STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676153	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of League City	2620 W Walker League City, TX 77573

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on interviews, and record review the facility failed to immediately consult with the resident's physician when there is a significant change in the resident's physical status for 1 of 4 residents (CR #1) reviewed for notification of changes. The facility failed to ensure CR #1's physician was consulted when he was short of breath while receiving oxygen treatment. This failure could place residents at risk of respiratory distress or significant decline in physical or mental functioning. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 7:11 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that was not an immediate jeopardy and a scope of pattern because all staff had not been trained on notification of changes to the physician. The findings included: Record review of Resident #1's face sheet dated [DATE] revealed a [AGE] year-old male was admitted to the facility on [DATE]. Resident #1 had diagnoses included: heart failure, (heart cannot pulp enough blood and oxygen to the body's organ), morbid obesity (body mass index greater than 35 combined with other health issues), diabetes mellites (body does not manage blood sugar properly), and atrial fibrillation (irregular heartbeat). Record review of CR#1's admission MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 15 out of 15 which indicated intact cognition. Further review revealed Resident #1 needed moderate assistance with mobility. Record review of CR#1's care plan dated [DATE] revealed Resident #1 resident was at risk for shortness of breath. Intervention: alert my nurse for concentrator and/oxygen tank needs to be changed, provide oxygen as ordered by physician. Record review of CR#1's order summary report did not reveal that the resident had an order for oxygen administration. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's NEMAR for [DATE] revealed there was no order found for Respiratory(oxygen). Record review of CR#1 progress notes from ,d+[DATE]/ 24 to [DATE] revealed there was no documentation that CR #1 was in any distress. Record review of CR #1 hospital discharge record printed [DATE] did not reveal any order for oxygen. During an interview on [DATE] at 2:07 p.m., RN G said CR #1 was on PRN oxygen. RN G said CR #1 would feel winded when he stood up for her during wound care and he would put his oxygen on. RN G said she was unsure if CR #1 had an order for oxygen. RN G said oxygen should be administered with a physician's order to ensure CR #1 received the appropriate liters of oxygen. RN G said if CR #1 did not receive adequate oxygen, he could go into respiratory distress. RN G said nurse managers monitored the nurses when they made random rounds. During a telephone interview on [DATE] at 4:15 p.m., LVN T said CR #1 had oxygen in his room and believed CR #1 had an order for oxygen. LVN T said CR #1 had an order for oxygen; the nurses would document it on the NEMAR. LVN T said CR #1 must have an order before oxygen would be administered because if CR #1 did not have an order, CR #1 may not receive the required liters of oxygen to prevent respiratory complications such as shortness of breath or a crisis. LVN T said she had an in-service on oxygen administration, and the nurse managers monitored the nurses during random rounds. During an interview on [DATE] at 5:27 p.m., LVN H said she verified the admission orders with the physician, and the physician gave an order for oxygen. LVN H was supposed to put the oxygen order in but did not know she did not put the oxygen order in the computer, and she could not remember how many liters of oxygen the physician prescribed for CR #1. LVN H said oxygen was a medication, and she should have put the order in the computer. LVN H also said if CR #1 did not get the prescribed liters of oxygen, CR #1 could have respiratory distress. LVN H said she had a skill- check off on the admission process, and the nurse manager should have checked the paperwork the day after admission. During an interview on [DATE] at 9:58 a.m., the OT said CR#1 could walk to the restroom and shower room, but he would need his oxygen. The OT said CR#1 kept his oxygen on with any activity, but he could take it off for a little while during the shower. During an interview on [DATE] at 10:38 a.m., PTA said she had worked with CR #1 during therapy and he wore an oxygen tank. She said they worked with him at his pace because of his size, he was mobility obese. She said he wore his oxygen at all times during therapy and he runs out of breath (SOB) and she would let him rest and continued again. She said that when the resident was able to walk to the bathroom in his room, and they told the resident he would have to have staff with him if he wants to walk past the bathroom in his room. During an interview on [DATE] at 10:57 a.m., the ADON said CR #1 did not have an order for oxygen from the hospital. The ADON said the nurse managers should have done chart checks and checked the orders to ensure CR #1's medication was correct the next day. The ADON said LVN H should have put in a PRN order because CR #1 had oxygen, but LVN H did not transcribe the oxygen order. The ADON said CR #1 should not have oxygen on without an order. The ADON said CR #1 could go into respiratory distress if he did not get adequate liters of oxygen, and if CR #1 got more than required, it could cause CR #1 to depend on oxygen. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on [DATE] at 1:55 p.m., the State Surveyor and the MDS Nurse reviewed CR #1's physician orders, and the MDS nurse said she did not see the order for oxygen. The MDS nurse said CR#1 should have an order for oxygen before the nurses could administer oxygen to him. The MDS nurse said it was a medication error because LVN H had to enter the physician's orders before nurses could administer oxygen to CR #1. The MDS nurse said there could be a negative effect on CR #1 if the nurse's administered oxygen to CR#1 without an order. The MDS nurse said the negative effect could cause CR #1 to depend on oxygen or could have an adverse respiratory crisis if he did not receive the recommended liters of oxygen. The MDS nurse said CR #1 was care planned by LVN H, not her. During an interview on [DATE] at 3:02 p.m., the Administrator said that for a resident to be on oxygen, the resident should have an order for oxygen. The Administrator said she was sure there could be some side effects, but she did not think it would be dangerous. The Administrator said the DON monitored the nurses to ensure the nurses transcribed the orders correctly. During an interview on [DATE] at 4:16 PM 4: 16 p.m., the DON said CR #l 's 02 was RPN the nurse would make the decision if the resident could take off the oxygen. The DON said the therapy dept did not tell her that CR#1 got winded during activity even with oxygen. During a telephone interview on [DATE] at4:37 p.m., the Physician said he gave intermitter oxygen order and he could not remember how many liters of oxygen he gave, but the nurse could titrate the liter for CR #1 to be comfortable. He said the resident used oxygen intermittently said CR #1 refused to use oxygen sometimes and he had experienced hypoxia and he was still comfortable. The physician said normal order for oxygen was between 2 to 3 liters. The Physician said the nursing or therapy did not communicate to him that CR #1 still has shortness of breath during activities even with oxygen. He said maybe the nursing staff spoke to the NP about the resident having SOB with oxygen during activity. He said it was his understanding that the resident was on oxygen while he was in the facility. During a telephone interview on [DATE] at 4:58 p.m., the NP refused to answer questions regarding CR #1. Record review of the facility oxygen administration dated [DATE], Revised [DATE] read in part . a resident receives oxygen therapy when there is an order by a physician. The resident's disease, physical condition, and age will help determine the most appropriate method of administration and should be reflected in the physician . The following Plan of Removal was accepted on [DATE] at 12:30 PM, PLAN OF REMOVAL: Abatement Plan Immediate Response: o The identified resident expired on [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Director of Nursing Services/Assistant Director of Nursing Services identified all residents in the community (12) on continuous oxygen and verified accurate orders were in the electronic health record. All residents with supplemental oxygen (7) have orders in place in the electronic health record. There were no other residents identified in the community who require continuous/supplemental oxygen. Date completed: [DATE] . o Director of Nursing Services/Assistant Director of Nursing services will conduct skills validations for all licensed nurses to validate competency for inputting physician orders. Date completed: [DATE]. o Rehabilitation Director will be present in the morning meeting. Director of Nursing Services/Assistant Director of Nursing Services will review all residents who are on oxygen. In addition, the Audit Listing Report for residents on oxygen will we be printed, and a copy given to therapy. This process will be monitored , d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide 100% education to all team members in therapy on notification of changes on condition to the Charge nurse/Assistant Director of Nursing/Director of Nursing. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide education to all direct care staff on notification of changes in condition to report to the charge nurse/Assistant Director of Nursing/Director of Nursing Services. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completion: [DATE] o Director of Nursing/Assistant Director provided 100% education to all licensed nurses in regard to resident's changes in condition (shortness of breath, low oxygen saturations and all changes in condition). The nurse will immediately assess the resident and document in the electronic health record, notify the physician and responsible party. The charge nurse will proceed with any new orders from the physician. Date of completion: [DATE] . Community will ensure all staff on leave/agency/PRN staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. The community will ensure all residents who require respiratory care are provided such care. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Risk Response: All new admissions/readmissions have the potential to be affected by the deficient practice. Systemic Response: o Director of Nursing Services/Assistant Director of Nursing Services identified all residents in the community (12) on continuous oxygen and verified accurate orders were in the electronic health record. All residents with supplemental oxygen (7) have orders in place in the electronic health record. There were no other residents identified in the community who require continuous/supplemental oxygen. Date completed: [DATE] . o Director of Nursing Services/Assistant Director of Nursing services will conduct skills validations for all licensed nurses to validate competency for inputting physician orders. Date completed:[DATE]. o Rehabilitation Director will be present in the morning meeting. Director of Nursing Services/Assistant Director of Nursing Services will review all residents who are on oxygen. In addition, the Audit Listing Report for residents on oxygen will we be printed, and a copy given to therapy. This process will be monitored , d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide 100% education to all team members in therapy on notification of changes on condition to the Charge nurse/Assistant Director of Nursing/Director of Nursing. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide education to all direct care staff on notification of changes in condition to report to the charge nurse/Assistant Director of Nursing/Director of Nursing Services. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completion: [DATE] o Director of Nursing/Assistant Director provided 100% education to all licensed nurses in regard to resident's changes in condition (shortness of breath, low oxygen saturations and all changes in condition). The nurse will immediately assess the resident and document in the electronic health record, notify the physician and responsible party. The charge nurse will proceed with any new orders from the physician. Date of completion: [DATE] . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Community will ensure all staff on leave/agency/PRN staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. The community will ensure all residents who require respiratory care are provided such care. Monitoring Response: o The Director of Nurses/Assistant Director of Nurses will conduct weekly skills validations of order entry for , d+[DATE] nurses, ,d+[DATE] days a week for 2 months. o Director of Nurses/Assistant Director of Nurses will review all admission/re-admission orders daily in the clinical meeting to validate orders are transcribed per discharge orders for the reconciliation process for , d+[DATE] days a week for 2 months. o Director of Nursing Services/Assistant Director of Nursing Services will review all residents who are on oxygen in the morning meeting. A review of residents who are on oxygen will be reviewed with the rehabilitation representative. In addition, the Audit Listing Report for residents on oxygen will we be printed, and a copy given to therapy. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. o Director of Nursing/Assistant Director of Nursing will validate the process of reporting changes in condition with ,d+[DATE] random therapy team member ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. o Director of Nursing/Assistant Director of Nursing will validate the process of reporting changes in condition with ,d+[DATE] random therapy team member ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services . o Director of Nursing Services/Assistant Director of Nursing Services will validate the process to implement with the notification of a change in condition from ,d+[DATE] random licensed nurses ,d+[DATE] days a week for 2 months. o All the monitoring will be monitored by the Director of Nursing/Assistant Director of Nursing. This plan will remain in place for the next 2 months to ensure compliance or to identify any further training needs. Findings of those observations will be reported to the QAPI committee during monthly meeting for the next 2 months. Medical Director notified of the Immediate Jeopardy on [DATE] @ 7:22pm per Director of Nursing Services. Surveyor monitored the plan of removal for effectiveness as follows: Observation and interviews starting from [DATE] to [DATE] revealed no concerns with oxygen therapy for Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6. There were no signs of shortness of breath or labored breathing, each resident received oxygen therapy within the parameters of their physician order. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of physician orders and care plans for Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 revealed no concerns, each resident had physician orders and were care planned for oxygen therapy. Record review of [DATE] to [DATE] oxygen saturations and MAR/TAR's for Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 revealed each resident was being monitored for oxygen therapy. Record review of the facility plan or removal training, skills check-off, and in-service revealed the facility had 12 residents on oxygen, and the DON reviewed and completed their clinical records on [DATE]. Record review of the facility training revealed that the corporate nurse trained the DON, nurse managers, and administrator on physician follow-up chart checks, completed on [DATE]. Record review of the facility training for the nurses on changes of condition and notifications to physicians completed on [DATE]. A record review of the facility's training revealed that the DON sent all staff training via Care Feed(electronic training system via telephone) on [DATE]. Record review of the facility's oxygen monitoring log revealed that the DON started monitoring on [DATE] and would be monitored 1 - 7 days/week for 1 - 2 months. Record review of the facility's clinical meeting dated [DATE] revealed daily oxygen review for nurse managers, administrators, and physical therapists would be present during morning meetings, residents on oxygen would be reviewed daily. A copy of this report will be given to the therapy representative at this time. Record review of the facility training dated from [DATE] - [DATE] on Kardex(quick reference to resident care) for all the nursing team revealed how to assess the care provided to the resident, how many staff, and equipment needed during care. Record review of the facility plan of removal training dated from [DATE] - [DATE] revealed the nurses had skills check off on change in condition for oxygen, and any general change in condition. Record review of the facility plan of removal revealed the facility had started monitoring on [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews conducted on [DATE] between 9:31 a.m. and 2:31 p.m., with staff on shifts (4 CNAs: CNA A, CNA B, CNA D, and CNA E from 6:00 a.m. -to 2:00 p.m. and 4 LVN: LVN C, LVN D, LVN M, and LVN T from 6:00 a.m. -6:00 p.m.) to verify the in-services were conducted and to validate the staff understanding of the information presented to them. No concerns were found regarding the knowledge of verification of admission medication from the discharged facility with the physician. They said any order given by the physician should be entered into the computer, and the nurse managers would follow up with chart checks and clarification of any discrepancies. The LVNs and CNAs said the DON conducted in-service on any change in condition would be reported immediately, and the staff should transport residents on oxygen with their concentrator or oxygen tank. The LVNs and CNAs said they had a skills check-off on Kardex on how to assess how much staff and equipment are needed for resident care when providing care to any resident. During a telephone interview on [DATE] between 10:48 a.m. and 11:28 a.m., OT and PTA said the DON texted in service on change in condition of any resident during physical therapy. The OT or PTA would fill out stop and watch and sign the form, then give a copy to the nurse and the second copy to the DON. They said the DON called them on the phone and conducted the in-service. She said the physical therapist must report any change in condition, including the resident on oxygen, and the physical director had to attend morning meetings. During interviews conducted on [DATE] between 7:45 a.m., and 8:43 p.m., with staff on shifts (4 CNAs: CNAF, CNA G, CNA H, and CNA I from 2:00 p.m. -10:00 p.m., 3 CNAs: CNA J, CNA K, and CNA L from 6:00 p.m. - 6: 00a.m., and 3 LVN: LVN E, LVN F, and LVN G from 6:00p.m. -6 :00 a.m.) to verify the in-services were conducted and to validate the staff understanding of the information presented to them. No concerns were found regarding the knowledge of verification of admission medication from the discharged facility with the physician. They said any order given by the physician should be entered into the computer, and the nurse managers would follow up with chart checks and clarification of any discrepancies. The LVNs and CNAs said the DON conducted in-service on any change in condition would be reported immediately, and the staff should transport residents on oxygen with their concentrator or oxygen tank. The LVNs and CNAs said they had a skills check-off on Kardex on how to assess how much staff and equipment are needed for resident care when providing care to any resident. During an interview on [DATE] at 1:45 p.m., ADON L said the corporate nurse did an in-service for the nurse manager and the administrator. ADON L said the in-service and skills checkoff included change in condition, care plans, medication verification, and chart check after admission; Kardex and oxygen were part of the change in condition. During an interview on [DATE] at 1:57 p.m., the DON, corporate, and administrator were in the room. The DON said she had training from the corporate nurse on change in condition, oxygen, admission process, and the physical therapy director would come to the meetings. The DON said she would monitor the skills check-off and in-service progress for 1 to 7 days for 2 months. During an interview on [DATE] at 2:0 p.m., The Corporate Nurse said staff should report immediately when there was any change in condition, including shortness of breath. The Corporate Nurse said she validated the aide's competencies on Kardex. She also said she reviewed the removal plan with the administrator, DON, and the [NAME] President of operation. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:03 p.m., the Administrator said the Corporate Nurse trained her and the nurse managers on Kardex and change in condition. The Administrator said the DON would give the names of residents on oxygen to the therapy director so that they could communicate if any of those residents had shortness of breath to the floor nurse and the DON. The Administrator said the nurse manager would monitor the progress of the training for the next two months. During an interview on [DATE] at 2:13 p.m., the DON said the system broke when the LVN H missed entering the oxygen order in the computer, and ADON J, who did the chart check, did not realize LVN H did not enter the oxygen order in the computer. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 7:11 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated because all staff had not been trained on consulting the physician during a change of condition.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observations, interviews, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (CR #1) of four residents reviewed for accidents, hazards, and supervision. -The facility failed to ensure CNA C followed CR#1's care plan when transferring CR#1 who required two staff for transfers. CR#1 slide out of shower chair onto the floor and became unresponsive and later died . -The facility failed to ensure CNA C followed CR#1's care plan when during ambulation. CR#1 ambulated with a walker instead of wheelchair as care planned. CR#1 slide out of shower chair onto the floor and became unresponsive and later died . These failures can place residents at risk of injury due to not being supervised properly. An IJ was identified on [DATE]. The IJ template was provided to the facility Administrator on [DATE] at 7:11 p. m. While the facility Administrator was informed that the IJ was removed on [DATE] at 2:58 PM, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated because all staff trained on how to pull up resident's care information from the Kardex, notifying the nurse regarding resident care and change in condition. Findings included: Record review of CR #1's face sheet dated [DATE]revealed a [AGE] year-old male was admitted to the facility on [DATE]. CR #1 had diagnoses included: heart failure (heart cannot pulp enough blood and oxygen to the body's organ), morbid obesity (body mass index greater than 35 combined with other health issues), diabetes mellites (body does not manage blood sugar properly), and atrial fibrillation (irregular heartbeat). Record review of CR #1's admission MDS assessment dated [DATE] revealed CR #1 had BIMS score of 15 out of 15 which indicated intact cognition. Further review revealed CR #1 needed moderate assistance with mobility. Record review of Resident #1's care plan dated [DATE] revealed CR#1 revealed resident had a self-care deficit. Interventions: mobility: I use a wheelchair, transfer: gait belt X2 team member CR#1 resident was at risk for shortness of breath. Intervention: alert my nurse for concentrator and/oxygen tank needs to be changed, provide oxygen as ordered by physician. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 4:15 p.m., LVN T said CNA C called her to the shower room, he saw CR #1 was lying on his back, and CR #1 told him to call the fire department to come and pick him up off the floor. LVN T said he told CNA C to call LVN M, and he went across the hall and brought CR #1's concentrator into the shower room and applied the oxygen to CR #1. LVN T said CR #1 was unresponsive, and his lips and fingertips were blue. LVN T said he could get CR #1's pulse at first, and it was 92, and then there was no pulse. LVN T said all the nurses came and started CPR before the paramedics arrived, and when the paramedic came, they took over but CR #1 expired. During an interview on [DATE] at 4:37 p.m., CNA C said the day CR #1 fell in the shower room was her first time working with him. CNA C said she did not know how CR#1 ambulated or transferred, and she asked CR #1, and he said he walked with a walker. CNA C said CR #1 got up from the bed, took off his oxygen, and walked with his walker to the shower room from his room. CNA C said when CR#1 walked past the door, from the hallway to the shower room to the door in the shower room before the shower stall. CR #1 asked her to turn the shower chair to face him, while she went to turn the shower chair, CR #1 started to slide down and fell before, she could get to him. CNA C said CR #1 fell on his bottom, but he did not hit his head on floor. CNA C said she told CR #1 not to move because she was going to call LVN T. CNA C said she went and called LVN T, and both came back to the bathroom, and CR #1 was still sitting on his buttocks. Then, CNA C said that when she came back with LVN T, CR #1 asked LVN T to go and get his oxygen because he was short of breath. Then LVN T told her to call LVN M. CNA C said some minutes later, CR #1 became unresponsive. CNA C said she would not have ambulated CR #1 with a walker if she knew he was supposed to ambulate with a wheelchair or tried to transfer him by herself to the shower chair if she knew CR #1 was supposed to be transferred by two staff and a gait belt. CNA C said CR #1 would not have fallen if two staff had assisted with the transfer. CNA C said she did not know where to check for how many staff needed to provide care for CR #1. CNA C did not respond when asked about the Kardex or asking a nurse about care needs for CR#1 During a telephone interview on 01//,d+[DATE] at 9:21 a.m., LVN M said CNA C told him to go to the shower room, and when he got to the shower room, CR #1 was lying on his back on the floor, and he was still alive. LVN T went to the CR#1's room, brought the oxygen concentrator to the shower room, and applied the oxygen to CR #1, but CR #1 became unresponsive. LVN M said he called EMS, and a CODE was called. LVN M said other nurses came with a crash cart, and CPR was started. EMS came and took over CPR, but CR #1 expired. LVN M said CNA C should talk to the nurse or look through the Kardex to find out how CR #1 should be transferred or ambulate. If it was recommended for two staff, then two staff should have transferred CR #1, and maybe CR #1 would not have fallen. CR #1 said the nurse monitored the aides when the nurse made rounds, and the ADON monitored the nurses during random rounds. During an interview on [DATE] at 9:58 a.m., the OT said CR#1 could walk to the restroom and shower room, but he would need his oxygen. The OT said CR#1 kept his oxygen on with any activity, but he could take it off for a little while during the shower. The OT said CR #1 was a fall risk and should ambulate with a wheelchair and be assisted by staff when he ambulates with a walker. The OT said she did not tell the nursing staff to make any changes to CR #1's care plan. (continued on next page)

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	676153	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of League City	2620 W Walker League City, TX 77573

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:57 a.m., the ADON said CR #1 should be transferred by two staff and a gait belt because he weighed 554 LB. The ADON said CR #1 could have fallen and been injured if one staff member had transferred the resident. ADON said, one of the nurses called a code blue after the resident fell in the shower room and became unresponsive, but the staff and EMS could not revive CR #1, and he expired. The ADON and the therapist (OT), were responsible for telling the aides how many staff members were needed for transfer. The ADON said the charge nurse monitors the aides and staffing coordinator, and everybody monitors nurses because nursing was a revolving door. The ADON said CNA C should check the Kardex(a system nurses use to access resident care information) to see how CR #1 should be transferred if she had not previously worked with CR #1 or ask the nurse how to care for CR #1. During an interview on [DATE] at 1:31 p.m., the MDS nurse said any change in CR #1's condition would be changed in the care plan and during the quarterly assessment. The MDS nurse said the floor nurse and the DON initiated the care plan for CR#1 upon admission, and when there was a change, she would change the care plan. The MDS nurse said she had not changed CR #1's care plan. The MDS nurse said the therapist (OT), or nursing had not notified her that there were any changes in mobility and transfer for CR#1. The MDS nurse said if CNA C assisted CR #1 from walking to a shower chair, then it was an assisted transfer, and if CR #1 was supposed to be assisted by two staff, then two staff should have assisted. MDS nurse said if CR #1 was not transferred according to the plan of care, the resident could fall and sustain an injury or die. During an interview on [DATE] at 2:47 p.m., LVN T said CNA C could find out what type of care and how many staff were needed to provide care to CR #1 in the POC. LVN T said if CR #1 required two persons' assistance and CNA C transferred CR #1, then the resident could fall, which happened to CR #1. LVN T said the nurses monitored the aides, and the ADON and the DON monitored the nurses during random rounds. LVN T said he had an in-service on admission, transfer, oxygen, and supervision. During an interview on [DATE] at 3:09 p.m., the Administrator said if CR #1 was a two-person transfer, and if CNA C transferred CR #1 by herself, then CR #1 could fall and hurt himself. The Administrator said the nurse monitored the aides during rounds, and the ADON and the DON monitored the nurses during random rounds. During a telephone interview on [DATE] at4:37 p.m., the Physician said he gave intermitter oxygen order and he could not remember how many liters of oxygen he gave, but the nurse could titrate the liter for CR #1 to be comfortable. He said the resident used oxygen intermittently said CR #1 refused to use oxygen sometimes and he had experienced hypoxia and he was still comfortable. The physician said normal order for oxygen was between 2 to 3 liters. The Physician said the nursing or therapy did not communicate to him that CR #1 still has shortness of breath during activities even with oxygen. Record review of the facility accident prevention dated February 2017, Revised [DATE] read in part . adequate supervision and assistance devices to prevent accident .assessment and care plans are used to develop and implement procedures to prevent accidents . The Administrator was informed the following Plan of Removal was accepted on [DATE] at 12:30 PM, PLAN OF REMOVAL: Abatement Plan (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 7:11pm Immediate Response: o The identified resident expired on [DATE]. o Director of Nursing Services/Assistant Director of Nursing Services identified all residents in the community (12) on continuous oxygen and verified accurate orders were in the electronic health record. All residents with supplemental oxygen (7) have orders in place in the electronic health record. There were no other residents identified in the community who require continuous/supplemental oxygen. Date completed: [DATE]. o Director of Nursing Services/Assistant Director of Nursing Services provided immediate education to all licensed nurses for the process of reconciliation of physician orders from the discharging facility. The charge nurse will then notify the md/np of the admission and review the hospital discharge orders. After this is completed with the md/np, the charge nurse will then enter orders into the electronic health record in PCC for the resident. The Director of Nursing Services/Assistant Director of Nursing will supervise this process and monitor ,d+[DATE] days a week for the next 2 months. Date completed:[DATE]. o Director of Nursing Services/Assistant Director of Nursing services will conduct skills validations for all licensed nurses to validate competency for inputting physician orders. Date completed: [DATE]. o Rehabilitation Director will be present in the morning meeting. Director of Nursing Services/Assistant Director of Nursing Services will review all residents who are on oxygen. In addition, the Audit Listing Report for residents on oxygen will we be printed, and a copy given to therapy. This process will be monitored , d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide 100% education to all team members in therapy on notification of changes on condition to the Charge nurse/Assistant Director of Nursing/Director of Nursing. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide education to all direct care staff on notification of changes in condition to report to the charge nurse/Assistant Director of Nursing/Director of Nursing Services. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date of completion: [DATE] o Director of Nursing/Assistant Director provided 100% education to all licensed nurses in regard to resident's changes in condition (shortness of breath, low oxygen saturations and all changes in condition). The nurse will immediately assess the resident and document in the electronic health record, notify the physician and responsible party. The charge nurse will proceed with any new orders from the physician. Date of completion: [DATE] o Director of Nursing/Assistant Director provided 100% education to all direct care team members on use and access of the Kardex to be informed of the residents needs with activities of daily living prior to providing care of the resident. Date of completion: [DATE] o Director of Clinical Operations provided education to the Director of Nursing Services and Assistant Director of Nursing Services on process and expectation of reconciliation of physician orders from the discharging facility. The charge nurse will then notify the md/np of the admission and review the hospital discharge orders. After this is completed with the md/np, the charge nurse will then enter orders into the electronic health record in PCC for the resident. Director of Nursing Services/Assistant Director of Nursing Services will conduct chart audits the next day of all admissions/readmissions to validate accurate orders were entered into the Electronic Health Record using the hospital discharge summary in collaboration with the admitting physician in the community. The RN supervisor will monitor this process on weekends, holidays, and when the Director of Nursing Services or Assistant Director of Nursing Services is not present in the community. Date completed: [DATE]. Community will ensure all staff on leave/agency/PRN staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. The community will ensure all residents who require respiratory care are provided such care. Risk Response: All new admissions/readmissions have the potential to be affected by the deficient practice. Systemic Response: o Director of Nursing Services/Assistant Director of Nursing Services identified all residents in the community (12) on continuous oxygen and verified accurate orders were in the electronic health record. All residents with supplemental oxygen (7) have orders in place in the electronic health record. There were no other residents identified in the community who require continuous/supplemental oxygen. Date completed: [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Director of Nursing Services/Assistant Director of Nursing Services provided immediate education to all licensed nurses for the process of reconciliation of physician orders from the discharging facility. The charge nurse will then notify the md/np of the admission and review the hospital discharge orders. After this is completed with the md/np, the charge nurse will then enter orders into the electronic health record in PCC for the resident. Date completed:[DATE]. o Director of Nursing Services/Assistant Director of Nursing services will conduct skills validations for all licensed nurses to validate competency for inputting physician orders. Date completed:[DATE]. o Rehabilitation Director will be present in the morning meeting. Director of Nursing Services/Assistant Director of Nursing Services will review all residents who are on oxygen. In addition, the Audit Listing Report for residents on oxygen will we be printed, and a copy given to therapy. This process will be monitored , d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide 100% education to all team members in therapy on notification of changes on condition to the Charge nurse/Assistant Director of Nursing/Director of Nursing. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide education to all direct care staff on notification of changes in condition to report to the charge nurse/Assistant Director of Nursing/Director of Nursing Services. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completion: [DATE] o Director of Nursing/Assistant Director provided 100% education to all licensed nurses in regard to resident's changes in condition (shortness of breath, low oxygen saturations and all changes in condition). The nurse will immediately assess the resident and document in the electronic health record, notify the physician and responsible party. The charge nurse will proceed with any new orders from the physician. Date of completion: [DATE] o Director of Nursing/Assistant Director provided 100% education to all direct care team members on use and access of the Kardex to be informed of the residents needs with activities of daily living prior to providing care of the resident. o Date of completion: [DATE] (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Director of Clinical Operations provided education to the Director of Nursing Services and Assistant Director of Nursing Services on process and expectation of reconciliation of physician orders from the discharging facility. The charge nurse will then notify the md/np of the admission and review the hospital discharge orders. After this is completed with the md/np, the charge nurse will then enter orders into the electronic health record in PCC for the resident. Director of Nursing Services/Assistant Director of Nursing Services will conduct chart audits the next day of all admissions/readmissions to validate accurate orders were entered into the Electronic Health Record using the hospital discharge summary in collaboration with the admitting physician in the community. Date completed: [DATE]. Community will ensure all staff on leave/agency/PRN staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. The community will ensure all residents who require respiratory care are provided such care. Monitoring Response: o The Director of Nurses/Assistant Director of Nurses will conduct weekly skills validations of order entry for , d+[DATE] nurses, ,d+[DATE] days a week for 2 months. o Director of Nurses/Assistant Director of Nurses will review all admission/re-admission orders daily in the clinical meeting to validate orders are transcribed per discharge orders for the reconciliation process for , d+[DATE] days a week for 2 months. o Director of Nursing Services/Assistant Director of Nursing Services will review all residents who are on oxygen in the morning meeting. A review of residents who are on oxygen will be reviewed with the rehabilitation representative. In addition, the Audit Listing Report for residents on oxygen will we be printed, and a copy given to therapy. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. o Director of Nursing/Assistant Director of Nursing will validate the process of reporting changes in condition with ,d+[DATE] random therapy team member ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. o Director of Nursing/Assistant Director of Nursing will validate the process of reporting changes in condition with ,d+[DATE] random therapy team member ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. o Director of Nursing Services/Assistant Director of Nursing Services will validate the proper process of use/access of the Kardex by ,d+[DATE] direct care staff ,d+[DATE] days a week for 2 months. o Director of Nursing Services/Assistant Director of Nursing Services will validate the process to implement with the notification of a change in condition from ,d+[DATE] random licensed nurses ,d+[DATE] days a week for 2 months. o All the monitoring will be monitored by the Director of Nursing/Assistant Director of Nursing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This plan will remain in place for the next 2 months to ensure compliance or to identify any further training needs. Findings of those observations will be reported to the QAPI committee during monthly meeting for the next 2 months. Medical Director notified of the Immediate Jeopardy on [DATE] @ 7:22pm per Director of Nursing Services. Surveyor monitored the plan of removal for effectiveness as follows: Observation and interviews starting from [DATE] to [DATE] revealed no concerns with oxygen therapy for Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6. There were no signs of shortness of breath or labored breathing, each resident received oxygen therapy within the parameters of their physician order. Record review of physician orders and care plans for Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 revealed no concerns, each resident had physician orders and were care planned for oxygen therapy. Record review of [DATE] to [DATE] oxygen saturations and MAR/TAR's for Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 revealed each resident was being monitored for oxygen therapy. Record review of the facility plan or removal training, skills check-off, and in-service revealed the facility had 12 residents on oxygen, and the DON reviewed and completed their clinical records on [DATE]. Record review of the facility training revealed that the corporate nurse trained the DON, nurse managers, and administrator on physician follow-up chart checks, completed on [DATE]. Record review of the facility training for the nurses on medication reconciliation with the physician from discharged facility order summary report with MD/NP and entering the medication in the PCC. The nurse validated how to enter medication into PCC, completed on [DATE]. A record review of the facility's training revealed that the DON sent all staff training via Care Feed(electronic training system via telephone) on [DATE]. Record review of the facility's oxygen monitoring log revealed that the DON started monitoring on [DATE] and would be monitored 1 - 7 days/week for 1 - 2 months. Record review of the facility's clinical meeting dated [DATE] revealed daily oxygen review for nurse managers, administrators, and physical therapists would be present during morning meetings, residents on oxygen would be reviewed daily. A copy of this report will be given to the therapy representative at this time. Record review of the facility training dated from [DATE] - [DATE] on Kardex(quick reference to resident care) for all the nursing team revealed how to assess the care provided to the resident, how many staff, and equipment needed during care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility plan of removal training dated from [DATE] - [DATE] revealed the nurses had skills check off on change in condition for oxygen, and any general change in condition. Record review of the facility plan of removal revealed the facility had started monitoring on [DATE]. During interviews conducted on [DATE] between 9:31 a.m. and 2:31 p.m., with staff on shifts (4 CNAs: CNA A, CNA B, CNA D, and CNA E from 6:00 a.m. -to 2:00 p.m. and 4 LVN: LVN C, LVN D, LVN M, and LVN T from 6:00 a.m. -6:00 p.m.) to verify the in-services were conducted and to validate the staff understanding of the information presented to them. No concerns were found regarding the knowledge of verification of admission medication from the discharged facility with the physician. They said any order given by the physician should be entered into the computer, and the nurse managers would follow up with chart checks and clarification of any discrepancies. The LVNs and CNAs said the DON conducted in-service on any change in condition would be reported immediately, and the staff should transport residents on oxygen with their concentrator or oxygen tank. The LVNs and CNAs said they had a skills check-off on Kardex on how to assess how much staff and equipment are needed for resident care when providing care to any resident. During a telephone interview on [DATE] between 10:48 a.m. and 11:28 a.m., OT and PTA said the DON texted in service on change in condition of any resident during physical therapy. The OT or PTA would fill out stop and watch and sign the form, then give a copy to the nurse and the second copy to the DON. They said the DON called them on the phone and conducted the in-service. She said the physical therapist must report any change in condition, including the resident on oxygen, and the physical director had to attend morning meetings. During interviews conducted on [DATE] between 7:45 a.m., and 8:43 p.m., with staff on shifts (4 CNAs: CNAF, CNA G, CNA H, and CNA I from 2:00 p.m. -10:00 p.m., 3 CNAs: CNA J, CNA K, and CNA L from 6:00 p.m. - 6: 00a.m., and 3 LVN: LVN E, LVN F, and LVN G from 6:00p.m. -6 :00 a.m.) to verify the in-services were conducted and to validate the staff understanding of the information presented to them. No concerns were found regarding the knowledge of verification of admission medication from the discharged facility with the physician. They said any order given by the physician should be entered into the computer, and the nurse managers would follow up with chart checks and clarification of any discrepancies. The LVNs and CNAs said the DON conducted in-service on any change in condition would be reported immediately, and the staff should transport residents on oxygen with their concentrator or oxygen tank. The LVNs and CNAs said they had a skills check-off on Kardex on how to assess how much staff and equipment are needed for resident care when providing care to any resident. During an interview on [DATE] at 1:45 p.m., ADON L said the corporate nurse did an in-service for the nurse manager and the administrator. ADON L said the in-service and skills checkoff included change in condition, care plans, medication verification, and chart check after admission; Kardex and oxygen were part of the change in condition. During an interview on [DATE] at 1:57 p.m., the DON, corporate, and administrator were in the room. The DON said she had training from the corporate nurse on change in condition, oxygen, admission process, and the physical therapy director would come to the meetings. The DON said she would monitor the skills check-off and in-service progress for 1 to 7 days for 2 months. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:0 p.m., the Corporate Nurse said she conducted an in-service for the nurse managers, which included the administrator on verification of new resident medication with the physician, and any new order given by the physician would be entered into the computer by the admitting nurse. The Corporate Nurse said the nurse manager would verify the orders in the computer, cross-check them with the admitting orders, and verify from the nurse whether the physician gave an additional order on admission and if the nurse entered the order in the computer. The Corporate Nurse said residents on oxygen were transferred with portable oxygen when they were not in the room. The Corporate Nurse said staff should report immediately when there was any change in condition, including shortness of breath. The Corporate Nurse said she validated the aide's competencies on Kardex. She also said she reviewed the removal plan with the administrator, DON, and the [NAME] President of operation. During an interview on [DATE] at 2:03 p.m., the Administrator said the Corporate Nurse trained her and the nurse managers on verification of order from the discharged summary report from the transferring facility. The Administrator said the admitting nurse should verify the order with the physician upon admission and enter the order accurately into the computer. She also said if the nurse received any order, such as an oxygen order, the nurse should enter the order accurately in the computer. The Administrator said the next nurse would also check the order, and the ADON would do a chart check and ensure the admitting nurse entered all the orders correctly into the computer. The Administrator said she was also trained on Kardex and change in condition. The Administrator said the DON would give the names of residents on oxygen to the therapy director so that they could communicate if any of those residents had shortness of breath to the floor nurse and the DON. The Administrator said the nurse manager would monitor the progress of the training for the next two months. During an interview on [DATE] at 2:10 p.m., the Administrator said the error in the system happened when the physician gave an oxygen order for CR #1 and LVN H did not put the order in the computer. The Administrator said that ADON J did not completely check the chart because she did not realize CR #1 was supposed to be on oxygen. During an interview on [DATE] at 2:13 p.m., the DON said the system broke when the LVN H missed entering the oxygen order in the computer, and ADON J, who did the chart check, did not realize LVN H did not enter the oxygen order in the computer. An IJ was identified on [DATE]. The IJ template was provided to the facility Administrator on [DATE] at 7:11 p. m. While the facility Administrator was informed that the IJ was removed on [DATE] at 2:58 PM, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated because all staff trained on how to pull up resident's care information from the Kardex, notifying the nurse regarding resident care and change in condition.

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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** 36918 Based on interviews, and record review the facility failed to ensure that a resident who needed respiratory care and services, including oxygen administration was provided such care, consistent with professional standards of practice for 1 of 4 residents (CR #1) reviewed for respiratory therapy. The facility failed to ensure CR #1 was provided with repiratory services to meet his needs. CR #1 ambulated with a walker approximately 30 feet without oxygen, slid out of a shower chair onto the floor and became unresponsive and later died . The facility failed to ensure CR #1 who was admitted with a verbal order for oxygen administration was documented, verified, and communicated to staff for proper implementation. This failure could place residents at risk of respiratory distress or dependency. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 7:11 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that was not an immediate jeopardy and a scope of pattern because all staff had not been trained on the process of medication reconciliation from the discharged facility with the physician during admission. The admitting nurse would enter the orders in PCC, and the nurse manager would conduct chart audits to validate accurate orders were entered into the computer using the discharge summary in collaboration with the admitting physician in the community. All staff trained on how to pull up residents care information from the Kardex, and change in condition. The findings included: Record review of Resident #1's face sheet dated [DATE] revealed a [AGE] year-old male was admitted to the facility on [DATE]. Resident #1 had diagnoses included: heart failure, (heart cannot pulp enough blood and oxygen to the body's organ), morbid obesity (body mass index greater than 35 combined with other health issues), diabetes mellites (body does not manage blood sugar properly), and atrial fibrillation (irregular heartbeat). Record review of CR#1's admission MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 15 out of 15 which indicated intact cognition. Further review revealed Resident #1 needed moderate assistance with mobility. Record review of CR#1's care plan dated [DATE] revealed Resident #1 resident was at risk for shortness of breath. Intervention: alert my nurse for concentrator and/oxygen tank needs to be changed, provide oxygen as ordered by physician. Record review of CR#1's order summary report did not reveal that the resident had an order for oxygen administration. Record review of CR#1's NEMAR for [DATE] revealed there was no order found for Respiratory(oxygen). (continued on next page)

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1 progress notes from ,d+[DATE]/ 24 to [DATE] revealed there was no documentation that CR #1 was in any distress. Record review of CR #1 hospital discharge record printed [DATE] did not reveal any order for oxygen. Record review of CR #1's Nurse Practitioner visit note dated [DATE] read, review of systems : Chief Complaint :seen today for admission visit .respiratory : chronically 02 dependent at 2L. Record review of CR #1's nursing progress note dated [DATE] at 5:45pm read in part, Around 3:40 p.m (CNA C) was in shower room with patient, as he was transfering to the shower chair he began sliding down, C.N.A assisted res to the floor. C.N.A notified this nurse of situation, this nurse observed res laying on bathroom/shower room floor supine. Res was alert and oriented, denied pain and discomfort at this time. Res skin color was within normal limits. Res stated to this nurse that we would need to call the fire department to get him up and that he needed oxygen. Res did not diplay any (signs or symptoms) of distress at this time. This nurse went across hallway to get res O2 concentrator. 45 seconds after returning to res with supplemental 02, res was unresponsive. lips where a purple coloration, unable to get readable (vital signs). Code blue was called, 911 was called and arrived on scene .Res was pronounced at (4:13pm). During an interview on [DATE] at 2:07 p.m., RN G said CR #1 was on PRN oxygen. RN G said CR #1 would feel winded when he stood up for her during wound care and he would put his oxygen on. RN G said she was unsure if CR #1 had an order for oxygen. RN G said oxygen should be administered with a physician's order to ensure CR #1 received the appropriate liters of oxygen. RN G said if CR #1 did not receive adequate oxygen, he could go into respiratory distress. RN G said nurse managers monitored the nurses when they made random rounds. During an interview on [DATE] at 2:45 p.m., the DON reviewed the discharge report from the hospital with the State Surveyor, and the DON said there was no oxygen order from the discharge summary hospital report. The DON said CR #1 was on oxygen PRN but could not see any order from the facility physician. The DON said CR #1 must have an order for oxygen to ensure the resident received the required liters of oxygen to prevent any respiratory distress for CR #1. During a telephone interview on [DATE] at 4:15 p.m., LVN T said CR #1 had oxygen in his room and believed CR #1 had an order for oxygen. LVN T said CR #1 had an order for oxygen; the nurses would document it on the NEMAR. LVN T said CR #1 must have an order before oxygen would be administered because if CR #1 did not have an order, CR #1 may not receive the required liters of oxygen to prevent respiratory complications such as shortness of breath or a crisis. LVN T said she had an in-service on oxygen administration, and the nurse managers monitored the nurses during random rounds. During an interview on [DATE] at 5:27 p.m., LVN H said she verified the admission orders with the physician, and the physician gave an order for oxygen. LVN H was supposed to put the oxygen order in but did not know she did not put the oxygen order in the computer, and she could not remember how many liters of oxygen the physician prescribed for CR #1. LVN H said oxygen was a medication, and she should have put the order in the computer. LVN H also said if CR #1 did not get the prescribed liters of oxygen, CR #1 could have respiratory distress. LVN H said she had a skill- check off on the admission process, and the nurse manager should have checked the paperwork the day after admission. (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 9:58 a.m., the OT said CR#1 could walk to the restroom and shower room, but he would need his oxygen. The OT said CR#1 kept his oxygen on with any activity, but he could take it off for a little while during the shower. During an interview on [DATE] at 10:38 a.m., PTA said she had worked with CR #1 during therapy and he wore an oxygen tank. She said they worked with him at his pace because of his size, he was mobility obese. She said he wore his oxygen at all times during therapy and he runs out of breath (SOB) and she would let him rest and continued again. She said that when the resident was able to walk to the bathroom in his room, and they told the resident he would have to have staff with him if he wants to walk past the bathroom in his room. During an interview on [DATE] at 10:57 a.m., the ADON said CR #1 did not have an order for oxygen from the hospital. The ADON said the nurse managers should have done chart checks and checked the orders to ensure CR #1's medication was correct the next day. The ADON said LVN H should have put in a PRN order because CR #1 had oxygen, but LVN H did not transcribe the oxygen order. The ADON said CR #1 should not have oxygen on without an order. The ADON said CR #1 could go into respiratory distress if he did not get adequate liters of oxygen, and if CR #1 got more than required, it could cause CR #1 to depend on oxygen. During an observation and interview on [DATE] at 1:55 p.m., the State Surveyor and the MDS Nurse reviewed CR #1's physician orders, and the MDS nurse said she did not see the order for oxygen. The MDS nurse said CR#1 should have an order for oxygen before the nurses could administer oxygen to him. The MDS nurse said it was a medication error because LVN H had to enter the physician's orders before nurses could administer oxygen to CR #1. The MDS nurse said there could be a negative effect on CR #1 if the nurse's administered oxygen to CR#1 without an order. The MDS nurse said the negative effect could cause CR #1 to depend on oxygen or could have an adverse respiratory crisis if he did not receive the recommended liters of oxygen. The MDS nurse said CR #1 was care planned by LVN H, not her. During an interview on [DATE] at 3:02 p.m., the Administrator said that for a resident to be on oxygen, the resident should have an order for oxygen. The Administrator said she was sure there could be some side effects, but she did not think it would be dangerous. The Administrator said the DON monitored the nurses to ensure the nurses transcribed the orders correctly. During an interview on [DATE] at 4:16 PM 4: 16 p.m., the DON said CR #l 's 02 was RPN the nurse would make the decision if the resident could take off the oxygen. The DON said the therapy dept did not tell her that CR#1 got winded during activity even with oxygen. During a telephone interview on [DATE] at4:37 p.m., the Physician said he gave intermitter oxygen order and he could not remember how many liters of oxygen he gave, but the nurse could titrate the liter for CR #1 to be comfortable. He said the resident used oxygen intermittently said CR #1 refused to use oxygen sometimes and he had experienced hypoxia and he was still comfortable. The physician said normal order for oxygen was between 2 to 3 liters. The Physician said the nursing or therapy did not communicate to him that CR #1 still has shortness of breath during activities even with oxygen. (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 of the facility oxygen administration dated [DATE], Revised [DATE] read in part . a resident receives oxygen therapy when there is an order by a physician. The resident's disease, physical condition, and age will help determine the most appropriate method of administration and should be reflected in the physician . The following Plan of Removal was accepted on [DATE] at 12:30 PM, PLAN OF REMOVAL: Abatement Plan F695 Respiratory/Tracheostomy Care and Suctioning [DATE] at 7:11pm Immediate Response: o The identified resident expired on [DATE]. o Director of Nursing Services/Assistant Director of Nursing Services identified all residents in the community (12) on continuous oxygen and verified accurate orders were in the electronic health record. All residents with supplemental oxygen (7) have orders in place in the electronic health record. There were no other residents identified in the community who require continuous/supplemental oxygen. Date completed: [DATE]. o Director of Nursing Services/Assistant Director of Nursing Services provided immediate education to all licensed nurses for the process of reconciliation of physician orders from the discharging facility. The charge nurse will then notify the md/np of the admission and review the hospital discharge orders. After this is completed with the md/np, the charge nurse will then enter orders into the electronic health record in PCC for the resident. The Director of Nursing Services/Assistant Director of Nursing will supervise this process and monitor ,d+[DATE] days a week for the next 2 months. Date completed:[DATE]. o Director of Nursing Services/Assistant Director of Nursing services will conduct skills validations for all licensed nurses to validate competency for inputting physician orders. Date completed: [DATE]. o Rehabilitation Director will be present in the morning meeting. Director of Nursing Services/Assistant Director of Nursing Services will review all residents who are on oxygen. In addition, the Audit Listing Report for residents on oxygen will we be printed, and a copy given to therapy. This process will be monitored , d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Director of Nursing/Assistant Director of Nursing will provide 100% education to all team members in therapy on notification of changes on condition to the Charge nurse/Assistant Director of Nursing/Director of Nursing. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide education to all direct care staff on notification of changes in condition to report to the charge nurse/Assistant Director of Nursing/Director of Nursing Services. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completion: [DATE] o Director of Nursing/Assistant Director provided 100% education to all licensed nurses in regard to resident's changes in condition (shortness of breath, low oxygen saturations and all changes in condition). The nurse will immediately assess the resident and document in the electronic health record, notify the physician and responsible party. The charge nurse will proceed with any new orders from the physician. Date of completion: [DATE] o Director of Nursing/Assistant Director provided 100% education to all direct care team members on use and access of the Kardex to be informed of the residents needs with activities of daily living prior to providing care of the resident. Date of completion: [DATE] o Director of Clinical Operations provided education to the Director of Nursing Services and Assistant Director of Nursing Services on process and expectation of reconciliation of physician orders from the discharging facility. The charge nurse will then notify the md/np of the admission and review the hospital discharge orders. After this is completed with the md/np, the charge nurse will then enter orders into the electronic health record in PCC for the resident. Director of Nursing Services/Assistant Director of Nursing Services will conduct chart audits the next day of all admissions/readmissions to validate accurate orders were entered into the Electronic Health Record using the hospital discharge summary in collaboration with the admitting physician in the community. The RN supervisor will monitor this process on weekends, holidays, and when the Director of Nursing Services or Assistant Director of Nursing Services is not present in the community. Date completed: [DATE]. Community will ensure all staff on leave/agency/PRN staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. The community will ensure all residents who require respiratory care are provided such care. Risk Response: (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All new admissions/readmissions have the potential to be affected by the deficient practice. Systemic Response: o Director of Nursing Services/Assistant Director of Nursing Services identified all residents in the community (12) on continuous oxygen and verified accurate orders were in the electronic health record. All residents with supplemental oxygen (7) have orders in place in the electronic health record. There were no other residents identified in the community who require continuous/supplemental oxygen. Date completed: [DATE]. o Director of Nursing Services/Assistant Director of Nursing Services provided immediate education to all licensed nurses for the process of reconciliation of physician orders from the discharging facility. The charge nurse will then notify the md/np of the admission and review the hospital discharge orders. After this is completed with the md/np, the charge nurse will then enter orders into the electronic health record in PCC for the resident. Date completed:[DATE]. o Director of Nursing Services/Assistant Director of Nursing services will conduct skills validations for all licensed nurses to validate competency for inputting physician orders. Date completed:[DATE]. o Rehabilitation Director will be present in the morning meeting. Director of Nursing Services/Assistant Director of Nursing Services will review all residents who are on oxygen. In addition, the Audit Listing Report for residents on oxygen will we be printed, and a copy given to therapy. This process will be monitored , d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide 100% education to all team members in therapy on notification of changes on condition to the Charge nurse/Assistant Director of Nursing/Director of Nursing. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completed: [DATE]. o Director of Nursing/Assistant Director of Nursing will provide education to all direct care staff on notification of changes in condition to report to the charge nurse/Assistant Director of Nursing/Director of Nursing Services. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. Date of completion: [DATE] (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Director of Nursing/Assistant Director provided 100% education to all licensed nurses in regard to resident's changes in condition (shortness of breath, low oxygen saturations and all changes in condition). The nurse will immediately assess the resident and document in the electronic health record, notify the physician and responsible party. The charge nurse will proceed with any new orders from the physician. Date of completion: [DATE] o Director of Nursing/Assistant Director provided 100% education to all direct care team members on use and access of the Kardex to be informed of the residents needs with activities of daily living prior to providing care of the resident. o Date of completion: [DATE] o Director of Clinical Operations provided education to the Director of Nursing Services and Assistant Director of Nursing Services on process and expectation of reconciliation of physician orders from the discharging facility. The charge nurse will then notify the md/np of the admission and review the hospital discharge orders. After this is completed with the md/np, the charge nurse will then enter orders into the electronic health record in PCC for the resident. Director of Nursing Services/Assistant Director of Nursing Services will conduct chart audits the next day of all admissions/readmissions to validate accurate orders were entered into the Electronic Health Record using the hospital discharge summary in collaboration with the admitting physician in the community. Date completed: [DATE]. Community will ensure all staff on leave/agency/PRN staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. The community will ensure all residents who require respiratory care are provided such care. Monitoring Response: o The Director of Nurses/Assistant Director of Nurses will conduct weekly skills validations of order entry for , d+[DATE] nurses, ,d+[DATE] days a week for 2 months. o Director of Nurses/Assistant Director of Nurses will review all admission/re-admission orders daily in the clinical meeting to validate orders are transcribed per discharge orders for the reconciliation process for , d+[DATE] days a week for 2 months. o Director of Nursing Services/Assistant Director of Nursing Services will review all residents who are on oxygen in the morning meeting. A review of residents who are on oxygen will be reviewed with the rehabilitation representative. In addition, the Audit Listing Report for residents on oxygen will we be printed, and a copy given to therapy. This process will be monitored ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. o Director of Nursing/Assistant Director of Nursing will validate the process of reporting changes in condition with ,d+[DATE] random therapy team member ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Director of Nursing/Assistant Director of Nursing will validate the process of reporting changes in condition with ,d+[DATE] random therapy team member ,d+[DATE] days a week for the next 2 months by the Director of Nursing Services/Assistant Director of Nursing Services. o Director of Nursing Services/Assistant Director of Nursing Services will validate the proper process of use/access of the Kardex by ,d+[DATE] direct care staff ,d+[DATE] days a week for 2 months. o Director of Nursing Services/Assistant Director of Nursing Services will validate the process to implement with the notification of a change in condition from ,d+[DATE] random licensed nurses ,d+[DATE] days a week for 2 months. o All the monitoring will be monitored by the Director of Nursing/Assistant Director of Nursing. This plan will remain in place for the next 2 months to ensure compliance or to identify any further training needs. Findings of those observations will be reported to the QAPI committee during monthly meeting for the next 2 months. Medical Director notified of the Immediate Jeopardy on [DATE] @ 7:22pm per Director of Nursing Services. Surveyor monitored the plan of removal for effectiveness as follows: Observation and interviews starting from [DATE] to [DATE] revealed no concerns with oxygen therapy for Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6. There were no signs of shortness of breath or labored breathing, each resident received oxygen therapy within the parameters of their physician order. Record review of physician orders and care plans for Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 revealed no concerns, each resident had physician orders and were care planned for oxygen therapy. Record review of [DATE] to [DATE] oxygen saturations and MAR/TAR's for Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 revealed each resident was being monitored for oxygen therapy. Record review of the facility plan or removal training, skills check-off, and in-service revealed the facility had 12 residents on oxygen, and the DON reviewed and completed their clinical records on [DATE]. Record review of the facility training revealed that the corporate nurse trained the DON, nurse managers, and administrator on physician follow-up chart checks, completed on [DATE]. Record review of the facility training for the nurses on medication reconciliation with the physician from discharged facility order summary report with MD/NP and entering the medication in the PCC. The nurse validated how to enter medication into PCC, completed on [DATE]. A record review of the facility's training revealed that the DON sent all staff training via Care Feed(electronic training system via telephone) on [DATE]. (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 of the facility's oxygen monitoring log revealed that the DON started monitoring on [DATE] and would be monitored 1 - 7 days/week for 1 - 2 months. Record review of the facility's clinical meeting dated [DATE] revealed daily oxygen review for nurse managers, administrators, and physical therapists would be present during morning meetings, residents on oxygen would be reviewed daily. A copy of this report will be given to the therapy representative at this time. Record review of the facility training dated from [DATE] - [DATE] on Kardex(quick reference to resident care) for all the nursing team revealed how to assess the care provided to the resident, how many staff, and equipment needed during care. Record review of the facility plan of removal training dated from [DATE] - [DATE] revealed the nurses had skills check off on change in condition for oxygen, and any general change in condition. Record review of the facility plan of removal revealed the facility had started monitoring on [DATE]. During interviews conducted on [DATE] between 9:31 a.m. and 2:31 p.m., with staff on shifts (4 CNAs: CNA A, CNA B, CNA D, and CNA E from 6:00 a.m. -to 2:00 p.m. and 4 LVN: LVN C, LVN D, LVN M, and LVN T from 6:00 a.m. -6:00 p.m.) to verify the in-services were conducted and to validate the staff understanding of the information presented to them. No concerns were found regarding the knowledge of verification of admission medication from the discharged facility with the physician. They said any order given by the physician should be entered into the computer, and the nurse managers would follow up with chart checks and clarification of any discrepancies. The LVNs and CNAs said the DON conducted in-service on any change in condition would be reported immediately, and the staff should transport residents on oxygen with their concentrator or oxygen tank. The LVNs and CNAs said they had a skills check-off on Kardex on how to assess how much staff and equipment are needed for resident care when providing care to any resident. During a telephone interview on [DATE] between 10:48 a.m. and 11:28 a.m., OT and PTA said the DON texted in service on change in condition of any resident during physical therapy. The OT or PTA would fill out stop and watch and sign the form, then give a copy to the nurse and the second copy to the DON. They said the DON called them on the phone and conducted the in-service. She said the physical therapist must report any change in condition, including the resident on oxygen, and the physical director had to attend morning meetings. During interviews conducted on [DATE] between 7:45 a.m., and 8:43 p.m., with staff on shifts (4 CNAs: CNAF, CNA G, CNA H, and CNA I from 2:00 p.m. -10:00 p.m., 3 CNAs: CNA J, CNA K, and CNA L from 6:00 p.m. - 6: 00a.m., and 3 LVN: LVN E, LVN F, and LVN G from 6:00p.m. -6 :00 a.m.) to verify the in-services were conducted and to validate the staff understanding of the information presented to them. No concerns were found regarding the knowledge of verification of admission medication from the discharged facility with the physician. They said any order given by the physician should be entered into the computer, and the nurse managers would follow up with chart checks and clarification of any discrepancies. The LVNs and CNAs said the DON conducted in-service on any change in condition would be reported immediately, and the staff should transport residents on oxygen with their concentrator or oxygen tank. The LVNs and CNAs said they had a skills check-off on Kardex on how to assess how much staff and equipment are needed for resident care when providing care to any resident. (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 1:45 p.m., ADON L said the corporate nurse did an in-service for the nurse manager and the administrator. ADON L said the in-service and skills checkoff included change in condition, care plans, medication verification, and chart check after admission; Kardex and oxygen were part of the change in condition. During an interview on [DATE] at 1:57 p.m., the DON, corporate, and administrator were in the room. The DON said she had training from the corporate nurse on change in condition, oxygen, admission process, and the physical therapy director would come to the meetings. The DON said she would monitor the skills check-off and in-service progress for 1 to 7 days for 2 months. During an interview on [DATE] at 2:0 p.m., the Corporate Nurse said she conducted an in-service for the nurse managers, which included the administrator on verification of new resident medication with the physician, and any new order given by the physician would be entered into the computer by the admitting nurse. The Corporate Nurse said the nurse manager would verify the orders in the computer, cross-check them with the admitting orders, and verify from the nurse whether the physician gave an additional order on admission and if the nurse entered the order in the computer. The Corporate Nurse said residents on oxygen were transferred with portable oxygen when they were not in the room. The Corporate Nurse said staff should report immediately when there was any change in condition, including shortness of breath. The Corporate Nurse said she validated the aide's competencies on Kardex. She also said she reviewed the removal plan with the administrator, DON, and the [NAME] President of operation. During an interview on [DATE] at 2:03 p.m., the Administrator said the Corporate Nurse trained her and the nurse managers on verification of order from the discharged summary report from the transferring facility. The Administrator said the admitting nurse should verify the order with the physician upon admission and enter the order accurately into the computer. She also said if the nurse received any order, such as an oxygen order, the nurse should enter the order accurately in the computer. The Administrator said the next nurse would also check the order, and the ADON would do a chart check and ensure the admitting nurse entered all the orders correctly into the computer. The Administrator said she was also trained on Kardex and change in condition. The Administrator said the DON would give the names of residents on oxygen to the therapy director so that they could communicate if any of those residents had shortness of breath to the floor nurse and the DON. The Administrator said the nurse manager would monitor the progress of the training for the next two months. During an interview on [DATE] at 2:10 p.m., the Administrator said the error in the system happened when the physician gave an oxygen order for CR #1 and LVN H did not put the order in the computer. The Administrator said that ADON J did not completely check the chart because she did not realize CR #1 was supposed to be on oxygen. During an interview on [DATE] at 2:13 p.m., the DON said the system broke when the LVN H missed entering the oxygen order in the computer, and ADON J, who did the chart check, did not realize LVN H did not enter the oxygen order in the computer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676153	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of League City	2620 W Walker League City, TX 77573

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	An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 7:11 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated because all staff had not been trained on the process of medication reconciliation from the discharged facility with the physician during admission. The admitting nurse would enter the orders in PCC, and the nurse manager would conduct chart audits to validate accurate orders were entered into the computer using the discharge summary in collaboration with the admitting physician in the community. All staff trained on how to pull up residents' care information from the Kardex, and change in condition.

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on interviews and record review, the facility failed to ensure a therapeutic diet was prescribed by the attending physician for one of 5 residents (CR #1) reviewed for food and nutrition services. The facility failed to ensure CR#1's diet order was transcribed and administered as ordered by the physician for a cardiac (2 GM sodium, low fat, low cholesterol) diet. This failure put residents at risk for health complications related to nonadherence to diet order. Findings included: Record review of CR#1's face sheet dated [DATE]revealed a [AGE] year-old male was admitted to the facility on [DATE]. CR#1 had diagnoses included: heart failure, (heart cannot pulp enough blood and oxygen to the body's organ), morbid obesity (body mass index greater than 35 combined with other health issues) diabetes mellites (body does not manage blood sugar properly), and atrial fibrillation (irregular heartbeat). Record review of CR #1's admission MDS assessment dated [DATE] revealed CR #1 had BIMS score of 15 out of 15 which indicated intact cognition. Further review revealed CR #1 needed moderate assistance with mobility. Record review of CR #1's care plan dated [DATE] revealed CR #1 resident was at risk for shortness of breath. Intervention: alert my nurse for concentrator and/oxygen tank needs to be changed, provide oxygen as ordered by physician, further review revealed resident had a self-care deficit. Interventions: mobility: I use a wheelchair, transfer: gait belt X2 team member. It also revealed admission/readmission care plan: I may be at risk for nutritional/hydration concerns. Interventions: nutrition/hydration within prescribed diet. Record review of CR #1's order summary report dated [DATE] read in part . regular diet texture, thin/regular related to acute on chronic heart failure . Record review of diet order on the communication slip dated [DATE] revealed no added salt, cardiac with regular texture. Record review of CR#1's discharge summary report from the hospital dated [DATE] read diet instructions: cardiac (2 GM sodium, low fat, low cholesterol) diet texture: regular. (continued on next page)

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:40 p.m., the DON said CR #1 was on a regular diet, and she spoke to the Dietary manager. The DON said she transcribed the order in the kitchen computer as regular because that was what she saw in CR #1's order. The DON said LVN H wrote the diet order on the communication slip and could not remember if she had clarified the order with the physician. The DON said LVN H wrote no sodium, cardiac diet, and regular texture from the discharge summary report from the hospital. The DON said the Dietary Manager should have verified the order with her since she had a diet communication slip that read cardiac, no sodium, cardiac diet. The DON said she would have verified with CR #1 physician. During an interview on [DATE] at 5:27 p.m., LVN H said she wrote on CR #1 the diet communication slip: No sodium cardiac diet with regular texture. LVN H said she sent the communication slip to the kitchen but transcribed it incorrectly in the computer because she input a regular diet. LVN H said if CR #1 was not provided with the cardiac diet, it could cause CR #1's health condition to worsen. LVN H said she had a skill check-off on the new admission process, and the nurse managers should have checked the new admission paperwork the day after admission. During an interview on [DATE] at 10:57 a.m., the ADON said LVN H did not transcribe the correct order in the computer for CR #1. The ADON said CR #1 was given the wrong diet until he expired in the facility. The ADON said administering a different diet from what the physician said could cause life-threatening emergencies or death for CR #1. The ADON said LVN H, who admitted CR #1, should have verified the order with the physician and entered the correct order in the computer. Then, the nurse managers should have verified the CR #1's the next day, but the mistake was not caught in time. The ADON said she was not sure if the nursing staff were provided any in-service on the admission process after this incident, but the nursing staff was provided an in-service on the admission process before the incident. During an interview on [DATE] at 1:05 p.m., the Dietary Manager said nursing staff would write a diet communication form and send it to the kitchen. The Dietary Manager said she would cross-check the order on the slip with the physician's order on the computer. The Dietary Manager said she input a regular diet for the meal ticket because the physician's order on the computer was regular. The Dietary Manager said she could not remember what the diet communication read. The Dietary Manager said a regular diet could affect CR #1's medical health because he was not provided with a 2gm sodium cardiac diet. The Dietary Manager said she made a mistake, but now she takes the meal communication slip to the morning meeting and checks the order with the DON. The Dietary Manager said, if there were any differences, then the DON would call the physician for clarification. During an interview on [DATE] at 2:58 p.m., the Administrator said LVN H should have gone through the discharge order from the hospital for CR #1, written the diet order on the communication sheet, and given the slip to the kitchen. The Administrator said the Dietary Manager should also check the order on the computer. The Administrator said the dietary manager should have consulted with the nursing staff to see if there was a discrepancy when she checked the order. The Administrator CR #1 health would be at risk if CR #1 were given the wrong diet. Record review of the facility undated policy on therapeutic diets read in part . residents receive and consume foods and fluids in the appropriate form and appropriate nutritive content as prescribed .