

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675981	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Mineola Heights Healthcare Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Mimosa Street Mineola, TX 75773	

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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958</p> <p>Based on interview and record review, the facility failed to immediately consult with the resident's physician and notify the resident representative of a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (Resident #1) of 6 residents reviewed for notification of changes.</p> <p>The facility failed to ensure LVN A notified the physician/designee and the resident's representative after Resident #1 had a change of condition with agonal breathing (the medical term for gasping for air), fixed pupils, no urine output and lethargy.</p> <p>The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 04/07/2025 and ended on 04/08/2025. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for not receiving appropriate care and interventions and/or death.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated 04/15/2025 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of chronic atrial fibrillation (a heart condition where the upper two chambers of the heartbeat irregularly and rapidly, lasting longer than 12 months), repeated falls and dementia (a group of thinking and social symptoms that interferes with daily functioning).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 which indicated moderate cognitive impairment. Resident #1 was usually understood by others and usually understands. Resident #1 required setup assistance for eating and moderate assistance for personal hygiene. Resident #1 required maximal assistance with bathing, dressing and dependent with toileting hygiene.</p> <p>Record review of Resident #1's care plan dated 10/17/2023, reflected I have chosen do not resuscitate status. Ensure resident wishes are followed as desired. Follow my advanced directive/code status.</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 0580</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 orders undated revealed advanced directives code status DNR (do not resuscitate).</p> <p>Record review of Resident #1's nurse progress note dated 04/07/2025 at 5:00 a.m., wrote by LVN A said she was called by CNA this nurse to resident's room and upon assessment resident shows agonal breathing, skin is cold, eyes are fixed. Resident #1 vital signs were 54/53, 54, 93%, 128. Resident was a DNR and on hospice. Will continue to monitor.</p> <p>Record review of Resident #1's SW progress note date 04/05/2025 revealed, this social intern called the resident's family today. Family Member #1 asked not to be called at 3 A.M. unless it's an emergency, Resident #1 has passed or is in the emergency room .</p> <p>Record review of Resident #1's hospital records dated 04/07/2025 revealed death due to cardiopulmonary arrest.</p> <p>During an interview on 04/15/2025 at 8:50 A.M., the DON said CNA B reported the change of condition of Resident #1 to LVN A. LVN A only monitored Resident #1. LVN C the oncoming nurse assessed Resident #1, called the MD and sent her out to the emergency room . The DON said all LVN A did from 5-6:00 A.M. was monitor Resident #1. The DON said LVN A should have called the MD and probably sent her out to the hospital. She said LVN A should have called the family, and she did not call anyone. She said LVN A was a DNR/do not return after this. She said she believed the resident was neglected by LVN A. The DON said from 5-6:00 A.M. Resident #1 had agonal breathing and a fast heart rate. The DON said LVN C called her 04/07/2025 at 7:17 A.M. to tell her what was going on with Resident #1.</p> <p>During an interview on 04/15/2025 at 10:37 A.M., LVN C said she got to the facility the morning of 04/07/2025 about 6:30 A.M. and LVN A gave her report. LVN C said LVN A told her the aide notified her about 5am that Resident #1 was not acting right, so she went to assess the Resident #1. LVN C said LVN A told her Resident #1's blood pressure was low; the resident's pupils were fixed and she was not responding. LVN C said LVN A said Resident #1 was on hospice and she told her she was not on hospice. LVN C said she asked LVN A if she had notified anyone about the change in condition of Resident #1 and she said no. LVN C said after she and LVN A were finished with report, she went to assess Resident #1 and she was not responding so she called 911. Then LVN C said she notified the NP of Resident #1's change of condition and Resident #1 was not responding. Then LVN C said she notified the family and the DON. LVN C said LVN A said she did not understand how that was a change in condition. LVN C said once she received report from LVN A, LVN A left the facility.</p> <p>During an interview on 04/15/2025 at 12:07 P.M., LVN A said CNA B was making her last rounds when she came and her told Resident #1 did not look right. LVN A said she went to assess Resident #1 and her vital signs were low. She said Resident #1 looked like she was actively dying. She said Resident #1 was a DNR. She said she saw there was a progress note from the social worker that said the family requested not to call at 3:00 A.M. or in the middle of the night. She said the social worker progress note was put in on the 04/05/2025. She said she monitored Resident #1 the rest of her shift and she did 15 minutes checks on her. She said eventually the next nurse came in. She said she was confused about if the resident was actively passing, because in her training if they were actively passing the nurse should do nothing if the resident was a DNR. She said she did not notify the MD or NP and she said she did not notify the family, because the social worker progress note said the family did not want to be contacted in throughout the night and early morning hours. She said felt like she did her job because she monitored the resident.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/15/2025 at 12:31 P.M., the SW said she usually worked in the facility 3 days a week, but it depends on what the census was. She said yes, she had an intern to put a progress note in PCC (electronic health record) for Resident #1 on 04/05/2025. The SW verified that there was a note that stated Resident #1's family requested not to be contacted in the middle of the night or early in the morning regarding the resident's care.</p> <p>During an interview on 04/15/2025 at 12:41 P.M., CNA B said when she did her last rounds, she noticed Resident #1 had not wet during the shift. She said she was not a heavy wetter but had not voided the whole shift and she had not rested well. She said she had worked for hospice before, and she knew that was not a good sign. She said she notified the nurse immediately. She said the nurse checked Resident #1's vital signs and told her she might be right, that something was going on with Resident #1. CNA B said Resident #1's eyes were already fixed. She said LVN A was agency staff, and she was agency staff also, but she had worked with Resident #1 for a while. She said she thought LVN A did not know Resident #1 well enough to know that there was a change in her condition on how she usually acts, she guessed. She said she thought LVN A may have received report on Resident #1 not feeling well. She said after she completed her last rounds, she went home. She said she thought LVN A should have sent Resident #1 out to the hospital. She said LVN A told her Resident #1 was on hospice and she told her she did not know she was on hospice. She said she thought to herself if Resident #1 was on hospice, she should have notified the hospice company. She said later she found out Resident #1 was not on hospice. She said if she was in LVN A's shoes she would have sent Resident #1 out to the hospital, with her breathing the way she was breathing.</p> <p>During an interview on 04/15/2025 at 2:07 P.M., the MD said it does not ever hurt to notify the MD. He said any time there was an emergency with a resident the nurse should notify the NP or MD. He said with the incident with Resident #1 having low vital signs and agonal breathing, he would have wanted to be notified and he would have given orders for the nurse to send Resident #1 out to the hospital. He said the incident occurred and it sound like the nurse did not do her job and got fired and that was appropriate.</p> <p>During an interview on 04/15/2025 at 3:05 P.M., the DON said when the nurse was notified of a change of condition with Resident #1, the nurse should have done her assessment, then based off of her assessment she should have notified the NP or the MD. She said after she notified them of the change in condition they would have given her further orders. She said she felt like the nurse neglected Resident #1 by not notifying the MD and taking no further actions for the resident. She said they try to keep check off agency staff when we are performing any kind of check offs and they are working in our building. She said the facility did in-services and the book stayed at the nurses' station and they are supposed to sign and read the in-services before they start work.</p> <p>During an interview on 04/15/2025 at 3:47 P.M., the ADM said as soon as the nurse knew that there was a change in condition with Resident #1 she should have called the NP. She said the NP could have told her what to do, but by her not calling him she made a decision that she was not allowed to make, which was to do nothing. She said LVN A should have notified Resident #1's family as well. She said if she would have notified the NP, she would have been able to tell the family what the NP said about the resident's condition. She said she felt like LVN A made a stupid decision in her heart and the resident's needs were not met. She said there are in-services over Change of Condition, Abuse, Neglect and Exploitation, and DNR at the front nurse station since the 04/08/2025 every nurse has been in serviced on this. She said if she or the DON is not in the facility the off-going nurses were responsible for in servicing the incoming nurses who had not been in serviced on the topics.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/16/2025 at 10:19 A.M., the ADM said on the in-services you have to go to PCC to work Stopwatch tool, but there was not an actual way to show what we have been working on. She said Stopwatch is noted to a specific person when they were flagged in PCC. She said the stopwatch tool was to the signature page. We have in serviced everyone on the physical tool.</p> <p>Record review of the facility's Change in a Resident's Condition or Status revised date 02/2021 indicated . Our community promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .</p> <p>.1.The nurse will notify the resident's attending physician or physician on call when there has been a(an)significant change of condition is a major decline or improvement in the resident's status .</p> <p>The facility corrected the noncompliance on 04/08/2025 by the following:</p> <p>-All staff interviewed (ADON, MDS Nurse, LVN C, CNA B, RN D, RN L, RN F, RN E,CNA G, CNA H, CWT I, CNA J, CNA K, SW, [NAME] M, CNA N, Maintenance O, DM P, Housekeeper Q, Housekeeper T, DA R, CNA S, CNA U and RN V) on 04/16/2025 verbalized understanding of In-services on COC (Change of Condition). All staff verbalized understanding CNAs are to alert nurses and nurses are to alert representative and physician of any changes in the resident's medical/mental condition or status. - Completed 04/08/2025.</p> <p>-All staff interviewed (ADON, MDS Nurse, LVN C, CNA B, RN D, RN L, RN F, RN E,CNA G, CNA H, CWT I, CNA J, CNA K, SW, [NAME] M, CNA N, Maintenance O, DM P, Housekeeper Q, Housekeeper T, DA R, CNA S, CNA U and RN V) on 04/16/2025 verbalized understanding of In-services on DNR (do not resuscitate). All staff verbalized education on DNR and meaning, but voiced it does not mean that the facility will not treat the resident in the event of a change of condition and does not mean do not send the resident to the hospital for emergency treatment. - Completed 04/08/2025.</p> <p>-All staff interviewed (ADON, MDS Nurse, LVN C, CNA B, RN D, RN L, RN F, RN E,CNA G, CNA H, CWT I, CNA J, CNA K, SW, [NAME] M, CNA N, Maintenance O, DM P, Housekeeper Q, Housekeeper T, DA R, CNA S, CNA U and RN V) on 04/16/2025 verbalized understanding of in-service on ANE (Abuse, Neglect and exploitation). Staff was able to identify the different types of abuse, neglect, exploitation and who to report it to. -Completed 04/08/2025.</p> <p>-All staff interviewed (ADON, MDS Nurse, LVN C, CNA B, RN D, RN E, RN L, RN F, CNA G, CNA H, CWT I, CNA J, CNA K, SW, [NAME] M, CNA N, Maintenance O, DM P, Housekeeper Q, Housekeeper T, DA R, CNA S, CNA U and RN V) on 04/16/2025 verbalized understanding of Stop and Watch, Early Warning Tool (Interact). Staff verbalizing if they identified a change while caring for or observing a resident/patient, please circle the change and notify a nurse. -Completed 04/15/2025.</p> <p>-All nurses interviewed (DON, ADON, MDS Nurse, RN L, RN E, and LVN C) on huddles an ongoing process was when the nurses got together during shift change to talk about any changes to the resident, anything new with the residents, anything to watch for. They said they talked about any new wounds would need to be reported. They said they always reported things as they happened but would go over it again in the huddle. They showed this surveyor in PCC how to find the flags for high-risk residents and anything the residents had flagged for. We looked at several residents with flags. There was only one resident with an SBar since 04/07/2025.Ongoing process.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- QAPI meeting held to discuss appropriate care interventions were not provided in a timely manner following a resident's change in condition. This failure to act accordingly may have contributed to a delay in an assessment, treatment, or escalation of care on 04/07/2025:</p> <p>-The resident exhibited clear signs of a change in condition, including agonal breathing, cold skin, eyes fixed vital signs:54/53, 54, 93%, 128.</p> <p>-Documentation indicates that the change was either not communicated promptly or not acted upon in accordance with facility protocol (i.e, call NP/MD/DON).</p> <p>-Care team did not initiate appropriate clinical interventions or notify the appropriate providers within the expected time frame. - Completed 04/08/2025.</p> <p>During an interview on 04/16/2025 at 2:00 P.M., Family Member#1 of Resident #1 said the care she received from the facility was not great. Family Member #1 said she had laryngitis and she could not talk.</p> <p>During an interview on 04/17/2025 at 9:43 A.M., RN D said she had only worked at the facility a couple of times. She said she could not remember the resident by name. She said that was her first time working on that hall, but the last day she worked which was 04/06/2025 none on her residents were in critical condition and she had no reports of a change of condition on any of them. She said if a resident had a change in condition, she would have notified the MD and sent the resident to the hospital and notified the family.</p> <p>During an interview on 04/17/2025 at 10:49 A.M., the DON said she felt like once LVN A had been notified of the change of condition with Resident #1 had occurred she should have assessed her, notified the NP or MD of the findings and followed the orders. She said she was totally mind blown by LVN A's reaction to what she was taught. She said LVN A said she thought she did not do anything wrong. She said the facility put a DNR (do not return) on LVN A and the agency terminated her as well.</p> <p>During an interview on 04/17/2025 at 11:08 A.M., the ADM said she felt that everything LVN C did should have been done during the incident with Resident #1. She said LVN A had the tools she needs at the facility and there was another nurse on duty to assist her for guidance and to help her. She said LVN A chose to monitor Resident #1. She said LVN A should have called the NP, she should have called anyone. She said she believed LVN A's biggest downfall was she did not call anyone. The ADM said she believed that Resident #1 was in a-fib (an irregular and often rapid heart rhythm, but they do not know, because LVN A did not make a phone call. She said LVN A should have made a phone call to the family of Resident #1. The ADM said if Resident #1 was her family, yes I would want to be notified of her condition. She said LVN A's reaction was unacceptable, and she would be referring her to the Texas board of nursing.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 04/07/2025 and ended on 04/08/2025. The facility corrected the noncompliance before the survey began.</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958</p> <p>Based on interview and record review, the facility failed to ensure each resident received treatment and care in accordance with professional standards of practice for 1 of 6 resident's reviewed for quality of care.</p> <p>The facility failed to notify the physician/designee and or seek a higher level of care on 4/07/2025 5:00 a.m. - 6:00 a.m. when Resident #1 had a change of condition with agonal breathing, fixed pupils, no urine output and lethargic.</p> <p>The facility failed to ensure LVN A documented any additional assessments/monitoring of Resident #1 after the initial assessment on 4/07/2025 at 5:00 a.m.</p> <p>The facility failed to ensure LVN A initiated any interventions to prevent a further decline in Resident #1.</p> <p>The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 04/07/2025 and ended on 04/08/2025. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for not receiving timely medical intervention.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated 04/15/2025 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of chronic atrial fibrillation (a heart condition where the upper two chambers of the heartbeat irregularly and rapidly, lasting longer than 12 months), repeated falls and dementia (a group of thinking and social symptoms that interferes with daily functioning).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 which indicated moderate cognitive impairment. Resident #1 was usually understood by others and usually understands. Resident #1 required setup assistance for eating and moderate assistance for personal hygiene. Resident #1 required maximal assistance with bathing, dressing and dependent with toileting hygiene.</p> <p>Record review of Resident #1's care plan dated 10/17/2023, reflected I have chosen do not resuscitate status. Ensure resident wishes are followed as desired. Follow my advanced directive/code status.</p> <p>Record review of Resident #1's orders undated revealed advanced directives code status DNR (do not resuscitate).</p> <p>Record review of Resident #1's SW progress note date 04/05/2025 revealed, this social intern called the resident's family today. Family Member #1 asked not to be called at 3 A.M. unless it's an emergency, Resident #1 has passed or is in the emergency room .</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/15/2025 at 12:07 P.M., LVN A said CNA B was making her last rounds when she came and her told Resident #1 did not look right. LVN A said she went to assess Resident #1 and her vital signs were low. She said Resident #1 looked like she was actively dying. She said Resident #1 was a DNR. She said she saw there was a progress note from the social worker that said the family requested not to call at 3:00 A.M. or in the middle of the night. She said the social worker progress note was put in on the 04/05/2025. She said she monitored Resident #1 the rest of her shift and she did 15 minutes checks on her. She said eventually the next nurse came in. She said she was confused about if the resident was actively passing, because in her training if they were actively passing the nurse should do nothing if the resident was a DNR. She said she did not notify the MD or NP and she said she did not notify the family, because the social worker progress note said the family did not want to be contacted in throughout the night and early morning hours. She said felt like she did her job because she monitored the resident.</p> <p>During an interview on 04/15/2025 at 12:31 P.M., the SW said she usually worked in the facility 3 days a week, but it depends on what the census was. She said yes, she had an intern to put a progress note in PCC (electronic health record) for Resident #1 on 04/05/2025. The SW verified that there was a note that stated Resident #1's family requested not to be contacted in the middle of the night or early in the morning regarding the resident's care.</p> <p>During an interview on 04/15/2025 at 12:41 P.M., CNA B said when she did her last rounds, she noticed Resident #1 had not wet during the shift. She said she was not a heavy wetter but had not voided the whole shift and she had not rested well. She said she had worked for hospice before, and she knew that was not a good sign. She said she notified the nurse immediately. She said the nurse checked Resident #1's vital signs and told her she might be right, that something was going on with Resident #1. CNA B said Resident #1's eyes were already fixed. She said LVN A was agency staff, and she was agency staff also, but she had worked with Resident #1 for a while. She said she thought LVN A did not know Resident #1 well enough to know that there was a change in her condition on how she usually acts, she guessed. She said she thought LVN A may have received report on Resident #1 not feeling well. She said after she completed her last rounds, she went home. She said she thought LVN A should have sent Resident #1 out to the hospital. She said LVN A told her Resident #1 was on hospice and she told her she did not know she was on hospice. She said she thought to herself if Resident #1 was on hospice, she should have notified the hospice company. She said later she found out Resident #1 was not on hospice. She said if she was in LVN A's shoes she would have sent Resident #1 out to the hospital, with her breathing the way she was breathing.</p> <p>During an interview on 04/15/2025 at 2:07 P.M., the MD said it does not ever hurt to notify the MD. He said any time there was an emergency with a resident the nurse should notify the NP or MD. He said with the incident with Resident #1 having low vital signs and agonal breathing, he would have wanted to be notified and he would have given orders for the nurse to send Resident #1 out to the hospital. He said the incident occurred and it sound like the nurse did not do her job and got fired and that was appropriate.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675981	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Mineola Heights Healthcare Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Mimosa Street Mineola, TX 75773	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/15/2025 at 3:05 P.M., the DON said when the nurse was notified of a change of condition with Resident #1, the nurse should have done her assessment, then based off of her assessment she should have notified the NP or the MD. She said after she notified them of the change in condition they would have given her further orders. She said she felt like the nurse neglected Resident #1 by not notifying the MD and taking no further actions for the resident. She said they try to keep check off agency staff when we are performing any kind of check offs and they are working in our building. She said the facility did in-services and the book stayed at the nurses' station and they are supposed to sign and read the in-services before they start work.</p> <p>During an interview on 04/15/2025 at 3:47 P.M., the ADM said as soon as the nurse knew that there was a change in condition with Resident #1 she should have called the NP. She said the NP could have told her what to do, but by her not calling him she made a decision that she was not allowed to make, which was to do nothing. She said LVN A should have notified Resident #1's family as well. She said if she would have notified the NP, she would have been able to tell the family what the NP said about the resident's condition. She said she felt like LVN A made a stupid decision in her heart and the resident's needs were not met. She said there are in-services over Change of Condition, Abuse, Neglect and Exploitation, and DNR at the front nurse station since the 04/08/2025 every nurse has been in serviced on this. She said if she or the DON is not in the facility the off-going nurses were responsible for in servicing the incoming nurses who had not been in serviced on the topics.</p> <p>During an interview on 04/16/2025 at 10:19 A.M., the ADM said on the in-services you have to go to PCC to work Stopwatch tool, but there was not an actual way to show what we have been working on. She said Stopwatch is noted to a specific person when they were flagged in PCC. She said the stopwatch tool was to the signature page. We have in serviced everyone on the physical tool.</p> <p>Record review of the facility's Change in a Resident's Condition or Status revised date 02/2021 indicated . Our community promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .</p> <p>.1.The nurse will notify the resident's attending physician or physician on call when there has been a(an)significant change of condition is a major decline or improvement in the resident's status .</p> <p>The facility corrected the noncompliance on 04/08/2025 by the following:</p> <p>-All staff interviewed (ADON, MDS Nurse, LVN C, CNA B, RN D, RN L, RN F, RN E,CNA G, CNA H, CWT I, CNA J, CNA K, SW, [NAME] M, CNA N, Maintenance O, DM P, Housekeeper Q, Housekeeper T, DA R, CNA S, CNA U and RN V) on 04/16/2025 verbalized understanding of In-services on COC (Change of Condition). All staff verbalized understanding CNAs are to alert nurses and nurses are to alert representative and physician of any changes in the resident's medical/mental condition or status. - Completed 04/08/2025.</p> <p>-All staff interviewed (ADON, MDS Nurse, LVN C, CNA B, RN D, RN L, RN F, RN E,CNA G, CNA H, CWT I, CNA J, CNA K, SW, [NAME] M, CNA N, Maintenance O, DM P, Housekeeper Q, Housekeeper T, DA R, CNA S, CNA U and RN V) on 04/16/2025 verbalized understanding of In-services on DNR (do not resuscitate). All staff verbalized education on DNR and meaning, but voiced it does not mean that the facility will not treat the resident in the event of a change of condition and does not mean do not send the resident to the hospital for emergency treatment. - Completed 04/08/2025.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-All staff interviewed (ADON, MDS Nurse, LVN C, CNA B, RN D, RN L, RN F, RN E,CNA G, CNA H, CWT I, CNA J, CNA K, SW, [NAME] M, CNA N, Maintenance O, DM P, Housekeeper Q, Housekeeper T, DA R, CNA S, CNA U and RN V) on 04/16/2025 verbalized understanding of in-service on ANE (Abuse, Neglect and exploitation). Staff was able to identify the different types of abuse, neglect, exploitation and who to report it to. -Completed 04/08/2025.</p> <p>-All staff interviewed (ADON, MDS Nurse, LVN C, CNA B, RN D, RN E, RN L, RN F, CNA G, CNA H, CWT I, CNA J, CNA K, SW, [NAME] M, CNA N, Maintenance O, DM P, Housekeeper Q, Housekeeper T, DA R, CNA S, CNA U and RN V) on 04/16/2025 verbalized understanding of Stop and Watch, Early Warning Tool (Interact). Staff verbalizing if they identified a change while caring for or observing a resident/patient, please circle the change and notify a nurse. -Completed 04/15/2025.</p> <p>-All nurses interviewed (DON, ADON, MDS Nurse, RN L, RN E, and LVN C) on huddles an ongoing process was when the nurses got together during shift change to talk about any changes to the resident, anything new with the residents, anything to watch for. They said they talked about any new wounds would need to be reported. They said they always reported things as they happened but would go over it again in the huddle. They showed this surveyor in PCC how to find the flags for high-risk residents and anything the residents had flagged for. We looked at several residents with flags. There was only one resident with an SBar since 04/07/2025.Ongoing process.</p> <p>- QAPI meeting held to discuss appropriate care interventions were not provided in a timely manner following a resident's change in condition. This failure to act accordingly may have contributed to a delay in an assessment, treatment, or escalation of care on 04/07/2025:</p> <p>-The resident exhibited clear signs of a change in condition, including agonal breathing, cold skin, eyes fixed vital signs:54/53, 54, 93%, 128.</p> <p>-Documentation indicates that the change was either not communicated promptly or not acted upon in accordance with facility protocol (i.e, call NP/MD/DON).</p> <p>-Care team did not initiate appropriate clinical interventions or notify the appropriate providers within the expected time frame. - Completed 04/08/2025.</p> <p>During an interview on 04/16/2025 at 2:00 P.M., Family Member#1 of Resident #1 said the care she received from the facility was not great. Family Member #1 said she had laryngitis and she could not talk.</p> <p>During an interview on 04/17/2025 at 9:43 A.M., RN D said she had only worked at the facility a couple of times. She said she could not remember the resident by name. She said that was her first time working on that hall, but the last day she worked which was 04/06/2025 none on her residents were in critical condition and she had no reports of a change of condition on any of them. She said if a resident had a change in condition, she would have notified the MD and sent the resident to the hospital and notified the family.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/17/2025 at 10:49 A.M., the DON said she felt like once LVN A had been notified of the change of condition with Resident #1 had occurred she should have assessed her, notified the NP or MD of the findings and followed the orders. She said she was totally mind blown by LVN A's reaction to what she was taught. She said LVN A said she thought she did not do anything wrong. She said the facility put a DNR (do not return) on LVN A and the agency terminated her as well.</p> <p>During an interview on 04/17/2025 at 11:08 A.M., the ADM said she felt that everything LVN C did should have been done during the incident with Resident #1. She said LVN A had the tools she needs at the facility and there was another nurse on duty to assist her for guidance and to help her. She said LVN A chose to monitor Resident #1. She said LVN A should have called the NP, she should have called anyone. She said she believed LVN A's biggest downfall was she did not call anyone. The ADM said she believed that Resident #1 was in a-fib (an irregular and often rapid heart rhythm, but they do not know, because LVN A did not make a phone call. She said LVN A should have made a phone call to the family of Resident #1. The ADM said if Resident #1 was her family, yes I would want to be notified of her condition. She said LVN A's reaction was unacceptable, and she would be referring her to the Texas board of nursing.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 04/07/2025 and ended on 04/08/2025. The facility corrected the noncompliance before the survey began.</p>