STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675222	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seabreeze Nursing and Rehabilitation	6602 Memorial Dr Texas City, TX 77590

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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on observations, interviews, and record review, the facility failed to obtain laboratory services when ordered by a physician in accordance with the State law, including scope of practice laws for 1 of 12 residents (CR #1) reviewed for laboratory services. 1. LVN A failed to document physician's orders and obtain weekly laboratory services (CMP, CBC, and CPK) as ordered by CR #1's infectious disease physician when she was discharged from an acute care hospital on 03/29/2024 and resulted in re-hospitalization on [DATE] with elevated WBC values, which indicated infection. 2. LVN A failed to document physician's orders and obtain weekly laboratory services (BMP and CBC) as ordered by CR #1's NP when she reconciled (the process of comparing a patient's medication orders) medication orders on 03/29/2024 and resulted in re-hospitalization on [DATE]. She was diagnosed with polymicrobial (multiple bacteria) skin and soft tissue infections and multifocal (having more than one location) osteomyelitis of the pelvis. On 04/25/2024 at 3:20 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 04/27/2024, the facility remained out of compliance at a scope of pattern with the severity level at a potential for more than minimal harm that is not immediate jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan or Removal. These findings placed residents at risk of experiencing pain, worsening of symptoms/condition, and possible death from not having vital laboratory tests completed to monitor/diagnose infection, disease, and other health conditions. Findings included: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's face sheet dated 04/24/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with metabolic encephalopathy (a series of neurological disorders caused by systemic illness), quadriplegia (paralysis that affects all of a person's limbs and body from the neck down), local infection of the skin and subcutaneous (under the skin) tissue, acute kidney failure (when the kidneys suddenly cannot filter waste from the blood), acute respiratory failure (sudden inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient), sepsis (life-threatening complication of an infection; when chemicals released in the bloodstream to fight an infection trigger inflammation throughout the body) due to staphylococcus, osteomyelitis (inflammation of bone or bone marrow, usually due to infection) - multiple sites, chronic pain (persistent pain that lasts weeks to years), hypotension (low blood pressure), anemia (a condition in which the blood does not have enough healthy red blood cells and hemoglobin), bipolar disorder (a disorder associated with episodes of mood swings ranging from depression lows to manic highs), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), stage 4 pressure ulcer (full thickness skin loss extends through the fascia with considerable tissue loss), and muscle wasting and atrophy (a decrease in size of muscle tissue). She was discharged from the facility to an acute care hospital on 04/17/2024 at 3:12 a.m. Record review of CR #1's quarterly MDS, dated [DATE] revealed she had a BIMS score of 15 (cognitively intact). CR #1 did not experience hallucinations or delusions. CR #1 did not exhibit behaviors which indicated rejection of care (bloodwork, taking medications, or ADL assistance). CR #1 had functional limitations in range of motion in both upper extremities and both lower extremities. CR #1 used a motorized wheelchair for ambulation. CR #1 required substantial/maximal assistance from staff for oral hygiene, toileting, showers, upper body dressing, personal hygiene, sitting, transfers, and rolling left and right. CR #1 received pain medications. CR #1 had six unhealed stage 4 pressure ulcers upon admission and was prescribed antibiotic medications. Record review of CR #1's care plan, revised on 04/22/2024 revealed the following care areas: * CR #1 refused wound treatments and labs at times. Goals included: Resident will allow wound treatments and labs to be complete as scheduled. Approach included: Staff will encourage wound treatments and labs as scheduled. * CR #1 was at risk for pressure sore infections. CR #1 was admitted with infected pressure injuries. CR #1 had osteomyelitis with recurring infections. Goals included: CR #1's pressure ulcer will not exhibit purulent discharge, foul odor, or peri ulcer inflammation (inflammation around the ulcer). Approach included: Enhanced barrier precautions, central line care per facility policy and MD orders, and administer antibiotics as ordered. Evaluate/record/report effectiveness/adverse side effects, observe and report signs of purulent discharge, foul odor, or peri ulcer inflammation. Report signs of cellulitis (bacterial skin infection), sepsis, tachycardia (increased heart rate), and osteomyelitis. On low air-loss alternating mattress for the treatment of pressure injuries. Record review of CR #1's progress notes for March 2024 and April 2024 revealed the following: On 03/22/2024 at 6:53 p.m., LVN D wrote, Resident stated she wants to go to the hospital because she feels her wounds are infected. Writer noted yellow discharge to wound during wound care. Resident refused protein supplement because she said it is nasty. New order per NP to send resident to ED for evaluation . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Seabreeze Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6602 Memorial Dr Texas City, TX 77590	

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 03/23/2024 at 7:41 a.m. (recorded as late entry from 03/22/2024), LVN C wrote, Received order from medical provider to transfer resident to hospital ER. Transfer order obtained from physician . Primary reason for transfer: Foul odor from wounds . Resident left the facility at 8:45 p.m. On 03/30/2024 at 1:59 p.m. (recorded as late entry from 03/29/2024), Treatment LVN B wrote, Resident arrived at facility on 03/29/2024 at 5:00 p.m. Primary admitting diagnosis: Osteomyelitis . Admission orders entered into system and medication orders sent to pharmacy: 5:20 p.m. Referrals made for the following: No referrals at time of admission . Additional Notes: Resident returned to facility with new orders for IV ABT's and with IJ tunnel catheter with CVC double lumen to right chest, dressing is clean, dry, and intact, with no signs and symptoms of infection observed at this time . On 04/04/2024 at 5:15 p.m., Treatment LVN B wrote, . Transmission based precautions in place: Type: Skin/Soft Tissue Infection: osteomyelitis/wound. Resident is receiving antibiotic: Daptomycin reconstituted (recomposed) solution (500 mg) and Ceftriaxone, IV administration. Resident has received treatment for 4 days . Resident has experienced the following signs/symptoms of infection during this shift: purulent discharge or drainage from wound . On 04/05/2024 at 2:26 p.m., Agency LVN E wrote, IV ABT therapy in progress due to osteomyelitis. Resident afebrile (no fever) with no adverse reactions noted . Resident has received treatment for 5 days . Resident has experienced the following signs/symptoms of infection during this shift: purulent discharge or drainage from wound . On 04/09/2024 at 12:57 a.m., LVN F wrote, Resident is being monitored for an active infection . Resident has received treatment for 8 days . The resident has experienced the following signs/symptoms of infection during this shift: purulent discharge or drainage from wound . On 04/09/2024 at 9:48 p.m., LVN F wrote, Resident is being monitored for an active infection . Resident has received treatment for 9 days . The resident has experienced the following signs/symptoms of infection during this shift: purulent discharge or drainage from wound . On 04/11/2024 at 4:32 p.m., LVN G wrote, Resident is being monitored for an active infection . Resident has received treatment for 10 days . The resident has experienced the following signs/symptoms of infection during this shift: purulent discharge or drainage from wound . On 04/13/2024 at 5:16 p.m., Treatment LVN B wrote, Resident is being monitored for an active infection . Resident has received treatment for 14 days . The resident has experienced the following signs/symptoms of infection during this shift: purulent discharge or drainage from wound . On 04/15/2024 at 1:12 a.m., LVN F wrote, Resident is being monitored for an active infection . The resident has experienced the following signs/symptoms of infection during this shift: purulent discharge or drainage from wound . On 04/15/2024 at 5:13 p.m., LVN G wrote, Resident noted sweating and complained of not feeling well. Resident's vitals are 100.4 temperature, pulse 84, blood pressure 145/86, O2 saturation 98% on room air, respirations 18. Placed call to NP. She instructed this writer to give 500 ml of normal saline per IV. Fluids were given as ordered. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 04/16/2024 at 3:37 p.m., Treatment LVN B wrote, Weekly Skin Assessment: 04/16/2024 at 12:30 p.m. Transmission Based Precautions in place: osteomyelitis/wounds . Resident has received treatment for more than 14 days . The resident has experienced the following signs/symptoms of infection during this shift: Fever . 500 ml of normal saline per IV. Laboratory/Diagnostic: wound culture was done. Spoke to medical provider at: 04/15/2024 at 1:30 p.m. Record review of CR #1's laboratory orders, dated 04/16/2024 revealed, CR #1; Start Date: 04/16/2024; Order Choices: CBC with Auto Differential, Basic Metabolic Panel; Recurrence Schedule: Starting on Tuesday, 04/16/2024, repeat every 1 week, on Tuesday, until 05/21/2024 . Record review of CR #1's wound culture laboratory results dated [DATE] revealed, Collected: 04/15/2024 at 10:35 a.m. Received: 04/16/2024 at 3:44 p.m. Reported: 04/19/2024 at 11:55 a.m. Pathogens Detected: Acinetobacter Baumannii complex (Heavy Growth); Escherichia coli (Heavy Growth) . Record review of CR #1's laboratory results (collected at the facility) dated 04/16/2024 revealed, Collection date/Time: 04/16/2024 at 10:55 a.m. Received Date/Time: 04/16/2024 at 2:44 p.m. Reported Date/Time: 04/16/2024 at 3:57 p.m. CBC with differential - WBC: 10.6 (high; range: 4.0 - 10.0) . Record review of CR #1's Observation Details, created by LVN C, dated 04/17/2024 revealed CR #1 was transferred to an acute care hospital on 04/16/2024 at 7:44 p.m. The document read in part, This resident was transferred to an acute care hospital. She was having severe pain, low O2 saturation, and severe shivers. She requested to go to the hospital . No vitals have been recorded for this observation . There are no associated progress notes. Record review of CR #1's hospital Nursing Note, dated 03/29/2024 revealed, Date of Service: 03/29/2024 at 4:04 p.m. Gave report to LVN A at the facility about the patient current vitals and discharge information . Record review of CR #1's hospital After Visit Summary dated 03/29/2024 (provided by facility) revealed CR #1 was admitted to the acute care hospital on 03/23/2024 and discharged on [DATE]. The electronic orders listed each medication CR #1 was discharged from the hospital with. Some of the listed medications had hand-written notes beside them, indicating they were new medications from the hospital which CR #1 did not take at the facility before she was discharged to the hospital. The document read in part, Sodium Chloride 100 ml with Daptomycin 500 mg Solution 500 mg . Last dose taken: 03/29/2024 at 2:25 p.m. New. CBC/BMP Once (per) week was hand-written in the box next to the listed medication. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's hospital discharge records sent to the facility from the hospital (provided by facility) dated 03/29/2024 revealed, . [AGE] year-old female with past medical history significant for gunshot wound complicated by quadriplegia complicated by sacral and lateral left buttock decubitus ulcers now complicated by polymicrobial (multiple bacteria) skin and soft tissue infections and multifocal (having more than one location) osteomyelitis of the pelvis . Will treat for 6 weeks with empiric Ceftriaxone and Daptomycin to minimize dosing complications and monitoring. Patient has historic venous access difficulty due to anatomic reasons and requires tunneled CVC catheter for IV antibiotic administration outpatient. She will need a SNF committed to turning her, aggressive wound care, and appropriate administration of IV antibiotics and lab monitoring as ordered . Overall plan will be . 2. 6 weeks IV abx and smoking cessation with monitoring of labs, ESR, CRP . quadriplegia secondary to gunshot wound, complicated by sepsis secondary to acute on chronic, multifocal polymicrobial osteomyelitis of the pelvis . [NAME] Instructions: . Obtain weekly CMP, CBC with differential and Creatine Kinase. Fax lab results to hospital: Attention Infectious Disease Doctor . Recommendations Summary: . When preparing for discharge, [NAME] instructions below: . Obtain weekly CMP, CBC with differential and Creatine Kinase. Fax lab results to hospital: Attention Infectious Disease Doctor . Labs: CBC with differential - Collection time: 03/28/2024 at 6:17 a.m. Result: WBC - 8.90 (normal range) . CBC with differential - Collection time: 03/29/2024 at 5:12 a.m. Result WBC - 7.95 (normal range) . admitted : 03/22/2024. discharge date : 03/29/2024 . Record review of CR #1's hospital records dated 04/24/2024 revealed, Date of Service: 04/16/2024 at 8:34 p. m. Emergency Department Note: . History of Present Illness: Resident is a [AGE] year-old female presents today with a chief complaint of weakness and wound (multiple sacral). Patient endorses that she has a fever taken yesterday temporarily of 100 degrees Fahrenheit. Has had nausea without emesis (vomiting) yesterday as well. Today has been having shaking chills . Physical Exam: Blood Pressure - 137/97 . Temperature - 99 degrees Fahrenheit . Skin: Skin is pale . Lab Results: CBC with differential - Abnormal. WBC - 12.32 (high) . Diagnosis/Impression: Chills, pain associated with wound, sepsis due to unspecified organism . Laboratory Results - . Erythrocyte sedimentation rate (monitored for the detection of inflammation in the body): 03/24/2024 - 127 (elevated); 04/16/2024 - 127 (elevated) . Record review of CR #1's physician's orders for March 2024 and April 2024 revealed the following order: * RN may access Central Line and perform blood draw as needed. Start Date: 03/29/2024. End Date: Open Ended. Further review of CR #1's physician's orders for March 2024 and April 2024 revealed no documentation of any routine laboratory orders. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with Treatment LVN B on 04/24/2024 at 10:45 a.m., she stated CR #1 was not compliant with care and she liked to stay in her wheelchair all the time. She said if she was not able to get to CR #1's wounds right when she wanted them done, CR #1 would tell her to come back, or she said she would get them done on the night shift (the staff worked 12-hour shifts, 7:00 a.m. - 7:00 p.m. and 7:00 p.m. - 7:00 a.m.). She said sometimes, the night shift nurse did not get a chance to do CR #1's wound care because she stayed in her wheelchair until 2:00 a.m. She said CR #1 complained of pain in her joints, so sometimes, she did not want to be turned or bothered. She said she sometimes talked to CR #1 about staying in the same position all the time, but she said her joints felt better in that position. She said on 04/15/2024, CR #1 was in the bed and the wound doctor did a culture on her wounds himself because they were milky and opaque. She said the wound doctor cleaned the wounds out. She said CR #1's wounds did not have an odor, but CR #1 always complained they did have an odor. She said the wounds did not smell foul, but they smelled like it would if a female left a menstrual pad on too long, like old blood, but not an infected smell. She said CR #1 was already on two oral antibiotics at that time and the wound doctor said maybe those were not the right antibiotics for CR #1's wounds. She said CR #1 was on antibiotics for her wounds since she was admitted to the facility in September 2024. She said the wound culture results came back after CR #1 was already gone. She said the only weekly lab orders she knew about were the CBC and CMP the NP ordered for every Tuesday. She said she was the nurse who put the orders into the computer system for the weekly draws on 04/15/2024 (to be drawn on 04/16/2024). Treatment LVN B looked through CR #1's MAR and said she did not see the order for the weekly labs. She said she did not know why it was not there. She said on 04/15/2024, LVN G called CR #1's NP and said she was not feeling well. She said the NP asked LVN G to put in orders for a CBC and BMP. Observation and interview with CR #1 at a local acute care hospital on 04/24/2024 at 3:30 p.m. revealed she was alert and oriented. CR #1 was on contact isolation. CR #1's hands were contracted but she could move her arms enough to operate her cellular phone. She said her wounds had an odor at the facility, but they did not stink at the hospital. She said she knew she was supposed to get weekly labs done after she left the hospital in March (03/29/2024) but she never had any labs drawn until right before she left. In a telephone interview with the hospital's infectious disease doctor on 04/24/2024 at 7:10 p.m., he stated whenever he sent a patient out (discharge from the hospital to a SNF) for IV antibiotic therapy, he always put all the details in the patient's orders. He stated all instructions for CR #1's weekly lab orders were in his notes. He said he went to the hospital's case manager and asked her what they needed to send to the facility to make sure they got the instructions. He said the case manager told him she was sending everything to the facility. He said a hospital nurse always called the facility before discharge, so CR #1's orders should have been communicated very well. He said the type of antibiotics he prescribed for CR #1 could have caused Rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), so CR #1's Creatine Kinase levels needed to be monitored for this. He said failure to monitor CR #1's blood chemistry could have resulted in renal failure, Rhabdomyolysis, sludge in the gallbladder, and increased liver enzymes, which were adverse effects of the antibiotics. He said CR #1 was oriented and she told him the facility did not check any of her labs. He said CR #1's pressure ulcers developed infections that went into her bone. He said he was surprised to see her back at the hospital on 04/16/2024 and her wounds were smelly with pus. He said CR #1's inflammatory markers (erythrocyte sedimentation rate), which tracked the bone infection were exactly the same when she returned to the hospital on 04/16/20524 as when she discharged on [DATE]. He said he expected at least a small decrease based on the amount of time she was on the antibiotics. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the DON on 04/25/2024 at 9:00 a.m., she said the facility did not usually get a resident's discharge summary from the hospital which documented everything that happened in the hospital. She said the hospital usually sent clinical updates and progress notes, which were very seldom completed by the actual doctor. She said she did not see any orders for labs on CR #1's discharge paperwork. She said the lab orders were not listed on the signed electronic orders. She said normally, the hospital called in report before the resident was discharged from the hospital. After review of the handwritten notes on the electronic hospital orders the facility received from the hospital, which read, New. CBC/BMP once (per) week, the DON said she assumed the handwritten notes were written by one of their (facility) nurses. She said she could not say the facility nurse who wrote the notes on the electronic orders was aware CR #1 was supposed to have weekly labs. She said she could not speak on what the nurse's handwriting meant or what she knew, but she would find out which nurse completed CR #1's admission on 03/29/2024. In a telephone interview with CR #1's physician (who was also the facility's medical director) on 04/25/2024 at 10:49 a.m., he stated he was familiar with CR #1 because she had very bad wounds and to his understanding, she was non-compliant with treatments. He said facility staff usually reconciled medications for residents who discharged from the hospital, but he did not reconcile CR #1's medications. He said the NP reconciled CR #1's medications and he was aware of CR #1's order for weekly labs (the labs ordered by the NP), either through conversations with the NP or reading her notes. He said he thought the labs were supposed to be done because he was concerned about the infection getting worse. He said part of it was to see if the infection got better or if it was the same or worse. He said it was usual protocol for them (him or his NP's) to request weekly labs on all residents on IV antibiotics. He said he was not aware the weekly labs were not being done. He said he assumed the labs were being done but never saw any results. He said some infectious disease doctors do not care to see the lab results, but they request the labs. In a telephone interview with the NP on 04/25/2024 at 11:00 a.m., she stated a facility nurse (she could not recall which nurse) reconciled CR #1's medications with her on 03/29/2024. The NP said she ordered weekly labs (CBC and BMP) for CR #1 on 03/29/2024 based on the antibiotics she was prescribed at the hospital. She said the weekly labs she ordered would have showed her if CR #1's infection was getting better and her kidney function. The NP said she asked for CR #1's lab results each time she visited the facility (she visited weekly), but she thought the facility nurses said CR #1 refused the labs. The NP said she did not think it was unusual because refusals were not uncommon for CR #1. She said she did not recall the nurse telling her that the hospital doctor requested weekly labs. She said it was normal to order weekly labs for residents on IV antibiotics like the ones CR #1 was prescribed, to make sure the kidneys functioned properly and to track the infection. She said she requested weekly labs on 03/29/2024 and on 04/15/2024 or 04/16/2024. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with LVN A on 04/27/2024 at 11:45 a.m., she stated she normally worked the 7:00 a.m. - 7:00 p.m. shift. She said CR #1 was admitted to the hospital on 03/22/2024 for infection symptoms. She said she was on shift when CR #1 returned to the facility on [DATE]. LVN A said she did not receive report from the hospital on 03/29/2024. She said CR #1 returned to the facility an hour before her shift ended. She said nobody from the hospital called her ahead of CR #1's return. She said CR #1 just showed up at the facility and she (LVN A) did not talk to anybody from the hospital at all that day. She said if the hospital had her name listed as the person, they gave report to, then it had been a while since that day, and she could not recall if she got report or not. She stated report sheets were handwritten and if she did not have a form, she wrote on a blank sheet of paper. She said the report sheet should go into the resident's admission packet and sent to medical records. She said eventually the report sheet would be scanned and put in the computer system for that resident. She said she did not recall if she did or did not do a report sheet for CR #1. She said she could have done a sheet for CR #1, but she did not recall. She said she recalled calling the NP to reconcile CR #1's medication. She said she got CR #1's discharge medications (from the hospital) from the packet the resident brought with her from the hospital. She said when she reconciled medications for readmitting residents from the hospital, she let the doctors know if anything was new, and they either approve the new medication or discontinue it. She said she also asked the doctors if they wanted to continue the medications the resident was on before they left the facility. She said she usually tried to read every page of the discharge packet sent from the hospital. She said she usually looked for the diagnosis to determine why the resident went to the hospital and if they started anything new at the hospital. She said usually, recurrent orders for labs were not on the electronic orders from the hospital. She said when she called the doctor to reconcile medications, they would usually add recurrent orders then. She said it was unusual for the hospital doctors to order recurring labs. She said she called the NP to reconcile CR #1's medication when she returned from the hospital on 03/29/2024. She said she informed the NP that CR #1 had two new IV antibiotics and the NP ordered a weekly CBC and BMP. She said she thought she wrote the requested labs on a piece of paper. She said after she got off the phone with the NP, she started reconciling the medications and entered the new medication orders into the computer system. She said she wrote the requested labs on the hospital discharge paperwork and on a little piece of paper. She said the little piece of paper probably got lost in the shuffle (possibly lost in a stack of paperwork). She said she forgot to enter the NP's requested orders for weekly labs. She said she was the admitting nurse, and it was her responsibility to enter the orders into the computer system. She said she guessed the requested labs were to determine if CR #1 still had infection, or something like that because the NP really did not say why she wanted the orders. She said it was important to get the labs done because the labs told you everything going on in the body and if something was off, it would tell you. She said it was easy to get distracted while admitting residents because she still had residents asking for PRN medications and other things. In an interview with an RN at a local acute care hospital on 04/29/2024 at 10:30 a.m., she stated she was the hospital nurse who called to give report to the facility when CR #1 was discharged on [DATE]. She said she wrote the nurse's name on the discharge paperwork (LVN A), and she specifically gave thorough instructions regarding CR #1's wounds. She said she could not recall if they talked about the labs the infectious disease doctor requested, but she knew about the labs because the infectious disease doctor always requested labs in CR #1's circumstances. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER: Seabreeze Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 6602 Memorial Dr, Texas City, TX 77590	

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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the DON on 04/30/2024 at 11:45 a.m., she stated she was the facility's interim DON and had only been working at the facility for a few days. She said she did not know if the facility's previous DON or the ADON (the facility recently hired a new ADON who had not started working at the facility yet) completed quarterly audits of physician's orders as referenced in the facility's Laboratory Tracking System policy (see below). She stated she did not find any documentation, as of 04/30/2024 to verify the audits were being done. She said it was important to carry out all physician's orders for the safety and well being of the residents. She said the nurses were supposed to read each page of the hospital discharge record if it was available. In an interview with the Administrator on 04/30/2024 at 1:19 p.m., he stated it was important to make sure physician's orders were carried out because following orders was how they cared for their residents. Record review of the facility's undated policy titled, Laboratory, Radiology, and Diagnostic Testing Services revealed, Policy Statement: This facility will provide the appropriate diagnostic services (laboratory and radiology) required to maintain the overall health of its residents and in accordance with State and Federal guidelines. Policy Interpretation and Implementation: 1. The facility must provide or obtain laboratory, radiology, and other diagnostic services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services. 3. The facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders. No diagnostic tests will be performed without specific physician, physician assistant, nurse practitioner or clinical nurse specialist orders in accordance with State law to include scope of practice laws . Record review of the facility's policy titled, Medication Orders revised November 2014 revealed, Purpose: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication order. Supervision by a Physician: . 2. A current list of orders must be maintained in the clinical record of each resident. 3. Orders must be written and maintained in chronological order . 5. Intravenous Orders - When recording orders for IV solutions, specify the type of solution, rate of flow and volume to be infused. 6. Treatment Orders - When recording treatment orders, specify the treatment, frequency, and duration of the treatment . This was determined to be an Immediate Jeopardy (IJ) on 04/25/2024 at 3:20 p.m. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 04/25/2024 at 3:20 p.m. The following Plan of Removal submitted by the facility was accepted on 04/25/2024 at 8:56 p.m.: PLAN OF REMOVAL: Laboratory Services, F-773 Name of Facility Date: 4/25/2024 The facility failed to obtain laboratory services as ordered by a physician in accordance with the State law, including scope of practice laws. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seabreeze Nursing and Rehabilitation	6602 Memorial Dr Texas City, TX 77590

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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failed to obtain weekly laboratory services (CMP, CBC, and CPK) as ordered by a hospital infectious disease doctor for CR #1, who was diagnosed with sepsis secondary to acute on chronic multifocal polymicrobial osteomyelitis of the pelvis, when she was discharged from an acute care hospital on 03/29/2024. The facility failed to obtain weekly laboratory services (CMP and CBA) as ordered by CR #1's NP when LVN A reconciled medication orders on 03/29/2024. Immediate Action: Action: CR#1 is currently in the hospital and is not returning to the facility Person(s) Responsible: Charge Nurse Date/Time: 4/16/2024 at 7:44 p.m. Facilities Plan to Ensure Compliance Quickly: Action: Lab audit performed facility wide to ensure no other labs were missed. If any other labs are identified the physician will be notified and the facility will follow orders. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date/Time: 4/25/2024 by 10:00 p.m. Action: Residents who have been admitted /readmitted in the past 30 days will have their admission/readmission orders reviewed to ensure lab orders, if present, were transcribed appropriately into the orders, we have the lab results, the MD has been notified, and new orders, if any, have been followed. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date/Time: 4/25/2024 by 10:00 p.m. Action: Laboratory, Radiology, and Diagnostic Testing Service Policy reviewed by Director of Clinical Operations and no changes are identified as needed at this time. Person(s) Responsible: Director of Clinical Operations Date/Time: 4/25/2024 by 10:00 p.m. Action: Director of Nursing and Assistant Director of Nursing have been educated regarding reviewing admission/readmission paperwork, transcribing orders (such as labs), lab communication to the MD and/or their extender and following physician orders by the Director of Clinical Operations. Charge Nurses will be educated over reviewing admission/readmission paperwork, transcribing orders (such as labs), lab communication to the MD and/or their extender and following physici [TRUNCATED]