STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F199	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEMORIAL NURSING AND REHABILITATION CENTER	**224 E 2ND ST DUMAS, TX 79029**

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 develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 1 resident (Resident #1) reviewed. The facility failed implement their written policies and procedures that prohibit and prevent abuse in that the facility failed to report an allegation of neglect involving Resident #1 to the State Survey Agency within 2 hours of the allegation being made. This failure could affect residents by placing them at risk of not having incidents of abuse, neglect, exploitation, and misappropriation of resident property being reviewed and investigated in a timely manner by the facility and State Survey Agency. The Findings Include: Record review of an undated document provided by the facility titled Reporting Procedure to the Texas Department of Aging and Disability Services included: The following procedure will be followed for any incident that has to be reported to the Department of Aging and Disability Services in Austin, Texas: 1) The facility must report incidents to the Consumer Rights and Service Sections, Department of Aging and Disability State Office Immediately (within 24 hours) upon learning of the incident and send a written investigation report to the Consumer Rights and Services Section no later the 5th working day after the oral report. Record review of Resident #1's clinical records revealed a [AGE] year-old female admitted to the facility 01/19/17. Her [DIAGNOSES REDACTED]. Record review of her Quarterly MDS dated [DATE] revealed a BIMS score is 02 out of 15, indicating severe cognitive impairment. Record review of Resident #1's Quarterly MDS section G dated 06/25/20 revealed she is a one-person assist with locomotion. Record review of Provider Investigation Report revealed that on 07/23/20 CNA A was going help Resident #1 in her wheelchair to her room. CNA A told Resident #1 to lift her feet up. When CNA A started pushing resident, her feet went down, and Resident #1 fell forward out of the wheelchair. It was revealed that on 07/24/20 that Resident #1 had a broken femur. Resident #1 had surgery on 07/27/20 and this is when the allegation was reported to the State Office on 07/29/20. During an interview on 08/12/20 at 12:04PM, CNA A stated that she was going to take Resident #1 to her room from the nurse's station. CNA A stated she asked Resident #1 to put her legs up and when she started to push her, the resident's feet went down, and she fell out of the wheelchair. CNA A stated she got help and put her in her wheelchair. CNA A stated the ADON was present during the incident. During an interview on 08/12/20 at 12:30PM, ADON stated that she heard CNA A tell Resident #1 to pick up her feet and then heard staff say, we need help. ADON stated that CNA A told her what happened. ADON did assessment on Resident #1 and she was not having any pain with movements. ADON stated the following morning, Resident #1was at nurse's station and eating her breakfast when she said her knee was hurting and when ADON touched her left leg, Resident #1 would scream. They called the hospitalist for x-rays and within 10 minutes he saw her. She stated that fall happened on 24th and on the 25th Resident #1 said it hurt and x-ray confirmed her femur was broken. Resident #1 had surgery a few days later. During an interview on 08/12/20 at 1:51PM, ADM stated the protocol on reporting is within 2 hours or 24 hours. When asked about the incident, he said he must have missed this one. He confirmed that it should have been reported within the time frame.
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, it was determined the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 24 hours if the events that caused 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) after the allegation was made in accordance with State law for 1 of 1 residents (Resident #1) reviewed. The facility failed to report an allegation of neglect involving Resident #1 to the State Survey Agency within 2 hours of the allegation being made. This failure could affect residents by placing them at risk of not having incidents of abuse, neglect, exploitation, and misappropriation of resident property being reviewed and investigated in a timely manner by the facility and State Survey Agency. The Findings Include: Record review of Resident #1's clinical records revealed a [AGE] year-old female admitted to the facility 01/19/17. Her [DIAGNOSES REDACTED]. Record review of her Quarterly MDS dated [DATE] revealed a BIMS score is 02 out of 15, indicating severe cognitive impairment. Record review of Resident #1's Quarterly MDS section G dated 06/25/20 revealed she is a one-person assist with locomotion. Record review of Provider Investigation Report revealed that on 07/23/20 CNA A was going help Resident #1 in her wheelchair to her room. CNA A told Resident #1 to lift her feet up. When CNA A started pushing resident, her feet went down, and Resident #1 fell forward out of the wheelchair. It was revealed that on 07/24/20 that Resident #1 had a broken femur. Resident #1 had surgery on 07/27/20 and this is when the allegation was reported to the State Office on 07/29/20. During an interview on 08/12/20 at 12:04PM, CNA A stated that she was going to take Resident #1 to her room from the nurse's station. CNA A stated she asked Resident #1 to put her legs up and when she started to push her, the resident's feet went down, and she fell out of the wheelchair. CNA A stated she got help and put her in her wheelchair. CNA A stated the ADON was present during the incident. During an interview on 08/12/20 at 12:30PM, ADON stated that she heard CNA A tell Resident #1 to pick up her feet and then heard staff say, we need help. ADON stated that CNA A told her what happened. ADON did assessment on Resident #1 and she was not having any pain with movements. ADON stated that the following morning, Resident #1was at nurse's station and eating her breakfast when she said her knee was hurting and when ADON touched her left leg, Resident #1 would scream. They called the hospitalist for x-rays and within 10 minutes he saw her. She stated that fall happened on 24th and on the 25th Resident #1 said it hurt and x-ray confirmed her femur was broken. Resident #1 had surgery a few days later. During an interview on 08/12/20 at 1:51PM, ADM stated the protocol on reporting is within 2 hours or 24 hours. When asked about the incident, he said he must have missed this one. He confirmed that it should have been reported within the time frame. Record review of an undated document provided by the facility titled Reporting Procedure to the Texas Department of Aging and Disability Services included: The following procedure will be followed for any incident that has to be reported to the Department of Aging and Disability Services in Austin, Texas: 1) The facility must report incidents to the Consumer Rights and Service Sections, Department of Aging and Disability State Office Immediately (within 24 hours) upon learning of the incident and send a written investigation report to the Consumer Rights and Services Section no later the 5th working day after the oral report.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and

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) transmission of communicable diseases and infections for 2 of 4 common areas (Recreation area and South Hall) reviewed for infection control. CNA A failed to always wear a face mask in the facility as mandated during the COVID-19 Pandemic while assisting residents in the recreation area. MA B failed to always wear a face mask in the facility as mandated during the COVID-19 Pandemic while in the south hall. This failure has the potential to affect residents by placing them at an increased and unnecessary risk of exposure to communicable diseases and infections, particularly COVID-19. Findings include: During an observation on 08/12/20 at 11:20AM, CNA A was assisting residents in the recreation area and her face mask was only covering her mouth and her nose was outside the mask. CNA A was in close proximity to resident's face assisting with resident positioning. During an interview on 08/12/20 at 11:22AM, CNA A said her mask had slipped down. When asked about infection control and PPE training, she said they had one yesterday. CNA A confirmed that she knew she needed to have her mask over her nose and mouth. During an interview on 08/12/20 at 1:25PM, DON stated that staff should be wearing PPE properly, being fully covering their mouth and nose. During an interview on 08/12/20 at 1:55PM, ADM stated staff are required to wear masks properly and masks are always to be worn around residents. When asked about their policy and procedure, he stated that they follow the CDC guidelines. During an observation on 08/12/20 at 3:20PM, MA B was in south hall by medication cart speaking with another staff member with her face mask only covering her mouth and her nose was outside the masks. During an interview on 08/12/20 at 3:32PM, MA B said that it slips off her nose. When asked if she had training on proper wearing of masks, she stated yes. Record review of facility's undated CDC handout titled Sequence for putting on personal protective equipment indicted: 2. MASK OR RESPIRATOR Secure ties or elastic bands at middle of head and neck Fit flexible band to nose bridge Fit snug to face and below chin Fit-check respirator Record review of Executive Order GA 29, dated 7-2-2020, reflected in part: NOW, THEREFORE, I, Greg Abbott, Governor of Texas, by virtue of the power and authority vested in me by the Constitution and laws of the State of Texas, do hereby order the following on a statewide basis effective at 12:01 p.m. on July 3, 2020: Every person in Texas shall wear a face covering over the nose and mouth when inside a commercial entity or other building or space open to the public, or when in an outdoor public space, wherever it is not feasible to maintain six feet of social distancing from another person not in the same household; Record review of Nursing Facility COVID-19 Response Emergency Rule, not dated, reflected in part: (k) All nursing facility staff must wear facemasks while in the facility. (m) If an executive order or other direction is issued by the Governor of Texas, the President of the United States, or another applicable authority, that is more restrictive than this rule or any minimum standard relating to a nursing facility, the nursing facility must comply with the executive order or other direction. Although requested, no policies related to wearing face mask were provided.