STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676025	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Leaves Nursing and Rehab Inc	321 Kilgore Drive Henderson, TX 75652

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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42190 Based on observation, interview, and record review, the facility failed to ensure that a resident who need respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences, for 3 of 11 residents (Residents #1, Resident #2, and Resident #3) reviewed for respiratory care. The facility failed to ensure Residents #1, #2 and #3's oxygen tubing and humidifier bottle was changed and dated as ordered. These failures could place residents at risk for upper respiratory infections and worsening of their physical condition. The findings included: Resident #1's cannula tubing was not changed as ordered, the concentrator water bottle was dated 06/09/2024 and was empty. Resident #2's cannula tubing was not changed as ordered, the concentrator water bottle was dated 06/19/2024. Resident #3's canula tubing was not changed as ordered, the concentrator water bottle was dated 06/20/2024. Record review of Resident #1's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses to include, pneumonitis due to inhalation of food and vomit, sepsis, unspecified organism, respiratory failure unspecified, unspecified, whether with hypoxia or hypercapnia, morbid (severe) obesity due to excess calories, hypertensive heart disease with heart failure, anxiety disorder due to known physiological condition and generalized anxiety disorder. Review of Resident #1's most recent MDS, dated [DATE], indicated she had a BIMS (Brief Interview for Mental Status) score of 15. Record review of Resident #1's comprehensive care plan, revision date of 4/01/2024, revealed the resident required oxygen therapy related to ineffective gas exchange. Record review of Resident #1's physician orders for June 2024 revealed the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Change and date oxygen tubing/humidifier bottle every week on Sunday, with order date 9/10/23 and no end date. - O2 (oxygen) at 2 to 4 liters per minute via nasal cannula continuous, every shift, with order date 1/29/24 and no end date. Record review of Resident #2's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses to include heart failure, unspecified, schizoaffective disorder, unspecified, other recurrent depressive disorders, other specified anxiety disorders, insomnia, unspecified sarcopenia and obstructive sleep apnea, adult. Review of Resident #2's most recent MDS, dated [DATE], indicated she had a BIMS (Brief Interview for Mental Status) score of 15. Record review of Resident #2's comprehensive care plan, revision date 4/11/2024 revealed the resident required oxygen therapy related to ineffective gas exchange. Record review of Resident #2's physician orders for June 2024 revealed the following: - Change and date oxygen tubing/humidifier bottle every week on Sunday, with order date 9/10/23 and no end date. - O2 (oxygen) at 2 to 4 liters per minute via nasal cannula continuous, every shift, with order date 1/29/24 and no end date. Record review of Resident #3's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses to include acute respiratory failure, unspecified whether with hypoxia or hypercapnia, chronic obstructive pulmonary disease, unspecified, type 2 diabetes, mellitus with other specified complication, morbid (sever) obesity due to excess calories hypertensive heart disease with heart failure and depression, unspecified. Review of Resident #3's most recent MDS, dated [DATE], indicated he was not able to complete the BIMS (Brief Interview for Mental Status) interview. Record review of Resident #3's comprehensive care plan, revision date 7/01/2024 revealed the resident required oxygen therapy related to sleep apnea and COPD. Record review of Resident #3's physician orders for June 2024 revealed the following: - Clean oxygen concentrator filter weekly, ever Sunday, with order date 6/02/2024 and no end date. - O2 (oxygen) at 2 to 4 liters per minute via nasal cannula continuous, every shift, with order date 5/30/24 and no end date. During observation and interview on 6/26/24 at 11:32 p.m., Resident #1 was lying in bed on her back, talking to a visitor. Resident #1's oxygen concentrator was on, the nasal cannula was in her nostrils. The cannula tubing and the humidifier bottle was dated 6/9/2024. The humidifier was noted to be empty, she said the bottle had been empty for several days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 6/26/24 at 12:15 p.m., Resident #2 was in bed, on her personal phone. The oxygen concentrator was on and the cannula was in her nostrils. She said her tubing had not been changed in 3 weeks, the tubing and the humidifier bottle was dated 6/19/24. She said she told the Social Worker and a nurse about her cannula tubing not being changed but nothing had been done. She said she could not remember the nurse's name. During observation and interview on 6/26/24 at 12:54 p.m., Resident #3 was in his room, sitting in his wheelchair, viewing his cell phone. He said he was treated good. Resident #3's concentrator was not operating, and the cannula tubing was not in his nostrils. He said he had no idea when the cannula tubing was last changed. The cannula tubing and humidifier bottle was dated 6/20/24. During interview with RN A on 6/26/24 at 1:55 p.m., she said no, the cannula tubing had not been changed out for the resident #3. She said the cannula tubing should have been changed every Sunday night, but they don't have the supplies. She said, if the cannula tubing is not changed on Sunday night, she'll change it while doing rounds on Monday, but she could not change them because there were no supplies. She said the tubing and the humidifier bottle came as one piece and would be changed at the same time. During interview with LVN B on 6/26/24 at 2:17 p.m., she said the cannula tubing should be change every Sunday. She said a night nurse on the 6:00 p.m. - 6:00 a.m. shift should change the cannula tubing and the humidifier bottle. She said it did not get done because there were no supplies. She said the medical records person used to order supplies, but she was not sure who order supplies now. During interview with RN C, on 6/26/24 at 2:25 p.m., she said the cannula tubing and the humidifier bottle is supposed to be change once per week, usually Sunday night. She said the cannula and the humidifier was usually changed by the RN on Sunday and they should have been dated when changed. She said she was not sure who orders supplies. She said if the cannula tubing is not changed and no water is in the humidifier, a resident could experience drying in the nostrils, bleeding in the nose and respiratory infection. During interview with the DON, on 06/26/24 at 2:39 p.m., she said the cannula tubing and humidifier bottle should be changed on Sunday night, by the nurses. She said they did not have the supplies, they were ordered, and she thought the supplies would have come in. She said the cannula tubing and humidifier bottles, came as one piece, therefore the staff could not change them out separately. She said the person who ordered supplies was new to the role and that may have contributed to the supply shortage. During interview with the ADM, on 6/26/24 at 2:52 p.m., he said the person who does medical records has now taken on the role of ordering supplies and is relatively new to the role. He said she was out for a few days, and he was trying to get supplies ordered. He said he ordered supplies on 6/20/24 but the order was not filled. He said he placed a second order for cannula tubing and water bottles and that order should be in on 6/27/24. The ADM provided an order slip placed to a medical supplier, which confirmed an order was placed on 06/25/2024, for cannula tubing and prefill water humidifier bottles. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with the Social Worker on 6/27/24 at 2:52 p.m., she said Resident #2 talked to her all the time and they had recently talked but Resident #2 had never mentioned anything about her oxygen concentrator. She said Resident #2 usually talked about other things, her brother, or her wife, but never said anything about her oxygen concentrator. Review of a facility policy titled: Oxygen Concentrator & Other Respiratory Equipment, with a revised date of February 2024, revealed: Steps in the Procedure .8. Check water level of any pre-filled bottle and replace when empty or at 7 day schedule/shift. Change oxygen cannula and tubing every seven (7) days or as needed .