STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676270	A. BUILDING _____ B. WING _____	**06/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRENTWOOD PLACE FOUR	**3505 S BUCKNER BLVD BLDG 5 DALLAS, TX 75227**

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from abuse for one (Resident #1) of five residents reviewed for abuse. CNA B failed to provide Resident #1, who was in a vegetative state and ventilator dependent, the necessary level of assistance with ADLs. On 04/20/20, CNA B provided Resident #1 incontinent care with no assistance, resulting in the resident rolling off the bed onto the floor and sustaining facial injuries. Resident #1 was transferred to the emergency roiagnom on [DATE], where he was diagnosed with [REDACTED]. The IJ was determined to have been removed on 04/22/20 due to the facility's implemented actions that corrected the non-compliance prior to the beginning of the investigation on 04/23/20. This failure placed residents at risk for serious injuries, a decline in the resident's condition, hospitalization or death. Findings included: Review of Resident #1's MDS Annual Assessment, dated 04/01/20, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His active [DIAGNOSES REDACTED]. According to the assessment he was in a persistent vegetative state/no discernible consciousness and was on a ventilator. He was totally dependent and required assistance of two staff for bed mobility and toileting, was frequently incontinent of bowel and bladder, and had upper and lower extremity impairment on both sides. Review of Resident #1's comprehensive care plan reflected the following: -He was incontinent of bowel and bladder; he was totally dependent on staff x 2 with incontinence needs. Initiated on 10/15/19 and last revised 05/06/20 - Resident #1 was high risk for falls related to paralysis and vegetative state. The interventions included: to anticipate and meet the resident's needs and to review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. Initiated on 01/27/20 and last revised 05/06/20 - Resident #1 had a [MEDICAL CONDITION] and oxygen therapy related to [MEDICAL CONDITION]. Resident #1 to wear 28% humidity with 5 LPM (liters per minute) O2 (oxygen) bleed-in in [MEDICAL CONDITION]-bar continuous q (every) shift. Initiated on 01/27/20 and last revised on 05/06/20, -Resident #1 had impaired cognitive function and nonverbal related to [MEDICAL CONDITION]. Initiated on 05/10/19 and last revised on 05/06/20 Review of the facility's Provider Investigation Report involving Resident #1 dated 04/24/20 reflected, .Incident date 04/20/20 at 6:30 AM revealed Agency Staff member (CNA B) was providing care to (Resident #1) and rolled out of bed. Head to toe assessment revealed Resident #1 had an abrasion to the head and his nose was bleeding. Resident #1 was transported to the hospital for further evaluation. Provider response included in-service on abuse/neglect completed, in-service on ensuring the Agency knew how to find ADL care information, notified Physician, family. Safe surveys were completed with other residents. The report revealed CNA B was terminated from further service with the facility and the staffing agency was notified of the neglect. The Investigation Summary revealed after reviewing the findings, it is summarized that the facility has confirmed that neglect occurred. Review of the facility's Fall with injury report completed by LVN A and dated 04/20/20 reflected, . Incident description .At approx. 0450 (4:50 AM) this nurse was in another patients (pt) room when the CNA notified that pt had fell on the floor during changing. Upon entry pt was found on his left lateral side and bleeding from his nose. After transferring pt to bed via hoyer lift, this nurse assessed patient. VS (vital signs) 107/74 (blood pressure) 96% (oxygen saturation), 99.9 F (temperature) HR (heart rate) 107, Eyes PERRLA, CNA used towel to clean blood from his face. Left message with DR (doctor) and DON. Called (company name) transport for pick up. Injuries observed at time of incident including abrasion to face and bruise to face. The report reflected Resident #1 had mobility of bedridden. Review of Resident #1's emergency room hospital discharge records, dated 04/20/20, reflected the following: Pt coming from (facility). Pt was dropped while staff was changing him. Facial bruising noted. Blood from trach, mouth and scalp. Patient Diagnosis: [REDACTED].Injury resulting from fall from height. Review of the Resident #1's hospital records dated 04/20/20 reflected the following: - Maxillofacial CT revealed small amount of fluid in the left maxillary sinus. No fractures or dislocations. - Chest CT revealed remote appearing rib fractures. No acute rib fractures identified. - An interview with CNA B on 05/14/20 at 3:22 PM revealed RN A was in another resident's room doing a code. CNA B stated she went to Resident #1's room to provide incontinent care and she knew he was a two-person assistance. She stated when she went into the room to provide incontinence care to Resident #1 he was on his left side. She instructed Resident #1 to stay still and not to continuing rolling. She stated Resident #1 was non-compliant and continued rolling. She could not hold him by herself and stop him from rolling out of the bed, so he fell out of the bed. She stated he was bleeding from his nose and face. She stated the facility was short staffed with only one other nurse and CNA in the whole facility. She stated she went to get a nurse immediately. She stated she knew most of her residents on the hall she was assigned were two-person assistance for ADLs but she provided assistance by herself throughout the shift. CNA B stated she did not ask anyone for assistance prior to providing care to Resident #1. She stated she had access to the electronic medical record kiosk system and charted on all her residents that night total dependence with one-person physical assistance. Review of CNA B's Witness Statement dated 04/20/20 at 6:05 AM signed by CNA B reflected, Upon performing peri-care on (Resident #1) pt was noted to the left side, and instructed to stay still and not to continue rolling. Pt was not compliant (sic), and continue to role. Pt was held on as long as possible, until pt. slipped out of hands and hit the floor. Pt incident was reported to charge nurse, and pt. was assisted x3 back to bed for further assessment. Interviews with RN A on 05/14/20 at 3:55 PM and 05/18/20 at 1:43 PM revealed on 04/20/20 on the night shift another nurse came and reported there was an emergency on the hall but she was in the middle of conducting a code on a resident. She stated once EMS had taken over the code, she went to check on Resident #1. She stated Resident #1 was on the floor next to his bed and on his left side. She stated he was bleeding from the nose and recalled a bruise on his nose and on one of his cheeks. She assessed injuries on his shoulder and chest. RN A stated Resident #1's ventilator did not get disconnected but it could have when he rolled out of bed. She stated they used a hoyer lift to transfer him back to the bed since Resident #1 was totally dependent. RN A stated they were able to stop the bleeding from his nose. She stated she called transportation to send him to the hospital for further evaluation and notified the physician, family and DON. She stated she asked CNA B what happened, and CNA B told her she was providing incontinent care to Resident #1 by herself and he rolled out of the bed. She stated she went over with CNA B at the beginning of the shift Resident #1 being a two- person assistance with all ADLs including incontinent care. She stated CNA B had access to the kiosk system and the electronic medical record to know resident care level needs and even document on the residents that shift. RN A stated she was unaware of any other time CNA B provided care to residents by herself on a two-person assistance resident. She stated CNA B did not ask her for assistance to provide care to Resident #1 prior to the incident. Review of RN A's emailed statement dated 04/20/20 at 10:41 AM reflected: I was with another patient when CNA came in and told me (Resident #1) had fallen. Upon entry into the room, I observed him laying on the floor (between the bed and the dresser)) on his left lateral side and he was bleeding from his nose. After assessing for injuries, he was transferred

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) from floor to bed via hoyer lift. VS (vital signs) were assessed. Eyes PERRLA (pupils equal, round, and reactive to light and accommodation). I observed an abrasion to his forehead redness on the left should/chest, bruise/abrasion on right cheek, and bruise on his nose. CNA brought a towel and cleaned blood from his face, he was no longer actively bleeding. He was suctioned by RT and inner cannula was cleaned . I informed the CNA that he is a 2 person assist and must be transferred with hoyer lift. I called (company name) for transport to ER for assessment/evaluation. I called to inform DON and DR. I called his wife who had the son translate due to her being Spanish-speaking only. They requested that the patient be sent to Hospital on (street name), used to be Doctors hospital. I resumed q 15 min neuro checks until transportation arrived. Informed transport of family request to go to specific hospital. He was then transported out. Interview on 05/18/20 at 10:15 AM with LVN C revealed on 04/20/20 in early morning CNA B, who was an agency aide, came and got her telling her she had an emergency and needed a nurse, so she went to see what was going on. She stated RN A was busy in another resident's room doing a code, so she went with CNA B. She stated she saw Resident #1 was on the ground and bleeding from his nose. She stated CNA B told her she was providing incontinent care to Resident #1 and rolled him over to one side. LVN C stated CNA B said she told Resident #1 to stop rolling but he kept rolling and fell off the bed. She stated she told CNA B Resident #1 was nonverbal, totally dependent and could not respond to what was said. She stated Resident #1's bed was not on the lowest position when she went in the room to find Resident #1 on the floor next to the bed. She stated that night, 04/20/20, there were only two CNAs instead of three CNAs but there were three nurses along with two Respiratory Therapists. She stated she did not understand why CNA B provided incontinent care to Resident #1 by herself. She stated CNA B had worked at the facility before and had access to the kiosk system to know Resident #1's ADL care needs . Interview on 05/21/20 at 3:48 PM with RT E revealed an Agency CNA (CNA B) on 500 hall came and told her Resident #1 had fallen. She stated she went into Resident #1's room and saw Resident #1 was bleeding from his nose and trach. She stated if she had not suctioned his trach, the blood could have gotten into his lungs. She stated his respirations were 20. She stated EMS was called and she suctioned him again before he went to hospital. She stated Resident #1 was nonverbal and could not follow commands. She stated the only time she had seen him move his arms was when he coughed for her and it could have been just a reflex. She stated Resident #1 was totally dependent . Review of the staff timesheet and sign-in sheets for 04/19/20 - 04/20/20 night shift reflected three nurses, two respiratory therapists and two Agency CNAs were working. Review of CNA B's timesheets reflected she worked on 04/11/20 on 300 and 400 halls from 9:45 PM to 6:15 AM, 4/12/20 on 500 hall from 10:00 PM to 6:30 PM, on 04/19/20 on 500 hall from 2:00 PM to 10:00 PM, and on 04/19/20 from 10:00 PM to 6:00 AM. In an interview on 05/15/20 at 2:08 PM the ADM revealed CNA B did not provide care to any other residents after the incident with Resident #1. He stated he informed the staffing agency of CNA B's neglect and she was not allowed to come back to the facility. He stated it was neglect because she knew the resident was a two-person assist. He stated the nurse did a head to toe assessment and sent Resident #1 to the hospital. He stated CNA B never returned to the facility. He stated there was adequate staff and CNA B should have waited to provide care to Resident #1 when she had assistance. In an interview with the DON on 05/18/20 at 1:42 PM revealed at the beginning of the shift the Charge Nurse went over care level needs including who was a two-person assistance and how to access their care needs in the kiosk system and electronic medical record with CNA B about all residents on her shift. She stated nurses were responsible for ensuring any agency staff or new staff were oriented prior to the start of their shift on resident care assistance needs, how to access kiosk system in the electronic medical record to document and see resident care level assistance needs. Review of facility's investigation of Resident #1's Incident undated by DON reflected agency staff members that did come back were in-serviced on care needs. The ADON position was responsible for making sure the agency staff were trained and the facility no longer had an ADON. The DON stated until a new ADON was hired, the DON would be responsible for making sure the training was being done. The agency staff were assigned an access code before they came to the floor so they could access the patient care record. The DON stated, .When we do have agency, we will utilize the form that the charge nurses will have them sign. Review of the facility's Abuse - Reportable Events, dated May 2017 reflected, It is the policy of this home to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/vent in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person Definition of abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Any act, failure to act, or incitement to act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident. Review of facility's in-services to Charge Nurses dated 04/20/20 to 04/22/20 reflected ten nurses were in-serviced on Agency staff and new staff receiving training on kiosk in the electronic medical record and giving report to Agency staff on residents' care assistance needs. They went over being aware of all residents who required two-person assistance and hoyer lift transfers . Review of facility's in-service for Agency Staff with start date of 04/21/20 reflected, make sure you review resident care information in (electronic medical record) prior to caring for the residents. You will receive your access code to the (electronic medical record) system when you arrive to the facility and your nurse will assist you in accessing the information. Receive a report from your nurse on the residents that you will care for that day. Please make sure you are aware of whether the resident is 1 or 2 person assist. Always get another person to help in 2 person assist residents . Interviews on 05/15/20 and 05/18/20 with RN A and LVN C revealed they were able to discuss their role in providing the required orientation and verbal report about residents' assistance level needs including which residents require two person assistance to agency staff at beginning of their shift. Observation on 05/15/20 at 9:37 AM with CNAs F and G conducting incontinent care for Resident #1 revealed no concerns with staff assistance level. Observation on 05/15/20 at 10:05 AM with CNAs F and H revealed no concerns with staff assistance level. On 05/15/20 at 7:12 PM the ADM was informed an Immediate Jeopardy was determined to have existed from 04/20/20 to 04/22/20. The IJ was determined to have been removed on 04/22/20 due to the facility's implemented actions that corrected the non-compliance prior to the beginning of the investigation on 04/23/20.