STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675689	A. BUILDING _____ B. WING _____	08/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE HEALTHCARE AND REHABILITATION	615 N WARE RD MCALLEN, TX 78501

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 record review and interview, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents, for one Resident (R#7) of one resident reviewed for transfers. CNA D and CNA E did not provide R#7 with a safe transfer, resulting in R#7 sustaining tibial plateau (shinbone that involves the knee joint) and proximal fibular (bone of the lower leg) fractures. This failure could place residents who required assistance with transfers at risk for injuries. Findings included: Record review of R#7's face sheet revealed R#7 was admitted to the facility on [DATE] and discharged on [DATE]. R#7's [DIAGNOSES REDACTED]. Record review of R#7's nurse's notes, dated 02/28/20 at 10:35 p.m., revealed, Resident arrived via stretcher accompanied by x2 paramedics from hospital which was admitted for R leg [MEDICAL CONDITION] and hx of HTN, [MEDICAL CONDITION], MI, paralysis to BLE . Record review of R#7's Modification of Medicare 5 day MDS, dated [DATE], revealed R#7: -had difficulty hearing (minimal), -had clear speech, -was usually understood, -was usually able to make herself understood, -required extensive assistance from two staff for bed mobility, toilet use, and personal hygiene, and -required total assistance by two staff for bathing. Record review of R#7's care plan, date initiated and revised on 03/13/20, revealed: -(R#7) has ADL Self Care Performance Deficit r/t Limited Mobility - Paralysis BLE, Rt leg [MEDICAL CONDITION] -Goal: Will demonstrate the appropriate use of adaptive device(s) to increase ability in Bed mobility, transfers, eating, dressing toilet use, and personal hygiene, through the review date. -Interventions included: Transfer: requires extensive assistance with transfers X 1 staff participation. Record review of R#7's nurse's notes, dated 06/27/20 at 10:31 p.m., revealed: Staff was transferring resident to w/c and resident sat on edge of w/c then began to slide down onto the ground. Staff assisted with lowering resident onto floor and resident stated that her right leg got caught under w/c and that it twisted a bit Record review of R#7's hospital paperwork, dated 06/29/20 at 8:14 p.m., revealed: Right knee x-ray done in trauma bay positive for tibial plateau and proximal fibular fractures. Right tib/fib and ankle ordered due to increased pain and swelling on re-exam of the lower extremity . In a telephone interview, on 08/25/20 at 4:55 p.m., CNA E said R#7 was only able to bear weight on one leg, and was too heavy to be transferred without a mechanical lift. CNA E said R#7 should have only been transferred with a mechanical lift. In a telephone interview, on 08/26/20 at 1:59 p.m., CNA D said she and CNA E were transferring R#7 by grabbing R#1 underneath R#7's arm, one CNA on each side. CNA D said they were transferring R#7 from R#7's bed to a shower chair. CNA D said R#7 was not transferred correctly and R#7 ended up on the edge of the shower chair. CNA D said, she and CNA E let R#7 slide down to the floor. CNA D said R#7 got her right foot caught underneath the shower chair. CNA D said the nurse was called, and R#7 was transferred back to bed. CNA D said the shower chair was high and R#7 was not able to fully reach it. CNA D said R#7 was not able to stand by herself and was only able to bear weight on one foot. CNA D said she was trained how to transfer a resident, but grabbing a resident underneath the arms was not one of the ways. In a telephone interview on 08/26/20 at 2:24 p.m., the DON said CNA D said R#7 was transferred from bed to chair. R#7 was not transferred all the way back in the shower chair. The DON said staff were able to transfer a resident by grabbing the resident underneath the arms. The DON said staff were also able to use a gait belt, depending on the weight of the resident, or a towel underneath the resident, for the support. The DON said the team leader did a checklist upon hire and annually. The DON said R#7 was able to move her legs, but had not walked in a long time. The DON said the facility had no written policy on transfers. Record review of CNA Ds - Skills checklist-Transfer Techniques, dated 01/24/20, and CNA E - Skills checklist- Transfer Techniques, dated 06/28/20, revealed: I. Ask the person being tested to demonstrate how they would transfer a resident with a [MEDICAL CONDITION], a resident with a total hip prosthesis, and a resident with a [MEDICAL CONDITION] from the bed to the wheelchair; and from the wheelchair back to the bed 1. Identified the precautions, weight bearing status, involved side 2. Resident was told what was going to happen 3. Had resident lean forward and push down with hands on bed to stand up 4. Resident was instructed to pivot to wheelchair and all precautions (weight bearing, total hip, etc) were carried out 5. Resident was instructed to reach for wheelchair armrest prior to sitting down 6. Resident's rights, safety, and proper positioning were maintained throughout the transfer. Record review of Guidelines for Nursing Homes, at https://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.html, revised March 2009, revealed: -Figure 1. Transfer to and from: bed to chair, chair to toilet, chair to chair, or car to chair Stand and pivot technique using a gait/transfer belt (1 caregiver) .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection control prevention and control program, including hand hygiene, designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection, for five Residents (R#1, R#2, R#3, R#4, and R#5) of six residents observed for infection control practice, in that: 1) LVN A did not perform hand hygiene before preparing and administering medications to R#1 and R#2. 2) LVN B took the same box of gloves and medical tape from resident room to resident room. 3) CNA C wore the same wet cloth gown to shower R#5, after showering R#4. The findings were: 1) Record review of R#1's Admission Record, dated 08/27/20, revealed R#1 was admitted to the facility on [DATE] and readmitted on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Quarterly MDS assessment, dated 08/06/20, revealed R#1: -had adequate hearing, -was able to make herself understood, -was able to understand others, and -had adequate vision. Record review of R#2's Admission Record, dated 08/27/20, revealed R#2 was admitted to the facility on [DATE] and readmitted on [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's Quarterly MDS assessment, dated 05/22/20, revealed R#2: -had difficulty hearing (minimal), -had unclear speech, -was sometimes understood by others, -was sometimes able to understand others, and -had highly impaired vision. Observation on 08/24/20 at 12:05 p.m. revealed LVN A opened an alcohol prep pad and without first performing hand hygiene, wiped down the top of the insulin bottle, injected air, then withdrew 5 units of insulin. LVN A walked into R#1's room, donned clean gloves without first performing hand hygiene, and checked R#1's blood glucose level. There was no hand hygiene done before withdrawing the insulin or before checking R#1's blood glucose level. Observation on 08/24/20 at 12:16 p.m. revealed LVN A prepared R#2's medications by measuring 30 ml of water and 5 ml of [MEDICATION NAME]. LVN A walked into R#2's room, donned cleaned gloves, stopped R#2's continuous feeding pump, checked R#2's peg for placement by placing the stethescope next to the peg, and pushing 30ml of air with the pistol syringe. LVN A proceeded to administer the [MEDICATION NAME] and water. There was no hand hygiene done before preparing the medication or administering the medication. In an interview on 08/24/20 at 12:25 p.m., LVN A said, You are supposed to wash your hands or use hand sanitizer before preparing the medications and before and after administering medications. In an interview on 08/24/20 at 2:30 p.m., the DON said staff were to perform hand hygiene before preparing medications or administering

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 -** Few	(continued... from page 1) medications, for infection control. Record review of the facility's Infection Control Surveillance Log, dated 08/12/20, for LVN A, revealed he checked off on: proper hand washing and/ or glove useage, with no corrective action needed. 2) Record review of R#3's Admission Record, dated 08/27/20, revealed R#3 was admitted to the facility on [DATE]. R#3's [DIAGNOSES REDACTED]. Record review of R#3's Medicare 5 Day MDS assessment, dated 08/07/20, revealed R#3: -had difficulty hearing (minimal), -had clear speech, -was able to make himself understood, -was able to understand others, and -had impaired vision. Observation on 08/24/20 at 2:51 p.m., down the presumptive hallway (300 hall), revealed LVN B took the wound care supplies into R#3's room, including a box of gloves and a roll of medical tape. LVN B provided wound care to R#3, then when finished placed, the box of gloves and medical tape back into the treatment cart. In an interview at the time of the observation, LVN B said she normally took the tape and box of gloves inside the residents' rooms. LVN B said it was fine as long as she cleaned the area she was going to put her supplies on before putting anything on it. In an interview on 08/24/20 at 3:17 p.m., the DON said staff were allowed to take the supplies into the rooms and bring them back out as long as it was not an isolation room. The DON said staff cleaned the area they put their supplies on, so everything that was taken in was on a clean area. In a telephone interview on 08/26/20 at 2:24 p.m., the DON said R#3 was in the presumptive hallway, which meant the residents were new admissions or readmissions and kept on a 14 day quarantine. The DON said only some of the residents were tested for COVID-19 prior to admission. The DON said R#3 was already off the 14 day quarantine, but had not been moved since there were no rooms on the COVID-19 negative hallway. The DON said she had always been told it was okay to take supplies into or out of residents' rooms as long as the area was cleaned before putting any supplies on it. 3) Observation on 08/24/20 at 3:42 p.m. revealed CNA C was wearing a light purple cloth long sleeve gown, with the front of both sleeves wet, showing a darker purple. In an interview, at the time of the observation, CNA C said she had just showered R#4 and her gown got wet from the shower. Observation on 08/24/20 at 4:20 p.m. revealed CNA C walked out of R#5's room, with the same purple cloth gown, and the sleeves of the gown still wet. In an interview, at the time of the observation, CNA C said she just gave R#5 a bed bath. CNA C said she was wearing the same cloth gown. CNA C said she was trained to switch out the gown if it became soiled, and to be switched out daily. CNA C said she was not trained to change it out if it became wet. In a telephone interview on 08/24/20 at 4:59 p.m., the DON said the staff were trained to change out their cloth gowns when they became dirty or visibly soiled. The DON said staff were not trained to change the gown when it became wet. Record review of facility policy, Infection Control and Prevention Policy - Emerging Infectious Disease: Coronavirus Disease 2019, dated 03/09/20, and revised on 04/08/20, revealed: Hand Hygiene - HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves.