

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2024
NAME OF PROVIDER OR SUPPLIER  Port Lavaca Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 524 Village Rd Port Lavaca, TX 77979	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42402</p> <p>Based on observation, interview, and record review the facility failed to immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there a significant change in the resident's physical, mental, or psychosocial status for 2 of 4 residents (Residents #1 and #2) reviewed for notification of change of condition, in that:</p> <p>The facility failed to ensure the MD was notified of a missed dialysis appointment when Resident #1 and Resident #2 missed scheduled dialysis appointments on 3/30/24 due to transportation being late.</p> <p>This failure could place residents at risk for not having their change of condition addressed appropriately by their attending physician which could cause serious harm.</p> <p>Findings include:</p> <p>1. Record review of Resident #1's electronic medical record, dated 4/2/2024, reflected a [AGE] year old male with an original admitted [DATE] with readmission on 11/1/2023 with diagnoses including: end stage renal disease(kidney failure)with dependence of renal dialysis, difficulty in walking, hypertensive heart, and Diabetes Mellitus type 2.</p> <p>Record review of Resident #1's MDS Assessment, dated 2/2/2024, reflected he had rejected dialysis care at times within the assessment period and received had dialysis treatments while a resident. Further review revealed the resident's cognitive status was documented in section C for BIMS score of 13 indicating cognitive stability.</p> <p>Record review of Resident #1's Care Plan reflected initiated date of 5/3/2022 and revision on 2/26/24 with focus of renal failure r/t end stage disease, resident is dependent on hemo-dialysis. Interventions included: encourage resident to go to dialysis if he refuses.</p> <p>Record review of Resident #1's order Summary dated 3/6/2024 reflected the following entry: Dialysis days are Tuesday, Thursday, and Saturdays at 5:00 am.</p> <p>Record review of Resident #1's Progress notes from 3/29/2024 to 4/2/2024 at 11:49 am revealed no entries to reflect MD notification of Resident #1 not going to dialysis on scheduled day. no documentation reflecting Resident #1 missed dialysis appointment due to transportation being late.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility's 24-hour nursing report revealed no documentation of Resident #1 missing dialysis on 3/30/2024.</p> <p>Record review of Resident #1's Dialysis Binder revealed Dialysis Communication Form for 3/30/2024 was blank.</p> <p>During an observation and interview on 4/2/2024 at 12:45 p.m. at Resident #1 was observed to be in his room lying in bed. He was easily aroused and alert. He stated he received dialysis on Tuesday, Thursday and Saturdays. He stated on Saturday March the 30th he did not go to dialysis due to the transport van driver oversleeping. He further stated he and another resident meet at the front of the building for the driver to pick them up for dialysis at 4:30 am. He said the driver had not shown up by 6:00 am so he told the facility he wasn't going to dialysis. He said the facility nurse was trying to get another driver but he refused to go, because it was to late. He further revealed he received dialysis on 4/2/2024 and did not have any ill effects from not getting dialysis on Saturday March the 30th.</p> <p>2. Record review of Resident #2's electronic medical record, dated 4/2/2024, reflected a [AGE] year old male with an original admitted [DATE] with diagnoses including: end stage renal disease(kidney failure),Diabetes Mellitus Type 1, and hypertensive heart disease. Dependence on renal dialysis.</p> <p>Record review of Resident #2's MDS assessment dated [DATE] reflected he had not rejected any care within the assessment period and received dialysis treatments while a resident. His cognitive status was documented in section C for BIMS score of 14 indicating cognitively stable.</p> <p>Record review of Resident #2's Care Plan reflected an initiated date of 3/1/2024 Focus: Resident has potential to be verbally aggressive(cusses) and is irritable (short responses, isolates) to staff related to ineffective coping skill when there is a change in his routine. Interventions: the resident triggers for verbal aggression happen when there is a change in routine as evidenced by late bus schedule, dialysis wait time. Attempt to de-escalate by reassuring resident of time of event happening.</p> <p>Record review of Resident #2's order Summary dated 3/8/24 reflected the following entry: Dialysis days are Monday, Wednesday, and Friday at 5:00 a.m Days may vary based on holidays and dialysis center schedule. Changed to Tuesday, Thursday, and Saturday.</p> <p>Record review of Resident #2's Progress notes 3/30/2024 7:53 am revealed a Late entry: due to delay in transportation, resident refused to go to dialysis today. Resident highly encouraged and educated on the importance of going however continues to refuse. No documentation of physician being notified.</p> <p>Record review of facility's 24-hour nursing report revealed no documentation of Resident #2 missing dialysis on 3/30/2024.</p> <p>Record review of Resident #2's Dialysis Binder revealed Dialysis Communication Form blank.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 4/2/2024 12:53 p.m. Resident #2's was observed to be in his room sitting on bed. Alert and oriented. During interview Resident #2 stated he did not go to dialysis on Saturday March the 30th because the van driver had overslept. Resident #2 stated, I got tired of waiting for almost 2 hours to go and told them I wasn't going. He said he did not feel sick from missing the Saturday treatment and he did go today (4/2/2024).</p> <p>During an interview with facility Van Driver on 4/2/2024 at 1:27 p.m. she stated she had overslept on 3/30/2024. She stated she received a text from facility ADON about 5:30 am asking her if she was coming to transport the 2 residents to dialysis. She further revealed she text back but did not speak with ADON that she had overslept. She stated she did not confirm if residents had a ride or if she still need to come in. During interview Van Driver stated she should have called to see if someone was taking the residents to dialysis. She further revealed it was her scheduled day to come in and take residents to dialysis and have them to the dialysis center by 5:00 am.</p> <p>During an interview with facility DON on 4/2/2024 at 1:10 p.m. revealed Resident #1 and Resident #2 should have been transported to dialysis on 3/30/2024 at the scheduled 4:30 am time and when they did not go their physicians should have been notified to determine if a new treatment plan should be done. She stated dialysis is very important for residents' health. She further revealed she was notified by the ADON who manager on call was, that she was coming in to take the residents to dialysis, but the residents had decided they were not going due to the time being late.</p> <p>During an interview with Administrator on 4/2/2024 at 1:20 p.m. he stated he would have come in to take the residents to dialysis if the staff would have let him know in time.</p> <p>During an interview with facility ADON on 4/2/2024 at 1:56 p.m. revealed she was the manager on call on 3/30/2024. She stated she was notified about 5:30 am that 2 residents had not been picked up at 4:30 am for dialysis. She further revealed she called the van driver but there was no answer, and she sent a text. She stated she received a phone text from the van driver about 5:30 am that she had overslept. ADON said she was going to the facility to take the residents and was called by the day shift nurse to not come because both residents said they were not going because it was too late.</p> <p>On 4/2/24 at 5:00 p.m. and 4/3/24 at 8:20 am. telephone interviews were unsuccessful for LVN C.</p> <p>During a telephone interview on 4/3/24 at 8:27 am Physician A for #1 stated he was not notified until a later date of 4/2/2024 that Resident #1 had refused to go to dialysis due to not having the scheduled van driver be on time. He stated residents should have dialysis and if they do not other interventions may have to occur.</p> <p>During a telephone interview on 4/3/2024 at 9:00 am Physician B for Resident #2 stated he was not notified until a later date of 4/2/2024, Resident #2 had refused to go to dialysis due to not having the scheduled van driver be on time.</p> <p>During an interview on 4/3/2024 at 10:00 am the Administrator and DON stated there was no policy related to dialysis services and transportation.</p> <p>(continued on next page)</p>

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F 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Record review of the facility's policy provided by DON, titled Notification of Changes with an implemented date of 10/24/22, reflected in section Compliance Guidelines: Circumstances requiring notification include: 3. Circumstances that require a need to alter treatment. The facility must still contact the resident's physician.		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42402</p> <p>Based on interview and record review, the facility failed to maintain in accordance with accepted professional standards and practices medical records on each resident that were complete and accurately documented for 2 of 4 residents (Residents #1 and #2) reviewed for accuracy of medical records. in that:</p> <p>The facility failed to ensure Electronic Medical Records documented of Residents #1 and #2 not receiving transportation to dialysis treatment on 3/30/2024.</p> <p>This deficient practice could place Residents at risk for errors in care and treatment.</p> <p>The findings were:</p> <p>1. Record review of Resident #1's electronic medical record, dated 4/2/2024, reflected a [AGE] year old male with an original admitted [DATE] with readmission on 11/1/2023 with diagnoses including: end stage renal disease(kidney failure)with dependence of renal dialysis, difficulty in walking, hypertensive heart, and Diabetes Mellitus type 2.</p> <p>Record review of Resident #1's MDS Assessment, dated 2/2/2024, reflected he had rejected dialysis care at times within the assessment period and received had dialysis treatments while a resident. His cognitive status was documented in section C for BIMS score of 13 indicating cognitive stability.</p> <p>Record review of Resident #1's Care Plan reflected an initiated date of 5/3/2022 and revision on 2/26/24 with focus of renal failure r/t end stage disease, resident is dependent on hemo-dialysis. Interventions included: encourage resident to go to dialysis if he refuses.</p> <p>Record review of Resident #1's order Summary dated 3/6/2024 reflected the following entry: Dialysis days are Tuesday, Thursday, and Saturdays at 5:00 am.</p> <p>Record review of Resident #1's Progress notes from 3/29/2024 to 4/2/2024 at 11:49 am reflected no entries to reflect MD notification of Resident #1 not going to dialysis on scheduled day. no documentation reflecting Resident #1 missed dialysis appointment due to transportation being late.</p> <p>Record review of facility's 24-hour nursing report reflected no documentation of Resident #1 missing dialysis on 3/30/2024.</p> <p>Record review of Resident #1's Dialysis Binder reflected Dialysis Communication Form for 3/30/2024 was blank.</p> <p>2. Record review of Resident #2's electronic medical record, dated 4/2/2024, reflected a [AGE] year old male with an original admitted [DATE] with diagnoses including: end stage renal disease(kidney failure),Diabetes Mellitus Type 1, and hypertensive heart disease. Dependence on renal dialysis.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's MDS Assessment, dated 1/22/24, reflected the resident had not rejected any care within the assessment period and received dialysis treatments while a resident. His cognitive status was documented in section C for BIMS score of 14 indicating cognitively stable.</p> <p>Record review of Resident #2's Care Plan reflected an initiated date of 3/1/2024 Focus: Resident has potential to be verbally aggressive(cusses) and is irritable (short responses, isolates) to staff related to ineffective coping skill when there is a change in his routine. Interventions: the resident triggers for verbal aggression happen when there is a change in routine as evidenced by late bus schedule, dialysis wait time. Attempt to de-escalate by reassuring resident of time of event happening.</p> <p>Record review of Resident #2's Order Summary, dated 3/8/24, reflected the following entry: Dialysis days are Monday, Wednesday, and Friday at 5:00 a.m Days may vary based on holidays and dialysis center schedule. Changed to Tuesday, Thursday, and Saturday.</p> <p>Record review of Resident #2's Progress notes 3/30/2024 7:53 a.m. reflected a Late entry: due to delay in transportation, resident refused to go to dialysis today. Resident highly encouraged and educated on the importance of going however continues to refuse. No documentation of physician being notified.</p> <p>Record review of facility's 24-hour nursing report reflected no documentation of Resident #2 missing dialysis on 3/30/2024.</p> <p>Record review of Resident #2's Dialysis Binder revealed Dialysis Communication Form blank.</p> <p>During an interview with facility DON on 4/2/2024 at 1:10 p.m. revealed nursing staff should document in the resident's electronic medical record when a resident did not attend dialysis and notification of physician. This is to ensure communication between medical professionals.</p> <p>During an interview with facility ADON on 4/2/2024 at 1:56 p.m. revealed she was the manager on call on 3/30/2024. She further revealed nursing staff should document in the resident's electronic medical record when a resident does not attend dialysis and also notification of physician.</p>		