STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F603	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDWARD ABRAHAM MEMORIAL HOME	**803 BIRCH ST CANADIAN, TX 79014**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure all residents had the right to formulate an advanced directive for 2 (Resident #127 and Resident #128) of 16 residents reviewed for advance directives Resident #127 had a DNR Order that was not completed correctly. Resident #128 had a DNR Order that was not completed correctly. The facility's failure to ensure accuracy of resident medical records for advanced directives such as a DNR (Do Not Resuscitate), recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care. This deficient practice could place residents a risk for not receiving healthcare as per their or their legal representatives wishes. Findings include: Resident #127 Record review of the clinical record for Resident #127 revealed an [AGE] year-old female resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #127's clinical records revealed a DNR that was incorrectly filled out. At the bottom of the DNR page, where signatures are required to acknowledge that the document has been correctly filled out, both witnesses signed the form in the incorrect place. Resident #128 Record review of the clinical record for Resident #128 revealed an [AGE] year-old male resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #128's clinical records revealed a DNR that was incorrectly filled out. Under the section titled Physician's Statement, the physician did not print his/her name beside the Printed Name section. Also, at the bottom of the DNR page, where signatures are required to acknowledge that the document has been correctly filled out, the physician did not sign beside the Attending Physician blank, and instead signed beside the Person's Signature blank. During an interview with the DON on 3-12-2020 at 9:44 AM concerning both DNR forms, she confirmed that both DNRs were filled out incorrectly. She stated that this issue would be corrected quickly. Record Review of facility policy titled Administration, not dated, reflected in part: Policy: Edward Abraham Memorial Home staff will follow directions on properly executed Advance Directives and Do Not Resuscitate forms. Treatment will be provided or withheld in accordance with instructions on these forms. Edward Abraham Memorial Home staff will follow instructions of these forms in as much as it is in their power to do so. No other policies related to Advance Directives or Do Not Resuscitate Orders were provided by the facility.
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, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 29 residents (Resident #16) reviewed for abuse and neglect. The facility failed to report to the State Survey Agency an unwitnessed fall with serious injury involving Resident #16 in which Resident #16 had an unwitnessed fall and was sent to the ER for injuries. 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 Reporting Abuse to Facility Management, dated 01/01/2008, reflected in part: Policy: 4. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident: a. The state licensing/certification agency responsible for surveying/licensing the facility. Record review of Resident # 16's face sheet revealed a [AGE] year-old female with a current admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident # 16's last MDS dated [DATE] revealed a BIMS score of 05 out of 15 indicating moderately cognitive impairment. The MDS revealed that she required assistance from staff with dressing, toilet use, and personal hygiene. Record review of facility Accident or Incident Reports revealed an Accident or Incident Report dated 12/16/2019 regarding Resident #16 that reflected in part: Nature of accident or incident and injuries received: Called to short hall by CNA. Observed resident sitting up against wall beside room [ROOM NUMBER] with a pillow to her head. Observed a laceration to forehead approx. 4 cm and a skin tear approx. 5 cm to top of left hand. ROM wnl (within normal limits). Denies pain or discomfort upon ROM. Pressure applied to laceration to forehead. Placed call to daughter . and notified her of fall. Resident sent to ER for evaluation and treatment. 24 Hour condition and injury appearance: Laceration to forehead well approx. 4 cm with staples. Covered with bandage. 0 S/S (signs and symptoms) of infection noted. Skin tear to left hand approximated and covered with bandage. 0 S/S of infection noted. Record review of facility records indicated that this incident was not reported to the State Agency as required by regulations. During an interview with DON on 03/11/2020 at 2:34 PM, she stated that most of the time they know what happened when a resident had an unwitnessed fall. DON confirmed that they do not always report unwitnessed falls if they don't suspect abuse.
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 allegations involving abuse, neglect, exploitation or mistreatment were reported immediately but not later than 2 hours 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 29 residents (Resident #16) reviewed for abuse and neglect. The facility failed to report to the State Survey Agency an unwitnessed fall with serious injury involving Resident #16. 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 # 16's face sheet revealed a [AGE] year-old female with a current admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident # 16's last MDS dated [DATE] revealed a BIMS score of 05 out of 15 indicating moderately cognitive impairment. The MDS revealed that she required assistance from staff with dressing, toilet use, and personal hygiene. Record review of facility Accident or Incident Reports revealed an Accident or Incident Report dated 12/16/2019 regarding Resident #16 that reflected in part: Nature of accident or incident and injuries received: Called to short hall by CNA. Observed resident sitting up against wall beside room [ROOM NUMBER] with a pillow to her head. Observed a laceration 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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) forehead approx. 4 cm and a skin tear approx. 5 cm to top of left hand. ROM wnl. Denies pain or discomfort upon ROM. Pressure applied to laceration to forehead. Placed call to daughter and notified her of fall. Resident sent to ER for evaluation and treatment. 24 Hour condition and injury appearance: Laceration to forehead well approx. 4 cm with staples. Covered with bandage. 0 S/S of infection noted. Skin tear to left hand approximated and covered with bandage. 0 S/S of infection noted. Record review of facility records revealed the incident was not reported to the State Agency within the timeframes required by regulations. During an interview with DON on 03/11/2020 at 2:34 PM, she stated that most of the time they know what happened when a resident had an unwitnessed fall. DON confirmed that they do not always report unwitnessed falls if they don't suspect abuse. Record review of facility provided policy titled Reporting Abuse to Facility Management, dated 01/01/2008, reflected in part: Policy: 4. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident: a. The state licensing/certification agency responsible for surveying/licensing the facility.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive care plan for each resident that was prepared by an interdisciplinary team, that includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, and a member of food and nutrition services staff for 12 of 13 residents (Residents #1, #5, #6, #10, #11, #12, #13, #14, #16, #18, #21, and #127) who were reviewed. The comprehensive care plan for Residents #1, #5, #6, #10, #11, #12, #13, #14, #16, #18, #21, and #127 were not developed or reviewed and revised by an interdisciplinary team that included a physician or physician delegated NPP. This failure could place residents at risk of receiving care that is not person-centered, substandard, unable to meet their needs, or inadequate to prevent complications. Findings Include: Resident #1 Record review of Resident #1's face sheet revealed an [AGE] year-old female admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's clinical record documented IDT meeting dated 01/09/2020 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #5 Record review of Resident #5's face sheet revealed a [AGE] year-old male admitted [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #5's clinical record documented IDT meeting dated 12/12/19 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #6 Record review of Resident #6's face sheet revealed a [AGE] year-old male admitted [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #6's clinical record documented IDT meeting dated 12/12/19 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #10 Record review of Resident #10's face sheet revealed an [AGE] year-old female admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #10's clincal record documented IDT meeting dated 01/16/20 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #11 Record review of Resident #11's face sheet revealed a [AGE] year-old male admitted [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #11's clinical record documented IDT meeting dated 02/13/20 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #12 Record review of Resident #12's face sheet revealed a [AGE] year-old female admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #12's clinical record documented IDT meeting dated 02/13/20 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #13 Record review of Resident #13's face sheet revealed an [AGE] year-old female admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #13's clinical record documented IDT meeting dated 01/23/20 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #14 Record review of Resident #14's face sheet revealed a [AGE] year-old female admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #14's clinical record documented IDT meeting dated 01/23/20 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #16 Record review of Resident #16's face sheet revealed a [AGE] year-old female admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #16's clinical record documented IDT meeting dated 12/23/19 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #18 Record review of Resident #18's face sheet revealed a [AGE] year-old female admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #18's clinical record documented IDT meeting dated 02/20/20 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #21 Record review of Resident #21's face sheet revealed a [AGE] year-old male admitted [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #21's clinical record documented IDT meeting dated 02/20/20 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. Resident #127 Record review of Resident #127's face sheet revealed an [AGE] year-old female admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #127's clinical record documented IDT meeting dated 02/13/20 was conducted. However, there was not a physician or physician delegated NPP that participated as part of the IDT. During an interview on 03/11/20 at 09:16 AM, DON confirmed that the Physician was not present for care plan meetings and does not sign off on care plans. During an interview on 03/12/20 at 09:43 AM, ADM stated that the Physician does not attend or delegate someone for care plan meetings. Record review of facility document with revised date September 2013, titled Care Planning - Interdisciplinary Team: Policy Statement - Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. 2. The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily limited to the following personnel: a. The resident's Attending Physician; b. The Registered Nurse who has responsibility for the resident; c. The Dietary Manager/Dietician; d. The Social Services Worker responsible for the resident . 5. The mechanics of how the Interdisciplinary Team meets its responsibilities in the development of the interdisciplinary care plan (e.g., face-to-face, teleconference, written communication, etc.) is at the discretion of the Care Planning Committee.
F 0689 **Level of harm** - Minimal harm or potential for 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 observation, interview, and record review, the facility failed to ensure that resident environments remained free from accidents and hazards as possible, for 1 of 16 (Resident #11) residents reviewed for accidents and hazards. - Resident #11 was not assessed for possible hazards of having bedrails based on his diagnoses. This failure has the potential to affect residents by putting the residents at an increased and unnecessary risk of harm and/or fatal injury. Findings include: Resident #11 Record review of Resident #11's clinical records revealed a [AGE] year-old male resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #11's MDS, dated [DATE], revealed a BIMS score of 11 showing moderate cognitive impairment. Section G of the MDS revealed that he required extensive assistance with Transfers, Dressing, Toilet Use and Personal Hygiene. He required supervision with bed mobility, Locomotion (Wheelchair), and eating. Record review of Resident #11's AIMS Assessment Section B. Extremity Movements revealed severe #5 upper, #6 lower, and #7 trunk movements; Section D. Global Judgments #8 revealed that the severity of the abnormal movements was severe; #10 revealed that the resident was not aware of the abnormal movements. During an observation on 3-10-2020 at 10:23 AM, Resident #11 was seen sitting in his juswheelchairt outside of his room. Steel quarter bed rails were raised on both sides of his bed. The steel rails were not padded. During an observation of Resident #11 on 3-11-2020 at 10:21 AM, steel quarter bed rails were again raised on both sides of his bed. The steel rails were not padded. During an interview with the DON on 3-12-2020 at 9:44 AM, she confirmed that Resident #11 had a [DIAGNOSES REDACTED].#11 had

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) severe involuntary movements of his upper and lower extremities as well as his trunk per his AIMS assessment. She then was shown that the resident had steel quarter rails up bilaterally on his bed. She confirmed that the resident and his guardian had signed a bed rail consent but had not had any ongoing assessments for safety and efficacy. The DON was then asked if she thought that it was safe for a resident who has [MEDICAL CONDITION]'s Disease to have steel bed rails up on both sides of his bed. She stated that the resident used the bed rails to assist staff during incontinent care. The DON was asked if it was possible for entrapment to happen with a resident who has severe involuntary movements. Record review of facility provided policy titled Bed Safety, dated 2001, revised December 2007, reflected in part: e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., AMS, Restlessness, etc.) Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical condition or symptom. No other policies received regarding bedrail safety and assessments.
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain informed consent from a resident or the resident's representative and complete an assessment for efficacy of bedrails for 4 (Resident #10, Resident #11, Resident #13, Resident #14) of 16 residents reviewed for bedrails. The facility failed to perform ongoing assessments and evaluation of bedrails for residents who had bedrails installed. This deficient practice could place all residents who use bed rails at risk for injuries such as abrasion, fractures, entrapment, and death from strangulation. Finding include: Resident #10 Record review of Resident #10's clinical records revealed an [AGE] year-old female resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #10's MDS, dated [DATE], revealed a BIMS score of 08 showing moderate cognitive impairment. This MDS indicated the Resident needs limited assistance with ADL care. Record review of clinical records revealed that Resident #10 did not have any ongoing assessments for the continued need for bedrails, or evaluations for risks of bedrails. During an observation on 03/10/20 at 10:20 AM, Resident #10 had 1/4 bed rails on the bed with both sides raised. Resident #11 Record review of Resident #11's clinical records revealed a [AGE] year-old male resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #11's MDS, dated [DATE], revealed a BIMS score of 11 showing moderate cognitive impairment. Section G of the MDS revealed that he required extensive assistance with Transfers, Dressing, Toilet Use and Personal Hygiene. He required supervision with bed mobility, Locomotion (Wheelchair), and eating. Record review of Resident #11's clinical record revealed that he did not have any ongoing assessments for the continued need for bedrails, or evaluations for risks of bedrails. During an observation on 3-10-2020 at 10:23 AM, Resident #11 was seen sitting in his WC just outside of his room. Steel quarter bed rails were raised on both sides of his bed. The steel rails were not padded. During an observation of Resident #11 on 3-11-2020 at 10:21 AM, steel quarter bed rails were again raised on both sides of his bed. The steel rails were not padded. Resident #13 Record review of Resident #13's face sheet revealed an [AGE] year-old female admitted [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #13's MDS, dated [DATE], revealed a BIMS of 15 indicating no cognitive impairment. Record review of Resident #13's clinical records revealed that her bedrail consent form stated that bedrails not be used on her bed, yet bedrails were seen up on her bed. Record review of Resident #13's clinical record revealed that she did not have any ongoing assessments for the continued need for bedrails, or evaluations for risks of bedrails. During an observation on 3-10-20 at 02:12 PM, Resident #13 had 1/4 side rails on both sides the bed. Resident #14 Record review of Resident #14's clinical record revealed a [AGE] year-old female resident admitted to the facility 2-8-2017 with [DIAGNOSES REDACTED]. Record review of Resident #14's MDS, dated [DATE], revealed a BIMS of 15 showing no cognitive impairment. Section G of the MDS revealed that she is independent with all ADLs except for dressing, in which she needs limited assistance. Record review of Resident #14's clinical record revealed that she did not have any ongoing assessments for the continued need for bedrails, or evaluations for risks of bed rails. During an observation on 03/12/20 at 09:13 AM, Resident #14 had bedrails up on both sides of the bed. During an interview with the DON on 3-12-2020 at 9:44 AM, she was asked if the facility had any ongoing assessments or evaluations for continued bedrail use for residents with bedrails. DON replied that she did not have any ongoing assessments or evaluations for continued bedrail use for residents with bedrails. Record review of facility provided policy titled Bed Safety, dated 2001, revised December 2007, reflected in part: The facility's education and training activities will include instruction about risk factors for resident injury due to beds, and strategies for reducing risk of factor for injury, including entrapment. The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to use. Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical condition or symptom. No other policies received regarding bedrail safety and assessments.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, interview and record review the facility failed to ensure drugs and biologicals were stored under proper temperature controls in 1 of 1medication rooms reviewed for medication storage. - The medication room did not have a temperature log for room temperature, nor was the room temperature thermostatically controlled. The facility's failure to ensure drugs and biologicals were stored at the correct temperature could place residents at risk for receiving drugs and biologicals that were not stored at the correct temperature Findings include: During an observation of the medication room on 3-11-2020 at 2:59 PM, there was no temperature log for the temperature of the room, no thermometer to detect the temperature of the room, and the room itself was not thermostatically controlled. During an interview with the LVN A on 3-11-2020 at 3:01 PM, she was asked if the facility kept a temperature log for the current temperature of the med room, or if they had a thermometer in the med room to assess the temperature. She stated she did not think they did. During an interview with ADM on 3-11-2020 at 3:05 PM, he confirmed that the facility did not have a thermometer or temperature log inside the med room to monitor the current temperature of the med room. He was then asked how the facility could ensure that the medications were being stored at recommended temperatures. He stated that he would have a log and a thermometer in the med room before the end of the survey. Facility could not provide an applicable policy.