STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455455	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MERIDIAN CARE OF ALICE	218 219 N KING ST ALICE, TX 78332

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 each resident received adequate supervision to prevent accidents, for one Resident (R#9) of one resident reviewed for accidents. The facility did not provide adequate supervision to prevent R#9 from falling in his room/restroom eight times in less than seven months. This failure could place residents with a fall history at risk for additional falls and injuries. The findings were: Record review of R#9's March 2020 Order Summary Report (Physician Orders) revealed R#9 was [AGE] years-old and was admitted to the facility on [DATE]. R#9's [DIAGNOSES REDACTED]. Record review of R#9's Quarterly Minimum Data Set (MDS) assessment, dated 02/23/20, revealed R#9: -exhibited no [MEDICAL CONDITION] or behavioral issues, -required extensive assistance from staff for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene, -was totally dependent on staff for locomotion on and off unit. -had falls since admission/entry or reentry or prior assessment, -had one fall with major injury, -used antianxiety medications in the past seven days, and -used antidepressants in the past seven days. Record review of R#9's Care Plan, initiated 08/01/19, revealed: I require assistance with ADLs due to sensory impairment and functional decline. I use a wheelchair for mobility. LEGALLY BLIND. Interventions included: -assist resident as needed with ADLs -transfers- extensive assistance X two person physical assist -walk in room- activity did not occur -walking in corridor- activity did not occur 1) Review of R#9's Incident Report, dated 09/21/19 at 3:00 a.m., revealed: -Incident Location: R#9's bathroom -Incident Description: CNA informed writer that upon answering resident call light in restroom resident sitting on floor. Upon entering restroom writer noted resident sitting on floor .holding onto rail. Review of R#9's Care Plan, revealed: -I am at risk for falls- falls on 09/21/19 and fall on 09/20/19 Goal: I will not sustain a fall with serious injury -Anti lock brakes -Assist with transfers as needed -Assure that lighting is appropriate -Call bell within reach -Instruct resident not to have sudden changes in position -Monitor environment for hazards that may contribute to falls. Examples: wet floor, placing items below field of visions, proper fitting shoes, etc. 2) Review of R#9's Incident Report, dated 09/29/19 at 6:35 a.m., revealed, -Incident Location: Resident's room -Incident Description: (LVN) Called to resident's room by LVN, found resident sitting (on the) floor in front of w/c, CNA stated upon transfer from bed to w/c, resident leaned towards right side of w/c causing fall onto floor, landing on right side. Resident noted with X2 skin tears to right arm. No other injuries noted. No c/o pain. VSS. Assisted resident back up to w/c. MD and RP notified. Hourly checks started. 3) Review of R#9's Incident Report, dated 01/26/20 at 2:35 p.m., revealed: Incident Location: Resident's bathroom Incident Description: CNA transferred resident to toilet. CNA went to assist another CNA. When she returned, resident was sitting on floor and wheelchair was turned over on its side next to him, resident assessed. No injuries noted, able to move all extremities without pain. Vitals within normal limit. Helped resident back to wheelchair, notified MD, RP did not answer, left message. Resident able to use call bell to call for assist and when toileted. Review of R#9's Care Plan, revealed: -I am at risk for falls, fall on 01/26/20 -Environment assessed MD/RP notified Neuro checks X 72 hours One hour checks X 24 hours Pain assessment done Encourage to use call bell Will have maintenance assess w/c for any malfunction. -Goal: I will have no injuries from fall Interventions: -Anti lock brakes -Assist with transfers as needed -Assure that lighting is appropriate -Call bell within reach -chair pad alarm to alert staff when attempting to arise without assistance -instruct resident not to have sudden changes in position -monitor environment for hazards that may contribute to falls. Examples: wet floor, placing items below field of visions, proper fitting shoes, etc. -monitor for side effects from medications, lab results and poor appetite as causes for falls. -monitor resident for steadiness -pain mgmt. prn -place bed in lowest position -resident to be toileted post meals -toileted after meals -w/c alarm and pressure pad alarm to bed when in bed -X1 staff assistance. 4) Review of R#9's Incident Report, dated 02/07/20 at 9:41 p.m., revealed: Incident Location: Resident's Bathroom Incident Description: Charge nurse was called to room by CNA stating resident had received a fall. Resident was found with alarm ringing, wheelchair locked, and on the side of the wheelchair resident was sitting on the floor with back almost touching the wall. 2nd digit to left knuckle received a skin tear that was addressed and cleaned, the right shoulder also received skin tear that was superficial in nature, also cleaned and dressed. 5) Review of R#9's Incident Report, dated 02/23/20 at 8:42 p.m., revealed: Incident Location: Resident's Bathroom Incident Description: Writer heard thud coming from a room when checking room by room resident was noted in restroom on floor in a sitting position with back and head against the wall and with legs crossed. Resident was moaning in pain when asked where his pain was resident stated to his right hip. No bump was noted to back of head. MD notified and ADON was notified at 842, EMS was called at 845 called report to ER at 850 and RP was called at 853 RP voiced understanding and stated just to update her if he was going to be admitted or if he returns to facility. Resident is noted on ASA and [MEDICATION NAME]. EMS arrived at 9pm and took resident to ER. Staff nurses stayed with resident the entire time until EMS arrived. No change in LOC was noted. Review of a hospital Radiology Report, dated 02/24/20, revealed: Findings: Bones/Joints: There is an acute comminuted intertrochanteric [MEDICAL CONDITION] right femur. There is resultant coxa vara deformity (deformity of the hip, whereby the angle between the head and the shaft of the femur is reduced to less than 120 degrees. This results in the leg being shortened and the development of a limp.) 6) Review of R#9s Incident Report, dated 03/02/20 at 6:40 p.m., revealed: Incident location: Resident's room Incident Description: Resident noted on side of bed. Bed was noted in low position and alarm sounding off asked resident multiple times if he was in pain resident denied pain. Resident was noted with small skin tear to left hand and left elbow. 7) Review of R#9's Incident Report, dated 03/05/20 at 3:05 a.m., revealed: Incident location: Resident's room Incident Description: Nurse heard a thud and alarm activated, nurse and staff went to resident's room to find him on floor on top of bed side floor mat feet to doorway and sitting half way upright with face facing doorway to room and resident continuously talking to himself. Resident unable to voice how the incident happened d/t increased confusion. No other injury visible at this time. Resident has no c/o pain at this time and is able to say 'no I don't have pain.' No injury to head visible assessed head with palpation and no abnormalities present. Nurse and two other CNAs assisted resident back to bed carefully keeping BLE straight without any over extension of R hip fx. No noted pain with movement present. Head to toe assessment performed as well as vitals check prior to transfer. Hourly checks and neuros initiated. Bed remains at lowest position with floor mats to each side of the bed alarm in place as well. Will cont to monitor. 8) Review of R#9's Incident Report, dated 03/11/20 at 6:05 a.m. revealed: Incident Location: Resident's room Incident Description: Morning shift walking in and noted resident laying on right side of bed on floor mat with alarm activated staff, immediately notified charge nurse. Nurse and incoming nurse went in room to assess situation and resident was noted laying on floor with confusion and verbalizing jibber in Spanish. Full head to toe assessment performed while resident was on floor prior to lifting and placing back in bed. Resident appeared to have no concern with being on the floor but continued to talk about working and other things. No pain reported, resident in bed at this time.

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Review of R#9's Care Plan, Date initiated: 08/01/19 revised on 08/13/19 revealed I am at risk for falls due to impulsive behaviors, weakness, poor balance, unsteady gait, and sensory impairment. I have had multiple falls due to functional decline. Goal: I will not sustain a fall with serious injury Interventions: -on 01/26/20 Pt was instructed on call bell use, pt verbalized 100% understanding and return demonstration was successful. -01/26/20 pt to continue on nursing restorative program for AROM and transfers to maintain current level of function. -01/26/20 raised toilet seat implemented -02/07/20- Environment assessed no clutter, spills or other hazards noted in resident's bathroom -neurological checks per protocol and was placed on Q1 hour checks X 24 hours. -re-inforced resident teaching on calling for assist and demonstrated use of emergency call bell, return demonstration successful. -pt to continue on nursing restorative toilet transfer program -02/23/20 - Environment assessed, clutter r/t wc in bathroom next to resident noted, no spills or other hazards were noted. -pain assessment done -head to toe assessment done on resident, no injuries noted. -neurological checks initiated Q1 hr X24 hrs. -a clip installed to call bell string to pin on resident when he is on the toilet so it will alert staff when he is rising without staff assist -a sign will be placed on the wall near toilet as well to alert staff and in service initiated on call bell pin. -rehab to evaluate and treat as necessary when resident returns from acute hospital to help improve pts functional status. -03/02/20 -Environment assessed status [REDACTED]. -neurological checks per protocol. -side rails to both sides of bed placed to aid in repositioning and mobility -floor mats to be placed to both sides of bed while resident is in bed -anti lock brakes -assist with transfers as needed -assure that lighting is appropriate -call bell within reach -chair pad alarm to alert staff when attempting to arise without assistance -instruct resident not to have sudden changes in position -monitor environment for hazards that may contribute to falls. Examples: wet floor, placing items below field of visions, proper fitting shoes, etc. -monitor for side effects from medications, lab results and poor appetite as causes for falls. -monitor resident for steadiness -pain mgmt. prn -place bed in lowest position -resident to be toileted post meals -Toileted after meals -w/c alarm and pressure pad alarm to bed when in bed -X1 staff assistance. Observation on 03/11/20 at 10:45 a.m. revealed R#9 lying in bed. The bed was in the lowest position, bilateral floor mats were in place, and the call light was within reach. CNA C was at R#9's bedside. Surveyor attempted to interview R#9, but R#9 was unable to answer any questions. In an interview on 03/11/20 at 10:50 a.m., CNA C said he helped monitor R#9. CNA C said R#9 did not use the call light but called out nurse. In an interview on 03/12/20 at 9:01 a.m., CNA D said R#9 always tried to get up when he was in bed. CNA D said staff had to continously monitor R#9 since R#9 had the [MEDICAL CONDITION]. In an interview on 03/12/20 at 10:17 a.m., LVN H said R#9 had a fall (on 02/07/20)before his fall with his [MEDICAL CONDITION] (02/23/20). LVN H said that fall was the exact same way R#9 fell when he had his fall and fractured his hip. LVN H said R#9 did not use the call light. LVN H said R#9 was blind and could not find the call light, so he just yelled for help. LVN H says interventions were not put into place since R#9 [MEDICAL CONDITION] since fall precautions were put into place. LVN H said R#9 still attempted to get out of bed since his fall with [MEDICAL CONDITION]. In an interview on 03/12/20 at 12:02 p.m., the DON said they were trying different interventions with R#9. The DON said R#9 normally used the call light when he was in the restroom. Review of the facility's policy on, Falls and Fall Risk, Managing, revised December 2007 revealed: -Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. -The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. -If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. -The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. -If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.