STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676089	A. BUILDING _____ B. WING _____	**09/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINNIE L LTC PARTNERS INC	**2104 N KARNES CAMERON, TX 76520**

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and records review the facility failed to, in response to allegation of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations are thoroughly investigated for one (1) of one (1) residents (Resident #1) reviewed for abuse, neglect, exploitation or mistreatment. The facility failed to thoroughly investigate the allegation that Resident #1 was injured during an inappropriate transfer. This failure could place residents at risk of abuse, neglect, exploitation or mistreatment. Findings included: A review of Resident #1's Face Sheet dated 7/30/2020 reflected an [AGE] year-old female, admitted [DATE] with [DIAGNOSES REDACTED]. A review of Resident #1's quarterly MDS dated [DATE] reflected her BIMS was 99 indicating she was unable to complete the interview. Section G indicated she was a two-person transfer. A review of Resident #1's Care Plan noted under the category of skin impairment to use caution with transfers to prevent striking arms, legs and hands against any sharp or hard surface. The Care Plan also reflected under the category of ADL care, she was a total assist, two-person transfer. A review of Social Worker Quarterly assessment for Resident #1 dated 07/29/2020, Resident #1 was non-verbal. In an interview on 9/30/2020 at 10:22 AM ADM stated the incident was thoroughly investigated and he concluded the resident must have bumped her toes during transfer. In an interview on 9/30/2020 at 1:41 PM ADM stated he thought LVN A was telling the truth about her statement. When asked what he thought of LVN A's written statement dated 7/28/2020, he said he did not clearly see the statement written by LVN A before today. When asked why he didn't thoroughly read LVN A's statement two months ago he said he thought he did. He said he asked the nurse aides, and both said they helped each other, and he did not focus on LVN A's statement. He said that was a failure on his part, but still felt that Resident #1 bumped her toes during the shower. He said if he had read that statement back then he would have had her in-serviced for not assisting CNA B. Review of the Provider Investigation Report dated 7/28/2020 reflected a hand-written statement, signed by LVN A, dated 7/28/2020, that she observed CNA B transfer Resident #1 by herself. In an interview on 9/30/2020 at 3:28 PM Hospice RN stated she saw Resident #1's toes for the first time on 7/23/2020 and the resident flinched when toes were touched so she reported it to the nursing department immediately. She stated an x-ray was ordered and the results were four fractures of right foot; metatarsals #2, #3, #4, and #5. She said the administrator told her the resident was dropped in the shower or maybe bumped her toes, he was not sure, and she confirmed he said that three times during the conversation. Review of the undated facility policy on abuse and neglect reflected the facility was responsible for screening and the administrator was responsible for investigation of incidents of abuse or neglect.
F 0656 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that residents received care in accordance with professional standards of practice, and the comprehensive person-centered care plan for one (1) of seven (7) residents reviewed for quality of care. (Resident #1) CNA B failed to follow Resident #1's care plan. Resident #1 required 2 person transfer and CNA B transferred Resident #1 without assistance which resulted in fractures to Resident #1's toes. This failure could place residents at risk of not having their needs met, decreased quality of life or injury. Findings included: A review of Resident #1's facility face sheet dated 07/30/2020 reflected an [AGE] year old female, admitted [DATE] with [DIAGNOSES REDACTED]. A review of Resident #1's quarterly MDS dated [DATE] reflected her BIMS was 99 indicating she was unable to complete the interview. Section G indicated she was a two-person transfer. A review of Resident #1's Care Plan noted under the category of skin impairment to use caution with transfers to prevent striking arms, legs and hands against any sharp or hard surface. The Care Plan also reflected under the category of ADL care, she was a total assist, two-person transfer. A review of Social Worker Quarterly assessment for Resident #1 dated 07/29/2020, Resident #1 was non-verbal. In an interview on 9/30/2020 at 10:22 AM the ADM stated the facility found Resident #1's toes to be red on 7/24/2020 at 5:00 PM and called the physician for an x-ray. He stated the incident was thoroughly investigated and he concluded the resident must have bumped her toes during transfer in the shower. In an interview on 9/30/2020 at 11:38 AM LVN A stated she was aware Resident #1 was a two-person transfer. She stated she regretted not helping CNA B with the transfer back to bed. In an interview on 09/30/2020 at 12:03 PM CNA B stated she could not remember anything about that day. CNA B stated Resident #1 was a two-person transfer. As her statement was read aloud she said LVN A did help her with the transfer of Resident #1 on that day. Review of the provider investigation report dated 7/24/2020 reflected that after the investigation it appears that the resident may have inadvertently bumped her right toes during a transfer on 7/23/2020. The report contained a signed, handwritten statement by LVN A dated 7/28/2020 who wrote she observed CNA B transfer Resident #1 by herself. LVN A wrote that on 07/23/2020, she saw CNA B putting her arms underneath under Resident #1's arms to transfer her to a standing position from the shower chair. She wrote then CNA B then used one arm behind the resident's back and one arm underneath the resident's legs to transfer her to the bed placing her in a sitting position before lying her down on the bed for wound care. Review of CNA B's personnel file indicated she was trained on two-person transfers. Review of facility's in-service trainings revealed a training on 7/24/2020 specific to Resident #1's transfers and care. There were also 2 other trainings on transfers dated 7/21/2020 and 6/23/2020. Review of facility's CNA job description, job knowledge section, #3, Provides nursing care in accordance with Resident Care Policies and Procedures and ensures the safety and well-being of the residents is maintained. Review of the facility's resident transfer policy and procedure, undated, reflected step by step directions for two-person transfer.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations and interviews the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness meet the standards of professional food safety. The facility failed to ensure the proper storage, dating, and labeling of foods used by 69 of 70 residents who consume food from the facility's one kitchen. The facility failed to ensure the kitchen was free of flies; that the work surface was clean and free of food scraps and that all food was stored and labeled appropriately. Failure by the facility to provide proper food storage by not maintaining sealed and dated bags of food placed residents who eat from the kitchen at risk for food borne illness. Findings Included: A review of the facility infection control policy and practice lists under number 2 (b) Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. An observation at 1:21 PM revealed

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) three flies, one of which landed on a prep surface with scraps of food. Two more flies were flying around. The refrigerator contained open packages that were undated and unlabeled: cabbage, limes, tomatoes, grated cheese, celery that was turning brown. A jar of minced garlic was not dated. A red plastic cup was noted empty, except for a small amount of congealed brown liquid in the bottom of it. In the freezer there were the following open containers but no label or date: raw chicken, breaded chicken patties, bread slices, and a box of meat with a factory label of smoked pulled pork. There was a box on the floor in the refrigerator. In an interview on 09/30/2020 at 1:22 PM the Dietary Manager stated the foods should have been closed, labeled, and dated. She said the box on the floor was because she got her truck in that day and had not had time to put it up. Review of the Texas Food Establishment Rules dated October, 2015 reflected: 228.69 Preventing contamination from the Premises (1) Food storage Except as specified in paragraphs (2) and (3) of this subsection, food shall be protected from contamination by storing the food (c) at least 15 cm (6 inches) above the floor.