STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675437	A. BUILDING _____ B. WING _____	06/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED REHABILITATION & HEALTHCARE OF LIVE OAK	8221 PALISADES DRIVE LIVE OAK, TX 78233

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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs to meet the needs of each resident for 1 of 3 Residents (Resident #1) reviewed for medications, in that: Resident #1 was administered another resident's medication of Donepezil HCl 10 mg (cognition-enhancing medication) and [MEDICATION NAME] 10 mg (used to treat high cholesterol) due to Resident #1's medication not being available. This deficient practice could place residents who were prescribed Donepezil and [MEDICATION NAME] at risk of medications being unavailable. The findings were: Record review of Resident #1's face sheet, dated 6/11/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 11 which indicated moderate cognitive impairment for daily decision-making skills. Record review of Resident #1's care plan, revised on 3/10/2020, revealed a focus area for cognitive impairment and further decline in cognitive and functional abilities related to pain, altered mental status, [MEDICAL CONDITION] and history of [MEDICAL CONDITION]. Care plan interventions included to administer medication per physician's orders. Record review of Resident #1's June 2020 Order Summary Report, revealed the following orders: -Donepezil HCL Tablet 10 mg, give one tablet by mouth at bedtime for Dementia with an order date of 4/29/2019 and start date of 5/17/2019. -Donepezil HCL Tablet 10 mg, give one tablet by mouth in the morning for [MEDICAL CONDITION] with an order date of 5/12/2020 and start date of 5/13/2020. -[MEDICATION NAME] Tablet 10 mg, give one tablet by mouth at bedtime for [MEDICAL CONDITION] with an order date of 5/12/2020 and start date of 5/12/2020. Record review of Resident #1's MAR for June 2020 revealed Resident #1 was scheduled at 9:00 p.m. to be administered Donepezil HCL, one 10 mg tablet by mouth at bedtime for Dementia and [MEDICATION NAME] one 10 mg tablet by mouth at bedtime for [MEDICAL CONDITION]. The Donepezil HCl and [MEDICATION NAME] were documented as administered on 6/1, 6/2, 6/3, 6/5, 6/6, 6/7, 6/8, 6/9 and documented as not given on 6/10/2020 due to resident refusal. Observation on 6/11/2020 at 1:30 p.m. of Resident #1's medications with CMA B revealed there was no Donepezil HCl 10 mg or [MEDICATION NAME] 10 mg belonging to Resident #1 located in the medication cart. During an interview on 6/11/2020 at 1:37 p.m., CMA B confirmed there was no Donepezil HCl 10 mg or [MEDICATION NAME] 10 mg available on the medication cart or on stock for Resident#1. CMA B stated she did not know why the medications were not available due to the medications being administered on the evening shift. During an interview on 6/11/2020 at 4:50 p.m., CMA A stated Resident #1 had been out of Donepezil HCl and [MEDICATION NAME] for 1-2 weeks and that he borrowed the medications from other residents to administer Resident #1's Donepezil on 6/1, 6/3, 6/8 and 6/9 and [MEDICATION NAME] on 6/3, 6/8 and 6/9. CMA A stated he had informed LVN C that Resident #1 was out of the medications. During an interview on 6/11/2020 at 3:05 p.m., LVN C stated he was not informed Resident #1 was out of Donepezil HCl and [MEDICATION NAME]. LVN C confirmed the duplicate order for Donepezil HCL Tablet 10 mg and stated Resident #1's Donepezil should be given at bedtime and not in the morning. During an interview on 6/11/2020 at 6:34 p.m. the Administrator stated medications should be reordered when they reach a three-day supply and that either the CMA or Nurse can reorder medications. The Administrator stated medications should not be borrowed from other residents. Review of the facility policy, Medication Management, dated 7/3/2015 revealed: Timely delivery of new/re-orders is required so that medication administration is not delayed. If available, the emergency kit is used when the resident needs a medication prior to pharmacy delivery.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain clinical records that were complete and accurate, and in accordance with accepted professional standards and practices, for 1 of 6 residents (Resident #1) whose clinical records were reviewed for complete and accurate clinical records, in that: Resident #1's did not have a documented physician's order to administer [MEDICATION NAME] 650 mg tablet twice a day and had two orders for Donepezil HCL Tablet 10 mg to be given at different times when ordered to give once a day. This deficient practice could place residents at risk for medication errors. The findings were: Record review of Resident #1's face sheet, dated 6/11/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 11 which indicated moderate cognitive impairment for daily decision-making skills. Record review of Resident #1's MAR for June 2020 revealed Donepezil HCL, one 10 mg tablet was scheduled to be administered by mouth at bedtime for Dementia at 9:00 p.m. and was documented as given on 6/1, 6/2, 6/3, 6/5, 6/6, 6/7, 6/8, 6/9. Further review of the MAR indicated [REDACTED]#1's June 2020 Order Summary Report, revealed there was no order for [MEDICATION NAME] 650 mg tablet to be given twice a day and there were two orders for: Donepezil HCL Tablet 10 mg, give one tablet by mouth at bedtime for Dementia with an order date of 4/29/19 and start date of 5/17/19 and Donepezil HCL Tablet 10 mg, give one tablet by mouth in the morning for [MEDICAL CONDITION] with an order date of 5/12/20 and start date of 5/13/20. During an interview on 6/11/2020 at 3:05 p.m., LVN C confirmed there was no order for [MEDICATION NAME] 650 mg tablet to be given twice a day for Resident #1. LVN C further confirmed that Resident #1's consolidated orders contained two orders of Donepezil and stated the medication should be given once a day at bedtime and the order dated 5/12/20 for Donepezil HCL Tablet 10 mg to be given in the morning should have been discontinued. Review of the facility policy, Orders Management, dated 2/10/2020 revealed in part . When a physician order is completed, it is necessary to transcribe or note the information received onto the appropriate forms to ensure care provision. The instructions for care provisions is entered on a physician order for [REDACTED]., Electronic Physician Order system, calendar etc. Physician orders are written and transcribed, noted and discontinued by the Charge Nurse onto the MAR, TAR or other center designated area. .

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.