STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675712	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOMESTEAD NURSING AND REHABILITATION OF ITASCA	**409 S FILES ST ITASCA, TX 76055**

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 -** Actual harm **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 interview and record review, the facility failed to ensure residents were free from neglect for one of seven residents (Resident #1) reviewed for neglect, in that; Resident #1 was not positioned in her wheelchair as per her assessment and care plan. On 8/20/2020, Resident #1 fell out of her wheelchair and sustained a [MEDICAL CONDITION]. This failure could place residents at risk of not receiving care and services to meet their needs, resulting in injury, illness, and death. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged to the hospital on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed no BIMS score. Further review revealed the resident required total assistance of one to two persons for mobility, transfer, and locomotion. Record review of Resident #1's Care Plan dated 08/20/2020, revealed Resident #1 had history of falls: has experienced a fall due to confusion and stated resident rocks legs back and forth causing her to slide down in chair, wheelchair has to be in tilt back position. The goal states Resident#1 will have no falls and be free from significant injury through next review date. The approaches include: attempt to discover cause and resolve reasons for falls, conduct fall assessment per policy, monitor for pain during task, notify physician/responsible party as needed of issues, provide assistance as needed, document ADL performance of resident and assistance provided by staff per policy, provide assistance as needed to perform transferring as needed, provide needed equipment, refer to therapy prn. Continued review revealed Resident#1 is at risk for falls due to confusion and requires total assistance. The goal stated Resident#1 will have one or fewer falls and be free from significant injury through next quarter. The approaches stated call bell in reach, fall risk assessment per policy, notify charge nurse, Responsible Party and/or physician as appropriate of changes, Physical therapy to evaluate for safe wheelchair positioning and caregiver training. Record review of Resident #1's Progress note dated 08/13/2020, at 6:22 pm, revealed the resident was seen sliding out of wheelchair and nurse guided her down to the floor. Progress note dated 8/20/2020, at 4:30 pm, revealed resident found lying on floor in room in front of wheelchair. Resident's wheelchair wasn't in tilt back position. Progress note dated 8/27/2020, at 3:15 pm, as late entry on 8/28/2020, at 11:17 am, revealed resident to have 2+ [MEDICAL CONDITION] to lower leg and foot. Progress note dated 8/28/2020, at 9:45 am, as late entry on 9/2/2020, at 9:45 am, revealed noted bruising to inside of left thigh. Progress note dated 8/28/2020, at 10:00 am, revealed [MEDICAL CONDITION], redness and swelling. Progress note dated 8/29/2020, at 4:53 pm, revealed that physician was notified of left [MEDICAL CONDITION] and an order for [REDACTED]. Record review of facility Incident report dated 9/2/2020, revealed incident occurred 8/20/2020, Resident #1 was found lying on floor next to her wheelchair. Resident #1 is non-verbal and has contracted legs and arms. Post assessment, nurse and nurse aide positioned resident back in w/c with slight recline to w/c back as this is the usual position of the chair. Resident #1 was no longer in the facility. In an interview on 9/14/2020, at 12:03 pm, LVN-A stated she had received in-service and training on resident rights, abuse and neglect. She stated an example of abuse would be yelling at a resident and example of neglect would be refusing to feed them. She stated she had not witnessed abuse or neglect but would report it to the Administrator. In an interview on 9/15/2020, at 2:48 pm DON stated there was no documentation that Resident #1's wheelchair should have been reclined. She stated the seat had not been dropped, but intermittently the back would be reclined. At the time the resident was found on the floor, the back was not reclined. She stated the staff felt, the resident may not have scooted out of her chair, if the back had been reclined. She stated during the assessment at the time of the fall, there were no visible signs or symptoms of pain or injury. The resident was assisted back to bed. She stated eight days later the swelling and bruising appeared, so an X-ray was ordered which revealed a fracture and the resident was transported to ER for medical treatment. She stated when the resident was discharged from the hospital her family requested she be sent to another nursing facility to be closer to the family. In an interview on 9/15/2020, at 3:11 pm, CNA-B, stated she had been off for several days and returned to work on 8/26/20. She stated she noticed Resident #1's left leg was swollen, she stated she reported it and was told it was normal disease issues. On 8/27/20, she was providing incontinent care for the resident and noticed a bruise around the left groin area and notified the nurse. She stated on 8/27/2020, the Administrator had done ROM with the resident prior to her going in to provide incontinent care. She stated on 8/28/20, she asked CNA-C to assist her when she was changing Resident #1 and she noticed the bruise was lighter in color, but it was farther down the leg. In an interview on 9/15/2020, at 3:15 pm CNA-C stated she was working on 8/27/2020, and was asked by CNA-B to assist with changing Resident #1. She stated she noticed bruising around the groin area of the left leg. She stated CNA-B told her it was bigger than the day before and had moved farther down her leg. She and CNA-B reported it to the Administrator and an X-ray was ordered that day. On 9/14/2020 and 9/15/2020, an interview with the administrator who was the facility Abuse and Neglect reporting coordinator was not possible, as she was out for personal reasons. Record review of the complaint report submitted by SW-E, for the hospital, revealed Resident #1 had a [MEDICAL CONDITION] hip. The hospital doctor was concerned, and nursing staff at the facility had noticed left hip swelling and that the resident was in pain. The report stated this had to be a bad fall to be consistent with the swelling and pain. Resident #1 was not a candidate for surgery with extensive knee and hip flexion contractures and is non-weight bearing for the lower extremities. The facility policy and procedures titled Abuse and Neglect - Clinical Protocol dated 2005, (Revised April 2013) revealed in part: . Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness . The facility management and staff will institute measure to address the needs of residents and minimize the possibility of abuse and neglect. In-service Logs dated 8/29/2020, revealed training was provided for Falls and Post Fall assessments and Proper Positioning.
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 interviews and record reviews, the facility failed to ensure that residents environment remained as free of accident hazards as possible for one of seven residents reviewed for accidents (Resident #1) . Resident #1 was not postioned appropriately in her wheelchair, fell out and sustained a [MEDICAL CONDITION] hip on 8/20/2020. This failure could place residents at risk of not receiving care and services to meet their needs, resulting in injury, illness, and death. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged to the hospital on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's Quarterly MDS dated [DATE] revealed no BIMS. Further review revealed the resident required total assistance of one to two

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) persons for mobility, transfer, and locomotion. Record review of Resident #1's Care Plan dated 08/20/2020, revealed Resident #1 had history of falls: has experienced a fall due to confusion and stated resident rocks legs back and forth causing her to slide down in chair, wheelchair has to be in tilt back position. The goal states Resident#1 will have no falls and be free from significant injury through next review date. The approaches include: attempt to discover cause and resolve reasons for falls, conduct fall assessment per policy, monitor for pain during task, notify physician/responsible party as needed of issues, provide assistance as needed, document ADL performance of resident and assistance provided by staff per policy, provide assistance as needed to perform transferring as needed, provide needed equipment, refer to therapy prn. 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