STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675305	A. Building B. Wing	09/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Valley Healthcare and Rehabilitation Cent	1525 Pleasant Valley Rd Garland, TX 75040

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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interviews and record review, the facility failed to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of six residents reviewed for Dialysis Care. 1)The facility failed to follow Resident #1's Dialysis Communication: Special instructions/progress note dated Thursday [DATE] for Resident #1 to go to the hospital for a permacath placement because she was not able to be dialyzed that day. 2)LVN A failed to notify Resident #1's Doctor or NP about the Dialysis Center's special instructions for Resident #1 to go to the hospital on [DATE]. 3)LVN A failed to properly assess and document Resident #1's vital signs on [DATE], before leaving for dialysis and after she returned from dialysis. After administrative review, an IJ was identified on [DATE]. The Administrator was notified and an IJ Template was provided on [DATE] at 12:43 pm. While the Immediate Jeopardy was removed on [DATE] at 3:48 pm, The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. These failures could place all dialysis residents at risk of not being assessed and treated in a timely manner if they were not able to be dialyzed, which could cause abnormal vital signs and changes in condition, resulting in a decline in their health, psycho-social well-being, or death. Findings included: Record review of Resident #1's Admission MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted on [DATE] with a BIMS score of 08 (moderate cognitive impairment) and used a manual wheelchair and walker. She had no upper or lower impairments and dependent: helper does all assistance with all ADL care. Active diagnoses of other neurological conditions, anemia, hypertension, gastroesophageal reflux, renal insufficiency and diabetes mellitus, malnutrition, depression, asthma, and morbid obesity. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's Order Summary Report printed [DATE] revealed, she took Advair Diskus Aerosol Powder breath activated (for shortness of breath, COPD, mild persistent asthma), Albuterol Sulfate inhalation nebulization solution (for COPD, mild persistent asthma), carvedilol (for hypertension), renal-vite oral tablet (for kidneys), and Sevelamer Carbonate (for chronic kidney disease). And to monitor & record every shift AV (arteriovenous) shunt/fistula for bleeding. Redness, swelling, pain, s/s of infection. Document (-) absent or if (+) present notify MD and Dialysis center every shift. Record review of Resident #1's Order Summary Report printed on [DATE] did not reveal any Doctor/NP orders for a vascular consult. Record review of Resident #1's Care Plan dated [DATE] revealed, she needed dialysis (hemodialysis) r/t renal failure. Will have immediate intervention should any s/sx of complications from dialysis occur through the review date. Will have no s/sx of complications from dialysis through the review date. Check and change dressing daily at access site. Document. Check arteriovenous fistula every day for bruit and thrill HEMODIALYSIS (filtering a patient's blood to remove waste and excess fluid) 3X/WEEK EVERY Tuesday/Thursday/Saturday AT 11AM DIALYSIS CENTER [The Dialysis Center] every day and evening shift every Tuesday, Thursday, Saturday Monitor/document report to MD s/sx of depression. Obtain order for mental health consult if needed. Record review of Resident #1's last Blood Pressure check in the facility's EMR dated [DATE] at 7:43 am by MA P revealed, her blood pressure was ,d+[DATE] sitting left arm. Record review of Resident #1's Nurse Progress note dated [DATE] at 11:00 am by LVN A revealed, Resident up in a wheelchair ready for dialysis, denies pain when asked , and no s/s of distress noted, medications administered as ordered and well consumed, resident is on routine tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth four times a day for PAIN Pregabalin Oral Capsule 75 MG (Pregabalin) Give 2 capsule by mouth two times a day for NEUROPHATIC PAIN, resident has a behavior of yelling, when care is being provided, requires redirection at times . Will continue with her current plan of care. Record review of Resident #1's Social Services note dated [DATE] at 12:15 pm by SW G revealed, FM P called writer and advised resident needs to be picked up from dialysis. Writer notified nurse . Record review of Resident #1's Nursing Dialysis Communication Form by unknown nurse dated [DATE] at 11:24 am revealed, Fasting Blood sugar: 124, BP ,d+[DATE], Temp 98.2, Pulse 82, and respirations 17. Behavior: Yells. And at the bottom half of sheet by Dialysis Nurse special instructions/progress note, Patient was not dialyzed today, access site bruised, FM P will take patient to hospital for permacath placement. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's Dialysis Progress Note dated [DATE] revealed, Patient came in today brought in by nursing home transport patient was very lethargic, AVF site is still bruised and swollen, from previous infiltration on [DATE] as patient was always moving her access arm which is the reason why pt had permcath for a long time. So, I called FM P, I told her of the situation that we are not able to dialyze patient this day due to swollen access site, FM P said she will bring patient to Hospital today for permcath placement. I also consulted this with Nephrologist Doctor, and she is ok with permcath placement again as patient always move her arm during HD and causing infiltration. I called [The Nursing Facility] to make them aware of the plan. After about ,d+[DATE] minutes, Patient was picked up by nursing home transport via wheelchair, patient was stable at the time, patient was talking to staff when asked questions. Record review of Resident #1's Nurse Progress note dated [DATE] at 12:45 pm by the ADON in training I, revealed, Received request for patient to be picked up from dialysis at approximately 12:30 pm, placed call to [The Dialysis Center]and spoke with Dialysis Nurse stating that attempt to access patient fistula was unsuccessful due to swelling to the RUE and recommended patient be seen by vascular in hospital or at office, dialysis nurse did not have information for vascular, transport arranged to have patient picked up from dialysis center. Call placed to FM P at 12:40 and informed her that dialysis could not be completed and that transport was be arranging for pick up from dialysis and patient needed to have vascular appointment to establish access site, FM P provided vascular office information, at 12:47 pm call placed to [The Vascular Center] informed of need for appointment to establish dialysis access, [The Vascular Center] to return call with further instructions. FM P updated and aware of plan. Record review of Resident #1's Nurse Progress note dated [DATE] at 4:46 pm by ADON D revealed, This nurse passing by Resident's room approx. 2:35 pm noticed resident position in w/c with arms hanging at side. This nurse called out Resident's name while walking toward Resident no response, noticed chest not moving up and down called out for help while palpitating for pulse. No pulse palpitated initiated code blue. Staff transferred Resident to floor. CPR initiated. Resident review of Resident #1 Nurse Progress note dated [DATE] at 3:00 pm by ADON I revealed, At 2:47 pm this nurse and social services notified FM P, of change up call placed at 2:55 pm to update FM P that patient was being transported to hospital via 911 ambulance. Record review of Resident #1's Nurse Progress note by LVN A dated [DATE] at 3:21 pm revealed, At around 2:35 pm wound nurse called for help that Resident is unresponsive, Entered the room, on assessment Resident unresponsive, Code status verified. Resident is Full code, CPR initiated, 911 called. Foam like secretions from resident's mouth, suctioned EMS and Police arrived at 2.45 CPR taken over by EMS, 14:52 FM P notified, DON/ ED (Executive Director) notified. Resident transported to the hospital via stretcher. Record review of Resident #1's Nurse Progress note dated [DATE] at 3:46 by the DON and LVN A revealed, Change in Condition : Symptoms or signs noted of Condition change: Cardiac arrest Refer to e-INTERACT Change in Condition for Full Evaluation Vital Signs : BP ,d+[DATE] - [DATE] 07:43 Position: Sitting l/arm P 77 - [DATE] 07:43 Pulse Type: Regular R 0 - [DATE] 15:47 T 97.9 - [DATE] 19:52 Route: Forehead (non-contact) O2 93.0 % - [DATE] NP Date and time of clinician notification: [DATE] 2:45 PM. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the Paramedic Prehospital Report dated [DATE] revealed, At [DATE] at 2:40 pm 911 called and at [DATE] at 2:43 pm paramedics arrived. Cardiac Arrest - Possible DOA: A female lying supine on the floor with staff performing CPR. Staff was using a bag valve mask with 100% O2 and performing chest compressions with an AED attached to the pt. Staff said pt was supposed to have dialysis today but it was not completed, and she was returned to the nursing/rehab facility. Staff said pt was last seen about 2pm and the arrest was not witnessed. Compressions continued while we prepared to move pt to the stretcher. We lifted pt and placed her on the stretcher without incident. We transported pt to the hospital while continuing CPR. Upon arrival to the ER, we were directed to a room and met by a team of nurses and a doctor. O2 at bedside was 90. We moved pt over to the ER bed with Paramedic still providing compressions. Pt care transferred to ER nurse. Transfer of care: [DATE] at 3:13 pm. Record review of Resident #1's Hospital Report dated [DATE] revealed, at 3:15 pm revealed, Pulse: 204, respiration:101, BP --, SPO2 --, Chief Complaint: Cardiac Arrest: 4:26 PM Resident #1 is a 67 y.o. female with past medical history of anemia, asthma, COPD, dementia, depression, diabetes, hypertension who presents to the ED (emergency department) c/o (complaints of) cardiac arrest. Patient was last seen at 2 PM. EMS was called at 2:35 pm when staff found her unresponsive. There was bystander CPR EMS responded and placed a [NAME] (airway device) and continued CPR. She received 3 rounds of epinephrine, sodium bicarbonate, calcium gluconate. Patient was still asystolic (no heartbeat) upon arrival. History limited secondary to patient's medical status. bicarbonate. Patient was defibrillated twice and regained a pulse. Patient in normal sinus rhythm currently. Blood pressure dropped transiently in the ER so Levophed (low blood pressure medications) was initiated. Plan is admission to the ICU. I spoke to the ICU app. The hospitalist will admit. Labs Reviewed - CBC WITH AUTO DIFFERENTIAL - Abnormal Result Value WBC 22.5 (*) RBC 2.75 (*) Hemoglobin 8.8 (*) Hematocrit 28.9 (*) MCV 105.1 (*) MCH 32.0 MCHC 30.4 (*) RDW-CV 15.9 (*) Platelet Count 284 (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	7.11 (*) Osmolality Calc 280 [NAME] Score -2.02 (*) Icterus <2.0 Turbidity <20.0 Hemolysis 21.0 And on [DATE]: Hospital Course and Treatments Rendered: Status postcardiac arrest Etiology unclear, Family decided on withdrawal of care. Patient was terminally extubated on [DATE] and started on comfort measures. Patient expired and was pronounced deceased at 2:35 pm on [DATE]. Acute respiratory failure as above, Septic shock, S/p pressors and antibiotics, ESRD S/p hemodialysis. Initiated comfort measures as above. In an interview on [DATE] at 1:08 pm, ADON B stated Resident #1 was a new admit and on [DATE], FM P called this facility asking if they could send Resident #1 to the hospital for a problem with her catheter. He stated he was not sure what was going on, because the Dialysis Nurse said he called FM P to take Resident #1 to the hospital and not the facility. He stated the Dialysis Nurse said he called FM P about her shunt (dialysis access port) site not working right and she was not dialyzed. He stated he spoke to the dialysis nurse, but could not remember his name, he was told they were in the process of sending her to the hospital. He stated [The Nursing Facility] driver picked up and dropped off Resident #1 to this facility and FM P gave Resident #1's vascular Doctor information. He stated the last report was of Resident #1 watching TV and nothing was out of the ordinary going on with her then she became unresponsive. He stated they started CPR and called 911 and she was revived and transferred to the hospital. Resident #1 went to dialysis at 11:00 am and returned to this facility around 1:30 pm then she had a change in condition and the paramedics took her to the hospital at 2:45 pm. He stated Resident #1 had not returned yet and was unsure of her medical status. In an interview on [DATE] at 2:37 pm, CNA C stated a few weeks ago and a little after 2:00 pm, they announced the code blue to Resident #1's room and she was laid onto the floor to start CPR compressions. He stated a nurse was getting O2, ADON B and ADON D started doing CPR, then the paramedics arrived within 30 minutes. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 3:00 pm, ADON D stated on the morning of [DATE] Resident #1 was her normal self and her vitals were within normal limits. She stated she saw Resident #1 back from dialysis around 1:30 pm or 1:45 and she appeared fine. She stated around 2:30 pm she was walking down the hallway and noticed Resident #1 was in her room sitting in her wheelchair, with both of her hands down. She stated her chest was not rising and going down, then she called for help immediately, and LVN A and ADON B came in. She stated she was doing a sternal rub and CNA C and CNA E came and they lowered her to the floor to start doing chest compressions. She stated she continued doing chest compressions, the crash cart and AED was brought in and were used, and 911was called. She stated CPR compressions were being rotated between her, the DON in training, and LVN A until the paramedics arrived, and they took over chest compressions. She stated they were able to get Resident #1's heartbeat back and the paramedics took her on a stretcher to the hospital. She stated last she heard; she was on a ventilator in the ICU. She stated last week Resident #1's family came to pick up her personal belongings and FM P wanted to know what happened to their mother. In an interview on [DATE] at 3:54 pm, LVN F stated around the change of shift, LVN A was giving her report about Resident #1 and how she went to dialysis but was not dialyzed because a of problem with her access port. She stated being told vascular was pending to change Resident #1's access port when she received the code blue. She stated ADON D was the staff that initially saw the resident unresponsive, they started CPR and 911 was called, and the paramedics took over. She stated Resident #1 was then taken to the hospital and last she heard she was on a ventilator. In an interview on [DATE] at 4:18 pm, SW G stated on [DATE] around 11:00 am or 12:00 pm, FM P called saying the Dialysis Center wanted them to pick Resident #1 up. She stated there was never any mention for Resident #1 to go to the hospital, but she did notify the Facility's Van Driver H to pick her up from the Dialysis Center. In an interview on [DATE] at 4:06 pm, Facility Driver H stated he dropped Resident #1 off to dialysis at 11:00 am and she appeared to be fine. He stated he received a call to pick up Resident #1 because she was not dialyzed, and he picked her up around 12:00 pm or 12:30 pm. He stated she looked fine and dropped her to [This Nursing Facility] and he was not told to take her to the hospital. He stated he rolled her to her room, she said thank you, and he left to pick up another resident. He stated she was not in any distress. She had on her O2 and did not appear to be out of breath. In an interview on [DATE] at 4:52 pm, the DON in training I stated on [DATE] Resident #1 did not have a change in condition until after she returned to the facility. She stated SW G told her Resident #1 needed to be picked up from dialysis. She stated she called the Dialysis Nurse who said she was not dialyzed at all because they were not able to access her catheter port and needed to see her vascular Doctor. She stated she called FM P and asked if she had Resident #1's Vascular Doctor's number and said she was able to locate that, Doctor. She stated around 12:30 pm or 12:45 pm, she called FM P informing her the Vascular center said they could see her that day and would call back with a time. She stated she heard a code blue call shortly after the 2:00 pm shift change because the day shift staff were still in the building. She stated she went to Resident #1's room, CPR was being done, AED Pads were on her, and she was getting O2. She stated nurses were alternating doing chest compressions and rescue breaths then the paramedics arrived, and she was stable and breathing. She stated Resident #1 was transferred to the hospital and admitted to the ICU. She stated the nursing staff had a debriefing about Resident #1's incident to ensure they did not have any issues with what they did during her Code Status. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 10:02 am, the DON stated Resident #1 was admitted for rehabilitation and needed dialysis. She stated she was not at work this day but heard that on [DATE] Resident #1 went to dialysis and later that day around 12:30 pm, FM P called the DON in training to pick up Resident #1. She stated she needed to be picked up because of a problem with her dialysis port. She stated they called the dialysis center to confirm what FM P said and the Dialysis nurse said Resident #1 needed to see her Vascular Doctor because she was unable to dialyze. She stated Resident #1 returned to the facility around 1:30 pm by their Transport Driver H. She stated Resident #1 returned stable, had no change in condition, and they were in the process of setting an appointment for her with the Vascular Doctor. She stated around 2:30 pm ADON D found Resident #1 unresponsive, called for help, other nursing staff assisted with performing CPR, and 911 was called. She stated the paramedics arrived and took over CPR efforts and FM P and the NP were notified as to which hospital she was being transferred to. She stated anytime there was a code blue they reviewed what happened to the resident to ensure they practiced proper procedures with CPR, calling 911, and notifying the Doctor and the RP. She stated they were not able to determine any errors with how the code blue was done. She stated they had an AD HOC meeting with the Administrator, the SW, two ADON's, and the MDS Coordinator about Resident #1's incident and trainings with the staff were conducted. She stated FM P and other family members came to the facility on Labor Day ([DATE]) wanting her medical records and picked up her belongings. She stated they wanted to know what happened to Resident #1 because she had a lack of oxygen. She stated she educated them because they were not comprehending when the heart stops O2 was not getting to her. She stated she heard Resident #1 passed away on [DATE] at the hospital. She stated the dialysis residents had orders to check their access ports and vital signs before the resident goes to dialysis and after they return. She stated to her knowledge there were no issues with her dialysis port. In an interview on [DATE] at 10:55 am, LVN A stated on [DATE] she checked Resident #1's dialysis port around 11:00 am or 11:30 am. She stated she did not see anything abnormal with her dialysis access site and her vitals were checked and were within normal limits. She stated she was her normal baseline when she left the dialysis center and then FM P called the DON in training to have Resident #1 pick her up because she was not able to be dialyzed. She stated Resident #1 returned around 1:39 pm and her access site was checked, and the resident stated she felt ok and was not in any pain. She stated Resident #1 was sitting in her wheelchair, watching tv, then around 2:30 pm she heard the code blue. She stated Resident #1's chest was not rising, she had no pulse, and was full code so they transferred her from her wheelchair to the floor. She stated the paramedics came and CPR efforts continued and then she had a pulse. She stated her Doctor and FM P were notified and last she was told was that she was on a ventilator. She stated the reason why her vitals at 1:45 pm were not in Resident #1's EMR was because she misplaced the paper, she wrote the vitals on because she just got busy. In an interview on [DATE] at 11:29 am, the Dialysis Nurse stated Resident #1 had been a dialysis patient since 2018 and her last dialysis day was [DATE]. He stated on [DATE] she was not able to be dialyzed because her access port was swollen. He stated they thought possibly a needle got dislodged in the fistula access port and said he spoke to FM P and was told FM P was going to take Resident #1 to the hospital. He stated [The Nursing Facility] came to pick her up within 15 minutes and he thought she was being taken to the hospital. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 1:52 pm, LVN A stated on [DATE] she received Resident #1's dialysis binder and her communication form said the patient did not get dialyzed today and her FM P was sending Resident #1 to the hospital, for a Permacath placement. She stated the reason Resident #1 did not go to the hospital was because one of the managers was working on getting Resident #1 a Vascular appointment. She stated based on her observation Resident #1 did not look like she needed or warranted going to the hospital. She stated they were waiting for the Vascular office to get back with them on an appointment. She stated the dialysis center did not send Resident #1 to the hospital because they were giving them an option to get a Vascular Doctor appointment or send the resident to the hospital. She stated she spoke to Resident #1's NP and she stated she was not dialyzed, and she said to monitor Resident #1 for change in condition and for fluid overload. She stated her fistula port did not look bad. She stated her usual timeframe for checking dialysis patient's vitals were as soon as the resident came back to this facility. She stated on [DATE], Resident #1's vitals were stable, and she wrote them down on her a sheet of paper. She stated she was not sure where she placed her vitals and stated if the vital signs were not checked and documented they would not know if there were any abnormalities. She stated for Resident #1's change in condition form, she did not have the vitals she took at 1:30 pm and used the early morning 7:43 am vitals. She stated Resident #1 returned to the facility at 1:30 pm, she saw Resident #1 at 1:45 pm, and at 2:30 pm she was nonresponsive. She stated she had a 1:1 training today ([DATE]) by the DON, HR, and the ADON on documenting timely when the residents return to the facility and to call the dialysis for clarification. She said when she looked at Resident #1's communication form and spoke to Van Driver I she was told she was not dialyzed. She stated the purpose of the dialysis treatment was to get the impurities out of their blood. She stated it was important for the nurses to check the resident's vitals due to any change in their body could cause the resident to decline causing them to have a change in condition from their normal baseline. In an interview on [DATE] at 2:18 pm, the DON stated vital sign checks of the dialysis residents were checked after dialysis and depended on the resident's circumstances. She stated there was not a scheduled time the nurses needed to check the resident's vitals, but she expected them to be checked within 1 hour of returning to this facility. She stated LVN A did Resident #1's vitals between 1:30 and 2:30 pm and would follow up once she reviewed the EMR. She stated FM P called them to pick up Resident #1 and they called dialysis and confirmed the Dialysis Nurse said to seek getting a Vascular Doctor's appointment or hospital transfer. She stated there was a process that they first called the Vascular office and talked to [The Vascular office representative]. She stated she was not sure about a contract needing to be signed before Resident #1 could be scheduled to the Vascular office. She stated FM P was aware of their plans for Resident #1 to get a doctor's appointment and told them the name of the vascular doctor. She stated ideally, they liked to document vitals into the EMR system after they were taken which was why they educated LVN A on documentation. She stated Resident #1's [DATE] Change in condition at 2:35 pm SBAR form had her vitals from [DATE] at 7:43 am because the SBAR prefilled what the last vitals on file were. She stated not documenting resident's vitals and nurses notes depended on the resident and the circumstances as to how it could affect the residents. She stated the nurse on duty was responsible for their own documentation and nurse managers. (continued on next page)

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	675305	A. Building B. Wing	09/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Valley Healthcare and Rehabilitation Cent	1525 Pleasant Valley Rd Garland, TX 75040

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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 - Few Note: The nursing home is disputing this citation.	In an interview on [DATE]/ at 3:31 pm, the Administrator stated he heard Resident #1 went to dialysis and returned earlier than normal. He stated Resident #1 returned to this facility around 1:30 pm. He stated then she had a code blue and the nurse's provided CPR, and the paramedics picked her up and took her to the hospital. He stated he was not aware LVN A wrote Resident #1' vitals on a sheet of paper that she misplaced. He stated often the nurses were pulled in too many directions from staff and residents, and as far as he was aware she was stable. He stated not being aware of any contracts given to the Vascular Office and was not aware she needed to go to the hospital for a permacath placement. He stated it did not seem the Dialysis Center saw a need for her to go to the hospital and thought the Dialysis Center used hospital as a word of choice. He stated they had an AD HOC meeting the first week of September with the Medical Director, the DON, the ADON, and himself and was not sure what they went over. He stated he was not sure if LVN A not documenting in the EMR about Resident #1's change in condition was discussed but nurse management addressed that. He stated Nurse management was responsible for ensuring vital signs and documentation were completed. He stated he heard FM P came to the facility on Labor Day ([DATE]) and believed they asked questions about the resident not sure on the specifics. He stated he would check to see if they did a grievance about Resident #1. In an interview on [DATE] at 4:23 pm, the Medical Director stated he was also Resident #1's Facility Doctor. He stated Resident #1 was a dialysis patient who had a cardiac arrest late last month and she passed away. He stated he was not sure what her cause of death was and stated there were no issues with how the nursing staff responded when Resident #1 had a change in condition. He stated he had an on-call NP who was contacted on [DATE] about Resident #1's change in condition. He stated he was not sure of the day and time of what the nursing department did and the HHSC Surveyor needed to talk to the nursing department. He stated the last QA meeting was last month he attended but did not recall anything about Resident #1's incident and documentation of resident's vital signs. He stated generally the resident's vitals were done before the resident was transported to and from dialysis. He stated vital signs were of importance to understand the clinical condition of the patient. He stated he was not going to speak to what the Dialysis communication form said to take Resident #1 to the hospital for a permacath placement and would have to refer the HHSC Surveyor to nurse management. In an interview on [DATE] at 4:43 pm, LVN J stated she cared for Resident #1 on [DATE] and she was fine and had increased confusion. She stated she did not work [DATE] and when she returned, she heard Resident #1 passed away. She stated she heard Resident #1 was foaming from her mouth and they rushed to do CPR. In an interview on [DATE] at 5:25 pm, the DON stated she wanted to ensure the HHSC Surveyor had the timeline right. She stated Resident #1 went to dialysis on [DATE] around 11:00 am and at 12:00 pm they received a call from FM P that she needed to be picked up from dialysis. She stated Van Driver H picked Resident #1 up and brought her back to this facility around 1:30 pm. She stated LVN A assessed Resident #1

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interviews and record reviews, the facility failed to maintain medical records on each resident that were complete and accurately documented for one (Resident #1) of six residents reviewed for medical records. The facility failed to ensure LVN A documented Resident #1's vital signs check in the EMR before she left and after she returned for dialysis on [DATE]. The facility failed to ensure LVN A completed documentation on [DATE] about the special instructions from Resident #1's Dialysis Center for her to go to the hospital for a permacath placement. The facility failed to ensure LVN A documented notifying Resident #1's Doctor/NP about the need to go to the hospital per the Dialysis Communication sheet on [DATE] and the outcome of what the Doctor/NP said. These failures could affect all residents and cause errors in care, treatments and communication which could result in a decline in their health and psycho-social well-being. Findings included: Record review of Resident #1's Admission MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted on [DATE] with a BIMS score of 08 (moderate cognitive impairment) and used a manual wheelchair and walker. She had no upper or lower impairments and dependent: helper does all assistance with all ADL care. Active diagnoses of other neurological conditions, anemia, hypertension, gastroesophageal reflux, renal insufficiency and diabetes mellitus, malnutrition, depression, asthma, and morbid obesity. Record review of Resident #1's Order Summary Report printed [DATE] revealed, she took Advair Diskus Aerosol Powder breath (activated (for asthma), Albuterol Sulfate inhalation nebulization solution (for asthma), carvedilol (for hypertension), renal-vite oral tablet (for kidneys), and Sevelamer Carbonate (for chronic kidney disease). Record review of Resident #1's Care Plan dated [DATE] revealed, she needed dialysis (hemodialysis) r/t renal failure. Will have immediate intervention should any s/sx of complications from dialysis occur through the review date. Will have no s/sx of complications from dialysis through the review date. Check and change dressing daily at access site. Document. Check arteriovenous fistula every day for bruit and thrill HEMODIALYSIS 3X/WEEK EVERY Tuesday/Thursday/Saturday AT 11AM DIALYSIS CENTER [The Dialysis Center] every day and evening shift every Tuesday, Thursday, Saturday Monitor/document report to MD s/sx of depression. Obtain order for mental health consult if needed. Record review of Resident #1's last Blood Pressure check in the facility's EMR dated [DATE] at 7:43 am by MA P revealed, her blood pressure was ,d+[DATE] sitting left arm. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Nursing Dialysis Communication Form by unknown nurse dated [DATE] at 11:24 am revealed, Fasting Blood sugar: 124, BP ,d+[DATE], Temp 98.2, Pulse 82, and respirations 17. Behavior: Yells. And at the bottom half of sheet by Dialysis Nurse, Patient was not dialyzed today, access site bruised, FM P will take patient to hospital for permacath placement. In an interview on [DATE] at 10:55 am, LVN A stated on [DATE] she checked Resident #1's dialysis port around 11:00 am or 11:30 am. She stated she did not see anything abnormal with her dialysis access site and her vitals were checked and were within normal limits. She stated she was her normal baseline when she left the dialysis center and then FM P called the DON in training to have Resident #1 pick her up because she was not able to be dialyzed. She stated Resident #1 returned around 1:39 pm and her access site was checked, and the resident stated she felt ok and was not in any pain. She stated Resident #1 was sitting in her wheelchair, watching tv, then around 2:30 pm she heard the code blue. She stated Resident #1's chest was not rising, she had no pulse, and was full code so they transferred her from her wheelchair to the floor. She stated the paramedics came and CPR efforts continued and then she had a pulse. She stated her Doctor and FM P were notified and last she was told was that she was on a ventilator. She stated the reason why her vitals at 1:45 pm were not in Resident #1's EMR was because she misplaced the paper, she wrote the vitals on because she just got busy. In an interview on [DATE] at 1:03 pm, the DON in training I stated the outcome of not checking the resident's vital signs varied and it depended on each resident's health condition and said she did not know what could happen to a resident if their vital signs were not checked and documented, it was just a wide variety of what if's. In an interview on [DATE] at 1:52 pm, LVN A stated on [DATE] she received Resident #1's dialysis binder and her communication form said the patient did not get dialyzed today, FM P sending Resident #1 to the hospital for permacath placement. She stated she had a 1:1 training today [DATE] by the DON, HR, and the ADON on documenting timely when the residents return to the facility and getting clarification of the communication forms, if needed. She stated the purpose of dialysis treatment was to get the impurities out of their blood. She stated it was important for the nurses to check the resident's vital signs due to any change in their body could cause the resident to decline causing them to have a change in condition from their normal baseline. In an interview on [DATE] at 2:18 pm, the DON stated vital sign checks of the dialysis residents were checked after dialysis and depended on the resident's circumstances. She stated there was not a scheduled time the nurses needed to check the resident's vital signs, but she expected them to be checked within 1 hour of returning to this facility. She stated LVN A did Resident #1's vital signs between 1:30 and 2:30 pm and would follow up once she reviewed the EMR. She stated ideally, they liked to document vital signs into the EMR system after they were taken, which was why they educated LVN A on documentation. She stated Resident #1's [DATE] Change in condition at 2:35 pm SBAR form had her vitals from [DATE] at 7:43 am because the SBAR prefilled what the last vitals on file were. She stated not documenting resident's vitals and nurses notes depended on the resident and the circumstances as to how it could affect the residents. She stated the nurse on duty was responsible for their own documentation and nurse managers. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE]/ at 3:31 pm, the Administrator stated he heard Resident #1 went to dialysis and returned earlier than normal. He stated Resident #1 returned to this facility around 1:30 pm. He stated then she had a code blue and the nurses provided CPR and the paramedics picked her up and took her to the hospital. He stated he was not aware LVN A wrote Resident #1' vitals on a sheet of paper that she misplaced. He stated often the nurses were pull into many directions from staff and residents and as far as he was aware she was stable. He stated Nurse management was responsible for ensuring vitals and documentation were completed. He stated he heard FM P came to the facility on Labor Day [DATE] and believed they asked questions about the resident not sure on the specifics. He stated he would check to see if they did a grievance about Resident #1. In an interview on [DATE] at 10:51 am, the DON stated Resident #1's vital signs were checked before and after she was sent to dialysis and would follow up with HHSC Surveyor to provide the documentation. She stated dialysis said they did not do her vital signs because she was not treated on [DATE] and stated if they missed dialysis [This Facility] still needed their vital signs done because there was a change in their dialysis treatment plan. She stated LVN A had 1:1 counseling covering the documentation components in EMR system. She stated when they called the Dialysis Nurse to confirm what FM P said Resident #1 was not dialyzed and needed to go to the Vascular Doctor or hospital for permacath replacement. She stated she was not sure why Resident #1's vitals were not documented before and after dialysis in the EMR system and maybe LVN A misplaced the sheet of paper during the change of shift on [DATE]. In an interview on [DATE] at 10:32 am, Dialysis Nurse stated Resident #1 had been on dialysis services for a long time and at times she pulled out her catheter line. He stated in the past year FM P usually took Resident #1 to the hospital emergency room to get a catheter replacement. He stated No, no, no [The Nursing Facility] did not need to schedule her a vascular appointment and was not sure where that came from. He called Resident #1's Nephrologist, he wanted her to go to the hospital for the catheter placement which was what was also on the dialysis communication form on [DATE]. In an interview on [DATE] at 12:34 pm, LVN A stated she was trained this week on ensuring the resident's vital signs and access ports were checked and that head-to-toe assessments were completed prior to and post dialysis. She stated she was trained on checking their access site ask the resident how they felt and reviewing the communication form. She stated they needed to document their findings of any abnormalities and communicate that to the Doctor, family, and DON. She stated she was trained on making sure they were on the same page with the dialysis center and to know the plan of care to provide adequate care. She stated she was trained yesterday [DATE] on documentation of assessments, vitals, checking dialysis access sites and looking at how the resident was doing. And was trained on ensuring the resident's vitals were on the dialysis communication form and in the facility's EMR. She stated she was not sure why she did not put Resident #1's vitals into the EMR before and after dialysis and maybe she was in a rush. She stated on [DATE] she told Resident #1's Doctor she did not dialyze this day but did not mention what the dialysis communication form said about going to the hospital. She stated the importance doing the resident's vital signs was to get a baseline of the resident to see if they had a change in condition. She stated the importance of documenting was to ensure the resident was getting the proper plan of care and alert all nursing about the resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 2:17 pm, the Administrator stated the Dialysis Communication Form was not a doctor's order and his facility nurse did call the Dialysis Center to understand what was needed. He stated things happened when it came to LVN A misplacing the sheet with Resident #1's vital signs on [DATE] and was not sure what happened to the sheet. He stated in an ideal world she should have documented the vital signs in the EMR, but she could have got stopped to help pass out trays or answer the phone. He stated LVN A was not going to stop taking care of the resident's if she needed to document something. He stated it was concerning that Resident #1 vitals were not entered on [DATE] and seven days later Resident #1 passed away. He stated although LVN A failed to document Resident #1's vital signs in the EMR did not mean she did not check her vitals. He stated not putting documentation in the EMR and Resident #1 having a change in condition and coding was not a related. He stated he had to believe what his DON and nurses said that her vital signs were checked at 1:30 pm despite not having any documentation in the EMR. He stated his expectations for dialysis residents was whatever the standard of practices was and added the nurse leadership team ensured the nursing department did all they were supposed to do for each resident. He stated yesterday [DATE] and day before [DATE], they had staff trainings on dialysis care and were being tested for competency. In an interview on [DATE] at 2:47 pm, the DON stated she started trainings and knowledge checks on pre and post dialysis care and after auditing their three dialysis residents had no irregularities. She stated skills check offs on assessments and documentation, and dialysis access port care were done. She stated they trained on the expectations for their staff and Dialysis staff. Record review of LVN A's Counseling/Disciplinary Notice form dated [DATE] revealed, Counseling: per nurse, nurse misplaced assessment information completed on a patient and therefore was unable to document. Nurse was educated on importance of documenting assessments completed. Nurse is aware that if there are any documentation issues needs to notify DON or nurse manager. Signed by LVN A and DON. Record review of the facility's Nursing Care of Dialysis Resident Knowledge Check undated revealed, Learning Objective: Assist the resident in maintaining homeostasis pre and post renal dialysis: 1. Pre dialysis - nurse should obtain the resident's vital signs and document prior to being transported to dialysis center .5. Nurse should assess resident and obtain vital signs, document, and report .7. Nurse must complete and document on the pre and post dialysis communication .9. Nurse should document communication between the facility, dialysis staff, education, family, appointments, and transportation arrangements. Record review of the facility's Dialysis policy dated ,d+[DATE] revealed, It is the policy of this facility to: Assist resident in maintaining homeostasis (balance of all body systems to survive and function properly) pre- and post-renal dialysis, Documentation: Documentation related to pre- and post-dialysis care will be placed in the clinical record and include Resident assessments, interventions, and any provided education. Assessment of renal dialysis access site, to include presence or absence and quality of a bruit and thrill for residents with an arteriovenous fistula. Communication between facility and dialysis staff or medical provider. Record review of the facility's Medical record policy was requested on [DATE] at 3:48 pm, [DATE] at 1:01 pm, from the DON and Administrator and was told they did not have a policy.