STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676218	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JEFFERSON NURSING AND REHABILITATION CENTER	3840 POINTE PARKWAY BEAUMONT, TX 77706

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 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 interview and record review, the facility failed to ensure the right to be treated with respect and dignity and receive care in a manner that promoted maintenance or enhancement of his or her quality of life was provided for 1 of 14 residents reviewed for resident rights. (Residents #10) The facility did not provide a dignified dining experience for Residents #10 when his pull-up needed to be changed during a meal. This failure could place the residents at risk for decreased quality of life and quality of care. Findings included: The Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 was admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. The assessment indicated Resident #10 had moderate cognitive impairment, required one-person assistance with dressing and transfers, and was continent of bowel and bladder. A care plan revised 3/24/20 for Resident #10 did not include information pertaining to Resident #10's ADL's or incontinence. A note dated 6/21/20 at 10:26 p.m. indicated during dinner time, Resident #10 came out of his bedroom to get his brief changed after he had an incontinent episode. In the presence of a CNA, told Resident #10 it was during meal time and he would have to wait until after meal time to be changed. Resident #10 then proceeded to yell out in a loud voice '[***] you [***] es.' During an interview on 6/30/20 at 4:30 p.m., when shown the progress note by surveyor, the interim DON said Resident #10 should have been changed. She said they (referring to staff) would not want to sit in a dirty brief and eat. During an interview on 6/30/20 at 6:00 p.m. the interim DON said she talked to the LVN who wrote the progress note and was told that was how she (the nurse) had always done it. During an interview on 6/30/20 at 4:40 p.m., Resident #10 was not able to recall staff saying they could not take care of him.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to immediately consult the physician regarding a need to alter treatment for 1 of 14 residents reviewed for physician notification. (Resident #13) The facility did not immediately notify Resident #13's physician when the facility was not able to obtain antibiotics to treat [MEDICAL CONDITION] (C. diff; sometimes a fatal infection which can cause severe damage to the colon). Resident #13's [MEDICAL CONDITION] went untreated for [REDACTED]. Findings included: The Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #13 was admitted [DATE], was [AGE] years old, and had a [DIAGNOSES REDACTED]. She had moderate cognitive impairment, required extensive assistance with all activities of daily living (ADL's), and was incontinent of bowel and bladder. An admission physician order [REDACTED].#13 had an order for [REDACTED]. Comprehensive care plan initiated 6/15/20 indicate an intervention to give medications as ordered and monitor/document side effects and effectiveness. A nursing progress note dated 6/16/20 at 11:42 a.m. indicated the nurse who documented the progress note contacted Resident #13's physician and left a message informing him the Diflicid he ordered cost $1500 and she requested a less expensive medication. A nursing progress note dated 6/16/20 at 12:55 p.m. indicated the nurse practitioner changed the medication for [DIAGNOSES REDACTED] to [MEDICATION NAME] (an antibiotic) 500 mg 1 tablet twice a day. During an interview on 7/1/20 at 10:29 a.m., LVN A said the Diflicid for Resident #13 never came in. She said she called the pharmacy on an unknown date and was told they were waiting on approval. She said she did not call the physician or tell administration the medication did not arrive from the pharmacy. She said a nurse who worked another shift had the medication changed. During an interview on 7/1/20 at 7:58 a.m., the nurse practitioner said Resident #13 was admitted from the hospital with a [DIAGNOSES REDACTED]. She said the resident admitted from the hospital with orders for Diflicid for [DIAGNOSES REDACTED]. The nurse practitioner said she was not notified the facility had not given the resident the medication to treat the [MEDICAL CONDITION] until three days after her admission. During an interview on 6/30/20 at 6:00 p.m., the administrator said had she known there was a problem with the medication, she would have first asked if there was a cheaper alternative and if not she would have paid for it. The CDC website <https://www.cdc.gov/cdiff/what-is.html> was accessed on 7/10/20 and indicated [MEDICAL CONDITION] often called [DIAGNOSES REDACTED]licile or [DIAGNOSES REDACTED]. is a bacterium (germ) that causes diarrhea and [MEDICAL CONDITION] (an inflammation of the colon). The website indicated most cases of [DIAGNOSES REDACTED] occur while taking antibiotics or soon after the completion of antibiotics. The CDC indicates [DIAGNOSES REDACTED] can be deadly.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure timely laboratory services were provided to meet the needs for 2 of 14 residents reviewed for physician's orders [REDACTED].#2 and #11) The facility did not follow physician orders [REDACTED]. The facility did not obtain a COVID-19 (a new respiratory disease which can cause mild to severe illness with most severe illness in adults [AGE] years and older and people of any age with serious underlying medical problems) test as ordered for Resident #2. The facility did not test Resident #11 for [MEDICAL CONDITION] (C. diff; a sometimes fatal infection which can cause severe damage to the colon) as ordered by the nurse practitioner. Resident #11 was diagnosed with [REDACTED]. This failure could place residents at risk of COVID 19 infection and not receiving timely medical intervention. Findings included: 1. The Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #2 was admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. Resident #2 had moderate cognitive impairment, and required extensive assistance with all activities of daily living (ADLs). Consolidated physician orders [REDACTED].#2 had an order for [REDACTED].#2's nurse practitioner gave an order to have him tested for COVID. She said the social worker and admissions coordinator decided to remove Resident #2 from quarantine and in with a roommate because he had been in quarantine for 14 days. The interim DON said the admissions coordinator and social worker did not discuss this move with nursing prior to moving the resident. During an interview on 6/30/20 at 12:45 p.m., the nurse practitioner said she ordered a stat COVID test for Resident #2 on 6/29/20 because she had ordered the original test a week prior (on 5/21/20) due to a possible COVID exposure while in the facility from a lab technician. She said the resident was moved to another room with a roommate without being tested . During an observation on 6/30/20 at 12:15 p.m., Resident #2 was sitting within arm's reach of his roommate watching television. Neither resident had a mask on. 2. The MDS assessment dated [DATE] indicated Resident #11 was admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. Resident #11 had severe cognitive impairment, and required extensive assistance with all ADLs. A progress note from the nurse practitioner dated 6/22/20 indicated Resident #11 had been having diarrhea for 2 days. The nurse practitioner ordered a [MEDICAL CONDITION] (C. diff) test for

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676218	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JEFFERSON NURSING AND REHABILITATION CENTER	**3840 POINTE PARKWAY BEAUMONT, TX 77706**

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 0770 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Resident #11. There was no lab result in the medical record or in the lab request book indicating the facility obtained the specimen. The nursing progress notes dated 6/26/20 at 8:11 p.m., 6/27/20 at 8:00 p.m., and 6/28/20 at 9:13 p.m., indicated there were no loose stools for Resident #11 during the shift and the nurses would continue to monitor. There was no documentation of loose stools prior to 6/26/20, except on 6/2/20 and 6/7/20. A nursing progress note dated 6/30/20 at 12:34 a.m., indicated Resident #11 had multiple episodes of diarrhea. The note indicated there was a new order for a portable KUB (an x-ray for the kidney, ureter, and bladder to assess the organs and structures of the urinary and/or gastrointestinal system) due to the resident's diarrhea. The note indicated the specimen collected for the [MEDICAL CONDITION] was picked up on 6/30/20. During an interview on 6/30/20 at 6:00 p.m., the DON said Resident #11 had diarrhea for several days. She said when they received the first order to test the resident for [DIAGNOSES REDACTED], Resident #11 did not have any diarrhea over the weekend. During an interview on 7/1/20 at 7:58 a.m., the nurse practitioner said she told the facility to get a sample to test Resident #11 for [DIAGNOSES REDACTED]. on 6/22/20 because the resident had been having diarrhea for 2 days. She said the facility did not get the sample until 6/30/20 and the resident was positive for [DIAGNOSES REDACTED]. During an interview on 7/1/20 at 1:07 p.m., CNA B said Resident #11 had been having diarrhea for about a week, but he was not aware of any diarrhea over the weekend. A nursing progress note dated 6/30/20 at 8:40 p.m. indicated critical lab results for Resident #11 were received from the hospital (the stool specimen was sent to the hospital lab) by phone. Resident #11 tested positive for [DIAGNOSES REDACTED]. The CDC website <https://www.cdc.gov/cdiff/what-is.html> was accessed on 7/10/20 and indicated [MEDICAL CONDITION] often called [DIAGNOSES REDACTED]icile or [DIAGNOSES REDACTED]. is a bacterium (germ) that causes diarrhea and [MEDICAL CONDITION] (an inflammation of the colon). The website indicated most cases of [DIAGNOSES REDACTED] occur while taking antibiotics or soon after the completion of antibiotics. The CDC indicates [DIAGNOSES REDACTED] can be deadly.