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 _____	05/14/2020

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 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 record review and interview, the facility failed to ensure the resident had a right to be treated with respect and dignity regarding personal possessions, for one Resident (R#1) of five residents reviewed for dignity issues. R#1's personal cell phone was removed from R#1's room and put in a lock box without consent or notification to the responsible party. This failure could place residents at risk of feeling uncomfortable and disrespected and could decrease residents' self-esteem and/or quality of life. The findings were: Record review of R#1's Admission Record, dated 05/13/020, revealed R#1 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#1's [DIAGNOSES REDACTED]. pacemaker. Record review of R#1's Minimum Data Set (MDS) assessment, dated 03/26/20, revealed R#1: -had clear speech, -was understood by others, -was able to understand others, and -had mildly impaired cognition. In an interview on 05/13/20 at 11:23 a.m., Admissions Coordinator A said R#1's phone had been kept in a lock box in the facility's business office since 04/22/20. Admissions Coordinator A said there had been a couple occasions that R#1's phone had been misplaced but was found again. Admissions Coordinator A said, when R#1 was first admitted to the facility, the family would call to R#1's phone, but R#1 was not able to answer the calls. Admissions Coordinator A said R#1 would make no attempts to try to reach for the phone to answer it. Admissions Coordinator A said, on more than one occasion, R#1's family called to the facility asking staff to answer R#1's phone because they wanted to talk to him. Admissions Coordinator A said, on one occasion, he went to help R#1 answer his personal phone at the family's request and he was not able to find the phone. Admission's Coordinator A said he asked R#1 where his phone was and he kept saying it was under his arm. Admissions Coordinator A said he looked under R#1's arm and the phone was not there. Admissions Coordinator A said R#1 was confused and did not know where his phone was. Admissions Coordinator A said the phone was later found because someone had turned it in to social services. Admissions Coordinator A said he recognized the phone and told the social services worker that it belonged to R#1. Admissions Coordinator A said he thought it would be best for the phone to be put in the lock box in the business office for safe keeping, so it did not get lost. Admissions Coordinator A said he tried to contact R#1's family regarding putting the phone in the lock box, but was not successful. Admissions Coordinator A said he probably made additional attempts to contact R#1's family, but did not document them. Admissions Coordinator A said the family would call and the facility would make a phone available to the resident so he could keep in contact with his family. Admissions Coordinator A said he gave the phone to the Business Office Manager and it was put in the safe until the family picked it up on 05/07/20. Record review of R#1's electronic record, under the General Notes tab, revealed: 04/22/2020 at 7:54 a.m. Tried to reach RP in efforts of asking him if he would like to keep patients phone in the lock box in the business office for safe keeping. Due to patient being unable to answer phone on his own at the time and avoid misplacement. Call to RP was unsuccessful. In an interview on 05/13/20 at 2:31 p.m., SW B said she was not aware R#1's phone had been kept in the lock box in the business office. SW B said sometimes when residents were admitted to the hospital they did not take their phones so they would not get lost. SW B said she was not aware of how R#1's phone ended up in the business office lock box. In an interview on 05/13/20 at 2:34 p.m., BOM C said Admissions Coordinator A brought R#1's cell phone to her office and told her to put it away in the lock box. BOM C said she was told it belonged to R#1 but was not told why the phone was removed from R#1's room. BOM C said the phone was in the lock box from 04/22/20 until 05/07/20. Record review of R#1's progress notes dated 05/07/20 at 17:35 (5:35 p.m.) indicated R#1 had been transported out of the facility via EMS to the hospital as per family request. In an interview on 05/13/20 at 2:39 p.m., DON D said she was not aware of R#1's phone ever being lost. DON D said she thought the phone was dead and R#1 was unable to use it. DON D said she thought the phone was probably put away for safe keeping when R#1 was sent to the hospital. DON D said when R#1 came back from the hospital he was declining and maybe that was why the phone was put in the lock box, so it did not get lost. DON D acknowledged that removing the phone without appropriate notification to the family was a resident rights concern. In an interview via telephone, R#1's Family Member (FM) R said R#1's family had been calling the resident's phone and no one would answer. FM R said they did not know the phone was in the facility safe until the family went to pick up R#1's belongings. Record review of the facility policy titled, Rights and Obligations of the Resident revealed: Resident Rights. As a resident of Facility, Resident is entitled to various rights that Facility encourages Resident to exercise. A Statement of Rights is available on the Texas Secretary of State website and is attached here. The Facility manual and Forms to be completed upon admission outline additional rights of Resident, including: Rights of Elderly Individuals (Human Resources Code, Title 6, Chapter 102).
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect, for one Resident (R#1) of five residents reviewed for abuse and neglect. The facility did not recognize when R#1 had a change of status while at the facility. This failure could place residents at risk for serious untreated conditions. The findings were: Record review of R#1's Admission Record, dated 05/13/020, revealed R#1 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#1's diagnoses included metabolic [MEDICAL CONDITION], acute kidney failure, acute on chronic diastolic (congestive) heart failure, diabetes mellitus with [MEDICAL CONDITIONS], hypertension, [MEDICAL CONDITIONS], ischemic [DIAGNOSES REDACTED], dementia, moderate protein calorie malnutrition, end stage [MEDICAL CONDITION], muscle wasting and atrophy multiple sites, other lack of coordination, age-related physical debility, dysphagia, cognitive communication deficit, unsteadiness on feet, hypertensive emergency, abnormalities of gait and mobility, symbolic dysfunctions, and presence of cardiac pacemaker. Record review of R#1's Minimum Data Set (MDS) assessment, dated 03/26/20, revealed R#1: -had clear speech, -was understood by others, -was able to understand others, -had mildly impaired cognition. -required extensive assistance from staff for bed mobility, transfers, locomotion, dressing, toilet use, and personal hygiene, -required supervision for eating, and -had no functional limitations in range of motion to upper or lower extremities. Record review of R#1's progress note, dated 03/20/20 at 7:25 p.m., revealed: Note Text: 1200- received report from (name of person), RN from (hospital name and city). (Maintenance Manager S) from facility, notified and picked up resident. 1300-Received resident from (hospital name and city) via company van. A comprehensive head to toe assessment performed on resident (please see admission notes). No respiratory distress noted not any complaints from resident such as pain or discomfort. Resident in bed. Bed low position and call light within reach. Progress note was signed by LVN T. Surveyor made attempts to contact LVN T on 05/12/20 at 4:11 p.m. and 05/13/20 at 10:25 a.m. but did not get an answer.

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

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Voice messages were left on LVN T's voicemail box. No phone call was returned. Record review of R#1's Initial Nursing Evaluation, dated 03/20/20, revealed no documentation that R#1 had left sided weakness. Record review of R#1's admission evaluation, dated 03/20/20, did not reveal R#1 had left sided weakness or contractures to upper or lower extremities upon admission to facility. Record review of R#1's care plan, dated 03/22/20, revealed R#1: Problem: (R#1) has limited physical mobility r/t physical limitations such as weakness. Interventions/Tasks: (R#1) is weight-bearing; Ambulation: (R#1) requires assistance by 1-2 staff for ambulation in WC; Monitor/document/report PRN any s/sx of immobility: contractures forming or worsening, thrombus formation, skin breakdown, fall related injury; Provide supportive care, assistance with mobility as needed. Document assistance as needed; PT/OT referrals as ordered, PRN. The care plan/interventions were not specific to R#1's left sided weakness. Record review of R#1's Occupational Therapy document titled, OT Evaluation & Plan of Treatment, dated 03/21/20 revealed: Assessment Summary Clinical Impression: Pt presents with numerous personal factors and/or comorbidities that impact the plan of care including active [MEDICAL CONDITION], exacerbation, HTN, hx of falls, recurrent UTI, [MEDICAL CONDITION], hx of tobacco abuse, chronic [MEDICAL CONDITION], [DIAGNOSES REDACTED], and [MEDICAL CONDITION]. Pt presents with evolving clinical presentation with changing characteristics as well as multisystem impairments including 1) decreased in bilateral UE muscle strength, 2) decreased AROM of BUE, 3) impaired coordination, 4) impaired balance reaction speed and accuracy, 5) impaired postural alignment and control, and 6) impaired ADL performance which are contributory to decline and require the skills of OT to facilitate return to LOF that permits a safe and successful discharge to a lower level of care. There was no mention of left sided weakness in the assessment summary. Record review of the facility's Speech Therapy Progress Report, dated 03/23/20, revealed: Progress & response to Tx: Pt. is demonstrating minimal positive responses to the skilled interventions being delivered secondary to apparently increased L sided weakness since admission. Nursing is aware. Care plan was held with both (family members) and they stated that he has had a weaker L side since before they were born and that it gets weaker when he is sick. Record review of R#1's Physical Therapy document titled, PT Evaluation & Plan of Treatment, dated 03/23/20 revealed: Assessment Summary Clinical Impression: (R#1) is a [AGE] year-old male admitted from (hospital name), referred to skilled PT services due to decline in functional mobility status. Patient presents with multisystem impairments including 1. decreased bilateral LE muscles power and recruitment, 2. impaired coordination, 3. impaired balance reaction speed and accuracy, 4. Impaired postural alignment and control, and 5. Impaired gait mechanics which are contributory to decline and require the skills of a PT to facilitate return to PLOF. There was no mention of left sided weakness in the assessment summary. Record review of R#1's re-admission evaluation, dated 04/17/20, revealed R#1 had right arm contracture with multiple bruises. Record review of R#1's progress note, dated 04/17/20 at 6:06 p.m., revealed: Note Text: RESIDENT admitted TO ROOM (room number), UNDER SERVICES OF DR. (DOCTOR'S NAME). RESIDENT AAOX2 EENT FREE FROM DRAINAGE. LUNGS WITH RONCHI TO RT AND LEFT UPPER LOBES. SPO2 97% AT ROOM AIR. RESIDENT WITH O2 PRN. RT CHEST PORTOCATH DISCONTINUED AT HOSPITAL RT ARM WITH MULTIPLE BRUISES, LT ARM CONTRACTURE REMAINS UNCHANGED . The progress note was signed by LVN E. Record review of R#1's progress notes dated 05/07/20 at 5:35 p.m., revealed R#1 had been transported out of the facility via EMS to the hospital, as per family request. Record review of R#1's progress note, dated 05/08/20 at 12:00 p.m. revealed: Note Text: Called (hospital name and city) regarding patient status spoke with (name of nurse), RN who stated pt. was admitted for AMS, kidney failure and R/O stroke. She was questioning if patient had hx of contracture informed her no that pt. did have weakness since 1st admission with stiffness to left arm and leg but that he was able to extend arm and leg with stiffness. She said ok and hung up. At this time went and spoke with therapy (name of therapist) who stated that resident does have stiffness to that arm but is able to fully extend arms and fingers with assistance and hold the position. Called back to speak with Nurse was placed on hold for 10 min no answer. Will try again at a later time. Progress note was signed by LVN/ADON O. Record review of R#1's hospital records titled, Consultation Notes, dated 03/15/20 revealed: -Review of Systems: Neurologic: Currently patient claims no focal numbness, weakness, [MEDICAL CONDITION] or tremors, no dizziness, no [MEDICAL CONDITION], no visual disturbance. -CT Head or Brain W/O Contrast (03/15 14:14): Findings: .There is no evidence of acute ischemic infraction, [MEDICAL CONDITION], mass effect or brain herniation . Impression: 1. No acute intracranial abnormality 2. Age-related diffuse volume loss and chronic macroangiopathic changes of the white matter. Record review of R#1's hospital records titled, Progress Note, dated 03/16/20 at 6:48 p.m. revealed EXT: Moves all 4 extremities equally, 2+pulses to PT and DP NEURO: Alert and oriented x3, cranial nerves II through XII, no neuro focal deficits. Record review of R#1's hospital records titled Discharge Summary Date/Time Note Created: 03/23/20 at 4:24 p.m. revealed: Date of Admission: 03/15/2020 Date of Discharge: 03/20/2020 Discharge Diagnosis: [REDACTED]. Physical Examination at Discharge: Extremities: poor strength without cyanosis Neuro: alert. No new deficits. Record review of R#1's hospital records titled, Emergency/Urgent Care, dated 05/07/20 at 4:41 p.m. revealed: History of Present Illness: The patient with 'Left upper extremity [DIAGNOSES REDACTED].' The onset was not reported. The course/duration of symptoms is constant. Location: left upper extremity. The character of symptoms is [DIAGNOSES REDACTED]. The degree of onset was minimal. Risk factors consist of hypertension and [MEDICAL CONDITION] . [AGE] year-old male patient with history of HTN, [MEDICAL CONDITION], and Alzheimer's presents to the emergency department via EMS from (name of nursing home) for evaluation of left upper extremity [DIAGNOSES REDACTED] onset unspecified. As per (family member), Patient started with new onset of left arm [DIAGNOSES REDACTED] that he has never had before. As per nursing note, patient has been at the nursing home for about 1-2 months and patient's family wanted patient brought to ED due to concerns of stroke . Physical Examination: Neurological: limited due to patient with Alzheimer's, acute left upper extremity [DIAGNOSES REDACTED]. Record review of R#1's hospital records titled, History and Physical, dated 05/08/20 at 10:39 a.m. revealed: -Problem list: -Suspected right parietal-occipital subarachnoid hemorrhage versus calcification. -Subacute right parietal-[MEDICAL CONDITION] the last 2 months, CT head on 03/15/2020 was negative. -Acute urinary tract infection. -Left-sided contracture present on admission . -Deep tissue injury to left heel and left buttock, present on admission. Chief Complaint: Concern of stroke This is a [AGE] year-old male who is a nursing home resident who was brought to the ED due to the time was concern of possible stroke. According to the family, patient never had a history of [REDACTED]. Due to the COVID pandemic, they have unable to visit the patient at the nursing home. There have been in contact with the nursing home only via telephone, they are always told that the patient is doing 'fine.' Over the last 2 to 3 days, they were under the impression that the patient was not doing well, there were suspecting this is likely due to his [MEDICAL CONDITION], patient still receiving [MEDICATION NAME] but apparently was not doing well with this. Patient was brought to an ER in Brownsville area a few days ago, when they saw the patient in the ER, they noticed that his left arm was contracted which states that was not present prior to the patient going to the nursing home. They were concerned that the patient is having stroke, they sent the patient to this facility for further evaluation. CT of the head showing subtle areas of high density within chronic infarct, which could be representing calcification versus subtle subarachnoid hemorrhage, this in the area of the right parietal occipital lobe. Patient had a CT of the head previously on 03/15/2020 which showed no acute infarcts, only age-related volume loss. Urinalysis suggestive of urinary tract infection. EKG in the ED interpreted as [MEDICAL CONDITION], on his previous EKGs that are on record patient has no history of [MEDICAL CONDITION]. Currently he is on telemetry, however there is too much artifact as the patient is very fidgety, we will recollect a twelve-lead EKG to make sure the patient does not have [MEDICAL CONDITION]. Which if he did, this may have been the reason because of his previous stroke. On physical exam, patient is alert and oriented to self, location, and certain events, he is aware that the president is Donald Trump. Left upper extremity and lower extremity are contracted. Multiple ulcers and deep tissue injury present on admission. CT Head or Brain W/O Contrast (05/07 17:37) IMPRESSION: 1. Subtle areas of high density within chronic infarct as described above. These may represent areas of calcification versus subtle subarachnoid hemorrhage. 2. No evidence of acute fracture or subluxation involving the cervical spine. [MEDICAL CONDITION] changes as above. In an interview on 05/08/20 at 2:08 p.m., CNA G said she worked in hall 300, where R#1 was during his first admission to the facility. CNA G said R#1 had contractures to his left arm. CNA G said R#1 was not able to use his left upper extremity and required assistance with feeding. In an interview on 05/08/20 at 3:09 p.m., CNA H said she worked in hall 300, where R#1 resided before being admitted to the hospital. CNA H said R#1 had weakness to his left arm, R#1 was not able to move it without the assistance of his other arm. CNA H said R#1 required assistance with feeding. CNA H said R#1 could hold a cup of water with his right hand but needed assistance to bring it up to his mouth. In an interview on 05/08/20 at 3:27 p.m., LVN I said she was the Treatment Nurse and was responsible for conducting skin assessments on all the residents every week. LVN I said she recalled R#1 having weakness to his left upper extremity. LVN I said R#1 could move the left arm, but only with the assistance of his right arm. LVN I said she was not aware of R#1 having a history of a stroke. LVN I said R#1 could move his lower extremities because she recalled seeing R#1 kicking his sheets and pillows off the bed. LVN I said R#1 had a DTI to his left heel. LVN I said she recalled seeing R#1 digging his heels into the mattress.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) In an interview on 05/11/20 at 12:58 p.m., PT U said he conducted the initial assessment on R#1 upon admission. PT U said R#1 had an assortment of diagnoses. PT U said he recalled R#1 had a deformity to his right lower extremity. R#1 said it was due to a MVA. PT U said R#1 had weakness to the left upper extremity and left lower extremity. PT U said R#1 was not able to grasp the walker when they would get him up to walk him with a gait belt and walker. PT U said R#1 did not have a contracture to the left upper extremity. PT U said R#1 could extend the left upper extremity with assistance slowly. PT U said R#1 had weakness to the left side of his body but he did not have a [DIAGNOSES REDACTED]. PT U said R#1 started off as moderate assist but then declined to total dependence when discharged . PT U said R#1 declined gradually. In an interview on 05/11/20 at 1:05 p.m., OT V said when he worked with R#1 and tried to get R#1 up from bed and pivot him to the wheelchair, R#1 had a lot of weakness to the left side and required a lot of assistance. OT V said R#1 gradually declined and required total assistance upon discharge. In an interview on 05/11/20 at 1:16 p.m., SLP W said when she conducted the initial evaluation on R#1 upon admission, she observed asymmetry to the face and left sided weakness to the upper extremity. SLP W said she participated in a care plan meeting with R#1's family member and asked him about R#1's left sided weakness. SLP W said R#1's family member said R#1 has had left sided weakness since he can remember and it would get worse when R#1 was sick. SLP W said there was no [DIAGNOSES REDACTED].#1's left-sided weakness. In an interview on 05/12/20 at 4:33 p.m., LVN E said she was the nurse who readmitted R#1 on 04/17/20. LVN E said R#1 had a contracture to his left arm. LVN E said she knew this because R#1 was not able to move the left arm. LVN E said R#1 had the left arm close to his body. LVN E said R#1 did not have contractures to his left hand. LVN E said the contracture was to R#1's left arm. In an interview on 05/14/20 at 4:21 p.m., MDS/LVN F acknowledged R#1 had left sided weakness. MDS/LVN F said he would not put R#1's left sided weakness in the care plan because then it would be as if they were saying that it was an impairment and it was not. MDS/LVN F said R#1 could move the left upper extremity, carefully and with assistance. MDS/LVN F said the weakness to R#1's upper extremity would not be coded as a contracture because R#1 does not have a contracture, it was weakness to the left side. In an interview on 05/14/20 at 5:30 p.m., DON D acknowledged R#1 had weakness, but was not able to recall to which side. DON D said the patients came to the facility for therapy from the hospital. DON D said there was no reason to call the Physician's office to get a history of the resident since R#1 was admitted to the facility for therapy and having weakness. DON D said R#1 had left sided weakness upon admission. DON D acknowledged the left sided weakness was not noted on the initial assessment conducted by the nurse admitted R#1. There was no written policy provided regarding reporting changes of condition. The facility policy titled, Abuse, Neglect and Exploitation, revised December 2017, revealed: Our residents have the right to be free from abuse/neglect/misappropriation of resident property/corporal punishment and involuntary seclusion.
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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet the resident's mental and psychosocial needs, for one Resident (R#1) of five residents reviewed for care plans. R#1's care plan did not address weakness to R#1's left upper extremity. This failure could place residents at risk for not receiving necessary care and services. The findings were: Record review of R#1's Admission Record, dated 05/13/020, revealed R#1 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#1's [DIAGNOSES REDACTED]. pacemaker. Record review of R#1's Initial Nursing Evaluation, dated 03/20/20, revealed no documentation that R#1 had left sided weakness. Record review of R#1's Minimum Data Set (MDS) assessment, dated 03/26/20, revealed R#1: -had clear speech, -was understood by others, -was able to understand others, -had mildly impaired cognition. -required extensive assistance from staff for bed mobility, transfers, locomotion, dressing, toilet use, and personal hygiene, -required supervision for eating, and -had no functional limitations in range of motion to upper or lower extremities. Record review of R#1's care plan, dated 03/22/20, revealed R#1: Problem: (R#1) has limited physical mobility r/t physical limitations such as weakness. Interventions/Tasks: (R#1) is weight-bearing; Ambulation: (R#1) requires assistance by 1-2 staff for ambulation in WC; Monitor/document/report PRN any s/sx of immobility: contractures forming or worsening, thrombus formation, skin breakdown, fall related injury; Provide supportive care, assistance with mobility as needed. Document assistance as needed; PT/OT referrals as ordered, PRN. The care plan/interventions were not specific to R#1's left sided weakness. Record review of the facility's Speech Therapy Progress Report, dated 03/23/20, revealed: Progress & response to Tx: Pt. is demonstrating minimal positive responses to the skilled interventions being delivered secondary to apparently increased L sided weakness since admission. Nursing is aware. Care plan was held with both (family members) and they stated that he has had a weaker L side since before they were born and that it gets weaker when he is sick. Record review of R#1's re-admission evaluation, dated 04/17/20, revealed R#1 had right arm contracture with multiple bruises. Record review of R#1's progress note, dated 04/17/20 at 6:06 p.m., revealed: Note Text: RESIDENT admitted TO ROOM (room number), UNDER SERVICES OF DR. (DOCTOR'S NAME). RESIDENT AAOX2 EENT FREE FROM DRAINAGE. LUNGS WITH RONCHI TO RT AND LEFT UPPER LOBES. SPO2 97% AT ROOM AIR. RESIDENT WITH O2 PRN. RT CHEST PORTOCATH DISCONTINUED AT HOSPITAL RT ARM WITH MULTIPLE BRUISES, LT ARM CONTRACTURE REMAINS UNCHANGED . The progress note was signed by LVN E. Record review of R#1's progress notes dated 05/07/20 at 5:35 p.m., revealed R#1 had been transported out of the facility via EMS to the hospital, as per family request. In an interview on 05/08/20 at 2:08 p.m., CNA G said she worked in hall 300, where R#1 was during his first admission to the facility. CNA G said R#1 had contractures to his left arm. CNA G said R#1 was not able to use his left upper extremity and required assistance with feeding. In an interview on 05/08/20 at 3:09 p.m., CNA H said she worked in hall 300, where R#1 resided before being admitted to the hospital. CNA H said R#1 had weakness to his left arm, R#1 was not able to move it without the assistance of his other arm. CNA H said R#1 required assistance with feeding. CNA H said R#1 could hold a cup of water with his right hand but needed assistance to bring it up to his mouth. In an interview on 05/08/20 at 3:27 p.m., LVN I said she was the Treatment Nurse and was responsible for conducting skin assessments on all the residents every week. LVN I said she recalled R#1 having weakness to his left upper extremity. LVN I said R#1 could move the left arm, but only with the assistance of his right arm. LVN I said she was not aware of R#1 having a history of a stroke. In an interview on 05/12/20 at 4:33 p.m., LVN E said she was the nurse who readmitted R#1 on 04/17/20. LVN E said R#1 had a contracture to his left arm. LVN E said she knew this because R#1 was not able to move the left arm. LVN E said R#1 had the left arm close to his body. LVN E said R#1 did not have contractures to his left hand. LVN E said the contracture was to R#1's left arm. In an interview on 05/14/20 at 4:21 p.m., MDS/LVN F acknowledged R#1 had left sided weakness. MDS/LVN F said he would not put R#1's left sided weakness in the care plan because then it would be as if they were saying that it was an impairment and it was not. MDS/LVN F said R#1 could move the left upper extremity, carefully and with assistance. MDS/LVN F said the weakness to R#1's upper extremity would not be coded as a contracture because R#1 does not have a contracture, it was weakness to the left side. In an interview on 05/14/20 at 5:30 p.m., DON D acknowledged R#1 had weakness, but was not able to recall to which side. RN/DON D said R#1's weakness should be care planned. Record review of the facility policy titled, Care Planning, revised December 2017, revealed: A comprehensive resident centered care plan is developed and implemented for each resident to meet the resident's physical, psychosocial and functional needs.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that nursing staff had the competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, for two Residents (R#2 and R#1) of five residents reviewed, in that: 1) RN J increased R#2's oxygen delivery rate without consulting with R#2's Physician or obtaining a Physician's order. 2) LVN K did not document verbal orders from R#1's Physician. 3) LVN L sent out R#1 to the hospital for a procedure on the wrong appointment date. These failures could place residents at risk of not receiving adequate services and possible exposure to COVID-19 during an unnecessary hospital visit. The findings included: 1) Record review of R#2's Admission Record, dated 05/13/20, revealed R#2 was [AGE] years-old and was admitted to the facility on

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	675635	A. BUILDING _____ B. WING _____	05/14/2020

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.

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's care plans revealed: -Problem: (R#2) has [MEDICAL CONDITION]. Date initiated: 04/14/20 Interventions: OXYGEN SETTINGS: O2 via nasal prongs/mask @ 3LPM as tolerated. Date Initiated: 04/14/2020 -Problem: (R#2) has altered respiratory status/difficulty breathing r/t Congestion/Right pleural effusion date initiated: 04/24/20 Interventions: Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Date initiated 04/24/20 Monitor for s/sx of respiratory distress and report to MD PRN: Increased Respirations; Decreased Pulse oximetry; Increased heart rate ([MEDICAL CONDITION]; Restlessness; Diaphoresis; Headaches; Lethargy; Confusion; Hemoptysis; Cough; Pleuritic pain; Accessory muscle usage; Skin color changes to blue/grey. Date initiated 04/24/20 Nebulizer treatments as ordered. Date initiated 04/24/20. Record review of R#2's MDS dated [DATE] indicated R#2: -had clear speech, -was usually understood by others, -was usually able to understand others, -was cognitively intact, -required extensive assistance of two staff for personal hygiene, toilet use, dressing, transfers, and bed mobility, and -required oxygen use. Record review of R#2's May 2020 Physician's orders revealed: Oxygen at 3LPM via Nasal Cannula as tolerated. Observation on 05/11/20 at 1:50 p.m. revealed RN J conducted a skin assessment on R#2. R#2 had a nasal cannula in his nose that was connected to an oxygen concentration machine. Surveyor observed the oxygen gauge was set at 3.5LPM. In an interview on 05/11/20 at 2:04 p.m., RN J acknowledged R#2's oxygen was set at 3.5LPM. RN J said while she was conducting her rounds at around 8:00 a.m. that morning she measured R#2's oxygen saturation level and it was at 91%. RN J said she turned the oxygen up to 3.5LPM since R#2's oxygen level was low. RN J said she did not notify the physician of R#2's low oxygen saturation level and did not obtain an order to raise the oxygen gauge to 3.5LPM. Record review of R#2's progress notes revealed: 05/11/20 at 14:42 (2:42 p.m.) Note Text: late entry for 0800: patient laying supine in bed with HOB elevated, eyes closed, respirations regular and unlabored. Oxygen at 90% on 3L/min via n/c notified Dr. (doctor's name). new order for prn oxygen at 3.5L/min via N/C to keep above 92% oxygen. Bed low and locked, call light within reach. Record review of R#2's physician's orders revealed: -Oxygen at 3.5LPM via N/C to keep O2 at >92%. Start date: 05/11/20 at 8:05 a.m. In a telephone interview on 05/13/20 at 3:43 p.m., RN J said she called R#2's Physician after surveyor intervention at around 2:00 p.m., not at 8:05 a.m. as indicated on R#2's Physician's orders. RN J said she put 8:05 a.m. by mistake because that was the time she set the oxygen at 3.5LPM. In an interview on 05/11/20 at 2:25 p.m., DON D said nurses can give residents more oxygen if it was an emergency. DON D said nurses were not going to wait to get a physician's order to give the residents more oxygen if they were in respiratory distress. DON D said if this did happen, the nurse needed to document and report the resident's condition to the physician immediately. Record review of the facility policy titled, Medication and Treatment Orders, revised December 2017, revealed: Medications shall be administered upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Record review of the facility policy titled, Charting Errors and/or Omissions, revised December 2017, revealed: Late entries in the medical record shall be dated at the time of entry and noted as a 'late entry.' 2) Record review of R#1's Admission Record, dated 05/13/020, revealed R#1 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#1's [DIAGNOSES REDACTED]. pacemaker. Record review of R#1's Minimum Data Set (MDS) assessment, dated 03/26/20, revealed R#1: -had clear speech, -was understood by others, -was able to understand others, -had mildly impaired cognition. -required extensive assistance from staff for bed mobility, transfers, locomotion, dressing, toilet use, and personal hygiene, -required supervision for eating, and -had no functional limitations in range of motion to upper or lower extremities. Record review of R#1's care plan, dated 03/30/20, revealed: Problem: (R#1) has acute [MEDICAL CONDITION]. Interventions: Assist (R#1) with ADLS and ambulation as needed; Fluids as ordered. Restrict or give as ordered; Give medications as ordered by physician; Monitor for s/sx of infection, UTI; Monitor/document/report for s/sx of acute failure: Oliguria (urine output <400ml per 24hr.) Increased BUN and Creatinine. In Diuretic phase, (output >500 ml/24 hs) the BUN and Creatinine level out.; Monitor/document/report PRN the following s/sx: [MEDICAL CONDITION], weight gain of over 2lbs a day, neck vein distension, difficulty breathing (Dyspnea), increased heart rate ([MEDICAL CONDITION], elevated blood pressure (Hypertension), skin temperature, peripheral pulses, level of consciousness, monitor breath sounds for crackles. Record review of R#1' s progress notes revealed: -05/04/20 15:50 (3:50 p.m.) Note Text: Sn called DR (Doctor's name)'s office at this time regarding resident's 24hr urine recollection for creatinine clearance with total protein. SN spoke to (name of staff), MA she stated, 'I gave an order on Friday (05/01/20) to send resident to hospital for [MEDICAL TREATMENT] and to be dialyzed. I reviewed the CBC and CMP which is the reason why we gave that order.' Per MA new order: disregard 24HR urine recollection; send resident to the hospital to have [MEDICAL TREATMENT] insertion and to have [MEDICAL TREATMENT] as needed. This SN reported new order to DON and to 200 hall nurse. RP made aware. Progress note was signed by LVN N. -05/01/20 at 16:32 (4:32 p.m.) Late Entry: (entry made on 05/08/20) Note Text: SN received phone call from Doctors office, regarding on how the resident's condition was. SN informed MA that resident was stable, no respiratory distress at the moment. MA informed sn that resident was to be sent out to hospital on MONDAY 05/04/20 if he continued to be stable, but if any changes or if resident went into respiratory distress during the weekend the resident was to be sent out immediately to hospital. SN monitored resident & o2 every 15 minutes, was stable throughout the whole shift. Progress noted was signed by LVN K. -05/07/20 at 17:35 (5:35 p.m.) - Note indicated R#1 had been transported out of the facility via EMS to the hospital as per family request. In an interview on 05/08/20 at 4:17 p.m., DON D said she remembered LVN K had mentioned to her about R#1's doctor giving the order to send R#1 out to the hospital, but did not recall what date. DON D said the nurses should document any verbal orders by the physicians in the physician's orders and the progress notes. DON D said she would have to go back and look at R#1's chart to see where this order was documented. In an interview on 05/11/20 at 4:23 p.m., LVN N said when she called R#1's Nephrologist's office regarding the 24-hour urine collection, she was told by the MA that R#1 was supposed to have been sent out to the hospital since Friday (05/01/20). LVN N said the MA from the Nephrologist's office told her that she had given this order to LVN K when the MA called to the facility on [DATE]. LVN N said she did not know anything about this order. LVN N said she checked the progress notes and did not see any progress notes or physician's orders indicating R#1 was to be transferred out to the hospital for [MEDICAL TREATMENT]. LVN N said she reported it to the DON. In an interview on 05/11/20 at 4:51 p.m., LVN K said she was a new nurse at the facility. LVN K said on 05/01/20 she received a call from R#1's Nephrologist's office. LVN K said this was the very first time she had ever answered the phone at the facility and received an order. LVN K said she spoke to a lady from the doctor's office, but did not remember her name. LVN K said the lady asked about R#1. LVN K said the lady told her R#1 was to be sent out to the hospital on Monday 05/04/20, but if R#1 had any respiratory distress, to send R#1 out immediately. LVN K said she verified the order with the lady from the physician's office twice by repeating the order and got confirmation. LVN K said the lady did not specify a time R#1 should be sent out to the hospital, she only said Monday. LVN K said she reported this order verbally to the DON but did not document it anywhere. LVN K said she was a new nurse and was not familiar with where orders needed to be documented. LVN K said she made a late entry into R#1's chart on 05/08/20 regarding the order that was given to her on 05/01/20. In an interview on 05/11/20 at 5:00 p.m., DON D said LVN K made a late entry of the instructions that were given to her over the phone by the physician's office. DON K said she was not able to find documentation anywhere else of this order. DON K acknowledged the importance of documenting in the residents' charts. Record review of the facility policy titled, Charting Errors and/or Omissions, revised December 2017, revealed: Late entries in the medical record shall be dated at the time of entry and noted as a 'late entry.' Review of the website at https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/provider-portal/QMP/NurseDocumentationPPT.pdf revealed: Texas Administrative Code (TAC) Title 22, Part 11, Chapter 217, 217.11: Standards of Nursing Practice (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall: o (D) Accurately and completely report and document: - (i) the client's status including signs and symptoms; - (ii) nursing care rendered; - (iii) physician, dentist or podiatrist orders; - (iv) administration of medications and treatments; - (v) client response(s); and - (vi) contacts with other health care team members concerning significant events regarding client's status; 3) Record review of the Hall 200 24-hour Report, dated 05/04/20, revealed: (R#1) - Follow up on outpatient appointment for permacath placement possible appt May 7th at 9:00 a.m. Record review of the Hall 100 24-hour Report, dated 05/07/20, revealed: (R#1) 0900 APPT AT (HOSPITAL) PRE OP FOR PERMACATH PLACEMENT SEND VIA EMS CALL 1 HR PRIOR APPT. DR (doctor's name) 05/12/20 at 12PM- (handwritten note) Resident for plc. tomorrow at 8:00 AM Record review of R#1's progress notes revealed: -05/07/20 14:20 (2:20 p.m.) Note Text: 2:20PM- Notified by Supervisor that (family member) (RP) had just called and wanted patient to be sent to (name of hospital) ER for eval of possible stroke. (Family member) had been informed pt did not present with s/s of stroke at this time. Per (family member) he has slurred speech and doesn't look right. He had went to register patient at (name of hospital and city) for Permacath placement in which pt went for registration and then AM Nurse was informed he didn't have to go to register it just needed to be the RP

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) . Progress note signed by LVN/ADON O. -05/07/20 16:07 (4:25 p.m.) Note Text: RESIDENT IN BED WITH NO COMPLAINTS AT THIS TIME. KEPT N.P.O. FOR PLACEMENT OF PERMA CATH. NO DISTRESS NOTED. AT 8 A.M. EMS CALLED FOR TRANSFER TO (name of hospital). AT 9 RESIDENT LEFT BY EMS WITH MASK ON, RESIDENT A/O X3, VITAL SIGNS WITHIN NORMAL LIMITS NO DISTRESS NOTED. RESIDENT BACK, AS PER (name of person) FROM (name of hospital) RESIDENT WILL HAVE PROCEDURE DONE TOMMORRW. Progress note was signed by LVN L. In an interview on 05/12/20 at 1:28 p.m., LVN L said she worked on the morning of 05/07/20 in Hall 100 and was the nurse who arranged the EMS transportation for R#1 to be taken to the hospital for the permacath procedure. LVN L said she was told by RN M during report about R#1's appointment for the permacath placement. LVN L said she did not verify the appointment or notify the family. LVN L said the Secretary was in charge of verifying appointments and notifying the resident's family about the appointments. LVN L said she was just told to arrange the transportation with EMS that morning, an hour before the appointment. LVN L said R#1 was sent back to the facility and she was informed that it was not necessary for R#1 to go to the pre-op appointment. LVN L said R#1 would have to go back the next day 05/08/20 for the procedure. LVN L said she was not told R#1's appointment was for pre-op. LVN L said the hospital staff told her '(RN M) must've misunderstood. LVN L said that was how she knew it was RN M that set up the appointment. LVN K said she thought R#1 was going to have the procedure that day (05/07/20). In an interview on 05/12/20 at 2:53 p.m., RN M said he worked on Hall 200 on 05/04/20. RN M said he was the nurse that called the hospital outpatient clinic to arrange R#1's appointment for the permacath placement as ordered by the physician. RN M said the scheduler at the hospital was supposed to call him back to finish setting up the appointment but the scheduler did not call him back during his shift. RN M said he was not sure if the next shift nurse got a call back. RN M said he was told R#1's 05/07/20 appointment was for pre-op, but was not given instructions on whether R#1 had to go to the appointment or not. RN M said he was not sure if anyone got a call back from the scheduler to complete the appointment. RN M said R#1 was moved to another hallway the next day and he did not take care of R#1 anymore. In an interview on 05/12/20 at 3:27 p.m., LVN/ADON O said she was working on 05/07/20 when R#1 was sent to the hospital for a procedure that was scheduled for 05/08/20. LVN/ADON O said R#1's RP's family member called to the facility and was upset that R#1 was sent to the hospital on the wrong date and may have unnecessarily exposed to the [MEDICAL CONDITION]. LVN/ADON O said R#1's appointment was scheduled for 05/08/20, 05/07/20 was for pre-op and R#1 did not have to go to the hospital for that. In an interview on 05/13/20 at 2:03 p.m., Receptionist P said she was in charge of the appointments for the residents. Receptionist P said she had a binder where she wrote down all the appointments. Receptionist P said she would make the residents' appointments when the nurses asked her to, but sometimes the nurses would make the appointments and then tell her so she could write them down in the schedule binder. Receptionist P said she would review the scheduled appointments the day before the appointment dates and would call a day or two before the appointment to confirm the appointments and to also notify the family members. Receptionist P said LVN K came to her desk on 05/06/20 and told her about R#1's appointment at the hospital for the permacath placement. Receptionist P said she did not call to verify the appointment because LVN K had a document with her that looked like a document from the hospital with the appointment date and time and she figured it was a set appointment. Receptionist P said she did not set up the EMS transportation for R#1, she believed the nurse was the one that set it up. Receptionist P said R#1 was brought back to the facility by EMS on 05/07/20 and she was told by EMS that R#1's procedure was scheduled for the next day 05/08/20. Receptionist P said she was told by EMS that 05/07/20 was for the registration and R#1 did not have to be there. In an interview on 05/13/20 at 3:55 p.m., LVN K said she worked they day before the appointment (05/06/20) and was told during report by the previous nurse that she needed to make sure to tell the Receptionist that R#1 had an appointment at the hospital on [DATE] at 9:00 a.m., for permacath placement. LVN K said she went up to the Receptionist during the 2-10 shift and had the 24-hour report with her and told the Receptionist that she needed to set up EMS transportation for R#1's appointment. LVN K said she was told to do that and that was what she did. LVN K said she was not R#1's nurse the next day, but since the appointment was going to be early the next morning, she needed to let the Receptionist know. In an interview on 05/14/20 at 4:01 p.m., Administrator Q said he received a call from R#1's family member stating that he was concerned R#1 was sent to the hospital a day before the scheduled procedure by mistake. Administrator Q said he told R#1's family member that it was a mistake to send R#1 on the wrong date and he would address this with the staff. Administrator Q said he received another call from another of R#1's family members saying the facility had been negligent in sending R#1 to the hospital on the wrong date and possibly exposing R#1 to the [MEDICAL CONDITION]. There was no written facility policy provided regarding scheduling appointments.