STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676010	A. BUILDING _____ B. WING _____	**09/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGACY REHABILITATION AND LIVING	**4033 W 51ST AVE AMARILLO, TX 79109**

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 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure residents were free of any significant medication errors for 1 of 8 residents (Resident #1) reviewed for medication administration. Resident #1, who was a new admit to the facility, did not receive a prescribed IV antibiotic medication for 7 days. The facility's failure to administer medications correctly could affect all residents resulting in exacerbation of their condition resulting in complications from deterioration in health, extended recoveries, hospitalization s, and death. The evidence is as follows: Record review of Resident #1's clinical record revealed an admitted [DATE]. Resident #1 was [AGE] years of age, with the following Diagnoses: [REDACTED]. -A Medicare 5-Day MDS resident assessment, dated 9/7/2020, documented the resident scored 15 of 15 on a mini-mental exam, required extensive assistance by two staff for transfers, required extensive assistance by one staff for bed mobility, dressing, toileting, personal hygiene and bathing, indwelling catheter, occasionally incontinent of bowel, 65 inches tall and 204 pounds. -Nurses notes documented the following: 9/10/2020 at 12:57 p.m. - Son called concerning the antibiotic resident was on in hospital. Notified NP, new order given for [MEDICATION NAME] 1gm via IV q 8 hrs. x 10 days. Notified family member of new order. 9/10/2020 at 2:28 p.m. - by Social Services - spoke with her son and informed him that I spoke with RN A and RN C, the discharge medication list from {hospital} did not consist of any antibiotic treatments to be continued, informed him they received order from NP to start IV antibiotic tomorrow and last for 10 days, he stated he thinks that's why she has been confused and I expressed to him yes that could be why, he is upset with {hospital} for not continuing the antibiotic because he feels it set her back and is going to call them and express his concern, He inquired why we didn't have her on antibiotics if we knew she had a UTI, explained to him if it wasn't on the medication list it might've been assumed that the antibiotic had been completed but we go off of the hospital discharge medication list. Record review of the Discharge Instructions from {hospital}, dated 9/4/2020, documented on the front page, the following: -Your medications have changed : . water for injection solution 10 ml with [MEDICATION NAME] 1 gram recon. solution 1 gram. On the last page of the Medication List, this medication order was found to start - Water for injection solution 10 ml with [MEDICATION NAME] 1 gram recon. solution 1 gram - infuse 1 gram into a venous catheter every 8 (eight) hours. Last time this was given - 9/4/2020 at 8:33 a.m. There was not a check mark in the time needed to be given but there was hand written documentation - how many days - 10 days. During an interview on 9/12/2020 at 9:19 a.m., the DON stated when Resident #1 was admitted to the facility on [DATE], an IV antibiotic got missed and the medication did not get transcribed. DON stated that on 9/10/2020, the NP was notified and the antibiotic was ordered to start on 9/11/2020 but Resident #1 had already left the facility and was sent to the hospital due to family request. During an interview on 9/12/2020 at 12:45 p.m., RN A stated he did not admit Resident #1 but LVN C was using his access code to put stuff in the computer. RN A stated he guessed LVN C did not put in all the medication for Resident #1. RN A stated he did not take care of Resident #1 at all. During an interview on 9/12/2020 at 3:10 p.m., LVN C stated she did the admission for Resident #1. LVN C stated she remembered calling the pharmacy because that medication - [MEDICATION NAME] - was not in the computer. LVN C stated RN A also helped her with the admission and RN A also called the pharmacy to help her. LVN C stated there was a question about the medication and she spoke with the NP for clarification on the medication. LVN C stated the IV medication order for Resident #1 did not state how many times a day to administer the medication or for how long. LVN C stated she wrote on the report to the next shift that the IV medications were ordered and there was a concern with the medication and to please recheck the orders for Resident #1. LVN C stated she was an agency nurse and sometimes they did not have the authority to put in some medications. Record review of a policy and procedure titled Nursing Administration, Section: Continuum of Care, Subject: Admission, revised 5/2007, documented the following: Policy: It is the policy of this facility to have well defined guidelines for processing the Resident's entry into the nursing facility and the resident's right guaranteed under federal and state law are protected. Procedures: Licensed Nurse Procedure 2. Initiate any required treatments (oxygen, intravenous) necessary at time of admission per transfer orders. 4. Inform physician of admission and verify transfer and admission orders [REDACTED]. 9. Note and initiate physician orders. Initiate medications and treatment sheets. Record review of the Admission Checklist for the facility documented the following: 1. Notify Physician of arrival and verify orders 6. Enter Medications/fax to pharmacy
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 interviews and record review, it was determined the facility failed to ensure that in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, and readily accessible for 1 of 8 residents (Resident #1) reviewed for clinical records. Resident #1's medication orders were not transcribed and put in the computer/Resident's clinical record,. The facility's failure to ensure medical records on each resident were complete, accurately documented, and readily accessible, placed all residents requiring nursing care at risk for incorrect or omitted treatment, duplicated treatments, poor self-esteem and self-worth, and a failure to ensure continuity of care. The evidence is as follows: Record reviewe of Resident #1's clinical record revealed an admitted [DATE]. Resident #1 was [AGE] years of age, with the following Diagnoses: [REDACTED]. -A Medicare 5-Day MDS resident assessment, dated 9/7/2020, documented the resident scored 15 of 15 on a mini-mental exam, required extensive assistance by two staff for transfers, required extensive assistance by one staff for bed mobility, dressing, toileting, personal hygiene and bathing, indwelling catheter, occasionally incontinent of bowel, 65 inches tall and 204 pounds. -Nurses notes documented the following: 9/10/2020 at 12:57 p.m. - Son called concerning the antibiotic resident was on in hospital. Notified NP, new order given for [MEDICATION NAME] 1gm via IV q 8 hrs. x 10 days. Notified family member of new order. 9/10/2020 at 2:28 p.m. - by Social Services - spoke with her son and informed him that I spoke with RN A and RN C, the discharge medication list from {hospital} did not consist of any antibiotic treatments to be continued, informed him they received order from NP to start IV antibiotic tomorrow and last for 10 days, he stated he thinks that's why she has been confused and I expressed to him yes that could be why, he is upset with {hospital} for not continuing the antibiotic because he feels it set her back and is going to call them and express his concern, He inquired why we didn't have her on antibiotics if we knew she had a UTI, explained to him if it wasn't on the medication list it might've been assumed that the antibiotic had been completed but we go off of the hospital discharge medication list. Record review of the Discharge Instructions from {hospital}, dated 9/4/2020, documented on the front page, the following: -Your medications have changed : . water for injection solution 10 ml with [MEDICATION NAME] 1 gram recon. solution 1 gram. On the last page of the Medication List, this medication order was found to start - Water for injection solution 10 ml with [MEDICATION NAME] 1 gram recon. solution 1 gram - infuse 1 gram into a venous catheter every 8 (eight) hours. Last time this was given -

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

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 9/4/2020 at 8:33 a.m. There was not a check mark in the time needed to be given but there was hand written documentation - how many days - 10 days. During an interview on 9/12/2020 at 9:19 a.m., the DON stated when Resident #1 was admitted to the facility on [DATE], an IV antibiotic got missed and the medication did not get transcribed. DON stated on 9/10/2020 , the NP was notified and the antibiotic was ordered to start on 9/11/2020 but Resident #1 had already left the facility and was sent to the hospital due to family request. During an interview on 9/12/2020 at 12:45 p.m., RN A stated he did not admit Resident #1 but LVN C was using his access code to put stuff in the computer. RN A stated he guessed LVN C did not put in all the medication for Resident #1. RN A stated he did not take care of Resident #1 at all. During an interview on 9/12/2020 at 3:10 p.m., LVN C stated she did the admission for Resident #1. LVN C stated she remembered calling the pharmacy because that medication - [MEDICATION NAME] - was not in the computer. LVN C stated RN A also helped her with the admission and RN A also called the pharmacy to help her. LVN C stated there was a question about the medication and she spoke with the NP for clarification on the medication. LVN C stated the IV medication order for Resident #1 did not state how many times a day to administer the medication or for how long. LVN C stated she wrote on the report to the next shift that the IV medications were ordered and there was a concern with the medication and to please recheck the orders for Resident #1. LVN C stated she was an agency nurse and sometimes they did not have the authority to put in some medications. Record review of a policy and procedure titled Nursing Administration, Section: Continuum of Care, Subject: Admission, revised 5/2007, documented the following: Policy: It is the policy of this facility to have well defined guidelines for processing the Resident's entry into the nursing facility and the resident's right guaranteed under federal and state law are protected. Procedures: Licensed Nurse Procedure 2. Initiate any required treatments (oxygen, intravenous) necessary at time of admission per transfer orders. 4. Inform physician of admission and verify transfer and admission orders [REDACTED]. 9. Note and initiate physician orders. Initiate medications and treatment sheets. Record review of the Admission Checklist for the facility documented the following: 1. Notify Physician of arrival and verify orders 6. Enter Medications/fax to pharmacy