STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455804	A. BUILDING _____ B. WING _____	**06/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHGATE HEALTH AND REHABILITATION CENTER	**5757 N KNOLL SAN ANTONIO, TX 78240**

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 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents have reasonable access to and privacy in their use of communication methods.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the resident had the right to have reasonable access to the use of a telephone and a place in the facility where calls could be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense for 1 of 3 Residents (#1) whose records were reviewed. 1. Resident #1 was not able to use the facility phone because the range did not reach the Resident's room. 2. Facility staff did not give Resident #1 a package mailed by a family member as of 5/11/20 which included a cell phone. This deficient practice could affect any Resident and resulted in feelings of anxiety and helplessness. The findings were: 1. Review of Resident #1's face sheet revealed he was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Interview on 6/1/20 at 10 AM with Resident #1 revealed he had not talked with his mother whom he lived with for years prior to being admitted into the facility. He stated it was important that he be able to talk with her but had not had much telephone contact because the phone did not work in his room. Interview on 6/1/20 at 1:20 AM with CNA B revealed he had worked at the facility for about 4 months. CNA B stated Resident #1 would ask to use the cordless phone available to the Resident's. However, CNA B stated the cordless phone did not work in Resident #1's room and would show a message, out of range. He stated he had let the ADON know that it did not work. Interview on 6/1/20 with the ADON revealed she did not know the phone accessible for Resident #1 did not work. Observation on 6/1/20 at 2:15 PM revealed the cordless phone by the nurse's station located between the 100 and 200 halls did not have a dial tone. Interview with LVN A at this same time revealed the phone only worked while on speaker phone. He stated he had told the Maintenance Director about the phone about 1 week ago. LVN A stated he did not know the phone did not work in Resident #1's room. Interview on 6/1/20 at 2:30 PM with the ADM stated he did not know the cordless phone was not working properly. 2. Interview on 5/27/20 at 10:43 AM with Resident #1's family member revealed she had sent Resident #1 a package containing a cell phone, reading glasses and a book. She stated that Resident #1 told her he had not received it. The family member stated she called and spoke with the DON (named her by her first name) a few days prior. She stated the DON told her it was related to COVID-19 and that they would have to wait 14 days before they could release the package to Resident #1. The family member stated it had been over 2 weeks since she sent the package. Interview on 6/1/20 at 10 AM with Resident #1 confirmed he had not received the cell phone that his family member mailed to him. He stated he wanted it so that he could call his mother. Interview on 6/1/20 at 10:20 AM with HR personnel revealed the facility had several Administrators and that they (staff) had received different guidance about the Resident's receiving packages due to COVID-19. The HR personnel stated the last she was told was that they would have to hold the package 14 days before releasing it to the Resident. She confirmed Resident #1 had received a package a while ago. Observation at this same time revealed a package on top of a filing cabinet in HR personnel's office with a statement reading due to arrive on or before 5/11/20. The HR personnel stated it had been more than 14 days. Interview on 6/1/20 at 10:40 AM with the DON confirmed staff had received different guidance on whether it was safe for Resident's to receive packages due to a question about [MEDICAL CONDITION] being able to live on the surface of the package. The DON stated she thought the previous Administrator had given Resident #1 his cell phone. The DON and Surveyor at this same time walked to the Human Resources Office and picked up the package with Resident #1's name on it and delivered it to Resident #1. The DON asked the Resident if she could open it. The DON opened the package which contained a cell phone, reading glasses and a book. The DON confirmed that she also understood that staff was to wait 14 days before delivering packages and stated it had been more than 14 days based on the date on the package, 5/11/20. Review of the facility's Resident Admission Guide dated 12/1/18 read in part: Your mail will be delivered every day unless there is not mail service. Private telephone providing privacy is provided for local calls.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 interview and record review the facility failed to consult with the resident's physician when there was a significant change in the resident's mental or psychosocial status for 1 of 3 Residents (#1) whose records were reviewed. LVN A did not call Resident #1's physician after expressing suicidal ideation's. This deficient practice could affect any Resident and could contribute to a Resident's further decline in mental status. The findings were: Review of Resident #1's face sheet revealed he was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Review of progress note dated 5/1/20 revealed that Resident #1 was upset because he had not been out of bed for three weeks and that no one ever came into his room. LVN A reminded him the Resident he had been up and that staff had changed him that same day. Resident commented, That's not true! I'm going to do the suicide. Further review revealed LVN A probed Resident #1 about a plan and the Resident did not verbalize a plan other than he would die. Further review of progress note did not reflect that LVN A called Resident #1's physician. Interview on 5/28/20 at 2:55 PM with LVN A confirmed that a few weeks prior Resident #1 stated he wanted to die and re-iterated the details as provided in the progress note dated 5/1/20. Further interview revealed LVN A did not contact Resident #1's physician. Interview on 5/28/20 at 3:23 PM with the SW revealed she knew that Resident #1 had stated he wanted to die. She stated that it was related to Resident #1 wanting to visit with his mother and wanting to get out of bed more. Interview on 6/1/20 at 2 PM the Director of Rehabilitation (DOR) revealed that Resident #1 had received therapy off and on his entire stay at the facility. The DOR stated they put Resident #1 back on therapy following [MEDICAL CONDITION] during February 2020. He stated some time after Resident #1 talked about wanting to die. He stated he talked with the nurse and SW about the Resident's statements and discussed the Resident's status during morning meetings. Interview on 6/1/20 at 5:30 PM with the DON revealed that LVN A never said anything to her about Resident #1's suicidal ideation's. The DON stated she did not call Resident #1's physician and the DON confirmed that LVN A should have called the physician. Review of a facility policy, Change of Condition-Observing, Reporting and Recording dated 12/2017 read in part: It is the policy of this home to inform the residents physician of the following. 2. A significant change in the resident's physical, mental or psychosocial conditions or clinical complications. Procedure: 3. The attending physician should be notified as soon as possible if immediate attention is required or as soon as feasible if the resident is stable.

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.