STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676037	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESLACO NURSING AND REHABILITATION CENTER	**422 E 18TH ST WESLACO, TX 78596**

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility nursing staff failed to maintain medical records on each resident that were complete and accurately documented, for one Resident (R#1) of three residents reviewed for medical records, in that: Nursing staff documented a [DIAGNOSES REDACTED].#1's Physician had not given. This failure could put residents at risk for inadequate care. Findings included: Record review of R#1's electronic medical record revealed R#1 was an [AGE] year-old female who was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's progress notes revealed: -08/30/20 - Summary: Clinical observations and noted response to treatments; Continues on [MEDICATION NAME] 500 mg PO (oral) TID (three times a day) DX (diagnosis)[MEDICAL CONDITION] ([MEDICAL CONDITION]-resistant staphylococcus aureus) to Wound, contact isolation. -08/31/20 - Summary: Clinical observations and noted response to treatments; Continues on [MEDICATION NAME] 500 mg PO TID [MEDICAL CONDITION] to Wound, contact isolation. -09/02/20 - Summary: clinical observations and noted response to treatments: resident continues on [MEDICATION NAME] 500 mg 2 tab via peg tube TID, [MEDICATION NAME] 1 gm (gram) IV (intravenous) Q8hrs (every eight hours), [MEDICATION NAME] 500 1 tab via peg BID (twice daily), [MEDICAL CONDITION] to wound, no adverse reactions noted. Resident continues on contact isolation [MEDICAL CONDITION] of wound. Observation on 09/02/20 at 9:10 a.m., accompanied by LVN A, revealed there was no sign outside R#1's door indicating R#1 was on contact isolation. LVN A entered the room, donned a gown and gloves, and proceeded to take R#1's glucose reading. Surveyor observed two CNAs that wore only gloves when they assisted R#1 with repositioning. In an interview on 09/03/20 at 10:35 a.m., LVN A said R#1 was on contact isolation but had been moved from another room and staff forgot to put the contact isolation sign and the PPE rack outside R#1's door. In an interview on 09/03/20 at 11:07 a.m., CNA C said she knew when a resident was on contact isolation because outside the room there would be a sign for contact isolation and usually a caddy with PPE hanging outside the door. CNA C said when she assisted R#1 with repositioning, she was not aware that R#1 was on contact isolation. CNA C said that, if she had known, would have worn full PPE including gown, gloves, face mask and face shield. In an interview on 09/03/2020 at 11:19 a.m., DON was in the process of clarifying R#1's orders. The DON said R#1's Physician said only wound infection, [MEDICAL CONDITION]. The DON said LVN D was the nurse who received the order. In an interview on 09/03/20 at 11:30 a.m., LVN D said R#1's Physician had given a verbal order for a wound infection for R#1 and never [MEDICAL CONDITION]. LVN D said when he came back to work, he noticed that R#1 had a [DIAGNOSES REDACTED].#1 had not been diagnosed with [REDACTED].#1 had [MEDICAL CONDITION] diagnosis. LVN B said she did not verify the diagnosis, but documented it in R#1's progress notes. LVN B said R#1 only had a wound infection. In an interview on 09/03/20 at 12:00 p.m., the DON said she reviewed R#1's lab work and the lab results did not indicate R#1 [MEDICAL CONDITION]. The DON said she was going to clarify with R#1's doctor. In an interview on 09/03/20 at 4:15 p.m., the DON said nurses should not have documented a [DIAGNOSES REDACTED].#1 was under contact isolation, because there was no doctor's order for it. The facility had no written policy on nursing documentation.

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