

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Harmony Care at Beaumont		STREET ADDRESS, CITY, STATE, ZIP CODE 2660 Brickyard Rd Beaumont, TX 77703	

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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115</p> <p>Based on observation, interview, and record review, the facility failed to ensure basic life support, including cardiopulmonary resuscitation (CPR), was provided to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 2 residents (Resident #1) reviewed for CPR.</p> <p>The facility failed to ensure staff utilized the AED (automated external defibrillator- a medical device that analyzes the heart's rhythm and, if necessary, delivers an electrical shock to the heart in attempt to re-establish an effective rhythm) when Resident #1 was found on [DATE] unresponsive, not breathing, and no pulse. Resident #1 was pronounced deceased on [DATE].</p> <p>An IJ was identified on [DATE] at 3:57 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.</p> <p>This failure could place residents at risk of not receiving necessary life-saving measures, decline in health, and death.</p> <p>Findings include:</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 0678</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 face sheet dated [DATE] indicated he was a [AGE] year old male admitted to the facility on [DATE] with diagnoses including type II diabetes (a disease that occurs when blood glucose, also called blood sugar, is too high), cerebral infarction (pathologic process that results in an area of necrotic tissue in the brain), chronic combined systolic and diastolic congestive heart failure (systolic CHF, the ventricles cannot produce enough pressure in the contraction phase to push blood into circulation, diastolic CHF, the ventricles cannot relax, expand, or fill with enough blood-combined CHF is a combination of the two), hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time) with heart failure, acute kidney failure (kidneys are suddenly not able to filter waste products from the blood), hyperlipidemia (also known as high cholesterol, means too many lipids (fats) in the blood), morbid obesity, hypokalemia (low blood potassium levels), respiratory failure with hypoxia (not have enough oxygen in your blood), and angina pectoris (chest pain or discomfort due to coronary heart disease). The face sheet indicated Resident #1 was a full code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures would be provided to keep them alive. This process can include chest compressions, artificial ventilation and defibrillation and is referred to as CPR.).</p> <p>Record review of Resident #1's quarterly MDS dated [DATE] indicated he had clear speech, was usually understood and usually understood others, he had moderate impaired cognitive function (BIMS score 11).</p> <p>Record review of Resident #1's care plan dated [DATE] (revised [DATE]) indicated Resident #1's RP requested full code status. Interventions included if Resident #1's heart stops, initiate CPR and call 911 for transfer to the hospital.</p> <p>Record review of Resident #1's physician order dated [DATE] indicated Resident #1 was full code-CPR.</p> <p>Record review of the facility's incident report dated [DATE] at 11:10 p.m. (per LVN A the time was an error) completed by LVN A indicated Resident #1 was noted lying face down on the floor. Resident #1 was unresponsive. His name was called and he was rolled on to his back. Code team was initiated and 911 was called. Staff performed resuscitation efforts until paramedics took over. Physician, RP, and DON notified. Resident #1's breathing was noted as noisy, labored, long period of hyperventilation, ([NAME] Stokes Respiration- respiration is a type of breathing disorder characterized by cyclical episodes of apnea and hyperventilation). He was comatose-(unrousable to verbal or physical stimuli).</p> <p>Record review of the progress note dated [DATE] at 2:50 a.m., completed by LVN A indicated LVN A reassessed Resident #1 post fall. Resident #1 was lying on the floor face down. Resident #1 was not breathing. LVN attempted to get BP, pulse ox (electronic device that measures the saturation of oxygen carried in red blood cells). Resident #1 did not respond to his name or sternum rub. Code team was initiated and 911 was called. After several attempts to resuscitate Resident #1, he was pronounced expired by doctor via EMS. Notified physician. Family notified and present in facility.</p> <p>Record review of the EMS run time provided by SW I indicated EMS received an alarm on [DATE] at 11:28 p. m. EMS left the facility on [DATE] at 12:29 a.m.</p> <p>Record review of the facility's crash cart check of list dated [DATE] and [DATE] indicated there was no AED device listed.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:43 a.m., LVN A said Resident #1 had a fall at approximately 10:45 p.m. on [DATE]. She said the time indicated on the incident report was an approximate time and not the correct time. She said CNA B assisted to get Resident #1 up and into his wheelchair. She said he was yelling and cussing. When she asked him why he did not push the call light for help, Resident #1 got up from his wheelchair and went to the toilet then got clean clothes and went to bed. She said she assessed Resident #1 and all his vital were WNL. She said he did not hit his head and had clear speech. She said she told Resident #1 she would be back in 15 minutes to complete another set of neurological checks. She said she went to administer medications to two other residents and was returning to Resident #1's room at approximately 11:15 p.m. when CNA B indicated Resident #1 was on the floor. She said Resident #1 was face down on the floor and did not respond to his name or to sternum rub. She said he had no pulse and she could not get a pulse. She said she called for the crash cart and directed a CNA (she could not recall which CNA) to call 911. She said she began CPR because Resident #1 was a full code. She said she continued CPR until EMS arrived and took over. She said she did not call for the AED and did not use the AED during CPR for Resident #1. She said she could not recall why she did not call for the AED or use the AED during CPR. She said she had her CPR training and CPR card. She said she should have used the AED and followed the prompts. She said the AED device was used for giving the heart a shock if it was needed.</p> <p>During an interview on [DATE] at 10:55 a.m., the DON said she received a call on [DATE] at 11:38 p.m. from LVN A. LVN A reported Resident #1 was unresponsive and the paramedics were working on him. She said she arrived in the facility on [DATE] at 11:42 p.m. to cover a shift.</p> <p>Observation on [DATE] at 11:05 a.m. revealed the facility's crash cart was adjacent to the nurse station. The check off list did not include AED inspection. Observation of the AED device indicated it was in a red box with a sign hanging on a wall halfway between the nurse's station and the dining room area. There was no inspection or check off list available for review.</p> <p>During an interview on [DATE] at 11:39 a.m., the DON said she asked LVN A why she did not use the AED during CPR for Resident #1 on [DATE]. She said LVN A said she did not know and that she was probably busy with CPR and did not think about the AED. She said LVN A should have called for the AED and the crash cart. She said the AED device was used for giving the heart a shock if it was needed. She said the only AED was located down the hall from where the crash cart was located (by the nurse station). She said she had scheduled training for 2:00 p.m. today ([DATE]) to re-train staff to remember to use the AED during CPR. The DON said there was no separate check off list for the AED device. She said she checked the device daily and replaced the pads when necessary.</p> <p>During an interview on [DATE] at 3:15 p.m., CNA B said on [DATE] at approximately 11:15 p.m., she was passing Resident #1's door and saw he was lying face down on the floor. She said he did not respond when she called his name. She said she called for LVN A as LVN A was coming up the hall and she went immediately into the room. She said she assisted to roll Resident #1 over on to his back. She said LVN A called Resident #1's name and rubbed his chest and Resident #1 did not respond. She said CNA D arrived and was directed to call 911. She said LVN A began CPR. CNA B said she went to get LVN C from another area of the facility. She said LVN C brought the crash cart. She said CNA D returned to the room and said she called 911. She said she did not recall anyone calling for the AED device. She said she did not think or remember to get the AED device. She said she had her CPR card and knew the AED device was should have been implemented during the CPR for Resident #1. She said the AED device was used for giving the heart a shock if it was needed.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interviews were conducted on [DATE] from 9:00 a.m. through 10:35 a.m. with the Administrator, the DON, LVN E ,d+[DATE], LVN F ,d+[DATE], CNA G ,d+[DATE] and ,d+[DATE], CNA H ,d+[DATE], prn other shifts, CNA J ,d+[DATE], prn other shifts, RNA K ,d+[DATE] Monday-Friday, CMA L ,d+[DATE], prn other shifts, CNA M ,d+[DATE], LVN A ,d+[DATE], and LVN N weekend doubles. They indicated they received an in-service on [DATE] and were aware the AED was supposed to be collected with the crash cart and utilized when staff called for the crash cart/911. They were aware the crash cart was moved from the nurse station and located under the AED on the wall, in the hall between the nurse station and the dining room. The nurses also said that checking the box marked AED meant the AED was above the crash cart and the AED's blinking green indicator light was observed. The nurses said the flashing green indicator light the AED was ready for use.</p> <p>Record review of an in-service dated [DATE] indicated all nursing staff were trained on the CPR policy including the use of AED and daily checks of the crash cart and of the AED to ensure it was working.</p> <p>Record review of the daily check sheet for the crash cart was updated on [DATE] with checks to include the AED. The sheet was checked off on [DATE] by nursing staff.</p> <p>While the IJ was removed on [DATE] at 10:37 a.m., the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.</p>