STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. BUILDING _____ B. WING _____	**08/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LONGVIEW HILL NURSING AND REHABILITATION CENTER	**3201 N FOURTH ST LONGVIEW, TX 75605**

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 **Residents Affected -** Few	**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** Based on observation, interview and record review, the facility failed to immediately consult with the physician regarding a significant change of condition for 1 of 4 residents reviewed for physician notification. (Resident #1) The facility did not notify the physician when Resident #1 had a respiratory rate of 40 (normal respirations ,[DATE]) and abnormal wet breathing sounds (a rapid onset of [MEDICAL CONDITION] caused by the inability of the lungs to perform normal gas exchange), Resident #1 was found dead in his room approximately an hour and a half later. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a potential for more than minimal harm with a scope identified as a isolated due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents with a change in condition at risk for delayed medical evaluation, serious impairment, and death. Findings included: A face sheet dated [DATE] indicated Resident #1 was [AGE] years old, admitted on [DATE], and had [DIAGNOSES REDACTED]. Physician orders [REDACTED].#1 was a full code and had oxygen at 2 LPM via nasal cannula every 1 hour as needed. A care plan initiated [DATE] indicated Resident #1 had a full code status, interventions included: if the resident had a [MEDICAL CONDITION], initiate CPR and call 911, notify the MD/RP and follow MD orders after notification, and mark chart and all pertinent documents with full code. A nursing note dated [DATE] at 12:16 p.m., completed by LVN E indicated she inserted a catheter and noted yellow urine drainage. Resident #1 had slow respirations alternating with rapid respirations, the NP assessed the resident and was aware of respiratory status. PRN oxygen applied and oxygen at 99 percent with oxygen at 2 liters per nasal cannula. A nursing note dated [DATE] ([DATE]) at 11:40 p.m., completed by LVN C indicated Resident #1's blood pressure was ,[DATE] (Normal blood pressure is less than 120 over 80), pulse was 91(normal pulse ,[DATE] beats per minute), temperature was 98.9 , respirations were 40 breaths a minute (normal ,[DATE] breaths per minute), and oxygen saturation was 90% via nasal cannula (normal ,[DATE]%). The nurse increased the resident's oxygen to 3 liters. The resident was awake but unable to focus and withdrawn, had had generalized [MEDICAL CONDITION] in his bilateral upper extremities, had amber colored urine and was suctioned by previous nurse. LVN C indicated she would continue to monitor for changes. A nursing noted dated [DATE] at 1:10 a.m., completed by LVN C indicated Resident #1 had white frothy secretions in his mouth and no vital signs of life. During an interview on [DATE] at 9:30 a.m. LVN A said on [DATE] between 6:30 p.m. and 6:40 p.m. she checked on Resident #1 with no complications noted. She said between 10:10 p.m. and 10:15 p.m., she peeped into Resident's #1 room and from the door heard Resident #1 had wet abnormal breathing, LVN A said she did not assess the resident because he was not assigned to her, she said she did not immediately notify his nurse of the change of condition, and she did not notify the MD of the residents change of condition. During a telephone interview on [DATE] at 9:38 a.m., LVN B said during report on [DATE] at 6 p.m., LVN E notified her Resident #1 had breathing issues and the NP had seen the resident about the issue. LVN B said after report she went to check on Resident #1 and noted no issues. LVN B said she made another round at 11:30 p.m. and noticed the resident had difficulty breathing. The nurse said she gave the resident a PRN breathing treatment and the resident started coughing up phlegm with difficulty, so she suctioned the resident and he appeared to be breathing better. LVN B said she did not notify the NP or the MD about the abnormal breathing because LVN E said the NP was aware. The [DATE] MAR indicated [REDACTED]. During an interview on [DATE] at 3:56 p.m., LVN B said LVN A never mentioned to her Resident #1 had a change in condition. During a telephone interview on [DATE] at 7:16 a.m., LVN C said on [DATE] she received report from LVN B and made her initial assessment of Resident #1 and noted the he had increased breathing and sounded wet, she said she increased his oxygen to 3 liters. The nurse said she did not notify the MD, or the NP of the residents increased respirations because she was informed the NP was already aware of his condition. LVN C said on her second observation of Resident #1, he was sitting up in bed and had a mouth full of foam. LVN C said she suctioned the resident, she noticed the resident was not breathing. LVN C said she remembered during report LVN B said the resident needed hospice care. She said she assumed the resident was a DNR. She said she did not initiate CPR and did not verify if the resident had a DNR. The nurse said there was no reason to verify his status, because she thought he was a DNR. LVN C said the resident was still warm to touch and his skin was normal in color. During an interview on [DATE] at 5:07 a.m., LVN A said on [DATE] 10 to 15 minutes after she told LVN C the resident had wet and abnormal breathing sounds LVN C told her Resident #1 had coded and died . LVN A said she looked at Resident #1's hard chart and saw the resident was a full code. LVN A said she questioned the full code status and asked LVN C about attempting CPR and was told the resident was dead and CPR would not matter. LVN A said she did not know how to respond to LVN C, she said she questioned herself about whether she should start CPR on her own, but she did not want to over step the other nurses' decisions. During an interview on [DATE] at 7:44 a.m., ADON D said on [DATE] at 1:21 a.m. she received a call from LVN C who notified her Resident #1 had passed away. She said she asked LVN C if the resident was a DNR and she replied, yes. She said LVN C called her a second time at 1:51 a.m. to ask who was going to pronounce the resident due to the resident not being on hospice care. ADON D said she again asked if the Resident # 1 was a DNR and LVN C said she thought he was. ADON D said she asked was CPR performed and LVN C said CPR was not administered. The ADON said she was not aware Resident #1 was a full code until the following day ([DATE]). During an interview on [DATE] at 12:42 p.m., the NP said she nor the MD was notified of Resident #1's change of condition. She said a respiratory rate of 40 was very significant and they (NP/ MD) should have been notified. She said she saw the resident on [DATE]th or 28th for abnormal breathing. The NP said if she was notified of the resident's declined condition she would have sent him to the hospital. She said she expected the nurses to update her on a resident change of condition. The NP said she was concerned the nurse did not think a rapid respiratory rate was not significant. A provider investigation report was not available. An undated Change of Condition protocol indicated when you have a resident with a change of condition you must: complete a full assessment of the resident, document the assessment findings in PCC, notify the physician, DON, and RP of the residents change of condition, complete the change of condition form in PCC, carry out any orders the physician gives ., and follow up with the Don, Physician and RP. The administrator and DON were notified on [DATE] 12:44p.m., that an IJ situation was identified due to the above failure. The administrator was provided the IJ template on [DATE] at 12:43 p.m. The facility's Plan of Removal was accepted on [DATE] 4:47p.m., and included the following interventions: 1.LVN C was suspended on [DATE] and terminated on [DATE]; 2.LVN A was suspended on [DATE] have been removed from duties until ,[DATE] in-service provided by the DON on [DATE]; 3. All licensed nurses will be in-serviced on the facility protocols of completing assessments, documenting, reporting to DON/designee, and physician by [DATE]. 4. A change of condition form will be completed in PCC (e chart) reflecting change in the resident. 5. The DON/ designee will monitor change of conditions daily and follow-up for completion with interventions. Nurses will be in-serviced on notification to the physician, DON, and responsible party. Notification 6. licensed nurses will be in-serviced on facility protocol for notifying physician be

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

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F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) [DATE]; 7. MD and DON will be notified of any changes of condition, new admit, and other concerns, as soon as possible. DON/ designee will review the 24-hour report and discuss in morning clinical meeting and change of conditions for follow up. All issues of any of the above will be addressed monthly in QAPI. Quality assurance measures The administrator of the facility held ADHOC QAPI committee meeting on [DATE] at 2p.m. with the MD to discuss POR. Discussion included steps taken to re-educate staff on assessing, documenting, and follow-up; physician notification of change of condition; and CPR-regarding code statues and when to initiate CPR. On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: During interviews with 15 staff (DON, Administrator, 1 RN, 5 LVNs, 2 MAs, and 5 CNAs,) they were able to appropriately define full code status and DNR status, identify the location of the resident code status, provided the procedure for a resident found unresponsive with no vital signs that was a full code, provided a procedure for change of condition, accurately assess/ document/ and report a significant change of condition. Chart reviews were completed and reflected code status. Resident care plans included their code status. The crash cart was observed to have a list of all residents' names in alphabetical order with current code statuses. On [DATE] at 4:55p.m., the administrator and DON was informed the IJ was removed; however, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.
F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure cardiopulmonary resuscitation (CPR) was provided in accordance with professional standards of practice for 1 of 4 residents reviewed for CPR. (Resident # 1) The facility did not provide CPR and call 911 for Resident #1 who was a full code (wanted all possible life saving measures in the event his heart or breathing stopped) when LVN C found the resident without vital signs, she did not verify his code status. Resident #1 expired in the facility. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a potential for more than minimal harm with a scope identified as a isolated due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents who are a full code status at risk of death. Findings included: A face sheet dated [DATE] indicated Resident #1 was [AGE] years old, admitted on [DATE], and had [DIAGNOSES REDACTED]. Physician orders [REDACTED].#1 was a full code and had oxygen at 2 LPM via nasal cannula every 1 hour as needed. A care plan initiated [DATE] indicated Resident #1 had a full code status, interventions included: if the resident had a [MEDICAL CONDITION], initiate CPR and call 911, notify the MD/RP and follow MD orders after notification, and mark chart and all pertinent documents with full code. A nursing note dated [DATE] at 12:16 p.m., completed by LVN E indicated she inserted a catheter and noted yellow urine drainage. Resident #1 had slow respirations alternating with rapid respirations, the NP assessed the resident and was aware of respiratory status. PRN oxygen applied and oxygen at 99 percent with oxygen at 2 liters per nasal cannula. A nursing note dated [DATE] ([DATE]) at 11:40 p.m., completed by LVN C indicated Resident #1's blood pressure was ,[DATE] (Normal blood pressure is less than 120 over 80), pulse was 91(normal pulse ,[DATE] beats per minute), temperature was 98.9 , respirations were 40 breaths a minute (normal ,[DATE] breaths per minute), and oxygen saturation was 90% via nasal cannula (normal ,[DATE]%). The nurse increased the resident's oxygen to 3 liters. The resident was awake but unable to focus and withdrawn, had had generalized [MEDICAL CONDITION] in his bilateral upper extremities, had amber colored urine and was suctioned by previous nurse. LVN C indicated she would continue to monitor for changes. A nursing noted dated [DATE] at 1:10 a.m., completed by LVN C indicated Resident #1 had white frothy secretions in his mouth and no vital signs of life. During an interview on [DATE] at 9:30 a.m. LVN A said on [DATE] between 6:30 p.m. and 6:40 p.m. she checked on Resident #1 with no complications noted. She said between 10:10 p.m. and 10:15 p.m., she peeped into Resident's #1 room and from the door heard Resident #1 had wet abnormal breathing, LVN A said she did not assess the resident because he was not assigned to her, she said she did not immediately notify his nurse of the change of condition, and she did not notify the MD of the residents change of condition. During a telephone interview on [DATE] at 9:38 a.m., LVN B said during report on [DATE] at 6 p.m., LVN E notified her Resident #1 had breathing issues and the NP had seen the resident about the issue. LVN B said after report she went to check on Resident #1 and noted no issues. LVN B said she made another round at 11:30 p.m. and noticed the resident had difficulty breathing. The nurse said she gave the resident a PRN breathing treatment and the resident started coughing up phlegm with difficulty, so she suctioned the resident and he appeared to be breathing better. LVN B said she did not notify the NP or the MD about the abnormal breathing because LVN E said the NP was aware. The [DATE] MAR indicated [REDACTED]. During an interview on [DATE] at 3:56 p.m., LVN B said LVN A never mentioned to her Resident #1 had a change in condition. During a telephone interview on [DATE] at 7:16 a.m., LVN C said on [DATE] she received report from LVN B and made her initial assessment of Resident #1 and noted the he had increased breathing and sounded wet, she said she increased his oxygen to 3 liters. The nurse said she did not notify the MD, or the NP of the residents increased respirations because she was informed the NP was already aware of his condition. LVN C said on her second observation of Resident #1, he was sitting up in bed and had a mouth full of foam. LVN C said she suctioned the resident, she noticed the resident was not breathing. LVN C said she remembered during report LVN B said the resident needed hospice care. She said she assumed the resident was a DNR. She said she did not initiate CPR and did not verify if the resident had a DNR. The nurse said there was no reason to verify his status, because she thought he was a DNR. LVN C said the resident was still warm to touch and his skin was normal in color. During an interview on [DATE] at 5:07 a.m., LVN A said on [DATE] 10 to 15 minutes after she told LVN C the resident had wet and abnormal breathing sounds LVN C told her Resident #1 had coded and died . LVN A said she looked at Resident #1's hard chart and saw the resident was a full code. LVN A said she questioned the full code status and asked LVN C about attempting CPR and was told the resident was dead and CPR would not matter. LVN A said she did not know how to respond to LVN C, she said she questioned herself about whether she should start CPR on her own, but she did not want to over step the other nurses' decisions. During an interview on [DATE] at 7:44 a.m., ADON D said on [DATE] at 1:21 a.m. she received a call from LVN C who notified her Resident #1 had passed away. She said she asked LVN C if the resident was a DNR and she replied, yes. She said LVN C called her a second time at 1:51 a.m. to ask who was going to pronounce the resident due to the resident not being on hospice care. ADON D said she again asked if the Resident # 1 was a DNR and LVN C said she thought he was. ADON D said she asked was CPR performed and LVN C said CPR was not administered. The ADON said she was not aware Resident #1 was a full code until the following day ([DATE]). During an interview on [DATE] at 12:42 p.m., the NP said she nor the MD was notified of Resident #1's change of condition. She said a respiratory rate of 40 was very significant and they (NP/ MD) should have been notified. She said she saw the resident on [DATE]th or 28th for abnormal breathing. The NP said if she was notified of the resident's declined condition she would have sent him to the hospital. She said she expected the nurses to update her on a resident change of condition. The NP said she was concerned the nurse did not think a rapid respiratory rate was not significant. A provider investigation report was not available. 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All licensed nurses will be in-serviced on the facility protocols of completing assessments, documenting, reporting to DON/designee, and physician by [DATE]. 4. A change of condition form will be completed in PCC (e chart) reflecting change in the resident. 5. The DON/ designee will monitor change of conditions daily and follow-up for completion with interventions. Nurses will be in-serviced on notification to the physician, DON, and responsible party. Notification 6. licensed nurses will be in-serviced on facility protocol for notifying physician be [DATE]; 7. MD and DON will be notified of any changes of condition, new admit, and other concerns, as soon as possible. DON/ designee will review the 24-hour report and discuss in morning clinical meeting and change of conditions for follow up. All issues of any of the above will be addressed monthly in QAPI. Quality assurance measures The administrator of the facility held ADHOC QAPI committee meeting on [DATE] at 2p.m. with the MD to discuss POR. Discussion included steps taken

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) to re-educate staff on assessing, documenting, and follow-up; physician notification of change of condition; and CPR-regarding code statues and when to initiate CPR. On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: During interviews with 15 staff (DON, Administrator, 1 RN, 5 LVNs, 2 MAs, and 5 CNAs,) they were able to appropriately define full code status and DNR status, identify the location of the resident code status, provided the procedure for a resident found unresponsive with no vital signs that was a full code, provided a procedure for change of condition, accurately assess/ document/ and report a significant change of condition. Chart reviews were completed and reflected code status. Resident care plans included their code status. The crash cart was observed to have a list of all residents' names in alphabetical order with current code statuses. On [DATE] at 4:55p.m., the administrator and DON was informed the IJ was removed; however, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. A face sheet dated [DATE] indicated Resident #1 was [AGE] years old, admitted on [DATE], and had [DIAGNOSES REDACTED]. Physician orders [REDACTED].#1 was a full code and had oxygen at 2 LPM via nasal cannula every 1 hour as needed. A care plan initiated [DATE] indicated Resident #1 had a full code status, interventions included: if the resident had a [MEDICAL CONDITION], initiate CPR and call 911, notify the MD/RP and follow MD orders after notification, and mark chart and all pertinent documents with full code. 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LVN C indicated she would continue to monitor for changes. A nursing noted dated [DATE] at 1:10 a.m., completed by LVN C indicated Resident #1 had white frothy secretions in his mouth and no vital signs of life. During an interview on [DATE] at 9:30 a.m. LVN A said on [DATE] between 6:30 p.m. and 6:40 p.m. she checked on Resident #1 with no complications noted. She said between 10:10 p.m. and 10:15 p.m., she peeped into Resident's #1 room and from the door heard Resident #1 had wet abnormal breathing, LVN A said she did not assess the resident because he was not assigned to her, she said she did not immediately notify his nurse of the change of condition, and she did not notify the MD of the residents change of condition. During a telephone interview on [DATE] at 9:38 a.m., LVN B said during report on [DATE] at 6 p.m., LVN E notified her Resident #1 had breathing issues and the NP had seen the resident about the issue. LVN B said after report she went to check on Resident #1 and noted no issues. LVN B said she made another round at 11:30 p.m. and noticed the resident had difficulty breathing. The nurse said she gave the resident a PRN breathing treatment and the resident started coughing up phlegm with difficulty, so she suctioned the resident and he appeared to be breathing better. LVN B said she did not notify the NP or the MD about the abnormal breathing because LVN E said the NP was aware. The [DATE] MAR indicated [REDACTED]. During an interview on [DATE] at 3:56 p.m., LVN B said LVN A never mentioned to her Resident #1 had a change in condition. During a telephone interview on [DATE] at 7:16 a.m., LVN C said on [DATE] she received report from LVN B and made her initial assessment of Resident #1 and noted the he had increased breathing and sounded wet, she said she increased his oxygen to 3 liters. The nurse said she did not notify the MD, or the NP of the residents increased respirations because she was informed the NP was already aware of his condition. LVN C said on her second observation of Resident #1, he was sitting up in bed and had a mouth full of foam. LVN C said she suctioned the resident, she noticed the resident was not breathing. LVN C said she remembered during report LVN B said the resident needed hospice care. She said she assumed the resident was a DNR. She said she did not initiate CPR and did not verify if the resident had a DNR. The nurse said there was no reason to verify his status, because she thought he was a DNR. LVN C said the resident was still warm to touch and his skin was normal in color. During an interview on [DATE] at 5:07 a.m., LVN A said on [DATE] 10 to 15 minutes after she told LVN C the resident had wet and abnormal breathing sounds LVN C told her Resident #1 had coded and died . LVN A said she looked at Resident #1's hard chart and saw the resident was a full code. LVN A said she questioned the full code status and asked LVN C about attempting CPR and was told the resident was dead and CPR would not matter. LVN A said she did not know how to respond to LVN C, she said she questioned herself about whether she should start CPR on her own, but she did not want to over step the other nurses decisions. During an interview on [DATE] at 7:44 a.m., ADON D said on [DATE] at 1:21 a.m. she received a call from LVN C who notified her Resident #1 had passed away. She said she asked LVN C if the resident was a DNR and she replied, yes. She said LVN C called her a second time at 1:51 a.m. to ask who was going to pronounce the resident due to the resident not being on hospice care. ADON D said she again asked if the Resident # 1 was a DNR and LVN C said she thought he was. ADON D said she asked was CPR performed and LVN C said CPR was not administered. The ADON said she was not aware Resident #1 was a full code until the following day ([DATE]). During an interview on [DATE] at 12:42 p.m., the NP said she nor the MD was notified of Resident #1's change of condition. She said a respiratory rate of 40 was very significant and they (NP/ MD) should have been notified. She said she saw the resident on [DATE]th or 28th for abnormal breathing. The NP said if she was notified of the resident's declined condition she would have sent him to the hospital. She said she expected the nurses to update her on a resident change of condition. The NP said she was concerned the nurse did not think a rapid respiratory rate was not significant. A provider investigation report was not available. 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All licensed nurses will be in-serviced on the facility protocols of completing assessments, documenting, reporting to DON/designee, and physician by [DATE]. 4. A change of condition form will be completed in PCC (e chart) reflecting change in the resident. 5. The DON/ designee will monitor change of conditions daily and follow-up for completion with interventions. Nurses will be in-serviced on notification to the physician, DON, and responsible party. Notification 6. licensed nurses will be in-serviced on facility protocol for notifying physician be [DATE]; 7. MD and DON will be notified of any changes of condition, new admit, and other concerns, as soon as possible. DON/ designee will review the 24-hour report and discuss in morning clinical meeting and change of conditions for follow up. All issues of any of the above will be addressed monthly in QAPI. Quality assurance measures The administrator of the facility held ADHOC QAPI committee meeting on [DATE] at 2p.m. with the MD to discuss POR. Discussion included steps taken to re-educate staff on assessing, documenting, and follow-up; physician notification of change of condition; and CPR-regarding code statues and when to initiate CPR. On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: During interviews with 15 staff (DON, Administrator, 1 RN, 5 LVNs, 2 MAs, and 5 CNAs,) they were able to appropriately define full code status and DNR status, identify the location of the resident code status, provided the procedure for a resident found unresponsive with no vital signs that was a full code, provided a procedure for change of condition, accurately assess/ document/ and report a significant change of condition. Chart reviews were completed and reflected code status. Resident care plans included their code status. The crash cart was observed to have a list of all residents' names in alphabetical order with current code statuses. On [DATE] at 4:55p.m., the administrator and DON was informed the IJ was removed; however, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.
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 observation, interview, and record review, the facility failed to ensure treatment and care was provided in

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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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) accordance with professional standards of practice, the comprehensive person-centered care plan, and choices for 1 of 5 residents reviewed for change of condition. (Resident # 1) LVN A, LVN B and LVN C did not provide interventions to address a significant change of condition for Resident #1. Resident #1 had abnormal breathing sounds that were wet (a rapid onset of [MEDICAL CONDITION] caused by the inability of the lungs to perform normal gas exchange), a respiratory rate of 40 (normal respirations ,[DATE]), and a decreased oxygen saturation level of 90% (normal blood oxygen level ,[DATE]%) while on 2 liters of oxygen, Resident #1 was found dead in his room approximately an hour and a half later. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: A face sheet dated [DATE] indicated Resident #1 was [AGE] years old, admitted on [DATE], and had [DIAGNOSES REDACTED]. Physician orders [REDACTED].#1 was a full code and had oxygen at 2 LPM via nasal cannula every 1 hour as needed. A care plan initiated [DATE] indicated Resident #1 had a full code status, interventions included: if the resident had a [MEDICAL CONDITION], initiate CPR and call 911, notify the MD/RP and follow MD orders after notification, and mark chart and all pertinent documents with full code. A nursing note dated [DATE] at 12:16 p.m., completed by LVN E indicated she inserted a catheter and noted yellow urine drainage. Resident #1 had slow respirations alternating with rapid respirations, the NP assessed the resident and was aware of respiratory status. PRN oxygen applied and oxygen at 99 percent with oxygen at 2 liters per nasal cannula. A nursing note dated [DATE] ([DATE]) at 11:40 p.m., completed by LVN C indicated Resident #1's blood pressure was ,[DATE] (Normal blood pressure is less than 120 over 80), pulse was 91(normal pulse ,[DATE] beats per minute), temperature was 98.9 , respirations were 40 breaths a minute (normal ,[DATE] breaths per minute), and oxygen saturation was 90% via nasal cannula (normal ,[DATE]%). The nurse increased the resident's oxygen to 3 liters. The resident was awake but unable to focus and withdrawn, had had generalized [MEDICAL CONDITION] in his bilateral upper extremities, had amber colored urine and was suctioned by previous nurse. LVN C indicated she would continue to monitor for changes. A nursing noted dated [DATE] at 1:10 a.m., completed by LVN C indicated Resident #1 had white frothy secretions in his mouth and no vital signs of life. During an interview on [DATE] at 9:30 a.m. LVN A said on [DATE] between 6:30 p.m. and 6:40 p.m. she checked on Resident #1 with no complications noted. She said between 10:10 p.m. and 10:15 p.m., she peeped into Resident's #1 room and from the door heard Resident #1 had wet abnormal breathing, LVN A said she did not assess the resident because he was not assigned to her, she said she did not immediately notify his nurse of the change of condition, and she did not notify the MD of the residents change of condition. During a telephone interview on [DATE] at 9:38 a.m., LVN B said during report on [DATE] at 6 p.m., LVN E notified her Resident #1 had breathing issues and the NP had seen the resident about the issue. LVN B said after report she went to check on Resident #1 and noted no issues. LVN B said she made another round at 11:30 p.m. and noticed the resident had difficulty breathing. The nurse said she gave the resident a PRN breathing treatment and the resident started coughing up phlegm with difficulty, so she suctioned the resident and he appeared to be breathing better. LVN B said she did not notify the NP or the MD about the abnormal breathing because LVN E said the NP was aware. The [DATE] MAR indicated [REDACTED]. During an interview on [DATE] at 3:56 p.m., LVN B said LVN A never mentioned to her Resident #1 had a change in condition. During a telephone interview on [DATE] at 7:16 a.m., LVN C said on [DATE] she received report from LVN B and made her initial assessment of Resident #1 and noted the he had increased breathing and sounded wet, she said she increased his oxygen to 3 liters. The nurse said she did not notify the MD, or the NP of the residents increased respirations because she was informed the NP was already aware of his condition. LVN C said on her second observation of Resident #1, he was sitting up in bed and had a mouth full of foam. LVN C said she suctioned the resident, she noticed the resident was not breathing. LVN C said she remembered during report LVN B said the resident needed hospice care. She said she assumed the resident was a DNR. She said she did not initiate CPR and did not verify if the resident had a DNR. The nurse said there was no reason to verify his status, because she thought he was a DNR. LVN C said the resident was still warm to touch and his skin was normal in color. During an interview on [DATE] at 5:07 a.m., LVN A said on [DATE] 10 to 15 minutes after she told LVN C the resident had wet and abnormal breathing sounds LVN C told her Resident #1 had coded and died . LVN A said she looked at Resident #1's hard chart and saw the resident was a full code. LVN A said she questioned the full code status and asked LVN C about attempting CPR and was told the resident was dead and CPR would not matter. LVN A said she did not know how to respond to LVN C, she said she questioned herself about whether she should start CPR on her own, but she did not want to over step the other nurses' decisions. During an interview on [DATE] at 7:44 a.m., ADON D said on [DATE] at 1:21 a.m. she received a call from LVN C who notified her Resident #1 had passed away. She said she asked LVN C if the resident was a DNR and she replied, yes. She said LVN C called her a second time at 1:51 a.m. to ask who was going to pronounce the resident due to the resident not being on hospice care. ADON D said she again asked if the Resident # 1 was a DNR and LVN C said she thought he was. ADON D said she asked was CPR performed and LVN C said CPR was not administered. The ADON said she was not aware Resident #1 was a full code until the following day ([DATE]). During an interview on [DATE] at 12:42 p.m., the NP said she nor the MD was notified of Resident #1's change of condition. She said a respiratory rate of 40 was very significant and they (NP/ MD) should have been notified. She said she saw the resident on [DATE]th or 28th for abnormal breathing. The NP said if she was notified of the resident's declined condition she would have sent him to the hospital. She said she expected the nurses to update her on a resident change of condition. The NP said she was concerned the nurse did not think a rapid respiratory rate was not significant. A provider investigation report was not available. An undated Change of Condition protocol indicated when you have a resident with a change of condition you must: complete a full assessment of the resident, document the assessment findings in PCC, notify the physician, DON, and RP of the residents change of condition, complete the change of condition form in PCC, carry out any orders the physician gives ., and follow up with the Don, Physician and RP. The administrator and DON were notified on [DATE] 12:44p.m., that an IJ situation was identified due to the above failure. The administrator was provided the IJ template on [DATE] at 12:43 p.m. The facility's Plan of Removal was accepted on [DATE] 4:47p.m., and included the following interventions: 1.LVN C was suspended on [DATE] and terminated on [DATE]; 2.LVN A was suspended on [DATE] have been removed from duties until ,[DATE] in-service provided by the DON on [DATE]; 3. All licensed nurses will be in-serviced on the facility protocols of completing assessments, documenting, reporting to DON/designee, and physician by [DATE]. 4. A change of condition form will be completed in PCC (e chart) reflecting change in the resident. 5. The DON/ designee will monitor change of conditions daily and follow-up for completion with interventions. Nurses will be in-serviced on notification to the physician, DON, and responsible party. Notification 6. licensed nurses will be in-serviced on facility protocol for notifying physician be [DATE]; 7. MD and DON will be notified of any changes of condition, new admit, and other concerns, as soon as possible. DON/ designee will review the 24-hour report and discuss in morning clinical meeting and change of conditions for follow up. All issues of any of the above will be addressed monthly in QAPI. Quality assurance measures The administrator of the facility held ADHOC QAPI committee meeting on [DATE] at 2p.m. with the MD to discuss POR. Discussion included steps taken to re-educate staff on assessing, documenting, and follow-up; physician notification of change of condition; and CPR-regarding code statues and when to initiate CPR. On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: During interviews with 15 staff (DON, Administrator, 1 RN, 5 LVNs, 2 MAs, and 5 CNAs,) they were able to appropriately define full code status and DNR status, identify the location of the resident code status, provided the procedure for a resident found unresponsive with no vital signs that was a full code, provided a procedure for change of condition, accurately assess/ document/ and report a significant change of condition. Chart reviews were completed and reflected code status. Resident care plans included their code status. The crash cart was observed to have a list of all residents' names in alphabetical order with current code statuses. On [DATE] at 4:55p.m., the administrator and DON was informed the IJ was removed; however, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.