STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455333	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHARPVIEW RESIDENCE AND REHABILITATION CENTER	7505 BELLERIVE HOUSTON, TX 77036

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 0697 **Level of harm -** Actual harm **Residents Affected -** Some	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 (CR #1 and #2) of 7 residents reviewed for pain, in that: -CR #1 complained of pain and swelling in right arm for four days and the facility failed to follow physician's orders [REDACTED].#1 sent to the hospital and was diagnosed with [REDACTED]. -CR #2 had unrelieved pain that was delayed in being treated effectively by staff not assessing the pain or following physician's orders [REDACTED].#2 was transferred to the hospital to receive effective pain management and diagnostic tests not conducted at the facility as orderd. After administrative review on [DATE], it was determined that additional information was needed and a Surveyor returned to the facility on [DATE]. These failures placed all residents who experience pain at risk of inadequate therapeutic outcomes, a decline in health and hospitalization s. Findings included: CR #1 Record review of CR #1's face sheet revealed he was an [AGE] year-old male admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. He died in Hospice care on [DATE]. Record review of CR #1's admission MDS dated [DATE] revealed he had a BI[CONDITION] of a 9 which indicated he had moderate cognitive impairment. No routine or PRN pain management was noted on the MDS. He needed ,[DATE] person extensive staff assistance with bed mobility, transfers, eating, toilet use and personal hygiene. Record review of CR #1's [DATE] MAR indicated [REDACTED]. There was an X in each box indicating pain level was not assessed. Record review of CR #1's MAR for [DATE] revealed -[MED] extra strength 500mg by mouth one time a day for [MEDICAL CONDITION] given daily [DATE]st-12th and discontinued on [DATE]. -[MEDICATION NAME] Tablet 600mg three times a day for swollen right upper arm x 4 days. Start date of [DATE] and completed on [DATE]. Record review of CR #1's Nurse Progress Note written by RN A, dated [DATE] at 6:13 a.m. read in part . observed patients right elbow area slightly swollen . Noted area painful as patient states my arm hurt . Able to move right arm per passive range of motion . Record review of facility 72-hour summary/nurse report from [DATE] at 9:00 a.m. identified a nurse note on [DATE] for CR #1, read in part x-ray pending, order to start [MEDICATION NAME] x 4 days, and physician will assess tomorrow . There was no nurses note related to CR #1's continued pain or swelling to the right arm. Record review of a phone order dated [DATE] for CR #1 that read in part . right elbow X- ray, reason pain . Record review of a phone order dated [DATE] for CR #1 that read in part . right elbow X- ray, reason swelling and pain.outpatient imaging. Record review of CR #1's physician progress notes [REDACTED]. History of present illness: Patient discovered to have a swollen and warm right elbow over the weekend. He is noted to have reduced ROM and now requires help with feeding, pain is noted with movement . Physical exam: right elbow swollen, reduced passive and active ROM, pain with movement, does not seem to be in pain with palpation of elbow . treatment plan: [REDACTED]. Record review of CR #1's phone order for CR #1 dated [DATE] phone order revealed MD ordered a stat chest x-ray. Record review of CR #1's Nurse Progress Note dated [DATE] at 9:08 p.m. by ADON B read in part . patient has altered mental status, and lethargic . Right elbow has begun to swell again following completion of [MEDICATION NAME] . Record review of emergency room Medical Screening dated [DATE] for CR #1 revealed he had a right upper extremity doppler ultrasound that showed [MEDICAL CONDITION] in the right brachial vein. The X-ray of the right arm showed a healing [MEDICAL CONDITION] and a [MEDICAL CONDITION]. Interview on [DATE] at 10:40 a.m. with ADON, she said RN B told her CR #1 had swelling to his arm. The ADON said she saw CR #1's arm and it was swollen. She said they informed CR #1's Family Member and the Family Member thought the pain may have been due to arthritis. Interview on [DATE] at 11:04 a.m. with CNA A, she said she told LVN A that CR #1's right arm was swollen on [DATE]. She said if she touched it he would make a noise and pull his arm back. She said she told LVN A several times that CR #1 was complaining about pain to his arm, but she was not sure if LVN A followed-up. She said if she touched under his arm, he would say it hurts. Interview on [DATE] at 4:23 p.m. with RN A said she was the nurse on duty overnight. She said her last round she was told by CNA D that CR #1's arm looked swllen. RN A said she touched his arm and he said my arm as if it hurt him. I told the ADON (no longer employed at the facility). RN A said she gave him pain medication. I could not document the pain level because the system did not allow me to. Interview on [DATE] at 5:26 p.m. with ADON, a copy of CR #1's care plan was requested and was not provided by exit. Interview on [DATE] at 6:07 p.m. with the Administrator, he said the electronic charting system was not set up to have nurses input the level of pain at the time of giving medications. Interview on [DATE] at 3:12 p.m. with RN B (wound care nurse), she said she seen CR #1 for a skin assessment in early [DATE] and identified that he had pain with PROM and localized swelling to right elbow. She said he had no redness or discoloration. RN B said signs of a fracture would be limited mobility, pain, change in tissue color, possible recent fall, change in bone alignment and skin may be warm to touch. She said signs of a [MEDICAL CONDITION] are pain, decreased pulse sensation, change in skin color and swelling. She said CR #1 did not have signs of a [MEDICAL CONDITION] because there was no localized swelling or tenderness. She said she informed the floor nurse of her findings and documented them on her skin assessment. She said the floor nurse should have documented this information on the 24-hour report. Telephone Interview on [DATE] at 3:54 p.m. with CR #1's physician, she said she remembered she was notified by nursing on [DATE] that CR #1 had pain with ROM. She said she assessed the resident and he had some swelling and pain with ROM, but he looked comfortable and no pain when sitting up in wheelchair undisturbed. She said signs of a [MEDICAL CONDITION] are swelling, pain and redness. She said CR #1 had no signs or symptoms of a [MEDICAL CONDITION]. She said a [MEDICAL CONDITION] in the arm would not cause concern for [MEDICAL CONDITION] emboli. She said she ordered an x-ray to his elbow because of swelling and tenderness with passive range of motion. She said the resident was very old and frail and they would have a field day with him, referring to the hospital. CR #2 Record review of CR #2's face sheet revealed he was a [AGE] year old male admitted and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of CR #2's quarterly MDS dated [DATE] revealed a BI[CONDITION] score of 12 indicating moderate impaired cognition. He needed limited help of 1 staff for bed mobility, extensive help of 1 staff with dressing, toileting, personal hygiene, and locomotion in the facility using a wheelchair. Record review of CR #2 Medication Review Report revealed orders for: .Pain assessment every shift using the verbal pain scale order date of [DATE]. .[MEDICATION NAME] Tablet ,[DATE] mg ([MEDICATION NAME]-[MEDICATION NAME]) Give 1 tablet by mouth every 4 hours as needed for pain. Order date [DATE]. [MEDICATION NAME] Tablet ,[DATE] mg ([MEDICATION NAME]-[MEDICATION NAME]) Give 1 tablet by mouth every 8 hours for pain. Order date [DATE]. Record review of CR #2's Order Summary Report read in part . [MEDICATION NAME] Tablet ,[DATE] mg ([MEDICATION NAME]-[MEDICATION NAME]) Give 1 tablet by mouth every 6 hours as needed for pain . effective date [DATE] . Record review of CR #2's Care Plan read in part: . Acute pain right abdomen & right flank aspect r/t kidney stones . Interventions: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain, grimacing and/or guarding . Monitor/document for side effects of pain medication. Observe for constipation, new onset or increase agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness, and falls. Report occurrences to the physician . initiated [DATE] . Record review of CR #2's Nurse Progress Note dated [DATE] by LVN C at 9:00 p.m. read in part . complaints of abdominal pain rate ,[DATE] on verbal scale. Abdominal assessment done and observed the following . Abdomen distention . complain of pain upon touch

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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F 0697 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) during palpation . New order for stat KUB and stat abdominal ultrasound . Record review of CR #2's Nurse Progress Note by RN B dated [DATE] at 10:42 p.m. CR #2 transferred to hospital related to abdomen pain that is not well managed by pain med. Record review of CR 2's Nurse Progress Note by LVN A dated [DATE] at 9:20 a.m. read in part . returned from ER . diagnosed with [REDACTED].Treated with [MEDICATION NAME] while in ER . Follow up with urologist and PCP . urology appointment set up . pain management in progress and well tolerated . Ultrasound of the abdomen order was received from MD . Observation and Interview on [DATE] at 12:58 p.m. with CR #2. He was alert to surroundings and his situation. He admitted he did get forgetful at times and asked the surveyor for her name a couple times throughout the conversation. He rubbed at his right side of abdomen during the conversation and said he had pain in his abdomen that was very annoying. He said he had a recent hernia surgery. CR #2 pulled his shirt up and observation of a healed mid abdominal incision and a small reddened open area on the right lower abdomen. The abdomen appeared to be slightly more distended on the right side then the left side. He rubbed his hand around the mid to lower abdomen and said that was where he had pain. He rated his pain a 6 to 8 on a ,[DATE] pain scale. He said pain medications helped the pain, but the pain never went away. He said he received a pain med around 10:00 a.m. by LVN A but the medication had not helped. Interview on [DATE] at 1:30 p.m. with LVN A, she said she had given CR #2 pain medication that morning because he complained of abdominal pain. She said CR #2 received [MEDICATION NAME] 1 tablet for a pain of 7 but unsure when she gave the medication. She said the pain medication was effective. She said he was forgetful at times and did not remember when he received his pain med. LVN A said she had not done an abdominal assessment on CR #2. Interview on [DATE] at 1:51 p.m. with ADON, she said CR #2 had a hernia surgery in January. She said the resident was always forgetful and always complained of pain. Surveyor asked if pain was objective or subjective and she said pain was what the resident said it was, but CR #2 would constantly ask for a pain med because he forgot when he last received them. Observation and Interview on [DATE] at 7:05 p.m. of CR #2, he was lying in bed alert and orientated to his surroundings. CR #2 greeted surveyor on first name basis when entering. He said he was still having pain in his stomach and he was not feeling well. He rated his pain a 7 to 8 on a pain scale of ,[DATE]. He had some facial grimacing, rubbing at the right side of abdomen, and his abdomen appeared more distended from the day before. Interview on [DATE] at 7:15 p.m. with LVN D, she said she recently had an in-service related to pain. She said she was to follow up on a resident's pain ,[DATE] hours after pain med given. She said if a resident had concerns of new pain she would notify the doctor. She would document on the MAR pain and the effectiveness of the pain medication. Surveyor had told LVN D of CR's pain. She said she gave CR #2 pain meds around 2:00 p.m. and followed up around 4:00 p.m. to check the effectiveness. LVN D said CR #2 complained of pain often because he of his dementia. She then went back to completing her other nursing tasks she was doing before surveyor stopped her. Observation and Interview on [DATE] at 7:30 p.m. LVN D went into CR #2's room and asked the resident about his pain. The resident reported a pain of 7 to 8 on a pain scale of ,[DATE]. He said the pain had worsened. Observation of LVN D gave CR #2 [MEDICATION NAME] 10- 325mg, 1 tablet at 7:35 p.m. She said she had to multi task and prioritize which was more important when doing her nursing tasks. Observation and Interview on [DATE] at 7:42 p.m. with LVN D and RN C completed an abdominal assessment on CR #2. RN C initiated by lifting residents shirt and began to push on abdomen. CR #2 complained of pain and had facial grimacing and told the nurses that the pain felt like it was inside his stomach. He pointed to the right lower part of his abdomen and told them that his pain had worsened in his stomach and said I'm sick and abnormal. I don't enjoy dealing with all this. LVN D listened to his stomach and reported bowel sounds were normal. The nurses talked with the resident and told him that they would call the doctor because of his pain. The nurses explained the abdominal assessment was good. LVN D said she was going to contact the doctor about CR #2's pain. Surveyor asked if LVN D had any further concerns she would report to the doctor and she replied no. She said she would make a progress note. Observation and Interview on [DATE] at 12:28 p.m. of CR #2, he was lying in bed asleep. He easily awoke when knocked on door. He could not remember the surveyor. He said he had right sided abdominal pain of a 7.5 on a pain scale of ,[DATE] and he had some facial grimacing. He said he could not remember what they had done for him the night before related to his pain and he requested to be left alone. Observation of his abdomen appeared round and distended. Observation and Interview on [DATE] at 5:01 p.m. of CR #2. He was lying in bed awake and alert to his surroundings. He was complaining of pain in his right abdomen but not too bad. He rated his pain a 6. CR #2 was rubbing the right side of his stomach. He said the pain had gotten a little better, but now was having pain in back and top of head. He said he could not remember if he had told the nurse staff. Interview on [DATE] at 5:20 p.m. with ADON, she said CR #2 had no pain today, she said she had checked on him twice. Interview on [DATE] at 3:25 p.m. with RN A she said she had a recent in-service by the previous DON on pain assessment/ pain management which included resident assessment for pain before pain medications are given and follow up in a half hour to an hour to assess the resident's pain. She said if the medication was noneffective report to the physician such as if the resident still had pain after medications were given. She said a resident could not go over 2 days in pain without a follow-up with the physician. She said it was her duty as a unit manager to make sure the orders were followed through as well as the floor nurses. Record review of the facility's undated Resident Assessment Pain Assessment and Management policy read in part . General Guidelines. 2. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident . 3b. Effectively recognizing the presence of pain . 3d. Addressing the underlying causes of the pain . 3g. Monitoring for the effectiveness of interventions . 5. Conduct a comprehensive pain assessment . whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain . 6. Assess the resident's pain and consequences of pain at least each shift for acute pain . Monitoring and Modifying Approach . 1. Re-assess the resident's pain . 3. Monitor the resident by performing a basic assessment with enough detail . Reporting: report the following information to the physician or practitioner . 1. Significant changes in the level of resident's pain . 3. Prolonged, unrelieved pain despite care plan interventions .
F 0776 **Level of harm -** Actual harm **Residents Affected -** Some	**Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide radiology services to the resident and have an agreement to obtain these services from a provider or supplier that was approved to provide these services under Medicare for 2 (CR #1 land CR #2) of 7 residents reviewed for radiological services, in that: -CR #1's physician ordered an x-ray for CR #1's arm after swelling and complaints of pain from the resident. The facility did not obtain the x-ray for four days due to not having a contract with a radiology company to provide this service. CR#1 was sent to the hospital and was diagnosed with [REDACTED]. -CR #2's physician ordered abdominal ultrasound on [DATE] and on [DATE] that were not completed until [DATE]. CR #2 had consistent complaints of pain to his right side which required him to be transferred to the hospital. After administrative review on [DATE], it was determined that additional information was needed and a Surveyor returned to the facility on [DATE]. These failures could affect all residents who required diagnostic services to assist the physician to [DIAGNOSES REDACTED].#1 Record review of CR #1's face sheet revealed he was an [AGE] year-old male admitted on [DATE]. His [DIAGNOSES REDACTED]. He died in Hospice care on [DATE]. Record review of CR #1's admission MDS dated [DATE] revealed he had a BI[CONDITION] of a 9 which indicated he had moderate cognitive impairment. He needed ,[DATE] person extensive staff assistance with bed mobility, transfers, eating, toilet use and personal hygiene. Record review of CR #1's Nurse Progress Note dated [DATE] at 6:13 a.m. written by RN A, read in part . observed patients right elbow area slightly swollen . Noted area painful as patient states my arm hurt . Able to move right arm per passive range of motion . Record review of facility 72-hour summary/ nurse report identified a nurse note on [DATE] read in part . x-ray pending, order to start [MEDICATION NAME] x 4 days, and physician will assess tomorrow . Many attempts have been made to talk to staff at the diagnostic center, no luck . Record review of CR #1's weekly skin assessment dated [DATE] read in part . right elbow with localized swelling . passive range of motion with tenderness . X-rays pending and new medication from MD . Record review of a phone order dated [DATE] for CR #1 that read in part . right elbow X- ray, reason swelling and pain. Outpatient imaging. Record review of CR #1's physician progress notes [REDACTED]. History of present illness: Patient discovered to have a swollen and warm right elbow over the weekend. He is noted to have reduced ROM and now requires help with feeding, pain is noted with movement . Physical exam: right elbow swollen, reduced passive and active ROM, pain with movement, does not seem to be in pain with palpation of elbow . treatment plan: [REDACTED]. Record review of phone order dated [DATE] for CR #1 revealed MD ordered a stat chest x-ray. Record review of CR #1's Nurse Progress Note dated [DATE] at

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F 0776 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) 2:40 p.m. by LVN A read in part .new order stat chest x-ray at outpatient imaging . Outpatient imaging sent resident back for order clarification . rescheduled for next available [DATE] . Record review of CR #1's Nurse Progress Note dated [DATE] at 9:08 p.m. by ADON B read in part . patient has altered mental status, and lethargic . Right elbow has begun to swell again following completion of [MEDICATION NAME] . Pending chest x-ray scheduled for Monday. Resident sent to ER . Record review of emergency room Medical Screening dated [DATE] for CR #1 revealed he had a right upper extremity doppler ultrasound that showed [MEDICAL CONDITION] in the right brachial vein. The X-ray of the right arm showed a healing [MEDICAL CONDITION] and a [MEDICAL CONDITION]. Interview on [DATE] at 10:05 a.m. with Administrator, he said he was not sure how Resident #1 received the fracture to his elbow. He said there were several attempts to schedule a mobile x-ray to come to the facility starting on [DATE]. He said the company that they usually used had gone bankrupt. He said another local X-ray provider was taking too long. He said a different management company took over the facility and further delayed securing a contract with a mobile x-ray service. He said CR #1 was sent out to an outpatient imaging center but returned because the order needed to be clarified by the doctor. CR #1 was sent to the hospital for a chest x-ray on [DATE] and he also received a x-ray to his right elbow which revealed the fractures. Record review of email sent to the Administrator dated [DATE] at 10:42 a.m. from the mobile x-ray company read in part . Subject - Radiology service . I'm working on getting pricing approval. Once completed I can send you a contract for radiology services. How are you handling exams now? . Interview on [DATE] at 10:40 a.m. with ADON, she said RN B told her CR #1 had swelling to his arm. She said the MD came on that Wednesday ([DATE]). She said she transcribed an order given by the MD to get an x-ray. She said they had a problem with getting a mobile x-ray company to come to the facility. She said she tried a different x-ray provider, but they took too long. She said she tried on [DATE] and [DATE] without success to get an x-ray company to come to the facility, before she looked for an outpatient hospital for the x-ray. CR #1 was scheduled for the outpatient x-ray on [DATE] but was sent back to the facility because the outpatient clinic wanted the order clarified by the MD. She said the order was clarified but the next available appointment was [DATE]. She said the residents' elbow swelled even more. Interview on [DATE] at 11:42 a.m. with CR #1's MD, she said she was told about CR #1's swollen arm. She said she gave an order for [REDACTED]. She expected the x-ray to be completed within 24 to 48 hours. Interview on [DATE] at 2:28 p.m. with LVN A, she said she was told by CNA A that CR #1 had pain in his right arm. She said the facility did not have a contract with a mobile x-ray unit at that time. She said CR #1 should have been sent out to get the x-ray. She said there was a problem with the MD x-ray order when CR #1 went on [DATE] to get an x-ray of his arm. CR #1 was sent back to the facility without getting a x-ray. She said CR #1 went to the ER before the scheduled x-ray appointment on [DATE]. Interview on [DATE] at 3:22 p.m. with the Administrator, he said they should have followed the MD orders and sent CR #1 to an out-patient imaging center for an x-ray to his elbow as soon as possible. He said when they did send him, there was a problem with the order according to the imaging center, which was out of our control, and the MD was needed to clarify the order. Interview on [DATE] at 4:32 p.m. with CNA C, he said he saw CR #1's arm was swollen, and he said he told the ADON. He said there was a problem with the mobile x-ray company coming out. He said CR #1 would wince if his arm was touched. Interview on [DATE] at 5:26 p.m. with ADON, a copy of CR #1's care plan was requested and was not provided by exit. Interview on [DATE] at 12:30 p.m. with LVN A, she said a routine x-ray was to be done within the same day and a stat within 4 hours. If the mobile x-ray company could not follow through she would send the resident to an outpatient or ER. She said CR #1 had pain to his right elbow. She said she had given him routine [MED] and notified the doctor and an x-ray was ordered. She said she also had the CNA place a pillow under his arm for comfort. LVN A said she had trouble getting the mobile x-ray company out to the facility and she had tried for a couple days. She said she notified the previous ADON about not getting the x-ray. She said later the resident was having some respiratory issues and the doctor ordered a stat chest x-ray. She said the resident was sent to an outpatient imaging but returned because the order needed to be clarified. Telephone Interview on [DATE] at 3:54 p.m. with CR #1's physician, she said she remembered she was notified by nursing on [DATE] that CR #1 had pain with ROM. She said she assessed the resident and he had some swelling and pain with ROM, but he looked comfortable and no pain when sitting up in wheelchair undisturbed. She said she was aware the facility was having trouble with the mobile x-ray company and she felt an outpatient x-ray would be a better choice than sending the resident to the hospital. She said the resident was very old and frail and they would have a field day with him. She said she expected stat x-rays to be done that day and routine x-rays were generally done by the next day. She said it was very rare to send a resident out for imaging. CR #2 Record review of CR #2's face sheet revealed he was a [AGE] year old male admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of CR #2's quarterly MDS dated [DATE] revealed a BI[CONDITION] score of 12 indicating moderate impaired cognition. He needed limited help of 1 staff for bed mobility, extensive help of 1 staff with dressing, toileting, personal hygiene, and locomotion in the facility using a wheelchair. Record review of CR #2's Care Plan read in part . (CR #2) has surgery site at mid gastric with J-P drain relate to hernia repair surgery, [MEDICAL CONDITION] of abdomen wall . initiated [DATE] . Interventions . Monitor mid gastric surgery incision for sign of pain, drainage, odor, skin color change (sign of infection) report to physician . initiated [DATE] . Acute pain right abdomen & right flank aspect r/t kidney stones . Interventions: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain, grimacing and/or guarding . Monitor/document for side effects of pain medication. Observe for constipation, new onset or increase agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness, and falls. Report occurrences to the physician . initiated [DATE] . Record review of CR #2 Medication Review Report revealed orders for: Abdominal KUB stat order date of [DATE]. Abdominal ultrasound stat order date of [DATE]. Record review of CR #2's Nurse Progress Note by LVN C dated [DATE] at 9:00 p.m. read in part . complaints of abdominal pain rate ,[DATE] on verbal scale. Abdominal assessment done and observed the following. Abdomen distention . complain of pain upon touch during palpation . New order for stat KUB and stat abdominal ultrasound . Record review of CR #2's Nurse Progress Note by RN B dated [DATE] at 10:42 p.m. CR #2 transferred to hospital related to abdomen pain that is not well managed by pain med. Record review of CR 2's Nurse Progress Note by ADON dated [DATE] at 9:20 a.m. read in part . returned from ER . diagnosed with [REDACTED]. Follow up with urologist and PCP . urology appointment set up . Ultrasound of the abdomen order was received from MD . Record review of CR #2's Nurse Progress Note by LVN A dated [DATE] at 10:33 a.m. abdominal ultrasound, order noted and carried out . Record review on [DATE] of CR #2's ER hospitalization paperwork revealed a [DIAGNOSES REDACTED]. Recommend following up with urologist in ,[DATE] days . CT Abdomen/ pelvis without contrast identified revealed punctate non-obstructing right renal stone . Record review of CR #2's abdomen ultrasound completed on [DATE] at 6:29 p.m. Conclusion: prominent fatty liver. Noted on report called to doctor at 6:30 p.m. on [DATE], no new orders. Observation and interview on [DATE] at 12:58 p.m. with CR #2. He rated his pain a 6 to 8 on a ,[DATE] pain scale. He said pain medications helped the pain, but the pain never went away. He said he received a pain med around 10:00 a.m. by LVN A but the medication had not helped. Interview on [DATE] at 5:20 p.m. with ADON, she said CR #2 had no pain today, she said she had checked on him twice. She was unable to find the results of the resident's ER visit or stat KUB results. She said CR #2's abdominal ultrasound was just completed and did not have results. She said she reviewed the hospital paperwork and she had no concerns. Interview on [DATE] at 6:13p.m. with LVN C said CR #2 was sent out to ER for a KUB on [DATE] but had no results. She said CR #2's abdominal ultrasound was done. Surveyor reviewed the stat order for abdominal ultrasound on [DATE] with LVN C and she said that the order had been changed to routine. She said the doctor was notified and gave approval for ultrasound to be done on [DATE]. She said she a follow up order should have been written by the nurse who called the doctor, but will make sure a late entry note was documented about the order change. Interview on [DATE] at 3:25 p.m. with RN A said she was stepping into the ADON position and nurse manager position because there was no ADON or DON working at the facility. She said she was in-serviced on a new diagnostic company because the other company went bankrupt. She said a stat x-ray was to be done within 4 hours and a routine x-ray was to be done within the same day or at least 24 hours. She was unsure who was to follow up on orders to make sure they were completed. She said she would have to ask, left the room and returned momentarily. She said it was her duty as a unit manager to make sure the orders were followed through as well as the floor nurses. She said nurses had a couple different ways of entering an order for [REDACTED]. She said the nurse who ordered the test would discuss and document on the computer for next shift as a communication between nurses. Interview on [DATE] at 5:05 p.m. with the administrator. He explained that they had a diagnostic company that went out of business and currently have a contract with another imaging company that was started on [DATE]. He said nurses received training on mobile diagnostic protocol and who to notify if they had concerns. He said if the mobile diagnostic testing did not come out in the time frame necessary the facility also had a contract with an out-patient hospital imaging. Record review of facility in-services for January and February 2020 revealed no in-services related to following physician orders [REDACTED]. Record review of facility's Change of Condition reporting and diagnostic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455333	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHARPVIEW RESIDENCE AND REHABILITATION CENTER	**7505 BELLERIVE HOUSTON, TX 77036**

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 0776 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 3) testing revision date of ,[DATE] read in part .The center will notify the resident's physician . whenever there is a significant change in the resident . there is a change in the resident's condition that although not significant is prudent to report using good nursing judgement . The nurse will 1. Assess the resident's condition . 2. Notify the physician of the change of condition . 4. Document . The DON/ ADON or designee will provide oversight as needed whenever there is significant change of condition noted in a resident . Record review of facility's Physician order [REDACTED]. Written orders . c. Carry out the orders as appropriate (i.e. schedule lab) . Physician order [REDACTED]. Confirm that other orders were carried out as appropriate . .