

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 01/17/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095</p> <p>Based on interviews, observations and record reviews, the facility failed to ensure the residents had the right to be free from physical abuse for 1 of 6 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to ensure CNA B did not hit Resident #1 on her head while trying to get her undressed to take a shower on 11/13/24.</p> <p>The noncompliance was identified as PNC IJ. The noncompliance began on 11/13/2024 and ended on 11/13/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for harm and continued abuse.</p> <p>The findings included:</p> <p>Record review of Resident #1's admission record reflected a [AGE] year-old resident with an admitted [DATE] and diagnoses of cerebral palsy (a group of disorders that affect movement, balance, and posture) and aphasia (a language disorder that affects a person's ability to communicate effectively).</p> <p>Resident #1's Annual MDS with a completion date of 12/23/2024 reflected that she was not understood and was severely impaired cognitively. Resident #1 also require extensive assistance with all Activities of Daily Living.</p> <p>Record review of Resident #1's Care Plan revealed she was PASRR positive and received habilitative PT/OT/ST services due to mild intellectual disability; had a mood problem related to schizophrenia, depression, anxiety; and she is resistant to care and at risk for injury, a decline in functional abilities, and not having her needs met in a timely manner. Interventions included PT/OT/ST 3 times per week; anticipate and meet needs; and monitor/document for physical/nonverbal indications of discomfort or distress, and follow up as needed.</p> <p>Review of Provider Incident Report dated 11/13/24 revealed CNA A and CNA B were preparing Resident #1 for a shower on 11/13/24. While CNA B was getting Resident #1 undressed, resident was hitting out. CNA A stated Resident #1 was hit by CNA B on her hands and feet. Then CNA A stated she witnessed CNA B hit Resident #1 with her fist in the forehead. Resident #1 had a visible knot to the right side of her forehead.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation of Resident #1 on 01/15/25 at 3:18 pm revealed a petite woman in the bed. Upon seeing surveyor, she appeared to get upset, was pointing and babbling and was unable to communicate. Resident #1 then calmed down after surveyor talked softly and calmly to her. Resident #1's bed was pushed against the wall on one side and she had a fall mat on the open side of the bed. There were no obvious signs of bruising or trauma to her head since these areas had healed prior to surveyor's entry.</p> <p>An attempted telephone interview on 01/15/25 at 3:18 pm was made to CNA B but the phone number was no longer in service.</p> <p>Interview with CNA A on 1/15/25 at 4:13 pm revealed while CNA B was getting Resident #1 undressed, she went to get some gloves. Upon her return she heard Resident #1 screaming, which she frequently does when she does not know someone. Resident #1 was also swinging her hands and feet at CNA B at which time CNA B used her fist and hit Resident #1 in the head and left the resident's room. CNA A then said she finished the shower and put Resident #1 in bed. CNA A began brushing Resident #1's hair and noted a knot on her head. CNA A said she reported the incident to Med Aide C who reported the incident to LVN D.</p> <p>Interview with Med Aide C on 01/16/25 at 11:00 am revealed she had been advised by CNA A about the incident. Med Aide C said she told CNA A that she needed to report it but CNA A expressed fear of CNA B. Med Aide C then reported to LVN D who reported it to the DON. Med Aide C stated CNA B seemed a little rough with residents but felt it was because she was a big girl and did not believe she would actually hurt a resident. Med Aide C stated the staff was given an inservice on the abuse policy immediately following the incident and she has also watched an online class on abuse as part of their annual training.</p> <p>Interview with LVN D via telephone on 01/15/25 at 1:59 pm revealed Resident #1 was in bed and had had a fall the week prior to this incident. Resident #1 was noted to have slight injuries to her face from the fall. LVN D stated she had pictures of Resident #1's injuries from that fall and the knot on the head following this incident was not present after her fall. LVN D stated she had worked with CNA B and some residents had complained about her attitude, but she had not been known to be physically aggressive toward residents. LVN D stated she reported the incident to the DON who then reported it to the Administrator.</p> <p>Interview with the DON on 1/15/25 at 1:38 pm revealed CNA B had told her she was just trying to assist CNA A and denied going in the shower. When the DON talked with CNA B, she denied she had hit Resident #1. The DON stated she asked CNA A to demonstrate how hard CNA B hit resident by having her hit a water bottle. The DON stated it was a substantial hit which she demonstrated for the surveyor. A loud pop could be heard as the fist hit the bottle. The DON also stated the Treatment Nurse had assessed the resident and found a 1 inch diameter mark on the resident's right eyebrow.</p> <p>Record review of CNA B's employee file revealed she was a Certified Nurse Aide hired on 07/15/24 and was employable. There were no disciplinary actions in her file prior to this incident.</p> <p>Record review of the facility Policy and Procedures: Abuse, Neglect and Exploitation dated 10/24/22 and Revised 09/06/24 stated:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of property. Components of the facility abuse prohibition plan included:</p> <p>3. Prevention of Abuse, Neglect and Exploitation including establishing a safe environment, Identifying, correcting, and intervening in situations in which abuse is suspected .and providing residents, representatives, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed.</p> <p>4. Identification of Abuse, Neglect and Exploitation including possible indicators of abuse .</p> <p>5. Investigation of Alleged Abuse, Neglect and Exploitation that included An immediate thorough investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.</p> <p>7. Reporting/Response included reporting all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes.</p> <p>The Administrator was notified on 01/17/25 at 1:40 p.m., that a past non-compliance IJ situation had been identified due to the above failures and was presented with a PNC IJ Template.</p> <p>It was determined these failures placed Residents #1 in an IJ situation on 11/13/24.</p> <p>During an interview with the Administrator on 1/16/25 at 2:22 pm, she stated the facility took the following measures after the incident:</p> <ol style="list-style-type: none"> 1) The Administrator began an immediate investigation into the incident. 2) A police report was made and the physician and guardian were notified. 3) Both of the CNAs were suspended pending the outcome of the investigation. 4) CNA B was terminated, and the Administrator stated she tried to report her to the EMR but was told she could not do so. 5) CNA A was suspended for a couple of days due to not reporting the incident immediately and not intervening to prevent the aggression from CNA B. CNA A finished the shower and was brushing Resident #1's hair when she noted the knot on her head before she reported it. CNA A was then brought back to work after a 1:1 counseling about the abuse policy. 6) All facility staff were in-serviced on the Abuse and Neglect policy and the requirement to intervene to prevent injury to the resident. All new hires are also in-serviced as part of the new hire onboarding process. 7) The facility reported the incident to the state. <p>(continued on next page)</p>		

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