

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/01/2024
NAME OF PROVIDER OR SUPPLIER  Advanced Rehabilitation & Healthcare of Live Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 8221 Palisades Drive Live Oak, TX 78233	
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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26869</p> <p>Based on interview and record review the facility failed to ensure the Facility requirements, The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless When the facility transfers or discharges a resident under any of the circumstance, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. All other necessary information, and including a copy of the resident's discharge summary, for 1 of 2 (#1) resident that was discharged in that:</p> <p>Resident #1 was discharged from the facility, after not coming back from leave within 72 hours. Resident #1 notified the facility that she would be late due to having car issues, Resident was back in the facility the morning after. Resident #1 was told by ADM she was discharged and had her belongings packed and out of her room. Resident #1 was not allowed to re-enter the facility or given the right to pay privately. Resident #1 was not given a documented discharge and the right to appeal the discharge.</p> <p>This could affect all residents and could result in residents not having the opportunity to appeal the discharge from the facility.</p> <p>The findings were:</p> <p>Record review of Resident #1's Admission Record dated 5/31/2024 revealed she was admitted on [DATE], readmitted on [DATE] she was [AGE] years old. Record review of Resident #1's Admission Record included diagnosis of history of falling, chronic pain, lack of coordination, muscle weakness, osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), artificial knee joint, anemia, dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), cognitive communication deficit, major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), and psychosis (when people lose some contact with reality). The Admission Record for Resident #1 revealed she was dually certified for Medicare and Medicaid services.</p> <p>Record review of Resident #1's discharge MDS was dated 5/24/2024 and was signed by MDS on 5/28/2024. The discharge MDS revealed Resident #1 was discharged on [DATE], no BIMS score and was modified independence with cognition, she required assistance with walking (supervision or touching),</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675437
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan dated revision/canceled date was 5/28/2024 revealed she had impaired poor safety awareness, behavior to include noted to talk other resident times and refusal to make appointments for her, trying to tell resident where to sit in dining room, complaints that she was not able to receive her trust fund money, and states he was in so much pain that no one can touch her then had to stay in wheelchair, then can be seeing walking fast. The care plan revealed she was at risk for cognitive decline and functional abilities related to chronic pain, mild neurocognitive disorder(mild neurocognitive disorder due to known physiological condition with behavioral disturbance). Care plan stated Resident #1 had impaired communication related to cognitive impairment secondary to dementia as evidenced by sometimes not being understood by staff and sometimes not understanding staff which places her at risk for not having her needs met in a timely manner. Dx of Cognitive communicative deficit. Care plan stated Resident #1 has ADL Self Care Performance Deficits and is at risk for not having her needs met in a timely manner and Performance deficit is related to: Cognitive impairment, Functional limitations in range of motion and decreased mobility, Activity intolerance, Impaired balance/impaired coordination, Chronic Pain, and poor safety awareness. Care plan for Resident #1 stated has a psychosocial well-being problem (actual or potential) r/t general anxiety, unspecified behavioral syndromes associated with physiological disturbances and physical factors, insomnia, major depressive disorder, unspecified psychosis. Care Plan for Resident #1 stated she had behaviors to include verbal behavior towards the staff and resist care at times. Care plan for Resident #1 stated she had a potential for falls due to poor posture, lack of coordination, convulsions, pain, and osteoarthritis. Care Plan for Resident #1 Discharge Plans is in the facility for long-term care placement as a result of a continued need for the services of skilled nursing staff as evidenced by an inability to provide selfcare and discharge planning is not needed.</p> <p>Record review of Resident #1's out on pass record for 5/24/2024 revealed she signed herself out on 5/24/2024 at 3:30 PM. (Resident #1 was supposed to return to facility on 5/27/2024 by 3:30 PM.)</p> <p>Record review of the resident list by rooms dated 5/28/2024 revealed on the long-term side Resident #1's room was given to a existing female resident that was on the skilled side of the facility. Record of resident list revealed there was 1 female room, and 1 male room available. Record review of the skilled beds available were 11 beds.</p> <p>Record review of the resident list by rooms dated 5/30/2024 revealed on the long-term side Resident #1's room was given to a existing female resident that was on the skilled side of the facility. Record of resident list revealed there was 1 female room, and 2 male rooms available. Record review of the skilled beds available were 14 beds.</p> <p>Record review of Trial balance dated 5/31/2024 revealed Resident #1's trust fund was closed on 5/29/2024.</p> <p>Record review of Resident #1's complaint Concerns with discharge from facility. On 05/24/2024 at 3:30PM signed herself out for Memorial Day Weekend to stay with a friend. At 6:30 pm picked up by friend &amp; on 5/26/2024 on the way back to the facility, vehicle broke down and spoke to RN A about delayed return. On 5/27/2024, resident returned &amp; was informed she was gone more than 72 hrs &amp; Medicaid was lost. Facility had packed up her room &amp; informed her that she was not longer a resident. Told she could sit in the lobby until someone picked her up. *Desired outcome is for facility to be investigated for unsafe (discharge) and failure to provide 30-day notice.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 5/24/2024 at 3:30PM with Resident #1 stated she went out on a 3-day pass. I didn't leave until 6:30pm but the front desk receptionist said to sign out at 3:30p.m. since they were leaving. Resident #1 went out to the front and sat outside until she was picked up. Resident #1 stated she went to the coast and when heading back on Memorial Day, we broke down on the highway. We had a flat tire on one vehicle and a broken axle on the other. I called the nursing home 3 times to let them know where I was and two times they didn't answer. I called the night nurse, my personal night nurse, and told her what happened and I would not make it back until my curfew, 3-day pass. She didn't imply that my being late would be a problem. When I got back, they told me that I no longer lived there. They had already put a new individual in my room, 408. I asked what I should do because I didn't have any place to go. I don't have family. She told me that you can sit on the couch for a few minutes but then you can go home with your friend. Resident #1 explained that we had an accident, but staff said they didn't care we had an accident and it does not matter. They never gave me documentation of Medicare being discontinued or discussed appeal process. Resident #1 stated, no, I did not appeal the discharge yet because I don't have any paperwork to show that I had been discharged, but we did call the Ombudsman and told her what happened. The Ombudsman said she called and got a case number. There was no 30-day notice or NOMNC</p> <p>Interview on 5/31/2024 at 3:44 PM with ADM regarding Resident #1, she went out on pass, she offered bed hold, she said she would be back on time, she had a bed hold policy in the past. ADM stated she called Resident #1, she called 3 times on Monday, at 5pm -she does have personal phone, text her with no response, ADM stated she was notified by RN A Resident #1 would be back the next day had had car trouble. The ADM stated Resident #1 did not come back within 72 hours and she filled her Medicaid bed. The ADM stated she did not issue Resident #1 a 30-day notice. ADM stated she did not have a Medicaid bed available for a female resident, the 1 room that was available had a air conditioner (A/C) that was not working, and had stated she had ordered a new ac unit the day she was notified.</p> <p>Interview on 5/31/2024 at 4:10 PM with the Business Office Manager (BOM) stated she over head from her office in front of facility, Resident #1 came back to facility on Tuesday (5/28/2024) before lunch she could hear her in lobby. BOM heard ADM and DON was talking with Resident #1. BOM stated Resident #1 came to pick up her trust fund check and had zero balance.</p> <p>Interview on 5/31/2024 at 5:21 PM with DON regarding Resident #1 stated she did not see her leave the facility, but on the out on pass record was documented she left on Friday (5/24/2024) at 3:30 PM. DON stated Resident #1 came back on Tuesday (5/28/2024) after 11 AM approximately.</p> <p>Interview on 6/1/2024 at 11:11 AM with RN A stated she worked the nights, regarding Resident #1 she was not there to go out on pass, Resident #1 said she went out on pass on Friday. RN A stated Resident #1 called her on Monday at 6:45-7:00 PM, because had issues with car, asked her what time she left, she stated she left Friday evening. RN A stated she was not supposed to stay out for more than 72 hours. RN A stated Resident #1 stated she knew when was supposed to come in, but had issues with care, she made management aware, notified the ADM. RN A stated to ADM Resident #1 would be here the following morning. ADM stated she would call the resident #1. ADM stated if she was not here by Monday at 11:59 PM, she will be discharged. RN A did let ADM know Resident #1 was having car trouble. The ADM said she would follow up with resident #1. RN A did the discharge progress note that night, when Resident #1 was not here at 11:59pm on Monday (5/27/2024). RN A stated on Tuesday (5/28/2024) at 6pm and had not seen Resident #1 in her room and the room was clean with no personal belongings, no resident was in that room, that Resident #1 lived. RN A stated she did not expect a resident in Resident #1's room that night.</p> <p>(continued on next page)</p>		

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