STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675159	A. BUILDING _____ B. WING _____	**08/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHBROOKE MANOR NURSING AND REHABILITATION CENTE	**1401 W MAIN ST EDNA, TX 77957**

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all necessary documentation of transfer was provided to the receiving health care provider and ensured an effective transition of care for 1 of 1 residents (Resident #1) reviewed for transfers and discharges, in that: The facility failed to provide the local EMS and hospital necessary documentation to ensure a safe transfer. This deficient practice could place residents at risk for not receiving care and services to meet their needs upon transfer. The findings were: Record review of Resident #1's face sheet, dated 08/20/2020, revealed the resident was admitted to the facility on [DATE], returned from the hospital on [DATE], and was discharged again to the hospital on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Admission MDS, dated [DATE], revealed a BIMS score of 6, which indicated the resident was severely cognitively impaired for daily decision-making skills. Record review of the EMS Run report, dated 08/16/2020, revealed, Nurses were unable to provide copies of medication records, demographics, or other documentation stating that they were having computer and fax problems. During an interview with CNA A on 08/24/2020 at 10:43 a.m., CNA A stated the computer was down and LVN B could not send Resident #1's records. During an interview with LVN C on 08/24/2020 at 10:50 a.m., LVN C confirmed the facility's printer was not working during the time of Resident #1's transfer. LVN C stated, We could have written it (Resident #1's transfer documentation) out. During an interview with LVN B on 08/24/2020 at 11:18 a.m., LVN B stated she attempted to get the paperwork ready for Resident #1, but nothing would work. LVN B further stated she looked in Resident #1's paper chart and could not find any documentation to send such as a face sheet, orders, and medications. LVN B confirmed the printer had been down for a couple of days, and further confirmed the hospital kept calling and stated they needed the paperwork. During an interview with the DON on 08/24/2020 at 12:50 p.m., the DON stated the printer was new to the facility in the last couple of months. The DON stated, It would jam very easily, print really dark and at times not print. I was unaware it was down when (Resident #1) was sent out. The DON confirmed the staff could have written down the documentation needed for the transfer. During an interview with the Administrator on 08/24/2020 at 1:04 p.m., the Administrator stated he was told by staff that the documentation with the facility's printer was resolved. The Administrator confirmed the staff could have written down Resident #1's information with pen and paper. Record review of the facility's policy titled, Transfer or Discharge Documentation, dated 12/2017, revealed, When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. When a resident is transferred or discharged from the facility, the discharge transfer form will be completed and sent to the resident.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure treatment and care was provided in accordance with the comprehensive assessment and professional standards of practice that met the physical, mental and psychological needs for 1 of 1 resident (Resident #1) reviewed for quality of care, in that: The facility did not implement Resident #1's blood glucose monitoring (accuchecks) when the resident returned from the hospital on [DATE]. This deficient practice could place residents who are diabetic at risk for a decline in health. The findings were: Record review of Resident #1's face sheet, dated 08/20/2020, revealed the resident was admitted to the facility on [DATE], returned from the hospital on [DATE], and was discharged again to the hospital on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Admission MDS, dated [DATE], revealed a BIMS score of 6, which indicated the resident was severely cognitively impaired for daily decision-making skills. Record review of Resident #1's Care Plan, dated 7/27/2020, revealed a focus that Resident #1 is at risk for impaired blood glucose levels due to diabetes. The goal was Resident #1 will be free from any signs/symptoms of [MEDICAL CONDITION], [DIAGNOSES REDACTED], and complications related to diabetes. One of the interventions was to perform accuchecks every morning. Record review of Resident #1's Physician order [REDACTED].#1's Physician order [REDACTED]. Record review of Resident #1's Progress Note, dated 07/28/2020, revealed the resident was septic and was sent to the ER. Record review of Resident #1's Progress Note, dated 08/12/2020, revealed the resident returned to the facility. Record review of Resident #1's Progress Note, dated 8/16/2020, revealed the resident was unresponsive and her blood sugar was 46. Record review of the EMS Run Report, dated 08/16/2020, for Resident #1 revealed a primary impression of Diabetic [DIAGNOSES REDACTED] (a condition in which a persons blood sugar level is lower than normal). During an interview with LVN D on 08/24/2020 at 10:36 a.m., LVN D stated if she gave a resident insulin she would check their blood sugar first. During an interview with the DON on 08/24/2020 at 12:50 p.m., the DON stated, we check a resident's blood sugar if we feel they are off. The DON further stated she was not sure why Resident #1's accucheck order was not there since the resident had an order for [REDACTED]. During an interview with the Administrator on 08/24/2020 at 1:04 p.m., the Administrator stated he was not aware that Resident #1's blood sugars were not being checked. At the time of exit, the DON did not provide a policy of blood glucose monitoring for diabetics requested on 08/24/2020.

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.