STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675346	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE OAKS NURSING AND REHABILITATION CENTER	5301 UNIVERSITY AVE LUBBOCK, TX 79413

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, and record review the facility failed to immediately inform the resident; consult with the resident's physician, and notify, consistent with his or her authority the resident's representative of a significant change in the resident's physical, mental or psychosocial status for 1 of 5 residents (Resident #1), reviewed for change in condition notifications made. The facility failed to promptly notify resident #1's physician of new wounds and request treatment orders. The facility did not implement interventions to prevent the potential failure to report significant changes in the resident's physical, mental or psychological status for the residents. 1) The facility failed to notify the physician about a change in condition for resident #1. The findings included: During an interview on 7/12/20 at 2:35 PM, LVN 1 stated she had worked on 7/11/20 from 6 AM-10 PM and worked with Resident #1. LVN #1 stated she went in to Resident #1's room shortly after her shift started at 6 AM to obtain a blood sugar from Resident #1's left hand and noticed the pinky side of Resident #1's hand was discolored red in color and small blisters on her hand, palm and some fingers. LVN #1 stated she kept an eye on it, then around 11:30 AM she went in the room to check on Resident #1's hand and the blisters were getting bigger and bigger. LVN #1 stated she applied some moister barrier to Resident #1's hand. LVN #1 stated around 2:00 PM she went back to Resident #1's room to check on her and at the time there were no changes in her hand and she continued to monitor Resident #1. LVN #1 stated around 8:00 PM she returned to check on Resident #1's hand and at that time LVN #1 stated she went and got RN #1 to come and look at Resident #1's hand. LVN #1 stated RN #1 advised her to call the physician on call. LVN #1 stated she then used the Third Eye Tele-Health system to video call the physician on call. LVN #1 stated during the video call around 8:00 PM the physician stated to send Resident #1 to the hospital. LVN #1 stated she did not call the physician when she first noticed Resident #1 had a change in her condition because she wanted to get a baseline and monitor for changes. During an interview on 7/12/20 at 1:05 PM, RN #1 stated she was notified on 7/11/20 around 8:00 PM by LVN #1 that Resident #1 had some discoloration and blisters to her left hand. RN #1 stated LVN #1 asked if she had noticed any changes to Resident#1's hand on 7/10/20 when she had worked with Resident #1. RN #1 stated Resident #1 did not have any discoloration to her hand or blisters on 7/10/20. RN #1 stated LVN #1 told her when she came to work on 7/11/20 at 6:00 AM she noticed discoloration and small blisters to Resident #1's hand and had monitored Resident#1's hand throughout LVN #1's shift. RN # stated LVN #1 asked her to come and look at Resident #1's hand around 8:00 PM and she did. RN #1 stated she advised LVN #1 to call the physician on call when she saw Resident #1's hand. Record review of face sheet for Resident #1 documented the following: Resident #1 was admitted to the facility on [DATE] with the following nontraumatic subarachnoid hemorrhage, cerebral aneurysm non-ruptured, type II diabetes, acute [MEDICAL CONDITION], need for personal care, lack of coordination, and functional [MEDICAL CONDITION]. Record review of progress notes for Resident #1 documented the following by LVN #1: 7/11/20 at 6:07 AM, on doing resident blood sugar noticed the resident hand palm had blisters and the blister was blue in color resident does not exhibit any sign of pain the hand is warm to touch. 7/11/20 at 8:45 PM, received order from Medical Provider to transfer resident to : Hospital emergency room (ER) (Name of Hospital) University Medical Center (UMC), Transfer order obtained from: Tele-Health Physician. Transfer order entered in resident record: Yes, primary reason for transfer: resident have blister on left hand. Responsible party notified of transfer: yes Time notified 7/11/20 8:28 PM, Transportation notified of transport, Ambulance Service, Report called to Hospital, yes ER, documents sent to ER medication list, continuity of care document, face sheet, resident left facility at 7/11/20 8:46 PM. 7/11/20 9:53 PM, recorded as late entry 7/12/20 at 10:53 AM: Monitoring the resident during the shift the blister were getting big and bigger and the pinky finger was turning blue. Notified the Third Eye doctor and he stated it looks like a second degree burn and to send resident to the hospital for further evaluation. Resident is a total assist with ADL's and feedings. No heating pad or anything that could cause a burn. Notified a family member about transporting resident to the hospital, notified the DON, transported via ambulance to ER. Record review of Third Eye Health progress notes documented service date and time as 7/11/202 at 8:07 PM, by LVN #1 documented the following: Resident #1, complaint as skin, blisters, orders to transfer to hospital ER for evaluation and treatment, minutes spent on interaction with facility from request received to last point of contact 20 minutes. Record review of Employee Memorandum for LVN #1 documented the following: Type of action taken: Suspension State subject of code of conduct rule violated: not calling physician in a timely manner. Describe in detail information you have available which supports taking the above course of action. State the action that will be taken if the problem persists: Resident #1 had blisters to hand at 6 AM called doctor until later in the day. Record review of facility policy Change in a Resident's Condition or Status dated Revised May 2017: Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of any changes in the residents medical/mental condition and/or status (e.g., changes in level of care, billing/payments resident rights, etc.). Policy Interpretation and Implementation 1. B. discovery of injuries of an unknown source. 4. A. The resident is involved in any accident or incident that results in any injury including injuries of an unknown source; B. There is a significant change in the resident's physical, mental or psychosocial status.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE