STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. BUILDING _____ B. WING _____	05/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHEAST NURSING & REHABILITATION CENTER	4302 E SOUTHCROSS BLVD SAN ANTONIO, TX 78222

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior, in 1 of 1 Resident room (Resident #36), in that: Facility staff did not change Resident #36's bed linens for five days. This deficient practice could affect residents residing in the facility and place residents at risk to feelings of dissatisfaction. The findings were: Record review of Resident #36's admission record, dated 4/15/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #36's 5-day scheduled assessment MDS, dated [DATE], revealed the resident had a BIMS score of 15, which indicated the resident had intact cognitive skill for daily decision making, and was totally dependent on assistance for bathing. Record review of Resident #36's care plan, dated 3/24/2020, revealed: ADLs: (Resident #36) requires weight bearing assistance of staff to complete his activities of daily living related to functional limitation secondary to multiple fractures and is at risk for not having his needs met in timely manner. Interventions: Bed Mobility: Extensive Assist, 2 staff. Record review of Flags for No Bath > 5 days, dated 3/18/2020, revealed Resident #36's name listed as not having a bath for more than five days. Record review of the facility's group bathing type chart, dated 4/17/2020, revealed Resident #36 had two bed baths and 46 other documented events which were noted by Regional Nurse Consultant - RN EE. Record review of Bath type detail report, dated 4/17/2020, revealed Resident #36 received a bed bath on 3/6/2020 and 4/16/2020. During an interview on 04/28/2020 at 12:24 PM, Resident #36 stated it had been five days since his bed linens were changed. During an interview on 04/28/2020 at 12:24 PM, CNA HH while at the bedside of Resident #36, confirmed the resident's bed linens were supposed to be changed at every shower and/or bed bath. CNA HH further confirmed Resident #36 did not have a draw sheet on his bed, and stated the resident should ask for his bed linens to be changed if the CNA staff did not offer for them to be changed. Record review of the facility's policy titled, Bathing, dated 02/10/2020, revealed: To cleanse skin, prevent infection and promote circulation 2 times or more weekly or as patient requires. Under the section, Completing the Procedure: 8. Change bed linen.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report the results of investigations in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for 2 of 2 residents (Resident #60 and #76) in that: The facility did not provide the state agency (HHSC) with a Provider Investigation Report within five working days after Residents #60 and #76 were involved in a physical altercation in the facility. This deficient practice could place residents at risk for injury related to neglect. The findings were: Record review of a facility intake, dated 3/15/2020, revealed the facility had notified HHSC that Residents #60 and #76 were involved in a physical altercation. 1. Record review of Resident #60's face sheet, dated 4/30/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #60's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 7, which indicated a severe cognitive impairment. Record review of Resident #60's nursing progress note, dated 3/15/2020 at 2:48 PM, revealed: (Resident #60) was in his room going to the bathroom when Resident #76 came in and a fight broke out. 2. Record review of Resident #76's face sheet, dated 4/30/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #76's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 99, which indicated the resident was unable to complete the assessment. During an interview with the Administrator on 4/9/2020 at 2:46 PM, the Administrator confirmed she had submitted the Provider Investigation Report Form 3613 to HHSC. During an interview with the Regional Director NFA on 4/17/2020 at 11:01 AM, the Regional Director NFA confirmed the facility had not located the Provider Investigation Report relating to Residents #60 and #76. Record review of the facility's Abuse Policy, revised 09/13/2017, revealed: Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility must annually notify covered individuals obligation to comply with the following reporting requirements: a. Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any responsible suspicion of a crime against any individual who is a resident of, or is receiving care from the facility. . e. The report is made to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities). V. Investigation: B. The facility must have evidence that all violation, including allegations, are thoroughly investigation. C. The results of the investigation must be reported to the Administrator and to other officials in accordance with state law (including the State Survey Agency and certification agency) within 5 working days of the incident.
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident when the resident wanted to pay for charges to remain in the facility for 1 of 1 resident (Resident #77) reviewed for transfer and discharge rights, in that: The facility discharged Resident #77 despite the resident's family wanting to pay for charges out of pocket past his allowed respite stay. This deficient practice could place residents residing in the facility for respite stays at risk of not being able to remain at the facility. The findings were: Record review of Resident #77's face sheet, dated 4/20/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review of the face sheet revealed Resident #77 was discharged on [DATE]. Record review of Resident #77's physician orders, dated 3/24/2020, revealed: Admit to facility for 5-day respite. During an interview on 4/20/2020 at 12:25 PM, Business Office Manager MM stated she received a call from Resident #77's hospice case manager who asked if the resident could stay in the facility while the resident's spouse coordinated the necessary paperwork for the resident to become a long-term resident. Business Office Manager MM stated the resident's case manager

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. BUILDING _____ B. WING _____	05/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHEAST NURSING & REHABILITATION CENTER	4302 E SOUTHCROSS BLVD SAN ANTONIO, TX 78222

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) told her Resident #77's family wanted to pay for charges out of pocket until the transition could be completed. Business Office Manager MM stated she asked the Administrator if this was possible and the Administrator stated no. Business Office Manager MM stated the resident was still in the facility and his transport had already been arranged when the resident's spouse contacted Business Office Manager MM and stated she would pay for charges out of pocket if the resident could stay past his scheduled respite stay. Business Office Manager MM further stated she spoke to the Administrator and explained the spouse said they were willing to pay for charges out of pocket until Resident #77's Medicaid coverage could be coordinated. Business Office Manager MM stated the resident would have to be discharged as planned. Business Office Manager MM stated that when residents want to pay out of pocket for stays there were usually no problems, and that as far as she knew there were no reasons why Resident #77 could not have stayed at the facility. An interview was attempted with the former Administrator on 4/20/2020 at 2:23 PM, but the former Administrator did not return the voicemail message. During an interview on 4/20/2020 at 2:57 PM, Social Worker KK stated she was not involved in the discharge process for Resident #77. Social Worker KK stated that for any residents' discharges she was usually involved with discharge planning. Social Worker KK stated she was unaware of any reasons why Resident #77 was not allowed to stay in the facility or if the family was willing to pay out of pocket. Social Worker KK further stated she had never heard of a resident not being allowed to stay at the facility if they or the resident's family was willing to pay out of pocket. During an interview on 4/20/2020 at 3:46 PM, Hospice Social Worker NN stated he assisted Resident #77's family during the resident's stay at the facility. Hospice Social Worker NN stated that on the day of the resident's discharge on 3/27/2020 he contacted facility Business Office Manager MM and stated the resident would like to stay long term and the resident's family would pay out of pocket. Hospice Social Worker NN stated that Business Office Manager MM replied the resident could not stay at the facility and would be discharged as planned. Hospice Social Worker NN stated his call was placed on hold while Business Office Manager MM spoke with the former Administrator. Hospice Social Worker NN stated that Business Office Manager MM came back and stated: No, the resident could not stay. During an interview on 4/22/2020 at 11:28 AM, Regional Consultant M stated she was not sure why Resident #77 was not allowed to stay if the resident's family was willing to pay out of pocket. Regional Consultant M was asked to provide the facility policy for Admission/Transfer/Discharges during this interview. Record review of the facility's policy titled Transfer and Discharge, dated 2/20/2020, revealed: This facility complies with federal regulations to permit each resident to remain in the facility, and not transfer or discharge unless the following criteria is met: 1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; 2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the service provided by the facility; 3. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident; 4. The health of individuals in the facility would otherwise be endangered; 5. Respite residents are discharged based upon the agreed length of stay and plan of care; 6. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility; or 7. The facility ceases to operate.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at 483.10(c)(2) and 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 10 residents (Resident #72) reviewed, in that: Resident #72's care plan did not address a treatment plan for his care of COVID-19 ([MEDICAL CONDITION] infection) [DIAGNOSES REDACTED]. The findings were: Record review of Resident #72's face sheet revealed an admission date of [DATE], and readmission date of [DATE], with [DIAGNOSES REDACTED]. Further review revealed Resident #72's family member was listed as financial contact. Record review of Resident #72's telephone order, dated 04/09/2020, revealed orders for [MEDICATION NAME] daily today then [MEDICATION NAME] once daily for 4 days. Record review of Resident # 72's Quarterly MDS, dated [DATE], revealed the resident understands and was understood. BIMS score of 6 (severely cognitive impaired). Record review of Resident #72's care plan, revised 3/16/20, revealed the resident was at risk for alteration in psychosocial well-being related to possible restriction on visitation due to COVID-19. Further review revealed the resident's care plan did not address care or treatment for [REDACTED]. Record review of Resident #72's telephone order, dated 4/9/2020, revealed orders for [MEDICATION NAME] ([MEDICATION NAME]) 400 mg oral twice daily today then [MEDICATION NAME] 200 mg oral twice daily for 4 days. Record review of Resident # 72's telephone order dated 4/12/2020, revealed orders to hold [MEDICATION NAME] evening dose on 4/12/2020 and administer [MEDICATION NAME] 200 mg once daily on day 4 and 5. Record review of Resident # 72's MAR from April 2020 revealed Resident received 6 doses of [MEDICATION NAME] from 4/10/2020- 4/14/2020 with no consent form for the off-label use. Record review of Resident #72's physician progress notes [REDACTED].#72 was actively declining, had fever, cough, shortness of breath, antibiotics not helping at this time, likely due [MEDICAL CONDITION] infection . Plan to start [MEDICATION NAME] .Vital signs every 6 hours, close monitor, given resident's advanced age, history of cardiac [MEDICAL CONDITION] disease, recent emergency room visit, high risk to deteriorate. Further review revealed talked to patient's (family member), update patient's condition to her, discussed the treatment plan including [MEDICATION NAME], its off-label use for COVID-19, FDA approved for emergency use at this time, the major side effect is QT prolongation, . During an interview on 4/16/20 at 11:34 AM, the Regional Nurse Consultant EE confirmed Resident #72's care plan did not address care or treatment for [REDACTED].#72's care plan did not address the off-label use of [MEDICATION NAME].
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide for a resident who is unable to carry out activities of daily living the necessary services to maintain good personal hygiene for 3 of 3 residents (Residents #57, #36, and #25) reviewed for activities of daily living, in that: 1. Resident #57 had no showers between dates 4/6/2020 - 4/15/2020. 2. Resident # 36 had only two bed baths between dates 3/1/2020 - 4/16/2020. 3. Resident # 25 had three showers between dates 3/1/2020 - 4/16/2020. These deficient practices could affect residents dependent upong care and place residents at risk for feelings of hopelessness and frustration. The findings were: 1. Record review of Resident #57's Face Sheet, dated 9/11/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #57's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 15 out of 15, which indicated the resident's cognitive skills for daily decision making were intact, and the resident required total dependence of one person. Record review of Resident #57's Comprehensive Plan of Care, dated 7/4/2019, revealed the problem area of, Resident has Episodes of Resistance to ADL care as evidenced by: Refuse (sic) shower. During an interview on 4/15/2020 at 4:01 PM, Resident #57 stated showers or baths were, very few and far between. Resident #57 stated the last time she received a shower was the Monday before Easter (4/6/2020). Resident #57 stated she was going to be showered today but was out smoking when they were on her hall. Resident #57 stated she would wipe herself down in the bathroom. During an interview on 4/17/2020 at 11:26 AM, CNA P stated Resident #57 would usually be showered on the 2:00 PM-10:00 PM shift. CNA P stated in the past, Resident #57 would just need stand-by assistance when she showered. CNA P stated Resident #57 had been showered between Easter and 4/15/2020 on the afternoon shift but could not state when. Record review of the Group Bathing Type Chart, dated 4/17/2020, revealed Resident #57 was not showered, bathed, or had received a bed bath from 4/1/2020 to 4/16/2020. During an interview on 4/17/2020 at 1:26 PM, Regional Nurse Consultant EE, after she looked at the Group Bathing Chart for Resident #57, confirmed the chart was from 4/1/2020 to 4/15/2020. When asked if the chart indicated Resident #57 had not received a shower or bed bath during that time period Regional Nurse Consultant EE did not respond. Surveyor asked if there was any other documentation that would show the resident had been bathed/showered. During an interview on 4/18/2020 at 11:25 AM, Regional Nurse Consultant EE confirmed she was not able to find any further documentation from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. BUILDING _____ B. WING _____	05/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHEAST NURSING & REHABILITATION CENTER	4302 E SOUTHCROSS BLVD SAN ANTONIO, TX 78222

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) 4/1/2020 to 4/15/2020 that showed Resident #57 had received a shower, bath, or bed bath. During an interview on 4/21/2020 at 5:19 AM, CNA HH, who was documenting in the care tracker, stated she documents in care tracker if a resident had received a shower of bath. CNA HH stated the bathing Schedule for Resident #57 was on Tuesday-Thursday-Saturday and would be provided by the shower aide. CNA HH stated when there was no shower aide the showers would be divided between the morning shift and evening shift. CNA HH stated that in the past Resident #57 would tell her that she could shower herself and just needed supervision. CNA HH stated she could not remember if Resident #57 had or had not been bathed or showered between 4/6/2020 and 4/15/2020. The CNA stated she was good at documenting in the care tracker if a resident received a bath/shower or bed bath. 2. Record review of Resident #36's admission record, dated 4/15/2020, revealed an admitted d of 3/ with [DIAGNOSES REDACTED]. Record review of Resident #36's 5-day scheduled assessment MDS revealed the resident had a BIMS score of 15, which indicated the resident had intact cognitive skill for daily decision making and was total dependent on bathing. Record review of Resident #36's care plan, dated 3/24/2020, revealed, ADLs: (Resident #36) requires weight bearing assistance of staff to complete his activities of daily living related to functional limitation secondary to multiple fractures and is at risk for not having his needs met in timely manner. Interventions: bathing: 1 staff extensive assist. Provide shower, shave, oral care, and nail care per schedule and when needed. Record review of Flags for Bo Bath > 5 days, dated 3/18/2020, revealed Resident #36's name listed as no bath for more than 5 days. Record review of the facility's Group Bathing Type Chart dated 4/17/2020 revealed Resident #36 had two bed baths and 46 other documented which noted by Regional Nurse Consultant - RN EE, Other: per conversation resident state they were receiving daily face and hand hygiene, from 3/1/2020 to 4/16/2020. Record review of Bath type detail report, dated 4/17/2020, revealed Resident #36 received bed baths on 3/6/2020 and 4/16/2020 from observed date 3/1/2020 to 4/16/2020. During an interview on 4/15/2020 at 5:32 PM, Resident #36 confirmed he did not have a bath for three weeks. Resident #36 further confirmed he had to use the disposable wash cloth to wipe himself. 3. Record review of Resident #25's admission record, dated 4/17/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #25's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 15, which indicated the resident had cognitive skill intact for daily decision making, and bathing coded 8, which indicated activity itself did not occur or family and/or non-family staff provided care 100% of the time for the activity over the entire 7-day period. Record review of Resident #25's care plan, revised 2/6/2020, revealed, ADLs (Resident #25) requires assistance of staff to complete his activities of daily living related to stroke and is at risk for not having his needs in timely manner. Interventions: Personal hygiene: extensive assist of 1 staff. Bathing: activity did not occur during look back period. Provide shower, shave oral care, and nail care, per schedule and when needed. Record review of Flags for Bo Bath > 5 days, dated 2/12/2020, 2/20/20/20, 3/13/2020, 3/17/2020, revealed Resident #25's name listed as no bath more than five days. Record review of the facility's Group Bathing Type Chart dated 4/17//2020, revealed Resident #25 had three showers and 46 other documented which noted by Regional Nurse Consultant - RN EE, Other: per conversation resident state they were receiving daily face and hand hygiene. from 3/1/2020 to 4/16/2020. Record review of Bath type detail report, dated 4/17/2020, revealed Resident #25 received showers on 3/6/2020, 3/18/2020, and 3/23/2020 from observed date 3/1/2020 to 4/16/2020. During an interview on 4/15/2020 at 5:18 PM, Resident #25 confirmed he had to wait for three weeks to get shower. Resident #25 stated staff told him he/she could not assist him with shower because he/she did not have time, or he/she was the only CNA in the hallway. Record review of the facility policy's titled with ADL Care, dated 2/10/2020, revealed, Resident will received essential services for activity of daily living to maintain good nutrition, grooming, and personal and oral hygiene. Process: Resident participate in and receive the following person-centered care. Bathing: include grooming activities such as shaving, and brushing teeth and hair.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was as free of accident hazards as possible and that each resident received adequate supervision to prevent accidents for 2 of 5 halls (Halls A and B), 1 of 2 Residents (Resident #24) whose care was reviewed for transfers, and 1 of 2 Residents (Resident #26) reviewed for smoking, in that: 1. A box of bleach wipes and a bottle of hand sanitizer was left on a bedside table in the Halls A and B. 2. CNAs C and D lifted Resident #24 under the armpits when transferring the resident from a chair to the bed. 3. Resident #26 smoked without supervision when the resident's care plan indicated he was an unsafe smoker. These deficient practices could place residents in the facility who had cognitive impairment, needed transfer assistance, and smoked at risk for injury. The findings were: 1. Observation on 4/18/2020 at 8:30 AM revealed there was a lb. tub of germicidal bleach wipes with a sticker that read, keep out of reach, and a 4-ounce bottle of hand sanitizer that read, keep out of reach of children, on a bedside table in the A Hallway (Secured Unit). Further observation revealed there were no residents or staff members present. During an interview on 4/18/2020 at 9:00 AM, CNA P stated residents on the Secured Unit wandered. CNA P confirmed she had not noticed the germicidal bleach wipes and hand sanitizer on the bedside table, and further confirmed they were not supposed to be left out. During an interview on 4/18/2020 at 9:10 AM, the Regional Nurse Consultant EE confirmed the hand sanitizer and germicidal bleach wipes should have been kept secured in the medication cart. The Regional Nurse Consultant EE stated if a LVN was going to keep the items on a bedside table they should have been within his eyesight. During an interview on 4/18/2020 at 9:22 AM, LVN J confirmed he left the bleach wipes and hand sanitizer on the bedside table unattended in the A Hall (Secured Unit). LVN J further confirmed the items should be kept secured or within eye sight if in use. Observation on 4/19/2020 at 11:31 AM revealed LVN J left Hall B to go to Hall A. Further observation revealed LVN J left a box of bleach wipes and a bottle of hand sanitizer on the bedside table in the hallway - B. During an interview on 4/19/2020 at 11:39 AM, LVN, J confirmed he left the bottle of bleach wipes and hand sanitizer on the bedside table in hallway B before he went to hallway A. Observation on 4/20/2020 at 1:16 PM revealed of a box of bleach wipes and a bottle of hand sanitizer in the hallway A - secured unit without the presence of any residents or staff. Observation on 4/21/2020 at 5:29 AM on Hall A (Secured Unit) revealed on an over bed table was one bottle of hand sanitizer and one plastic canister of Germicidal Bleach Wipes. Further observation revealed the over bed table was in the dining area where the television was located and the height of the table was about 3 to 4 feet from the ground. Further observation revealed there were no residents in the dining area or in the hallway and there was no staff member by the over-bed table. During an interview on 4/21/2020 at 5:31 AM, CNA HH confirmed the sanitizer and bleach wipes were on the over bed table. CNA HH stated when residents were out in the hall, then someone would have to monitor the products on the over bed table. CNA HH stated they did not have sanitizer dispensers mounted on the wall on this hall because the residents could have reached up and dispensed the sanitizer, therefore they had the bottle on the over bed table. 2. Record review of Resident #24's admission record, dated 4//22/2020, revealed an admitted d of 3/4/2020 with [DIAGNOSES REDACTED]. Record review of Resident #24's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 13, which indicated the resident was cognitively intact for daily decision making. Further review revealed Resident #24's functional status needed one-person physical assist for transfer. Record review of Resident #24's care plan, dated 3/24/2020, revealed, (Resident #24) requires assistance from staff to complete his activities of daily living related to functional limitation and cognitive impairment and is at risk for not having his needs met in a timely manner. Interventions: transferring 2 staff extensive assist. Observation on 4/19/2020 at 12:59 PM revealed CNAs C and D transferred Resident #24 from his chair to bed. Further observation revealed CNA C stood on Resident #24's left side and put her arm under Resident #24's left armpit, and CNA D stood on Resident #24's right side and put his arm under Resident #24's right armpit. Then, CNAs C and D lifted Resident #24 up by holding his armpits and pivoting to transfer the resident from the chair to bed. During an interview on 04/19/2020 at 1:01 PM, CNA D confirmed he put his arm under Resident #24's armpit to lift him up and turned to put the resident to bed. During an interview on 04/19/2020 at 1:03 PM, CNA C confirmed she put her arm under Resident #24's armpit to lift him up and turned to transfer the resident from chair to bed. During an interview on 04/19/2020 at 4:37 PM, Regional Director NFA confirmed the CNAs C and D should have transferred Resident #24 by using an assistive device according to the resident's care plan. Record review of the facility's policy titled Transfer Activities, undated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. BUILDING _____ B. WING _____	**05/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHEAST NURSING & REHABILITATION CENTER	**4302 E SOUTHCROSS BLVD SAN ANTONIO, TX 78222**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) revealed: . Transfer from bed to wheelchair (Resident unable to assist) . 7. place yourself with your legs apart and your knees flexed, facing the resident. 8. Grasp the resident around the waist, supporting his/her back. use of a gait belt may be helpful during the transfer. Assist to the standing position by straightening your knees and supporting the resident's knees inside your knees . Transfer dependent resident (two person) from bed to wheel chair: . 5. Help the resident to sit up in bed, keeping legs and feet on the bed. The nursing assistant at the head will reach around the resident, cross resident's arms, and grasp the resident at the wrist area. The other person reaches under resident's knee and thighs. 6. On a count of three, lift and move the resident to the edge of the bed. 7. Adjust you base of support. On a count of three lift the resident into the wheel chair, keeping you back straight and your knees bent. 3. Record review of Resident #57's Face Sheet, dated 9/11/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #26's Face Sheet, dated 4/22/2020 revealed the resident was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Observation on 4/20/2020 at 2:07 PM of walking rounds with ADON JJ and ADON CC, revealed Resident #30 walked up to ADON JJ and asked about the smokers being outside. ADON JJ looked out the window from room [ROOM NUMBER], where the smoking patio could be seen. At this point the surveyor stepped over to the window to also observe. Further observation revealed on the patio were three residents (one female - Resident #57, one male in an electric wheel chair - Resident #26, and one unidentified male resident in manual wheel chair) and there was no employee outside with the residents. The male resident (Resident #26) in the electric wheel chair was smoking a cigarette. During an interview on 4/20/2020 at 2:07 PM, at the same time as the observation, ADON JJ stated someone (an employee) should be out there with the residents, and confirmed he did not see an employee outside with the three residents. At this point ADON JJ stated he was going to tell someone and left the room to notify a staff member to be present with the residents. Observation on 4/20/2020 at 2:14 PM of the smoking patio from the window in room [ROOM NUMBER] revealed the three residents were still out in the smoking patio and Resident #26 was smoking without a staff member present. During an interview on 4/21/2020 at 7:56 AM, Resident #57 stated Resident #26 was in the electric wheel chair yesterday at 1:30 PM when they were outside in the smoking area and she did not know who the other gentleman was that was out there talking to them, but he did not smoke. Resident #57 stated she was under the impression that the staff member who was going to accompany them to smoke was right behind them when they went to the smoking patio. Resident #57 confirmed that she, Resident #26, and another male resident who did not smoke were out there without a staff member present while Resident #26 was smoking. Resident #57 stated it was only about five minutes the residents were out in the smoking area alone. Resident #57 stated, it was wrong for her to go outside without a staff member and would not do it again. Resident #57 stated she has been determined to be a safe smoker and did not need to wear a smoking apron when she smoked. Record review of Resident #57's Comprehensive Plan of Care, dated 8/8/2019, revealed the problem area of, Resident is a Smoker and is at Risk for Injury. Further review revealed under Approach read, Monitor prn (as needed) when smoking to assure residents (sic) safety. Record review of Resident #57's Smoking Evaluation, dated 10/01/2018 and 4/21/2020 revealed the resident was determined to be an Independent Smoker, required no supervision to smoke at facility designated time/location and off premises. Record review of Resident #57's Quarterly MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognitive skills for daily decision making were intact. Record review of Resident #26's Care Plan for Smoking, initiated on 2/7/2017 and revised on 9/25/2019, revealed the resident was, a smoker and is at risk for injury. (Resident #26) is an at risk smoker: he does require the use of a smoking apron, and, (Resident #26) refuses to wear a smoking apron. Further review revealed under Interventions was, Staff to supervise unsafe smokers. Record review of Resident #26's Smoking Evaluations, dated 10/02/2018, 2/21/2019, and 4/21/2020 revealed the resident was an, Independent Smoker: Capable and independent, requires no supervision to smoke at facility designated time/location and off premises. Record review of Resident #26's Quarterly MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognitive skills for daily decision making were intact. Record review of the facility's Smoking Policy, revised 4/24/2018, revealed: To evaluate a patient's ability to participate and exercise the privilege to smoke while residing within the facility. . Procedure . Evaluate patients that smoke utilizing the Smoking Evaluation Tool: (a) upon admission; (b) when a previous non-smoking patient takes up smoking; (c) if unsafe smoking practices are observed in a current smoker; or, (d) when a patient that smokes has a significant change in medical condition. Request therapy screen as indicated. . Education on Smoking Guidelines is provided when: (a) a new patient is identified as a smoker; (b) a previous non-smoking patient takes up smoking; (c) if unsafe smoking habits are observed in a current smoker; or, (d) a patient that smokes has a significant change in medical condition. The education is documented and filed in the patient's clinical record.

F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 interview and record review, the facility failed to provide pharmaceutical services (including procedures for administration of all drugs) to meet the needs of each resident for 4 of 10 residents (Residents #33, #66, #3, and #36) reviewed for medications, in that: Residents #33, #66, #3, and #36 MARs did not reflect the correct dosage of [MEDICATION NAME] ([MEDICATION NAME]) as ordered by the physician for days 2-5 of treatment. This deficient practice could place residents who receive [MEDICATION NAME] ([MEDICATION NAME]) at risk of not receiving a therapeutic effect or being over medicated or under medicated. The findings were: 1. Record review of Resident #33's Face sheet, dated 4/15/2020, revealed the resident was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Further review revealed Resident #33 was diagnosed with [REDACTED]. Record review of Resident #33's telephone order, dated 4/11/2020, revealed an order for [REDACTED].#33's Physician Telephone Order, dated 4/13/2020 revealed an order for [REDACTED].#33's April 2020 MAR indicated [REDACTED]. Further review Resident #33's April 2020 MAR indicated [REDACTED]. The MAR indicated [REDACTED]. During an interview on 4/21/2020 at 7:33 AM, LVN B, after he reviewed looked Resident #33's April 2020 MAR, confirmed the resident's MAR indicated [REDACTED]. LVN B reviewed the order for the [MEDICATION NAME] and the April MAR, which was initialed that the resident had received one dose a day of [MEDICATION NAME] and confirmed the resident had received the medication as prescribed and the order on the MAR indicated [REDACTED]. LVN B looked through the MAR book with the April MARS and stated he could not find the green MAR for Resident #33. 2. Record review of Resident #66's Face Sheet, dated 4/16/2020, revealed the resident was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Further review revealed Resident #66 was diagnosed with [REDACTED]. Record review of Resident #66's Physician Telephone Order, dated 4/12/2020, revealed an order for [REDACTED].#66's Physician Telephone Order, dated 4/13/2020, revealed an order to hold the evening dose of 400 mg [MEDICATION NAME], and to administer [MEDICATION NAME] 200 mg 1 tab by mouth once a day on day 2-5 instead of twice a day as previously ordered. Record review of Resident #66's April 2020 MAR indicated [REDACTED]. Further review of Resident #66's April 2020 MAR indicated [REDACTED]. The MAR indicated [REDACTED]. During an interview on 4/21/2020 at 7:47 AM, LVN JJ, after he reviewed Resident #66's April 2020 MAR for [MEDICATION NAME] 200 mg BID, confirmed the MAR indicated [REDACTED]. LVN JJ looked at the telephone orders for [MEDICATION NAME] and stated the order for 200 mg was initially written for as BID but another telephone order was written later which changed the administration to once a day. LVN JJ stated the H written on the second line for daily administration indicated the medication was held and confirmed Resident #66's MAR indicated [REDACTED]. 3. Record review of Resident #3's admission record, dated 4/16/2020, revealed an admitted [DATE], with re-admitted on 11/23/2019, with [DIAGNOSES REDACTED]., hypertension, ad major [MEDICAL CONDITION]. Record review of Resident #3's paper chart revealed a telephone order, dated 4/10/2020, with the orders of [MEDICATION NAME] 400 mg PO BID one day stat, and [MEDICATION NAME] 200 mg PO BID x 4 days Record review of Resident #3's Licensed Nurse MAR, dated 4/14/2020, revealed there was initial on 4/11/2020 at 0900 (9:00 AM) and 1700 (5:00 PM) for [MEDICATION NAME] tablet 200 mag ([MEDICATION NAME] sulfate) give 400 mg by mouth two times a day for COVID 19 x 1 day. Further review revealed there were initials on 4/12/2020, 4/13/2020, 4/14/2020, and 4/15/2020 at 0900, there were letter X were handwritten on 4/12/2020, 4/13/2020, 4/14/2020, and 4/15/2020 at 1700 for [MEDICATION NAME] tablet 200 mg ([MEDICATION NAME]) give 200 mg by mouth two times a day for 4 days. 4. Record review of Resident #46's Admission Record, dated 4/16/2020, revealed [DIAGNOSES REDACTED]. Record review of Resident #46's paper chart revealed the resident had a telephone order, dated 4/10/2020, of [MEDICATION NAME] 400 mg PO BID on Friday STAT, [MEDICATION NAME] 200

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. BUILDING _____ B. WING _____	**05/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHEAST NURSING & REHABILITATION CENTER	**4302 E SOUTHCROSS BLVD SAN ANTONIO, TX 78222**

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 -** Some	(continued... from page 4) mg PO BID x 4 days, Z-pack as ordered. Hold [MEDICATION NAME] x 5 days STOP [MEDICATION NAME]. Record review of Resident #46's Licensed Nurse MAR, dated 04/11/2020, revealed a note written, Completed doses 4/15/2020 initial on 4/11/2020 at 0900 and 1700 for [MEDICATION NAME] tablet 200 mg ([MEDICATION NAME] sulfates) give 400 mg by mouth two times a day related to COVID 19. Further review revealed there were initials on 4/12/2020, 4/13/2020, 4/14/2020, and 4/15/2020 at 0900, but there were letter X were handwritten on /12/2020, 4/13/2020, 4/14/2020, and 4/15/2020 at 1700 for [MEDICATION NAME] for 200 mg ([MEDICATION NAME]) give 200 mg by mouth two times a day related to COVID 19 for 4 days. During an interview on 4/20/2020 at 12:51 PM, LVN JJ confirmed, after review of Residents #3 and #46's MARs, Residents #3 and #46 received [MEDICATION NAME] 200 mg one time per day from day 2 to day 5 of the therapy. LVN JJ further confirmed Dr. BB reduced the dose of [MEDICATION NAME] 200 mg for Residents #3 and #46 from two times per day to one time per day on day 2 to day 5 of the therapy. During an interview on 4/20/2020 at 1:32 PM, LVN JJ confirmed he could find the orders for reducing [MEDICATION NAME] 200 mg two times per day to one time per day for Resident #3 and Resident #46. Record review of the facility's policy titled Transcribing or Noting and Discontinuing Orders, dated 2/10/2020, revealed: When a physician order [REDACTED]. The instructions for care provision is entered onto a Physician order [REDACTED]. DC (discontinue) the previous medication order on the MAR, enter date and initials.

F 0773 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain laboratory services ordered by a physician for 6 of 10 residents (Residents #33, #66, #7, #72, #16, and #40) whose medical records were reviewed for COVID 19 treatment, in that: 1. Resident #33 did not have an EKG done on day 2 of treatment with [MEDICATION NAME] ([MEDICATION NAME]) as ordered by the physician. 2. Resident #66 did not have a magnesium lab drawn prior to treatment and after treatment with [MEDICATION NAME] as recommended by the facility's COVID-19 Treatment Guidelines. 3. Resident #7 did not have a magnesium lab drawn after treatment with [MEDICATION NAME] as ordered by the physician and during treatment as recommended by the facility's COVID-19 Treatment Guidelines. 4. Resident #72 did not have his Magnesium level drawn as ordered by physician prior to the start of [MEDICATION NAME]. 5. Resident #16 did not have magnesium and CMP - comprehensive metabolic panel drawn after treatment with [MEDICATION NAME] as recommended by facility's COVID-19 treatment guideline. (CMP comprehensive metabolic panel is a test which provides important information about body's chemical balance and metabolism.) 6. Resident #40 did not have Magnesium level drawn prior to the treatment with [MEDICATION NAME] as ordered by the physician prior to the start of [MEDICATION NAME]. These deficient practices could place residents with ordered lab services at-risk of worsening infections, including [MEDICAL CONDITION], cardiovascular events and possibly death. The findings were: 1. Record review of Resident #33's Face sheet, dated 4/15/2020, revealed the resident was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Further review revealed Resident #33 was diagnosed with [REDACTED]. Record review of Resident #33's telephone order, dated 4/11/2020, revealed an order for [REDACTED].#33's Physician Telephone Order, dated 4/13/2020 revealed an order for [REDACTED].#33's April 2020 MAR indicated [REDACTED]. Record review of Resident #33's COVID-19 Positive Care plan, dated 4/1/2020, revealed Approach was, Administer [MEDICATION NAME] COVID-19 medication as ordered, and, Monitor for the following: Loss of consciousness in patients with or without the use of antidiabetic medications, convulsions in patients with a history of [MEDICAL CONDITION], psoriasis may precipitate a severe attack of psoriasis, any change in resident condition, monitor labs as ordered, and contact the physician with any of the above resident changes. Record review of Resident #33's clinical record revealed an EKG was not done on 4/12/20 (day 2 of treatment) as ordered. Record review of Resident #33's Nurse's Progress Note, dated 4/22/2020 revealed, Was noted that the resident had EKGs ordered during the [MEDICATION NAME] (sic) tx (treatment). Upon further review it was noted that resident did not have EKG done on day 2. Action: Call placed to (Dr. BB). Informed of the EKG not being done. Response: (Dr. BB) stated, 'Okay, that's fine. There's nothing that can be done. Treatment has been completed.' No orders received. During an interview on 4/23/2020 at 3:34 PM, LVN CC confirmed an EKG was not done on Resident #33's second day of treatment of [REDACTED]. BB who commented the resident had completed her treatment and there was nothing that could be done now. 2. Record review of Resident #66's Face Sheet, dated 4/16/2020, revealed the resident was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Further review revealed Resident #66 was diagnosed with [REDACTED]. Record review of Resident #66's Physician Telephone Order, dated 4/12/2020, revealed orders for [MEDICATION NAME] 400 mg 1 tab by mouth twice a day for one day, [MEDICATION NAME] 200 mg 1 tab by mouth twice a day on day 2-5; and EKG on day 0, 2, and 5. Further review revealed physician's orders did not include to monitor magnesium level prior to treatment and after treatment per the facility's COVID-19 Treatment Guidelines. Record review of Resident #66's Physician Telephone Order, dated 4/13/2020, revealed an order to hold the evening dose of 400 mg [MEDICATION NAME], and to administer [MEDICATION NAME] 200 mg 1 tab by mouth once a day on day 2-5 instead of twice a day as previously ordered. Record review of Resident #66's April 2020 MAR indicated [REDACTED]. Record review of Resident #66's COVID-19 Positive Care plan, dated 4/2/2020, revealed under Approach was, Administer [MEDICATION NAME] COVID-19 medication as ordered, and, Monitor for the following: Loss of consciousness in patients with or without the use of antidiabetic medications, convulsions in patients with a history of [MEDICAL CONDITION], psoriasis may precipitate a severe attack of psoriasis, any change in resident condition, monitor labs as ordered, and Contact the physician with any of the above resident changes. Record review of Resident #66's clinical record revealed a magnesium level was not obtained prior to treatment or after treatment of [REDACTED].#66's Nurses' Progress Note, dated 4/22/2020 at 18:17 (6:17 PM), revealed, Resident received [MEDICATION NAME] tx (treatment) for COVID. Upon further review of tests ordered. (sic) It was noted that magnesium level was not collected. (Dr. BB) notified of lab not being done. (Dr BB) stated, 'Treatment was been completed and there is nothing that can be done.' No new orders received. During an interview on 4/23/2020 at 3:15 PM, LVN CC confirmed the magnesium lab for Resident #66 was not obtained as ordered when he received [MEDICATION NAME] treatment. LVN CC stated when they were gathering the information for the surveyor on 4/22/2020, it was discovered the magnesium lab result was not obtained as ordered so she notified Dr. BB who commented that the resident had completed his treatment and there was nothing that could be done now. During an interview on 4/25/2020 at 12:47 PM, Regional Nurse Consultant FF confirmed the post-magnesium lab was not ordered by the physician for Resident #66 after he was treated with [MEDICATION NAME]. 3. Record review of Resident #7's Face Sheet, dated 4/16/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review revealed Resident #7 was diagnosed with [REDACTED]. Record review of Resident #7's Physician's Telephone Order, dated 4/11/2020, revealed orders for [MEDICATION NAME] ([MEDICATION NAME]) 400 mg p.o. bid for 1 day, [MEDICATION NAME] 200 mg p.o. bid x 4 days, EKG stat today, EKG Day 2 & 5 with use of [MEDICATION NAME]. Record review of Resident #7's Physician's Telephone Order, dated 4/17/2020, revealed an order for [REDACTED].#7's COVID-19 Positive Care plan, dated 4/2/2020, revealed under Approach was, Administer [MEDICATION NAME] COVID-19 medication as ordered, and, Monitor for the following: Loss of consciousness in patients with or without the use of antidiabetic medications, convulsions in patients with a history of [MEDICAL CONDITION], psoriasis may precipitate a severe attack of psoriasis, any change in resident condition, monitor labs as ordered, and Contact the physician with any of the above resident changes. Further review of Resident #7's clinical record revealed there was no post Magnesium lab obtained and vital signs were not obtained every 6 hours. During an interview on 4/25/2020 at 1:36 PM, Regional Nurse Consultant FF confirmed Resident #7 had an order to have a post-magnesium lab drawn after the resident received [MEDICATION NAME] treatment and confirmed the lab was not obtained. 4. Record review of Resident #72's face sheet revealed an admission date of [DATE], and a readmission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #72's telephone order, dated 4/9/20, revealed orders for EKG today, EKG on 4/10/20, EKG on 4/13/20. CMP and Magnesium today. Record review of Resident #72's MARS for April 2020 revealed Resident #72 received initial dose of [MEDICATION NAME] on 4/10/20 and last dose (day 5) on 4/14/20. Record review of Resident #72's medical records revealed EKG result for 4/9/20 and 4/11/20 and no EKG results found for 4/14/20. Further review revealed no pre-treatment Magnesium level was drawn prior to treatment of [REDACTED]. BB, who stated the following diagnostics and labs are completed for [MEDICATION NAME] treatment: EKG-Pretreatment, Day 2 and Day 5, Magnesium, CMP- Pretreatment, Post-Repeat Magnesium and CBC. During an interview on 4/23/20 at 9:35 AM, the RD NFA confirmed there was no pre-treatment Magnesium level for 4/9/20 and no EKG for 4/14/20, which was day 5 of [MEDICATION NAME] treatment. During an interview on 4/24/20 at 12:52 PM, Dr. BB stated the following diagnostics and labs are completed for [MEDICATION NAME] treatment: EKG-Pretreatment, Day 2 and Day 5, Magnesium, CMP-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. BUILDING _____ B. WING _____	**05/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHEAST NURSING & REHABILITATION CENTER	**4302 E SOUTHCROSS BLVD SAN ANTONIO, TX 78222**

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 0773 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) Pretreatment, Post-Repeat Magnesium, CMP and CBC. During an interview on 4/25/20 at 12:47 PM, Regional Nurse Consultant FF confirmed Resident #72 did not have a pre-treatment Magnesium level drawn as ordered. 5. Record review of Resident #16's admission record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #16's telephone order, dated 4/13/2020, revealed orders, [MEDICATION NAME] 400 mg tablet PO BID x 1 day today; [MEDICATION NAME] 200 mg tablet PO BID day 2-5. Record review of Resident #16's MAR for April 2020 revealed the resident received initial dose of [MEDICATION NAME] 400 mg BID on 4/14/2020, received [MEDICATION NAME] 200 mg BID on 4/15/2020 and 4/16/2020, and received the morning dose of 200 mg [MEDICATION NAME] on 4/17/2020. Record review of Resident #16's clinical record revealed there was no magnesium level and CMP drawn after Resident #16 completed treatment of [REDACTED].#16 did not have an order for [REDACTED]. Record review of Resident #40's admission record revealed an admitted d of 6/13/2018 revealed [DIAGNOSES REDACTED]. Record review of Resident #40's telephone order, dated 4/9/2020, revealed orders, [MEDICATION NAME] 400 mg one tablet BID PO today COVID positive; 4/10/020: [MEDICATION NAME] 200 mg one tablet PO BID x 4 days; Magnesium and CMP today - 4/9/ /13/2020 [MEDICATION NAME] 200 mg QD for 2 remaining days hold night dose 4/13/2020. Record review of Resident #40's April 2020 MAR indicated [REDACTED]. Record review of Resident #40's clinical record revealed there was no magnesium level was drawn on 4/9/2020 prior to [MEDICATION NAME] ([MEDICATION NAME]) treatment as physician ordered. During an interview on 4/25/2020 at 1:14 PM, Regional Nurse Consultant FF confirmed Resident #40 did not have a pre-magnesium lab drawn prior to his administration of [MEDICATION NAME] after she looked in the computer for the lab and confirmed it was not there. Regional Nurse Consultant FF further confirmed Resident #40 had an order for [REDACTED]. 2) Discontinue and avoid all non-critical drugs that interact significantly with [MEDICATION NAME] or [MEDICATION NAME]. 3) Evaluate ALL non-essential medications for discontinuation. 4) Review existing CMP or EKG, if available. 5) Strongly recommend ordering a pre-treatment EKG, CMP, Mg . Monitoring During Treatment: 1) Vital Signs q 6 hours during treatment and for one day after. 2) Daily provider visits, via Telehealth or in person, to monitor patient and to assess treatment efficacy. 3) Strongly recommend repeat EKG on Day 2 and Day 5.

F 0836 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility for 66 of 84 (Residents #1 - #64, #70 and #71) residents reviewed for notifications of their positive COVID-19 status, in that: A. The facility did not prevent 66 residents (Residents #1-#64, #70, and #71) and nine staff members (LVNs B and I, Med Aide A, RN E, and CNAs C, D, H, N, and X) from contracting COVID-19. B. The facility did not prevent six staff members (ADON JJ, Med Aide A, RN E, and LVNs B, F, and J) who were listed on a document provided by the facility that indicated they were exposed to Resident #1 who was positive for COVID-19, from returning to work to provide care for residents. The facility allowed four staff (ADON JJ, LVN F, RN E and Med Aide A) who were pending their COVID-19 test results to continue to work in the facility from 03/28/2020 - 04/06/2020. C. The facility failed to separate residents who were identified as being positive for COVID-19 from the rest of the resident population. These deficient practices could affect all residents and place the residents at risk for mental anguish, COVID-19 infections, and possible death. The findings were: Interviews throughout the duration of the investigation revealed that on 3/26/2020 Texas Health and Human Services (HHSC) received a complaint and self-reported incident which revealed there was one positive resident, Resident #1, who was confirmed to have COVID-19 and one staff member, CNA H, who was identified as being positive for COVID-19. On 3/28/2020 at 10:58 AM, HHSC surveyors were notified of a 2nd resident, Resident #2, who was identified as being positive for COVID-19, and who was at the facility at the time. On 3/30/2020 at 11:31 AM, HHSC surveyors were notified by the Administrator of a 3rd resident, Resident #64, who was identified as being positive for COVID-19, and who was at the facility at the time. At the time of this notification, the Administrator was asked to provide a list of positive staff members. The Administrator stated, There are no staff members who are showing signs and symptoms, but we sent staff who were listed on the medium exposure list to get tested . According to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html, titled Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) with a revision date of 04/15/2020. Defining Risk Exposure: Medium-risk exposures generally include HCP (Health Care Personnel) who had prolonged close contact with patients with COVID-19 who were wearing a facemask while HCP nose and mouth were exposed to material potentially infectious with [MEDICAL CONDITION] causing COVID-19. Some low-risk exposures are considered medium-risk depending on the type of care activity performed. Further review revealed: Low-risk exposures generally refer to brief interactions with patients with COVID-19 or prolonged close contact with patients who were wearing a facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator would further lower the risk of exposure. Further review revealed however, HCP exposures could involve a PUI (Person Under Investigation) who is awaiting testing. Implementation of monitoring and work restrictions described in this guidance could be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. A record of HCP exposed to a PUI should be maintained and HCP should be encouraged to perform self-monitoring while awaiting test results. According to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html, titled: Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance), last revised 4/30/2020. Under the section titled, Return to Work Criteria for HCP with confirmed of suspected COVID-19: Use of the below strategies to determine when HCP may return to work in healthcare settings. 1. Test-based strategy. Exclude from work until: Resolution of fever without the use of fever-reducing medications and Improvement in respiratory symptoms (e.g., cough, shortness of breath), and Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab (a swab of the nasal passageway to test for infectious organisms) specimens collected 24 hours apart (total of two negative specimens). Footnotes: All test results should be final before isolation is ended. Record review of the facility policy titled Abuse Policy, revised on 9/13/2017, revealed under the section titled Policy: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, physical and chemical restraint not required to treat the resident's symptoms, involuntary seclusion and corporal punishment. c. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made. VI. Resident Protection after Alleged Abuse, Neglect and Exploitation - The facility will make efforts to protect all residents after alleged abuse, neglect and/or exploitation. Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. 1. Review/evaluate identify trends in situations in which abuse, neglect or misappropriation, exploitation and mistreatment of [REDACTED]. 2. This includes an analysis of: the deployment of staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned has the knowledge of the individual residents' care needs. A. Record review of Residents #1-#66, #70, and #71 clinical records revealed: 1. Record review of Resident #1's face sheet, dated 4/6/2020, revealed an original admission date of [DATE], with [DIAGNOSES REDACTED]. Record Review of Quarterly MDS, dated [DATE], for Resident #1 revealed a BIMS (staff assessment for cognitive ability) score of 15, which indicated the resident was cognitively intact. Record review of progress notes, dated 3/21/2020, revealed Resident #1 was transferred to an Acute Care Hospital for an elevated temperature of 104.3 and dry cough. Record review of the facility Self-Report, dated 3/26/2020, revealed Resident #1 was diagnosed with [REDACTED]. 2. Record review of Resident #2's face sheet, dated 4/6/2020, revealed an original admitted [DATE], with [DIAGNOSES REDACTED]. Record Review of Annual MDS, dated [DATE], for Resident #2 revealed a BIMS score of 99, was performed on Resident #2 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. BUILDING _____ B. WING _____	05/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHEAST NURSING & REHABILITATION CENTER	4302 E SOUTHCROSS BLVD SAN ANTONIO, TX 78222

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 0836 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) determined had a severely impaired cognitive ability. Record review of progress notes, dated 3/26/2020, revealed Resident #2 was transferred to an acute care hospital on [DATE] for an elevated temperature of 102.1 and coughing. Further review of the nursing progress notes revealed an entry, dated 3/27/2020, which read, received call from hospital emergency room nurse stating that Resident is to return to facility under strict isolation precautions pending Covid Swab results and Blood culture results. CXR (chest x-ray) showing Small RT (right) lower lobe infiltrate. RSV (respiratory [MEDICAL CONDITION]), Flu swabs negative. Current temp 99.5. 02 SATS 98-100 on RA (room air). Active bowel sounds and passing gas. ETA (estimated time of arrival) at 0400. Record review of a nursing progress note for Resident #2, dated 3/27/2020, revealed Notified local health department regarding positive COVID-19 test. A document provided by the Metropolitan Health Department, dated 4/2/2020, revealed Residents #3 - 65, #71 and #72 were identified as being positive for COVID-19. 3. Record review of Resident #3's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 4. Record review of Resident #4's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 5. Record review of Resident #5's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 6. Record review of Resident #6's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 7. Record review of Resident #7's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 8. Record review of Resident #8's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 9. Record review of Resident #9's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 10. Record review of Resident #10's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 11. Record review of Resident #11's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 12. Record review of Resident #12's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 13. Record review of Resident #13's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 14. Record review of Resident #14's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 15. Record review of Resident #15's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 16. Record review of Resident #16's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 17. Record review of Resident #17's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 18. Record review of Resident #18's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 19. Record review of Resident #19's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 20. Record review of Resident #20's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 21. Record review of Resident #21's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 22. Record review of Resident #22's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 23. Record review of Resident #23's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 24. Record review of Resident #24's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 25. Record review of Resident #25's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 26. Record review of Resident #26's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 27. Record review of Resident #27's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. Record review of Resident #28's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 29. Record review of Resident #29's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 30. Record review of Resident #30's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 31. Record review of Resident #31's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 32. Record review of Resident #32's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 33. Record review of Resident #33's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 34. Record review of Resident #34's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 35. Record review of Resident #35's face sheet, dated 4/3/2020, with an original admission date of [DATE] revealed [DIAGNOSES REDACTED]. 36. Record review of Resident #36's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 37. Record review of Resident #37's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 38. Record review of Resident #38's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 39. Record review of Resident #39's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 40. Record review of Resident #40's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 41. Record review of Resident #41's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 42. Record review of Resident #42's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 43. Record review of Resident #43's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 44. Record review of Resident #44's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 45. Record review of Resident #45's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 46. Record review of Resident #46's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 47. Record review of Resident #47's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 48. Record review of Resident #48's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 49. Record review of Resident #49's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 50. Record review of Resident #50's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 51. Record review of Resident #51's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 52. Record review of Resident #52's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 53. Record review of Resident #53's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 54. Record review of Resident #54's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 55. Record review of Resident #55's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 56. Record review of Resident #56's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 57. Record review of Resident #57's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 58. Record review of Resident #58's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 59. Record review of Resident #59's face sheet, dated 4/3/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 60. Record review of Resident #60's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 61. Record review of Resident #61's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 62. Record review of Resident #62's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 63. Record review of Resident #63's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 64. Record review of Resident #64's face sheet, dated 4/6/2020, with an original admission date of [DATE], revealed [DIAGNOSES REDACTED]. 65. Record review of Resident #70's face sheet, dated 4/3/2020, with an original admission date of [DATE] revealed [DIAGNOSES REDACTED]. 66. Record review of Resident #71's face sheet, undated, with an original admission date of [DATE] revealed [DIAGNOSES REDACTED]. During an interview on 4/2/2020 at 9:00 AM, CNA K stated she was tested on [DATE] after the facility told her she was exposed to Resident #1. CNA K stated, I don't know how this happened, families weren't allowed into the facility and they have been screening at the door. Record review of the initial staff listing exposure list that the facility identified after Resident #1 was confirmed to be positive for COVID-19 revealed the following: - LVN B had contact with Resident #1 from 3/18/2020 to 3/20/2020. - LVN F had contact with Resident #1 on 3/21/2020. - CNA W had contact with Resident #1 from 3/18/2020 to 3/21/2020. - CNA K had contact with Resident #1 from 3/19/2020 to 3/20/2020. - CNA X had contact with Resident #1 on 3/18/2020. - CNA C had contact with Resident #1 from 3/18/2020 to 3/20/2020. - CNA H had contact with Resident #1 on 3/18/2020. - CNA N had contact with Resident #1 on 3/21/2020. - CNA Y had contact with Resident #1 on 3/21/2020. Staff listed as having low exposure: - LVN J had contact with Resident #1 from 3/18/2020 to 3/20/2020. - LVN I had contact with Resident #1 on 3/18/2020. - ADON JJ had contact with Resident #1 on 3/18/2020. - RN E had contact with Resident #1 on 3/19/2020. - Med Aide A had contact with Resident #1 from 3/18/2020 to 3/20/2020. Record review of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. BUILDING _____ B. WING _____	**05/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHEAST NURSING & REHABILITATION CENTER	**4302 E SOUTHCROSS BLVD SAN ANTONIO, TX 78222**

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 0836 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) facility tracking list received on 4/6/2020 revealed the following staff members were listed as being positive for COVID-19: CNA C, LVN I, LVN B, Med Aide A, CNA H, CNA X, RN E, CNA N, CNA D. B. Resident #1 was sent to the hospital on [DATE] and was confirmed as being positive for COVID-19 on 03/25/2020. Throughout the course of the investigation it was revealed that staff members were allowed to work in the facility without knowing their COVID-19 test results. Facility management did not adhere to CDC guidelines and relied on local health authorities for guidance on allowing staff members to return to work. During a telephone interview on 3/28/2020 at 11:19 AM, the Administrator was asked to send staff sign in sheets which captured their temperatures and the answers to questionnaires regarding signs and symptoms of COVID-19 prior to staff beginning their shift. The Administrator stated she would send the staff sign-in sheets. At the time of the exit the Administrator did not send those staff sign in sheets that included their temperatures and answers to the questionnaire. During an interview on 3/27/2020 at 2:27 PM, the Administrator stated the city Health Department had not arrived at the facility. The Administrator and DON were asked to provide a list of all staff members who signed into work for the last two weeks and the DON stated she would provide that list. That list at the time of exit was not provided by the facility. During a telephone interview on 03/30/2020 at 2:33 PM, LVN B stated he was sent home on 3/26/2020 due to possible exposure to Resident #1. LVN B stated he was tested for COVID-19 on 3/28/2020 and was awaiting his results. An interview was attempted on 3/31/2020 at 8:40 AM with CNA H. A telephone voicemail message was left for CNA H and at the time of the exit, CNA H had not returned any voicemail messages. During an interview on 3/30/2020 at 3:17 PM, LVN I stated she was sent home on 3/26/2020 after possible exposure to Resident #1. LVN I stated she received a COVID-19 test on 3/28/2020. LVN I stated the ADON called her to work on 3/29/2020 for the overnight shift from 10:00 p.m. to 6:00 a.m. LVN I stated she did not feel comfortable working at the facility without knowing her results and did not go to work because she did not know her results. During an interview on 3/30/2020 at 4:21 PM, CNA X stated she was tested on [DATE] for COVID-19. CNA X stated she last worked at the facility on 03/20/2020 and confirmed she assisted CNA H provide perineal care to Resident #1 along with CNA H in the days leading up to Resident #1 being sent to the hospital. CNA X stated at the time of the perineal care Resident #1 was coughing. During an interview on 3/31/2020 at 3:05 PM, ADON JJ stated he was tested for COVID-19 on 3/28/2020. ADON JJ confirmed he has been working at the facility despite not knowing his test results because he was considered a low risk for the initial exposure to Resident #1. ADON JJ stated he was considered low risk because he only dropped something off to Resident #1 in her room prior to her identification of being positive for COVID-19. ADON JJ further stated he had fed Resident #2 in the dining room the week of 3/23/2020 but could not recall the dates. ADON JJ stated he did not wear a mask or PPE while he was feeding Resident #2. ADON JJ stated some of the staff were listed as low and medium risk depending on what kind of care they provided to the resident. ADON JJ stated RN E was listed as a low exposure risk due to her only performing a skin assessment on Resident #1. During an interview on 3/31/2020 at 3:24 PM, LVN J stated he was considered a low risk exposure because he had only provided an Accu-check (blood sugar test meter) for Resident #1 the day before the resident was sent to the hospital on [DATE]. LVN J stated he did not receive a test on the weekend on 3/28/2020. At the time of this interview, LVN J stated he had received a telephone call from a physician who worked at the city health department immediately prior to this interview and the physician conducted a telephone interview and had stated that his exposure to Resident #1 did not warrant a COVID-19 test. An attempted interview was made on 04/01/2020 at 7:03 PM, with LVN F, a telephone voicemail message was left and at the time of the exit, LVN F did not return the telephone calls. During an interview on 4/2/2020 at 9:43 AM, LVN B stated he was tested on Saturday 3/28/2020 and had not worked in 14 days. LVN B stated, the facility told me I could go back today since it has been 14 days since I had last contact with the resident (Resident #1). I am confused about what to do, and I am being told different things. A corporate lady called me from the staff number, but it wasn't the Administrator. I was one of the first staff members contacted. I was given a form to fill out, but it was already filled out and she wanted me to sign the bottom. It basically said I needed to self-quarantine and notify about symptoms. They asked me to return to work today (04/02/2020), and I am scheduled for 10pm-6am shift (overnight). During an interview on 4/2/2020 at 10:30 AM, LVN I stated she had just received her positive results and her last work day was 3/18/2020. LVN I stated she had a cough on 3/19/2020 with maybe a low-grade temp and was told to self-quarantine for seven days from last symptoms. LVN I stated ADON JJ asked her to work on 3/31/2020 and LVN I stated she told ADON JJ she would not work. During an interview on 4/2/2020 at 2:23 PM, CNA C stated she last entered the facility on 3/26/2020 but was told she was exposed to a resident that teste
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 interview and record review, the facility failed to maintain medical records on each resident that were accurate and complete in accordance with accepted professional standards and practices for 1 of 1 residents (Resident #36) reviewed for medical records, in that: The facility did not document on Resident #36's MAR indicated [REDACTED]. The findings were: Record review of Resident #36's admission record, dated 4/15/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #36's 5-day scheduled assessment MDS revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact. Record review of Resident #36's physician orders [REDACTED]. [MEDICATION NAME] 600 mg, give 1 tablet by mouth every 6 hours for pain. 2. [MEDICATION NAME] (an anticoagulant) 30 mg/0.3 ml subcutaneous injection every 12 hours. Record review of Resident #36's MAR for March 2020 revealed there were blank spaces for Resident #36's medication administration for the following: 1. [MEDICATION NAME] 600 mg medication administration at 6:00 p.m. on 03/07/2020, 12:00 a.m. on 03/08/2020, 12:00 a.m. on 03/09/2020, 6:00 a.m. and 12:00 p.m. on 03/10/2020, 12:00 a.m. on 3/11/2020, 12:00 p.m. on 3/17/2020, 12:00 a.m. on 3/19/2020, 12:00 p.m. on 3/20/2020, 12:00 p.m. on 3/21/2020, 12:00 a.m. and 6:00 a.m. on 3/22/2020, 12:00 p.m. on 3/23/2020, 6:00 a.m., 12:00 p.m. and 6:00 p.m. on 3/28/2020, 12:00 p.m. and 6:00 p.m. on 3/29/2020. 2. [MEDICATION NAME] 30 mg did not have entries for the following administration times: 8:00 a.m. on 03/08/2020, 8:00 p.m. on 03/17/2020 -03/21/2020 and 8:00 p.m. on 03/28/2020 and 03/29/2020. Record review of Resident #36's MAR for April 2020 revealed there were blank spaces for Resident #36's medication administration for the following: 1. [MEDICATION NAME] 600 mg medication administration at 12:00 p.m. on 04/26/2020 and 12:00 p.m. on 04/27/2020. 2. [MEDICATION NAME] 30 mg subcutaneous injections at 8:00 p.m. on 04/23/2020, 8:00 a.m. on 04/25/2020, and 8:00 p.m. on 04/27/2020. During an interview on 4/28/2020 at 3:37 p.m., ADON JJ confirmed the nurse or staff did not document on the Medication Administration Record [REDACTED]. Record review of the facility's policy titled Clinical Document Guideline, revised 03/25/2014, revealed: The patients clinical record provides a record of the health status, including observations, measurements, history and prognosis and serves as the primary document describing healthcare services provided to the patient. Procedure: 11. Initials are used to authenticate entries on flow sheets, medication record or treatment records. Documentation on flow sheets, medication and treatment records are completed daily or based on physician orders.