STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676399	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAN SABA REHABILITATION LP	2400 WEST BROWN STREET SAN SABA, TX 76877

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident was free from neglect for 1 of 4 residents reviewed for neglect (Resident #1). The facility did not initiate CPR for Resident #1 when she was found with no pulse. Resident #1 was a full code. Resident #1 was pronounced dead in the facility on [DATE]. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at a level of actual harm with a scope identified as isolated due to the facility's need to complete training of all staff and monitor the plan of removal. This failure affected one resident who died on [DATE] and could place 25 residents who are documented as requesting full code status at risk of not being provided resuscitation, which could lead to death. Findings include: Review of face sheet reflected Resident #1 was an [AGE] year old female admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan (last revised [DATE]) reflected interventions to address [MEDICAL CONDITION], cognitive impairment, gastro-[MEDICAL CONDITION] reflux disease, [MEDICAL CONDITIONS], hypertension, incontinence, activities of daily living, falls, catheter care, pain, skin integrity, pain and anticoagulation. The most recent Minimum (MDS) data set [DATE] reflected full code status. Review of the Resident #1's medical record (undated) reflected a green full code status sheet at the front of the chart. Review of the 'Go' list (Do CPR) (undated) maintained on the facility crash cart reflected 26 residents, including Resident #1. Review of progress notes dated [DATE] reflected CNA B made rounds and changed Resident #1's bedding at 2:00 a.m. A second progress note dated [DATE] revealed CNA B made rounds and had spoken with Resident #1 about her nails at 3:00 a.m. Resident #1 complained that she was cold so CNA B covered her with a blanket. A progress note dated [DATE] reflected LVN A entered Resident #1's room at 5:15 a.m. to administer [MEDICATION NAME] for [MEDICAL CONDITION] and found Resident #1 cold. The note indicated that LVN A felt for a pulse, called Resident #1's husband and the DON. A late entry note dated [DATE] for 5:16 a.m. reflected the DON spoke over the phone with LVN A, who informed the DON that Resident #1 had passed away and asked the DON to come to the facility to pronounce. At 6:15 a.m., the DON arrived and assessed Resident #1, who was determined to be unresponsive, no pulse, no respirations, pupils fixed, and cold to the touch with general cyanosis and rigor mortis present - pronounced dead at this time. The note also reflect at 6:20 a.m., the DON looked at Resident #1's chart and discovered the full code status. Interview on [DATE] at 1:00 p.m., DON stated LVN A called her on the phone about 5:15 a.m. and informed her that Resident #1 had passed and asked her to come into the facility to pronounce her dead. The DON stated she arrived and assessed Resident #1 and pronounced her dead. When she went to the nurses' station to enter her documentation in the chart, she discovered Resident #1 was a full code. The DON then spoke with LVN A and asked if LVN A had checked Resident #1's code status. LVN A reported she had asked LVN B to check for her and informed her Resident #1 was a full code. The DON asked if CPR had been initiated and LVN A replied no because she didn't have a pulse. A telephone interview on [DATE] at 3 p.m. LVN B stated she was passing morning medications about 5:15 a.m., when LVN A called her over to Resident #1's room to help her check Resident #1's pulse. LVN B went to the room and found Resident #1 cold and clammy, with vomit on her. LVN A asked LVN B if she knew if she was a full code or DNR, so LVN B went to the nurses' station to check status. LVN B returned to Resident #1's room and informed LVN A that Resident #1 was a full code. LVN B stated she recalled that LVN A asked CNA C to help clean up Resident #1 and heard LVN A say she was going to call the DON and Resident #1's husband. LVN B stated she returned to passing morning medications so she was uncertain what happened after this. LVN B stated there was no discussion about starting CPR or calling 911 or EMS. LVN B stated there was no discussion about calling the DON to clarify what to do. When asked why CPR was not started, LVN B stated because Resident #1 did not have a pulse. A telephone interview on [DATE] at 3:30 p.m. CNA C stated LVN A called her to come to Resident #1's room and help her check her pulse. CNA C stated Resident #1 was covered in vomit, even her bed linens were soiled. CNA C stated she was unable to find a pulse. CNA C reported LVN A had called LVN B to check if Resident #1 was a full code or DNR. LVN B returned and informed LVN A that Resident #1 was a full code. CNA C reported seeing LVN A heading to the nurses' station to call the DON and family. CNA C then began to clean up Resident #1. CNA C stated CPR was not started and EMS was not called. A telephone interview on [DATE] 11:20 a.m. LVN A stated at 8:30 p.m. Resident #1 c/o nausea so she gave her prn [MEDICATION NAME]. At 2 a.m., the aides told her that Resident #1 was good and they had just changed her bedding. At 3:00 a.m., CNA C went in to her room to answer the call light for Resident #1's roommate. While there, CNA C spoke with Resident #1 about her nails and covered her up because Resident #1 told her she was cold. At 5:10 a.m., LVN A went into Resident #1's room to give her her [MEDICATION NAME]. She found Resident #1 cold, ghost-like; shook her and called for her; looked at her eyes; but Resident #1 did not respond. LVN A called for LVN B for help and CNA C joined them in Resident #1's room. LVN A asked LVN B if she could check on Resident #1's code status and she informed her that Resident #1 was a full code. LVN A contacted the DON and told the DON that Resident #1 had passed (specifically that she was cold, clammy and not responding to voice/touch) and that she didn't know what to do. The DON told LVN A she was getting dressed and would be at the facility shortly. A telephone interview on [DATE] at 3:00 p.m., the facility doctor stated that an LVN should not be making the determination of death and he would expect the LVN to initiate CPR and activate the emergency response system by calling 911. Interview on [DATE] at 1:15 p.m., the Administrator stated if a resident is listed as a full code, then an LVN should start CPR and have another staff person call 911 and the DON. LVN A should have started CPR and had someone call 911 as soon as Resident #1 was identified as a full code. The Administrator added that an LVN does not have the authority to determine time of death. A Cardiopulmonary Resuscitation policy last revised (MONTH) (YEAR) indicated It is the policy of this facility to provide Cardiopulmonary Resuscitation to those residents who experience [MEDICAL CONDITION] and have made their desire for Cardiopulmonary Resuscitation known. The policy specifies if a resident has no pulse: perform external chest compressions .open the airway and deliver two rescue breaths . Once CPR is started do not discontinue unless qualified help arrives (paramedics) or a physician pronounces the resident dead and gives orders to discontinue CPR.

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 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) An Abuse/Neglect Prohibition policy last revised (MONTH) (YEAR) indicated it is the policy of this facility to prohibit resident abuse, neglect in any form, misappropriation of resident property and exploitation, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse, neglect, misappropriation, or exploitation caused by another person. Neglect is defined as the failure of the facility, its employees or service providers to provide good s and services necessary to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The administrator was notified on [DATE] at 12:24 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The following Plan of Removal was submitted by the Administrator on [DATE]. The final Plan of Removal was accepted by the Survey Team on [DATE]. The facility's plan was as follows: The DON took statements from the nursing staff regarding the incident and immediately suspended both LVN A and LVN B for not initiating CPR on Resident #1. Statements were also obtained from C.N.A staff who had helped care for Resident #1 through the night. A self-report form was submitted to the state regarding the incident. Police Chief was called and notified of the initiation of investigation of potential neglect. An in-service was begun on [DATE] with all nursing staff by the DON on use of AED abuse and neglect, and advance directives: the ability to determine full code versus do not resuscitate (DNR) order. Met with family of Resident #1 and they are sad about her passing but not angry or upset at the facility regarding her passing. During the course of the investigation, the ADM and DON reviewed all CPR certifications and found that all 16 currently employed licensed nursing staff have current CPR certification. We initiated post training tests to include questioning regarding the determination of competencies of the training on [DATE]. These post training tests are being administered to individual employees by administrator and or DON to test competencies regarding the identification of code status, the process to follow for Full Code verses DNR, measure their level of comfort with the initiation and/or assisting with CPR, and to give them scenarios to ensure competencies have been successfully trained. Both C.N.A staff and licensed LVN/RN staff have been administered the post training. AED competencies were completed by the DON on [DATE] to all nursing staff. The nursing staff that is on leave during this time will be in serviced by either the Administrator or DON on abuse/neglect, use of AED, and advanced directives: the ability to determine full code versus do not resuscitate. The training and post test will be administered individually by either the DON or administrator prior to their next scheduled shift until all nursing employees have completed all competencies satisfactorily. If competencies are not satisfactorily completed, the employees will be monitored 1:1 with staff that has successfully demonstrated competencies until which time the employee can demonstrate competencies regarding the process and use of CPR for the residents in our care. An audit of all resident charts was performed on [DATE] by ADM, DON, and social worker to ensure correct code statuses were accurate and complete. Two lists are maintained on the crash cart. One list indicated all residents that are Full Code and the other all residents that are DNR. That list was audited for accuracy by the DON and ADON, and no discrepancies were found. New nursing employee orientation and training will be done with all new nursing employees to include the system of identification of code status and the process to follow once a situation arises. New nursing employee orientation and annual CPR training will be done with all nursing staff. In addition to our current system of orientation, we will add the post training survey to ensure competence in the areas of Advance directive acknowledgment and process to follow if the different scenarios are presented. Effective immediately, new employee licensed nursing staff will be required to present current CPR certification before being assigned to charge nurse duties. CPR certification will be required to be maintained by all licensed nursing staff during the duration of employment with the facility. DON will maintain CPR certifications with nurse license and will ensure that all licensed staff are current by looking 90 days ahead and requiring the nursing staff to maintain certification and licensure. Effective immediately, when creating a schedule for the following month, the DON and/or designee will ensure that all staff on the upcoming schedule are current with CPR certifications and licensures. On [DATE] at 5:15 p.m. this surveyor confirmed the Plan of Removal had been implemented sufficiently to remove the Immediate Jeopardy by: Interviews on [DATE] and [DATE] with 1 RN, 3 LVNs and 3 CNAs regarding the assessment and inservice they received on identification of code status, the process for Full Code versus DNR, and abuse. Each knew to look at either the resident's chart or the crash cart to identify code status. Staff were able to accurately explain the steps to take in the event they find a resident unresponsive - determine unresponsiveness, ask someone to call 911/DON/Physician, open the airway, check for breathing-perform rescue breathing, check for pulse-start chest compressions. Staff understood that CPR is to be continued until paramedics arrive. Staff interviewed stated they had previous experience running a full code and felt comfortable doing it. Review of 15 resident records indicated correct code status. Review of the undatedGo list on the crash cart indicated it was updated to include all residents that are full code. Review of 24 personnel files indicated current CPR training. On [DATE] at 5:15 pm the Administrator was informed the IJ was removed. However the facility remained out of compliance at a level of actual harm with a scope identified as isolated due to the facility requiring additional time to train all staff and monitor their plan of removal. The Administrator indicated on [DATE] there were 26 residents with full code status.
F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide basic life support, including CPR, for 1 of 4 residents reviewed for advanced directives (Resident #1). The facility did not initiate CPR for Resident #1 when she was found with no pulse. Resident #1 was a full code. Resident #1 was pronounced dead in the facility on [DATE]. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at a level of actual harm with a scope identified as isolated due to the facility's need to complete training of all staff and monitor the plan of removal. This failure affected one resident who died on [DATE] and could place 25 residents who are documented as requesting full code status at risk of not being provided resuscitation, which could lead to death. Findings include: Review of face sheet reflected Resident #1 was an [AGE] year old female admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan (last revised [DATE]) reflected interventions to address [MEDICAL CONDITION], cognitive impairment, gastro-[MEDICAL CONDITION] reflux disease, [MEDICAL CONDITIONS], hypertension, incontinence, activities of daily living, falls, catheter care, pain, skin integrity, pain and anticoagulation. The most recent Minimum (MDS) data set [DATE] reflected full code status. Review of the Resident #1's medical record (undated) reflected a green full code status sheet at the front of the chart. Review of the 'Go' list (Do CPR) (undated) maintained on the facility crash cart reflected 26 residents, including Resident #1. Review of progress notes dated [DATE] reflected CNA B made rounds and changed Resident #1's bedding at 2:00 a.m. A second progress note dated [DATE] revealed CNA B made rounds and had spoken with Resident #1 about her nails at 3:00 a.m. Resident #1 complained that she was cold so CNA B covered her with a blanket. A progress note dated [DATE] reflected LVN A entered Resident #1's room at 5:15 a.m. to administer [MEDICATION NAME] for [MEDICAL CONDITION] and found Resident #1 cold. The note indicated that LVN A felt for a pulse, called Resident #1's husband and the DON. A late entry note dated [DATE] for 5:16 a.m. reflected the DON spoke over the phone with LVN A, who informed the DON that Resident #1 had passed away and asked the DON to come to the facility to pronounce. At 6:15 a.m., the DON arrived and

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) assessed Resident #1, who was determined to be unresponsive, no pulse, no respirations, pupils fixed, and cold to the touch with general cyanosis and rigor mortis present - pronounced dead at this time. The note also reflect at 6:20 a.m., the DON looked at Resident #1's chart and discovered the full code status. Interview on [DATE] at 1:00 p.m., DON stated LVN A called her on the phone about 5:15 a.m. and informed her that Resident #1 had passed and asked her to come into the facility to pronounce her dead. The DON stated she arrived and assessed Resident #1 and pronounced her dead. When she went to the nurses' station to enter her documentation in the chart, she discovered Resident #1 was a full code. The DON then spoke with LVN A and asked if LVN A had checked Resident #1's code status. LVN A reported she had asked LVN B to check for her and informed her Resident #1 was a full code. The DON asked if CPR had been initiated and LVN A replied no because she didn't have a pulse. A telephone interview on [DATE] at 3 p.m. LVN B stated she was passing morning medications about 5:15 a.m., when LVN A called her over to Resident #1's room to help her check Resident #1's pulse. LVN B went to the room and found Resident #1 cold and clammy, with vomit on her. LVN A asked LVN B if she knew if she was a full code or DNR, so LVN B went to the nurses' station to check status. LVN B returned to Resident #1's room and informed LVN A that Resident #1 was a full code. LVN B stated she recalled that LVN A asked CNA C to help clean up Resident #1 and heard LVN A say she was going to call the DON and Resident #1's husband. LVN B stated she returned to passing morning medications so she was uncertain what happened after this. LVN B stated there was no discussion about starting CPR or calling 911 or EMS. LVN B stated there was no discussion about calling the DON to clarify what to do. When asked why CPR was not started, LVN B stated because Resident #1 did not have a pulse. A telephone interview on [DATE] at 3:30 p.m. CNA C stated LVN A called her to come to Resident #1's room and help her check her pulse. CNA C stated Resident #1 was covered in vomit, even her bed linens were soiled. CNA C stated she was unable to find a pulse. CNA C reported LVN A had called LVN B to check if Resident #1 was a full code or DNR. LVN B returned and informed LVN A that Resident #1 was a full code. CNA C reported seeing LVN A heading to the nurses' station to call the DON and family. CNA C then began to clean up Resident #1. CNA C stated CPR was not started and EMS was not called. A telephone interview on [DATE] 11:20 a.m. LVN A stated at 8:30 p.m. Resident #1 c/o nausea so she gave her prn [MEDICATION NAME]. At 2 a.m., the aides told her that Resident #1 was good and they had just changed her bedding. At 3:00 a.m., CNA C went in to her room to answer the call light for Resident #1's roommate. While there, CNA C spoke with Resident #1 about her nails and covered her up because Resident #1 told her she was cold. At 5:10 a.m., LVN A went into Resident #1's room to give her her [MEDICATION NAME]. She found Resident #1 cold, ghost-like; shook her and called for her; looked at her eyes; but Resident #1 did not respond. LVN A called for LVN B for help and CNA C joined them in Resident #1's room. LVN A asked LVN B if she could check on Resident #1's code status and she informed her that Resident #1 was a full code. LVN A contacted the DON and told the DON that Resident #1 had passed (specifically that she was cold, clammy and not responding to voice/touch) and that she didn't know what to do. The DON told LVN A she was getting dressed and would be at the facility shortly. A telephone interview on [DATE] at 3:00 p.m., the facility doctor stated that an LVN should not be making the determination of death and he would expect the LVN to initiate CPR and activate the emergency response system by calling 911. Interview on [DATE] at 1:15 p.m., the Administrator stated if a resident is listed as a full code, then an LVN should start CPR and have another staff person call 911 and the DON. LVN A should have started CPR and had someone call 911 as soon as Resident #1 was identified as a full code. The Administrator added that an LVN does not have the authority to determine time of death. A Cardiopulmonary Resuscitation policy last revised (MONTH) (YEAR) indicated It is the policy of this facility to provide Cardiopulmonary Resuscitation to those residents who experience [MEDICAL CONDITION] and have made their desire for Cardiopulmonary Resuscitation known. The policy specifies if a resident has no pulse: perform external chest compressions .open the airway and deliver two rescue breaths . Once CPR is started do not discontinue unless qualified help arrives (paramedics) or a physician pronounces the resident dead and gives orders to discontinue CPR. An Abuse/Neglect Prohibition policy last revised (MONTH) (YEAR) indicated it is the policy of this facility to prohibit resident abuse, neglect in any form, misappropriation of resident property and exploitation, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse, neglect, misappropriation, or exploitation caused by another person. Neglect is defined as the failure of the facility, its employees or service providers to provide good s and services necessary to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The administrator was notified on [DATE] at 12:24 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The following Plan of Removal was submitted by the Administrator on [DATE]. The final Plan of Removal was accepted by the Survey Team on [DATE]. The facility's plan was as follows: The DON took statements from the nursing staff regarding the incident and immediately suspended both LVN A and LVN B for not initiating CPR on Resident #1. Statements were also obtained from C.N.A staff who had helped care for Resident #1 through the night. A self-report form was submitted to the state regarding the incident. Police Chief was called and notified of the initiation of investigation of potential neglect. An in-service was begun on [DATE] with all nursing staff by the DON on use of AED abuse and neglect, and advance directives: the ability to determine full code versus do not resuscitate (DNR) order. Met with family of Resident #1 and they are sad about her passing but not angry or upset at the facility regarding her passing. During the course of the investigation, the ADM and DON reviewed all CPR certifications and found that all 16 currently employed licensed nursing staff have current CPR certification. We initiated post training tests to include questioning regarding the determination of competencies of the training on [DATE]. These post training tests are being administered to individual employees by administrator and or DON to test competencies regarding the identification of code status, the process to follow for Full Code verses DNR, measure their level of comfort with the initiation and/or assisting with CPR, and to give them scenarios to ensure competencies have been successfully trained. Both C.N.A staff and licensed LVN/RN staff have been administered the post training. AED competencies were completed by the DON on [DATE] to all nursing staff. The nursing staff that is on leave during this time will be in serviced by either the Administrator or DON on abuse/neglect, use of AED, and advanced directives: the ability to determine full code versus do not resuscitate. The training and post test will be administered individually by either the DON or administrator prior to their next scheduled shift until all nursing employees have completed all competencies satisfactorily. If competencies are not satisfactorily completed, the employees will be monitored 1:1 with staff that has successfully demonstrated competencies until which time the employee can demonstrate competencies regarding the process and use of CPR for the residents in our care. An audit of all resident charts was performed on [DATE] by ADM, DON, and social worker to ensure correct code statuses were accurate and complete. Two lists are maintained on the crash cart. One list indicated all residents that are Full Code and the other all residents that are DNR. That list was audited for accuracy by the DON and ADON, and no discrepancies were found. New nursing employee orientation and training will be done with all new nursing employees to include the system of identification of code status and the process to follow once a situation arises. New nursing employee orientation and annual CPR training will be done with all nursing staff. In addition to our current system of orientation, we will add the post training survey to ensure competence in the areas of Advance directive acknowledgment and process to follow if the different scenarios are presented. Effective immediately, new employee licensed nursing staff will be required to present current CPR certification before being assigned to charge nurse duties. CPR certification will be required to be maintained by all licensed nursing staff during the duration of employment with the facility. DON will maintain CPR certifications with nurse license and will ensure that all licensed staff are current by looking 90 days ahead and requiring the nursing staff to maintain certification and licensure. Effective immediately, when creating a schedule for the following month, the DON and/or designee will ensure that all staff on the upcoming schedule are current with CPR certifications and licensures. On [DATE] at 5:15 p.m. this surveyor confirmed the Plan of Removal had been implemented sufficiently to remove the Immediate Jeopardy by: Interviews on [DATE] and [DATE] with 1 RN, 3 LVNs and 3 CNAs regarding the assessment and inservice they received on identification of code status, the process for Full Code versus DNR, and abuse. Each knew to look at either the resident's

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) chart or the crash cart to identify code status. Staff were able to accurately explain the steps to take in the event they find a resident unresponsive - determine unresponsiveness, ask someone to call 911/DON/Physician, open the airway, check for breathing-perform rescue breathing, check for pulse-start chest compressions. Staff understood that CPR is to be continued until paramedics arrive. Staff interviewed stated they had previous experience running a full code and felt comfortable doing it. Review of 15 resident records indicated correct code status. Review of the undated Go list on the crash cart indicated it was updated to include all residents that are full code. Review of 24 personnel files indicated current CPR training. On [DATE] at 5:15 pm the Administrator was informed the IJ was removed. However the facility remained out of compliance at a level of actual harm with a scope identified as isolated due to the facility requiring additional time to train all staff and monitor their plan of removal. The Administrator indicated on [DATE] there were 26 residents with full code status.