STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675489	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DEVINE HEALTH & REHABILITATION	104 ENTERPRISE AVE DEVINE, TX 78016

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity for 1 of 12 residents (Resident #22) reviewed for dignity in that: Resident #22's preference of having his pants on while he was in bed was not honored. This deficient practice could affect residents and could cause them to feel uncomfortable and disrespected. The findings were: Record review of Resident #22's face sheet, dated 3/5/20, revealed he was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #22's Quarterly MDS dated [DATE] revealed a BIMS score of 5 which indicated severe cognitive impairment for daily decision-making skills. Review of Resident #22's care plan dated 10/18/19 revealed that he was totally dependent on staff for dressing. Observation on 3/5/20 at 10:00 a.m. revealed Resident #22 lying in bed with a clean disposable brief on and no pants on. During an interview on 3/3/20 at 2:27 p.m. with Resident #22's spouse stated when she came to visit him, he never had his warm ups on or if he did they were pulled down to his knees. His spouse further revealed that when she questioned the staff they told her it was easier for them if he did not have his pants on while he was in bed. During an interview on 3/5/20 at 10:03 a.m. Resident #22 said he wanted some pants on and they forgot to put his pants on. Resident #22 said that it happened pretty frequently, but he preferred them on. During an interview on 3/5/20 at 10:04 a.m. LVN A confirmed that Resident #22 was not wearing any pants and did not know why they were not being worn. During an interview on 3/6/20 at 8:00 a.m. the Interim DON confirmed it is the resident's preference and not our convenience if Resident #22 wanted to wear pants while in bed. Review of the Resident Bill of Rights provided by the facility on 3/6/20 revealed 36. Dignity/Self Determination and Participation. You have the right to receive care from the facility in a manner and in an environment that promotes, maintains, or enhances your dignity and respect in full recognition of your individually. You have the right to: a. Choose activities, schedules, and health care consistent with your interest, assessments, and plans of care.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan, activities designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident for 2 of 2 residents (Resident #7,#31) reviewed for activities in that: 1. Resident #7 had no record of documentation of in room activities and had not been provided in room activities as of [DATE]20. 2. Resident #31 had no record of documentation of in room activities and had not been provided in room activities as of 2/28/2020. This deficient practice could affect all residents who were unable to leave their room and could result in a decline in social and mental psychosocial well-being. The findings were: 1. Review of Resident #7's Face Sheet dated 3/5/2020 revealed an initial admission date of [DATE] and readmission on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #7's Significant Change MDS dated [DATE] revealed BIMS was not conducted and resident was rarely/never understood. Further review of MDS revealed staff assessment for mental status for Resident #7 was at 3 which indicated moderate cognitive impairment for daily decision making. Significant Change MDS Staff Assessment of Daily and Activity Preferences revealed Resident #7 liked to listen to music. Review of Resident #7's Care Plan revised [DATE]20 revealed needed 1 to 1 bedside/in-room visits and activities if unable to attend out of room events, staff to turn on TV or music in room to provide sensory stimulation. Multiple observations of Resident #7 throughout the survey from 3/3/2020 - 3/6/2020 revealed resident lying in bed or in geri chair in silence and TV off. Observation also revealed no in room one on one visits for in room socialization and sensory stimulation. Interview on 3/5/2020 at 10:14 a.m. with the Activity Director confirmed she had not documented any in room one on one activities/visits on Resident #7, the last visit for in room activities was [DATE]20 and no visits had occurred since that date though they should have. 2. Review of Resident # 31's Face Sheet, dated 3/5/2020, revealed an admitted on 1/5/2018 and readmission on 2/4/2020 with [DIAGNOSES REDACTED]. Review of Resident #31's Annual MDS, dated [DATE], revealed a BIMS score of 8 indicating moderate cognitive impairment and that it was very important for the Resident to have books, newspapers and magazines to read, to listen to music, keep up with the news, do favorite activities, get out in fresh air, participate in religious activities and somewhat important to be around animals/pets and do things with groups. Review of Resident #31's Care Plan, revised 2/25/2020, revealed needs in room socialization and sensory stimulation with interventions of the Activity director will provide me with one on one visits with sensory stimulation at least 3 times per week and the Activity director will praise me when I join in with in room visits. Multiple observations of Resident #31 throughout the survey from 3/3/2020 - 3/6/2020 revealed no in room one on one visits for in room socialization and sensory stimulation. Interview on 3/5/2020 at 10:14 a.m. with the Activity Director confirmed she had not documented any in room one on one activities/visits on Resident #31, the last visit for in room activities was 2/28/020 and no visits had occurred since that date though they should have. Review of the facility policy Activity Programming, undated, revealed in part .5. Those who cannot participate in group setting are provided individual programming. Inability to participate could include those who refuse to participate in activities, those who are in isolation, or physician ordered bed rest.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for oxygen therapy for 1 of 3 residents (Resident #5) reviewed for respiratory care in that: Resident #5 was not administered oxygen per physician's orders. This deficient practice could affect residents who received continuous oxygen therapy and could result in receiving incorrect or inadequate oxygen support and could result in a decline in health. The findings were: Record review of Resident #5's face sheet, dated 3/4/2020 revealed the resident was originally admitted into the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #5's Quarterly MDS dated [DATE] revealed a BIMS score of 11 which indicated moderately impaired cognitive status for daily decision making. Further review of the MDS revealed Resident #5 received oxygen therapy in the last 14 days. Record review of Resident #5's Physician Orders Summary dated (NAME)2020 revealed an order to use oxygen at 2 liters/minute via nasal canula every shift for shortness of breath with an order date of 6/19/19 and no end date. Record review of Resident #5's Care Plan revised on 3/29/19 revealed the resident was on oxygen and received oxygen at 2

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

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

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) liters/minute via nasal cannula. Observation on 3/3/2020 at 9:14 a.m. revealed Resident #5 was lying in bed without any oxygen. Further observation revealed there was an oxygen concentrator next to resident's bed, the cannula and the tubing were coiled and was on the top of the concentrator. During an interview on 3/3/2020 at 9:14 a.m., Resident #5 stated she used oxygen continuously. Resident # 5 further stated not using now, staff forgot to put it on, careless, something very important. Resident #5 further revealed she used the call light and a staff member, unknown name said someone would be in soon. Resident #5 also reported that she was without oxygen since 3:00 a.m. Resident #5 further complained of shortness of breath. During an interview on 3/3/2020 at 9:21 a.m., LVN B confirmed Resident #5 was on continuous oxygen and Resident #5 was not receiving oxygen as ordered. LVN B further said she did not know how long Resident #5 had been without oxygen. LVN B placed the nasal cannula to Resident #5's nose without checking oxygen saturation. Further interview with LVN B stated she should have checked oxygen saturation, assessed Resident #5 for distress prior to putting on the oxygen. Observation on 3/3/2020 at 9:25 a.m. revealed LVN B checked Resident #5's oxygen saturation and it was at 96. During an interview on 3/4/2020 at 2:46 p.m., the Interim DON stated that her expectation was for the charge nurse to check on residents during the first round and then every 2 hours. The Interim DON also said she held nurses responsible for monitoring oxygen; however, she would hope CNAs would inform the nurse if they knew the resident was on oxygen and it was being provided. The interim DON further said she was aware of the incident and LVN B informed her that the oxygen tubing was coiled around and put away on the oxygen concentrator. Record review of the facility policy titled, Oxygen Administration revised 2/13/2007, revealed in part The resident will maintain oxygenation with safe an effective delivery of prescribed oxygen. Place the nasal cannula, in nares with the prongs straight or curving downward and around the ear and under the chin. Adjust to snug fit. Turn on the oxygen after properly setting the volume and place device in position.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all irregularities identified by the licensed pharmacist were reviewed and what, if any, action was taken to address it by the attending physician to minimize or prevent adverse consequences to the extent possible for 1 of 5 residents (Resident #19) reviewed for unnecessary medications, in that: Resident #19's Pharmacist Consultant recommendation requested a gradual dose reduction for the use of [MEDICATION NAME] in the treatment of [REDACTED]. This deficient practice could affect residents who receive monthly pharmacy reviews and place them a risk of receiving unnecessary medications and dosages. The findings were: Record review of Resident #19's face sheet, dated 3/6/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Consultant Pharmacist letter to the Physician dated 1/23/20 revealed the following: Reduction Request per Regs-Currently on [MEDICATION NAME] 1 mg qd, Please evaluate for potential reduction. Would you like to: __Agree to reduce to or __Disagree, please provide rationale Review of the Physician's Order Summary with active orders as of 3/6/20 revealed [MEDICATION NAME] tablet 1 mg, give 1 tablet by mouth one time a day for [MEDICAL CONDITION] related to delusional disorders. During an interview on 3/5/20 at 3:35 p.m. the Interim DON confirmed the pharmacist recommendation dated 1/23/20 for Resident #19 had a physician signature, date and response of disagree but no physician rationale within the medical record. During an interview on 3/6/20 at 8:00 a.m. the Interim DON stated she was aware that a rationale should be provided when a physician disagreed with the GDR. Review of the facility policy titled Consultant Pharmacist dated 10/25/17 revealed 10. The attending physician will review the identified irregularity and will document what, if any, action is to be taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation in that: 1. There were opened food items without a 'use by date'. 2. There was a bottle of sanitizing solution sitting next to a food processor. 3. There was no water as recommended in the rinse compartment of the three- compartment sink. 4. The documented three-compartment sink temperatures and sanitation concentration were below recommended levels. 5. The dish washing machine was dirty. 6. There was a water pipe with peeled paint across the tray line exposing food for possible contamination. 7. Cook E had long hair and was in the kitchen without a hair net. These deficient practices could place all residents who received meals from the main kitchen and could place them at risk for food borne illnesses. The findings were: 1. a. Observation of the reach in freezer on 3/3/2020 at 8:44 a.m. revealed loose pepperoni in a plastic bag dated 11/23/19 with no expiration or best use date. Interview on 3/3/2020 at 8:45 a.m. with the Food Service Manager (FSM) revealed she was not aware the product should be labeled with the best use date from the manufacturer on the open products. Further interview revealed the best use by date was on the box the product came in and the box was discarded. Review of facility policy Food Storage and Supplies dated 2012 revealed in part when items are received from the vendor, they should be first examined for expiration date and if an expiration date is present, it is beneficial to mark it by circling it so it is readily visible and noticeable. b. Observation of kitchen counter on 3/5/2020 at 1:48 p.m. revealed an opened 15 ounces lemon juice ~1/3 used with a manufacturer's expiration date of 5/13/2020 and no open date. Interview with the FSM confirmed lime juice was sitting on the counter and further stated she did not know when the lime juice was opened and how long it had been sitting outside. Record review of the Texas Food Establishment Rules (TFER) 2015, page 71, section 228.75(f)(1)(a) revealed refrigerated, ready-to-eat, time/temperature controlled for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and held at a temperature of 41 degrees Fahrenheit or less if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises .(A) the day the original container is opened in the food establishment shall be counted as Day 1 .(I) A food specified in subsection (g) (1) or (2) of this section shall be discarded if it .(B) is in a container or package that does not bear a date or day, or (C) is appropriately marked with a date or day that exceeds a temperature and time combination as specified in subsection (g) (1) of this subsection. 2. Observation on 3/4/2020 at 11:07 a.m. revealed a red bucket of solution with a cloth towel inside next to the food processor where Cook C was pureeing meat. Further observation revealed Cook C used the cloth towel in the solution to wipe the food processor base after use. During an interview on 3/4/2020 at 11:25 a.m. with Cook C confirmed the solution in the red bucket was sanitizer and was used to clean the counter and the food processor base. During an interview on 3/4/2020 at 11:27 a.m., the FSM stated the sanitizing solution was on the bottom shelf till the previous day, somehow got knocked down and moved the sanitizing solution on the counter next to the food processor. The FSM further acknowledged the possible danger of sanitizing solution splashing into the pureed foods and removed the sanitizing solution to the bottom of the counter. Review of facility policy Food Storage and Supplies dated 2012 revealed in part insecticides, sprays and cleaning supplies are stored separately from food products and disposable supplies. 3. Observation on 3/4/2020 at 11:24 a.m. revealed Cook C pureed the meat and washed the food processor in the three-compartment sink. Further observation revealed there was no water in the rinse (middle) compartment per manufacturer's recommendation and Cook C washed the food processor under running water and did not check water temperature. During an interview on 3/4/2020 at 11:25 a.m., Cook C said she did not fill the rinse compartment with required water level and should have. Cook C further confirmed she did not check the water temperature prior to use of the three- compartment sink. During an interview on 3/4/2020 at 3:00 p.m., the FSM revealed the cooks were to follow the manufacturer's recommendation when three-compartment sink was used for cleaning. Review of the three-compartment sink procedures posted by the sink revealed rinse all items in clean, hot water until all soap is removed. Change water often to prevent soap residue. Rinse water temperature 120 degrees Fahrenheit (F). 4. Review of Temperature/Chemical Log for three-compartment sink dated 2/1/2020-3/5/2020 revealed rinse water temperatures were 110-115 except 2 days ([DATE] & 2/15/2020) at 120 degrees Fahrenheit (F). Further review revealed the sanitizing solution concentration were between 75-100 ppm. Review of the three-compartment sink procedures posted by the sink revealed recommended rinse water temperature was 120 degrees F and the sanitizing solution must read 150-400 ppm. 5. a. Observation on 3/4/2020 at 11:35 a.m. revealed the dish machine was dirty with food debris and dried food particles on the

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) top clean side of the machine and around the machine. Further observation revealed white calcium build up on the dish machine. During an interview on 3/4/2020 at 11:46 a.m., the Dietary Aide D confirmed the dish machine was dirty with food debris. Dietary Aide D further stated the dish machine was supposed to be cleaned every day and did not look like it had been cleaned. b. Observation on 3/5/2020 at 1:44 p.m. revealed the dish machine had dried food particles on the edge of the machine where the clean dishes came out. Further observation revealed the top back part of the machine was dirty with accumulation of food particles. During an interview on 3/05/20 at 1:44 p.m. with the FSM confirmed the dish machine was dirty. The FSM also said it did not look like the employees were cleaning the dish machine correctly and needed monitoring to assure cleaning done correctly. During an interview on 3/4/2020 at 3:39 p.m., the registered Dietitian (RD) stated she visited the facility every month. RD further stated she checked on sanitation during her visits. Review of RD report dated 12/11/19, 1/7/2020 and 2/4/2020 revealed sanitation was not checked off. Review of facility policy Cleaning Schedules dated 2012, revealed in part The dietary department and all equipment in the dietary department will be cleaned on a regular schedule basis. Cleaning schedules are to be individualized to the facility, and it is the responsibility of the FSM to ensure that the assigned tasks are completed when assigned, and in a thorough manner. The cleaning schedules should be updated routinely to include areas that are noted as needing additional cleaning by the white glove inspection check list, the Registered Dietitian (RD) sanitation check, FSM or Administrator walk through inspections, as well as the CMS kitchen observation audit form that is performed monthly by dietary manager. Review of weekly cleaning schedule dated February 2020 revealed dish machine was de-limed weekly and daily cleaning schedule dated [DATE]-3/4/2020 revealed dish machine was wiped down each shift. Review of the Texas Food Establishment Rules (TFER) 2015, page107, section 228.113(3) indicated non-food contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 6. Observation of tray line on 3/4/2020 at 12:00 p.m. revealed a pipe with chipped paint across the steam table. During an interview on 3/4/2020 at 12:05 p.m., the FSM revealed the pipe running across steam table was a water line and there was chipped paint. The FSM further said the pipe had been with chipped paint for a while and she acknowledged the possibility of food contamination. 7. Observation of kitchen on 3/5/2020 at 1:42 p.m. revealed Cook E with long hair in the kitchen without hair restraint. An interview with Cook E confirmed she was not wearing a hair restraint. Cook E further said she was running late and forgot to put on the hair net. Review of the Texas Food Establishment Rules (TFER) 2015, page 39, section 228.43(a) revealed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.
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, in accordance with accepted professional standards and practices, for 1of 1 resident (Resident #15) whose clinical records were reviewed for [MEDICAL TREATMENT] in that: Resident #15 did not have a documented physician's orders [REDACTED]. This deficient practice could affect residents that reside in the facility and could result in errors in care and treatment. The findings were: Record review of Resident #15's face sheet, dated 3/4/2020, revealed an admission date of [DATE] and readmission of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #15's most recent Quarterly MDS, dated [DATE], revealed a BIMS score of 14, which indicated cognitively intact for daily-decision making skills, and Resident #15 received [MEDICAL TREATMENT] treatment. Record review of Resident #15's (NAME)2020 physician Order Summary Report revealed no order for [MEDICAL TREATMENT] treatment. Review of Resident #15's Care Plan, revised [DATE], revealed Resident # 15 required [MEDICAL TREATMENT] related to [MEDICAL CONDITION] on Monday, Wednesday and Fridays. During an interview on 3/4/2020 with the Interim DON, she confirmed Resident #15 had been receiving [MEDICAL TREATMENT] treatment on Monday, Wednesday and Fridays and the (NAME)2020 physician Order Summary Report did not include an order for [REDACTED]. Review and confirm the physician's orders [REDACTED].