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 _____	09/05/2020

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.

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide reasonable accommodation of resident needs and preferences for 1 of 18 residents (Resident #81) reviewed for call lights, in that: 1. Resident #81's call light was not within her reach for 2 of 2 days observed. This failure could affect the residents' inability to contact the nursing staff and could result in harm or injury. Findings included: 1. Record review of Resident # 81's face sheet, dated 9/04/20, revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 81's Order Summary Report, dated 9/02/20, revealed an order for [REDACTED]. Record review of Resident #81's Quarterly Change MDS, dated [DATE], revealed the resident had a BIMS score of 1 which indicated the resident was moderately cognitively impaired. The same record also revealed Resident #81 requires supervision of one person for bed mobility and transfer; while requiring extensive assistance of one person with toileting and personal hygiene. Record review of Resident #81's electronic Care Plan, dated with a revision on 8/28/20, revealed a focus of Falls: (Resident #81) has the potential for falls related to [MEDICAL CONDITION], cognitive impairment, debility, antihypertensive drug use, Incontinence, Gait/balance problems, Confusion, Unaware of safety need with an intervention to ensure/provide a safe environment: call light in reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation. During and observation on 9/01/20 at 2:17 p.m., the surveyor was walking down the hall heard Resident #81 crying out down the hall for help. Surveyor walked into the room and Resident #81 was sitting up in the center of her bed asking for some help to turn the air conditioner off. The surveyor asked Resident #81 to push her call light and so that she could alert the staff she needed assistance. Resident #81 stated she could not reach it. The surveyor found Resident #81's call light tangled and caught under the left side of the bed frame by the head board. The surveyor left the call light there and went to find help from the resident's nurse. During an interview and observation in Resident #81's room on 9/01/20 at 2:19 p.m., RN D confirmed Resident #81's call light was caught and tangled underneath her bed frame where the resident could not reach it. During and observation on 09/03/20 at 6:50 p.m., the surveyor was walking down the hall heard Resident #81 crying out down the hall for help. Surveyor walked into the room and Resident #81 was laying in her bed with a sweater and gloves on. Resident #81 indicated that she needed to be changed because she was wet. The surveyor asked Resident #81 to push her call light and so that she could alert the staff she needed assistance. Resident #81 stated she could not reach it. The surveyor found Resident #81's call light hanging on the humidifier bottle of her oxygen concentrator that was pushed against the wall. The surveyor left the call light there and went to find help from the resident's nurse. During an interview and observation in Resident #81's room on 9/03/20 06:52 PM LVN K came to help after surveyor got her attention. The resident said she needed to be changed because she was all wet. LVN Kconfirmed the call light was hanging off the oxygen humidifier bottle that was not within reach of the resident and then handed her the call light. Record review of the facility policy titled Call Light/Bell Respone, dated reviewed 2/10/20, revealed ( ) provide call light/bell within patients's reach regardless of patient location such as: in bed, on commode, unaccompanied in sitting area.
F 0573 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to allow the resident to obtain a copy of the records upon request and upon 2 working days advance notice to the facility for 1 of 6 residents (Resident #16) whose records were reviewed. Staff failed to provide a copy of Resident 16 's medical records upon request by the Resident's representative. This deficient practice could affect any resident and could contribute to a delay in the due legal process for residents. The findings were: Review of Resident #16's face sheet, dated 9/3/20, revealed he was admitted to the facility on [DATE] and discharged on [DATE]. Review of document, Medical Power of Attorney dated 9/13/2018 revealed that Resident #16 named a family member as his MPOA. Review of a letter dated 8/5/20 revealed the Resident #16's MPOA requested labs and x-ray and imaging from 7/15/20 to 8/5/20. Interview on 9/4/20 at 8:51 AM with Resident #16's MPOA revealed that she requested medical records from the facility and never received them. She stated Resident #16 had follow up appointments in which the lab and imaging results would be reviewed. Resident #16's MPOA further stated she wanted to review the records prior to the appointments so that she could be informed. Interview on 9/5/20 at 11:28 AM with Medical Records Staff confirmed she received a medical records request from Resident #16's MPOA dated 8/5/20. She stated she had forwarded it to the corporate risk manager for approval and further stated it had not been approved. Interview on 9/5/20 at 11:45 AM with the Medical Records Staff revealed that according to the verbiage on the MPOA document Resident #16 would have to be deemed to be incompetent before they could release medical records to Resident #16's MPOA. She stated Resident #16 was able to make decisions. Therefore, Resident #16 would have to make a request for medical records. Upon asking, the Medical Records staff stated she had not talked to Resident #16 or to Resident 16's representative to let them know Resident #16 would have to be the one to request the records. Interview on 09/5/20 at 12:33 PM with the ADM revealed she reiterated what the Medical Records staff stated. Although,, the ADM confirmed that Resident #16's representative was named as the MPOA and the RP. The ADM stated that Resident #16 was able to make decisions and that according to the risk manager, Resident #16 would have to make the request for medical records. Upon asking, the ADM stated she had not talked to Resident #16 or to Resident 16's representative to let them know Resident #16 would have to be the one to request the records. Review of facility policy, Release of Medical Records revised 9/9/19 read in part as follows: Medical Records will be released with valid request and in accordance with state and federal laws. Medical Records are a collection of documents prepared and maintained during the course of a resident's stay in the facility that records the clinical/medical care of the resident. 5. Upon request to access or obtain copies of the medical record, the facility's Privacy Officer should review the authorization to ascertain access rights of that person. Authority to access or release records is only granted by the resident or the resident's legal medical representative. The facility should request copies of any legal medical power of attorney papers necessary to authenticate authority.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, clean, comfortable and homelike environment, for

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

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) daily living for the 1 of 18 resident rooms (Resident room [ROOM NUMBER]) and for 2 of 6 residents (Resident #29 and #74) reviewed for environmental conditions in that: 1. The facility failed to maintain a fan from being covered in gray fuzzy matter in resident room [ROOM NUMBER]. 2. Nursing staff failed to discard Resident #74's breakfast tray once the Resident was finished eating. 3. Nursing staff failed to clean the Resident #29's bathroom after personal care and after a shower. These failures could affect residents who resided at the facility and could put them at risk of living in an unsafe, unclean, uncomfortable, and an un-homelike environment. Findings include: 1. Observation on 9/01/20 at 12:13 p.m. revealed in Resident room [ROOM NUMBER] there a black free-standing fan with gray fuzzy matter covering the back cover of the fan. Observation on 9/02/20 at 12:12 p.m. revealed in Resident room [ROOM NUMBER] there a black free-standing fan with gray fuzzy matter covering the back cover of the fan. During an interview on 9/02/20 at 12:12 p.m. in resident room [ROOM NUMBER], LVN J confirmed the black free-standing fan with gray fuzzy matter in room [ROOM NUMBER]. LVN J reported she had not seen the fan before and that the resident just moved to the room this week. LVN J reported she would report the fan to housekeeping to be cleaned. 2. Review of Resident #74's face sheet dated 9/5/20 revealed she was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Observation on 9/1/20 at 11:41 AM revealed Resident #74 lying in bed with HOB at 45 degrees. Resident #74 appeared to be sleeping; she had her eyes closed. Further observation revealed Resident #74's breakfast tray on top of the night stand and it had not been touched. Interview on 9/1/20 at 11:46 AM with CNA U revealed she started her shift at 6 AM. She stated breakfast trays were delivered about 8:30 AM. CNA U stated Resident #74 did not want to eat at that time. CNA U stated Resident #74 told her to come back later which she did but Resident #74 still refused to eat. CNA U stated she knew she was supposed to trash the breakfast tray but had not had the time. Observation on 9/2/20 at 11:15 AM revealed Resident #74 lying in bed with HOB at 45 degrees. There was a breakfast tray on top of her bedside table. Resident #74 responded to her name but was fading in and out of sleep. Interview on 9/2/20 at 11:20 AM with CNA V revealed she delivered Resident #74's breakfast tray earlier in the morning. CNA V stated she would usually start picking up trays about 30 minutes after delivering them. CNA V stated Resident #74 told her to leave it. CNA V stated she had not been back in Resident #74's room and confirmed she should have returned to trash the tray. 3. Review of Resident #29's face sheet dated 9/3/20 revealed she was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Observation on 9/3/20 at 5:50 PM revealed Resident #29 eating dinner in her room. Further observation of the bathroom revealed a toothbrush on top of the vanity beside a hair brush with a wad of hair in the bristles. There were used face towels on the floor; the shower chair in the shower had soap scum all over it as well as on the shower tile; there were clothing items on the floor and hooked on the grab bar beside the toilet; the basin on the bottom shelving unit was full of debris; the floor looked like it had not been swept and the floor was sticky. Interview with CNA S at this same time revealed she was fairly new to the facility and was still getting to know the Resident's. CNA S stated she had been assigned to work with Resident #29 for the last couple of days. CNA S confirmed the findings in Resident #74's bathroom and stated it was dirty and needed to get cleaned. CNA S stated the aides were responsible for cleaning the shower stall after showering the Resident and picking up all dirty towels and clothing from the floor. She stated she had not showered the Resident in the last 2 days. CNA S stated she was trying to get the rooms in order, but she had been working alone. Interview on 9/3/20 at 6:00 PM of Resident #74's bathroom, LVN C confirmed there was a toothbrush on top of the vanity beside a hair brush with a wad of hair in the bristles; used face towels on the floor; the shower chair in the shower had soap scum all over it as well as on the shower tile; there were clothing items on the floor and hooked on the grab bar beside the toilet; the basin on the bottom shelving unit was full of debris; the floor looked like it had not been swept and the floor was sticky. LVN C confirmed that the aides were responsible for picking up used face towels, Resident clothing from the floor, storing the toothbrush away from the hairbrush and for cleaning the showers after showering a Resident. LVN C stated housekeeping was responsible for keeping the bathroom clean. She stated the bathroom was not clean.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the resident, resident's representative, and Ombudsman of the transfer or discharge and the reasons for the move in writing for 3 of 3 Resident's (Resident #74, #16 and #42) reviewed for Discharge Rights. 1. The facility failed to notify the Ombudsman of Resident #74's transfer or discharge and the reasons for the move in writing and in a language and manner they understand. 2. The facility failed to notify the Ombudsman of Resident #16's transfer or discharge to the hospital. 3. The facility failed to notify the Ombudsman of Resident #42 transfer or discharge to the hospital. This deficient practice could affect all residents who were transferred or discharged to the hospital and place them at risk of having their discharge rights violated. The findings included: 1. Review of Resident #74's face sheet dated 9/04/2020 revealed an admission date of [DATE] and readmission date of [DATE] with [DIAGNOSES REDACTED]. The resident was readmitted after a hospital stay for a urinary tract infection. Currently resident is on a 14-day precautionary quarantine period for COVID 19. She will return to her previous room after a successful quarantine period. Review of Resident #74's annual MDS dated [DATE] revealed a BIMS score of 99, the resident could not complete the questions, which indicated a severe cognitive impairment. Interview with Ombudsman 9/2/2020 at 2:00 P.M. revealed the facility had not provided notification when a resident was transferred or discharged to another Facility. Interview with the Regional Nurse Consultant on 9/4/2020 at 3:00 P.M. revealed there was no notification in writing to the Responsible Party when a resident is transferred or discharged to another Facility. The information is provided via a telephone call. A policy on bed hold was requested but not received by the conclusion of the survey. 2. Review of Resident #16's face sheet dated 9/4/20 revealed he was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review revealed a discharge date of [DATE]. Interview on 9/4/20 at 3:05 PM with the ADM revealed she had been sending out notices until they hired a SW. She stated the last Resident notices of discharge she sent to the Ombudsman was back during March 2020. She stated the previous SW took over afterwards and stated she would check the SW records. Within a few minutes the ADM stated she did not find any discharge notices in the SW records. 3. Review of Resident #42 face sheet dated 9/3/20 revealed a most recent admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of Resident #42 progress note dated 7/29/20 revealed Resident #42 was sent out to the hospital. Review of Resident #42 progress note dated 8/12/20 revealed Resident #42 returned to the facility from the hospital. Interview on 9/4/20 at 1:47 PM with the Ombudsman revealed the NF had not sent her any Resident transfer or discharge notices to the hospital or elsewhere since the start of COVID-19 in early March 2020. Interview on 9/4/20 at 3:05 PM with the ADM revealed she had been sending out notices until they hired a SW. She stated the last Resident notices of discharge she sent to the Ombudsman was back during March 2020. She stated the previous SW took over afterwards and stated she would check the SW records. Within a few minutes the ADM stated she did not find any discharge notices in the SW records.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #66 Nutrition 09/04/20 04:50 PM no care planned interventions for diet.Based on interview and record review, the facility failed to ensure the care plan accurately reflected the resident's status for 1 of 18 residents (Resident #66) whose care plan was reviewed in that: 1. Resident #66's care plan failed to address his code status nor nutritional status. This deficient practice could place residents on Hospice care and/or resident with contractures and at risk of poor or improper care being provided due to inaccurate care plans. The findings were: 1. Record review of Resident #66's face sheet, dated 9/04/20, revealed the resident was initially admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #66's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 15, which meant the resident was cognitively intact. Record review of Resident #66's paper chart revealed no color-coded sheet indicating the residents code status at the front of the char, green for full code and red for DNR. Further review of

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Resident #66's paper chart revealed the resident's admission orders [REDACTED]. Record review of Resident #66's Order Summary Report, dated 9/03/20, revealed no orders for the resident's code status or diet. Record review of Resident #66's Comprehensive Care Plan, dated revised on 9/01/20, revealed it did not address the resident's code status. The care plan had a focus for Nutritional Status: (Resident #66) is on a and at nutritional & hydration risk related to poor po intake, Diet restrictions, but the side to list the interventions to address the focus area was blank. The focus does not reveal a specific diet nor diet restrictions. During an interview on 9/04/20 at 2:57 p.m., the Regional Nurse confirmed resident's code status should be transcribed onto their electronic orders. The Regional Nurse revealed the facility's SW would be the one who gets the code status from the resident, but they currently don't have a social worker. The Regional Nurse confirmed Resident #66's code status was not transcribed onto his active electronic physician orders. Interview with the MDS Coordinator on 9/05/20 at 12:56 p.m., the MDS Coordinator confirmed Resident #66's care plan was just updated yesterday to address his code status because the resident's code status was just added to his orders yesterday. The MDS Coordinator confirmed the care plan for Resident #66's nutritional status was blank for interventions and that there needed to be interventions added to address his nutritional status focus.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review a resident who is unable to carry out activities of daily living did not receive the necessary services to maintain good grooming and personal oral hygiene for 2 of 6 Residents (#29 and #42) observed for care. 1. Nursing staff did not provide Resident #29 with oral hygiene or a replacement toothbrush. 2. Nursing staff did not provide Resident #42 with grooming and oral hygiene. These deficient practices could affect any Resident dependent on care and could contribute to feelings of poor self-esteem. This findings were: Review of Resident #29's face sheet dated 9/3/20 revealed she was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #29's quarterly MDS dated [DATE] revealed a BIMS score of 9 indicating moderate cognitive impairment, she had limited range of motion on one side (upper and lower extremity) and she required assistance in part with hygiene. Review of Resident #29's Care Plan revised on 9/1/20 revealed Resident #29 had an ADL Self Care Performance Deficit secondary to dementia and poor eye sight which placed her at risk for not having her needs met in a timely manner. Interventions included to provide shower, shave, oral care, hair care, and nail care per schedule and when needed. Observation on 9/1/20 at 10:36 AM revealed Resident #29 lying in bed. Resident #29 presented as being alert and oriented to person, place and time with some forgetfulness. Noted plaque around upper/lower teeth. Observation on 9/2/20 at 3:49 PM revealed Resident #29 still had plaque around her teeth. Resident stated she needed a new toothbrush and when asked if she had brushed her teeth she commented that hasn't happened in a very long time. Resident #29 stated she was not sure if anyone would help her with grooming or brushing her teeth. Observation on 9/2/20 at 3:55 PM revealed a toothbrush on top of the bathroom sink. The bristles were a brownish color. It appeared to be a very old toothbrush. Observation on 9/3/20 at 5:50 PM revealed Resident #29 was eating dinner. Interview with CNA S at this same time revealed she was fairly new to the facility and still getting to know the Resident's. CNA S stated she had been assigned to work with Resident #29 for the last couple of days. CNA S confirmed Resident #29 had plaque around both her upper and lower teeth. CNA S confirmed she had not assisted Resident #29 with brushing her teeth for the last 2 days, but commented it looked like it had been longer than 2 days that the Resident had brushed her teeth. CNA S stated they would provide Resident's with a new toothbrush as needed. CNA S confirmed the toothbrush was old. 2. Review of Resident #42's face sheet dated 9/3/20 revealed her most recent admission after a hospital stay was on 8/12/20 with a [DIAGNOSES REDACTED]. Review of Resident #42's quarterly MDS dated [DATE] revealed Resident #42 required extensive assistance by 2 people with personal hygiene and was totally dependent for showers and required assistance by 2 people. Review of Resident #42's Care Plan revised on 7/24/20 revealed Resident #42 had an ADL Self Care Performance Deficit and was at risk for not having her needs met in a timely manner. Interventions included: Personal Hygiene: Total assistance x 1 person; Bathing: Total assistance x 2 person- bed bath; Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. Observation on 9/3/20 at 10:58 AM revealed Resident #42 lying in bed. Further observation revealed Resident #42 had white chunks of white particles in her hair, her hair looked dull and oily. She had dry flakes on her face, her lips looked dry lips and had white crust on them, it was dry and flaky between her toes and her mattress was full of white particles all over it. Interview on 9/3/20 at 11:04 AM with CNA T and LVN M revealed Resident #42 was supposed to receive bed baths on MWF (Monday, Wednesday and Friday) and should have hair washed at those times. CNA T stated grooming (face washing and oral care) was done in the morning before breakfast; before meals. CNA T confirmed Resident #42 had dry flakes in her hair, on her face and her mouth needed cleaning. LVN M confirmed Resident #42 had dry skin between her toes and there were flakes all over her mattress and it should be cleaned daily. CNA T and LVN M both confirmed Resident had poor hygiene and required total assistance with activities of daily living. Review of facility policy, Activities of Daily Living Care Guidelines reviewed 2/10/20 read in part as follows: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, based on the comprehensive assessment of a resident with pressure injuries receives the necessary treatment and services, consistent with professional standards of practice, to promote healing of pressure ulcers for 2 of 5 residents (Residents #42 and #81) reviewed for pressure ulcers. 1. Nursing staff did not apply wedges for offloading Resident #42 from bony prominences. 2. The facility failed to ensure Resident #81's pressure reducing mattress was set on the correct setting. These deficient practices could place residents with pressure ulcers who had a pressure reducing mattress or wedges at risk for new development of pressure injuries or worsening of existing pressure injuries. Findings included: 1. Review of Resident #42's face sheet dated 9/3/20 revealed her most recent admission was on 8/12/20 after a hospital stay with a [DIAGNOSES REDACTED]. Review of Resident #42's quarterly MDS dated [DATE] revealed Resident #42 had a Stage 4 pressure ulcer. Review of Resident #42's Care Plan revised on 7/24/20 confirmed Resident #42 had a reoccurring stage 4 pressure ulcer to sacral region, and was at risk for infection, pain, and a decline in functional abilities. Interventions included Reposition the resident x 4 per shift or more often as needed or requested. When possible avoid directly positioning the resident on their pressure ulcer; Pressure relieving/reducing devices on bed/chair. Observation on 9/2/20 at 10:43 AM revealed Resident #42 lying in bed on her back. Further observation revealed 2 wedge cushions on top of the recliner. Observation on 9/3/20 at 10:58 AM revealed Resident #42 lying in bed on her back. Further observation revealed 2 wedge cushions on top of the recliner. Observation on 9/4/20 at 1:25 PM revealed Resident #42 lying in bed on her back. Further observation revealed 2 wedge cushions on top of the recliner. Interview with LVN U at this same time confirmed that staff should apply the wedge cushions for offloading every 2 hours and or as tolerated. She further stated nursing staff should alternate them from side to side which would promote wound healing for Resident #42. LVN U confirmed the wedge cushions had not been applied to Resident #42. Review of facility policy, Skin Prevention Training Guide revised 3/23/17 read in part as follows: Anticipated Outcome: To provide process steps skin prevention program that stabilizes, reduces and manages risk factors related alteration in skin integrity. CNA - apply skin prevention devices and process. 2. Record review of Resident # 81's face sheet, dated 9/04/20, revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #81's Quarterly Change MDS, dated [DATE], revealed the resident had a BIMS score of 1 which indicated the resident was moderately cognitively impaired. The same record also revealed Resident #81 did not have any current deep tissue injuries or pressure ulcers. Record review of Resident #81's electronic Care Plan, dated with a revision on 8/28/20, revealed a focus of Pressure Ulcer Risk: (Resident #81) has the potential for the development of a pressure ulcer due to incontinence, impaired mobility, hx of MASD, and hx of pressure ulcer with an intervention for pressure relieving/reducing devices on bed/chair. Record review of Resident #81's Order Summary Report, dated 9/02/20, did not reveal an order for [REDACTED]. Record review of Resident #81's September 2020 MAR and TAR, did not revealed any documentation of an order to check or monitor the setting and/or functioning of an air mattress. Record review of Resident #81's Progress Notes revealed a Skilled Nursing Note dated 8/09/20 that revealed notified hospice ( ) air

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) mattress is needed for resident. On call nurse states will follow up in am. Record review of Resident #81's weights record revealed on 9/01/20 she weighed 123.4 lbs. During an observation on 9/02/20 at 12:12 p.m., revealed Resident #81 sitting up on the center of her bed with her feet resting on the floor. The resident's air mattress was still set in between a weight of 210 and 250 lbs. There was not a sticker indicating the air mattress setting had been checked. During an interview with LVN J on 9/02/20 at 12:14 p.m., LVN J and H confirmed Resident #81's air mattress was set for a resident in between a weight of 210 and 250 lbs. LVN J confirmed Resident #81 was not 200 lbs. LVN J revealed she usually does not mess with residents' air mattresses settings, she just checks to make sure they are on. Record review of the air mattresses instruction manual revealed to turn the Pressure Adjust Knob to set a comfortable pressure level by using the weight scale as a guide. (http://www.integraequipment.com/wp-content/uploads/2019/01/drive-apm-manual.pdf). Record review of the facility's policy on Comfort Level Settings for Low Air Loss Mattresses, dated 12/2005, revealed the licensed nurse will pace a sticker on the top of the air power unit which reflects the desired setting. ( ) The setting will be checked every shift by a licensed nurse. If the setting requires adjusting, the licensed nurse will do so.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections, based on the resident's comprehensive assessment for 1 of 2 Residents (#42) whose records were reviewed. CNA held Resident #42's urinary tubing over the Resident's bladder causing the urine to flow backwards. Nursing staff failed to apply a leg strap to stabilize the indwelling catheter tubing for Resident #42. These deficient practices could affect any Resident with an indwelling catheter and could result in avoidable UTI's and trauma to the urethral. The findings were: Review of Resident #42's face sheet dated 9/3/20 revealed her most recent admission after a hospital stay was on 8/12/20 with a [DIAGNOSES REDACTED]. Review of Resident #42's quarterly MDS dated [DATE] revealed Resident #42 had an indwelling catheter. Review of Resident #42's Care Plan revised on 7/24/20 revealed Resident #42 had a urinary catheter and was at risk for urinary tract infections and injury. Two of the interventions included to use a stabilizer or securement device to keep the urinary catheter securely in place; position catheter bag and tubing below the level of the bladder. Observation on 9/3/20 at 10:38 AM revealed Resident #42 lying in bed with indwelling catheter. Further observation revealed CNA N entered the room at this same time. She stated she was going to empty the urinary bag. CNA N stood up, was looking at the tubing and holding it up over Resident 43's bladder. Further observation revealed urine flowing backwards. CNA N stated she did not realize she was holding the tubing over the bladder. CNA N stated she was going to get a nurse. Observation on 9/3/20 at 10:50 AM revealed Resident #42 did not have a leg strap on. Interview at this same time with LVN O confirmed that Resident #42 did not have a leg strap on. She stated usually the aids would apply the leg strap. LVN O stated the tubing should not be held over the bladder. Review of a facility policy, Urinary Catheter Management dated 2/10/20 read in part as follows: Residents with indwelling catheters (urethral or suprapubic) shall receive appropriate care and services to prevent and manage catheter-related complications. 2. Use a catheter-anchoring device such as a catheter strap or adhesive device to prevent tension on the catheter and dislodgement of catheter, thus minimizing urethral and bladder friction and trauma. 3. Properly position drainage bag and tubing below the level of the bladder and in a dependent position to facilitate flow of urine.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who was fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding for 2 of 5 residents (Residents #13 & #8) whose records were reviewed. 1. LVN P failed to turn Resident #13's enteral pump back on after providing care and for an undetermined amount of time. 2. Resident #8's enteral feeding was not infused at the rate ordered by the physician for 2 of 2 days observed and the formula was held in the bag for over 24 hours when the packaging indicated not to use it. These deficient practices could place residents who had feeding tubes at risk for dehydration, weight loss, and/or metabolic abnormalities. The findings were: 1. Review of Resident #13's face sheet dated 9/5/20 revealed she was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #13's quarterly MDS dated [DATE] revealed Resident #13 was receiving eternal feeding through a feeding tube. Review of Resident #13's Care Plan revised on 6/19/20 revealed she required the use of a feeding tube and was at risk for aspirations, weight loss, and dehydration. One of the interventions was to administer tube feeding and water flushes as ordered. Review of consolidated physician orders [REDACTED]. Observation on 9/2/20 at 11:04 AM revealed Resident #13 was lying in a low bed with the [DEVICE] infusing eternal feeding. Further review revealed the pump screen was displaying a message, on hold/error message. Interview on 9/4/20 at 5:33 PM LVN P revealed that on 9/2/20 the PT was in Resident #13's room providing therapy that morning. LVN P stated she helped the PT reposition Resident #13's bed and she put the pump on hold. LVN P stated she forgot to restart it and did not know how long it was on hold. 2. Record review of Resident #8's face sheet, dated 9/04/20, revealed he was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #8's Quarterly MDS, dated [DATE], revealed a BIMS score of 0, indicating the resident was severely cognitively impaired. The record also revealed the resident received the nutritional approach of a feeding tube with equal to or greater than 51% of her calories from a feeding tube and 501 cc/day or more of her average fluid intake from a feeding tube. Record review of Resident #8's Comprehensive Care Plan, dated revised on 6/09/20, revealed Feeding Tube: (Resident #8) requires the use of a feeding tube and is at risk for aspirations, weight loss, and dehydration. Feeding tube is related to: feeding difficulties, [DEVICE], dysphagia, with an intervention to administer tube feeding and water flushes as ordered. Record review of Resident #8's Order Summary Report, dated 9/02/20, revealed orders for: - Other diet NPO texture, TUBE FEED for diet with a start dated of 1/27/20 and no end date. - Enteral Feed Order every shift Start continuous enteral feeding. Formula: Glucerna 1.2; Rate: 50mL/hr; start at 1900 and run until 1100 mLs has been delivered. with a start date of 8/26/20 and no end date. - Enteral Feed Order every shift Start water flush q hour with 30 mLs of water to run concurrently with enteral feeding, with a start date of 8/26/20 and no end date. Record review of Resident #8's weight record, revealed the resident lost 2.4 lbs, a loss of 2.15% within a month, from August to September 2020 but it was not a significant weight loss. During an observation on 9/01/20 at 11:57 a.m., revealed of Resident #8 laying in bed. The resident's feeding pump was next to the bed going at a rate of 40 ml/hr with the Kangaroo bag labeled Glucerna 1.2 in with a date of 9/01/20. During an observation on 9/02/20 at 2:33 p.m., revealed of Resident #8 laying in bed. The resident's feeding pump was next to the bed going at a rate of 40 ml/hr with the bag labeled Glucerna 1.2 in a Kangaroo enteral formula bag. The enteral formula bag and the water full bag were labeled with the date and time of 9/01/20 at 3:50 p.m. with a rate of 40 ml/hr. This observation revealed the enteral feeding had been running for 23 hours. Following the physician ordered rate (1100 mls at a rate of 50 ml/hr) would have finished delivering is formula after 22 hours (about 1:50 pm). The physician's orders [REDACTED].#8's room, LVN J confirmed Resident #8's enteral feeding was flowing at a rate of 40 ml/hr. When the surveyor showed LVN J Resident #8's active physician orders, LVN J confirmed the resident's enteral feeding should have been flowing at a rate of 50 ml/hr. LVN J confirmed the flush and enteral formula bags were dated as started at 3:50 p.m. instead of the ordered start of 7:00 p.m. LVN J also confirmed the enteral feeding was nearing 24 hours of use. LVN J reported they normally turn Resident #8's pump off at 5:00 p.m. and then start a new enteral feeding at 7 p.m. During an observation on 9/02/20 at 3:28 p.m. in Resident #81's room, the resident's feeding pump was going at a rate of 50 ml/hr with the bag labeled Glucerna and dated 9/01/20 at 3:50 p.m. with a rate of 40 ml/hr. The bag still had a little over 300 mls left and the water flush bag had about 400 mls of water left. The flush was infusing at a rate of 30 ml/hr. The pump indicated that 757 ml of the formula and 123 ml of flush had been delivered. The enteral formula and water flush bags were labeled from the manufacturer do not use for greater than 24 hours. During an observation and interview on 9/02/20 at 5:10 p.m. with the Regional Nurse Consultant in Resident #8's room, the Regional Nurse Consultant confirmed Resident #8's enteral feeding pump was still going and that the formula and water flush bags

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	675437	A. BUILDING _____ B. WING _____	09/05/2020

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.

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F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) were labeled 9/01/20 at 3:50 pm. The Regional Nurse Consultant confirmed the formula and water flush bag had been used for greater than 24 hours. The Regional Nurse Consultant confirmed that if the formula and water flush were started at 3:50 p.m. they were started to early because the order was to start at 7:00 p.m. Record review of the facility's policy titled Clinical Practice Guideline: Care of Tube Feed Resident, dated reviewed 2/10/20, revealed to provide formula at prescribed rate using appropriate delivery method.
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice for 3 of 3 resident (Resident #42, #52 and #81) reviewed for oxygen treatments in that: 1. Resident #52's oxygen was not being administered as ordered for 2 of 2 days observed. 2. Resident #81's oxygen was not being administered as ordered for 2 of 2 days observed. Resident #81's oxygen concentrator's filter was covered with gray fuzzy matter. 3. Resident #42's oxygen concentrator filter had a layer of white lent. This deficient practices could affect residents who received oxygen continuously and could result in Residents receiving incorrect or inadequate oxygen support and result in a decline in health. The findings were: 1. Record review of Resident # 52's face sheet, dated 9/04/20, revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 52's Order Summary Report, dated 9/04/20, revealed an order for [REDACTED].#52's Quarterly Change MDS, dated [DATE], revealed the resident had a BIMS score of 13 which indicated the resident was cognitively intact. The same record also revealed Resident was receiving oxygen therapy while a resident. Record review of Resident #52's electronic Care Plan, dated with a revision on 9/04/20, revealed a focus of Oxygen: (Resident #52) uses oxygen therapy and is at risk for ineffective gas exchange. This is related to: [MEDICAL CONDITION], SOB Per resident she does not want the 02 water she does not like it becomes upset if staff attempts to put in on with an intervention to administer oxygen therapy per physician's orders [REDACTED].#52 lying in her bed with oxygen cannula in her nares going at a rate of 4.5 liter per minute (LPM). During an observation on 9/03/20 at 3:45 p.m., revealed Resident #52 lying in her bed with oxygen cannula in her nares going at a rate of 4.5 LPM. During an observation and interview on 9/03/20 at 3:47 p.m., with LVN C in Resident #52's room, LVN C confirmed Resident #52's oxygen concentrator was flowing at a rate of 4.5 LPM. LVN C then moved the flow rate from 4.5 to 2 LPM. LVN C revealed the resident was ordered 2 LPM. LVN C revealed Resident #52 is non-compliant with keeping her oxygen on and staff may have turned her oxygen flow rate up to make sure she was getting enough oxygen. 2. Record review of Resident # 81's face sheet, dated 9/04/20, revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 81's Order Summary Report, dated 9/02/20, revealed an order for [REDACTED]. Record review of Resident #81's Quarterly Change MDS, dated [DATE], revealed the resident had a BIMS score of 1 which indicated the resident was moderately cognitively impaired. The same record also revealed Resident was receiving oxygen therapy while a resident. Record review of Resident #81's electronic Care Plan, dated with a revision on 8/28/20, revealed a focus of Oxygen: (Resident #81) uses oxygen therapy routinely and is at risk for ineffective gas exchange. This is related to right [MEDICAL CONDITION], SOB, [MEDICAL CONDITION], with an intervention to administer oxygen therapy per physician's orders [REDACTED].#81 was in her room seated in her wc with the oxygen cannula's in her nares and an oxygen tank hanging behind the chair at a flow rate of 3 LPM. During an observation on 9/02/20 at 12:12 p.m., Resident #81 was seated on her bed with oxygen cannula's in her nares with the oxygen flowing from a concentrator at a rate of 3 LPM. The oxygen concentrator also had a filter on the back that was entirely covered in gray fuzzy matter. During an observation and interview on 9/02/20 at 12:14 p.m. with LVN J in Resident #81's room, revealed when the surveyor showed LVN J Resident #81's filter on oxygen concentrator she stated wow and that she would clean it. LVN C confirmed Resident #81's oxygen concentrator was flowing at 3 LPM. 3. Review of Resident #42's face sheet dated 9/3/20 revealed her most recent admission after a hospital stay was on 8/12/20 with a [DIAGNOSES REDACTED]. Review of Resident #42's quarterly MDS dated [DATE] revealed Resident #42 was receving oxygen therapy. Review of Resident #42's Care Plan revised on 7/24/20 revealed Resident #42 used oxygen therapy routinely and was at risk for ineffective gas exchange related to SOB. Observation on 9/2/20 at 10:43 AM revealed Resident #42 lying in bed with 02 infusing via nasal cannula at 2.5 liters. Further observation revealed there was a layer of white lint covering the filer. Observation on 9/3/20 at 10:58 AM revealed the filter on Resident #42's oxygen concentrator still had a layer of white lint. Interview at this same time with LVN M confirmed that the filter had a layer of white lint. She stated usually the filter was changed out every Wednesday during the night shift. LVN M confirmed the filter had not been changed. Record review of the facility's policy titled Oxygen Administration, dated reviewed on 1/05/20, revealed to verify the physician's orders [REDACTED]. and) clean the oxygen concentrator's filter weekly.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 18 residents (Resident #81) being reviewed for pharmacy services, in that: Resident #81's September MAR indicated [REDACTED]. These deficient practices could affect resident prescribed pain, antifungal and anti-hypertensive medications and place residents at risk for receiving less than therapeutic benefits from medications. The findings were: Record review of Resident # 81's face sheet, dated 9/04/20, revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #81's Quarterly Change MDS, dated [DATE], revealed the resident had a BIMS score of 1 which indicated the resident was moderately cognitively impaired. Record review of Resident #81's electronic Care Plan, dated with a revision on 8/28/20, revealed a focus of Pressure Hypertension: (Resident 81) has hypertension and is at risk for fluctuations in blood pressure with an intervention for administer anti-hypertensive medications as ordered (and) monitor for side effects such as orthostatic [MEDICAL CONDITION], headache, [MEDICAL CONDITION], chest pain, and decreased heart rate ([MEDICAL CONDITION]). Record review of Resident # 81's Order Summary Report, dated 9/02/20, revealed orders for: - [MEDICATION NAME] Pain Relief Patch 4 % ([MEDICATION NAME]) Apply to Left Shoulder topically in the morning for Pain with a start date of 2/07/20 and no end date. - [MEDICATION NAME] HCl Tablet Give 60 mg by mouth two times a day for Hypertension hold for B/P <110/60 and/or Pulse <60 with a start date of 2/06/20 and no end date. - [MEDICATION NAME] Powder Apply to Peri Area topically two time a day for Incontinence with a start date of 2/06/20 and no end date. Record review of Resident #81's MAR for September 2020, reviewed on 9/03/20, revealed the resident was coded for the following medications: [REDACTED]. -For the [MEDICATION NAME] HCl Tablet on 9/02/20 for the 8:00 am dose: the resident had a blood pressure of 101/63 which is less than 110/60 and there was still a signature indicating the medication was administered. -For the [MEDICATION NAME] Powder on 9/01/20 at 5:00 pm and 9/02/20 at 9:00 am were blank indicating that it was not administered. During an interview with MA A on 9/04/20 at 2:38 p.m., the Regional Nurse Consultant confirmed Resident #81's September MARs had blanks that indicated the medication was not administered. The Regional Nurse Consultant confirmed Resident #81's [MEDICATION NAME] was to be held if the parameters were not met, and the person administering the medication would sign and then circle their signature to indicate that it was held. The Regional Nurse Consultant confirmed this was not done for Resident #81's [MEDICATION NAME] when the parameters were not met on 9/02/20.

F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that based on a comprehensive assessment of a resident PRN orders for [MEDICAL CONDITION] drugs are limited to 14 days for 2 of 6 Residents (#13 and #42) whose records were reviewed. 1. Nursing staff did not discontinue a PRN order for a [MEDICAL CONDITION] medication not administered exceeding 14 days for Resident #13 2. Nursing staff did not discontinue a PRN order for a [MEDICAL CONDITION] medication not administered exceeding 14 days for Resident #42 This deficient practice could affect any Resident with PRN [MEDICAL CONDITION] medications and could result in prolonged use of unnecessary [MEDICAL CONDITION] medications. The findings were: 1. Review of Resident #13's face sheet dated 9/5/20 revealed the Resident was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #13's physician orders [REDACTED].#13 revealed Pharmacist noted no irregularities. No recommendations were made regarding open ended [MEDICAL CONDITION] order. 09/04/20 02:54 PM Interview on 9/4/20 at 2:54 PM with RN R revealed that any PRN [MEDICAL CONDITION] medication required a 14 day order. She stated the Resident should be reevaluated to determine whether the medication should be continued as PRN order or on routine basis based on the

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) medication use. RN R stated staff should call the physician and have the order discontinued if the PRN [MEDICAL CONDITION] medication was not administered within the 14 -day period. Further interview with RN R confirmed Resident #13 had a PRN order for [MEDICATION NAME] that should have been discontinued as of June 2020. 2. Review of Resident #42's face sheet dated 9/3/20 revealed her most recent admission was on 8/12/20 after a hospital stay with a [DIAGNOSES REDACTED]. Review of Resident #42's admission orders [REDACTED]. Review of Resident #42's MAR for August 2020 and September 2020 revealed Resident #42 had not received the medication. 09/04/20 02:54 PM Interview on 9/4/20 at 2:54 PM with RN R revealed that any PRN [MEDICAL CONDITION] medication required a 14 day order. She stated the Resident should be reevaluated to determine whether the medication should be continued as PRN order or on routine basis based on the medication use. RN R stated staff should call the physician and have the order discontinued if the PRN [MEDICAL CONDITION] medication was not administered within the 14- day period. Further interview with RN R confirmed Resident #42 had a PRN order for [MEDICATION NAME] that should have been discontinued. Review of a facility policy, [MEDICAL CONDITION] Medication dated 1/15/19 read in part as follows: It is the facility's policy that each resident's drug regimen is free from unnecessary drugs, including unnecessary [MEDICAL CONDITION] drugs. 5. PRN orders for [MEDICAL CONDITION] drugs are limited to 14 days, except if the prescribing practitioner documents appropriate [DIAGNOSES REDACTED]. Then he/she must document the rationale in the resident's medical record and writes a new PRN prescription every 14 days after the resident has been evaluated.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. These deficient practices could place residents at risk for not receiving the intended therapeutic benefit of their medication.There were 2 errors out of 27 opportunities which resulted in a 7.41 percent error rate involving Resident #37 in that: 1. LVN (Licensed Vocational Nurse) B could not administer [MEDICATION NAME] 150 Capsule 150 MG ([MEDICATION NAME] Iron Complex), Give 150 mg by mouth in the morning for Supplement -Start Date-06/22/2020 0800, as the medication was not available. 2. LVN B pulled Rena-Vite Tablet (B Complex-C-Folic Acid) to give 1 tablet by mouth one time a day for Supplement on 9/4/ - Start Date-09/03/2020 0800. The medication bottle had an expired date of 08/2020 on it. The LVN had pulled the medication into the portion cup. The findings were: 1. Review of Resident #37's undated face sheet revealed an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #37's consolidated physician's orders [REDACTED].M. revealed LVN B could not administer [MEDICATION NAME] 150 Capsule 150 MG ([MEDICATION NAME] Iron Complex), as the medication was not available on the medication cart and according to the LVN is was due to come in this afternoon. LVN B obtained a new order from the physician 9/4/2020 at 0900 A.M. to administer Iron Tablet 325 (65 Fe) MG ([MEDICATION NAME]). Order to give 325 mg by mouth in the morning for [MEDICAL CONDITION], -Start Date-09/04/2020 0900. In an interview on 9/4/2020 at 8:45 A.M. LVN B confirmed the [MEDICATION NAME] 150 Capsule 150 MG ([MEDICATION NAME] Iron Complex) was not available on the cart. LVN B knew the order was due to arrive from the pharmacy in the afternoon. 2. Review of Resident #37 undated face sheet revealed an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #37 consolidated physician's orders [REDACTED]. Observation of medication pass on 9/4/2020 at 8:30 A.M. revealed LVN B had removed the Rena-Vite Tablet (B Complex-C-Folic Acid) from the container and placed it in the portion cup. When the medication container was checked by the surveyor, the medication expired 8/2020. LVN B was informed of the expiration date and discarded the medication in the trash bin on the medication cart. There was another botleof themed available which was opened, appropriately dated as opened and dispensed to the resident. The pulled tablet and expired bottle of medication were discarded n the trash bin on the medication cart. Interview with LVN B on 9/4/2020 at 8:35 A.M. confirmed he did not check the expiration date and failed to validate the expiration date prior to pulling the medication into the portion cup.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation in that: 1. Dietary Aide A did not sanitize the thermometer before inserting it into a food item. 2. Plastic cups, a pitcher and sheet pans were stored without being air-dried. These deficient practices could place residents who received meals and snacks from the kitchen at risk for food borne illness. The findings were: 1. During an observation on 9/03/20 at 4:32 p.m., in the kitchen revealed Dietary Aide L behind the steam table with the dinner meal items assembled on the steam table. Dietary Aide L was going to begin temping the food before the dinner meal service. Dietary Aide L pulled the thermometer out of the plastic protector and then inserted it into the green beans. The surveyor then asked Dietary Aide L if there were any sanitizer strips to clean the thermometer. Dietary Aide L confirmed the thermometer should have been cleaned before inserting it into the food. During an observation on 9/03/20 at 4:40 p.m., in the kitchen revealed Dietary Aide L next to pears that were to be served for the dinner meal. Dietary Aide L pulled the thermometer out of the plastic protector and then inserted it into the pears without cleaning it off. 2. During an observation on 9/01/20 at 11:39 p.m. in the kitchen, revealed two 3-shelved metal racks used to store clean kitchen equipment and utensils. One of the shelving had 2 trays of plastic cups that were stored on plastic trays. The plastic trays had puddled water on it and the plastic cups had water inside of them when the were picked up. The other rack had a pitcher that was stored with a lid on it and water droplets inside. On the same rack there was metal sheet pans stacked on top of each other, but when the pans were lifted up there were water droplets on the area where they were stacked on top of each other. Record review of the TFER, p. 114, 228.122(a)(1)-(2) revealed equipment and utensils, air-drying required. After cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining before contact with food; and may not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 interview and record review the facility failed to maintain medical records in accordance with accepted professional standards and practices on each resident that are accurately documented for 1 of 18 Residents (Resident #66) reviewed for records in that: 1. Resident #66's code status was no transcribed on to his electronic active physician orders [REDACTED]. This deficient practice could affect residents with a full code advanced directive and could place them at risk for in errors in care and treatment. Findings included: 1. Record review of Resident #66's face sheet, dated 9/04/20, revealed the resident was initially admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #66's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 15, which meant the resident was cognitively intact. Record review of Resident #66's Comprehensive Care Plan, dated revised on 9/01/20, revealed it did not address the resident's code status. Record review of Resident #66's paper chart revealed no color-coded sheet indicating the residents code status at the front of the char, green for full code and red for DNR. Further review of Resident #66's paper chart revealed the resident's admission orders [REDACTED]. Record review of Resident #66's Order Summary Report, dated 9/03/20, revealed no order for the resident's code status. During an interview on 9/04/20 at 2:57 p.m., the Regional Nurse confirmed resident's code status should be transcribed onto their electronic orders. The Regional Nurse revealed the facility's SW would be the one who gets the code status from the resident, but they currently don't have a social worker. The Regional Nurse confirmed Resident #66's code status was not transcribed onto his active electronic physician orders. Record review of the facility's policy titled Physician Monitoring Orders, dated 1/23/16, revealed to enter the order into the medical record.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 days observations were made for infection control. LVN P entered multiple

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 _____	**09/05/2020**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) Resident rooms on the 700 hall (warm zone) and then entered the donning station without changing her gown. This deficient practice could affect Residents on the 700 hall and could contribute to the spread of infections and diseases. The findings were: Observation on 9/2/20 at 11:02 AM on the 700 hall revealed LVN P making rounds going in and out of Resident rooms. LVN P then entered the donning station. LVN P proceeded to pick trash up from the floor; she picked up the trash can and put it on top of the 3-drawer compartment containing the clean gowns. Interview at this same time with LVN P confirmed she was making rounds and the last room she entered was 704. LVN P stated she thought she could enter the donning station after going into Resident rooms on the 700 hall and without doffing and re-donning a clean gown. Interview on 9/2/20 at 12:00 PM with RN Q and RN R revealed room [ROOM NUMBER] was the donning station and then the last room on the right side was the doffing station. RN R said the 700 hall was the admission/readmission hall (warm zone) and all staff had to wear a mask, gown, and gloves when entering the Resident rooms. Furthermore, staff had to doff their PPE and exit the hall from the back door before re-entering the facility. Further interview on 9/2/20 at 1:00 PM with RN R confirmed staff should not enter the donning station after entering Resident rooms to prevent cross contamination and the spread of infections and diseases. Review of facility policy, Infection Prevention and Control Program revised 9/29/17 read in part as follows: It is the policy of NF to implement infection control measures to prevent the spread of communicable diseases and condition.