STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675635	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebony Lake Nursing and Rehabilitation Center	1001 Central Blvd Brownsville, TX 78520

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on interviews and record review, the facility failed to develop and implement a person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 4 residents (Resident #34) reviewed for comprehensive care plans. Resident #34's comprehensive care plan was not revised after the code status was changed from DNR to a Full Code. This failure could place residents at risk for inadequate care during an emergent situation. The findings included: Record review of Resident #34's face sheet dated [DATE] reflected a [AGE] year-old-male with an original admitted [DATE]. Diagnoses included bone cancer, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), and type two diabetes (insufficient production of insulin in the body). Record review of Resident #34's care plan dated [DATE] and revised on [DATE] stated Resident #34 was a DNR. Interventions included: Ensure signed DNR is in medical record. If resident has a cardiac arrest, do not call 911 or initiate CPR. Notify MD/RP and follow instructions after notification. Record review of Resident #34's physician orders dated [DATE] reflected a code status of CPR (full code). (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] 03:04 PM the MDS Coordinator stated Resident #34 was supposed to be a full code and the care plan should have reflected Resident #34's current code status. The MDS Coordinator stated Resident #34 used to be a DNR. The MDS Coordinator stated Resident #34 had gone to the hospital sometime in June or July of this year and when he returned to the facility from the hospital, Resident #34 and family wanted the code status to be changed to full code. The MDS Coordinator stated Resident #34's code status was overlooked. The MDS Coordinator stated staff follows the code status that was found at the top the of the chart which did state Resident #34 was a full code. The MDS Coordinator stated the DNR code status should have been removed and the care plan updated so it would have Resident #34's individualized plan of care. The MDS Coordinator stated she was going to correct Resident #34's care plan immediately. In an interview on [DATE] 09:55 AM the DON stated Resident #34's care plan should have been updated when the change in code status happened. The DON stated Resident #34 used to be a DNR and was on hospice services. The DON stated Resident #34 came back to the facility from the hospital and Resident #34 and his family agreed for the code status be updated to a full code. The DON stated Resident #34's care plan should match the correct code status so staff are able to know the correct plan of care and what action to take in case of an emergency. The DON stated the IDT looks over care plans and are audited quarterly or as needed. The DON stated Resident #34's care plan was missed. The DON stated she felt Resident #34 was not affected by the care plan not having the correct code status as the correct code status was in the Resident #34's chart and physician orders. Record review of facility's Care Plan Revision Upon Status Change policy dated [DATE] stated: Policy: The purpose of this procedure is to provide a consistent process for reviewing process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on observation, interview and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 (Resident #8) of 6 residents reviewed for respiratory care in that: 1, The facility failed to date and/or change the suction canister, suction tubing, and suction device for Resident #8. 2. The facility failed to ensure there was a physician order to change the suction canister, suction tubing, suction device, oxygen tubing, and nebulizer for Resident #8. These failures could place residents that had a need for oxygen or suctioning at risk of infection. The findings included: Record review of Resident #8's Admission record reflected a [AGE] year-old male that had an original admitted [DATE] and was readmitted on [DATE]. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), Congestive Heart Failure (the heart does not beat effectively enough and can cause fluid buildup in the lungs), Alzheimer's (a progressive disease that destroys memory and other important mental functions), and Dementia (loss of memory, language, problem-solving and other thinking abilities). Record review of Resident #8's Quarterly MDS dated [DATE] reflected a BIMS score of 2 which indicated Resident #8 had severe cognitive impairment. Resident #8's MDS also reflected that he was coded for oxygen therapy while a resident. Record review of Resident #8's comprehensive care plan reflected in part: Problem: Resident #8 has COPD and COPD with exacerbation (an increase in difficulty breathing). Initiated: 2/17/18, revised 3/8/21. Goal: Resident #8 will be free of signs/symptoms of respiratory infections through review date. Initiated: 2/17/18, revised: 3/6/24, target date: 11/26/24. Interventions: Give aerosol, nebulizer treatments or bronchodilators as ordered. Monitor/ document any side effects and effectiveness. Initiated: 2/17/18, revised: 5/12/21. Monitor for difficulty breathing on exertion. Initiated: 2/17/18, revised: 11/2/18. Monitor/document/report PRN (as needed) any signs/symptoms of respiratory infection: fever, chills, increase in sputum (document the amount, color, and consistency), chest pain, increased difficulty breathing, increased coughing and wheezing. Initiated 2/17/18. Record review of Resident #8's physician orders on 9/26/24 reflected an order dated 9/24/24 that stated, Oxygen at 3 lpm (liters per minute) via nasal cannula every shift for hypoxia, and an order dated 8/30/24 that stated, Suctioning by mouth every 8 hours as needed for congestion. There were no orders found that related to changing out oxygen or suction supplies. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #8's room on 9/24/24 at 9:31am revealed a suction canister was on top of a rolling table next to Resident #8's bed. The suction canister did not have a date on it and had approximately 400ml of a clear colored cloudy liquid inside. There was suction tubing connected to the suction canister on one end and to a Yankauer suction device (hard suction device used to suction secretions out of the mouth) on the other end. The suction tubing was not dated and the Yankauer suction device was slid into its previously opened packaging. The date on the Yankauer suction device packaging was 9/16/24. Observation of Resident #8's room on 9/26/24 at 9:02am revealed the suction canister was in the same location as before but had been dated 9/23 with [initials] below it written with black marker on the lid of the suction canister. The suction canister still contained approximately 400ml of a clear colored cloudy liquid. The suction tubing was still attached to the suction canister at one end and to the Yankauer suction device (hard suction device used to suction secretions out of the mouth) at the other end. The Yankauer suction device was still in the packaging dated 9/16/24. In an interview on 09/26/24 at 9:21am, RN B stated the suction canisters were one time use for a week. RN B stated they would change them out sooner than a week if they were smelly or if the resident had some kind of respiratory infection. RN B stated the suction tubing and Yankauer were supposed to be changed out weekly or as needed if soiled, as was the oxygen tubing. RN B stated the Yankauer, and suction tubing should have been changed when the canister was. RN B stated he last worked Monday night and if he would have had to suction Resident #8, he would have changed out the suction supplies, but Resident #8 has not needed to be suctioned. RN B stated if Resident #8 had needed a nebulizer treatment, he would check the date on the oxygen tubing and nebulizer and change it if it was over a week old. RN B stated he was going to go change out the suction supplies at the end of the interview. RN B stated if the supplies were not changed out, nosocomial infection, bacterial growth, and hospitalization could occur. In an interview on 9/26/24 at 9:49am the ADON stated suction supplies were to be changed every 7 days and as needed. The ADON stated if the suction or oxygen supplies were not changed out, bacteria could start to grow, and it could cause infection for the resident. The ADON stated, With the Yankauer dated 9/16/24, it makes me doubt the 9/23 date on the canister. The ADON stated [initials] might have been the respiratory therapist, but they did not have a nurse with those initials. The ADON stated the respiratory therapist had not been to the facility to see a resident for at least four days. The ADON stated the respiratory therapist worked as needed and would come in to see specific patients or do in-services. The ADON stated the did do in-service on supplies and the last one was in August for all staff. The ADON stated it was on the orders when the oxygen tubing was supposed to be changed out. In an interview on 9/26/24 at 9:53am the DON stated disposable supplies were to be changed out weekly or as needed if they were soiled. The DON stated if suction and oxygen supplies were not changed out, it could cause infection and possibly hospitalization . Record review of the facility's Infection Prevention and Control Program Policy dated 5/13/23 reflected in part: Policy: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. 2. All staff are responsible for following all policies and procedures related to the program. 10. Equipment Protocol: a. Single use disposable equipment is an alternative to sterilizing reusable medical instruments. Single use devices must be discarded after use and are never used for more than one resident. 11. Supplies Protocol: a. Sterile supplies shall be appropriately packaged and sterilized or purchased prepackaged and sterile from the manufacturer. b. Prepackaged sterile items are considered sterile until opened or damaged. Packaging shall be inspected prior to use. 16. Staff Education: a. All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. b. All staff shall demonstrate competence in resident care procedures established by our facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46038 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 (Cook E) of 3 kitchen staff reviewed for storage, preparation and sanitation. The facility failed to ensure [NAME] E performed hand hygiene for at least 20 seconds while prepping resident meals for breakfast. This failure could place residents at risk for cross-contamination and infections. The findings included: During a kitchen tour observation on 09/24/24 at 7:17 AM [NAME] E was observed washing her hands for 5 seconds after picking up an item off the kitchen floor. During a second observation on 09/24/24 at 7:31 AM [NAME] E was observed washing her hands for 3 seconds after taking food temperatures. In an interview on 09/24/24 at 07:30 AM [NAME] E stated handwashing should be done for 20 seconds as to avoid cross-contamination in food and spreading germs to residents. [NAME] E stated she dropped something on the floor and after picking it up, she went to wash her hands and became nervous because she knew she was being watched. [NAME] E stated she was last in-serviced on handwashing a few weeks ago but could not remember the date. In an interview on 09/24/24 at 01:29 PM the DM stated all staff should wash hands for at least 20 seconds as they are in-serviced regularly. The DM stated if hands were not washed it could lead to cross-contamination of food that was served to the resident. The DM stated she was going to conduct an in-service on hand hygiene immediately to all kitchen staff as to prevent cross-contamination to food. In an interview on 09/26/24 at 09:49 AM the ADON/Infection Control Preventionist, stated handwashing should be done for 20 to 30 seconds. The ADON stated handwashing should be done appropriately to stop the spread of infections and bacteria to residents, staff, and visitors. The ADON stated when infection control and handwashing in-services are conducted monthly, all staff including kitchen staff are in-serviced. The ADON stated it was important for all staff including kitchen staff to wash hands appropriately as they handle food. In an interview on 09/26/24 at 09:53 AM the DON stated handwashing should be at least 20-30seconds to prevent the spread of bacteria or germs to residents, staff, and visitors. The DON stated and record review revealed, a hands-on in-service on handwashing was conducted on 9/25/24 for all staff. Record review of facility's Hand Hygiene policy dated 10/24/22 stated: Policy: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 5. Hand hygiene technique when using soap and water: c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. References: FDA Food Code 2022 Title 21, Chapter 1, Subchapter B S 112.32: Washing hands thoroughly, including scrubbing with soap (or other effective surfactant) and running water that satisfies the requirements of S 112.44(a) (as applicable) for water used to wash hands, and drying hands thoroughly using single-service towels, sanitary towel service, electric hand dryers, or other adequate hand drying devices: (i) Before starting work; (ii) Before putting on gloves; (iii) After using the toilet; (iv) Upon return to the work station after any break or other absence from the work station; (v) As soon as practical after touching animals (including livestock and working animals), or any waste of animal origin; and (vi) At any other time when the hands may have become contaminated in a manner that is reasonably likely to lead to contamination of covered produce with known or reasonably foreseeable hazards.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on observations, interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #31) of 6 residents reviewed for accuracy and completeness of clinical records. The facility failed to accurately document in the treatment administration record when Resident #31 received supplemental oxygen. This failure could result in residents' records not accurately reflecting the administration of treatments and could result in further error and a decline in heath. The findings included: Record review of Resident #31's face sheet dated 09/26/24 reflected an [AGE] year-old female with an admitted [DATE] and an original admitted [DATE]. Pertinent diagnoses included Dementia (loss of cognitive functioning that interferes with daily life activities), and Diastolic Heart Failure (condition in which your heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly) Record review of Resident #31's Comprehensive MDS assessment section C, cognitive patterns, dated 09/05/24 reflected an inability to obtain a BIMS score due to Resident #31's status as rarely/never understood. MDS assessment section O, special treatments, procedures, and programs reflected Resident #31 had not received oxygen therapy in the past 14 days at the facility. Record review of Resident #31's care plan reflected the problem [Resident #31] had altered respiratory status/difficulty breathing r/t SOB, Anxiety initiated on 10/14/22. An intervention to treat the problem reflected Oxygen at 2 LPM via nasal canula as needed as per MD orders initiated on 11/04/22. Record review of Resident #31's order summary reflected an active order dated 11/03/22 for Oxygen at 2 LPM via nasal canula every 2 hours as needed for hypoxia [condition that occurs when the body or a part of the body does not receive enough oxygen] if < 92% Record review of Resident #31's MAR on 09/26/24 reflected the order for Oxygen at 2 LPM via nasal canula every 8 hours as needed for hypoxia IF < 92% had not been administered during the month of August 2024 and September 2024. During an observation at 8:53 AM on 09/24/24, Resident #31 laid in bed in her room and received 2 LPM of oxygen via nasal canula. Interview with Resident #31 was attempted at 8:53 AM on 09/24/24, but Resident #31 was unable to communicate back with this surveyor. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation at 10:49 AM on 09/26/24, Resident #31 laid in bed in her room and received 2 LPM of oxygen via nasal canula. During an interview with the MDS coordinator at 10:52 AM on 09/26/24, the MDS coordinator stated the Comprehensive MDS assessment dated [DATE] indicated Resident #31 did not receive oxygen therapy in the last 14 days. The MDS coordinator stated the MAR showed Resident #31 had not received oxygen therapy in the months of August 2024 and September 2024. During an interview with LVN A at 12:49 PM on 09/26/24, LVN A stated Resident #31 will use the 2 LPM oxygen as needed on some days. LVN A stated Resident #31 goes through periods where she needed it more and some where she needed it less. LVN A stated Resident #31 was on oxygen earlier this morning, but Resident #31's oxygen level was at 98% so she took Resident #31 off the oxygen at around 11:45 AM this morning. LVN A stated the nurse who administered the oxygen should be the one to sign the MAR that it was completed. LVN A stated she arrived at 6 AM but did not recall if Resident #31 was on oxygen when she arrived in the morning. LVN A stated if nurses did not sign the MAR when administering treatment, a resident could get a double dose of medication. LVN A stated if they did not sign the MAR then they would not have a record of how much oxygen Resident #31 was using. During an interview with the ADON at 1:03 PM on 09/26/24, the ADON stated Resident #31 received PRN oxygen sometimes. The ADON stated every time a resident received a PRN treatment, the nurse administering the treatment should sign the MAR. The ADON stated it was important to document how much oxygen Resident #31 received so they can make more informed treatment decisions about the resident in the future. During an interview the DON at 1:10 PM on 09/26/24, the DON stated she visited Resident #31 today at around 12:00PM and she was not on oxygen. The DON stated she had seen Resident #31 on oxygen this month but did not remember specific days or times. The DON stated if the order was PRN and it was administered, the nurse who administered the treatment should sign the MAR. The DON stated if Resident #31 was on oxygen, but it was not on the MAR then it would not reflect reality. The DON stated it was important to keep a record of how often the resident used oxygen so they can make adjustments to the order as needed. A policy for medication administration was requested from the administrator on 09/26/24 but none was provided.