

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Cascades at Galveston		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	

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)
<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47358</p> <p>Based on interviews and record reviews, the facility failed to ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice for 1 (Resident # 1) of 7 residents reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #1 was provided oxygen during transport to doctors appointment in which Resident #1 arrived to appointment with O2 level at 73%, had difficulty breathing and required O2.</p> <p>An IJ was identified on 3/7/2024. The IJ template was provided to the facility on [DATE] at 4:20 pm. While the IJ was removed on 3/8/2024, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that was not immediate due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This failure placed residents who received oxygen therapy at risk of respiratory complications and/or death.</p> <p>The findings included:</p> <p>Record review of Resident # 1's Admission Records, dated 2/12/2022, revealed a [AGE] year-old male who was admitted on [DATE]. Resident's diagnoses included Chronic Obstructive Pulmonary Disease (obstructed airflow from the lungs), Atrial Fibrillation (an irregular rapid heart rate that causes poor blood flow), Atherosclerotic Heart Disease of Native Coronary Artery without Angina(Coronary artery disease starts when fats, cholesterol and other substances collect on the inner walls of the heart arteries), Diabetes Mellitus (A group of diseases that result in too much sugar in the blood), and Hypertensive Heart Disease with Heart Failure (Hypertensive heart disease can lead to either diastolic heart failure, systolic failure, or a combination of the two).</p> <p>Record review of Resident #1's care plan, dated 2/119/2024, revealed Resident # 1 had COPD, Hypoxic (an absence of enough oxygen), Hypercapnic(high levels of carbon dioxide in the blood) , Respiratory Failure(blood does not have oxygen or has too much carbon dioxide), Pulmonary Hypertension(high blood pressure that affects arteries), and Pulmonary Edema (excess fluid in the lungs). Goal: The resident would be free of s/sx of complications of cardiac problems through the review date. The resident will display optimal breathing patterns daily through the review date. Interventions: aerosol or bronchodilators as ordered, give cardiac medication as ordered by physician, monitoring for difficulty breathing (Dyspnea) on exertion, and monitoring for s/sx for acute respiratory insufficiency.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident # 1's physician orders, dated 1/9/2024, reflected in part oxygen at 5L/min via nasal cannula continuous. Directions: every shift for Dyspnea, start date 1/9/2024 .</p> <p>Record review of Resident # 1's O2 sat summary, dated 2/21/2024- 2/23/2024, reflected in part:</p> <p>Date/Time Value Method</p> <p>2/23/2024 at 8:19 am 97% Room Air</p> <p>2/22/2024 at 10:58 pm 97% Oxygen via Nasal Canula</p> <p>2/22/2024 at 8:29 pm 95% Oxygen via Nasal Canula</p> <p>2/22/2024 at 9:50 am 93% Oxygen via Nasal Canula</p> <p>2/21/2024 at 11:16 pm 94% Oxygen via Nasal Canula</p> <p>2/21/2024 at 10:44 am 95% Oxygen via Nasal Canula</p> <p>2/21/2024 at 6:30 am 94% Room Air</p> <p>2/21/2024 at 00:15 am 95% Oxygen via Nasal Canula</p> <p>In a telephone interview with the Clinic Nurse on 2/23/2024 at 11:00 am she reported that Resident #1 had an office visit on 2/22/2024. She reported that Resident # 1 arrived without a portable oxygen tank. She reported that Resident #1 oxygen level was at 73% and Resident # 1 stated he had shortness of breath but was not under respiratory distress. She reported that Resident # 1 was administered 4L O2 supply and Resident # 1 breathing improved. She stated that Resident # 1's oxygen saturation increased to 91-93%. She stated that Resident # 1 should have a portable oxygen tank. She stated that she contacted the Nursing Facility and she spoke with the ADON who confirmed that Resident # 1 was oxygen dependent.</p> <p>In an interview with Resident # 1 on 2/23/2024 at 12:10 pm he stated he was administered oxygen throughout the day 3 times a day. He stated that he was transported to a Pulmonary visit a on 2/22/2024. He stated was given oxygen earlier that day and when he left the facility he felt fine. He stated he walked from the waiting area to the examining room and was short of breath. He stated that he always had shortness of breath due to his COPD. He stated that the clinic nurse checked his oxygen, and it was low. He stated that the nurse at the clinic administered oxygen and he felt better. He stated that in the past when he left the facility, he was transported with a portable oxygen tank.</p> <p>In an interview with the ADON on 2/23/2024 at 2:40 pm she stated that Resident # 1 was transported to the clinic without a portable oxygen tank. She stated that Resident # 1 is on continuous oxygen and the portable oxygen tank should have been transported with Resident # 1. She stated that she was informed by the clinic nurse that when Resident # 1 arrived at the clinic his oxygen level was at 75%. The ADON stated that was Resident # 1's attending nurse LVN A) responsibility to make certain that he was transported with a portable oxygen tank. She stated if a residents oxygen level was 74%, he could have gone into respiratory failure. She stated it could have been fatal.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with LVN A on 2/23/2024 at 2:59 pm she stated she was Resident # 1's nurse and she was not aware that Resident # 1 had left the facility. She stated she was aware the Resident # 1 had an appointment. She stated that the transporter asked her to print out paperwork for Resident # 1. She stated that she informed the transporter that she would print the paperwork for Resident # 1 once she finished assisting another resident. She stated that when she returned to the desk to retrieve the paperwork Resident # 1 was gone. She stated that she did not assess Resident # 1 prior to him being transported to his appointment. She stated that Resident # 1 is oxygen dependent, and he should have been transported with a portable oxygen tank. She stated that Resident # 1 was on continuous oxygen. She stated that the nurse is responsible for making certain the resident is transported with a portable oxygen tank. She stated that if a resident's oxygen level is low the resident could have gone into respiratory distress.</p> <p>In an interview with the Transporter, on 2/23/2024 at 3:32 pm he stated that LVN A was aware that Resident # 1 was being transported to a clinic visit. The Transporter stated that LVN A printed the admission paperwork for Resident # 1 and gave it to him. He stated that he met Resident # 1 in the hallway, and he assumed Resident # 1 was ready for transport. He stated that Resident # 1 was transported to the clinic visit without the portable oxygen tank. The Transporter stated that the nurse is responsible for making certain that residents have all needed items prior to being transported. He stated that he does not review the Resident's paperwork. He stated that LVN A gave him Resident # 1 paperwork and he transported Resident # 1 to his appointment. He stated that he is aware that Resident # 1 is on oxygen, however, he normally saw Resident # 1 off oxygen as Resident # 1 is a smoker. He stated that Resident # 1 did not have portable oxygen tank during transport.</p> <p>In an interview with the Administrator, on 2/23/2024 at 4:00 pm he stated that he was aware that Resident # 1 was on oxygen, however, he did not know if the oxygen was prn or continuous. He stated he was not aware that Resident # 1 left the facility without the portable oxygen tank. The Administrator stated that when a resident is transported from the facility the transporter meets with the nurse regarding the resident needs.</p> <p>The Regional Nurse and Administrator were notified on 3/7/2024 at 4:20 pm that an Immediate Jeopardy (IJ) was identified due to the above failures. The IJ template was presented to the facility at this time and a plan of removal was requested</p> <p>The facility's Plan of Removal was accepted on 3/8/2024 at 1:41 pm and included:</p> <p>PLAN OF REMOVAL: F695</p> <p>Name of facility: Cascades at Galveston</p> <p>Date: March 7, 2024</p> <p>The facility failed to ensure Resident #1 was provided respiratory care consistent with professional standards of practice. Resident #1 was transported to an offsite physician's office and was not provided continuous oxygen as ordered by his physician.</p> <p>Immediate action:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1 was immediately assessed ADON upon return to the facility from appointment on 2/22/24 and found to have an O2 sat of 97%. Since time of incident, resident's oxygen order was changed and only to be administered PRN based on his oxygen level.</p> <p>On 3/7/24 the facility IDT reviewed/ revised the system for assuring that any resident that is to be on continuous oxygen has the oxygen in place prior to leaving the facility for any appointments where transportation is provided by the facility and created a plan of improvement to address changes including placing an additional transportation binder that identifies each resident that is on continuous oxygen. In addition, a blue alert sheet will be placed in front of the individual sign out sheet for resident that is on continuous oxygen that will alert anyone wishing to sign the resident out of the facility to Please see nurse prior to signing resident out on pass.</p> <p>Ad Hoc QAPI meeting completed with IDT, Regional Nurse Consultant, Administrator, Administrative Nurses, and Medical Director on 3/7/24 at 7 p.m.</p> <p>Policy for transportation reviewed and updated by IDT on 3/7/24 to address residents on continuous oxygen. Approved by medical director on 3/7/24.</p> <p>Facilities Plan to ensure compliance quickly:</p> <p>Facility interventions were implemented to remove immediate jeopardy:</p> <ol style="list-style-type: none"> 1. A facility audit was conducted by Regional Nurse Consultant (RNC), on 3/7/24 to identify any resident currently ordered to be on continuous oxygen to determine if they had any appointments within the last 30 days that they went to without oxygen in place. None were identified. 2. RNC completed education to transportation tech on 3/7/24 related to determining if a resident requires continuous oxygen by utilizing the transportation binder at the nurse's station that lists all residents with orders for continuous oxygen, assuring that the resident has the oxygen in place prior to leaving facility and steps to take if issues arise. In addition, a blue alert sheet will be placed in front of the individual sign out sheet for resident that is on continuous oxygen that will alert anyone wishing to sign the resident out of the facility to Please see nurse prior to signing resident out on pass. 3. Education initiated by RNC/ADON to nursing staff related to determining if a resident requires continuous oxygen, assuring that the resident has the oxygen in place prior to leaving for any facility transported appointment. If a resident is being transferred by an outside transportation company or family member, a copy of the blue alert sheet will be attached to the resident face sheet indicating that they require continuous oxygen. *Education to be completed with all nursing staff working 3/8/2024. Staff who did not receive the training will receive this training prior to their next shift and will not be allowed to provide direct resident care until they have completed the training. 4. Administrative nurse in-serviced 3/7/24 by RNC regarding assuring that any resident that is placed on continuous oxygen is placed in the binder and to check appointments daily in clinical meeting, updating the transport binder at the nurses station if needed, assuring that any resident that receives a new order for continuous oxygen is placed in the binder and an alert sheet is placed in the sign out book. Nursing staff and the transportation tech will have access to the transportation binder at the nurse's station. <p>(continued on next page)</p>		

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