STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675478	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE HOUSE LIVING CENTER	1301 MESA DR PLAINVIEW, TX 79072

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, it was determined the facility failed to implement its written policy and procedures that prohibit abuse and neglect for 1 of 6 residents (Resident #1 a) reviewed for abuse/neglect. The facility failed to report an allegation of abuse 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 facility provided policy titled Abuse Policy, dated 2/2005, revised 9/13/2017 reflected in part: Fundamental Information C. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours the allegation is made. Record review of Resident #1's clinical record revealed a [AGE] year-old female resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS score of 02 out of 15 indicating severe cognitive impairment. The MDS indicated she required extensive assistance from staff with bed mobility and transfers, and extensive assistance from staff with dressing, toilet use and personal hygiene. Record review of the Provider Investigation Report of the incident involving Resident #1 revealed that the resident had an unwitnessed fall with a significant injury on 5-2-2020 at 7:45 PM and was sent to the hospital. The document further indicated that the facility did not report the incident to the State Survey Agency until 5-3-2020 at 11:00 AM, 15 hours and 15 minutes after having become aware of the allegation. During an interview with the DON on 6-25-2020 at 1:15 PM, she was asked why she did not report Resident #1's fall within the required two-hour timeframe. The DON responded that she called the TULIP automated system within the two -hour timeframe but got kicked off and never received a reference number. DON was then asked if she could prove that she called the automated number within the two-hour window. The DON replied that he call history only went back to May 12th, and that she could not prove that she called the automated number. The DON was then asked if it was her expectation that falls with significant injuries be reported within two-hours of the incident. DON responded that it was her expectation the all falls with significant injuries be reported within two-hours of the incident.
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 2 hours after the allegation was made, if the events that cause the allegation involve abuse or 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 6 residents (Resident #1) reviewed for abuse/neglect. The facility failed to report an allegation of abuse 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 record revealed a [AGE] year-old female resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS score of 02 out of 15 indicating severe cognitive impairment. The MDS indicated she required extensive assistance from staff with bed mobility and transfers, and extensive assistance from staff with dressing, toilet use and personal hygiene. Record review of the Provider Investigation Report of the incident involving Resident #1 revealed that the resident had an unwitnessed fall with a significant injury on 5-2-2020 at 7:45 PM and was sent to the hospital. The document further indicated that the facility did not report the incident to the State Survey Agency until 5-3-2020 at 11:00 AM, 15 hours and 15 minutes after having become aware of the allegation. During an interview with the DON on 6-25-2020 at 1:15 PM, she was asked why she did not report Resident #1's fall within the required two-hour timeframe. The DON responded that she called the TULIP automated system within the two -hour timeframe but got kicked off and never received a reference number. DON was then asked if she could prove that she called the automated number within the two-hour window. The DON replied that he call history only went back to May 12th, and that she could not prove that she called the automated number. The DON was then asked if it was her expectation that falls with significant injuries be reported within two-hours of the incident. DON responded that it was her expectation the all falls with significant injuries be reported within two-hours of the incident. Record review of facility provided policy titled Abuse Policy, dated 2/2005, revised 9/13/2017 reflected in part: Fundamental Information C. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours the allegation is made.

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.