

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Parkview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 S Main St Lockhart, TX 78644	

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 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on observation, interview and record review, the facility failed to obtain laboratory services to meet the needs of its residents for 1 (Resident #1) of three residents reviewed for laboratory services.</p> <p>The facility failed to collect a urine specimen for a UA (urine analysis) for Resident #1 as ordered by the physician on 06/18/24 until 06/26/24. The UA results reflected blood in his urine.</p> <p>This failure could place residents with indwelling urinary catheters at risk of infection, renal failure, urinary tract infections, and pain.</p> <p>Findings Included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including quadriplegia (the dysfunction or loss of motor and/or sensory function in the cervical area of the spinal cord), urinary tract infection, and neuromuscular dysfunction of the bladder (muscles in the bladder wall not contracting or relaxing properly).</p> <p>Review of Resident #1's admission MDS assessment, dated 06/24/24, reflected a BIMS of 15, indicating no cognitive impairment. Section H (Bladder and Bowel) reflected he had an indwelling catheter.</p> <p>Review of Resident #1's admission care plan, dated 06/20/24, reflected he had urinary elimination altered due to Neuromuscular Dysfunction of the bladder requiring a foley catheter with an intervention of monitoring for signs and symptoms of a UTI.</p> <p>Review of Resident #1's hospital records, dated 06/05/24, reflected he had been admitted for a UTI with sepsis due to improper insertion with pain.</p> <p>Review of Resident #1's physician order, dated 06/18/24, reflected the type of lab ordered: UA c/s.</p> <p>During an observation and interview on 06/26/24 at 10:20 AM, Resident #1 stated he was concerned because he had a history of UTIs with sepsis and he discussed getting a UA done with the NP a few days ago and it still had not been done. He stated the output in his foley back was dark and it was usually that color when he had a UTI or sepsis. He stated he was extremely worried and hoped something got done soon. This Surveyor observed his foley bag which contained approximately 500 CCs of urine that was a dark amber color. There was sediment around the tubing.</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 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 06/26/24 at 10:45 AM, Resident #1's NP stated the facility had not gotten back to her with results from the UA that was supposed to have been done on 06/18/24. She stated the resident had a history of repeated UTI's based on poor foley care and he was very paranoid about repeating those incidents. She stated she ordered a UA just to make sure there was no lingering bacteria since he was admitted from the hospital after being treated for a UTI and sepsis. She stated she would have expected for a urine collection to have been done the same day she ordered it. She stated when she saw Resident #1 on 06/18/24 his urine was clear. This Surveyor informed the NP that his urine was now a dark amber color and the NP stated, Oh dear. That is not good.</p> <p>During an observation and interview on 06/26/24 at 11:00 AM, RN A stated she worked on the 100 hall (Resident #1's hall). She opened his EMR and stated she did not see that he had a UA completed during the past week. She stated she reviewed an order for a UA on 06/18/24 but could not recall why a specimen was not collected or sent to the lab. She stated when a UA was ordered, a specimen was normally collected that day and sent to the lab the next morning. She stated when she observed Resident #1's foley bag that morning it looked like it had sediment in it.</p> <p>During an interview on 06/26/24 at 12:22 PM, the DON stated she was not aware before today (06/26/24) that the NP had ordered a UA for Resident #1. She stated she was not aware he was having any signs or symptoms of a UTI. She stated she asked RN A if she remembered getting told to have a UA conducted and she could not recall. She stated she worked with Resident #1 the day prior (06/25/24) and there was not any sediment in the bag nor was his urine odorous. She stated their normal protocol was to collect urine on the day the lab came out to pick up specimen, which was on Tuesdays or Thursdays. She stated they could also order a STAT pick-up. She stated they would be collecting a specimen from Resident #1 that day and it would be a STAT order. She stated the importance of following the NP's orders regarding UA's was to be proactive, to catch any infectious diseases before they could happen, and to stay on top things.</p> <p>Review of the facility's Physician Visits Policy, revised August of 2022, reflected it had nothing regarding following physician orders.</p> <p>Review of the facility's Catheter Care Policy, Revised August of 2022, reflected it had nothing regarding following physician orders for a UA.</p>		