STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675635	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EBONY LAKE NURSING AND REHABILITATION CENTER	1001 CENTRAL BLVD BROWNSVILLE, TX 78520

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 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, including oxygen therapy, were provided such care, consistent with professional standards of practice, for one Resident (R#1) of five residents reviewed for respiratory care and services. R#1's physician's orders [REDACTED]. R#1's oxygen concentrator was set at 4LPM. This failure could place residents receiving respiratory care and services at risk of respiratory complications. The findings included: Record review of R#1's Admission Record, dated 08/14/20, revealed R#1 was 73-years-old and was admitted to the facility on [DATE] and readmitted on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Physician order [REDACTED]. Start date was 07/25/19 at 6:00 p.m. Record review of R#1's MDS assessment, dated 07/07/20, revealed R#1: -had no speech -was rarely/never able to make herself understood, -was rarely/never able to understand others, -was unable to complete a mental status interview, -had severely impaired cognitive skills for Daily Decision Making, and -was on oxygen therapy. Record review of R#1's care plan, dated 06/01/20, revealed: (R#1) has oxygen therapy r/t ineffective gas exchange. Interventions: Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate ([MEDICAL CONDITION], Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain. Accessory muscle usage, skin color. OXYGEN SETTINGS: O2 via nasal cannula @ 2 L/M Continuously date initiated 06/01/20. Observation on 08/13/20 at 12:45 p.m. revealed R#1 was lying in bed with HOB at 30 degrees, with her eyes closed. R#1 was receiving oxygen via nasal cannula connected to an oxygen concentrator set at 4LPM. On 08/13/20 at 1:00 p.m., RN A and surveyor went into R#1's room and RN A observed and acknowledged R#1's oxygen was set at 4LPM. RN A immediately changed the oxygen setting to 2LPM. RN A said she usually checked the settings on all of her residents at the beginning of her shift at 6:00 a.m. but did not know why the oxygen setting was at 4LPM instead of 2LPM as ordered by R#1's physician. In an interview on 08/13/20 at 1:13 p.m., DON B said the oxygen concentrator should be set at the level the physician ordered. DON B said ADON/LVN C told DON B she had checked the oxygen concentrators on all the residents on oxygen therapy and said R#1's oxygen concentrator was set at 2LPM when she checked at the beginning of the shift. DON B said she did not know how the oxygen level was moved from 2LPM to 4LPM. DON B said the facility did not have a written policy for oxygen therapy. In an interview on 08/13/20 at 1:19 p.m., ADON/LVN C said the last time she checked on R#1 was around 9:30 a.m. that morning and the oxygen concentrator was set at 2LPM. ADON/LVN C said she conducted rounds on all residents on the floor every day to ensure all the oxygen concentrators were on the correct settings. ADON/LVN C said the floor nurse was the only staff who was authorized to move the oxygen settings on the residents' oxygen concentrators.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, on one hall (Hall 100) of two halls reviewed for a safe environment, in that: The COVID-19 Warm hall (Hall 100) resident rooms had two receptacles in each room used for disposal of soiled linen and trash. The receptacles did not have lids. This failure placed residents and staff at risk of living and working in an unsafe, unsanitary, and uncomfortable environment. The findings were: Observation and interview on 08/13/20 at 12:28 p.m. of the presumptive COVID-19 hall (Hall 100 - Warm Hall) revealed there were eight residents residing in the hall. DON B stated to enter one of the rooms in hall 100, a plastic gown, gloves, face shield and N95 mask had to be worn at all times. DON B said, before exiting the resident rooms, the gown and gloves were to be disposed of in the receptacle with the red liner. Observation of R#1's room at the same time revealed there were two cardboard boxes with no lids. One of the cardboard boxes had a red plastic liner and the other had a yellow plastic liner. Observation revealed linen in the box with the yellow liner and disposed plastic PPE in the box with the red liner. In an interview on 08/13/20 at 12:42 p.m., CNA D said the boxes with the red liner were used for all biohazard waste, including soiled incontinent briefs, PPE, and other trash. CNA D said the boxes with the yellow liner were used for soiled linen removed when they were changing the residents. CNA D said the boxes did not have lids. CNA D said every room in this hall had its own pair of boxes. Observation on 08/13/20 at 12:45 p.m. revealed eight residents (R#1 - R#8) in Hall 100, each in their own private room. Each resident room had a set of boxes, one with a red plastic liner and the other with a yellow plastic liner. The boxes were open at the top and had no lids. Record review of an untitled list which listed the residents in hall 100 and in hall 200 revealed there were eight residents in Hall 100, each in their own individual room, and nine residents in Hall 200 with three rooms being shared by two residents each. In an interview on 08/13/20 at 2:40 p.m., DON B said the 100 Hall was for symptomatic residents who were awaiting COVID-19 test results. DON B said each resident room in Hall 100 and 200 had two receptacles in them, one for linen and one for trash. DON B acknowledged the boxes did not have lids. DON B said the facility did not have enough trash cans with lids on them so instead they used cardboard boxes. DON B said they were not aware the boxes needed to be covered. DON B said the facility did not have a written policy regarding covered trash cans.

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.