

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 04/17/2025
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on record review and interview, the facility failed to ensure all written grievance decisions included the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued and to maintain evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision for 1 of 30 residents (Resident #1) reviewed for grievances in that:</p> <p>Resident #1 verbally complained about his food being discarded, and a grievance form was not filled out on 02/12/2025.</p> <p>This could affect all residents at the facility who could voice grievances by preventing their concerns from being addressed and resolved.</p> <p>The findings were:</p> <p>Record review of Resident #1's facesheet, dated 04/17/25, revealed he was originally admitted to the facility on with diagnoses of Cerebrovascular Disease, Dysphagia Oropharyngeal Phase (difficulty controlling the mouth or throat for swallowing), Aphasia (inability to use spoken language), Depression and Generalized Anxiety Disorder.</p> <p>Record review of Resident #1's most recent MDS assessment, revealed he had a BIMS of 13 (indicating cognition is intact).</p> <p>Record review of Resident #1's care plan, dated 03/27/25, revealed that he chose not to eat what was served in the dining room, ordered in food/went grocery shopping often, had a refrigerator in his room, and used the microwave in the center.</p> <p>During an interview with the SW at 4:35 pm on 4/15/25, she said that Resident #1 didn't eat the food at the facility and did his own grocery shopping when he went on pass. The SW said that Resident #1 had his own refrigerator and had to sign a fridge policy. She said that Resident #1 was sometimes resistant if staff said something had to be thrown out. She said there was an issue with him using the big freezer when he wasn't labeling in the past</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident #1 at 9:00 am on 4/17/25, he said he had put his name and day on food he bought and placed it in the refrigerator near the nurses' station on 2/12/25 and it was discarded. Resident #1 stated, I only eat one meal a day and I half it. After I eat half, I store the remaining in the refrigerator near the nurses' station. Resident #1 said that he learned his food was missing when he asked staff for it.</p> <p>During an interview with LVN A at 9:36 am on 4/17/25, she said that she was Resident #1's charge nurse. LVN A said Resident #1 did not like to eat food from the facility kitchen and preferred to buy his own groceries and snacks. When asked if Resident #1 had ever voiced to her that his food was missing or discarded, she stated He has come to me with food that has been discarded. To my knowledge, there was no way to identify - no name or date/expiration date on the food. All food that is stored in the nurses' station clean utility room refrigerator requires proper labeling. LVN A said that Resident #1 had come to her with this complaint about 2 months ago. She said that he was upset and that she verbally elevated his grievance to her ADON at the time (currently the DON). LVN A said that upper management followed up on it. Staff is responsible for completing a grievance form, once a resident brings a concern to their attention or provide the resident with a copy of a grievance form to complete and submit. Staff then turns the grievance form in to the Administrator (grievance officer).</p> <p>Record review of the grievance log from 01/17/2025 - 04/17/2025 revealed no reports pertaining to Resident #1.</p> <p>During an interview with the DON at 12:35 pm on 4/17/25, when asked if she'd ever received a verbal grievance from a charge nurse regarding Resident #1 being upset that his food was missing, she stated I didn't receive it, but I heard about it. The DON said he had properly labeled food containers with his name and the date. When the surveyor mentioned that, in speaking with the charge nurse, LVN A recalled an instance when Resident #1's food was discarded because there was no identifying information on it and said that she verbally reported it to her for follow-up. The DON stated If a team member reported, it probably went to (the administrator) because he has had an ongoing issue with his food missing from the fridge. The DON confirmed that a grievance form should have been completed for that. She said that staff should not have accepted food items to store that were not labeled and should have taken a marker and wrote the date and time on the food items. The DON said that items were discarded if found in the stored area unlabeled. The DON stated that the process if a resident stored something that came up missing was A grievance is filed and investigated then compensate the resident if needed. The DON said anyone, including staff, could start the grievance form.</p> <p>During an interview with the administrator at 3:00 pm on 4/17/25, she said that Resident #1's food was discarded because there was no identifying information on it. The administrator stated This incident did happen a couple of years ago, every time the state comes in, he states that it happens all the time. We spoke with the resident and the food that was discarded was over the 7 days, per our policy. The administrator said it had been over a year since she heard any complaint pertaining to Resident #1. She said that, if staff had received a complaint from him, they should have brought it to her.</p> <p>Record of the facility's grievance policy, dated 05/1997 with latest revision dated 07/22/23, revealed residents and their families have the right to file a grievance without fear of reprisal. The designated grievance officer is the Administrator. Resident concerns should be taken seriously and that the ability to voice a grievance is an important right and protection for residents.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect and resulted in bodily injury, to other officials (including the State Agency) and the Abuse Coordinator for 1 (Resident #2) of 3 residents reviewed for exploitation.</p> <p>The facility failed to report to the state agency when Resident #2 alleged her ID card, social security card, bank cards were stolen from her wallet. Resident #2 also alleged her monthly social security check was moved to another account with out her knowledge.</p> <p>This failure could place residents at risk of Exploitation/Misappropriation of Property and financial distress.</p> <p>Findings include:</p> <p>Record review of Resident #2's admission record, dated 4/16/25, revealed a [AGE] year-old female resident was admitted on [DATE] with diagnosis that included cerebral atherosclerosis (disease that occurs when the arteries in the brain become hard, thick, and narrow due to the buildup of plaque (fatty deposits) inside the artery walls) and morbid obesity due to excess calories.</p> <p>Record review of Resident #2's quarterly MDS assessment, dated 3/18/25, revealed her cognition was moderately impaired for daily decision making.</p> <p>Record review of a grievance report, dated 1/9/25, revealed the SW completed the form for Resident #2. The grievance was cards missing from wallet after family visited. SS check money was moved to another acct or card w/out resident knowledge. Actions taken APS called and Police called. Resolution was APS report made against family that have taken her cards and cont to debit money out of her acct. The document was signed by the administrator on 1/10/25.</p> <p>Record review of Resident #2's nursing progress notes, dated 4/16/25, revealed a note written on 1/9/25 by the SW that stated SW was notified by residents [family] that residents ID, social security card and bank card were taken from her wallet. [family] stated that the residents [family] has the items. SW also discovered residents bank account is now overdrawn \$195. SW contacted [Police Department] PD to fill police report and will make APS report as well. Another note on 1/10/25 written by the SW stated Resident was interviewed today by law enforcement and APS re: misappropriation of funds. Resident stated she does want to pursue criminal charges.</p> <p>During an interview on 4/15/25 at 2:49 p.m. Resident #2 stated two family members came to visit her and after that her bank card, ID card, and social security card were missing. The Resident stated she had let the issue go and did not want to pursue criminal charges or discuss the details any further. The Resident stated those family members no longer visited her.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/15/25 at 4:23 p.m. the SW stated she was made aware by a family member of Resident #2 that another family member had Resident #1's driver's license. The SW stated the family was trying to use Resident #1's ID to do something without Resident #1's permission. The SW stated she then confirmed with Resident #2 that her family had come to visit her just prior and now bank cards, social security card, and ID card were missing from her wallet. The SW stated she contacted the police and APS. The SW stated in the past there were issues with the family taking her monthly social security check and prior reports had been made to APS about the resident and family. The SW stated they set up for the social security check to go directly to the facility since and closed her bank account. The SW stated she helped the resident open a new bank account with just her name on it. The SW stated she held the Resident's cards in her office now. The SW stated she was unaware allegations of misappropriation of property needed to be reported to the stated agency. The SW stated the training she had for reporting was to make the Administrator aware and the Administrator usually does all the reporting. The SW stated the Administrator signed off on the grievance and was aware of the allegations. The SW stated the Administrator was responsible for reporting allegations to the state agency.</p> <p>During an interview on 4/15/25 at 4:40 p.m. The Administrator stated she was aware of the allegations on the grievance from Resident #2 on 1/9/25 and a report was made to the police and APS. The Administrator stated she did not report it to the state agency because it only involved cards and no actual money. The Administrator stated she did not have access to the Resident money or cards to know if any money was stolen. The Administrator stated she was not familiar with the facility's reporting policy and would need to review it for reporting requirements.</p> <p>Record review of the facility policy titled Policy and Procedures: Abuse, Neglect, and Exploitation, stated 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 resident property . Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent .VII. Reporting/Response A. The facility reports The facility reports abuse and abuse allegations that include: 1. Reporting allegations involving .misappropriation of resident property exploitation, and mistreatment. 2. Reporting of 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 . C. Not later than 24 hours after the incident occurs or is suspected. An incident that does not result in serious bodily injury but that involves any of the following . Misappropriation of resident property 3. The facility does not have to report: a. an injury that is not suspicious or of unknown source b. an injury that is not related to abuse, neglect, exploitation, or other mistreatment c. emergency situations that do not pose a threat to resident health and safety secondary to proper management through facility emergency preparedness d. deaths that do not occur under unusual circumstances e. communicable disease situations that do no pose a threat to resident health .</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 3 residents (Resident #3) reviewed for accuracy of records, in that:</p> <p>The facility failed to ensure RN B and LVN C documented when they contacted the physician for Resident #3's high blood glucose levels (continuously over 200) for 5 days (1/25/25, 1/26/25, 1/27/25, 1/28/25, 1/29/25) and the physician's recommendations for Resident #3 who was not prescribed any insulin.</p> <p>This failure could put residents at risk due to inaccurate documentation and lead to missed or delayed diagnosis and treatment.</p> <p>The findings were:</p> <p>Record review of Resident #3's admission Record (face sheet), dated 4/15/25, revealed a [AGE] year-old female resident was admitted to the facility on [DATE] and discharged on 1/30/25 to a hospital with diagnosis which included sepsis unspecified organism (refers to a serious medical condition characterized by the body's extreme response to an infection, where the specific organism causing the infection is not identified. It involves the presence of pathogenic microorganisms or their toxins in the bloodstream, leading to a systemic reaction that can result in shock and organ failure), hypoglycemia (reading below 70 milligrams per deciliter (mg/dL) is generally considered too low and indicates hypoglycemia, which can lead to symptoms like shakiness, confusion, and sweating), narcolepsy with cataplexy (is a chronic neurological disorder that affects the brain's ability to control sleep-wake cycles. It can cause excessive daytime sleepiness, cataplexy (sudden muscle weakness), sleep paralysis, and other symptoms.), atherosclerotic heart disease of native coronary artery without angina pectoris (the build up of plaque in the arteries would limit the blood flow to the heart but severely impairs it to no extent for causing pain, which is angina), type 2 diabetes mellitus with ketoacidosis without coma (a person with type 2 diabetes has high levels of ketones (Ketones are produce when body burns fat for energy instead of glucose) in the blood but does not lose consciousness. This can lead to a serious complication if not treated.), and metabolic encephalopathy (a range of neurological disturbances that result from systemic metabolic dysfunction in the body. This condition can arise from various underlying causes, including liver failure, kidney dysfunction, infections, electrolyte imbalances, and endocrine disorders. In metabolic encephalopathy, the brain's normal functioning is compromised due to the buildup of toxins or deficiencies in essential nutrients, which can lead to symptoms such as confusion, altered consciousness, cognitive impairment, seizures, and even coma in severe cases).</p> <p>Record review of Resident #3's Discharge MDS assessment, dated 1/30/25, revealed the Resident #3 had moderately impaired cognition for daily decision making.</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 - Some</p>	<p>Record review of Resident #3's care plan, dated 1/23/25, revealed the resident had a diagnosis of diabetes and was at risk for unstable blood sugars and abnormal lab results with interventions to Administer diabetic medications as ordered by the physician, monitor for adverse reactions and report abnormal [sic] as detected and monitor for signs and symptoms of hyperglycemia such as: Reduced appetite, increased thirst, urinary frequency, weight loss, fatigue, nausea, vomiting, dry skin, muscle cramps, Kussmaul breathing (an abnormal breathing pattern characterized by rapid, deep breathing at a consistent pace. It ' s a sign of a medical emergency - usually diabetes-related ketoacidosis (DKA)), acetone breath (smells fruity), stupor, and coma. Document and report to the physician as needed.</p> <p>Record review of Resident #3's physician orders, dated 4/17/25, revealed an order for sitagliptin phosphate (antidiabetic medication used to treat type 2 diabetes) give 1 tablet via PEG tube in the morning related to type 2 diabetes with ketoacidosis without coma, with a start date of 1/22/25 and no end date.</p> <p>Record review of Resident #3's physician orders, dated 4/17/25, revealed an order for blood glucose check for 7 days with a start date of 1/23/25 and an end date of 1/30/25.</p> <p>Record review of Resident #3's glucose readings were as follows:</p> <p>1/29/2025 08:24</p> <p>288.0 mg/dL</p> <p>RN B (Manual)</p> <p>1/28/2025 08:28</p> <p>245.0 mg/dL</p> <p>LVN C (Manual)</p> <p>1/27/2025 08:42</p> <p>219.0 mg/dL</p> <p>LVN C (Manual)</p> <p>1/26/2025 08:55</p> <p>337.0 mg/dL</p> <p>RN B (Manual)</p> <p>1/25/2025 08:06</p> <p>225.0 mg/dL</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 - Some</p>	<p>RN B (Manual)</p> <p>1/24/2025 08:46</p> <p>269.0 mg/dL</p> <p>RN B (Manual)</p> <p>1/23/2025 08:11</p> <p>169.0 mg/dL</p> <p>LVN C (Manual)</p> <p>Record review of Resident #3's nursing progress notes, dated 4/17/25, revealed no nursing notes in reference to high blood glucose levels. Progress noted dated 1/30/25 at 8:14 p.m. written by RN D stated family called 911 due to change in condition. Notified family of chest x-ray ordered, family called 911. Vitals assessed BP: 103/80, O2 NC 3L 93%. No facial grimacing. Wheezing heard upon exhalation. HOB elevated to semi-Fowler_position. Blood sugar level 503. EMS arrived and tending to patient. Wound vac removed. Dressing applied to right hip. RP in room with patient and EMS. EMS transferring patient to [Hospital] via stretcher. Notified ADON, DON, and Administrator. Notified MD.</p> <p>During an interview on 4/17/25 at 9:43 a.m. LVN E stated she would notify the MD if a Resident blood glucose was over 300.</p> <p>During an interview on 4/17/25 at 10:54 a.m. RN B stated if a residents blood glucose is over 400 and they prescribed insulin they would administer the insulin and notify the doctor. RN B stated if the resident had a high glucose reading she would take it twice and then call the provider and let them know the resident does not take insulin and only takes an oral medication daily. RN B stated she did not recall if she notified the provider about the blood glucose reading of 337 on 1/26/25 or what interventions were provided. RN B stated she should document what happened. RN B stated the provider did rounds at the facility often and she most likely notified him in person and forgot to write a note.</p> <p>During an interview on 4/17/25 at 12:22 p.m. the DON stated staff should contact the provider if a resident is only on oral medication for blood glucose management and is regularly having glucose readings over 200. The DON stated they should contact the doctor and document. The DON stated best practice would be to write a note. The DON stated however the provider was there often and the staff mostly likely was updating him in person.</p> <p>During an interview on 4/17/25 at 2:23 p.m. The Doctor stated staff always notified him when Resident #3 had high blood glucose readings. The Doctor stated he recalled the family was more concerned with pain medication for the resident and never stated they thought the blood glucose was an issue. The Doctor stated he knew the Resident's family had called 911 and the resident went to the hospital, but he did not know anything else about her status after he discharged .</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 - Some</p>	<p>Record review of the facility's policy titled Following Physician Orders, dated 9/28/21, stated Policy: The policy provided guidance on receiving and following physician orders .3. For consulting physician/practitioner orders received via telephone, the nurse will: a. Document the order on the physician order form, notating the time, date, name and title of the person providing the order, and the signature and title of the person receiving the order. b. Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record. c. Carry out and implement physician orders d. Document resident response to physician order in the medical record as indicated .</p>