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 _____	09/02/2020

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 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 2 of 7 residents reviewed for medications. (Resident #s 1 and 2) The facility did not administer [MEDICATION NAME] (used to treat [MEDICAL CONDITION]) for three days to Resident #1 as ordered upon readmission to the facility. The facility did not administer Fluconazole (used to treat yeast infection) for two days to Resident #2 as ordered upon admission to the facility. This failure could place residents at risk of not receiving therapeutic benefits of medications. Findings included: 1. Physician orders [REDACTED].#1 was readmitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. An MDS assessment dated [DATE] indicated Resident #1 had moderate cognitive impairment, required extensive assistance with her ADLs, was incontinent of bowel and had a Foley catheter due to pressure sores. The MDS indicated the resident [MEDICAL CONDITION]. The hospital Discharge Medications dated 8/17/20 indicated Resident #1 was to receive [MEDICATION NAME] 80 mg by mouth twice daily for the treatment of [REDACTED]. last dose given: Monday August 17, 2020 12:11 p.m. The order was not put into the computer until 8/19/20 to be started on 8/20/20. A MAR indicated [REDACTED]. During an interview on 9/1/20 at 2:46 p.m., LVN B said she missed the medication when she readmitted Resident #1. She said the nurse practitioner caught the error on 8/19/20. During an interview on 8/20/20 at 12:06 p.m., Resident #1's NP said she was reviewing the discharge orders from the hospital when she noticed the facility did not transcribe the [MEDICATION NAME] for Resident #1. She said she told the staff the resident needed the medication for her [MEDICAL CONDITION] and it was not to be stopped. 2. Physician orders [REDACTED].#2 admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. Resident #2 had a Fluconazole order dated 8/30/20 with a start date of 8/31/20. The hospital Discharge Medications dated 8/29/20 indicated Resident #2 was to receive Fluconazole (used to treat yeast) 200 milligrams (mg) by mouth daily for 3 days. A MAR for Resident #2 dated August 2020 and September 2020 indicated Resident #2 received the first dose of Fluconazole on 9/1/20. During an interview on 9/2/20 at 3:00 p.m., the NP for Resident #2 said the resident had been on the Fluconazole while in the hospital because she had yeast in her sacral wound. She said the Fluconazole was supposed to be continued three more days when she was admitted to the facility. During an interview on 9/2/20 at 11:30 a.m., LVN A, who is also the ADON, said Resident #2's medications were put into the computer when she was admitted on [DATE] but they were not activated until 8/31/20. He was not sure why the medications were no activated. He said Resident #2 received her first dose of Fluconazole at the facility on 9/1/20. He said the medications should have been started upon admission. The admission policy provided by the facility revised December 2017 did not address medications. Our facility will admit resident whose medical and nursing care needs can be met.
F 0777 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the nurse practitioner (NP) was promptly notified of x-ray results for 1 of 7 residents reviewed for radiology services. (Resident #3) The facility did not notify Resident #3's NP promptly when his KUB (kidney, ureter and bladder x-ray) indicated he had a possible bowel blockage or ileus (lack of movement in the intestine that can lead to a blockage). Resident #3 was sent to the hospital one day later and was diagnosed with [REDACTED]. Findings included: Physician orders [REDACTED].#3 admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. An MDS assessment dated [DATE] indicated Resident #3 had moderate cognitive impairment, required extensive assistance with ADLs, and was frequently incontinent of bowel and bladder. The active [DIAGNOSES REDACTED].#3 was to have a stat KUB due to constipation. A KUB result for Resident #3 dated 8/18/20 at 3:32 p.m. indicated Impressions: Stacked small bowel loops are worrisome for partial small bowel obstruction. A KUB result for Resident #3 dated 8/18/20 at 8:13 p.m. indicated Impressions: .2. Moderate gas in nondistended loops of small bowel and colon. Findings may represent ileus. Correlate clinically and consider follow up KUB as clinically warranted. During an interview on 9/2/20 at 11:50 a.m., LVN A, who is the ADON, said he worked the 2 p.m. - 10 p.m. shift on Resident #3's hall on 8/18/20 and did not know the KUB x-ray results on Resident #3 had been sent to the facility. He did not check the fax machine for any results. He said he would have sent the results to the NP. During an interview on 8/20/20 at 12:00 p.m. LVN B said she was not working the evening the KUB results for Resident #2 were sent to the facility. She said she faxed them to the NP on 8/19/20 around noon. She said the NP called back within 5 minutes and ordered to send Resident #3 to the emergency room . She said she did not know why two KUB's were done on 8/18/20. During an interview on 8/20/20 at 12:06 p.m., the NP for Resident #3 said she ordered a stat KUB for Resident #3 on 8/18/20 because he had loose stools and had some vomiting. She said she did not get the results until 8/19/20 between 11:30 a.m. and noon. She said the results indicated the resident may have an ileus and she sent him to the hospital. She said she had ordered the KUB stat and should have gotten the results on 8/18/20 when the facility received them. The hospital physician's Emergency Documentation dated 8/19/20 indicated Resident #3's admission [DIAGNOSES REDACTED]. The policy indicated The nurse will notify the resident's Attending Physician and Representative when a change in resident's physical and/or mental medical condition has occurred.

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