when a change in condition needs to be further documented . Record review of the facility Shift Change Communication Policy dated 7/23/2019 read in part, Shift change reports will occur during resident transfer of care from one provider to another to assure continuity of care . Exchange of information may include but is not limited to . 3c) Critical lab results, 3d) Recent addition, discontinuation or dosage change of medication . Record review of the facility Physician Orders policy dated 7/01/2016 read in part, The qualified licensed nurse will obtain and transcribe orders according to the facility practice guidelines . Medication/Treatment: 2) Transcribe the order onto the MAR . as appropriate. Initial and date the entry on the MAR .6) Record order changed in Progress Notes and 24-Hour Report. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator and the Director of Nursing were notified of Immediate Jeopardy (IJ) on 9/2/21 at 11:35 AM. The Administrator was provide the IJ template on 9/2/21 at 11:38 AM. The following Plan of Removal submitted by the facility was accepted after several revisions on 9/2/21 at 3:21pm. Identified resident is not currently in facility. Residents who reside in the facility and have physician orders for laboratory testing have the potential to be affected by the alleged deficient practice. An audit of physician ordered laboratory tests for the past 30 days for current residents was completed on 9/2/21 by the Director of Nursing / designee to identify any medication changes as a result of abnormal or critical laboratory results and validate that the physician ordered medication change was implemented timely. If any concerns identified related to timely implementation of the medication change, the resident will be assessed, and the physician contacted for further direction. Licensed nurses will be re-educated by the Director of Nursing / designee on the following: Orders given by the physician as a result of the critical laboratory test results are to be documented at the time the order is received and implemented timely Shift to shift report is to be given to oncoming nurse for effective communication regarding resident care and treatment, such as changes of condition, new orders, incident/accidents, abnormal labs. When a resident is found to be unresponsive or in need of emergency services, nurses are to use critical judgement to intervene for an emergency transfer to an acute care facility for changes in condition that cannot be treated effectively in the facility, such as unresponsiveness, inability to obtain a blood pressure or pulse, injury requiring immediate attention. This re-education will be completed on 9/2/21. Any licensed nurse not receiving this training by this date will receive prior to next scheduled shift. This information will be presented to licensed agency staff and in new hire orientation. The Director of Nursing / designee will review laboratory test results in the Clinical Morning meeting Monday through Friday and the charge nurse will review on the weekends to validate that any physician's order change as a result of abnormal or critical laboratory results was implemented timely. The Director of Nursing / designee will review the 24-hour report and will attend shift to shift report daily for 5 days or until compliance has been achieved to validate that communication is occurring related to the care and treatment of the residents. The Director of Nursing / designee will review the 24-hour report and the Facility Activity report Monday through Friday and the charge nurse on weekends to validate that if a resident had a change of condition and needed emergency services intervention that it occurred timely. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility in-service sheets 8/30/21 revealed nurses from both shifts, including weekends and weekdays, were in-serviced on pulling labs throughout each shift, notifying the doctor or nurse practitioner of lab results first and documenting intervention and notifications, interventions to be documented on 24-hour report and charting each shift and entering progress notes of all communications. Record review of the facility in-service sheets 8/30/21 revealed nurses from both shifts, including weekends and weekdays, were in-serviced on changes in conditions, noticing what the change is, completing change in condition assessments, notifying doctor and DON/Administrator, make a progress note and carry out all interventions and new orders, notifying the responsible party, and documenting all interactions or interventions put in place. Record review of the facility in-service sheets 8/30/21 revealed nurses from both shifts, including weekends and weekdays, were in-serviced on obtaining physicians orders via telephone and verbally, physician communications and contacting 911 immediately for life-threatening events, laboratory testing policy and what to do with a critical lab. Record review of the facility in-service sheets 8/30/21 revealed nurses from both shifts, including weekends and weekdays, were in-serviced on utilizing 911 emergency services for life threatening events when unable to obtain vitals, unresponsive residents, no pulse, respirations or code blue, and possible critical labs. Record review of the facility in-service sheets dated 9/2/21 revealed the DON and ADON will monitor and audit shift change and 24-hour reports to ensure communication is provided per the facility policy. The Administrator and the Director of Nursing was informed the Immediate Jeopardy was removed on 9/3/21 at 11:40 AM. The facility remained out of compliance at a scope of isolated and severity of actual harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.