STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	405031	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIMA SAN PABLO CUPEY SNF	**CARR 844 KM 0 5 CUPEY BAJO RIO PIEDRAS, PR 00928**

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** Based on observations of resident initial tour, interviews, and record review, it was determine that the facility failed to orient the resident in relation to their rights to choose when they do not want the food provided by the facility and to have the option to notify the nursing and diet personnel to provided other food that they like and that they meet their nutritional requirements in 1 out of 9 residents (R) #7. Findings include: Dining Observation: 07/08/2020 at 09:00 AM The resident #7 was visit at 9:00 am the food tray was observed over the resident dining table, in the interior of a tray it was observed bread, corn flakes, milk, juice and water. The surveyor ask, are you eating breakfast and she said yes, I am eating coffee, yogurt, cheese and raisins that I have in my reserve. The resident said I don't like this breakfast, in the morning I like hot creams and coffee. The surveyor I asked her if she notified the nursing personnel related to this and she said no. Nursing staff and diet department were notified at 9:10 am about the residents' diet and his/her rights to choose based on their nutrition requirements.
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** Based on a recertification survey, review of ten medical records, resident interview and interview with the facility manager (employee #1) performed from 07/08/2020 thru 07/09/2020, from 8:30 am thru 3:00 pm, it was determined that the facility failed to develop and implement a complete comprehensive person-centered care plan for each resident. This deficient practice was identified in 1 out of 9 active cases reviewed. (RS #6) Findings include: A mechanism to ensure that facility develop and implement a complete comprehensive person-centered care plan who include the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being was not performed, accordingly with the following findings identified during survey procedures performed from 07/08/2020 thru 07/09/2020, from 8:30 am thru 3:00 pm: [AGE] years old female resident admitted on [DATE] with a [DIAGNOSES REDACTED]. During admission initial assessment and accordingly with facility fall risk assessment (Using Morse Fall Scale) resident was identified with high risk to develop a fall. An interdisciplinary team (IDT) plan of care to prevent falls were developed during admission process. However plan of care developed, lack of interventions that could be selected to be included in the plan to promote resident fall prevention.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a recertification survey, review of ten medical records, resident interview and interview with the facility manager (employee #1) performed from 07/08/2020 thru 07/09/2020, from 8:30 am thru 3:00 pm, it was determined that the facility failed to ensure that the comprehensive care plan is reviewed and revised by the interdisciplinary team. This deficient practice was identified in 1 out of 9 active cases reviewed. (RS #6) Findings include: A mechanism to ensure that facility Interdisciplinary team (IDT) members review and revise the complete comprehensive person-centered care plan of care and involved in making decisions about resident's care to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being was not performed, accordingly with the following findings identified during survey procedures performed from 07/08/2020 thru 07/09/2020, from 8:30 am thru 3:00 pm: R #6 an [AGE] years old female resident admitted on [DATE] with a [DIAGNOSES REDACTED]. During admission initial assessment and accordingly with facility fall risk assessment (Using Morse Fall Scale) resident was identified with high risk to develop a fall. An interdisciplinary team (IDT) plan of care to prevent falls were developed during admission process. However plan of care developed, lack of interventions that could be selected to be included in the plan to promote resident fall prevention. On 7/6/2020 at 10:40 am resident felt down to the floor while was in the bathroom hitting the right knee area, despite multiple notifications to ask for help when need to go to the bathroom. MD notified evaluate resident who refers pain on right knee below surgery site. X rays of right knee was taken. After the fall incident on 07/06/2020 facility did not review the plan of care in order to include all interventions included in the plan of care template. No evidence was found documented of the revision of fall prevention plan of care or discussion performed by the IDT members in order to revise activities and planned interventions to prevent falls on this case. On 7/8/2020 at 2:54 am resident felt down to the floor again and hit left forearm and left Humerus. MD notified evaluate resident and X rays of left forearm and left Humerus were taken. After the fall incident on 07/08/2020 facility did not review the plan of care in order to include all interventions included in the plan of care template. No evidence was found documented of the revision of fall prevention plan of care or discussion performed by the IDT members in order to revise activities and planned interventions to prevent recurrence of falls on this case. Facility IDT plan of care policy were review and discussed with the facility manager (employee #1) on 07/09/2020, at 1:45 pm. Facility manager (employee #1) stated on interview on 07/09/2020 at 2:00 pm that facility policy include provisions who indicate that resident's plan of care must be reviewed if any change in condition is evident during the resident stay at the facility. Facility failed to evidence modifications in the interventions and care plan accordingly with resident needs since admission. (Identified with high risk for development of a fall incident and did not activate every intervention (as established in the fall prevention protocol) to avoid falls.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** Based on recertification survey, resident's records reviewed, observations and medication pass, it was determined that the facility failed to ensure that 1 out of 18 residents have all the telephone order sign by the physician in 24 hour as per facility policy and procedure (P&P). (R# 5) Findings includes: On 07/09/2020 at 1:20 pm during the record review and medication reconciliation of resident #5 it was found a telephonic written by the Register Nurse on 07/06/2020 at 7:50 pm and sign by the physician on 07/09/2020 at 8:00 am. As per facility P&P the physician have to sign the telephonic orders in 24 hours. The facility fail to ensure that all telephonic orders are sign by the physician on 24 hours.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.**

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on observations performed on 7/8/20 and 7/9/20 during the survey, it was determined that the facility failed to ensure a safe and functional environment floor level affecting 2 out of 18 admitted residents at rooms (R # 7 and #11). Findings include: 1. Resident # 11 07/08/2020 10:17 AM During performed observations on 7/8/20 at 9:00 am the bathtub curtain protrudes approximately two inches from the floor level, putting the resident at risk of falling during the resident entry and exit of the bathtub. 2. Resident #7 07/09/2020 10:01 AM During observations performed on 7/9/20 at 9:00 am the bathtub curtain protrudes approximately two inches at floor level, which puts the resident at risk of falling during the bath process during entry and exit of the bathtub.