STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675700	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKSHIRE RESIDENCE AND REHABILITATION CENTER	710 HWY 359 S BROOKSHIRE, TX 77423

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 observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one of 13 residents (Resident #1) reviewed for quality of care. The facility failed to accurately assess Resident #1 and failed to continue monitoring Resident #1 after a change in his condition was identified. The facility failed to identify and communicate Resident #1's deteriorating change in condition (fever, vomiting, elevated heart rate) to his physician/NP for properly intervention. The facility failed to call 911 for prompt transportation/ intervention for Resident #1 instead requested E[CONDITION] ambulance which took longer time to transfer the resident to the ER. Resident #1 was diagnosed with [REDACTED]. Resident #1 died at the hospital. An Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on [DATE]. While the IJ was lowered on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility continued to train staff and monitor the effectiveness of the Plan of Removal. These failures could affected all residents who experienced a change in condition. Findings include: Resident #1 Record review of Resident #1's face-sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. He was diagnosed with [REDACTED]. He was discharged from the facility on [DATE] when he was transferred to a local hospital where he passed away. Record review of Resident #1's Minimum Data Set (MDS), dated [DATE] revealed he had a BI[CONDITION] score of 10 indicating moderate cognitive impairment, he required extensive one-staff assistance with bed mobility, dressing, toilet use, and personal hygiene, extensive two-staff assistance with transferring, set-up assistance and supervision with eating and locomotion via wheelchair, he was always incontinent of bladder and frequently incontinent of bowel, he received scheduled and was at least offered PRN pain medication within the previous five days of the assessment, felt pain frequently, and he did not have any wounds at the time of the assessment. Record review of Resident #1's care plan, updated [DATE] revealed he had impaired circulation due to [MEDICAL CONDITION] (Interventions included: Inspect foot/ankle/calf skin for changes: maceration, redness, purple tinge, blue, rust coloring, weeping, [MEDICAL CONDITION], puffiness, tenderness, areas with no sensation), he was on pain medication ([MED] with [MEDICATION NAME] #3) due to poor circulation/disease process (Interventions included: Administer medications as ordered, For respiratory depression: Monitor respiratory rate, depth, and effort after administration of pain medications, Monitor for altered mental status, anxiety, lack of appetite, nausea, vomiting, pruritis, respiratory distress.Monitor for side effects such as orthostatic [MEDICAL CONDITION] and increased heart rate ([MEDICAL CONDITION] and effectiveness, monitor for and document any [MEDICAL CONDITION], notify doctor and he had scattered bruising to his left leg and discoloration to his toes (Interventions included: Monitor/document location, size and treatment of [REDACTED]. to doctor). Record review of Resident #1's weights and vitals summary from [DATE] through February 16, 2020 revealed the following vital signs: -,[DATE].2020: Pulse 71 bpm (Regular), Respiration 20 breaths/minute. - [DATE]: Pulse 75 bpm (Unable to Determine), Respiration 20 breaths/minute. - [DATE]: Pulse 120 bpm (Irregular - new onset), Respiration 26 breaths/minute, Temperature (1:06 a.m.) 100.7 degrees Fahrenheit (2:22 a.m.) 100.1 degrees Fahrenheit. Further review of the records revealed no other documentation of vital signs for Resident #1 on [DATE] or [DATE]. Observation and interview with Resident #1 on [DATE] at 10:50 a.m. revealed he was alert and oriented and was sitting in a wheelchair in his room. His right leg was amputated above the knee. He did not mention the blister on his left leg or complain of pain at that time. Record review of Resident #1's Progress Notes for [DATE] and February 2020 revealed the following entries: [DATE] - LVN A wrote: Resident was observed with a reddened area/blister on his left calf and that is none tender or painful, Nurse Practitioner (NP) was informed. [DATE] - Wound Care RN wrote: Weekly skin notes: Open blister to left calf noted with moderate amount or serous drainage. His [MEDICAL CONDITION] is decreasing and noted at 2+. Resident is in compliance with elevating left leg throughout the day ad he denies any pain/discomfort. Treatment performed and continues as indicated. [DATE] - Wound Care LVN wrote: Wound rounds noted to left leg calf wound macerated resident states that he had a shower. Wound assessed and noted moderate serous, wound bed 80% necrotic tissues, 20% granulation, surrounding skin reddened. Resident denies pain. NP notified, and new order placed in PCC. [DATE] (9:35 p.m.) - Wound Care RN wrote: During scheduled wound treatment resident's old dressing noted to left posterior calf with 75% saturated serous drainage. The wound bed displayed 100% granulation tissue with the surrounding skin exhibiting mild [DIAGNOSES REDACTED] and 3+ [MEDICAL CONDITION]. He denies any pain/discomfort with light palpation. No tingling, numbness, or changes from his baseline exhibited. [DATE] (6:49 p.m.) - RN C wrote: 24% or less for 2 or more meals in 24 hours. Resident has food at beside and eats throughout the day. [DATE] (1:00 a.m.) - LVN A wrote: [MED] with [MEDICATION NAME] #3 Tablet ,[DATE] MG, Give 1 tablet by mouth every 8 hours as needed for pain. [DATE] (1:38 a.m.) - LVN A wrote: Resident alert and oriented x3, complaining of left leg pain at level ,[DATE], [MED] #3 administered as scheduled with no relief. Started vomiting x3 and had a temperature 100.6. [MED] and [MEDICATION NAME] were administered, with no relief, vital signs BP ,[DATE], Pulse 120, Resp 26. [DATE] (1:40 a.m.) - LVN A wrote: NP ordered [MED] 650mg tab po Q6h for temperature over 100 and [MEDICATION NAME] 4mg x 1 dose for nausea/vomiting, and also to send to hospital if condition worsen. On further assessment noted that patient's lower leg is changing color. Patient sent to local hospital due to increase pain and darkening of lower extremity. Record review of a hand-written nurse's note by LVN A, dated [DATE] revealed At about 10 pm upon nurse's rounds, Resident was noted sitting in his wheelchair watching television. Nurse administered his scheduled medications with no complaints verbalized. At about 12:55 p.m. resident placed a call light and nurse checked on him and it is at that time he complained of left leg pain at a level of ,[DATE]. Resident stated I think I placed my leg on a bed remote control! On assessment noted dressing to left leg on the back intact with no drainage. No redness or skin impairment was noted on the entire left leg at that time. [MED] #3 tab was administered as needed for pain and after 30 minutes a re-assessment was performed, and resident was still complaining of pain of his left leg. Resident was observed vomiting yellowish vomit with food particles mixed at that time. Noted with chills and had a temperature of 100.6 degrees Fahrenheit (temporal) Orders were obtained from NP of [MEDICATION NAME] 4mg tab po start for vomiting and nausea, [MED] 650mg tab po Q6hrs for temperature more. Resident was re-assessed and noted his left leg had started changing color varying from light red to dark red warm and tender on touch. Resident was then sent to a local hospital emergency room for further management at 3:36 a.m. by ambulance. Record review of Resident #1's Wound Reports revealed the following measurements: [DATE] - [DATE] - Blister (start date [DATE]) left lower leg - length: 1.5cm, width: 2cm, depth: .1cm, (Treatment - Med/honey/calcium alginate). [DATE] - [DATE] - Blister (start date [DATE]) left lower leg - length: 1.5cm, width: 2cm, depth: .1 (Treatment - med/honey, calcium alginate). Record review of Resident #1's TAR for February 2020 revealed the following treatments: Left Lower Calf: Cleanse with normal saline/wound cleaner, pat dry followed by skin prep, leave open to air, until resolved.

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.

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Every day shift for blister. Order date: [DATE], Discontinued: [DATE]. Left Lower Calf: Cleanse with normal saline/wound cleaner, pat dry followed by triple antibiotic ointment, cover with dry dressing, until resolved. Every day shift for blister. Order date: [DATE], Discontinued: [DATE] Left Lower Calf: Cleanse with normal saline/wound cleaner, pat dry followed by [MEDICATION NAME]/calcium alginate, cover with dry dressing, until resolved. Every day shift for blister. Order date: [DATE], Discontinued: [DATE]. Left Lower Calf: Cleanse with normal saline/wound cleaner, pat dry followed by [MEDICATION NAME]/calcium alginate, cover with transparent film wound dressing, until resolved. Every day shift for blister. Order date: [DATE]. Record review of Resident #1's MAR for February 2020 revealed he was prescribed: Date of order: [DATE] - [MED] with [MEDICATION NAME] #3 Tablet ,[DATE] MG: Give 1 tablet by mouth every 8 hours as needed for pain (a dose was administered by LVN A on [DATE] at 1:00 a.m. and was documented to be ineffective). Date of Order: [DATE] - [MED] Tablet 325 MG: Give 2 tablets by mouth every six hours as needed for fever more than 100 for three days (a dose was administered by LVN A on [DATE] at 2:22 a.m. for temperature of 100.1). Date of order: [DATE] - [MEDICATION NAME] Tablet 4 MG: Give 1 tablet by mouth one time only for vomiting for 1 Day (a dose was administered by LVN A on [DATE] at 2:20 a.m.). In an interview with Wound Care LVN on [DATE] at 3:25 p.m., she stated Resident #1 had a history of [REDACTED]. He had an open blister on his left calf and self-transferred using a sliding board. She stated his death was heart-breaking for her because she was just kidding around with him the Thursday before he died . She said the blister was intact but had opened maybe two days prior to him asking her to cover it because transferred himself. Wound Care LVN said at that time she saw dark tissue and considered it necrotic. She called the NP who ordered [MEDICATION NAME]. The blister improved after a couple of days to 100% granulation. On Wednesday the previous week, he said he was doing well and was not in any pain. She did wound care that Thursday and he was fine and joking in the hallway. She was told he went out on that weekend with a low-grade fever, vomiting, and [MEDICAL CONDITION](fast heart rate) with leg discoloration. When asked if Wound Care LVN thought those were symptoms of infection, she stated they were not signs of infection but would be an indication of [MEDICAL CONDITION] embolism. She said the last time she saw the wound it was not dark, there was no bruising, and Resident #1, who was alert and oriented, was happy with the progress. In an interview with the DON on [DATE] at 3:45 p.m., she stated she, the Administrator, and ADON had just started working at the facility on [DATE]. She said fever, vomiting, [MEDICAL CONDITION] and a change in wound color were signs and symptoms of infection. In a telephone interview with Wound Care RN on [DATE] at 10:40 a.m., she stated Resident #1's did not know his blister opened. He was ordered to prop his leg up for the [MEDICAL CONDITION], so she said maybe it popped when he put the leg up. On the last day she saw him, his [MEDICAL CONDITION] was at 3, it had deceased but went back up to 3. He was not showing signs of infection and his wound bed looked good with 100% granulation and no pain. When asked if fever, vomiting, [MEDICAL CONDITION] and a change in wound color would indicate infection, Wound Care RN stated it would not indicate infection but would indicate [MEDICAL CONDITION]. In a telephone interview with LVN A on [DATE] at 1:15 p.m., she stated Resident #1 liked to take his evening medications at 10:00 p.m. At 12:00 a.m., the resident put on his call light and complained of leg pain. He said he thought he had pressed it up against the bed remote control. She said she gave him a [MED] #3 and checked with him again after 30 minutes. At that time, he said the pain had gone away a little bit. When she checked on him again at 1:00 a.m., he was still sitting in his chair. He vomited and said he thought it was something he ate. She went back after ,[DATE] minutes and Resident #1 said he was not well because of the nausea. The nurse got an order for [REDACTED]. She took his temperature and it was elevated. She looked at his leg at 2-something and it was changing colors. The nurse called transportation to take the resident to the hospital. Resident #1 asked not to go out because he wanted the NP to go to the facility to see him. She stated the transportation ambulance arrived in 30 minutes and took him to the hospital. The nurse stated the situation was not threatening enough to call 911. She had looked at the leg earlier and it was fine, it was clean, no oozing, and no redness. In an interview with the NP on [DATE] at 2:30 p.m., she stated she had gotten a call in the middle of the night that Resident #1's leg was red and hot to touch. She stated it was automatic to her with those symptoms in addition to a fever, the only solution was to send out to the hospital. She thought it might have been [MEDICAL CONDITION]. The NP said it was the middle of the night, she heard red and hot and said send out. She said it was in the nurse's judgement to call 911 because it depended on what she saw. When asked if the nurse relayed the resident's vital signs, including the [MEDICAL CONDITION] the NP stated she did not hear any of that. She heard red and hot and said send out. The NP said she did not recall if the nurse called her twice or if she ordered [MED] and [MEDICATION NAME]. She said the order must have been prior to the red and hot notification, but she was not saying she did not order the medications. In an interview with the DON on [DATE] at 10:00 a.m., she stated she had reviewed Resident #1's Wound Care notes and thought she could have described the color of the wound instead of using the term necrotic. She thought LVN A's course of action on [DATE] was appropriate because signs of infection were noted by the nurses and they sent the resident out appropriately. Record review of Resident #1's hospital records revealed Pre-Arrival Summary revealed his estimated time of arrival was documented as [DATE] at 5:06 a.m. Emergency Department Triage revealed he was triaged in the hospital's emergency roiagnom on [DATE], at 5:25 a.m. for fever and shortness of breath. His vital signs at that time were: blood pressure (,[DATE]), Pulse (133 bpm - High), Respiratory Rate (30 breaths/minute - High), [MED]gen saturation (90% - low). Emergency Department Assessment revealed the following critical lab values: Critical Result Comment: lactic acid was 6.3 was at 5.34am (which is high and indicates severe infection (sepsis), or shock) and rose to 9.6 at 7:42 a.m. Consultation ([DATE] at signed at 10:38 a.m.) revealed it read in part, .Plan: to operating room for debridement, IV antibiotics.I discussed at length the patient's condition with his family member.I explained that he may not survive this infection however surgery is the only thing that would potentially control the infection. I told the family member he would likely be in the ICU intubated for a week. After our discussion, the family member agrees to proceed with surgery but does not want his leg amputated. Consult Notes ([DATE] signed at 3:45 p.m.) revealed the reason for the consultation was listed as Severe septic shock. The note read in part, .He presented to the emergency room center this morning with right lower extremity [MEDICAL CONDITION]. He was noted to by hypotensive receiving 3 L of IV fluids in the ER. Noted to have severe lactic acidosis. Clinical suspicion for [DIAGNOSES REDACTED] (flesh-eating bacteria infection that results in the death of parts of the body's soft tissue, with severe disease of sudden onset that spreads rapidly.) was high. General surgery was consulted and after discussion with the patient's family member was planning to take him to surgery for [REDACTED]. However, patient continued to deteriorate. He was placed on max pressors with [MEDICATION NAME], and [MEDICATION NAME]. Despite this patient continued to be hemodynamically unstable. Further discussions were held with the resident's family member. We discussed optional courses of care. We talked about going to the operating room however it was extremely unlikely That he would make it there at that time given his hemodynamic instability. We then discussed palliative options and with comfort care and [MEDICATION NAME] extubation. Decision was made to make the patient comfort care which is appropriate in his case. Consultation ([DATE] signed at 3:45 p.m.) revealed the note read in part, Assessment/Plan: 1. Severe septic shock secondary to [DIAGNOSES REDACTED] 2. [MEDICAL CONDITION] of the left lower extremity with likely [DIAGNOSES REDACTED] 3. [MEDICAL CONDITION] with RVR which is likely appropriate given his septic state 4. Metabolic acidosis 5. Coronary Disease 5. [MEDICAL CONDITION] Plan: 1. Discontinue mechanical ventilation 2. Discontinue pressor therapy 3. Comfort care measures have been initiated 4. All of patient's family's questions and concerns have been answered. Disposition: Patient was pronounced dead at [DATE].[MEDICAL CONDITION] with septic shock. Record review of the facility's policy, Quality Of Care, revealed it was not dated. The policy read in part, Our Facility is committed to ensure that the care being provided to our residents is delivered safely.We want to promote effective communication in coordination of their care and effectively prevent and treat their chronic disease processes.Quality in healthcare means providing personal centered care that meets the needs of the resident in an affordable safe manner.Quality of care is a collaborative effort that involves the resident, the Attending Physician/Nurse Practitioner, family and the community as a whole. Record review of facility policy, Risk And Skin Assessment Of A Resident revealed it was not dated. The policy read in part, Our facility will assess all residents for factors that place them at risk for developing pressure injury and for ongoing monitoring of skin integrity. The nurse will complete a risk assessment using the Braden Scale for Predicting Pressure Injury Risk. This is completed on admission, weekly for the first four weeks, quarterly, and with any significant change in condition/cognition or functional ability. The nurse will complete weekly skin assessments for ongoing monitoring of resident's skin.The nurse will obtain appropriate treatment orders from the Attending Physician/Nurse Practitioner and appropriately carry them out. Record review of facility policy, Change in a Resident's Condition revealed it was not dated. The policy read in part, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (changes in level of care, billing/payments, resident rights, etc.). The nurse will notify the resident's Attending Physician and Representative when a change in resident's physical and/or mental medical

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) condition has occurred. Prior to notifying the Physician or healthcare provider, the nurse will make observations and gather pertinent information for the physician, including (for example) information prompted by change of condition. In an interview with the DON on [DATE], at 12:45 p.m., she stated the facility did not have a policy specifically concerning assessments or nursing services. She stated they use the Change in a Resident's Condition policy when referring to development of infection or any change of condition. On [DATE], at 4:15 p.m., the Administrator was notified that an IJ, IT, and SQC had been identified based on the above findings. A copy of the IJ template was provided and a plan to remove the IJ was requested. The final plan of removal was accepted on [DATE] after several revisions were submitted. Plan to remove immediate jeopardy The resident is no longer in the facility and is now deceased . The LVN who took care of the resident was identified and was provided training on the following areas: changes in condition, appropriate intervention, recognizing need to call 911, documentation including the SBAR and completion of transfer form. The LVN was also trained to consult with RN if there is any question related to assessment and to notify the MD/NP of any resident change of condition immediately. The training was provided by the DON (Director of Nursing) on [DATE]. All residents have the potential to be affected by the alleged deficient practice. A facility-wide audit was initiated on [DATE] to ensure changes in condition are identified promptly and appropriate intervention were implemented. The audits are conducted by the DON and ADON. No concern has been identified at this time. The audit was completed on [DATE]. The following policies and procedures were reviewed and revised by on [DATE], by the DON, NHA (Nursing Home Administrator) and Medical Director: Recognizing Change in Condition with Notification to the Practitioner, including following orders for new interventions and determining when to call 911. On [DATE], the DON and ADON (Assistant Director of Nursing) initiated training to the licensed nurses regarding recognizing the change of condition, recognizing change in skin/wound color, signs of infection, monitoring vital signs during acute change in condition and notifying 911 of acute change in condition for transfer to hospital. LVNs will be provided with training to consult RN if they have questions on their assessments. All in-services will be done on [DATE]. Licensed staff will not be allowed to work until they receive the training. CNAs will also be provided with training related to identifying and reporting any changes in conditions to charge nurse, utilizing stop and watch tool. All resident change of condition is discussed and reviewed during morning Clinical meetings and during all shift change clinical reporting, including the weekends. Clinical management team makes daily rounds and will identify resident changes in condition through nursing observation, staff/resident interview and review of 24-hour reports. The nursing supervisors during the weekend will conduct the clinical meetings. Ad-Hoc QAPI meeting was held on [DATE] to review the alleged deficiency and the review of the P&Ps concerning changes of condition and transfers. The medical director was involved with the reviews and plan of removal. All licensed staff will be required to have training before assuming patient care responsibilities. The DON will be responsible to ensure plan is completed by [DATE]. Monitoring: The surveyor monitored the plan to remove the immediate jeopardy as follows: Record review of the facility's policy, Change In A Resident's Condition, revealed it was revised on [DATE]. The document was revised to include the following statement, The nurse will follow the orders and initiate interventions from the Attending Physician/Nurse Practitioner and notify 911 for resident transport to the hospital. In an interview with the DON on [DATE], at 1:55 p.m., she stated she had already started in-services of staff, including the night nurse. The DON said there was no RN on duty that night and LVN A did not consult anyone for assessment, but she would prefer LVN A to not waste time consulting an RN, but she did call the NP for direction. She said LVN A's timeline was off and she attributed the [MEDICAL CONDITION] Resident #1's pain. LVN A told her the resident's pain level did decrease but she did not document it. Another nurse did come over and assist but they did not stay with the resident. They discussed in the in-services how often vitals should be done in that type of situation and it varied but every ,[DATE] minutes was the answer. The DON said it was protocol in the facility prior to the current administration to call a transportation ambulance rather than calling 911. In an interview with RN Manager D on [DATE], at 1:48 p.m., she stated she was the weekend supervisor, but her shift was over by the time the incident occurred. Resident #1 did not have any issues during the day. She stated she had been recently educated on the signs and symptoms of infection, which included fever, temperature above or below a resident's baseline, redness, changes in wound color, heat, nausea, vomiting. They were also educated on recognizing any change in condition, which included anything out of the ordinary for that resident, such as appetite changes, sleep habits, pain, diarrhea, and other symptoms. RN Manager D stated Resident #1's symptoms would have indicated infection/sepsis. She said it is important to know a resident's baseline. Her course of action would have been to call 911. Transport would delay treatment and 911 would have come quicker. She stated she would have called the doctor, take vitals, gave pain medications, and repeat vitals every 15 minutes to look at the trends until E[CONDITION] arrived. She stated all of their shifts have and RN. Based on what the state wants, the nursing board said RN's have to do the assessments but some LVN's do better than some R.N.'s. She stated even RN's needed help in an emergency. In an interview with LVN E on [DATE], at 4:15 p.m., she stated she was not at the facility that weekend. She was recently in-serviced on crisis emergencies. One nurse would enter information in the computer and another nurse should stay with the resident. She said the CNA's relay information to the nurses about the change in condition. They went over signs of infection, including fever, pain, and abnormal vitals. Even before the in-service, she would have recognized those symptoms of infection. She said in an acute incident, check vitals and call 911 straight away, don't wait. They would do vitals every ,[DATE] minutes and document according to times. They would also document resident appearance and changes in vitals. LVN E said LVN's cannot do assessments and have to consult and RN She stated there was an RN on each shift. In an interview with RN F on [DATE], at 4:32 p.m., she stated she was recently in-services on changes in vitals, calling another nurse to stay with the resident, doing vitals every 15 minutes, and knowing baseline. She said of a resident complained of nausea or pain, take vitals. Once they see a change in condition, check vitals every 15 minutes and call the doctor. If there is no answer, they call 911. Signs and symptoms of infection include fever, abnormal vitals like [MEDICAL CONDITION] and if there is a wound, redness, warmth, drainage, smell. bleeding, or any changes. If there [MEDICAL CONDITION], call 911. In an interview with RN G on [DATE], at 4:50 p.m., she stated she was recently in-serviced on signs and symptoms [MEDICAL CONDITION] [MEDICAL CONDITION] fever, changes in blood pressure, warmth, inflammation, nausea, vomiting, and chills. They were informed to call 911 for any emergency that cannot be treated in-house. Vitals should be done every ,[DATE] minutes, and someone should stay with a resident in an emergency at all times. She said RN's should do the assessments because LVN's cannot do them. There was always an RN on duty. They were also in-serviced on assessing wound color and temperature, calling 911, notification to physicians, completing SBAR's and transfer paperwork, timely documentation of vital signs. She stated she knew a lot about the signs and symptoms [MEDICAL CONDITION] but learned about [MEDICAL CONDITION] a symptom and how [MEDICAL CONDITION] could come about. In an interview with CNA H on [DATE], at 5:25 p.m., she stated the CNA's were also in-serviced recently on recognizing and reporting changes in residents' conditions, and the importance in knowing residents' normal behavior. They also talked about skin changes and documenting changes and reporting them to nurses. In an interview with CNA# I on [DATE], at 5:45 p.m., he stated he had recently been in-serviced on changes in resident conditions, stop and watch. The talked about recognizing changes in residents' normal behavior and baselines like pain, eating, nausea, bowel habits and other abnormal things. The CNA's report changes to the nurses and document in the computer. In an interview with RN J on [DATE], at 12:20 a.m., she stated there was always an RN on duty. They were recently in-serviced on giving thorough reports, calling 911 right away and not waiting for transport in emergencies, recognizing changes like abnormal vitals, shortness of breath, signs and symptoms of infection like increase in heart rate, respiratory rate, and fever. They were also educated on notification to NP and documenting vitals every 15 minutes until the ambulance arrived. In an interview with RN Manager K on [DATE], at 12:45 a.m., she stated there was not an RN on duty at all times. On the night Resident #1 went out, there was an LVN manager. She said she was taught in school that RN's were supposed to do assessments but generally, al nurses should assess. If there was anything unusual, the nurse should notify the charge nurse or DON. They were in-serviced on signs and symptoms of infection, including fever, malaise, pain, and warm skin. If there was a wound, they look for drainage, odor, and color changes. They should call the doctor for orders or call 911 not wasting time if they cannot treat in-house. If there was a change in condition, they do vitals and re-check in intervals, looking for trends. They talked about the importance of documenting everything they do. In an interview with LVN L on [DATE], at 11:55 p.m., he stated he was on duty the night Resident #1 went out. He was called over to help by LVN A. He had spoken to the resident earlier during the shift that day and he was fine. He could not recall what time LVN A went to get him for help but she said Resident #1's leg was hurting. LVN A gave him medicine. A short time later, LVN A noted swelling, altered mental status, and vomiting and that was when she called him for help. He knew Resident #1 had a blister on the back of his leg because he was getting treatments. The resident said he thought he laid his leg on something. There was swelling and different stages of discoloration from slightly under the knee and down the leg. Resident #1 was out of it by

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) this time. He helped the resident into bed and cleaned him up. They gave him medication for fever then the fever increased. Chills and vomiting were noted after that. He said he told LVN A to get more vitals and call the NP. He stated he told LVN A it looked like [MEDICAL CONDITION]. LVN A called transport. He left to do something else but went back to check at the end of the shift and LVN A said it took 45 minutes for the ambulance to arrive. She told him ,[DATE] days later she had called transport instead of 911. They were all in-serviced about calling 911 in emergencies. Nurses should do an assessment whenever any changes are identified. If the change is significant, they call 911. The old administration wan
F 0726 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering acuity of the facility residents for one of four nurses (LVN #A) reviewed for competency, in that : LVN A failed to identify Resident #1's change in condition. LVN A failed to consult with an RN for proper assessment of Resident #1 when he experienced a significant change in condition. LVN A failed to communicate all of Resident #1's symptoms to the NP when he experienced a significant change in condition. LVN A failed to call 911 for prompt medical transportation/ intervention for Resident #1 instead requested E[CONDITION] ambulance which took longer time to transfer the resident to the ER. Resident #1 was diagnosed with [REDACTED]. Resident #1 died at the hospital. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was lowered on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility continued to train staff and monitor the effectiveness of the Plan of Removal. These failures could affected all residents who experienced a change in condition. Findings include: Resident #1 Record review of Resident #1's face-sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. He was diagnosed with [REDACTED]. He was discharged from the facility on [DATE] when he was transferred to a local hospital where he passed away. Record review of Resident #1's Minimum Data Set (MDS), dated [DATE] revealed he had a BI[CONDITION] score of 10 indicating moderate cognitive impairment, he required extensive one-staff assistance with bed mobility, dressing, toilet use, and personal hygiene, extensive two-staff assistance with transferring, set-up assistance and supervision with eating and locomotion via wheelchair, he was always incontinent of bladder and frequently incontinent of bowel, he received scheduled and was at least offered PRN pain medication within the previous five days of the assessment, felt pain frequently, and he did not have any wounds at the time of the assessment. Record review of Resident #1's care plan, updated [DATE] revealed he had impaired circulation due to [MEDICAL CONDITION] (Interventions included: Inspect foot/ankle/calf skin for changes: maceration, redness, purple tinge, blue, rust coloring, weeping, [MEDICAL CONDITION], puffiness, tenderness, areas with no sensation), he was on pain medication ([MED] with [MEDICATION NAME] #3) due to poor circulation/disease process (Interventions included: Administer medications as ordered, For respiratory depression: Monitor respiratory rate, depth, and effort after administration of pain medications, Monitor for altered mental status, anxiety, lack of appetite, nausea, vomiting, pruritis, respiratory distress.Monitor for side effects such as orthostatic [MEDICAL CONDITION] and increased heart rate ([MEDICAL CONDITION] and effectiveness, monitor for and document any [MEDICAL CONDITION], notify doctor and he had scattered bruising to his left leg and discoloration to his toes (Interventions included: Monitor/document location, size and treatment of [REDACTED]. to doctor). Record review of Resident #1's weights and vitals summary from [DATE] through February 16, 2020 revealed the following vital signs: -,[DATE].2020: Pulse 71 bpm (Regular), Respiration 20 breaths/minute. - [DATE]: Pulse 75 bpm (Unable to Determine), Respiration 20 breaths/minute. - [DATE]: Pulse 120 bpm (Irregular - new onset), Respiration 26 breaths/minute, Temperature (1:06 a.m.) 100.7 degrees Fahrenheit (2:22 a.m.) 100.1 degrees Fahrenheit. Further review of the records revealed no other documentation of vital signs for Resident #1 on [DATE] or [DATE]. Observation and interview with Resident #1 on [DATE] at 10:50 a.m. revealed he was alert and oriented and was sitting in a wheelchair in his room. His right leg was amputated above the knee. He did not mention the blister on his left leg or complain of pain at that time. Record review of Resident #1's Progress Notes for [DATE] and February 2020 revealed the following entries: [DATE] - LVN A wrote: Resident was observed with a reddened area/blister on his left calf and that is none tender or painful, Nurse Practitioner (NP) was informed. [DATE] - Wound Care RN wrote: Weekly skin notes: Open blister to left calf noted with moderate amount or serous drainage. His [MEDICAL CONDITION] is decreasing and noted at 2+. Resident is in compliance with elevating left leg throughout the day ad he denies any pain/discomfort. Treatment performed and continues as indicated. [DATE] - Wound Care LVN wrote: Wound rounds noted to left leg calf wound macerated resident states that he had a shower. Wound assessed and noted moderate serous, wound bed 80% necrotic tissues, 20% granulation, surrounding skin reddened. Resident denies pain. NP notified, and new order placed in PCC. [DATE] (9:35 p.m.) - Wound Care RN wrote: During scheduled wound treatment resident's old dressing noted to left posterior calf with 75% saturated serous drainage. The wound bed displayed 100% granulation tissue with the surrounding skin exhibiting mild [DIAGNOSES REDACTED] and 3+ [MEDICAL CONDITION]. He denies any pain/discomfort with light palpation. No tingling, numbness, or changes from his baseline exhibited. [DATE] (6:49 p.m.) - RN C wrote: 24% or less for 2 or more meals in 24 hours. Resident has food at beside and eats throughout the day. [DATE] (1:00 a.m.) - LVN A wrote: [MED] with [MEDICATION NAME] #3 Tablet ,[DATE] MG, Give 1 tablet by mouth every 8 hours as needed for pain. [DATE] (1:38 a.m.) - LVN A wrote: Resident alert and oriented x3, complaining of left leg pain at level ,[DATE], [MED] #3 administered as scheduled with no relief. Started vomiting x3 and had a temperature 100.6. [MED] and [MEDICATION NAME] were administered, with no relief, vital signs BP ,[DATE], Pulse 120, Resp 26. [DATE] (1:40 a.m.) - LVN A wrote: NP ordered [MED] 650mg tab po Q6h for temperature over 100 and [MEDICATION NAME] 4mg x 1 dose for nausea/vomiting, and also to send to hospital if condition worsen. On further assessment noted that patient's lower leg is changing color. Patient sent to local hospital due to increase pain and darkening of lower extremity. Record review of a hand-written nurse's note by LVN A, dated [DATE] revealed At about 10 pm upon nurse's rounds, Resident was noted sitting in his wheelchair watching television. Nurse administered his scheduled medications with no complaints verbalized. At about 12:55 p.m. resident placed a call light and nurse checked on him and it is at that time he complained of left leg pain at a level of ,[DATE]. Resident stated I think I placed my leg on a bed remote control! On assessment noted dressing to left leg on the back intact with no drainage. No redness or skin impairment was noted on the entire left leg at that time. [MED] #3 tab was administered as needed for pain and after 30 minutes a re-assessment was performed, and resident was still complaining of pain of his left leg. Resident was observed vomiting yellowish vomit with food particles mixed at that time. Noted with chills and had a temperature of 100.6 degrees Fahrenheit (temporal) Orders were obtained from NP of [MEDICATION NAME] 4mg tab po start for vomiting and nausea, [MED] 650mg tab po Q6hrs for temperature more. Resident was re-assessed and noted his left leg had started changing color varying from light red to dark red warm and tender on touch. Resident was then sent to a local hospital emergency room for further management at 3:36 a.m. by ambulance. Record review of Resident #1's Wound Reports revealed the following measurements: [DATE] - [DATE] - Blister (start date [DATE]) left lower leg - length: 1.5cm, width: 2cm, depth: .1cm, (Treatment - Med/honey/calcium alginate). [DATE] - [DATE] - Blister (start date [DATE]) left lower leg - length: 1.5cm, width: 2cm, depth: .1 (Treatment - med/honey, calcium alginate). Record review of Resident #1's TAR for February 2020 revealed the following treatments: Left Lower Calf: Cleanse with normal saline/wound cleaner, pat dry followed by skin prep, leave open to air, until resolved. Every day shift for blister. Order date: [DATE], Discontinued: [DATE]. Left Lower Calf: Cleanse with normal saline/wound cleaner, pat dry followed by triple antibiotic ointment, cover with dry dressing, until resolved. Every day shift for blister. Order date: [DATE], Discontinued: [DATE] Left Lower Calf: Cleanse with normal saline/wound cleaner, pat dry followed by [MEDICATION NAME]/calcium alginate, cover with dry dressing, until resolved. Every day shift for blister. Order date: [DATE], Discontinued: [DATE]. Left Lower Calf: Cleanse with normal saline/wound cleaner, pat dry followed by [MEDICATION NAME]/calcium alginate, cover with transparent film wound dressing, until resolved. Every day shift for blister. Order date: [DATE]. Record review of Resident #1's MAR for February 2020 revealed he was prescribed: Date of order: [DATE] - [MED] with [MEDICATION NAME] #3 Tablet ,[DATE] MG: Give 1 tablet by mouth every 8 hours as needed for pain (a dose was administered by LVN A on [DATE] at 1:00 a.m. and was documented to be ineffective). Date of Order: [DATE] - [MED] Tablet 325 MG: Give 2 tablets by mouth every six hours as needed for fever more than 100 for three days (a dose was administered by LVN A on [DATE] at 2:22 a.m. for temperature of 100.1). Date of order: [DATE] -

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	675700	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKSHIRE RESIDENCE AND REHABILITATION CENTER	710 HWY 359 S BROOKSHIRE, TX 77423

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F 0726 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) [MEDICATION NAME] Tablet 4 MG: Give 1 tablet by mouth one time only for vomiting for 1 Day (a dose was administered by LVN A on [DATE] at 2:20 a.m.). In an interview with Wound Care LVN on [DATE] at 3:25 p.m., she stated Resident #1 had a history of [REDACTED]. He had an open blister on his left calf and self-transferred using a sliding board. She stated his death was heart-breaking for her because she was just kidding around with him the Thursday before he died . She said the blister was intact but had opened maybe two days prior to him asking her to cover it because transferred himself. Wound Care LVN said at that time she saw dark tissue and considered it necrotic. She called the NP who ordered [MEDICATION NAME]. The blister improved after a couple of days to 100% granulation. On Wednesday the previous week, he said he was doing well and was not in any pain. She did wound care that Thursday and he was fine and joking in the hallway. She was told he went out on that weekend with a low-grade fever, vomiting, and [MEDICAL CONDITION](fast heart rate) with leg discoloration. When asked if Wound Care LVN thought those were symptoms of infection, she stated they were not signs of infection but would be an indication of [MEDICAL CONDITION] embolism. She said the last time she saw the wound it was not dark, there was no bruising, and Resident #1, who was alert and oriented, was happy with the progress. In an interview with the DON on [DATE] at 3:45 p.m., she stated she, the Administrator, and ADON had just started working at the facility on [DATE]. She said fever, vomiting, [MEDICAL CONDITION] and a change in wound color were signs and symptoms of infection. In a telephone interview with Wound Care RN on [DATE] at 10:40 a.m., she stated Resident #1's did not know his blister opened. He was ordered to prop his leg up for the [MEDICAL CONDITION], so she said maybe it popped when he put the leg up. On the last day she saw him, his [MEDICAL CONDITION] was at 3, it had deceased but went back up to 3. He was not showing signs of infection and his wound bed looked good with 100% granulation and no pain. When asked if fever, vomiting, [MEDICAL CONDITION] and a change in wound color would indicate infection, Wound Care RN stated it would not indicate infection but would indicate [MEDICAL CONDITION]. In a telephone interview with LVN A on [DATE] at 1:15 p.m., she stated Resident #1 liked to take his evening medications at 10:00 p.m. At 12:00 a.m., the resident put on his call light and complained of leg pain. He said he thought he had pressed it up against the bed remote control. She said she gave him a [MED] #3 and checked with him again after 30 minutes. At that time, he said the pain had gone away a little bit. When she checked on him again at 1:00 a.m., he was still sitting in his chair. He vomited and said he thought it was something he ate. She went back after ,[DATE] minutes and Resident #1 said he was not well because of the nausea. The nurse got an order for [REDACTED]. She took his temperature and it was elevated. She looked at his leg at 2-something and it was changing colors. The nurse called transportation to take the resident to the hospital. Resident #1 asked not to go out because he wanted the NP to go to the facility to see him. She stated the transportation ambulance arrived in 30 minutes and took him to the hospital. The nurse stated the situation was not threatening enough to call 911. She had looked at the leg earlier and it was fine, it was clean, no oozing, and no redness. In an interview with the NP on [DATE] at 2:30 p.m., she stated she had gotten a call in the middle of the night that Resident #1's leg was red and hot to touch. She stated it was automatic to her with those symptoms in addition to a fever, the only solution was to send out to the hospital. She thought it might have been [MEDICAL CONDITION]. The NP said it was the middle of the night, she heard red and hot and said send out. She said it was in the nurse's judgement to call 911 because it depended on what she saw. When asked if the nurse relayed the resident's vital signs, including the [MEDICAL CONDITION] the NP stated she did not hear any of that. She heard red and hot and said send out. The NP said she did not recall if the nurse called her twice or if she ordered [MED] and [MEDICATION NAME]. She said the order must have been prior to the red and hot notification, but she was not saying she did not order the medications. In an interview with the DON on [DATE] at 10:00 a.m., she stated she had reviewed Resident #1's Wound Care notes and thought she could have described the color of the wound instead of using the term necrotic. She thought LVN A's course of action on [DATE] was appropriate because signs of infection were noted by the nurses and they sent the resident out appropriately. Record review of Resident #1's hospital records revealed Pre-Arrival Summary revealed his estimated time of arrival was documented as [DATE] at 5:06 a.m. Emergency Department Triage revealed he was triaged in the hospital's emergency roiagnom on [DATE], at 5:25 a.m. for fever and shortness of breath. His vital signs at that time were: blood pressure (,[DATE]), Pulse (133 bpm - High), Respiratory Rate (30 breaths/minute - High), [MED]gen saturation (90% - low). Emergency Department Assessment revealed the following critical lab values: Critical Result Comment: lactic acid was 6.3 was at 5.34am (which is high and indicates severe infection (sepsis), or shock) and rose to 9.6 at 7:42 a.m. Consultation ([DATE] at signed at 10:38 a.m.) revealed it read in part, .Plan: to operating room for debridement, IV antibiotics.I discussed at length the patient's condition with his family member.I explained that he may not survive this infection however surgery is the only thing that would potentially control the infection. I told the family member he would likely be in the ICU intubated for a week. After our discussion, the family member agrees to proceed with surgery but does not want his leg amputated. Consult Notes ([DATE] signed at 3:45 p.m.) revealed the reason for the consultation was listed as Severe septic shock. The note read in part, .He presented to the emergency room center this morning with right lower extremity [MEDICAL CONDITION]. He was noted to by hypotensive receiving 3 L of IV fluids in the ER. Noted to have severe lactic acidosis. Clinical suspicion for [DIAGNOSES REDACTED] (flesh-eating bacteria infection that results in the death of parts of the body's soft tissue, with severe disease of sudden onset that spreads rapidly.) was high. General surgery was consulted and after discussion with the patient's family member was planning to take him to surgery for [REDACTED]. However, patient continued to deteriorate. He was placed on max pressors with [MEDICATION NAME], and [MEDICATION NAME]. Despite this patient continued to be hemodynamically unstable. Further discussions were held with the resident's family member. We discussed optional courses of care. We talked about going to the operating room however it was extremely unlikely That he would make it there at that time given his hemodynamic instability. We then discussed palliative options and with comfort care and [MEDICATION NAME] extubation. Decision was made to make the patient comfort care which is appropriate in his case. Consultation ([DATE] signed at 3:45 p.m.) revealed the note read in part, Assessment/Plan: 1. Severe septic shock secondary to [DIAGNOSES REDACTED] 2. [MEDICAL CONDITION] of the left lower extremity with likely [DIAGNOSES REDACTED] 3. [MEDICAL CONDITION] with RVR which is likely appropriate given his septic state 4. Metabolic acidosis 5. Coronary Disease 5. [MEDICAL CONDITION] Plan: 1. Discontinue mechanical ventilation 2. Discontinue pressor therapy 3. Comfort care measures have been initiated 4. All of patient's family's questions and concerns have been answered. Disposition: Patient was pronounced dead at [DATE].[MEDICAL CONDITION] with septic shock. Record review of the facility's policy, Quality Of Care, revealed it was not dated. The policy read in part, Our Facility is committed to ensure that the care being provided to our residents is delivered safely.We want to promote effective communication in coordination of their care and effectively prevent and treat their chronic disease processes.Quality in healthcare means providing personal centered care that meets the needs of the resident in an affordable safe manner.Quality of care is a collaborative effort that involves the resident, the Attending Physician/Nurse Practitioner, family and the community as a whole. Record review of facility policy, Risk And Skin Assessment Of A Resident revealed it was not dated. The policy read in part, Our facility will assess all residents for factors that place them at risk for developing pressure injury and for ongoing monitoring of skin integrity. The nurse will complete a risk assessment using the Braden Scale for Predicting Pressure Injury Risk. This is completed on admission, weekly for the first four weeks, quarterly, and with any significant change in condition/cognition or functional ability. The nurse will complete weekly skin assessments for ongoing monitoring of resident's skin.The nurse will obtain appropriate treatment orders from the Attending Physician/Nurse Practitioner and appropriately carry them out. Record review of facility policy, Change in a Resident's Condition revealed it was not dated. The policy read in part, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (changes in level of care, billing/payments, resident rights, etc.). The nurse will notify the resident's Attending Physician and Representative when a change in resident's physical and/or mental medical condition has occurred. Prior to notifying the Physician or healthcare provider, the nurse will make observations and gather pertinent information for the physician, including (for example) information prompted by change of condition. In an interview with the DON on [DATE], at 12:45 p.m., she stated the facility did not have a policy specifically concerning assessments or nursing services. She stated they use the Change in a Resident's Condition policy when referring to development of infection or any change of condition. On [DATE], at 4:15 p.m., the Administrator was notified that an IJ, IT, and SQC had been identified based on the above findings. A copy of the IJ template was provided and a plan to remove the IJ was requested. The final plan of removal was accepted on [DATE] after several revisions were submitted. Plan to remove immediate jeopardy The resident is no longer in the facility and is now deceased . The LVN who took care of the resident was identified and was provided training on the following areas: changes in condition, appropriate intervention, recognizing need to call 911, documentation including the SBAR and completion of transfer form. The LVN was also trained to consult with RN if there is any question related to assessment and to notify the

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F 0726 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) MD/NP of any resident change of condition immediately. The training was provided by the DON (Director of Nursing) on [DATE]. All residents have the potential to be affected by the alleged deficient practice. A facility-wide audit was initiated on [DATE] to ensure changes in condition are identified promptly and appropriate intervention were implemented. The audits are conducted by the DON and ADON. No concern has been identified at this time. The audit was completed on [DATE]. The following policies and procedures were reviewed and revised by on [DATE], by the DON, NHA (Nursing Home Administrator) and Medical Director: Recognizing Change in Condition with Notification to the Practitioner, including following orders for new interventions and determining when to call 911. On [DATE], the DON and ADON (Assistant Director of Nursing) initiated training to the licensed nurses regarding recognizing the change of condition, recognizing change in skin/wound color, signs of infection, monitoring vital signs during acute change in condition and notifying 911 of acute change in condition for transfer to hospital. LVNs will be provided with training to consult RN if they have questions on their assessments. All in-services will be done on [DATE]. Licensed staff will not be allowed to work until they receive the training. CNAs will also be provided with training related to identifying and reporting any changes in conditions to charge nurse, utilizing stop and watch tool. All resident change of condition is discussed and reviewed during morning Clinical meetings and during all shift change clinical reporting, including the weekends. Clinical management team makes daily rounds and will identify resident changes in condition through nursing observation, staff/resident interview and review of 24-hour reports. The nursing supervisors during the weekend will conduct the clinical meetings. Ad-Hoc QAPI meeting was held on [DATE] to review the alleged deficiency and the review of the P&Ps concerning changes of condition and transfers. The medical director was involved with the reviews and plan of removal. All licensed staff will be required to have training before assuming patient care responsibilities. The DON will be responsible to ensure plan is completed by [DATE]. Monitoring: The surveyor monitored the plan to remove the immediate jeopardy as follows: Record review of the facility's policy, Change In A Resident's Condition, revealed it was revised on [DATE]. The document was revised to include the following statement, The nurse will follow the orders and initiate interventions from the Attending Physician/Nurse Practitioner and notify 911 for resident transport to the hospital. In an interview with the DON on [DATE], at 1:55 p.m., she stated she had already started in-services of staff, including the night nurse. The DON said there was no RN on duty that night and LVN A did not consult anyone for assessment, but she would prefer LVN A to not waste time consulting an RN, but she did call the NP for direction. She said LVN A's timeline was off and she attributed the [MEDICAL CONDITION] Resident #1's pain. LVN A told her the resident's pain level did decrease but she did not document it. Another nurse did come over and assist but they did not stay with the resident. They discussed in the in-services how often vitals should be done in that type of situation and it varied but every ,[DATE] minutes was the answer. The DON said it was protocol in the facility prior to the current administration to call a transportation ambulance rather than calling 911. In an interview with RN Manager D on [DATE], at 1:48 p.m., she stated she was the weekend supervisor, but her shift was over by the time the incident occurred. Resident #1 did not have any issues during the day. She stated she had been recently educated on the signs and symptoms of infection, which included fever, temperature above or below a resident's baseline, redness, changes in wound color, heat, nausea, vomiting. They were also educated on recognizing any change in condition, which included anything out of the ordinary for that resident, such as appetite changes, sleep habits, pain, diarrhea, and other symptoms. RN Manager D stated Resident #1's symptoms would have indicated infection/sepsis. She said it is important to know a resident's baseline. Her course of action would have been to call 911. Transport would delay treatment and 911 would have come quicker. She stated she would have called the doctor, take vitals, gave pain medications, and repeat vitals every 15 minutes to look at the trends until E[CONDITION] arrived. She stated all of their shifts have and RN. Based on what the state wants, the nursing board said RN's have to do the assessments but some LVN's do better than some R.N.'s. She stated even RN's needed help in an emergency. In an interview with LVN E on [DATE], at 4:15 p.m., she stated she was not at the facility that weekend. She was recently in-serviced on crisis emergencies. One nurse would enter information in the computer and another nurse should stay with the resident. She said the CNA's relay information to the nurses about the change in condition. They went over signs of infection, including fever, pain, and abnormal vitals. Even before the in-service, she would have recognized those symptoms of infection. She said in an acute incident, check vitals and call 911 straight away, don't wait. They would do vitals every ,[DATE] minutes and document according to times. They would also document resident appearance and changes in vitals. LVN E said LVN's cannot do assessments and have to consult and RN She stated there was an RN on each shift. In an interview with RN F on [DATE], at 4:32 p.m., she stated she was recently in-services on changes in vitals, calling another nurse to stay with the resident, doing vitals every 15 minutes, and knowing baseline. She said of a resident complained of nausea or pain, take vitals. Once they see a change in condition, check vitals every 15 minutes and call the doctor. If there is no answer, they call 911. Signs and symptoms of infection include fever, abnormal vitals like [MEDICAL CONDITION] and if there is a wound, redness, warmth, drainage, smell. bleeding, or any changes. If there [MEDICAL CONDITION], call 911. In an interview with RN G on [DATE], at 4:50 p.m., she stated she was recently in-serviced on signs and symptoms [MEDICAL CONDITION] [MEDICAL CONDITION] fever, changes in blood pressure, warmth, inflammation, nausea, vomiting, and chills. They were informed to call 911 for any emergency that cannot be treated in-house. Vitals should be done every ,[DATE] minutes, and someone should stay with a resident in an emergency at all times. She said RN's should do the assessments because LVN's cannot do them. There was always an RN on duty. They were also in-serviced on assessing wound color and temperature, calling 911, notification to physicians, completing SBAR's and transfer paperwork, timely documentation of vital signs. She stated she knew a lot about the signs and symptoms [MEDICAL CONDITION] but learned about [MEDICAL CONDITION] a symptom and how [MEDICAL CONDITION] could come about. In an interview with CNA H on [DATE], at 5:25 p.m., she stated the CNA's were also in-serviced recently on recognizing and reporting changes in residents' conditions, and the importance in knowing residents' normal behavior. They also talked about skin changes and documenting changes and reporting them to nurses. In an interview with CNA# I on [DATE], at 5:45 p.m., he stated he had recently been in-serviced on changes in resident conditions, stop and watch. The talked about recognizing changes in residents' normal behavior and baselines like pain, eating, nausea, bowel habits and other abnormal things. The CNA's report changes to the nurses and document in the computer. In an interview with RN J on [DATE], at 12:20 a.m., she stated there was always an RN on duty. They were recently in-serviced on giving thorough reports, calling 911 right away and not waiting for transport in emergencies, recognizing changes like abnormal vitals, shortness of breath, signs and symptoms of infection like increase in heart rate, respiratory rate, and fever. They were also educated on notification to NP and documenting vitals every 15 minutes until the ambulance arrived. In an interview with RN Manager K on [DATE], at 12:45 a.m., she stated there was not an RN on duty at all times. On the night Resident #1 went out, there was an LVN manager. She said she was taught in school that RN's were supposed to do assessments but generally, al nurses should assess. If there was anything unusual, the nurse should notify the charge nurse or DON. They were in-serviced on signs and symptoms of infection, including fever, malaise, pain, and warm skin. If there was a wound, they look for drainage, odor, and color changes. They should call the doctor for orders or call 911 not wasting time if they cannot treat in-house. If there was a change in condition, they do vitals and re-check in intervals, looking for trends. They talked about the importance of documenting everything they do. In an interview with LVN L on [DATE], at 11:55 p.m., he stated he was on duty the night Resident #1 went out. He was called over to help by LVN A. He had spoken to the resident earlier during the shift that day and he was fine. He could not recall what time LVN A went to get him for help but she said Resident #1's leg was hurting. LVN A gave him medicine. A short time later, LVN A noted swelling, altered mental status, and vomiting and that was when she called him for help. He knew Resident #1 had a blister on the back of his leg because he was getting treatments. The resident said he thought he laid his leg on something. There was swelling and different stages of discoloration from slightly under the knee and down the leg. Resident #1 was out of it by this time. He helped the resident into bed and cleaned him up. They gave him medication for fever then the fever increased. Chills and vomiting were noted after that. He said he told LVN A to get more vitals and call the NP. He stated he told LVN A it looked like [MEDICAL CONDITION]. LVN A called transport. He left to do something else but went back to check at the end of the shift and LVN A said it took 45 minutes for the ambulance to arrive. She told him ,[DATE] days later she had called transport instead of 911. They were all in-serviced about calling 911 in emer