STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455523	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MORNINGSIDE MANOR	**602 BABCOCK RD SAN ANTONIO, TX 78201**

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its written policies and procedures that prohibit and prevent abuse and neglect for 1 of 1 Resident (Resident #1) reviewed, in that: The facility did not follow written policies and report an allegation of abuse to HHSC for Resident #1 within the required 2-hour time frame. This failure could affect residents who resided in the facility and could result in further resident abuse and neglect. The findings were: Record review of the facility's policy titled I-14-005 Abuse Investigations, I - 14 - 006 Abuse Prevention Program, I - 14 - 013 Reporting Abuse to Facility Management dated 08/2016 revealed Employee who has reasonable cause to believe that a resident is in a state of abuse, neglect, or exploitation must report the abuse, neglect, or exploitation to the Department Director or Administrator immediately. The Department Director must then report the matter to the Administrator or Director of Nursing, who in turn will follow Texas Department of Aging and Disability Services guidelines. Record review of Long-Term Care Regulatory Provider Letter Number: PL 19-17 (Replaces PL 17-18) Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC) date issued 07/10/2019 revealed 2.1 Incidents that a NF must report to HHSC and the time frame for reporting: abuse (with or without serious bodily injury) report immediately, but not later than two hour after the incident occurs or is suspected. Record review of Resident #1's Admission Record dated 7/2/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's timeline provided by the Administrator revealed June 30, 2020 at 4 PM. Community Liaison called (the Administrator) stating Social Worker (at the hospital) reported daughter stated (Resident #1) was alleging inappropriate touching and potential sexual abuse and Resident #1 would not be returning to facility. The Social Worker at the hospital was going to report the concern to the State. In an interview on 7/02/2020 at 8:01 AM the Administrator confirmed the clinical liaison informed him on Tuesday (6/30/2020) that a case manager at the hospital told the clinical liaison that Resident #1 would not return to the facility because Resident #1 told her family member, and then Resident #1's family member told the social worker at the hospital that a male staff who drew Resident #1's blood made Resident #1 touch his genital. Further interview on 07/02/2020 at 8:08 AM with the Administrator confirmed he had not called to report the allegation of abuse to HHSC because he did not have enough information, and he was still in process of investigating. In an interview on 7/02/2020 at 6:01 PM with the Administrator confirmed he would follow the HHSC provider letter regarding the timeframe to report an allegation of abuse.
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 that all alleged violations involving abuse or mistreatment were reported immediately to the State Survey Agency, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse for 1 of 1 resident (Resident #1) whose records were reviewed for abuse and neglect. The facility did not report an allegation of abuse involving Resident #1 to HHSC within the required 2-hour time frame. This failure could affect residents who resided in the facility and could result in further resident abuse and neglect. The findings were: Record review of Resident #1's Admission Record dated 7/2/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's timeline provided by the Administrator revealed June 30, 2020 at 4 PM. Community Liaison called (the Administrator) stating Social Worker (at the hospital) reported daughter stated (Resident #1) was alleging inappropriate touching and potential sexual abuse and Resident #1 would not be returning to facility. The Social Worker at the hospital was going to report the concern to the State. In an interview on 7/02/2020 at 8:01 AM the Administrator confirmed the clinical liaison informed him on Tuesday (6/30/2020) that a case manager at the hospital told the clinical liaison that Resident #1 would not return to the facility because Resident #1 told her family member, and then Resident #1's family member told the social worker at the hospital that a male staff who drew Resident #1's blood made Resident #1 touch his genital. Further interview on 07/02/2020 at 8:08 AM the Administrator confirmed he had not called to report the allegation of abuse to HHSC because he did not have enough information, and he was still in process of investigating. Interview on 7/02/2020 at 6:01 PM with the Administrator confirmed he would follow the HHSC provider letter regarding timeframe to report allegation of abuse. Record review of the facility's policy titled I-14-005 Abuse Investigations, I - 14 - 006 Abuse Prevention Program, I - 14 - 013 Reporting Abuse to Facility Management dated 08/2016 revealed Employee who has reasonable cause to believe that a resident is in a state of abuse, neglect, or exploitation must report the abuse, neglect, or exploitation to the Department Director or Administrator immediately. The Department Director must then report the matter to the Administrator or Director of Nursing, who in turn will follow Texas Department of Aging and Disability Services guidelines. Record review of Long-Term Care Regulatory Provider Letter Number: PL 19-17 (Replaces PL 17-18) Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC) date issued 07/10/2019 revealed 2.1 Incidents that a NF must report to HHSC and the time frame for reporting: abuse (with or without serious bodily injury) report immediately, but not later than two hour after the incident occurs or is suspected.

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.