STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676258	A. Building B. Wing	05/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mememorial City Nursing and Rehabilitation Center	1341 Blalock Houston, TX 77055

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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 - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on interviews and record review, the facility failed to ensure residents requiring respiratory care, consistent with professional standards of practice for 1 (CR#1) of 5 residents reviewed for quality of care. The facility failed to provide immediate care to CR#1 when she experienced respiratory distress on [DATE]. After the resident was observed gurgling with emesis by LVN A, the NP was notified; monitoring nor interventions were initiated. When observed by the NP, CR #1 was unresponsive and oxygen saturation dropped to 60%. 911 was called and arrived at 12pm. During the course of hospitalization , CR #1 was declared brain dead and expired on [DATE] after atifical support was removed. This failure placed residents who developed a change in respiratory status at risk of physical harm, emotional distress, mental anguish, and hospitalization or death from possible neglect. On [DATE] at 1:11 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE] at 11:13am the facility remained out of compliance at a scope of isolated with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions. Finding included: Record review of the admission sheet (undated) for CR#1 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses which included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), vascular dementia (a general term describing problems with reasoning, planning, judgment, memory, and other thought processes caused by brain damage from impaired blood flow to brain), and paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs). CR#1 was discharged on [DATE] to acute care hospital. Record review of CR #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 3 out of 15 indicative of severely impaired cognition. CR#1 was dependent on staff for toileting hygiene, shower, and lower body dressing. Partial/moderate assistance with upper body dressing and personal hygiene. Record review of CR#1's care plan, initiated [DATE] and revised on [DATE] revealed the following: Problem: [CR#1] has an ADL self-care performance deficit r/t Dementia (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Goal: The resident will maintain current level of function through the review date. Interventions: Eating: the resident requires (supervision) with setup. Toilet use: the resident requires (extensive assistance) by (1) staff for toileting. Dressing: the resident requires (extensive assistance) by (1) staff to dress. Record review of CR#1's Nurses note dated [DATE] at 12:29pm written by LVN A revealed read in part: . Note Text: Nurse entered room and observed resident gurgling and with yellow emesis on her gown Nurse called resident name; resident was not responding Nurse initiate V/S BP ,d+[DATE] P 47 BS 194 O2 Sat 90% on RA. Resident V/S Rechecked BP ,d+[DATE] P 58 O2 Sat 83% oxygen applied NP is here to assesses Resident. Resident O2 Sat 74% non-rebreather is applied. NP gave order to send Resident out 911 to [Hospital name]. Resident Guardian is contacted but there was no answer, This Nurse left a voice message to call facility at her earliest convenience . Record review of CR#1's NP's notes dated [DATE] revealed read in part: .Chief Complaint: acute visit. History of Present Illness: Polite 57F long term nursing home resident. Nurse called me to see the resident for sudden change in condition. Per nurse, she had breakfast and medications in am as usual. But around 1150 AM, she did vomit and kept coughing. When I saw her at the bedside, she was unresponsive and very congested breathing was noted. The gown was soaked with gastric emesis. Initial VS, bp,d+[DATE], HR 88, O2sat 88%w/ RA, RR 40 and BG 194. No IM Lasix at this facility per nurse. Stat cxr, CBC, BNP, CMP, NH3 and oral suction and breathing tx and full o2 application. Unfortunately, oral suction was malfunctioning. Breathing tx was given but her o2 sat was down to 60%. it was not successful. Apply NRB with 15L and went up to 82%. bp 112/ 52, hr 68, rr 50, o2 sat 67% with NRB 15 L. Worsening hemodynamic status and still unresponsive. at 1200 PM, called 911 for the sudden neuro change, suspected aspiration related respiratory failure and possible ET for airway protection. Notified Dr. about the change in condition and agreed with the hospital transport for the higher level of care. 911 arrived and took her to the hospital around 12 15 pm without ET, o2sat 81%w/ NRB and no status changed . Record review of CR#1's EMS records dated [DATE] revealed read in part: .Primary Symptom: Neuro - Unconscious/Unresponsive Began: [DATE] 12:00:00 Location: General/Global Activity: General - Seated or Lying Down, Not Sleeping Possible Injury: No Cardiac Arrest: No Narrative: m050 was dispatched to a possible cardiac arrest. M050 aostf a 57 yo female with a cc of unconscious/unresponsive. the pt was found laying semi-Fowler on hospital bed inside of a nursing home. Staff was not present to give a report. It is unknown the pt baseline and when the pt was last seen normal. The pt was being ventilated with a bvm and o2 by e005. The pt had vomit coming from her nose and mouth. The pt was suctioned on scene. The pt was moved to the back of the ambulance. An igel size 4 and end tidal were established. The pt was hyperventilated do to a low o2 sat. The pads were placed on the pt. IV access was obtained. The pt was administered a normal saline bolus. The pt vitals were monitored enroute to the er. The pt bp dropped below 90 systolic. Nor epi was administered while enroute to the er. The pt was suctioned throughout transport. The pt vitals were monitored. The pt bp improved and vitals remained stable. Nor epi was discontinued pmhx as listed. nkda. The pt had a gcs of 3, pupils PERRL, lungs clear and equal, skin warm and dry. 12:29:42 HR 62 O2 Sat 18% , 12:33:19 HR 80 BP 73 / 32 HR 15 O2 Sat 75% . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's Emergency Department records dated [DATE] revealed read in part: . Procedure-Endotracheal intubation. Time: [DATE] 13:05. Confirmed: Patient, procedure, and site correct, Time-out taken prior to procedure. Indication: Airway protection. - The patient presents with an illness or injury that acutely impaired one or more vital organ systems. There was a high probability of imminent or life-threatening deterioration in the patient's condition during their evaluation in the ED . Record review of CR#1's Neurocritical Care Note dated [DATE] revealed read in part: .Chief Complaint [DATE] 12:50 Pt came from by EMS, unknown hx, unknown baseline. Found unresponsive, hypotensive at seen with BP of ,d+[DATE], started on levophed and 300ml NSS by EMS, ambu-bagged on way here. History of Present Illness 57yoF w/ PMHx prior stroke, stercoral colitis s/p colostomy, chronic paraplegia, wheelchair bound, DVT on Eliquis (unknown medication compliance), and bipolar disorder, is BIBEMS from after she was found unresponsive. Unknown last seen normal. Patient was reportedly GCS 3, and there was no staff available to provide additional history. EMS intubated the patient for airway protection and started a norepi drip when she was found to be hypoxic and hypotensive. Per EMS, patient had a copious amount of dark green mucus in the nose and mouth. CTA shows no intracranial flow. Patient is admitted to for close neuromonitoring and further evaluation with possible progression to brain death . Record review of CR#1's hospital discharge summary revealed read in part: .Date of Admission: Patient was admitted on [DATE]. Date of Discharge: Time of death 20:28 on [DATE]. All Diagnoses This Visit: Altered mental status, Anoxic brain injury, Coma Diffuse cerebral edema, other shock, Respiratory arrest. Hospital Course: 57yoF w/ PMHx prior stroke, stercoral colitis s/p colostomy, chronic paraplegia, wheelchair bound, DVT on Eliquis (unknown medication compliance), and bipolar disorder, is BIBEMS from after she was found unresponsive. Unknown last seen normal. Patient was reportedly GCS 3, and there was no staff available to provide additional history. EMS intubated the patient for airway protection and started a norepi drip when she was found to be hypoxic and hypotensive. Per EMS, patient had a copious amount of dark green mucus in the nose and mouth. CTA shows no intracranial flow. Patient is admitted to for close neuromonitoring and further evaluation with possible progression to brain death. Over the course of her hospitalization patient was declared brain dead (20:28 on [DATE]) by way of cerebral blood flow test. Guardian was contacted and funeral arrangements were made. Patient was taken off of artificial support on [DATE] and transported to the funeral home . In a telephone interview on [DATE] at 9:56a.m., with the Hospital Case Manager, she said CR#1 arrived from the nursing facility intubated and unresponsive. CR#1 was determined to be brain dead. She said per EMS CR#1's 02 was 18%. When the hospital nurse called the nursing home to get a report from the facility, she said there was no answer. She said the hospital had received many pts from that facility in poor condition. She said the facility's Administrator was contacted. The Administrator said it was clinical and asked ADON A to give report. ADON A said the NP was in the room at that time. Hospital Case Manager said she requested NP's number as the doctor had questions. In an interview on [DATE] at 1:13p.m., with LVN B, she said she had not worked with CR#1. She said she worked PRN at this facility, and this was her first day on the floor. When asked in the event of an emergency where would she get the oral suctioning machine from. LVN B said the oral suctioning machine should be at bedside if there was an order. I don't know where the machine is kept. But it's a good question I will definitely ask. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 1:27p.m., with LVN A, she said when she made her morning round CR#1 was alert, oriented, and talking. CR#1 ate breakfast and took her morning meds. LVN A said she was passing meds when she heard coughing and a gurgling noise. She said she entered CR #1's room and observed CR#1 slumped over. She said when she called CR#1's name, the resident was not responding. She said she checked vitals and her O2 was in the 80s, but the resident was still not responding. She said she called the Unit Manager to assess. The NP was in the facility, and the NP assessed CR#1. Resident O2 Sat were low, non-rebreather was applied. The NP gave the order to send the resident out 911 to the hospital. In an interview on [DATE] at 1:40p.m., with RN Care Coordinator, she said CR#1 was fairly new to their case load. CR#1started their services in [DATE]. She said CR#1was seen by the NP twice a week and once a week by the doctor. She said CR#1 was seen by the NP when CR#1 was transferred to the hospital. She said O2 sat less than 92% required oxygen via nasal cannula and non-rebreather mask was used to deliver high percentage of oxygen. Record review and interview on [DATE] at 1:48p.m., with the DON, ADON A, and ADON B. The DON said CR#1 was still breathing when CR#1 left the facility. ADON A said they were in a meeting when the nurse said CR#1 had a change of condition. On the way to assess the resident, the NP was met on the hallway and was asked to assess CR#1. The NP asked for Lasix IM and was told the facility did not have it. The NP ordered oral suctioning and a breathing treatment. After the treatment the O2 was in low 80s so they changed to nonrebreather mask and watched for a few minutes. ADON A said when she suctioned there were clear liquids, and nothing came out. The NP checked CR#1's eyes for neurological changes with the pen light. They called 911 and the EMS came within ,d+[DATE] minutes. She said the nurse and the NP were in the room with CR#1 while they gathered paperwork. ADON A said the oral suctioning machine was used. She said she connected the tubing to the suction machine and not the nurse so I know the suction machine was working. This State Surveyor asked to see the suction machine used on CR#1. ADON A said the machine was in the central supply to be decontaminated. The DON said the Respiratory Therapist checked the equipment once a month and as needed when visiting the facility as the facility did not have trach/vents. The DON said if the machine malfunctioned, the Respiratory Therapist would label it to be fixed. The State Surveyor reviewed the NP's note in which the NP documented oral suction was malfunctioning. ADON A said the NP was in and out of the room and on her phone most of the time don't know why she documented that. ADON A said CR#1 sats were in low 80s. She suggested to the NP to send CR#1 to the hospital. NP wanted to order stat x-rays and labs. ADON A said 911 wound not have taken CR#1 if she was not breathing. In a telephone interview on [DATE] at 2:16 p.m., the NP said the nurse called her to see CR#1 for sudden change in condition. Around 11:50 AM, CR#1 vomited and kept coughing. She said she saw CR#1 at the bedside. CR#1 was unresponsive and very congested breathing was noted. CR#1 gown was soaked with gastric emesis. There was no IM Lasix at this facility per nurse. She ordered oral suction, breathing treatment, and O2. Breathing tx was given but her O2 sat was down to 60%. It was not successful. Applied NRB with 15L and went up to 82%. CR#1 was still unresponsive. The NP said she documented, Unfortunately; oral suction was malfunctioning in her progress notes because she worked at the hospital and had not seen this suctioning machine before. She said there was clear liquid, no food when suctioning so she assumed the machine was malfunctioning. She said the staff brought 2nd suctioning machine and there was clear liquid. She said she called the Doctor and at 12:00 PM, the EMS was called for the sudden neuro change, suspected aspiration related respiratory failure and possible ET for airway protection. She said brain cells were very sensitive to a lack of oxygen. She said brain cells start dying less than 5 to 10 minutes after their oxygen supply disappears. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 2:50p.m., Hospital RN said CR#1's admitting diagnosis was anoxic brain injury, coma, and respiratory arrest. In an interview on [DATE] at 3:03p.m., Neurosurgery Doctor said CR#1 was found unresponsive and there was evidence that CR#1 had not gotten oxygen for 30 plus minutes as there was no blood flow to the brain. In an interview on [DATE] at 10:01a.m., with the DON, she said the facility had Lasix in the Ekit. The DON said nurses were reeducated on the contents of Ekit, to include a vial of Lasix and the procedure for updating the pharmacy for Ekit use. In an interview on [DATE] at 10:13a.m., with LVN A, she said one oral suctioning machine was used on CR#1. She said the machine was brought in the room by somebody there were too many people in the room she could not recall who brought the machine. She said she did not see who connected the tubing on the machine. LVN A said, I suctioned her I was the closest one to her. There was only clear liquid. She said the NP was in and out of the room at that time. She said nurses were responsible for sanitizing the used machine and to place it back in the storage room. She said she had not seen a Respiratory therapist in the facility as there were no trach/vent residents. In an interview on [DATE] at 10:33a.m., with CNA BB, she said CR#1 required extensive/total care with all ADLs. She said CR#1 was talking and ate her breakfast that morning. She said she went to take the food cart to the kitchen. It was matter of minutes resident had change of condition. When she returned to the hall the nurses were in the room with CR#1. In a telephone interview on [DATE] at 1:03p.m., with CR#1's Doctor. The Doctor said CR#1 had a change of condition and they started interventions. They checked BP, HR, and O2. Her O2 sat was low so the oxygen was given. Her O2 did not increase so the non-rebreather was applied. Pt was a full code and intended ET. Her BP was fluctuating on lower levels, unresponsive, and she did not respond well to oxygen so 911 was triggered. She said if the pt was full code, unresponsive, checked vitals, and had no pulse. CPR and 911 should be initiated. She said 911 would come in ,d+[DATE] minutes. She said if pt had BP staff should do interventions to keep pt stable until 911 arrives. Record review of facility's Abuse, Neglect, and Exploitation policy (Date Implemented: [DATE]) revealed read in part: . Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Definitions: Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Policy on Respiratory distress was requested along with Abuse/neglect policy. No policy on respiratory distress was provided on exit. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 1:11pm. The facility's Administrator, the DON, and the Regional Clinical Specialist (on phone) were notified. The Administrator was provided with the IJ template on [DATE] at 10:55am. (continued on next page)

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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 - Few	Record review was conducted of the facility's In-services Training Report dated [DATE] conducted by the DON to Licensed Nurses (RN and LVN). Topic: Oral Suctioning, Checking of Suction Machine for function, Ekit Contents, and updating pharmacy on use. Contents or summary of training session: Licensed Nurses were reeducated on oral suctioning with return demonstration. Reeducation also included how to check suction machines for function, documentation on crash cart check list, and how to validate suction machine function at onset of use with return demonstration on oral suctioning). Licensed Nurses were reeducated on the facility ekits and contents (Cubex, IV, Refrigerator). Reeducation included location of ekits, use of ekits, and pharmacy refill process and notification in the event medication was needed to be refilled. Observed head to toe assessments were completed by Licensed Nurses on all residents to identify any signs of change in condition. No concerns were identified. Observed the DON reviewed the resident progress notes for the last 30 days to ensure concerns related to abuse and neglect and changes of condition were identified and an investigation initiated, and physicians were notified with no concerns noted. During the monitoring phase, interviews were conducted by the state surveyor with various staff on different shifts (Administrator, DON, [NAME] Clinical Specialist, 9 LVNs, 3 CNAs and 4 Medication Aides). Staff interviewed indicated they had received above mentioned training. No concerns noted. The Administrator was informed that the Immediate Jeopardy was removed on [DATE] at 11:13am. The facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.