STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675217	A. BUILDING _____ B. WING _____	09/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELKHART OAKS CARE CENTER	214 JONES RD ELKHART, TX 75839

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident was treated with respect and dignity and care in a manner promoting maintenance or enhancement of his or her quality of life for 1 of 5 residents reviewed for resident rights. (Resident #1) The facility did not provide timely assistance to Resident #1 when he was ready to get out of the shower. Resident #1 waited more than 22 minutes for staff to assist him out of the shower. This failure could place residents at risk for diminished quality of life, embarrassment, decreased self-worth and dignity. Findings included: A face sheet dated 09/04/20 indicated Resident #1 was [AGE] years old, admitted on [DATE], and had [DIAGNOSES REDACTED]. A Minimum Data Set assessment dated [DATE] indicated Resident #1's cognition was intact, he made his needs known, and understood others. He required limited assistance of one-person with bed mobility, transfers, personal hygiene, and toileting. He required one-person assistance with transfers for bathing. A care plan dated 06/28/20 indicated Resident #1 required varying assistance with ADLs due to his weakness in his lower extremities (legs) and tired easily. The care plan indicated staff should provide assistance with toileting, dressing, bed mobility, and transfers. A physician's orders [REDACTED].#1 indicated he was on isolation precautions for 14 days after readmitting to the facility. During an observation on 09/04/20 at 3:21 p.m., a call light alert monitor was mounted to the wall near the nursing station. The call light alert monitor's timer indicated a bath call light on the quarantine hall was alarming for 22 minutes. The call light alarm had a faint bell sound that could be heard near the nursing station. The call light bell could not be heard on resident halls. The call light alarm was lit outside of the shower room on the quarantine hall. The fire doors were closed on the quarantine hall and no staff were on the quarantine hall. The speech therapist donned appropriate PPE and entered the quarantine hall. During an interview on 09/04/20 at 3:44 p.m., the speech therapist said she heard Resident #1 hollering when she entered the quarantine hall. She said Resident #1 was in the shower room and was upset because he was waiting for a long time for staff to assist him out of the shower. She said CNA K came to assist Resident #1 and she left the shower room. During an interview on 09/04/20 at 4:02 p.m., CNA K said she was working on another hall but went to assist Resident #1. She said he was finished with his shower and pressed the call light because he was ready to get out of the shower. She said she assisted Resident #1 from the shower and helped him get dressed. She said she was not scheduled to work the quarantine hall and returned to the halls she was assigned to work. During an interview on 09/04/20 at 5:13 p.m., Resident #1 was sitting in his wheelchair near the door of his room on the quarantine hall. He said he could shower himself, but he had weakness in his extremities because he had a stroke and needed staff assistance to transfer in and out of the shower. He said he was not able to walk and used a wheelchair for mobility. Resident #1 said when he was finished with his shower, he pressed the call light and waited close to 30 minutes before CNA K came to assist him. He said he was upset because he waited so long, and then said he was tired of being upset because he frequently waited a long time for his call light to be answered. During an interview on 09/04/20 at 5:21 p.m., CNA J said she was working another hall when she came to work at 2:00 p.m. but after the incident with Resident #1, she was pulled to work the quarantine hall. The daily staffing sheet dated 09/04/20 indicated there were 2 nurses, 1 MA, 2 CNAs, and one hospitality aide scheduled for the quarantine hall and 4 negative halls. During an interview on 09/04/20 at 6:14 p.m., the administrator said she expected call lights to be answered in 3 to 5 minutes. She said they staff one CNA on the quarantine hall and there should have been a CNA on the quarantine hall. The facility's dignity policy dated June 2020 indicated .each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .
F 0675 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor each resident's preferences, choices, values and beliefs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for 1 of 5 residents reviewed for quality of life. (Resident #1) The facility did not provide timely assistance to Resident #1 when he was ready to get out of the shower. Resident #1 waited more than 22 minutes for staff to assist him out of the shower. This failure could place residents at risk of not receiving needed care and services. Findings included: A face sheet dated 09/04/20 indicated Resident #1 was [AGE] years old, admitted on [DATE], and had [DIAGNOSES REDACTED]. A Minimum Data Set assessment dated [DATE] indicated Resident #1's cognition was intact, he made his needs known, and understood others. He required limited assistance of one-person with bed mobility, transfers, personal hygiene, and toileting. He required one-person assistance with transfers for bathing. A care plan dated 06/28/20 indicated Resident #1 required varying assistance with ADLs due to his weakness in his lower extremities (legs) and tired easily. The care plan indicated staff should provide assistance with toileting, dressing, bed mobility, and transfers. During an observation on 09/04/20 at 3:21 p.m., a call light alert monitor was mounted to the wall near the nursing station. The call light alert monitor's timer indicated a bath call light on the quarantine hall was alarming for 22 minutes. The call light alarm had a faint bell sound that could be heard near the nursing station. The call light bell could not be heard on resident halls. The call light alarm was lit outside of the shower room on the quarantine hall. The fire doors were closed on the quarantine hall and no staff were on the quarantine hall. The speech therapist donned appropriate PPE and entered the quarantine hall. During an interview on 09/04/20 at 3:44 p.m., the speech therapist said she heard Resident #1 hollering when she entered the quarantine hall. She said Resident #1 was in the shower room and was upset because he was waiting for a long time for staff to assist him out of the shower. She said CNA K came to assist Resident #1 and she left the shower room. During an interview on 09/04/20 at 4:02 p.m., CNA K said she was working on another hall but went to assist Resident #1. She said he was finished with his shower and pressed the call light because he was ready to get out of the shower. She said she assisted Resident #1 from the shower and helped him get dressed. She said she was not scheduled to work the quarantine hall and returned to the halls she was assigned to work. During an interview on 09/04/20 at 5:13 p.m., Resident #1 was sitting in his wheelchair near the door of his room on the quarantine hall. He said he could shower himself, but he had weakness in his legs because he had a stroke and needed staff assistance to transfer in and out of the shower. He said he was not able to walk and used a wheelchair for mobility. Resident #1 said when he was finished with his shower, he pressed the call light and waited close to 30 minutes before CNA K came to assist him. He said he was upset because he waited so long, and then said he was tired of being upset because he frequently waited a long time for his call light to be answered. During an interview on 09/04/20 at 5:21 p.m., CNA J said she was working another hall when she came to work at 2:00 p.m. but after the incident with Resident #1, she was pulled to work the quarantine hall. The daily staffing sheet dated 09/04/20 indicated there were 2 nurses, 1 MA, 2 CNAs, and one hospitality

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 0675 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) aide scheduled for the quarantine hall and 4 negative halls. During an interview on 09/04/20 at 6:14 p.m., the administrator said she expected call lights to be answered in 3 to 5 minutes. She said they staff one CNA on the quarantine hall and there should have been a CNA on the quarantine hall. The facility's call light policy dated June 2020 indicated .the purpose of this procedure is to respond to the resident's requests .answer the resident's call as soon as possible.
F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure personnel had the ability to provide basic life support care prior to the arrival of emergency medical personnel. The facility did not maintain a working automated external defibrillator (AED - used during sudden [MEDICAL CONDITION]) for use in the administration of CPR. The facility did not have a staff who was CPR certified available at all times. An Immediate Jeopardy (IJ) was identified on [DATE] at 4:35 p.m. While the IJ was removed on [DATE] at 4:25 p.m., the facility remained out of compliance at a pattern of potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents who had a full code status at risk of death. Findings included: An Advance Directives and Code Status Report dated [DATE] indicated 36 residents wished to be resuscitated in the event of [MEDICAL CONDITION]. During an observation on [DATE] at 11:00 a.m., the only available AED for the facility did not display a green illuminated light indicating readiness for use. The surveyor did not hear the AED alarming at this time. The owner's manual for the Philips HeartStart AED, the facility's AED, dated [DATE], recommended routine maintenance, including: .periodically checking the green Ready light . if the green Ready light is not blinking see Troubleshooting Tips . Replace any used, damaged, or expired supplies and accessories . Record each periodic check in an inspection log .If the Ready light is off, the Onsite (AED) is emitting a series of single chirps, and the i-button is flashing, a self-test error has occurred, there is a problem with the pads or the battery power is low. Press the i-button for instructions . During an observation and interview on [DATE] at 11:15 a.m., the DON removed the AED from the case. The AED was showing a blue illuminated light labeled i and emitting a chirping noise at regular intervals. The DON said she was not sure why the blue i light was illuminated and did not know who was responsible for conducting readiness checks on the AED or documenting those checks. The DON said she was not aware that the AED was not ready for use. During an interview on [DATE] at11:20 a.m., the administrator said the maintenance department was responsible for checking the AED and documenting the results. During an observation and interview on [DATE] at 11:30 a.m., the DON pressed the blue information button and the AED emitted a verbal prompt to insert fresh battery. The green light indicating operational readiness did not illuminate. The DON and administrator said after consulting with their corporate representatives they learned that checking the AED was the responsibility of the nursing department, and they were looking for the spare battery. The DON said there were no records indicating the AED was being checked for operational readiness. The DON said she did not know how long the AED battery had been low. During an interview on [DATE] at11:40 a.m. the administrator said the facility did not have an extra battery and provided a purchase order indicating the replacement battery for the AED would be delivered [DATE]. During an interview on [DATE] at 11:45 a.m., the DON said the AED should be checked daily by the 10p-6a nursing staff. During an observation on [DATE] at 1:50 p.m., the AED was hanging on the wall; the green light indicating operational readiness was not illuminated. During an interview on [DATE] at 2:08 p.m., LVN A said she had not received instruction from the facility about how to check the AED, although she had received training from other places she worked. LVN A said if the green light was not on, that usually meant the AED was not functional. During an interview on [DATE] at 3:10 p.m., the DON said the administrator was traveling to a nearby town to get a replacement battery for the AED. During an observation on [DATE] at 3:45 p.m. the AED displayed an illuminated green light indication operational readiness. During a telephone interview on [DATE] at 5:10 p.m., LVN E said she worked the 10p-6a shift. She said she had not received instruction on checking the AED or any type of check off sheet to ensure the AED was operational. During a telephone interview on [DATE] at 5:11 p.m., LVN F said she worked the 10p-6a shift. She said she had never used the AED, and the facility had not instructed her on required checks of the AED. During an interview on [DATE] at 9:30 a.m., the DON said CPR included the use of the AED. She said if a resident experienced [MEDICAL CONDITION] during the time the AED was not functional, the facility would not have been able to provide full and complete CPR. The DON said the facility did not have documentation of any AED checks for operational readiness being completed. A purchase order dated [DATE] (after surveyor intervention) indicated the facility ordered a replacement battery for the AED and the projected delivery date was [DATE]. The owners manual for the Philips HeartStart AED, used by the facility, dated [DATE] indicated: .The Ready Light (green) tells you the readiness of the HeartStart. If the light is off the AED needs attention . The Information Button (blue, labeled I) flashes when it has information you can access by pressing it . The beeper chirps to alert you when it needs attention . The battery is non-rechargeable . The only effective treatment for [REDACTED]. During a telephone interview on [DATE] at 3:30 p.m., LVN G said she had responded to an unresponsive resident at the facility on [DATE]. She said she had initiated CPR and used the AED but was unable to revive the resident. LVN G said the AED seemed to work fine, although she had never used it before. During an interview on [DATE] at 10:58 a.m., the DON said there was no record of CPR certification for LVN G, and she no longer worked at the facility. The DON said LVN H and LVN I's CPR certifications had expired but had been renewed after surveyor intervention. During an interview on [DATE] at 1:35 p.m., the administrator said the facility did not require all charge nurses be CPR certified, and that a couple of people (unnamed) had expired CPR certifications. The administrator said CPR certifications were supposed to be checked by the Human Resources manager and the ADON when hired and annually. The administrator was unable to provide a system regarding how the facility ensured there were CPR certified staff assigned on each shift. Detail Time Reports Dated [DATE] through [DATE] indicated there was no staff on duty certified to perform CPR on [DATE] from 6:09 p.m. through 9:00 p.m., and on [DATE] from 9:11 p.m. through 9:43 p.m. A policy titled ,[DATE] Charge Nurse Duties dated [DATE] indicated the AED should be checked on the night shift. An undated policy titled Emergency Procedure - Cardiopulmonary Resuscitation indicated early delivery of a shock with a defibrillator plus CPR within ,[DATE] minutes of collapse can further increase chances of survival but did not include instructions to utilize the AED. The policy indicated if an individual was found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR except in the case of a known Do Not Resuscitate order or obvious signs of irreversible death (e.g., rigor mortis). The policy indicated if the first responder is not CPR certified, that person will call 911 and follow the 911 operator's instructions until a CPR-certified staff member arrives. The policy indicated in preparation for cardiopulmonary resuscitation: .The facility would select and identify a CPR Team for each shift in the case of an actual [MEDICAL CONDITION] . The CPR Team in this facility shall include at least one nurse, one LVN and two CNAs, all of whom have received training and certification in CPR/BLS . During an interview on [DATE] at 9:58 a.m., Philips AED Technical Support was contacted at 800.263.3342. The Philips representative indicated the Philips Heartstart AED used a battery that was not rechargeable and required replacement once the battery was depleted. The Philips representative said once the battery was low there was no indicator to confirm there was enough power in the battery to deliver therapy. A publication by the American Heart Association at https://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_ 6.pdf , accessed [DATE] at 1:50 p.m., indicated .Immediate cardiopulmonary resuscitation (CPR) and early defibrillation, with and automated external defibrillator (AED), can more than double a victim's chance of survival. In fact, early defibrillation, along with CPR, is the only way to restore the victim's heart rhythm to normal in a lot of cases of [MEDICAL CONDITION]. For every minute that passes without CPR and defibrillation, however, the chances of survival decrease by ,[DATE] percent. The 2013 update of AHA's [MEDICAL CONDITION] and Stroke Statistics show that 23% of out-of-hospital [MEDICAL CONDITION] are shockable. The administrator and DON were notified on [DATE] at 4:35 p.m. that an Immediate Jeopardy was identified due to the above failures and the template was provided via email at 5:06 p.m. The facility's plan of removal was accepted on [DATE] at 6:15 p.m., and included: Maintaining Automatic External Defibrillator (AED) *The AED will be monitored daily by the ,[DATE] shift to validate the green light is on, showing the AED is ready for use. *This monitoring will be documented on the AED daily check off form. *If the green light is not solid, then the staff will check the battery or correct placement. Facility will have a backup battery in the AED case to replace if needed. If replacing the battery does not correct the problem, staff will contact the DON or the administrator for further instruction. Education *Staff will be educated during this shift or prior to the start of their next shift on AED daily check off form. *DON or administrator will provide this

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F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) training today and will ensure all staff nurses are educated by [DATE]. Staff that are on leave or not currently working in the facility will be rained on this process prior to returning to work. *New employees will be educated during orientation of this process and prior to assuming duties. Monitoring *The DON or designee will check documentation daily for two weeks, weekly for two weeks and then monthly until the Quality Assurance Performance Committee deems it no longer necessary. Medical Director *The Medical Director has been notified of the Immediate Jeopardy The DON or designee will present findings to the Quality Assurance Performance Committee monthly for 3 months and then quarterly until the Quality Assurance Performance Committee deems it no longer necessary. Any recommendations will be implemented and monitored until compliance is achieved. Corrective actions will be completed [DATE]. The POR was updated on [DATE] to include: 1. HR will ensure that all patient care nurses are CPR certified upon hire and will monitor monthly for expiration dates. 2. All current nurses will be educated on the importance of current CPR certification and keeping it current. 3. HR and Nursing Administration will ensure that CPR certifications are current and will alert the DON within 30 days of expiration. 4. RN Hobson will not assume a charge nurse role until she is CPR certified. 5. All nurses who serve in a patient care role are currently certified and any new nurses will be required to show certification prior to assuming the floor. 6. A QAPI tool was created to monitor the HR and Nursing Administration portion of this issue. 7. Corrective actions are in place as of [DATE] On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: During an interview on [DATE] at 3:36 p.m., the administrator said the HR manager had gone home ill. The administrator said CPR certifications had been checked for all nurses who provide patient care, and they were current. The administrator said it would be the facility practice to check all CPR certifications for licensed staff upon hire, and that all licensed staff would be required to maintain CPR certification. The administrator said CPR certifications had been entered into the payroll database. The administrator said this would allow the HR manager to run a report monthly to monitor CPR certifications that were nearing expiration. During an interview on [DATE] at 3:53 p.m., RN D said she currently was not CPR certified and would not work on the floor as a charge nurse without a current CPR certification. During an interview on [DATE] at 4:00 p.m., LVN A said she had received an in-service regarding the importance of maintaining a current CPR certification. She said her CPR certification was current at this time. LVN A said she had received an in-service on the AED regarding the requirements for checking the AED, how to tell if the AED was ready to use, and what to do if the green light signaling operational readiness was not illuminated. During an interview on [DATE] at 4:05 p.m., LVN C said she had received an in-service regarding the importance of maintaining a current CPR certification. She said her CPR certification was current at this time. LVN C said she had received an in-service on the AED regarding the requirements for checking the AED, how to tell if the AED was ready to use, and what to do if the green light signaling operational readiness was not illuminated. During an interview on [DATE] at 4:10 p.m., LVN B said she had received an in-service regarding the importance of maintaining a current CPR certification. She said her CPR certification was current at this time. LVN B said she had received an in-service on the AED regarding the requirements for checking the AED, how to tell if the AED was ready to use, and what to do if the green light signaling operational readiness was not illuminated. On [DATE] at 4:25 p.m., the administrator and DON were informed the IJ was removed; however, the facility remained out of compliance at a pattern of potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective system.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an infection prevention and control program designed to help prevent the development and transmission of communicable diseases was established and maintained for infection control related to COVID-19 ([MEDICAL CONDITION] that is spread from person to person causing mild to severe respiratory symptoms). The facility did not screen staff prior to their entry to the facility. Staff were taking their own temperature, documenting presence or absence of symptoms of COVID-19, international travel, and if they had exposure to COVID-19. This failure could place residents at risk for developing COVID-19. Findings included: The facility's COVID-19 policy revised on 09/01/20 indicated .the facility shall actively screen essential personnel and persons for international travel within the last 14 days to restricted countries, contact with someone with or under investigation for COVID-19, worked at multiple facilities, signs and symptoms of COVID-19, and additional symptoms. Answers shall be documented using the visitor log, including the person's name, the date, purpose of visit, and whether the person is a visitor or employee. The staff member completing the screen will initial the log and write in any relevant comments . The facility's employee and visitor logs dated from 08/16/20 to 09/08/20 indicated staff were self-screening prior to their shift. Staff initialed they screened themselves for fever, sore throat, new or change in cough, shortness of breath, worked at multiple facilities, contact with someone with or under investigation for COVID-19, and international travel in the last 14 days. During an interview on 09/08/20 at 11:03 a.m., LVN B said she screened herself when she arrived at the facility. She said she took her temperature and answered the questions on the screening log. During an interview on 09/08/20 at 11:12 a.m., LVN A said she screened herself when she arrived at the facility. She said she took her temperature and answered the questions on the screening log. During an interview on 09/08/20 at 11:41 p.m., RN D said she screened herself when she arrived at the facility. She said she took her temperature and answered the questions on the screening log. During an interview on 09/08/20 at 12:41 p.m., the speech therapist said she screened herself when she arrived at the facility. She said she took her temperature and answered the questions on the screening log. During an interview on 09/08/20 at 1:01 p.m., MA N said he screened himself when he arrived at the facility. He said he took his temperature and answered the questions on the screening log. During an interview on 09/08/20 at 1:09 p.m., CNA O said she screened herself when she arrived at the facility. She said she took her temperature and answered the questions on the screening log. During an interview on 09/08/20 at 1:37 p.m., CNA L said she screened herself when she arrived at the facility. She said she took her temperature and answered the questions on the screening log. During an interview on 09/08/20 at 1:54 p.m., CNA M said she screened herself when she arrived at the facility. She said she took her temperature and answered the questions on the screening log. During an interview on 09/08/20 at 11:57 a.m., the administrator said staff were allowed to screen themselves prior to their shift. She said staff were in-serviced on the screening process and if a staff member had a fever or answered yes to one of the questions, she would have to approve the staff member to enter. She said staff were in-serviced monthly on hand hygiene, donning and doffing PPE, social distancing, and the screening process. The administrator said the front door was locked and staff used a key code to enter the front door. She said visitors had to ring the doorbell and were screened by staff prior to entering. An undated in-service sheet indicated all persons must be medically screened prior to entering the facility, including all essential personnel and persons. The in-service sheet did not address staff screening themselves before their shift.