STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455895	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF LAKE HIGHLANDS	**9009 WHITE ROCK TR DALLAS, TX 75238**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to notify the resident representative when there was an accident involving the resident which resulted in injury and has the potential for requiring physician intervention for one (Resident #1) of five residents reviewed for notification of changes. The facility failed to notify Resident #1's responsible party when Resident #1 was discovered with a large bruise on her left eye from an unknown origin. This failure could place residents at risk of not having their responsible party notified of changes, resulting in a delay in medical intervention and decline in health. Findings included: Record review of Resident #1's Minimum Data Set (MDS) annual assessment, dated 03/05/20 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment revealed that the resident was sometimes understood and her cognitive skills for decision making were severely impaired. Record review of Resident # 1's care plan dated, 12/02/19, revealed the resident was at risk for falls due to balance problems, [MEDICAL CONDITION] and [MEDICAL CONDITION]. Observation of Resident #1 on 05/07/20 at 10:50 AM, revealed the resident had a large bruise to her left eye. Record review of Resident #1's nurse's note dated 05/05/20 at 7:18 AM by LVN A, revealed that Resident #1 was observed at approximately 5:30 AM, getting out of bed and crawling on the floor of room. Resident was non-combative and has no signs of pain or discomfort. Resident continued to get out of bed and crawl around on the floor. Will continue to monitor. Record review of Resident #1's nurses' notes revealed there was no documentation related to Resident #1's facial bruising or that Resident #1's representative was notified of the bruising. Interview with LVN C on 05/07/20 at 10:59 AM revealed she was given a verbal report of Resident #1 crawling on the floor that night (05/05/20) from LVN B. She stated she learned of the bruise from LVN B, and stated it was considered a delayed injury. She stated she did not know if Resident #1's family and doctor were notified as she could not find documentation or an incident report for the accident. Interview with the ADON on 05/07/20 at 11:23 AM revealed incident reports were not needed if an incident was witnessed without injury. She also stated she was unaware of why Resident #1's representative and physician were not notified nor could she locate an incident report for the incident on 05/05/20. As a result, she stated she would make the necessary contacts and in-service staff. Interview with the Responsible Party for Resident #1 on 05/07/20 at 1:16 PM revealed he was not notified about the bruise Resident #1 received on 05/05/20 until noon on 05/07/20. He stated his expectation was to notified of all incidents involving his wife. Interview with LVN A on 05/07/20 at 2:00 PM, revealed Resident #1 was initially observed getting on the floor to crawl and was assisted back to bed on 05/05/20 at approximately 5:30 AM. She stated about ten minutes later Resident #1's roommate came to her stating she was crawling on the floor again. She assisted Resident #1, as there were no visible injuries. She stated she documented the incident and reported the incident to LVN C and the ADON on 05/05/20. Interview with LVN B on 05/07/20 at 3:30 PM revealed she learned of the bruise to Resident #1's left eye from CNA D on 05/05/20 around 4:00 PM. LVN B stated, she failed to document or follow up due to an emergency involving another resident. She stated she notified LVN A of delayed injury at their next shift change on 05/05/20. Interview with CNA D on 05/07/20 at 4:02 PM revealed she notified LVN B of Resident #1's bruise after dinner on 05/05/20. She stated Resident A did not have a bruise on her eye on 05/04/20. Interview with the DON on 05/07/20 at 2:57 PM revealed an incident report was not completed on 05/05/20 when Resident #1's bruises was identified. She stated she spoke with LVN A on 05/05/20 about the incident and it was explained to her that the incident was witnessed without any injury. She stated LVN A informed her there was a second unwitnessed incident where Resident #1 got out of bed again and began crawling on the floor. She stated herself and the Administrator were notified on 05/07/20 of the bruise to Resident #1's eye. She stated she began an investigation and found out that LVN B was the first to discover the bruise. She stated she called in LVN A on 05/07/20 to complete the incident report and in-services on falls and reporting. She stated the second incident should have been considered an unwitnessed fall, an incident report should have been filled out and appropriate parties, including the resident representative and State Agency, should have been notified. Review of the facility's current Notification of Change in Patient/Resident Health Status, dated June 2017, reflected: Purpose To ensure all interested parties are informed of the patient's/resident's change in health status so that a treatment plan can be developed which is in the best interest of the patient/resident. Process The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the patient representative when there is: (A) An accident which results in injury and has the potential for requiring physician intervention, within 24 hours from the time of assessment.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving of abuse, neglect, abuse, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) for one (Resident #1) of five residents reviewed for abuse and neglect. The facility failed to report an injury of unknown source to the state agency within 24 hours when Resident #1 was found to have a bruise to her left eye on 05/05/20. Findings included: Record review of Resident #1's Minimum Data Set (MDS) annual assessment, dated 03/05/20 revealed that the resident was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment revealed that the resident was sometimes understood and her cognitive skills for decision making were severely impaired. Record review of Resident #1's care plan dated 12/02/19 revealed the resident was at risk for falls due to balance problems, [MEDICAL CONDITION] and [MEDICAL CONDITION]. Observation of Resident #1 on 05/07/20 at 10:50 AM, revealed the resident had a large bruise to her left eye. Record review of Resident #1's nurses' note dated 05/05/20 at 7:18 AM by LVN A revealed that Resident #1 was observed at approximately 5:30 AM, getting out of bed and crawling on the floor of room. Resident non combative and has no signs of pain or discomfort. Resident continued to get out of bed and crawl around on the floor. Will continue to monitor. Record review of Resident #1's nurses' notes for 05/05/20-05/07/20 revealed no documentation related to Resident #1's facial bruising. Interview with LVN A on 05/07/20 at 2:00 PM, revealed on 05/05/20 Resident #1 was initially observed getting on the floor and was assisted back to bed. She stated about ten minutes later Resident #1's roommate came to her stating Resident #1 was crawling on the floor again. LVN A stated Resident #1 did not have any visible injuries at that time. She stated she reported the incident to LVN C and the ADON on 05/05/20. Interview

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) with CNA D on 05/07/20 at 4:02 PM, revealed after dinner on 05/05/20 she notified LVN B that Resident #1 had facial bruising by her left eye. CNA D stated Resident #1 did not have any facial bruising on 05/04/20. Interview with LVN B on 05/07/20 at 3:30 PM revealed she learned of Resident #1's bruise from CNA D on 05/05/20 around 4:00 PM. LVN B stated, she failed to document the bruising or follow up on the injury due to an emergency involving another resident. She stated she notified LVN A of the bruising at shift change on the evening of 05/05/20. Interview with LVN C on 05/07/20 at 10:59 AM revealed she was given verbal report of Resident #1 crawling on the floor that night. She stated she learned of the bruise from LVN B, and stated it was considered a delayed injury. She stated she did not know if Resident #1's family and doctor were notified, as she could not find documentation or an incident report for the accident. Interview with the ADON on 05/07/20 at 11:23 AM revealed she was unaware of why Resident #1's representative and physician were not notified nor could she locate an incident report. She stated she would make the necessary contacts and in-service staff. Interview with the DON on 05/07/20 at 2:57 PM revealed an incident report was not completed on 05/05/20. She stated she spoke with LVN A on 05/05/20 about the incident and it was explained to her that the incident was witnessed without any injury. She stated she discovered from LVN A that there was a second unwitnessed incident where Resident #1 got out of bed again and began crawling on the floor. She stated herself and the Administrator were notified on 05/07/20 of the bruise to Resident #1's eye. She stated she began an investigation and found out that LVN B was the first to discover the bruise. She stated she called in LVN A on 05/07/20 to complete the incident report and in-services on falls and reporting. She stated the second incident should have been considered an unwitnessed fall, an incident report should have been filled out and appropriate parties, including the State Agency, should have been notified. Review of the facility's current Abuse, Neglect, Misappropriation, Exploitation Policy, dated January 2019, reflected: Purpose .to ensure reporting and investigation of alleged violations (to include injuries of unknown source) in accordance with Federal and State Laws . 7. Reporting/Response Immediately reporting all violations to the administrator, designee, state agency, adult protective services and to all other required agencies within specified time frames.