STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676398	A. BUILDING _____ B. WING _____	**05/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOX HOLLOW POST ACUTE	**310 AMERICA DRIVE BROWNSVILLE, TX 78526**

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, record review, and interview, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents, for one resident (R#2) of eight residents reviewed for falls. The facility did not provide the type and amount of supervision necessary to prevent R#2 from falling seven times in less than six months. This failure could place residents with a history of falls at risk for additional falls and injuries. The findings were: Record review of R#2's Admission Record, dated 04/29/20, revealed R#2 was admitted to the facility on [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's Minimum Data Set (MDS) assessment, dated 01/31/20, revealed R#2: -had unclear speech -was usually understood by others, -was usually able to understand others, -had adequate vision, -did not use corrective lenses, -had severely impaired cognition, -exhibited no behavioral symptoms, -required extensive assistance of two persons in bed mobility, transfers, locomotion on unit, dressing, toilet use, and personal hygiene, -required extensive assistance of one person for eating, and -required total assistance with locomotion off unit. 1) Record review of R#2's incident reports revealed: Un-witnessed #435, dated 12/11/19, revealed R#2 was found on the floor between the bed and the wall, resident was lying in a fetal position on the floor mat. R#2 sustained no injuries. Record review of R#2's Care Plans revealed: 12/11/19: Focus: (R#2) was observed on floor on 12/11/2019 with no injuries. Interventions/Tasks: Concave mattress added, ensure that the resident is properly positioned on bed when in room, Neuro checks x72 HRS, x-rays taken (negative). 2) Record review of R#2's incident reports revealed: Un-witnessed #441, dated 12/14/19, R#2 was found lying on the left side, head at the foot of the bed on floor mat between his bed and roommate's bed. R#2 sustained an abrasion to his left elbow and a laceration to his left eyebrow. Record review of R#2's Care Plans revealed: 12/14/19: Focus: (R#2) had an actual fall on 12/14/19 with laceration to top of left eyebrow. Interventions/Tasks: I have bilateral floor mats when in bed, keep call light within reach when I am in my room, monitor and tx laceration daily, monitoring for infection q shift, restorative nursing as warranted. 3) Record review of R#2's incident reports revealed: Un-witnessed #455, dated 12/24/19, R#2 was observed in his room lying on his back on the floor mat. R#2 sustained no injuries. Record review of R#2's Care Plans revealed: 12/24/19: Focus: (R#2) was observed laying on floor mat on 12/24/2019 with no injuries. Interventions/Tasks: Check range of motion S/P fall, Labs and U/A ordered, medication for anxiety added by MD, Neuro checks x72HRS. 4) Record review of R#2's incident reports revealed: Other #491, dated 01/28/20, R#2 was found on the floor in his room with blood to his legs and brief area. Foley catheter was found on top of the bed intact. R#2 sustained no injuries. Record review of R#2's Care Plans revealed: 01/28/20: Focus: (R#2) was observed on floor on 1/28/20 with no injury. Interventions/Tasks: call light within reach, foley cath changed and checked for any blood (negative) pt/ot to eval and tx, staff to redirect, x-rays. 5) Record review of R#2's incident reports revealed: Un-witnessed #527, dated 03/13/20, R#2 found in the bistro area on his left side after attempting to self-transfer. R#2 sustained no injuries. Record review of R#2's Care Plans revealed: 03/13/20: Focus: (R#2) was observed on floor after attempting to self-transfer from w/c in bistro with no injuries on 3/13/20. Interventions/Tasks: continue with restorative, neuro checks x72hrs, pt/ot to eval and tx, staff to recenter when observed off center on w/c. 6) Record review of R#2's incident reports revealed: Un-witnessed #548, dated 04/09/20, R#2 found on the floor in his room on top of the bed side mat on his left side. R#2 sustained no injuries. Record review of R#2's Care Plans revealed: 04/09/20: Focus: (R#2) was found on floor on top of mat on his rt side 4/9/20, d/t self-transfer attempt. Interventions/Tasks: labs, pt/ot to eval and tx, staff to redirect when observed self-transferring and to reposition in bed when off centered. 7) Record review of R#2's incident reports revealed: Un-witnessed #562, dated 04/27/20, R#2 found on the floor in the mini bistro area on his left side. R#2 sustained injuries to his right scapula and the back of the head. Record review of R#2's Care Plans revealed: 04/27/20: Focus: (R#2) fell in bistro after self-ambulating hitting head and sent to ER for evaluation 04/27/20. Interventions/Tasks: bed to lowest position and call bell in reach, sent to ER to eval and tx. Observation on 04/30/20 at 12:41 p.m. revealed floor mats on both sides of R#2's bed. R#2 was in the hospital. Further observations revealed the bistro area, where the 04/27/20 incident occurred, was located directly in front of the nurse's station. There were no residents in the area at the time of the observation. In an interview on 05/01/20 at 11:58 a.m., LVN G said she was the nurse working the day R#2 had the fall in the bistro area, in front of the nurse's station. LVN G said she had just gotten to the nurse's station to sit down and chart when she heard a loud noise. LVN G said she looked over at the bistro area and saw R#2 on the floor. LVN G said R#2 could stand up from his wheelchair but his posture was crouched over and, if he took any steps, he would fall. LVN G said R#2 was not steady on his feet. LVN G said R#2 was put in the bistro area because he was attempting to get out of bed. LVN G said, since the bistro area was a high traffic area, it was likely that more people could see R#2 if he attempted to get up. LVN G said she was made aware by CNA I that R#2 was going to be put up in the bistro area when she was out on the floor finishing her rounds. LVN G said she did not witness R#2's fall and there was no one in the area when the fall occurred. LVN G said she had just sat down at the nurse's station to chart when she heard the loud noise. LVN G said she was looking at the computer at the time because she was about to log in. LVN G said she was aware R#2 had a history of [REDACTED]. LVN G said when she assessed R#2 she observed that he had his eyes wide open but sounded like he was snoring for about 20 seconds, and his body made some jerky movements for about 10 seconds before it stopped. LVN G said R#2 did not lose consciousness. LVN G said there were no visible injuries when she and RN H assessed R#2 on the floor. LVN G said RN H and CNA I assisted her in getting R#2 back up to his wheelchair. LVN G said she and RN H continued to assess R#2 in the wheelchair and observed a raised area on the back of R#2's head and a bump to R#2's right scapula area. LVN G said R#2 was assisted back to bed by staff while she called the doctor to report the fall. LVN G said when they put R#2 in bed, R#2 continued to attempt to get out of bed. LVN G said RN H stayed with R#2 until EMS arrived. In an interview on 05/01/20 at 12:38 p.m., CNA J said she and CNA I were the CNAs assigned to hall 400, where R#2 resided on the date of the incident (04/27/20). CNA J said she did not witness R#2's fall. CNA J said she was in a room attending to another resident when the incident occurred. CNA J said CNA I was the person who put R#2 in the bistro area. CNA J said they would put R#2 in the bistro area since there were no activities for him to attend due to the COVID-19 response. CNA J said she observed R#2 being very agitated that day and had made several attempts to get up from the bed unassisted. CNA J said she believed CNA I reported R#2's agitation and self transfer attempts to LVN G, and that was why R#2 was put in the bistro area. CNA J said she did not assist CNA I in getting R#2 out of bed that day. CNA J said CNA I could transfer R#2 by himself and put him in the bistro area. CNA J said R#2 was put in the bistro area because he had tried to get up from his wheel chair on several occasions and, since the bistro was a high traffic area, it was likely that someone would see R#2 if he attempted to get up. In an interview on 05/05/20 at 2:09 p.m., CNA I said he and CNA J were assigned to care for R#2 (on 04/27/20). CNA I said R#2 was put up to his wheelchair in his room during breakfast. CNA I said R#2 had a tendency to

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) attempt to get up from his bed or the wheelchair without assistance and was in bed B in his room (bed farthest from the hallway door). CNA I said he did not like to leave R#2 in his bedroom unsupervised due to this history of attempting to get up unassisted. CNA I said he put R#2 in the bistro area because it was a high traffic area and it was likely that someone would pass by and see R#2 if he was attempting to get up, and redirect him. CNA I said he and CNA J were out on the floor and were not going to be able to keep an eye on R#2. CNA I said he did not recall if R#2 had attempted to get up from the wheelchair or the bed that day. CNA I said he notified LVN G that R#2 was going to be put in the bistro area. CNA I said LVN G was not in the nurse's station at the time he told her, she was in the hall way. CNA I said he did not witness the fall and was not sure if anyone witnessed the fall. In an interview on 05/05/20 at 2:29 p.m., RN H said she was not the nurse who was attending to R#2 on 04/27/20. RN H said she was at the nurse's station at the time of the fall but did not witness the fall. RN H said she was on the computer charting when she saw LVN G and a CNA going to the bistro area. RN H said she stood up and saw R#2 on the floor. RN H said she assisted LVN G in getting R#2 up from the floor after she had assessed him. RN H said, when they took R#2 to his room for further assessment, she observed a bump to the back of R#2's head and reported it to LVN G. RN H said shortly after R#2 was taken to his room, she was called back to her floor and LVN G took over the care of R#2. In an interview on 05/05/20 at 4:50 p.m., DON F said LVN G told her when she came back to the nurse's station, LVN G saw R#2 sitting in his wheelchair, with no signs or symptoms of distress. DON F said when LVN G sat down on the chair, that was when she heard the loud noise and saw R#2 on the floor. DON F said the facility was trying different intervention to try to keep R#2 safe. DON F acknowledged R#2 had multiple falls within the past six months. In an interview on 05/06/20 at 9:46 a.m., the Administrator said the facility had decreased the number of R#2's falls by bringing him up to the bistro area versus leaving R#2 in his room. The Administrator said R#2 had a history of [REDACTED]. The Administrator said R#2 was prone to falling due to dementia. The Administrator said the facility was focusing on preventing any serious injury. No facility policy on accidents/supervision was provided.

F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that nursing staff had the competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, for one Resident (R#1) of eight residents reviewed, in that: LVN A did not document swelling to R#1's lower extremities and treatment provided. This failure could place residents at risk of not receiving adequate services. The findings included: Record review of R#1's Admission record revealed R#1 was 89-years-old and was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Quarterly MDS assessment, dated 04/29/20, revealed R#1: -had unclear speech, -was sometimes understood by others, -was sometimes able to understand others, -had impaired vision with no corrective lenses, -had severely impaired cognition, and -was totally dependent on two staff for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. Record review of R#1's Care Plan, initiated 08/07/18 and revised 05/31/19 revealed R#1 had an ADL/Mobility deficit, was totally dependent, had poor cognition, and used a soft touch call light. Interventions/Tasks: Transfer: The resident requires, total assistance with transfers. (Hoyer Lift Transfer). Date Initiated: 08/07/18. Revision on 08/07/18. On 04/30/20 at 3:00 p.m., surveyor entered R#1's room with the DON and observed R#1 laying on her back in bed with the HOB at 30 degrees. R#1 was resting with eyes closed, with no signs or symptoms of distress or discomfort. The DON uncovered R#1's lower extremities and exposed R#1's feet and legs. Surveyor observed R#1's left foot was wrapped in an ace bandage, with a part of R#1's dorsal foot and toes exposed. Surveyor did not observe swelling to the exposed area of the foot. Surveyor observed multiple dry scabs to R#1's dorsal foot and toes. R#1 did not respond to DON's verbalizations. Record review of R#1's Progress Notes, completed by RN D, dated: 04/21/20 at 12:15 a.m. revealed: Note Text: @ 2107PM (9:07 a.m.) 4/20/20 WAS NOTIFIED BY FLOOR CNAS THAT RESIDENT HAD SWELLING TO LEFT FOOT. THIS NURSE WENT IN TO RESIDENT ROOM AND UPON FURTHER ASSESSMENT, NOTED REDNESS, [MEDICAL CONDITION] TO LEFT FOOT AND LEFT ANKLE AREA. REDNESS TO LEFT ANKLE AREA WITH SLIGHT WARMTH UPON TOUCH. RESIDENT WITH LEFT FOOT CONTRACTURE. RESIDENT WITH ABRASION TO LEFT FOOT SECOND TOE, 3RD TOE, AND 4TH TOES AND ON DORSUM OF FOOT. ASKED RESIDENT IF IN PAIN AND RESIDENT STATED 'SI' (Yes). RESIDENT NOTED WITH FACIAL GRIMACING. PRN TYLENOL GIVEN FOR PAIN RELIEF. RESIDENT UNABLE TO RECALL HOW IT HAPPENED V/S STABLE. B/P 152/5, P73, R18, O2SATS 93% ROOM AIR, T98.4. RESPIRATIONS EVEN AND UNLABORED. NO S/S OF DISTRESS. CAPILLARY REFILL LESS THAN 3 SECONDS. PEDAL PULSE PALPABLE.COMMUNICATED WITH TELEHEATH MD, (Name of Physician) AND NOTIFIED OF NEW FINDINGS. NEW ORDER RECEIVED FOR STAT PORTABLE X-RAY TO LEFT FOOT AND ANKLE. NEW ORDER FOR TX TO ABRASION SITES-CLEANSE WITH NORMAL SALINE, PAT DRY WITH 4X4 GAUZE AND APPLY [MEDICATION NAME] OINTMENT, COVER WITH DRESSING AND WRAP WITH KERLIX. ORDERS CARRIED OUT. RP AWARE OF NEW ORDERS. ON CALL NURSE AND DON NOTIFIED. WOUND CARE TX TO LEFT FOOT PROVIDED. @353AM COMMUNICATED WITH TELEHEALTH MD (Name of Physician) TO REPORT LEFT ANDKLE AND FOOT XRAY RESULTS. IMPRESSION. ACUTE DISPLACED FRACURE OF THE LATERAL MALLEOLUS. OVERLYING SOFT TISSUE [MEDICAL CONDITION] AND SWELLING. ACUTE OBLIQUE MILDLY DISPLACED [MEDICAL CONDITION] TIBIA METADIAPHYSEAL JUNCTION AT ITS DISTAL ASPECT, AS PER MD, SEND RESIDENT OUT TO HOSPITAL TO EVALUATE AND TREAT. MEDCAL DIRECTOR AWARE OF TRANSFER TO HOSPITAL (name of hospital). EMS CONTACTED AND NOTIFIED OF NEED FOR TRANSFER. REPORT GIVEN TO ER. @0503AM RESIDENT LEFT FACILTIY VIA EMS V/S STABLE. UNABLE TO REACH RP X2 PHONE CALL WENT TO VOICEMAIL AND UNABLE TO LEAVE MESSAGE DUE TO MAILBOX FULL. In a telephone interview on 05/04/20 at 3:23 p.m., RN D said he worked the 7:00 p.m. -7:00 a.m. shift on 04/20-21/20. RN D said CNA B reported to him at the beginning of his shift that R#1 had swelling to the left foot. RN D said, upon assessment, he observed the swelling to R#1's left foot/ankle area. RN D said he asked R#1 if she had pain and she verbalized the word si (yes). RN D said R#1 did not verbalize more than yes or no. RN D said the area was red, swollen, and warm to the touch, with dry scabbing abrasions. RN D said no falls or injuries were reported to him prior to finding the injury to R#1's left foot/ankle. RN D said initially he thought R#1 had an infection to the foot, due to the redness and swelling, but when he palpated the area, R#1 expressed pain. RN D said when he came onto the shift, this was not reported to him by the previous nurse, LVN A. RN D said R#1 was totally dependent on staff for all ADLs and required a hoyer lift for all transfers. RN D said he reported to the telehealth doctor the condition of the resident and an x-ray was ordered. RN D said when he received the results, they showed a fracture. RN D said the doctor ordered that R#1 be sent out to the hospital for evaluation and treatment. In a telephone interview on 05/04/20 at 4:05 p.m., LVN A said he was notified by CNA B (on 04/20/20) that R#1 had swelling to the lower extremities. LVN A said upon assessment he observed that both of R#1's lower extremities were swollen from the calf down. LVN A said this was not something out of the ordinary for R#1 because R#1 had a history of [REDACTED]. LVN A said R#1's lower extremities would swell at times. LVN A said, to relieve the swelling, he elevated R#1's lower extremities with a pillow and continued to monitor R#1. LVN A said, as he was assessing, he was also palpating R#1's lower extremities. LVN A said as he palpated, R#1 did not verbalize or make any non-verbal gestures that would signify she was in pain. LVN A said the swelling to R#1's lower extremities subsided by the end of the shift. LVN A said he notified RN D about the swelling and asked RN D to continue to monitor. LVN A said he did not document the swelling and did not notify the physician because the swelling subsided with the intervention of elevating R#1's lower extremities. LVN A said if the swelling had not subsided or if there were other signs and symptoms, like redness or pain, he would have reported it to the doctor. In a telephone interview, on 05/04/20 at 4:25 p.m., CNA B said she and CNA C got R#1 out of bed and into the shower chair via hoyer lift at around 2:00pm - 3:00 p.m. (on 04/20/20) because this was the usual time R#1 was bathed. CNA B said the hoyer transfer was uneventful and denied any incidents during transfer. CNA B said after R#1 was transferred to the shower chair, she (CNA B) took R#1 to the shower room while CNA C stayed in R#1's room to make the bed. CNA B said when she got to the shower room, she noticed R#1's left foot looked swollen. CNA B brought R#1 back to the room. CNA B said she and CNA C both agreed that R#1's left foot looked swollen. CNA B said she immediately went to report it to LVN A. CNA B said LVN A came to R#1's room and assessed R#1's left foot. CNA B said she was present when LVN A was in the room assessing R#1 and said R#1 did not verbalize or make non-verbal gestures that she was in pain. CNA B said she remembered R#1's left foot was swollen and looked a little red. CNA B denied both lower extremities were swollen. In a telephone interview on 05/04/20 at 4:35 p.m., CNA C said she and CNA B were getting R#1 ready for a shower (on 04/20/20). CNA C said she and CNA B conducted a hoyer transfer with R#1 from the bed to the shower chair. CNA C denied any injuries during the transfer. CNA C said, after the transfer, CNA B took R#1 to the shower room and she (CNA C) stayed in R#1's room changing the linens. CNA C said after CNA B showered R#1, she brought R#1 back and they were getting R#1 dressed. CNA C said, as she was putting R#1's socks on, she stopped and told CNA B that it looked

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F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) as if R#1's left foot/ankle was swollen. CNA B came over to R#1's feet and they both agreed the left foot/ankle looked swollen. CNA C said they both reported this observation to LVN A. CNA C said LVN A came immediately to assess R#1's foot. CNA C said R#1 did not express any pain or discomfort at the time of the assessment. CNA C said they continued their shift and R#1 did not make any non-verbal gestures of pain. CNA C said RN D was the nurse that came in for the evening shift. CNA C said she asked RN D if he was aware of R#1's swollen left foot/ankle. CNA C said RN D said he would be in shortly to assess. CNA C said she was not present when RN D assessed R#1. CNA C said she did not see R#1 anymore after RN D assessed R#1 because it was already the end of the CNA shift. CNA C said she later found out that R#1 had a broken bone and was sent out to the hospital. In a telephone interview on 05/05/20 at 10:52 a.m., LVN E said he last worked with R#1 on 04/19/20. LVN E said he did not observe any swelling or redness to R#1's lower extremities. LVN E said he was not aware of a history of swelling to R#1's lower extremities. In an interview on 05/05/20 at 1:37p.m., DON F said there was no documentation by LVN A regarding the swelling to R#1's lower extremities or the interventions that were put in place at the time of the finding. DON F said nurses should document regarding any abnormal finding and intervention that were done in the resident's record. Review of the website at https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/provider-portal/QMP/NurseDocumentationPPT.pdf revealed: Texas Administrative Code (TAC) Title 22, Part 11, Chapter 217, 217.11: Standards of Nursing Practice (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall: o (D) Accurately and completely report and document: - (i) the client's status including signs and symptoms; - (ii) nursing care rendered; - (iii) physician, dentist or podiatrist orders; - (iv) administration of medications and treatments; - (v) client response(s); and - (vi) contacts with other health care team members concerning significant events regarding client's status;