STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676380	A. BUILDING _____ B. WING _____	04/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BIG SPRING CENTER FOR SKILLED CARE	3701 WASSON RD BIG SPRING, TX 79720

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide adequate supervision to prevent R#1, who was identified with risk for falls from falling in the dining room. This resulted in a [MEDICAL CONDITION]. This failure could place residents with a fall history at risk for additional falls and injuries. The findings were: Record review of R#1 Admission Record indicated she was an [AGE] year-old female who was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Admission Minimum Data Set (MDS) assessment, dated 03/10/20, revealed R#1: -required extensive assistance with two-person physical assist for bed mobility, transfer, dressing, and toilet use, -required limited assistance with one-person physical assist for walking in room and corridor, locomotion on and off the unit, eating and personal hygiene, -was not steady, but able to stabilize without staff assistance when moving from seated to standing position, walking, turning around and facing the opposite direction while walking, and moving on and off the toilet -used a wheelchair -triggered [MEDICAL CONDITION], cognitive loss/dementia, communication, urinary incontinence in the indwelling catheter, psychosocial well-being, activities, falls, nutritional status, dental care, pressure ulcer/injury, and pain. Record review of R#1's Care Plan, initiated 03/11/19, revealed: -she had a fall, the interventions included notifying the charge nurse for increased weakness, attempting to transfer self, potential hazards in room, agitation, non-compliance calling for assistance; -she is at risk for wandering, the interventions included assess for fall risk, distract her form wandering by offering pleasant diversions, structured activities, food, conversation, television, book, identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. If R#1 is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc. -Activities of Daily Living (ADL) indicated she required one staff when eating and walking. Record review of R#1's Fall Risk assessment dated [DATE] revealed R#1 was disoriented times 3 at all times, had 1 - 2 falls in the past 2 to 3 months, and required use of assistive devices (cane, wheelchair, walker, furniture). Record review of R#1's Fall Risk assessment dated [DATE] revealed R#1 had intermittent confusion, had 1 - 2 falls in the past 2 to 3 months, had balance problem while standing and walking, decreased muscular coordination, and required use of assistive devices (cane, wheelchair, walker, furniture). Record review of Even Nurses-Note 12 hr. Fall dated 03/05/20 indicated R#1 stood up from wheelchair and attempted to ambulate without assistance and lost her balance and fell on to her left side R#1sustained a skin tear or laceration to left finger approximately 1cm and was bleeding. At the time of this incident, R#1 required 1 staff assist when walking, had unsteady gait, balance problem, and lack of mobility strength. This report indicated R#1's cognition/behavior included cognitive impairment, wanders daily, and required cueing. Fall Nurses-Note 12 hr. dated 03/06/20 and include intervention for 03/05/20 fall was for a low bed. Record review of Weekly Nurses Summary dated 03/06/20 indicated R#1 used a wheelchair and required oversight, encouragement, cueing, and resident nor chair is touched by staff. Report indicated R#1 had dementia and was severely impaired, she does not ask for help when needed, aware of need for device (cane, walker, wheelchair) but does not use it, rarely/never makes decisions, and needs verbal and/or physical cues to complete task. This report indicated R#1 displayed wandering behavior daily, mode of locomotion was a wheelchair, and mode of transfer was with staff assist. Record review of R#1's Fall Risk assessment dated [DATE] revealed R#1 was disoriented times 3 at all times, had 3 or more falls in the past 3 months, was wheelchair bound, had balance problem while standing and walking, decreased muscular coordination, change in gait pattern when walking through doorway, and required use of assistive devices (cane, wheelchair, walker, furniture). Record review of Even Nurses-Note 12 hr. Fall dated 03/11/20 indicated R#1 rolled herself onto the floor, on her back, as witnessed by CNA and nurse. Order for x-ray revealed R#1 did not sustain an injury. At the time of this incident, R#1 required 1 staff assist when transferring and walking, she had unsteady gait, balance problem, and lack of mobility strength. This report indicated R#1's cognition/behavior included cognitive impairment, refuses to call for assistance, wanders, required cueing, and is restless. Record review of Weekly Nurses Summary dated 03/13/20 indicated R#1 used a wheelchair and required oversight, encouragement, cueing, and resident nor chair is touched by staff. Report indicated R#1 has dementia and was severely impaired, does not ask for help when needed, aware of need for device (cane, walker, wheelchair) but does not use it, rarely/never makes decisions, needs verbal and physical cues to complete tasks. This report indicated R#1 displayed wandering behavior daily, mode of locomotion was a wheelchair, and mode of transfer was with staff assist. Record review of Weekly Nurses Summary dated 03/20/20 indicated R#1 used a wheelchair and required oversight, encouragement, cueing, and resident nor chair is touched by staff. Report indicated R#1 has dementia and was severely impaired, does not ask for help when needed, aware of need for device (cane, walker, wheelchair) but does not use it, rarely/never makes decisions, needs verbal and physical cues to complete tasks. This report indicated R#1 displayed wandering behavior daily, mode of locomotion was a wheelchair, and mode of transfer was with staff assist. Record review of Weekly Nurses Summary dated 04/07/20 indicated R#1 used a wheelchair and staff pushed the chair, but resident helps some. Report indicated R#1 has dementia and was severely impaired, does not ask for help when needed, aware of need for device (cane, walker, wheelchair) but does not use it, rarely/never makes decisions, needs verbal and physical cues to complete tasks. This report indicated R#1 displayed wandering behavior daily, mode of locomotion was a wheelchair and able to wheel self and wheeled by others, and mode of transfer was with staff assist. Record review of R#1's 04/13/20 Nursing Progress Report dated 04/13/20 at 7:45 PM R#1 had fallen in the dining room. R#2 who is alert witnessed R#1 walking approximately 15 feet from wheelchair and fell lying on her left sider per ADON. R#1 complained of left shoulder and hip pain. At 8:05 PM R#1 was transferred to a hospital due to falling out of wheelchair while in the dining area. Record review of R#1's eTransfer Form dated 04/13/20 indicated R#1 fell out of her wheelchair while in the dining room. R#1 fell on her left side and complained of left hip and shoulder pain. This report indicated R#1 does not walk, was full weight bearing, was at risk of falls, and utilized a wheelchair. Record review of R#1's hospital's History and Physical dated 04/14/20 indicated she had severe dementia, is wheelchair bound, and oriented to self only. R#1 presented to emergency room for pain of the left hip after a fall. R#1's facility nurse reported R#1 was by herself in the dining area and an oriented resident (R#2) witnessed R#1 leave her wheelchair, walk across the dining room about 15 feet, and falling to the floor. In addition, nurse reported R#1 is wheelchair-bound, and has had bilateral hip replacements in the past. R#1 was transferred to another hospital due to finding on x-ray a nondisplaced left femur fracture. Observation on 04/17/20 at 6 PM of facility's video revealed on 04/13/20 at 7:36 Resident (R#1) was sitting at the dining table with Certified Nurse Aide (CNA#1). CNA#1 assisted R#1 by feeding her a spoonful of food and then got up from the dining table and left the dining room. This left R#1, who was in her wheelchair, by herself as she continued to eat her meal. In addition, R#2, R#3 and R#4 remained in the dining room without any staff present in the dining area. Afterwards, the video's timer revealed at

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) 19:36:56 R#1 stood up and walked away from her wheelchair approximately 4 feet while holding onto the dining table; she turned around and released the table; she attempted to walk away when she lost her balance and fell on to the floor at 19:37:46; at 19:37:59 R#2, who was in her wheelchair, wheeled himself from the dining table towards the nurses' station, and at 19:38:08 ADON#1 and CNA#1 responded by entering dining area and going towards R#1, after R#3 pointed them towards R#1, who was on the floor. Interview on 04/17/20 at 6:20 PM was attempted with Resident #1(R#1), but she did not respond to questions asked of her. Interview on 04/17/20 at 3:37 PM with Resident (R#2) indicated on Monday (04/13/20) he was in the dining room eating his meal, when he saw R#1 walking and then falling to the floor. R#2 added that R#1 fell on her shoulder hard, and he had to go to nurses' station to ask for help because there were no staff in the dining area. R#2 recalled residents, R#3 and R#4 were the other residents in the dining area, and they also asked for help when R#1 fell . R#1 indicated there was nobody in the dining area to stop R#1 from getting up from her chair or from walking. Interview on 04/17/20 at 6:40 PM resident (R#3) recalled he was in the dining room talking to R#4, when R#1 fell on the floor. R#2 indicated there were no staff in the dining area so he [MEDICATION NAME] to alert staff, and when staff entered the dining area he pointed to R#1, who was lying on the floor. Interview 04/17/20 at 7:09 PM Licensed Vocational Nurse (LVN#1) indicated on 04/13/20, when resident (R#1) was found on the floor, she was conducting a blood sugar test at the end of hall 1, specifically room [ROOM NUMBER]. LVN#1 was informed by unknown Certified Nurse Aide (CNA#1) that R#1 was on the dining room floor. LVN#1 went into the dining room and found R#1 on the floor, while as other staff were assisting her, this is when LVN#1 attempted to turn R#1 but stopped after she reported being in pain. Afterwards, LVN#1 called 911; Emergency Medical Service (EMS) responded and assessed R#1; removed her from the floor and transported her to the hospital. LVN#1 indicated Assistant Director of Nurses (ADON #1) informed her R#2 witnessed R#1 walk away from her chair a few feet before falling to the floor. LVN#1 indicated all the CNAs on duty were not working the floors because they were called to a meeting, therefore, they were unable to care for residents. Interview on 04/20/20 at 4:36 PM with Certified Nurse Aide (CNA#2) indicated on 04/13/20 she and the other CNAs were informed over the facility's intercom to go to Administrator's office for a meeting. After this meeting CNA#2 exited the meeting and was walking towards the nurses' station, when she heard R#1 call out for help from the dining area. CNA#2 indicated she and ADON#1 entered the dining room and found R#1 on the dining room floor. CNA#2 placed a pillow under R#1's head as she reported being in pain. CNA#2 indicated as far as she knew R#1 could be left alone and was not sure why she stood up and walked away from her wheelchair, because she had not seen her do that before. CNA#2 indicated R#1m while in her wheelchair, would be placed by the nurses' station because she would refuse to stay in her room. Interview on 04/17/20 at 10:15 AM CNA#3 indicated 0n 04/13 20 she assisted Resident (R#1) with her evening meal in the dining room. CNA#3 indicated R#1 took a few bites, and then she fed her spoonsful of food, until she heard over the intercom a request for all CNAs to report to Administrator's office. CNA#3 indicated she left R#1 by herself at the dining table as she continued to eat her meal. CNA#3 revealed all the CNAs attended a meeting called by the Administrator in his office with the DON, which left ADON#1 and LVN#1 to care for the residents. Interviews on 04/17/20 with Certified Nurse Aides (CNA#3 at 10:15 PM, CNA#5 at 10:40 PM, #6 at 10:34 PM, CNA#7 at 10:46 PM, and CNA#8 on 04/20/20 at 4:21 PM) indicated they were not caring for residents on 04/13/20, when R#1 fell on the dining room floor and broke her femur, because the Administrator requested all CNAs attend a meeting he held in his office with the Director of Nurses (DON). Interview on 04/20/20 at 1 PM with Director of Nurses (DON) indicated Resident (R#1's) first fall in the facility was on 03/05/20, this fall was followed with a mobile x-ray revealing no injury; however, responsible party wanted her sent to the hospital for an x-ray, where the hospital x-ray confirmed she did not have an injury. Afterwards, R#1 continued to complain of pain and an order was received for physical therapy, which was implemented but discontinued after R#1 failed to make progress. DON indicated on 04/13/20 Mrs. Allen was in the dining area, when she got up and walked away from her wheelchair and fell sustaining a fracture to her femur. DON indicated when R#1 fell the CNAs were in a meeting called by Administrator, which she attended as well. DON indicated there was not a signature sheet for this meeting because it was a verbal discussion reminding CNAs to make sure they were conducting 2 hours rounds on the residents. Interview on 04/20/20 at 2:40 PM with facility's Medical Director (MD) indicated Resident (R#1) is an [AGE] year-old female with [DIAGNOSES REDACTED]. MD indicated on 04/13/20 R#1 fell and sustained a fracture to her femur. R#1 was sent to the local hospital and then transported to another hospital for surgeon to evaluate and pursue surgery; however, surgeon decline to perform surgery due to R#1's age and her medical condition. MD indicated R#1 should not have been left unsupervised in the dining area, because even if she is directed not to get up she will get up; however, if staff were in the area they could intervene by assisting her. Administrator confirmed, when resident R#1 fell and broke her femur in the dining area, there were no staff present in the dining room as seen on the facility's video. Review of Facility's policy to Preventive Strategies to Reduce Fall Risk with revision dated of 10/05/16 indicated The goal of fall prevention strategies is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the resident's mobility. This policy included nursing care for Place confused residents close to nurses' station for close observation, if possible. Establish frequent nursing rounds on high risk residents. Provide assistive ambulation. Encourage daily exercise. Increase nursing staff.