STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675329	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEVELLAND NURSING & REHABILITATION CENTER	**210 WEST AVE LEVELLAND, TX 79336**

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** - Minimal harm or potential for actual harm **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 interview, and record review the facility failed to consult with the resident's physician a significant change in the resident's physical, mental or psychosocial status for 1 of 5 residents (Resident #1), reviewed for change in condition notifications made. 1) The facility failed to notify the physician about a change in condition for resident #1. The facility did not implement interventions to prevent the potential failure to report significant changes in the resident's physical, mental or psychological status for the residents. The findings included: During an interview on 8/12/20 at 10:24 AM, LVN # 1 stated she had worked on 10/18/19 for the evening shift and worked with Resident #1. LVN #1 stated she was giving report to LVN #2 when the CNA informed them that the patient was having shortness of breath. LVN #2 went to assess the resident and stated that the residents O2 sats were in the 70%'s. LVN #1 then went to assess the resident and stated that he was having difficulty breathing and didn't look good. The ambulance was called, and the DON was notified via text that the resident was going out via ambulance. LVN #1 stated that she was about to leave for the day, so she did not contact the physician regarding Resident #1's change in status. LVN #1 stated that the DON advised the ambulance to go away and place oxygen on the resident. Resident #1's O2 sats came up to the 90%'s on 4/lpm of oxygen. LVN #1 stated she wasn't sure if the physician was ever contacted regarding this event. During an interview on 8/12/20 at 11:55 AM, DON stated she was notified on 10/18/19 around 11:00 PM by LVN #2 that Resident #1 had some shortness of breath and the O2 sats on room air were in the 70%'s. DON stated that she advised to place oxygen on the resident and his O2 sats came back up. Denies telling LVN #1 and LVN #2 to send the ambulance away that night. Reviewed the SBAR summary on 10/19/19 written by DON revealed Primary Care Clinician Notified: none at 10/19/2019 at 12:00 AM. DON stated that she doesn't remember writing that, but I guess I did. DON stated that she did advise the nurses on shift to call the MD and see what he wanted to do. During an interview on 8/12/20 at 1:58 PM, LVN #2 stated that she recalls the night of 10/18/19 when Resident #1 was having a change of condition. Stated she sent a text message to the physician that night but did not get a call or text back from the physician. Stated the day nurse may have told the physician, but she wasn't sure. During an interview on 8/12/20 at 1:02 PM, MD stated that he has no record of the facility contacting him on 10/18/19 or 10/19/19 regarding a change in status for Resident #1. MD stated that the first notification he had regarding Resident #1's change of status is when he went to the ER from the facility on 10/20/19. Record review of face sheet for Resident #1 documented the following: Resident #1 was admitted to the facility on [DATE] with the following other specified disorders of the male genital organs, abdominal distension,[MEDICAL CONDITION], other abnormalities of gait and mobility, muscle wasting and atrophy, cognitive communication deficit, dysphagia, chronic or unspecified [DIAGNOSES REDACTED] ulcer with perforation, essential hypertension, retention of urine, pure hypercholesteremia, major [MEDICAL CONDITIONS] pectoris, other specified symptoms and signs involving the digestive system and abdomen, abdominal pain and nausea with vomiting. Record review of progress notes for Resident #1 documented the following by LVN #1: Effective date: 10/18/19 at 11:00 PM, CNA came and informed me that patient was having shortness of breath. {LVN #2} went and checked patient and came back and stated that patient O2 Sat was 77%. I went and checked on patient and he was in distress. Ambulance was here. {LVN #2} and I both texted DON that we were sending patient out. We were instructed by DON not to send patient out and to put oxygen on patient. Patient was put on oxygen cylinder. We had to send ambulance away. Record review of progress notes for Resident #1 documented the following by DON: Effective date: 10/19/19 at 5:00 AM SBAR Summary, Vital Signs: BP 101/79 - 10/18/2019 23:14 Position: Lying l/arm, P 105 - 10/18/2019 23:15 Pulse Type: Irregular - new onset, R 28.0 - 10/18/2019 23:15, T 98.7 - 10/18/2019 23:15 Route: Temporal Artery, W 203.6 lb - 10/8/2019 13:27 Scale: O2 77% - 10/18/2019 23:16 Method: Room Air 4 l/m RN Assessment/LPN appearance of resident - What I think is going on the resident is: short of breath when he gets up himself. Additional Nursing Notes as applicable: Family/Health Care Agent Notified: wife did not answer the phone at 10/18/2019 11:45 PM. Primary Care Clinician notified: none at 10/19/2019 12:00 AM. Record review of facility policy Changes in Resident Condition dated April 2005 and Revised February 2017 revealed: The nursing staff, the resident, the attending physician and the resident's legal representative are notified when changes in the resident's condition occur. Communication with the Interdisciplinary Team and caregivers is also important to ensure that consistency and continuity are maintained for the resident's benefit. Guidelines: 1. For life-threatening events, call 911 if initial assessment indicates that such action is necessary. 2. Prompt notification is required when there is an accident involving the resident which results in injury and has the potential for the requiring physician intervention; a significant change in the resident's attending physical, mental, or psychosocial status in either life threatening conditions or clinical complications; or a need to alter treatment significantly. 3. If the attending physician cannot be reached, nursing attempts to contact the following providers in this order until a physician has been contacted: the physician on call, the facility medical director, the division medical director and emergency services

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.