STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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** 45328 Based on observations, interviews, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice for 1 (CR #1) of 5 residents reviewed for respiratory care. - The facility failed to ensure consistent oxygen therapy was provided to CR #1 who was on hospice and a DNR. CR #1 was pronounced deceased at approximately 3:48 p.m. on [DATE]. -The facility failed to respond to CR #1's numerous requests for help for an approximate 2 ,d+[DATE] hour period. -The facility failed to monitor CR #1's oxygen administration via nasal cannula while she was in bed. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 12:21 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of pattern because all staff had not been trained on [DATE]. This failure placed residents who received oxygen therapy at risk of respiratory complication and/or death. The findings included: Record review of CR #1's Face Sheet, dated [DATE], revealed a [AGE] year-old female whose initial admitted to the facility was [DATE]. Her diagnoses included acute and chronic respiratory failure with hypoxia (not enough oxygen in blood), chronic obstructive pulmonary disease (progressive lung disease) with (acute) exacerbation (sudden worsening of symptoms), and heart failure. Record review of CR #1's Quarterly MDS Assessment, dated [DATE], revealed a BIMS score of 0, indicating severe cognitive impairment. Further review revealed the resident was dependent (the assistance of 2 or more helpers were required for the resident to complete the activity) on eating, toileting, showering/bathing, and dressing. Section O, Special Treatments, Procedures, and Programs, Respiratory Treatments, C1, revealed she was on oxygen therapy. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675648	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's MAR dated, [DATE] - [DATE], revealed an order for oxygen administration at 3 LPM via nasal cannula or BiPAP continuous every shift, start date: [DATE], observation oxygen therapy every shift, start date: [DATE], and ipratropium albuterol inhalation solution every 4 hours, start date: [DATE]. CR #1's MAR reflects she was administered her ipratropium albuterol inhalation solution every 4 hours as ordered. Record review of CR #1's care plan, close date [DATE], revealed the resident had COPD, a history of respiratory failure, and was at risk for shortness of breath and interventions included oxygen as ordered. Further review revealed the resident received oxygen therapy r/t COPD/CHF and removed N/C at will. Interventions included check O2 saturations and provide respiratory treatments as ordered and O2 via NC per physician order. Observation on [DATE] at 7:05 a.m. of several video footage clips, dated [DATE], from approximately 11:46:38 a.m. to 15:30:41 (3:30 p.m.) revealed at 11:46:18 a.m. CR#1 removed her nasal cannula. At approximately 11:57:20 a.m., CNA C entered the room with the resident's meal tray and at approximately 11:59:03 a.m. was no longer in the room; the nasal cannula was still not in place. At approximately 12:30:48 p.m., an unidentifiable staff member walked past the resident and toward the door from the other side of the room; nasal cannula was still not in place. At approximately 12:39:09 p.m. a different unidentifiable staff member entered the room and exited at approximately 12:39:29 p.m.; nasal cannula was still not in place. At approximately 14:09:43 (2:09 p.m.) resident was having stomach breathing and at approximately 14:43:27 (2:43 p.m.) resident begins gasping for air. At approximately 15:28:54 (3:28 p.m.) CNA D found CR #1 unresponsive; nasal cannula was not in place. At approximately 15:28:58 (3:28 p.m.) Nurse A and CNA D were at CR #1's bedside; nasal cannula was still not in place. CR #1 was observed calling out nurse, help, and/or help me numerous times from approximately 12:07:56 p.m. to 14:26:33 (2:26 p.m.) with no response from staff; the nasal cannula was still not in place. Video footage clips did not show any other staff members entering CR #1's room between 12:39 p.m. until 3:28 p.m. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 7:30 a.m., CNA B said he had been picking up shifts at the facility for less than a year. He said he worked on [DATE] from 6:00 a.m. to 6:00 p.m. and was assigned to CR #1. He said he was familiar with the resident but on [DATE] was the first time he had picked up a shift in a while, approximately longer than 3 months. He said he started his shift by conducting rounds at approximately 6:30 a.m. He said he asked the residents what they needed, what they would like to drink, and passed out drinks for breakfast. He said CR #1 was awake during his first round and she asked him to reposition her in bed, asked for a nurse, and after that she was okay. He said he completed his rounds every 2 hours including before breakfast, after breakfast, before lunch, and after lunch. He said during his rounds he did not notice anything out of the ordinary or abnormal that stood out. He said the resident had to be fed. He said he passed out the resident's breakfast and lunch meals, but she turned down breakfast and took 2 bites out of her lunch and turned down the rest. He said the corner person (listed as CNA D on the nursing schedule) was assigned to his hall and residents when he took his lunch break from 2:30 p.m. to 3:00 p.m. He said CR #1 was still alive when he went on break. He said the resident tended to call out for the nurse and when she did, he would check on her. He said sometimes the resident would need water. He said he never heard the resident call out for the nurse on [DATE]. He said he did not know if the resident was on continuous oxygen and would have to ask the nurse. He said he recalled seeing an oxygen machine and tubing. He said the resident had on the oxygen tubing. He said CR #1's oxygen was on the entire time he was on shift and up until the time she passed away. He said if there was a resident that did not have their oxygen tubing in place, he would notify the nurse. He said he did not recall anyone else helping him out in the hall. He said CR #1 passed away at approximately 1:40ish p.m. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 8:14 a.m., Nurse A said she worked on [DATE] and one of her assigned residents was CR #1. She said she checked on the resident during her morning rounds but could not recall if she passed by her room door or went inside. She said the resident was awake and alert. She said that day, [DATE], the resident was doing a lot of yelling, but it was her normal behavior when no one was in the room. She said that day she believed the resident started hollering out nurse but did not recall what time it began. She said when the resident started hollering out nurse either another nurse, CNA, herself, or another staff member would go and check on her to see what she needed. She said with CR #1, in general, she would yell out all the time unless she had company, or someone was not with her, or if she just felt like yelling out nurse or help. She said when she did a lot of yelling it was usually an indicator that she was going to have a good day because it was something she normally did. She said she was sure at some point during her shift she went inside the resident's room and checked in on her but did not recall when and said it was hard to separate the days. She said she tried to pay a little more attention to her because she tended to remove her nasal cannula. She said she did not recall if the resident had her nasal cannula on when she checked on her that morning. She said she did not recall if she had to put the residents nasal canula back on because the resident had taken it out. She said every time she walked down the resident's hall, she would peek her head through the doorway to make sure the nasal cannula was on because of her tendency to remove the tubing from her nasal passage. She said she knew the nasal cannula was in place when she passed away. She said she knew this because the airway was the first thing she checked. She said when she was pronounced deceased that was when she took the nasal tubing from her nasal passage, turned the oxygen concentrator off, and disconnected everything. She said it was one of the CNA's that called her into the room but did not recall which CNA. She said once inside the room she assessed the resident, but was unable to get a BP reading, O2 sat with the oximeter, or a pulse. She said she notified Nurse B who pronounced the resident deceased . She said she did not recall if the resident specifically called out help or help me at any point during her shift but did remember the resident calling out nurse. She said the resident would yell most of the day, so any staff checked on her. She said she was not able to personally check on the resident every time she called out nurse because that was impossible but other staff members would check in on her when she called out nurse. She said she would check on her more than every 2 hours in passing or by entering her room, and every time she saw the resident, she had on her nasal cannula. She said she never noticed any labored breathing when she checked in on her. She said there were no significant changes with the resident before she passed away. She said the potential effect of not getting enough O2 to the brain, could cause hallucinations, talking out of their heads, and all the way up to death. During an interview on [DATE] at 10:27 a.m., CNA C said she worked on [DATE] from 6:00 a.m. to 6:00 p.m. She said she and CNA B went inside CR #1's room after breakfast and changed and repositioned her in bed. She said that day [DATE], she was calling out all her kids names and momma. She said CR #1 refused to drink or eat her breakfast. She said when she left the room she still had on her nasal cannula. She said she did not see CR #1 any other time that morning or during lunch. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:10 a.m., CNA D said she stepped in for CNA B when he went on his break, and was watching his hall, but did not recall what time it was or if it was after or before lunch. She said she saw CR #1 during his break. She said CR #1 was propped up in her bed, and her legs were elevated up in the bed a little bit. She said when she was with CR #1, she did not call out for the nurse. She said when she was working the hall, she heard the resident call out 'nurse, nurse, and she went inside her room and asked her what was wrong and she just repeated herself and said nurse, nurse. She said she told Nurse A and Nurse A said she was going down there to her room. She said she never heard the resident call out for help or say help me during this time. She said she checked on the resident approximately 2 times. She said the resident was afraid of being by herself and would call out for the nurse all the time. She said the first and second time she checked on the resident her nasal cannula was on. She said she never noticed her nasal cannula not being on. She said the resident did not sleep very well during the daytime, was always up and active, and sometimes got up and in her wheelchair for lunch and dinner. She said sometime after lunch she was passing drinks when she went inside CR #1's room to give her a drink and said she called her name 2 times, and she did not respond. She said she then ran and got Nurse A because she was not responding. She said once Nurse A arrived in the room she stepped out and stayed by the door but did not have a visual of inside the room. She said another nurse entered the room. She said the resident's nasal cannula was on. During an interview on [DATE] at 2:01 p.m., Nurse B said she probably would have seen her a little after 7 a. m. She said she saw her several times that day because her bed was situated to where you could see her from the doorway. She said the resident says nurse a lot. She said she did not remember her saying nurse that day but remembers her saying hey. She said when she said hey, she got up and got to the top of the hall and saw a CNA going into her room. She said that day there was nothing unusual and the resident was her normal self. She said she could not say she heard her say help or help me on [DATE]. She said she was shocked when staff called her because she did not seem to be at that point of passing away. She said the several times she saw her throughout the day she said the resident had her nasal cannula on. She said she saw her 30 to 45 minutes before the end of her shift. She said she walked past her room and the resident appeared to be fine. She said the resident was awake and fidgeting with her blanket. She said she was headed to clock out at approximately 3:30 p.m. when Nurse A called her name and said it appeared that the resident was no longer breathing. She said she went to the room, the resident was warm to the touch, had no spontaneous breathing, and no rising of the chest. She said the resident was a DNR, she did an examination, and pronounced her deceased . She said at no time during her shift did any CNA tell her that the resident's nasal cannula came out. She said it depended on the clinical status of the resident if there was a potential effect of them not having continuous O2. She said it could potentially lead to a health decline, respiratory distress, but it would depend on their clinical status. During an interview on [DATE] at 2:40 p.m., the DON said CR #1 had an order for continuous O2. She said she was contacted when the resident passed away by Nurse B. She said it was kind of shocking in a way because CR #1 did not have a change in condition that she had been notified about because that was one of the requirements that she must be notified. She said she was notified by Nurse B at approximately 4:09 p.m. that she passed away. She said Nurse B did the protocol of pronouncing her deceased . She said she called Nurse A and was told CR #1 did not have a change in condition, and nothing was out of the ordinary. She said the resident's actions were normal and she would holler out nurse occasionally but that was usual for CR #1. She said Nurse A said it looked like she peacefully went to sleep and had on her oxygen. She said after they pronounced her deceased the concentrator was turned off and they removed the nasal cannula. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:20 p.m., Hospice Nurse B said she last saw CR #1 on [DATE]. She said CR #1 was in her wheelchair, kind of in the entry of her room door, was alert, and nothing about her was unusual and O2 was in place. She said there were definitely no signs of imminent death. During an interview on [DATE] at 2:46 p.m., Hospice Nurse C said she saw CR #1 on [DATE]. She said the resident was in bed, asleep, but easily aroused. She said the resident had no labored breathing and all vitals were normal and O2 was in place. She said she was not actively passing away when she saw her. During a follow-up interview on [DATE] at 8:54 a.m., the NP said she would not know if CR #1 going for approximately 3 ,d+[DATE] hours without her O2 would contribute or cause her death. She said but if someone were to go without O2 for a long period of time they could go into respiratory distress. During an interview on [DATE] at 9:09 a.m., the MD said if the resident did not get O2 for a long period of time, anything more than 1 to 2 hours and depending on her O2 saturation, she would need to be back on O2 to keep closer to at least 92% sat. She said it was hard to say how much time but the brain being deprived of that much O2 could cause brain death. She said there was a possibility that not having the O2 for that period of time could be a contributing factor, but the resident had other comorbidities, conditions, and was on hospice. Record review of the facility's Provision of Quality Care, undated, read in part .Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residences choices .1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being . Record review of the facility's Oxygen Administration policy, undated, read in part .Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences . The Administrator, DON, and Regional Nurse were notified on [DATE] at 12:21 p.m. that an IJ was identified due to the above failures and the IJ template was provided. The following Plan of Removal (POR) was accepted on [DATE] at 8:20 p.m.: Re: Removal of Immediate Jeopardy/Letter of Removal [ ] Facility License: [ ] Facility ID/# [ ] [DATE]th, 2024 Dear Program Manager, (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This letter represents the facility's respectful request for [ ] to accept our revised removal plan with immediate implementation of corrected measures placing the facility back in substantial compliance. Allegation of Immediate Jeopardy: Resident #1 (CR #1), a [AGE] year-old female under hospice care with a diagnosis of chronic respiratory failure, COPD, and heart failure, did not receive consistent oxygen therapy as per physician orders. The resident was left without a nasal cannula for over 3 hours and called out repeatedly for help without response from staff. The resident passed away on [DATE], raising serious concerns about oxygen monitoring and response to resident needs. The following measures represent the immediate action [ ] has taken to address the alleged-deficient practice and to prevent serious harm from occurring or recurring. Immediate Actions to Address Immediate Jeopardy Date of Action: [DATE] Objective: Ensure that all residents are safe, their oxygen therapy is monitored, and that staff are trained in prompt response to resident needs. 1. Resident Assessments o Action: Conduct an immediate physical assessment of all residents receiving oxygen therapy to verify device placement, functionality, and settings. Document the condition of each resident and verify the delivery of prescribed oxygen. o Completion Date: [DATE] o Responsible Party: Director of Nursing (DON)/Designee 2. Review Resident Records o Action: Audit all records of residents with oxygen therapy orders to ensure each order matches the current oxygen delivery setup, including flow rates and frequency. o Action: Review each resident's care plan related respiratory status and oxygen requirements. o Action: Residents that require continuous oxygen therapy will have visual compliance checks and O2 saturations completed by a licensed nurse every shift. o Completion Date: [DATE] o Responsible Party: DON/Designee 3. Environmental and Equipment Checks (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Action: Conduct an audit of all oxygen equipment to ensure functionality, clean cannulas, and confirm that oxygen tanks and concentrators are operational. Replace any defective equipment immediately. o Completion Date: [DATE] o Responsible Party: Maintenance Team, overseen by the DON 4. Immediate Staff Training on Resident visual monitor of supplemental oxygen compliance o Action: Provide training to all nursing staff on the importance of promptly responding to resident calls and monitoring oxygen therapy. Reinforce procedures for identifying distress in residents. Signage for all staff to identify which patient is on oxygen. o Completion Date: [DATE] o Trainer: DON/Designee 5. Documentation of Immediate Training and Competency Checks o Action: Require return demonstrations from staff on proper oxygen device placement, O2 concentrator operation and protocols for checking and monitoring residents. Complete competency checklists for each licensed staff member currently on duty. o Action: Inservice's and demonstrations from staff on proper oxygen device placement and protocols for checking and monitoring residents will be completed for all active employed nurses prior to the start of the next scheduled shift. o Action: Education for all staff to identify who is on continuous O2 and who is on PRN O2. Notify the charge nurse if oxygen is not in place or other oxygen related concern. o Completion Date: [DATE] o Responsible Party: DON/Designee, documentation of completion on file. Facility's Plan to Ensure Compliance Quickly Goal: To establish comprehensive, sustainable protocols to monitor oxygen therapy, ensure swift response to resident needs, and maintain safe resident environments. 1. Training Sessions on Respiratory Care and Resident Monitoring o Action: Schedule in-depth training sessions for all nursing and CNA staff on respiratory care, focusing on the monitoring and maintenance of oxygen therapy devices and prompt response protocols. o Completion Dates: Initial training on [DATE]; competency checks completed by [DATE] or prior to next scheduled shift. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Trainer: DON/Designee o Competency Verification: All staff will be required to pass a posttest and return demonstration, documented in personnel files. 2. Resident Monitoring Logs Implementation o Action: Develop a resident monitoring log to be kept in each room, with sections for every 2-hour oxygen checks x 12, then every 4hrs x 12 then every shift ongoing documented in resident's EHR. o Completion Date: [DATE] o Responsible Party: DON to develop logs; Charge Nurse to implement and monitor 3. Quality Assurance and Performance Improvement (QAPI) Meeting o Action: Conduct a QAPI meeting to review the incident, corrective actions, and policy updates. Create a recurring agenda item for monitoring compliance with the new protocols. o Date of Meeting: [DATE] o Responsible Party: Administrator and QAPI Committee 4. Ongoing Audits and Compliance Checks o Action: Schedule weekly audits to ensure compliance with oxygen monitoring and response protocols. Document findings and review corrective actions in monthly QAPI meetings. o Start Date: [DATE], continuing weekly until confirmed compliance o Responsible Party: Administrator 5. Progressive Action/Counseling o Nurse A, B and CNA's B, C and D will receive 1:1 in servicing prior to next scheduled shift. They will also receive a skills validation test weekly x 4 weeks. o Medical Director was notified via telephone in regard to the IJ involving resident and attended ad-hoc QAPI via telephone. Documentation and Follow-Up Documentation of Training and Competency Checks: All staff training records, return demonstrations, and competency verifications will be filed in each employee's personnel record by [DATE]. Audit Logs and Monitoring Forms: Logs for each resident on oxygen therapy will be maintained and reviewed weekly. Compliance will be tracked, and corrective actions will be implemented as necessary. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review revealed 19 CNAs completed an oxygen posttest from [DATE]-[DATE]. Interviews were conducted from [DATE] to [DATE] with staff from all shifts: the DON, the ADON, 3 RNs, 5 LVNs, 9 CNAs, and 2 MAs. Nursing staff verbalized an understanding on responding to resident calls and monitoring of oxygen, identifying residents in distress, and identifying which residents were on oxygen. Nurses also verbalized an understanding on oxygen device placement, O2 concentrator operation, and protocols. The Administrator was notified the Immediate Jeopardy was removed on [DATE] at 6:51 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.