STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676263	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerbrook Skilled Nursing and Rehab Center	9250 Humble-Westfield Rd Humble, TX 77338

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	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on interview and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (CR #1) of 4 residents reviewed for respiratory care. The facility failed to ensure CR #1, who was on continuous oxygen, was provided with sufficient oxygen while out of the facility at an MD appointment on [DATE]. CR #1 was transported to the hospital from the MD appointment. An Immediate Jeopardy (IJ) was identified as past noncompliance on [DATE]. The noncompliance began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the investigation began on [DATE]. This failure could place residents who received oxygen therapy at risk of respiratory complications, hospitalization and/or death. The findings included: Record review of CR #1's Admission Record dated [DATE] revealed an [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included acute respiratory failure with hypoxia (low levels of oxygen in your body tissues), heart failure, pleural effusion (a collection of fluid around your lungs), dementia, chronic kidney disease, and fluid overload. Record review of CR #1's discharge assessment-return anticipated MDS dated [DATE] revealed his cognitive skills for daily decision making was moderately impaired. He required assistance from staff with ADL care. His MDS did not indicate he was on oxygen. Record review of CR #1's care plan revealed he was on oxygen therapy. Interventions were to have oxygen via nasal cannula at ,d+[DATE] L per minute continuously, and to observe for signs and symptoms of respiratory distress and report to MD prn: respirations, pulse oximetry (noninvasive method for monitoring blood oxygen saturation), increased heart rate, restlessness, diaphoresis (excessive and abnormal sweating), headaches, lethargy, confusion, atelectasis (the collapse of a lung or part of a lung), hemoptysis (when you cough up blood from your lungs), cough, pleuritic (two large, thin layers of tissue that separate your lungs from your chest wall) pain, accessory muscle usage, and skin color, date initiated [DATE]. (continued on next page)

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

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's physician's orders revealed an order for O2 at ,d+[DATE] L/minute via nasal cannula continuously every shift, order date [DATE]. Record review of CR #1's O2 saturation revealed it was at 95% out of 100% on [DATE] at 7:12 a.m. on room air. Record review of CR #1's nursing note dated [DATE] at 8:00 a.m. written by LVN D reflected in part, Res up in w/c in dining room eating breakfast. O2 on via n/c at this time. Res aware of doctor appt today and dressed and rdy per staff. Will monitor Record review of CR #1's nursing note dated [DATE] at 8:44 a.m. written by LVN D reflected in part, Res up in w/c alert and responsive. Resp even and unlabored. No distress noted. Appetite good. Will monitor. Record review of CR #1's nursing note dated [DATE] at 10:30 a.m. written by LVN D reflected in part, Res transported to doctor appt at this time. Record review of CR #1's MD progress note dated [DATE] written by MD R reflected in part, On exam pt is seen on home oxygen which was provided by his nursing home. On arrival pt was found to have an O2 saturation of 86% and during the visit developed cyanosis (medical term for when your skin, lips or nails turn blue due to a lack of oxygen in your blood) around his mouth and fingertips. Pt's [family member] reported that this has happened in the past and required prompt change in O2 tanks. Pt's oxygen tank was found to be empty and he was rapidly switched to another tank. Pt's O2 saturation at that time was found to be 72%, and EMS was called. Eventually O2 saturation improved to 92% and all other vitals remained stable and patient was taken to [Hospital Name] ER . Plan . 2. Acute hypoxemic respiratory failure Notes: Pt presented with cyanosis and dyspnea (shortness of breath) after O2 ran out of portable tank. Pt's tank was replaced and cyanosis resolved with replacement of supplemental O2, pt was sent to ER for further evaluation and treatment. Pt advised on importance of securing O2 and dangers of drops in oxygen . Record review of CR #1's hospital record dated [DATE] at 1:25 p.m. reflected in part, Patient is a [AGE] year old with past medical history CHF (progressive heart disease that affects pumping action of the heart muscles), hypertension (high blood pressure), hyperlipidemia (high cholesterol), diabetes who was brought in by EMS with complaints of shortness of breath, chest pain. Patient states that he began having symptoms a few hours ago. Patient states that he has chest pressure rated an 8 out of 10 not worsened or relieved by anything. Patient reportedly with a new diagnosis of CHF but has not been able to get a prescription for home oxygen. Patient denies other significant symptoms at this time. Patient was noticed by nephrology (medical specialty that focuses on the study of the kidneys) staff to be cyanotic which prompted EMS call. EMS states that the patient was hemodynamically stable (patient's vital signs-like heart rate, blood pressure, and oxygen saturation-are within normal ranges) throughout transport, placed on nonrebreather (a medical device used to deliver high concentrations of oxygen to patients in emergency situations) with 100% saturation throughout transport .Primary impression: Acute hypoxic respiratory failure . Secondary Impression: anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), elevated troponin (a protein, a complex chemical molecule, found in certain types of muscle in your body), hyperkalemia (high potassium), pleural effusion, pneumonia (a lung infection that can be caused by bacteria, viruses, or fungi), and thrombocytopenia (low blood platelet count). (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 hospital record dated [DATE] at 12:52 a.m. reflected in part, .Patient was at nephrology appointment and noted to be hypoxic did not have his oxygen, he is on 3 L nasal cannula at his nursing home, he was transported not on oxygen. Patient exhibited shortness of breath and chest pain radiating ,d+[DATE] but resolved once oxygen was placed . called [family member] for collateral information . In an interview on [DATE] at 11:15 a.m. LVN D said CR #1 had an appointment after breakfast (on [DATE]). She said she put a new oxygen tank on him, he went out to his appointment and the tank ran out of oxygen. She said he was on ,d+[DATE] L of continuous oxygen, and it should have lasted around ,d+[DATE] hours. She said she did not think he would run out. She said after the incident, the facility conducted an in-service to ensure the oxygen tank was new and full before the patient went out of the facility. She said since the incident, she would send an extra oxygen tank with the driver if the resident was out of the building for a while. In a telephone interview on [DATE] at 11:39 a.m. CR #1's family member said the MD office informed her his oxygen tank was empty. She said she was unsure if the oxygen tank was working or not. She said he could have had a stroke or died without his oxygen. In an interview on [DATE] at 12:22 p.m. the Corporate DON said 2 L of continuous oxygen should last approximately ,d+[DATE] hours. She said it would last a shorter timeframe if the resident was on a higher Liter. She said when a resident went out to an appointment, facility staff put on a new tank when they left and that should be enough for the allotted time. She said residents were not typically out of the building for longer than ,d+[DATE] hours. If residents were out longer than ,d+[DATE] hours, they could send an extra tank of oxygen with them. In an interview on [DATE] at 12:34 p.m. the Talent and Learning Director said she was previously the respiratory therapist at the facility years ago. She said the facility used E cylinder tanks for portable oxygen and each tank held 2000 psi (a commonly used E cylinder can hold nearly 680 liters of oxygen when filled to 2,000 psi). She said the length of time the oxygen lasted was based on the liter flow. She said if a resident was on 2 L the portable tank could last from ,d+[DATE] hours. She said the tank should be changed at 4 hours when it reached the red area, with 500 psi remaining. She said when she was the respiratory therapist, she ensured to calculate how long the resident would be out of the facility, call the MD office and ask about oxygen availability, and determine what mode of transportation was used. She said if the resident was on 2 L she would send an extra tank with the van in case of an emergency. In a follow up interview on [DATE] at 1:15 pm LVN D said she put a new, full oxygen tank on CR #1 at breakfast time around 7:30 a.m.- 8:00 a.m. She said he left the building for his appointment between 9:30 a. m. - 10:00 a.m. She said she glanced at the oxygen tank when he left the building, and it was a little less than full. She said he was on the oxygen tank for approximately 1 ,d+[DATE] hours when he left the facility. She said no one told her how to ensure the resident had enough oxygen while out of the facility, or how to calculate how much oxygen the resident would need while out of the facility. (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 8:31 a.m. CR #1's Clinic Staff said the first and only time CR #1 was seen in their office was on [DATE]. She said his appointment was scheduled for 11:30 a.m. She said he was in a w/c with an O2 tank, but it was out of oxygen, it was low. She said his O2 saturation was 86% on arrival. She said his O2 tank was found to be empty, and the office rapidly switched the tank. She said CR #1 looked tired and sick, but he was at the MD office for a hospital follow up. She said the nursing facility did not call beforehand to see if the office had oxygen on hand. In an interview on [DATE] at 11:06 a.m. the Administrator said on the day of his MD appt staff put an oxygen tank on CR #1 around 9:30 a.m. She said the same day they were notified he was sent to the hospital from the MD office due to blue tinge on his hand. She said he was sent to the MD's office with a full tank, and they were uncertain when the oxygen ran out due to the uncertain timeline and not being there. She said the resident could be at risk of not receiving the adequate amount of oxygen to support his needs. She said the facility could have anticipated some of the resident's needs but could also glean that the receiving entity would have emergency support. She said the facility should do what they could to provide support to the resident on their end. She said after the incident the facility instituted best practice for worst case scenario and in-serviced nurses on [DATE] to send residents out with 2 tanks and ensure drivers returned any remaining tanks. She said the new procedure was to ensure safety measures were in place. In a follow up interview on [DATE] at 12:44 p.m. LVN D said she sent CR #1 to his appointment with 1 portable O2 tank (the one in use). She said she did not know if the MD office had oxygen on hand and said the resident could be at risk of desaturating if he ran out of oxygen (Respiratory desaturation, known as hypoxemia in medical terms, is when you have low blood oxygen saturation.) In an interview on [DATE] at 1:06 p.m. RN S said she would ensure the resident had a full tank of oxygen if sent out of the facility. She said the tanks typically lasted around ,d+[DATE] hours on 2 L. She said 3 L would last a shorter time. She said she had to know the driving distance, where they were going and how long they would be gone. She said she would send the resident with an extra tank or two. In an interview on [DATE] at approximately 2:07 p.m. LVN C said she would send an extra O2 tank with a patient who went out of the facility. Record review of the facility's in-service entitled, O2 Management for outside appointments dated [DATE] conducted by the previous DON and provided to nurses and CNAs reflected in part, when residents are going out for outside appointments always check O2 tank to ensure it is full or place a brand-new tank when transportation arrives to pick up resident. Always send 1 extra O2 tank with resident to appointment and have transportation to bring both tanks back upon residents return. The in-service had 34 signatures. Record review of the facility's Oxygen Administration policy dated [DATE] reflected in part, The purpose of this procedure is to provide guidelines for safe oxygen administration .