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 _____	07/31/2020

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for complete and accurate clinical records. The facility did not document on Resident #1's MAR when the resident received medications or why medications were not administered. This deficient practice could affect residents that received medications and place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings were: Record review of Resident #1's face sheet, dated 7/30/2020 revealed an initial admission date of [DATE] and re-admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMs score of 6 which indicated severe cognitive impairment. Record review of Resident #1's physician orders [REDACTED]. the morning for supplement -Magnesium Oxide 400 mg, give one tablet by mouth one time a day for supplement -[MEDICATION NAME] HCl 500 mg, give one tablet by mouth in the morning for diabetes -[MEDICATION NAME] 75 mg, give 75 mg by mouth in the morning for depression -[MEDICATION NAME] 750 mg, give one tablet by mouth every morning for [MEDICAL CONDITION] -[MEDICATION NAME] 180 mg, give one tablet by mouth in the morning for allergic rhinitis -Aspirin 81 mg, give one tablet by mouth in the morning for CAD -Calcium-[MEDICATION NAME] 600 mg, give one tablet by mouth in the morning for antacid -[MEDICATION NAME] Delayed Release Particles 60 mg, give one capsule by mouth one time a day related to major [MEDICAL CONDITION] Record review of Resident #1's MAR for July 2020 revealed there were blank spaces for Resident #1's medication administration for the following: -[MEDICATION NAME], [MEDICATION NAME] on 7/27/2020 and 7/28/2020 -[MEDICATION NAME] and [MEDICATION NAME] on 7/27/20, 7/28/20 and 7/29/20 -Multivitamin Adult and Magnesium Oxide on 7/27/20 -[MEDICATION NAME] on 7/18/20, 7/27/20 and 7/28/20 -Aspirin and [MEDICATION NAME] on 7/23/20, 7/27/20 and 7/28/20 -Calcium [MEDICATION NAME] on 7/23/20, 7/25/20, 7/27/20, 7/28/20 Further review of Resident #1's MAR for July 2020 revealed the MAR had initials of staff circled, indicating medications were not administered. There was no documentation on the MAR as to why medications were not administered for the following: - [MEDICATION NAME], Multivitamin Adult, [MEDICATION NAME], Magnesium Oxide, [MEDICATION NAME], Aspirin and Calcium [MEDICATION NAME] from 7/15/20-7/17/20 -[MEDICATION NAME] on 7/15/20-7/17/20 and 7/25/20 -[MEDICATION NAME] and [MEDICATION NAME] on 7/16/20 and 7/17/20 -[MEDICATION NAME] and [MEDICATION NAME] on 7/17/20 During an interview on 7/30/2020 at 4:53 p.m., the DON confirmed staff did not document on Resident #1's MAR after giving the medications or provide a reason as to why medications were not administered for the July 2020 MAR. She stated there should not be any blanks on the MAR and stated that staff are to circle their initials when medications are not administered and document on the back of the MAR as to why the medication was not given. Record review of the facility's policy titled Medication-Treatment Administration and Documentation Guidelines, dated 2/10/2020, revealed: Document initials and/or signature for medications and treatments administered on the MAR or TAR immediately following administration. Circle initials for those medication or treatment that were not administered and document reason for the non-administration on the back of the MAR or TAR.
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, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 4 residents (Residents #1, #2 and #3) reviewed for infection control, in that: 1. LVN A did not disinfect the wrist blood pressure monitor in between Resident #1 and Resident #2 when checking their blood pressure. 2. Residents #1, #2 and #3 were not screened for signs and symptoms of COVID-19. These deficient practices could place residents at risk for cross contamination and the spread of infection. The findings were: 1. Record review of Resident #1's face sheet, dated 7/30/2020 revealed an initial admission date of [DATE] and re-admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's MAR indicated [REDACTED]. Resident #1's blood pressure was documented as 134/75 and pulse 67. Record review of Resident #2's face sheet, dated 7/30/2020 revealed an initial admission date of [DATE] and re-admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's MAR indicated [REDACTED]. Resident #2's blood pressure was documented as 122/76 and pulse 81. Observation on 7/30/2020 at 9:42 a.m. revealed LVN A used a wrist blood pressure monitor to check Resident #1's blood pressure. LVN A placed the blood pressure monitor on top of the medication cart, documented the blood pressure and gave Resident #1 her medications, which the resident spit out. Observation on 7/30/2020 at 9:59 a.m. revealed LVN A checked Resident #2's blood pressure with the same blood pressure monitor without disinfecting the monitor after using it for Resident #1. During an interview on 7/30/2020 at 11:33 a.m., LVN A stated she did not have any sanitizer wipes on the medication cart and confirmed she did not sanitize the blood pressure monitor in between Resident #1 and Resident #2. During an interview on 7/30/2020 at 4:57 p.m., the DON stated that staff should clean the blood pressure monitor after used on each resident. Record review of the facility's policy titled Care, Cleaning and Storage of Equipment dated 9/13/14 revealed in part . 1. Resident equipment is to be cleaned with EPA approved disinfectant or similar agent between residents and i. On a regular basis ii. When soiling and spills occur iii. When a resident is discharged from the facility. 2. Record review of Resident #1's face sheet, dated 7/30/2020 revealed an initial admission date of [DATE] and re-admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMs score of 6 which indicated severe cognitive impairment. Record review of the Resident COVID-19 symptom monitoring log from 7/23/2020- 7/29/2020 revealed only one screening had been documented as completed daily. Record review of Resident #2's face sheet, dated 7/30/2020 revealed an initial admission date of [DATE] and re-admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMs score of 10 which indicated moderate cognitive impairment. Record review of the Resident COVID-19 symptom monitoring log from 7/23/2020- 7/29/2020 revealed only one screening had been documented as completed daily. Record review of Resident #3's face sheet, dated 7/30/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Annual MDS, dated [DATE], revealed a BIMs score of 14 which indicated cognition was intact. Record review of the Resident COVID-19 symptom monitoring log from 7/23/2020- 7/29/2020 revealed there was no documentation that a screening had been completed on 7/27/20 and 7/29/2020. Further review of the log revealed only one screening had been documented as completed on 7/28/2020 and from 7/23/2020-7/26/2020 daily. During an interview on 7/30/2020 at 4:50 p.m., the DON stated residents were to be screened for COVID-19 symptoms twice per day, once per shift. She confirmed the monitoring log only documented one screening being done daily for Resident #1, #2 and #3 and that Resident #3 was missing screenings for 7/27/2020 and 7/29/2020. Record review of the facility's policy titled, Surveillance Plan: Infection Control Surveillance COVID19, dated 6/2/2020 revealed in part . Infection Control Measures. Resident Care.

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Actively monitor all residents upon admission and at least three times a day for fever and respiratory symptoms (use latest COVID-19 CDC Guidelines). Review of COVID-19 Response for Nursing Facilities, version 3.1, dated 6/02/20, page 52, Attachment 4: Comprehensive Mitigation Plan-NF without COVID-19 Positive Cases, revealed in part, Identify infections early: a. Actively screen all residents for fever and symptoms of COVID-19 at least each shift.