STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455731	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health & Rehab Center of Garland	1201 Colonel Drive Garland, TX 75043

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 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** 44405 Based on observation, interview, and record review, the facility failed to ensure that each resident received necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan and the residents' choice for 3 (Resident #1, Resident #2, and Resident #3) of 8 residents reviewed for respiratory care. 1. On [DATE] RN H failed to obtain a physician's order to administer oxygen to Resident #1 when readmitted to the facility after an acute care hospital stay with the primary diagnoses of Acute on Chronic Respiratory Failure with Hypoxia (a worsening of chronic respiratory failure that can lead to hypoxia [low blood oxygen]); COPD; and CHF. 2. The facility failed to provide appropriate dispensing of oxygen by providing Resident #1 oxygen via nasal cannula (usually delivers oxygen up to ,d+[DATE] liters per minute) at levels that ranged from 7 LPM - 10 LPM on [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE], LVN A failed to accurately assess for a respiratory change of condition when Resident #1 requested to go back to the hospital. 3. LVN A failed to perform adequate supervision or monitoring of Resident #1 for nearly 6 hours during his eight-hour scheduled shift on [DATE] 10:00 PM -6:00 AM ([DATE]) to oversee Resident #1 who required or received respiratory care services (i.e., oxygen therapy, ventilator/noninvasive ventilation, or nebulizer/metered-dose inhalers) to assure that Resident #1 received proper treatment and care. CNA U found Resident #1 unresponsive on [DATE] at approximately 5:05 AM. Resident #1 passed away in the facility. EMS officially declared Resident #1 dead on [DATE] at 5:23 AM. 4. The facility failed to safely handle and perform infection control practices for Resident #2's tracheostomy tubing that was dated [DATE] and was observed resting on the floor on [DATE]. 5. On [DATE], the facility failed to provide consistent oxygen therapy for Resident #3. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:45 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to all staff had not been in-serviced and the facility continuing to monitor the implementation and effectiveness of the corrective systems. (continued on next page)

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

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	These failures placed residents at the risk of not receiving enough or high levels of oxygen, which can cause difficulty breathing, result in a decline in health or possible worsening of symptoms, including death. Findings included: Record review of the nursing schedule dated [DATE] revealed LVN A [Station 3] was scheduled and worked on [DATE] 10:00 PM - 6:00 AM ([DATE]) shift. RESIDENT #1 Record review of Resident #1's 5-day MDS assessment, dated [DATE], reflected the resident was an [AGE] year-old female initially admitted to the facility on [DATE] with primary diagnoses of COPD; Pulmonary Fibrosis (a chronic lung disease that causes scarring of the lungs, making it difficult to breathe); T2DM (a disorder in which the body does not produce enough or respond normally to insulin, causing blood sugar levels to be abnormally high); and Acute and Chronic Respiratory Failure with Hypercapnia (also known as CO? retention, a condition where there is too much carbon dioxide in the blood). Resident #1's most recent readmission to the facility was on [DATE] after an acute care hospital stay [[DATE] - [DATE]] - primary diagnosis at discharge included Acute on Chronic Respiratory Failure with Hypoxia (a worsening of chronic respiratory failure that can lead to hypoxia [low blood oxygen]); COPD; and CHF. Resident #1 had a BIMS Summary Score of 15, which indicated Resident #1 was cognitively intact. The 5-day MDS assessment reflected Resident #1 had shortness of breath or trouble breathing when lying flat and required respiratory treatments - continuous oxygen therapy. The 5-day MDS assessment revealed respiratory therapy was administered for 7 days in the last 7 days. Record review revealed Resident #1 did not receive end of life care, hospice, or palliative care. Resident #1 passed away in the facility on [DATE]. Record review of Resident #1's care plan, closed [DATE], reflected: [Resident #1] refused to wear BiPAP (initiated [DATE]; revised [DATE]). Goal: will be clean, well groomed, and episodes of resistance will decrease to less than weekly through the next review (initiated: [DATE]; revised [DATE]; target [DATE]). Interventions included: Monitor behavior episodes and attempt to determine underlying cause; provide positive reinforcement for tasks accomplished and when accepted needed assistance (initiated [DATE]). [Resident #1] is on Antibiotic Therapy r/t infection. (Initiated [DATE]; cancelled [DATE]). Goal: will be free of any discomfort or adverse side effects of antibiotic therapy through the review date (initiated [DATE]; Target date [DATE]; cancelled [DATE]). Interventions included: Administer medication as ordered (Initiated [DATE]); encourage coughing and deep breathing exercises (Initiated [DATE]); Observe for possible side effects every shift. (Initiated [DATE]). (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[Resident #1] used oxygen therapy routinely or as needed and is at risk for ineffective gas exchange. (Date initiated: [DATE]). Goal: [Resident #1] will have no s/sx of hypoxia (poor oxygen) through the next review date (Date initiated: [DATE]; Target Date: [DATE]). Interventions included: Administer oxygen therapy per physician's orders; Monitor for s/sx of respiratory distress and report to MD PRN; Encourage resident to change position at least every two hours to promote lung expansion and to facilitate secretion movement and drainage; Position with head of bed elevated whenever possible to allow for optimal lung expansion and gas exchange. (Initiated: [DATE]) Respiratory Status: Impaired. [Resident #1] had impaired respiratory status and is at risk for shortness of breath, respiratory distress, increased anxiety, and hypoxia. This is related to a diagnosis of COPD. (Date initiated: [DATE]). Goal: [Resident #1] will have no reports of unrelieved shortness of breath through the next review date (Date initiated: [DATE]; Target Date: [DATE]). Interventions included: may use BiPAP with home settings (Initiated: [DATE]); Administer medications as ordered; Monitor for shortness of breath, respiratory distress, wheezing, fatigue, increased anxiety and implement appropriate ordered interventions. Notify physician if interventions are not effective; Encourage and remind resident to use call light to call for assistance. Instruct resident to report any shortness of breath immediately (initiated [DATE]). Record review of Resident #1's Order Summary Report, printed [DATE], reflected: - Verbal Order date - [DATE]: May see [telehealth] Physician PRN. - Verbal Order date - [DATE]: Albuterol Sulfate Inhalation Nebulization Solution (2.5 mg/3 mL) inhale orally every four hours as needed for Shortness of Breath, Wheezing. [DISCONTINUED on [DATE]] - Prescriber Entered Order date - [DATE]: Albuterol Sulfate Inhalation Nebulization Solution (2.5 mg/3 mL) inhale orally via nebulizer one time only for wheezes throughout; rhonchi bilateral lobes posterior r/t Acute and Chronic Respiratory Failure with Hypoxia and COPD until [DATE]. - Prescriber Entered Order date - [DATE]: Albuterol Sulfate Inhalation Nebulization Solution (2.5 mg/3 mL) 0.083% (Albuterol Sulfate) 2.5 mg inhale orally via nebulizer four times a day for fluid in lungs r/t COPD until [DATE]. - Phone Order date - [DATE]: Chest x-ray (CXR) for cough related to COPD exacerbation. [COMPLETED] - Prescriber Entered Order date - [DATE]: Azithromycin ([antibiotic] used to treat certain bacterial infections) Oral Tablet 500 mg by mouth one time a day for fluid in lungs until [DATE]. - Prescriber Entered Order date - [DATE]: Azithromycin Oral Tablet 250 mg by mouth one time a day for fluid in lungs until [DATE]. - Prescriber Entered Order date - [DATE]: CBC, CMP STAT r/t COPD with exacerbation. [COMPLETED] - Prescriber Entered Order date [DATE]: Furosemide (a strong diuretic [water pill]) Oral Tablet 20 mg. Give 20 mg by mouth three times a day r/t COPD until [DATE]. - Verbal Order date - [DATE]: Full Code (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Verbal Order date - [DATE]: Inspect external O2 filter weekly. Clean/change if needed every night shift every Wednesday for oxygen use. - Verbal Order date - [DATE]: Inspect external O2 filter weekly. Clean/change if needed every night shift for delivering clean oxygen. - Verbal Order date - [DATE]: BiPAP (a noninvasive form of mechanical ventilation delivered through nasal or full-face masks with inspiration (inspiratory positive airway pressure - [IPAP]) and exhalation pressures (expiratory positive airway pressure - [EPAP]) at 12 cm H2O Inspiration and 5 cm H2O Expiration with Oxygen at 5 LPM without humidification. BiPAP scheduled start at bedtime for sleep apnea related to Pulmonary Fibrosis, uns; COPD, uns. Discontinue upon waking. - Verbal Order date - [DATE]: Wipe down the mask, tubing, and machine after each use. Clean the machine, humidifier, mask, and tubing per the manufacturer's recommendations or weekly in the morning for sleep apnea. - Verbal Order date - [DATE]: Change Nebulizer tubing and administration device weekly. Clean/change the nebulizer filter every night shift every Monday for delivering oxygen in clean tubing. Ensure that tubing is dated when changed. - Verbal Order date [DATE]: Change O2 tubing, and humidifier bottle every night shift every Monday. Ensure that tubing is dated when changed. - Verbal Order date [DATE]: Change O2 tubing, and humidifier bottle every night shift for oxygen delivery system hygiene. - Verbal Order date - [DATE]: Incentive Spirometry. Assist/instruct resident to place the mouthpiece in the mouth, sealing lips around it, and breathe in as slowly and deeply as possible, trying to raise the piston towards the top of the column. Instruct them to hold their breath as long as possible before exhaling for 10 repetitions and 4 sets. Encourage the resident to cough between breaths. - Verbal Order date - [DATE]: Monitor respirations and oxygen saturation while using CPAP/BiPAP every 4 hours for sleep apnea. - Verbal Order date - [DATE]: O2 at 9 LPM via NC. Monitor O2 Saturation. Notify physician if SpO2 ([oxygen saturation], a measurement of the percentage of oxygen in the blood relative to its maximum capacity) falls below 90% every shift. [DISCONTINUED [DATE]] - Verbal Order date - [DATE]: Albuterol Sulfate Inhalation Nebulization Solution (2.5 mg/3 mL) 0.083% (Albuterol Sulfate). 1 vial inhale orally every four hours as needed for Shortness of Breath r/t Acute and Chronic Respiratory Failure with Hypoxia. - Prescriber Entered Order date - [DATE]: Nursing: [Resident] to do I/S after each nebulizer treatment. Goal is to pull 2000 mL. Device at bedside. Four times a day for mobilization of secretions related to COPD. - Phone Order date - [DATE]: STAT Chest x-ray r/t cough. [DISCONTINUED] (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Verbal Order date - [DATE]: STAT Chest x-ray r/t fluid overload. [DISCONTINUED] - Prescriber Entered Order date - [DATE]: CBC, CMP STAT r/t Acute and Chronic Respiratory Failure with Hypoxia; COPD with exacerbation. [COMPLETED] - Phone Order date - [DATE]: STAT BNP (blood test about how heart is working by measuring the levels of the BNP protein in the bloodstream) r/t fluid overload. [DISCONTINUED] - Verbal Order date - [DATE]: O2 at 5 LPM via NC. Monitor O2 Saturation. Notify physician if SpO2 falls below 90%. - Prescriber Entered Order date - [DATE]: Levofloxacin ([antibiotic] used to treat bacterial infections) Oral Tablet 500 mg. Give 500 mg by mouth one time a day for PNA (pneumonia) until [DATE] for 5 days. - Prescriber Entered Order date - [DATE]: Methylprednisolone ([a steroid] used to treat inflammatory conditions and respiratory disorders) oral tablet 4 mg. Give 4 mg by mouth two times a day for fluid in lungs r/t Acute and Chronic Respiratory Failure, COPD until [DATE]. Record review of Resident #1's [DATE] eMAR/eTAR, printed [DATE], reflected Methylprednisolone 4 mg tablet ordered to start [DATE] at 4:00 PM was not administered; Levofloxacin 500 mg tablet ordered on [DATE] was not started; oxygen ordered on [DATE] at 9 LPM via NC and [DATE] at 5 LPM via NC were not initialed by a nurse that indicated oxygen was administered. Albuterol Nebulizer treatments were scheduled at 8AM, 12 PM, 4 PM, and 8 PM. The [DATE] eMAR/eTAR did not reflect PRN Albuterol nebulizer treatments (ordered [DATE]; discontinued [DATE]) initialed by a nurse or LVN A that indicated a PRN nebulizer treatment was administered on [DATE] or [DATE]. Record review of Resident #1's Readmit Evaluation, dated [DATE], RN H documented Admitting Diagnosis Acute on chronic Respiratory Failure with Hypoxia, Chronic Pulmonary Edema. Vitals ([DATE] at 8:30 PM): BP ,d+[DATE]; HR 69; Respirations 18. No cough. Breath sounds were clear bilaterally, no shortness of breath noted while lying, sitting, or on exertion. Uses Oxygen at 4 LPM via NC. No sleep aids. Record review did not reflect physician orders for oxygen administration. Record review of Resident #1's progress notes reflected: Alert Note entered by RN H on [DATE] at 9:07 PM, Readmit from [Hospital] via stretcher by 2 paramedics for continued care under [PCP] with the diagnosis of Acute on chronic respiratory failure with hypoxia and Chronic Pulmonary Edema. Head to toe assessment completed. (Vital signs measured - BP, P, R, T), O2 sat 95% on O2 at 4 LPM via nasal cannula, no respiratory distress noted. [PCP] notified of [Resident #1] arrival, [PCP] said to continue hospital transfer orders and to use standard sliding scale for regular insulin. Alert Note entered by LVN A on [DATE] at 11:30 PM, Report received from outgoing nurse (RN H) that [Resident #1] refused the BiPAP and would like it applied later. [Resident #1] refused again. WCTM. Alert Note entered by LVN A on [DATE] at 1:00 AM, [Resident #1] refused the BiPAP again. WCTM. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Alert Note entered by LVN A on [DATE] at 4:22 AM reflected, [Resident #1] told this nurse [LVN A] to call [Resident #1's daughter] and inform that [Resident #1] was going back to the hospital. [LVN A] asked [Resident #1] why was she going to the hospital and [Resident #1] responded I don't know. [LVN A] indicated that Resident #1's oxygen level was difficult to read due to fingers and toes were too cold. Eventually, a 63% [O2 sat] resulted. LVN A indicated that he turned off the fan and covered [Resident #1] entire body up with blankets and obtained a (90% O2 sat) in less than 2 minutes. [Resident #1] stated, 'I was very cold. This feel better'. With resident calm, [LVN A] left the room and returned in about 5 minutes, gave resident her due medication (omeprazole 20mg) and oxygen level re-checked at 99. [Resident #1] denied having a breathing problem and responded yes when asked if she could see her oxygen level in the pulse ox. WCTM. Physician Progress Note entered by NP N (effective date: [DATE] 1:09 PM), New patient [Resident #1] here for COPD exacerbation and needing BiPAP; refusing. [Resident #1] says she feels shortness of breath just sitting up in bed with O2 at 3 LPM per NC. [Resident #1] clarified she does not 'refuse' the BiPAP, but that it makes her nose run and it gets in her mouth, making her feel like she's choking. Auscultated (heard by listening with a stethoscope) wheezes throughout and rhonchi in posterior lobes. c/o anxiety and shortness of breath. Assessment: Wheezes heard throughout; rales heard in both lower lobes posteriorly; [Resident #1] is short of breath just sitting and becomes 'more short' of breath and labored respiration when moves in bed. Alert Note entered by LVN A on [DATE] at 11:45 PM, [Resident #1] refused BiPAP. No SOB noted. WCTM. No Daily Skilled Note entered on [DATE]. Alert Note entered by LVN A on [DATE] at 5:46 AM, [Resident #1] is calm and with eyes closed. On continuous oxygen at 10 LPM via nasal canula and tolerating well. Nursing Note entered by LVN J on [DATE] at 11:12 AM, [NP N] in the building this shift doing rounds. New order per NP N for CXR due to COPD exacerbation. Order faxed to [mobile diagnostic]. Alert Note entered by RN H on [DATE] at 4:58 PM, Following chest x-ray result, [Resident #1] was placed on Zithromycin 500 mg by mouth, 1 dose today followed by 250 mg daily by mouth for four days for fluid in the lungs and nebulizer treatment every four hours. Order initiated. Family visiting, aware of new order. Alert Note entered by LVN I on [DATE] at 11:17 PM, [Resident #1] c/o SOB and had all her clothes off saying she is very hot and want to go back to the hospital. Vitals were T 97, P 82, R 18, BP ,d+[DATE], O2 sat was 78% via NC at the maximum (An oxygen concentrator can generate up to 15 liters of oxygen per minute. A nasal cannula usually delivers oxygen up to ,d+[DATE] liters per minute. A simple face mask is necessary to deliver oxygen at a flow rate of ,d+[DATE] liters per minute). [LVN I] remained at [Resident #1] bed side to reduce [Resident #1] anxiety. [Resident #1] was reassured dressed warm and nebulizer treatment was administered. After treatment, O2 sat was 97%. [Resident #1] showed sign of relief and went to sleep. WCTM. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Physician's Note entered by NP N dated [DATE] (effective date: [DATE] 5:45 AM), CXR late yesterday revealed fluid in most lobes. Per nurse, [Resident #1] is on 10 LPM O2 via NC with O2 sats at 97%. Nurse says [Resident #1] is moving around a lot, had taken off her clothes earlier in the night and O2 sats were found to be 79%. After clothes were placed back on by nurse, O2 sats increased to 95% on 10 LPM O2 per NC. No Daily Skilled Note entered on [DATE]. Daily Skilled Note LATE ENTRY entered by RN B dated [DATE] at 11:28 AM, [Resident #1] requires daily skilled observation for respiratory issues. Respiratory rate is regular. Has shortness of breath noted with exertion. Shortness of breath present when lying flat. Oxygen therapy utilized. Nebulizer treatment was administered. [Resident #1] was repositioned to alleviate SOB. Wheezes are noted upon auscultation of breath sounds. No cough noted this shift. [Resident #1] on O2 at 7 LPM via BiPAP. Daily Skilled Note entered by RN B on [DATE] at 10:45 AM, [Resident #1] requires daily skilled observation for respiratory issues. SpO2 at 96% with oxygen in place. Respiratory rate is regular. No shortness of breath noted this shift. Lungs are clear. No cough noted this shift. Resident on O2 at 7 LPM via BiPAP. OTHER OBSERVATIONS: Dyspnea on exertion. Daily Skilled Note entered by LVN J on [DATE] at 11:15 AM, [Resident #1] requires daily skilled observation for cardiac issues, circulatory issues, teaching/education. SpO2 at 95% on room air with oxygen in place. Respiratory rate is regular. No shortness of breath noted this shift. Lungs are clear. No cough noted this shift. [Resident #1] on O2 at 3 LPM via NC. No changes were noted to the resident's respiratory status. Record review of lab results dated [DATE] at 11:03 AM revealed CO2 (bicarbonate) levels 40.0 HIGH (normal range: 22.0 - 29.0). Record review of Resident #1's progress notes reflected: Lab Note entered by LVN J on [DATE] at 1:53 PM, Lab results in for CBC and CMP. Reviewed by NP N. No new orders. Physician Progress Note entered by NP N (effective date: [DATE] 2:22 PM), Follow up visit for COPD exacerbation. [Resident #1] on 9 LPM 02 via NC with 02 sats at 96%. Nurse says [Resident #1] is yelling out a lot saying she 'can't catch my breath'. Per night shift nurse 97% on 10L O2. [Resident #1] appears anxious. Physician Progress Note entered by NP N (effective date: [DATE] 4:16 AM), [PCP L] informed of [Resident #1's] condition. [PCP L] saw [Resident #1] suggested to give medication by mouth and to cancel midline. Physician Progress Note entered by NP N ([Addendum] effective date: [DATE] 6:09 AM), Lab results show [potassium] 4.0 and WBC 9.1. Will continue round of antibiotics and continue with Lasix and potassium replacement. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Alert Note entered by LVN A on [DATE] at 11:04 PM, Radiology report received, Moderate bilateral scattered pneumonias. Report forwarded to [APN K, on call TeleDoc provider]. No new orders. [Resident #1] already on treatment for pneumonia, per APN K. No Daily Skilled Note entered on [DATE]. [On call telehealth] Health Note entered by APN K dated [DATE] 2:11 AM (Effective Date: [DATE] at 11:02 PM), Details: Nurse Name (LVN A). Primary Chief complaint: Radiology review. Abnormal results requiring provider assessment. Received chest x-ray result. Result reveals moderate bilateral scattered pneumonias. Pt already started on Levaquin 500 mg one time daily today. [Resident #1] VSS. Reviewed past medical history and medications. Per nurse Vitals T 97.4; HR 67; BP ,d+[DATE]; Respirations 16; SpO2 95%. Physical exam findings per nurse and video observation. No new order. Will continue to monitor pt. Disposition: Stay at facility. Technology used: Audio and video with patient and nurse present. Alert Note entered by LVN A on [DATE] at 7:06 AM (Effective date: [DATE] at 1:00 AM), Resident in bed resting. No form of distress noted. Oxygen at 10 LPM in continuous use with nasal cannula in place. Respiration even and non-labored. WCTM. Alert Note entered by LVN A on [DATE] at 07:27 AM (Effective date: [DATE] at 2:45 AM), Rounds made and resident is awake and requested for a breathing treatment which this nurse administered and waited for the treatment to be completed. O2 sat after the treatment was 95%. This nurse exit the room around 3:04 AM. Alert Note entered by LVN A on [DATE] at 8:17 AM (Effective date: [DATE] at 4:50 AM) indicated that [LVN A] was called to the room that resident is unresponsive. This nurse left the med pass and went with the staff. Code blue is called and CPR started. A nurse called 911 and 2 policemen came followed by the emergency crew which pronounced resident dead around 0515. The nurse that called 911, also informed this nurse that the family had been notified and were on their way to the facility. The policemen obtained information, needed and gave a report number. The policemen gave the medical examiners numbers to this nurse to call, that the examiner is waiting on the call. This nurse called the medical examiner and was issued a report number. Alert Note entered by LVN A effective date [DATE] at 8:29 AM, DON and ADON aware. Physician Progress Note entered by PCP effective date [DATE] at 12:15 PM, Service date: [DATE], Pt seen today as routine visit. All recent notes and documents were reviewed; all recent vital signs and labs were reviewed; all medications were reviewed; no issues or concerns per nursing except for pt refusing CPAP at night. Pt was just hospitalized ; does not feel like her breathing is improving; pt appears in no distress but condition is guarded. Document e-signed by PCP on [DATE] at 10:15 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455731	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health & Rehab Center of Garland	1201 Colonel Drive Garland, TX 75043

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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	Record review of the F.D. Care Report dated [DATE] reflected a call date and time, [DATE] at 5:13 AM for a Cardiac Arrest - Possible DOA. The response mode was Emergent (Immediate Response) to the facility. The arrival time at scene was 5:20 AM and at Resident #1, 5:22 AM. The Care Report narrative reflected, [EMS] arrives on scene [at facility] and finds [Resident #1] lying in bed with facility staff performing CPR. EMS takes over and assesses. [Resident #1] has no pulse and has signs incompatible with life (Rigor and dependent lividity) [considered early postmortem changes that occur 3 to 72 hours after death]. Resuscitation efforts discontinued and [Resident #1] declared dead on scene. EMS clears from scene. The disposition reflected Patient Dead at Scene - No Resuscitation Attempted. EMS departed at 5:34 AM. Record review of the P.D. Incident Report dated [DATE] at 6:38 AM, the officer's [Officer V] narrative reflected officers were dispatched to the facility on [DATE] at 5:14 AM. Upon arrival, officers observed [LVN A] performing CPR on [Resident #1] who was lying fully dressed, on her back, in her bed. [LVN A] advised Officer V that approximately 3:00 AM ([DATE]), LVN A had gone to Resident #1's room to give oxygen. LVN A stated that Resident #1 was in good health, with no apparent complications. At approximately 5:00 AM ([DATE]), CNA U made her last checkup rounds before end of shift at 6:00 AM. CNA U found [Resident #1] to be unconscious and not breathing. CNA U immediately called for LVN A, at which point [LVN A] began to perform CPR on Resident #1 and shortly thereafter officers arrived on scene. Officer V spoke with CNA U who advised the same exact story. The F.D. arrived on scene and declared the time of death at 5:23 AM ([DATE]). Record review of the Detective's Clearance Statement dated [DATE] at 1:08 PM reflected, On [DATE] [Detective] reviewed the unattended death of [Resident #1]. [Detective] spoke with [family member] who described Resident #1 cold to touch upon arrival to facility after notification that Resident #1 passed away. [Family member] stated that there was video that revealed LVN A did not check on Resident #1 at 3:00 AM. Video was received from [family member] and reviewed. The video did not reveal that any staff appeared to check in on [Resident #1] (at approximately before or after 3:00 AM) until found deceased ([DATE] after 5:00 AM). During an interview on [DATE] at 11:50 AM, the MOD stated he was the RN weekend supervisor, 6A - 10P. The MOD said that he recalled Resident #1 and described her as able to verbalize wants and needs, received oxygen continuously, but was unaware of any respiratory distress during the weekend of [DATE] and [DATE]. The MOD said that [Resident #1] often complained about shortness of breath and if her O2 sat levels were below 88% with oxygen, [Resident #1] would be sent to the hospital. The MOD said other respiratory changes of condition included, difficulty speaking or gasping due to breathing difficulty; tightness in chest; or unresolved wheezes with breathing treatment. An attempt to interview PCP L by telephone on [DATE] at 11:58 AM was answered and routed to an automated system with hospital options. Unable to leave message. During an interview on [DATE] at 12:25 PM, the complainant stated that the police responded to a 911 call on [DATE] for a resident who was unresponsive. The complainant stated based on interviews and video evidence of the incident, the night nurse did not check on Resident #1 every two hours or provided treatments as [LVN A] stated to the police. The complainant stated the video evidence showed [Resident #1] was found around 5:00 AM unresponsive. The complainant stated that [Resident #1] was found deceased . The complainant stated that he would forward the video evidence to the investigator for review. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation of video surveillance recorded [DATE] 9:45 PM - [DATE] 9:00 AM was conducted. The following time stamps from the video surveillance revealed (privacy curtain was drawn): LVN A did not perform change of shift rounds at start of shift ([DATE] at 10:00 PM). [DATE] at 11:33 PM: CNA U responded to and turned off Resident #1's call light. [DATE] at 11:37 PM: LVN A entered room and approached Resident #1. LVN A exited the room at 11:39 PM. There were no rounds activity to Resident #1's room again until [DATE] at 5:05 AM. [DATE] at 5:05 AM: CNA U entered room with incontinent care supplies and approached Resident #1. CNA U exited room a few seconds later. [DATE] at 5:06 AM: CNA U returned to Resident #1's room with LVN A. Both staff approached Resident #1 at bedside. CNA U exited the room at 5:07 AM. [DATE] at 5:08 AM: An unidentified male nurse entered [Resident #1's] room and approached Resident #1's bedside. Unidentified male nurse exited room at 5:09 AM. [DATE] at 5:11 AM: An unidentified staff member entered the room. At 5:12 AM a second unidentified staff member entered the room. [DATE] at 5:12 AM: The unidentified male nurse returned to Resident #1's room pushing the crash cart. [DATE] at 5:13 AM: An unidentified female staff entered the room with the AED. [DATE] at 5:21 AM: Two officers entered the room. [DATE] at 5:22 AM: Five EMS entered the room and approach [TRUNCATED]