STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675437	A. BUILDING _____ B. WING _____	06/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED REHABILITATION & HEALTHCARE OF LIVE OAK	8221 PALISADES DRIVE LIVE OAK, TX 78233

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation for 1 of 1 resident (Resident #3) reviewed for abuse in that: The facility failed to implement its policy for reporting to the state agency an allegation abuse for Resident #3, within two hours. This deficient practice could affect residents who are dependent on care and could place residents at risk of abuse. The findings were: Review of a facility policy titled Resident Protection dated 09/13/2017 revealed V. Investigation: A. Investigate different types of incidents; and identify the staff member responsible for the initial reporting, investigation of alleged violations and reporting of results to the proper authorities. B. The Facility must have evidence that all violations, including allegations, are thoroughly investigated. Investigations are under the direction of the Abuse Coordinator who is the QAPI (Quality Assessment and Performance Improvement) Chair Person, therefore investigative documents are QAA (Quality Assurance Assessment) protected/confidential. C. The results of the investigation must be reported to the Administrator and to other officials in accordance with state law Including the State survey and certification agency) within 5 working days of the incident. If the alleged violation is verified, appropriate coercive and disciplinary action will be taken. D. The Charge Nurse or Supervisor must immediately contact the Administrator of Director of Nurses of the incident. E. The nurse must document all incidents of alleged abuse/neglect or Grievance Form which may include 24-hour report. A. Record review of Resident #3's face sheet dated 06/05/2020, revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's quarterly MDS dated [DATE] revealed a BIMS score of 11 (moderate cognitive impairment). Further review of the MDS revealed Resident #3 had difficulty paying attention and had verbal behaviors that occurred 1-3 days a week. Review of Resident #3's Care Plan dated 06/03/2020 revealed behaviors which included refusing oral care. Further review of the Care Plan revealed potential paradoxical side effects: mania, impulsive behavior, and hallucinations related to [MEDICAL CONDITION] drug use. B. In an interview with LVN B, on 06/08/2020 12:27 P.M., she reported Resident #3 informed her that 5/31/20 at approximately 8:30 P.M. that she had given a b*** j** to LVN A earlier that the morning. LVN B said she reported the event to ADON F, because she felt comfortable talking to her and did nothing more with the information. LVN B stated she did not ensure that LVN A was placed on suspension pending investigation. LVN B stated she did not enter the alleged sexual abuse on the 24-hour report. LVN B said she did not follow up to ensure the charge nurse notified the Administrator. LVN B stated she did not notify the Administrator what Resident #3 reported to her. LVN B she went into Resident #3 room to give her 8 pm medications, when out of the blue Resident #3 asked Did LVN A get in trouble? confused, I asked what she was talking about. Resident #3 then began to smile and motion preforming oral sex. LVN B notified ADON F immediately at 9:00 p.m. 5/31/20 as ADON F was in the building. C. In an interview with the Administrator on 06/05/2020 at 8:20 A.M., stated she and the Director of Nurses (DON) learned of the sexual allegation of Resident #3 by LVN B on the morning of 06/05/2020. The Administrator said she initiated an investigation and started in-services training on abuse. The Administrator said LVN A had worked his scheduled shift 6/3/2020 but was assigned to a different unit away from Resident #3. The Administrator said LVN A was placed on suspension on 6/5/20 pending investigation. The Administrator said Resident #3 had no history of sexual allegations. In an interview with the Activities Director (AD) on 6/5/2020 at 11:45 A.M. she stated Resident #3 was immobile in bed and that Rehab just recently started working with Resident #3 to get out of bed into a wheelchair. In an interview with Resident #3 on 06/05/2020 11:45 A.M., Resident #3 was able to answer yes/no questions. Resident #3, using yes or no question, did not recall telling LVN B about the sexual incident with LVN A. In an interview on 06/08/2020 at 10:25 A.M. with LVN A, he stated he worked as a CNA 05/31/2020 on the South Wing where Resident #3 resided. He worked as a CNA instead of a LVN because a CNA was needed. LVN A denied any encounter of a sexual nature with Resident #3 and was not aware of the alleged incident until the morning of 6/5/2020.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all violations involving abuse, neglect, exploitation or mistreatment, were reported immediately, but not later than 2 hours after the allegation is made, to the administrator of the facility and to other officials (including to the State Survey Agency) for 1 of 1 Resident (Resident #3) reviewed for abuse in that: The facility failed to report immediately, but not later than 2 hours, a violation involving abuse, neglect, exploitation, or mistreatment for [REDACTED]. This deficient practice could affect residents who are dependent on care and could place residents at risk of abuse. The findings were: A. Record review of Resident #3's face sheet dated 06/05/2020, revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's quarterly MDS dated [DATE] revealed a BIMS score of 11 (moderate cognitive impairment). Further review of the MDS revealed Resident #3 had difficulty paying attention and had verbal behaviors that occurred 1-3 days a week. Review of Resident #3's Care Plan dated 06/03/2020 revealed behaviors which included refusing oral care. Further review of the Care Plan revealed potential paradoxical side effects: mania, impulsive behavior, and hallucinations related to [MEDICAL CONDITION] drug use. B. In an interview with LVN B, on 06/08/2020 12:27 P.M., she reported Resident #3 informed her that 5/31/20 at approximately 8:30 P.M. that she had given a b*** j** to LVN A earlier that the morning. LVN B said she reported the event to ADON F, because she felt comfortable talking to her and did nothing more with the information. LVN B stated she did not ensure that LVN A was placed on suspension pending investigation. LVN B stated she did not enter the alleged sexual abuse on the 24-hour report. LVN B said she did not follow up to ensure the charge nurse notified the Administrator. LVN B stated she did not notify the Administrator what Resident #3 reported to her. LVN B she went into Resident #3 room to give her 8 pm medications, when out of the blue Resident #3 asked Did LVN A get in trouble? confused, I asked what she was talking about. Resident #3 then began to smile and motion preforming oral sex. LVN B notified ADON F immediately at 9:00 p.m. 5/31/20 as ADON F was in the building. C. In an interview with the Administrator on 06/05/2020 at 8:20 A.M., stated she and the Director of Nurses (DON) learned of the sexual allegation of Resident #3 by LVN B on the morning of 06/05/2020. The Administrator said she initiated an investigation and started in-services training on abuse. The Administrator said LVN A had worked his scheduled shift 6/3/2020 but was assigned to a different unit away from Resident #3. The Administrator said LVN A was placed on suspension on 6/5/20 pending investigation. The Administrator said Resident #3 had no history of sexual allegations. In an interview with the Activities Director (AD) on 6/5/2020 at 11:45 A.M. she stated Resident #3 was immobile in bed and that Rehab just recently started working with Resident #3 to get out of bed into a wheelchair. In an interview with Resident #3 on 06/05/2020 11:45 A.M., Resident #3 was able to answer yes/no questions. Resident #3, using yes or no question, did not recall telling LVN B about the sexual incident with LVN A. In an interview on 06/08/2020 at

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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