STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675468	A. BUILDING _____ B. WING _____	04/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HICO NURSING AND REHABILITATION	712 RAILROAD AVE HICO, TX 76457

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity for two (Resident #1 and Resident #2) of six residents reviewed for dignity in that: A. LVN A did not speak to Resident #1 in a respectful manner. B. LVN A did not close Resident #2's door when performing an accucheck. The deficient practice could place residents at risk for diminished quality of life, loss of dignity, and a decline in self-esteem Findings include: A. Review of Resident #1's facesheet reflected resident was a [AGE] year-old female who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's quarterly MDS, dated [DATE], reflected resident received a 2 on the BIMS assessment which indicated a significant cognitive impairment. Review of Resident #1's care plan, dated 11/9/2019, reflected the resident had been identified as having PASRR positive status related to an intellectual disability. Review of care plan reflected Resident #1 had an impaired cognitive function/dementia or impaired thought process related to Dow[DIAGNOSES REDACTED] diagnosis. Review of interventions reflected to present just one thought, idea, question or command at a time. Observation on 4/23/2020 at 11:01 a.m., revealed Resident #1 was in a common area, sitting on a couch, and watching television. Observation revealed LVN A had approached Resident #1 and stated she needed to put on the mask. Observation revealed Resident #1 shaking her head no. LVN A proceeded to stand and lean over the resident and stated there was a state lady in the building watching and she needed to put on the mask. In an interview on 4/23/2020 at 1:00 p.m., LVN A stated Resident #1 would hide her mask because she did not like the mask. LVN A stated when Resident #1 was approached she should have sat down and talked with the resident. LVN A stated the facility does baby the resident a lot and she is spoiled. B. Review of Resident #2's facesheet reflected resident was a [AGE] year old female who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's quarterly MDS, dated [DATE], reflected Resident #2 received a 5 on her BIMS assessment which indicated a significant cognitive impairment. Review of Resident #2's care plan, reviewed on 3/4/2020, reflected Resident #2 had impaired cognitive function/dementia or impaired thought processes related to [DIAGNOSES REDACTED]. Resident #2 had a [DIAGNOSES REDACTED].#2 and the resident's door remained opened. In an interview on 4/23/2020 at 1:00 p.m., LVN A stated she should have closed Resident #2's door during the accucheck but she wanted to keep an eye on her cart. In an interview on 4/23/2020 at 2:05 p.m., DON stated standing over a resident was not an appropriate way to approach the resident because this would not maintain the resident's dignity. DON stated the resident should be redirected and reeducated about the importance of wearing the mask. DON stated when doing an invasive procedure, to include accuchecks, the door should be closed because this would maintain the resident's dignity as well. Review of facility policy titled Resident Rights Guidelines for All Nursing Procedures, dated December 2007, reflected for any procedure that involves direct resident care follow these steps: d. Introduce yourself to the resident if he/she is unfamiliar with you, or if he/she may not recognize you due to memory loss. F. close the room entrance door and provide for the resident's privacy. Review of facility policy titled Quality of Life-Dignity, dated October 2009, reflected each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 1. Residents shall be treated with dignity and respect at all times, 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 7. Staff shall speak respectfully to the residents at all times, including addressing the resident by his or her name. 12. Staff shall treat cognitively impaired residents with dignity and sensitivity.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for four (Residents # 3, 4, 5 & 6) of five residents reviewed for infection control. A. CNA B and CNA C failed to perform appropriate hand hygiene prior to doing incontinence care for Resident #3. B. CNA C failed to perform appropriate hand hygiene prior to doing incontinence care for Resident #4. C. Transporter D failed to perform hand hygiene when delivering meals to Resident #5 and Resident #6 These failures could place residents at risk for cross-contamination and the spread of infection. Findings Include: A. Review of Resident #3's facesheet reflected resident was an [AGE] year old female who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's quarterly MDS, dated [DATE] reflected resident received a 1 on her BIMS assessment. A score of 1 reflected resident has a severe cognitive impairment. Review of Section G, titled functional status, reflected resident required extensive assistance of one staff member for toileting. Review of Resident #3's care plan, dated 4/14/2020, reflected Resident #3 had an ADL self-care performance deficit related to confusion and dementia. Review of toilet use reflected resident required assistance of one staff member for toileting. Observation on 4/23/2020 at 10:35 a.m., revealed CNA B and CNA C entering Resident #3's room to perform incontinence care. Upon entering Resident #3's room CNA B and CNA C did not perform hand hygiene prior to donning gloves. B. Review of Resident #4's facesheet reflected resident was a [AGE] year old female who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's quarterly MDS, dated [DATE] reflected resident received a 15 on her BIMS assessment. A score of 15 reflected resident was cognitively intact. Review of Section G titled Function status reflected resident required extensive assistance of two staff members for toilet use. Review of Resident #4's care plan, dated 4/28/2020, reflected Resident #3 had an ADL self-care performance deficit related to dementia and impaired balance. Review of interventions reflected resident was totally dependent on one staff member for toilet use. Observation on 4/23/2020 at 11:00 a.m., revealed CNA B and CNA C entering Resident #4's to perform incontinence care. Upon entering Resident #4's room CNA B did not perform hand hygiene prior to donning gloves. In an interview on 4/23/2020 at 1:10 p.m., CNA C stated she is trained to perform hand hygiene prior to placing on new gloves. CNA C stated it is important to perform hand hygiene because this would avoid cross contamination and would avoid infections to spread. In an interview on 4/23/2020 at 1:23 p.m., CNA B stated she did forget to perform hand hygiene prior to putting on her gloves. CNA B stated she has been trained to wash her hands and then put on gloves. CNA B stated hand hygiene was important to complete because this reduces the spread of germs. In an interview on 4/23/2020 at 2:05 p.m., DON stated it is her expectations for staff to wash their hands and then don gloves because this would reduce the spread of infection. C. Review of Resident #5's facesheet reflected resident was a [AGE] year-old female who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #5's quarterly MDS, dated [DATE] reflected resident received a 15 on her BIMS assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) which reflected resident was cognitively intact. Review of Section G, titled functional status, reflected resident #5 required supervision and set up only for eating. Review of Resident #5's care plan, reviewed on 2/7/2020, reflected Resident #5 [MEDICAL CONDITION] to inappropriate diet. Review of Resident #6's facesheet reflected resident was a [AGE] year-old female who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #6's quarterly MDS, dated [DATE], reflected resident received a 4 on her BIMS assessment which reflected a significant cognitive impairment. Review of Section G, titled functional status, reflected resident required supervision and one person physical assistance with eating. Review of Resident #6's care plan, reviewed on 4/3/2020, reflected resident had an ADL self-care performance deficit related to aggressive behavior, Alzheimer's, confusion, and dementia. Continuous observation on 4/23/2020 at 12:00 p.m. through 12:15 p.m., revealed, Transporter D assisting with meal delivery to the residents. Observations revealed: - Transporter D walking out of a unidentified residents room with gloves on her hands and hand hygiene was not observed prior to picking up Resident #5's tray. - Transporter D picked up a tray for Resident #5 and delivered the tray to the resident's room. Hand hygiene was not observed prior to picking up Resident #6's tray. In an interview on 4/23/2020 at 12:41 p.m., Transporter D stated that she was unsure when to perform hand hygiene when delivering meals to the residents. Transporter D stated they were to perform hand hygiene prior to assisting a resident to eat. In an interview on 4/23/2020 at 12:55 p.m., DON stated staff are to perform hand hygiene in between each of the resident's rooms. DON stated staff are to sanitize in between each resident because this would help to decrease the spread of infection. Review of facility policy dated December 2007, titled Infection Control Guidelines reflected employees must wash their hands for ten to fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with resident. In most situations, the preferred method of hand hygiene is with an alcohol based hand rub. If hands are not visible soiled, use an alcohol based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] before and after direct contact with residents and before donning sterile gloves.