STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455996	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE RENAISSANCE AT KESSLER PARK	**2428 BAHAMA DR DALLAS, TX 75211**

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards for one (Resident #1) of three residents reviewed for quality of care. LVN A failed to provide appropriate interventions when Resident #1 experienced a change of condition on [DATE] at 6:25 AM, including a change in breathing, the presence of chest congestion, and his speech. Two hours after initially experiencing a change in condition Resident #1 was found non-responsive. He was pronounced dead at 9:25 AM on [DATE]. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm this is not immediate jeopardy and a scope of isolated due to the facility still monitoring the effectiveness of the Plan of Removal . These failures could place resident'sresidents at the risk of not receiving appropriate medical interventions timely and effectively, which could result in severe illness, hospitalization or even death. Findings included: Review of Resident #1's Face Sheet revealed he was a [AGE] year-old male who admitted to the facility on [DATE]. Review of Resident #1's MDS assessment dated [DATE], revealed the resident's [DIAGNOSES REDACTED]. Review of Resident #1's nursing note dated [DATE] at 11:59 AM written by LVN A revealed , [DATE] the nurse did her round, resident was sleeping and opened his eyes when the nurse turned on the light, the nurse waved at the resident and turned the light back off. The nurse made rounds at 1:00 AM and resident was sleeping. Resident was sleeping when another resident walked in his room, the nurse went and got the other resident out of the room at 3:30 AM. When CNA changed him, that's when I did my last round, he was awake and responded when I said hi at 5:15 AM. At 6:25 AM The morning CNA called me in resident room, at this time resident appear to be congested, and rattling wet, I touched him and called his name and he answered. I contacted the nurse practitioner and before she could respond the CNA called me in resident's room. The resident gasped I called code and CPR was initiated. Coworker called 911 and CPR was performed until EMS took over and pronounced him at 9:25 AM . Review of Resident #1's nursing notes revealed no other entries on [DATE] or [DATE] regarding resident's change of condition. Review of Rresident #1's medical recordchart revealed oxygen saturation vitals onfor [DATE] at 2:01 PM was 64% on room air several hours after resident's death. The following vitals were documentated on ,[DATE] at 2:00PM; Review of Resident #1's clinical medical record revealed s there were no assessments completed was no documentation regarding change of condition such as SBAR. SBAR is The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition. Interview with LVN A on [DATE] at 3:00 PM revealed Resident #1 passed away. She stated at 10:22 PM on [DATE] she statedstated, he was fine and responsive. She stated he was checked on every two hours . She stated around 3:00 AM she went in the resident's room and he waved. She stated around 5:00 AM or 5:30 AM, a CNA changed the resident and he was fine. She stated he was fine during morning rounds and he talked back to her. She stated around 6:25 AM on [DATE] the morning CNA (CNA E) told her to check on the resident. She stated phlegm was coming out of the resident's mouth, he was experiencing respiratory issues, and was possibly aspirating .butaspirating. But was still responsive . She stated the CNA cleaned the resident's mouth. LVN A did not provide a clear explainationexplanation of aspirating. She stated around 6:00 or 6:30 AM she contacted the resident's nurse practitioner and left a voicemail. She stated at 6:28 AM she text messaged the nurse practitioner and did not receive a response. She then checked the resident's vitals and they were fine . LVN A stated she continued to monitor Resident # 1 but did not indicate any further actions taken. She stated around 8:00 AM she went to speak to the ADON about sending the resident to the hospital, and then thethen the CNA reported the resident was not doing well. She stated she rushed into the resident's room and his condition had worsened. She stated she told another nurse to call code blue and EMS. She stated she, the ADON, and a male staff performed CPR until the arrival of EMS. She stated the EMS pronounced the resident's death. She stated the ADON contacted the resident's family and the VA. She stated she followed facility protocol appropriately . and She stated if she had sent the resident to the hospital the hospital would have sent him right back. Interview with CNA E on [DATE] at 6:50 PM revealed at 6:25 AM on [DATE] Resident #1 looked different and weird. He stated the resident was not talking or breathing well . He stated the resident was not talking to LVN A. He stated LVN A checked the resident's vital signs and his vitals were good. He stated the resident was not speaking well and did not speak to LVN A at all. He stated at 8:45 AM the resident was a little worse, could not breathe, and was not talking. He stated he reported the change of condition to LVN A. He stated LVN A checked the resident's vital signs again and called 911. Interview with the ADON on [DATE] at 3:23 PM revealed Resident #1 had underlying issues that caused his death. She stated she clocked in at 8:30 AM and was told to go to Resident #1's room with the nurse. She stated upon arrival to the room, the resident was non-responsive. She yelled out code blue and started CPR. She stated the nurses and CNAs ran to call 911 and got the crash cart. She stated CPR was performed at 8:43 AM or 8:45 AM. She stated she initiated CPR and LVN A assisted. The ADON stated her understanding of the morning's events was that CNA ECNA E had gone into Resident #1's room to do rounds and reported to the nurse that the resident was having difficulty breathing breathing. She stated the LVN A called the physician around 6:25 AM but the physician still had not responded by 8:30 AM.AM. She stated she would have taken a full set of vitals since the resident was diabetic and checked to see if his airway was open, then completed a full assessment which would have contained vitals and SBAR. She mentioned an SBAR would have been completed had he not died . She stated she would have sent the resident to the hospital after not hearing back from the physician for 10 minutes. She stated LVN A was provided additional training but could not provide documentation. She stated she and the DON spoke with LVN A regarding notification of changes of condition. She stated there was no disciplinary action taken. Interview with the DON on [DATE] at 5:07 PM revealed she was not notified regarding Resident #1's change of condition. She stated she arrived at the facility at 8:45 AM on [DATE]. She stated she informed LVN A she should have sent the resident to the hospital. She stated the facility's protocol was to call the NP, ADON, and DON when there was a change of condition. She stated had she been contacted, LVN A would have received instructions to send the resident to the hospital. She stated a change of condition assessment would have been completed. The DON stated the cause of death was natural causes and the official death certificate had not been completed. Review of Associate Disciplinary Memorandum dated [DATE] revealed LVN A failed to notify per protocol and failed to document guidelines. Review of the facility policy Notification of Changes dated [DATE], revealed, To provide guidance on when to communicate acute changes in status to MD, NP, and/responsible party. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or appropriate family member(s) of the following: a significant change in the physical, mental, or psychosocial status of the resident. An Immediate Jeopardy (IJ) was identified on [DATE] and the Administrator was informed, and a Plan of Removal was requested. The Facility Plan of Removal was accepted on [DATE]. The plan of removal reflected: 1. Immediate action(s) taken for the resident(s) found to have been affected include: On [DATE], Director of Nursing reviewed all current residents for change

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455996	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE RENAISSANCE AT KESSLER PARK	**2428 BAHAMA DR DALLAS, TX 75211**

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) of condition. No residents were found with change of condition symptoms. On [DATE], Director of Nursing in serviced LVN A on Notification of Change Policy with Post Test, Telehealth Services Clinical Practice Guidelines, and the Resident Protection Abuse Policy with Post Test. On [DATE], Director of Nursing started in-service education to all license nurses regarding change of condition using the Notification of Change Policy with Post Test, Telehealth Services Clinical Practice Guidelines, and the Resident Protection Abuse Policy with Post Test. Medical Director was notified of immediate jeopardy by the Administrator 2. Actions taken/systems put into place to reduce the risk of future occurrence include: The following actions were taken to ensure occurrence or reoccurrence of process/system failure that could lead to serious adverse outcome and when those actions were completed. In-service education was started by the Director of Nursing/designee on Notification of Change with Post Test to provide guidance on when to communicate acute changes in status to MD, including MD contact via telehealth, NP, and / responsible party. Immediate Physician Notification - the physician is notified immediately and should respond timely (within minutes), if the physician does not respond, the Medical Director will be contacted before the resident is sent for emergency room evaluation. If the resident experiences an acute deterioration or life-threatening condition and the MD/NP cannot be contacted, the nurse will call 911 Non-Immediate Physician Notification - the physician is notified and there should be a return call during the same shift This education will continue until 100% of licensed nursing staff is completed. Post- test will be completed to validate knowledge base. Post Tests will be completed by [DATE] and any staff that has not had this education will not be allowed to return to work until this is completed. In-service education was started by the Director of Nursing/designee on Telehealth Services Clinical Practice Guidelines to provide guidance to meet resident's emergent and non-emergent change of conditions. This education will continue until 100% of licensed nursing staff is completed. Education will be completed by [DATE] and any staff that has not had this education will not be allowed to return to work until this is completed. In service education was started by the Director of Nursing/designee on the Resident Protection Abuse Policy with Post Test to provide guidance to ensure the resident is free from abuse, neglect, misappropriation of resident property, and exploitation, physical and chemical restraint not required to treat the resident's symptoms, involuntary seclusion and corporal punishment. This education will continue till 100% of staff is completed. Post- test will be completed to validate knowledge base. Post Tests will be completed by [DATE] and any staff that has not had this education will not be allowed to return to work until this is completed. In service education was started by the Director of Nursing/designee on the Clinical Documentation Guidelines to provide a record of the health status, including observations, measurements, history and prognosis and serves as the primary document describing healthcare services provided to the patient. This education will continue till 100% of staff is completed. This education will be completed by [DATE] and any staff that has not had this education will not be allowed to return to work until this is completed. 3. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing/designee will review residents daily for change of condition and timely MD notification. The Director of Nursing/designee will validate that acute changes of condition are communicated timely to the MD/NP. The acute changes of condition validation will be documented on a QAPI Tool daily for four weeks The Director of Nursing/designee will review documentation on residents with acute changes of condition daily for four weeks. 4. Findings from the plan of removal will be reviewed by the QAPI Committee and Medical Director. The Quality Assessment and Assurance Committee validates the actions taken are effectively resolving the cited issues and verifies the dates of completion. Monitoring of the Plan of Removal included the following: Interview with LVN B on [DATE] at 11:50 AM revealed he completed an in-service regarding abuse and notification of change in condition. He stated the in-service was about notifying the physician on-call immediately and following physician's orders. He stated the resident's family, DON, and Administrator were also notified. He stated if the physician did not call back, continue to call until there was an answer. He stated the facility informed him there was an IJ because something happened to a resident that passed. He stated the abuse policy was about reporting abuse; verbal, mental, sexual, misappropriation, neglect, and physical to the administrator. He stated the in-services and tests were completed on [DATE]. Interview with RN F on [DATE] at 12:12 PM revealed she received an in-service regarding abuse in [DATE]. She stated she received an in-service called change of condition about notifying the physician, family, and follow physician orders. She stated tele-health was also used to notify the physician after 7:00 PM during the week and all day on the weekend. She stated she informed the DON she knew what to do regarding change of condition and did not have to complete a test after her in-service. Interview with LVN C on [DATE] at 12:32 PM revealed he completed an in-service regarding abuse and change of condition. He stated the abuse in-service was about the different types, neglect, and timeframe to report to the administrator. He stated any time a resident has a change of condition a SBAR assessment was completed and the physician was notified. He stated he completed a test after the in-services. He stated the in-services were updates on information he already knew. Interview with LVN D on [DATE] at 12:41 PM revealed she completed an in-service regarding abuse and change of condition. She stated the abuse in-service was about physical, verbal, misappropriation, and sexual abuse, who to notify, and when to report. She stated the change of condition in-services was about notifying the physician, family, and management. Interview with the ADON on [DATE] at 3:38 PM revealed LVN A should have sent Resident #1 to the hospital within 10 minutes of change of condition and not being able to get ahold of the physician. She stated the nursing staff were in-serviced regarding change of condition and abuse. She stated the facility received an IJ because LVN A did not follow protocol regarding change of condition and documentation did not reflect actions taken. Interview with the DON on [DATE] at 3:47 PM revealed she made rounds, checked on nursing staff, followed up on tasks, demonstrations, in-services, clinicals check offs, and observations to ensure staff followed facility procedures and protocols. She stated the facility received an IJ because of poor documentation regarding Resident #1's condition, implementation of intervention, and lack of follow up. She stated the facility implemented new procedures and updated policy regarding telehealth and immediacy regarding change of condition. She stated the facility provided in-services, one on one, and group education to nursing staff. She stated the following in-services were completed; notification change of condition, abuse, and telehealth. Interview with the Administrator on [DATE] at 3:55 PM revealed he monitored his staff by having interdisciplinary team meetings to discuss issues that came up, QAPI plans, 24-hour report with nursing, and monthly education for staff. He stated he did not micro-manage staff and they were to bring issues to him or vice versa. He stated staff should align with the facility's goals. He stated the facility received an IJ because LVN A did not document she was following up with Resident #1. He stated, she knows as a nurse what should be done and did not give herself credit of work done with the resident. He stated notification of change of condition, abuse, and telehealth in-services were completed with staff. Review of the in-service, dated [DATE], revealed the facility conducted an updated training on facility policies notification of change, telehealth services, and abuse. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm this is not immediate jeopardy and a scope of isolated due to the facility still monitoring the effectiveness of the Plan of Removal.