STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676380	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BIG SPRING CENTER FOR SKILLED CARE	**3701 WASSON RD BIG SPRING, TX 79720**

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 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 alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source were reported immediately, but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury, or, 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury. The facility failed to report an incident that resulted in serious bodily harm to the State Survey Agency, within 24 hours of fall and within 2 hours of notification of serious bodily harm for 1 out of 5 residents (Resident #2) reviewed for neglect. The facility failed to report a fall resulting in serious bodily injury involving Resident #2 to the State Survey Agency within the appropriate time frames. This failure could affect resident's by placing them at risk of not having incidents of neglect being reviewed and investigated in a timely manner by the facility and State Survey Agency. The findings include: Record Review of Resident #2's clinical record revealed he was a [AGE] year old male that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #2's most recent quarterly MDS dated [DATE] indicates BIMS is unable to be completed due to the resident being rarely/never understood. Staff assessment of cognitive status indicates memory problems with both short and long-term memory, which indicates moderately impaired regarding daily decision making. Section G of the MDS indicates resident requires extensive assist with bed mobility, transfer, dressing, toileting, personal hygiene, and bathing. Limited assist with walking and eating. Record Review of Resident #'2 Significant Change MDS that is in process, dated 3/2/20 indicates staff assessment of cognitive status is severely impaired for daily decision making. Section G indicates extensive assist with bed mobility, transfer, dressing, eating, toileting, personal hygiene, and toileting, limited assist with walking. Record Review of Provider Investigation Report of the incident involving Resident #2, reveals incident date was 2/28/20 at 3:43 PM. In the description of the incident the facility reports Resident #2 had a fall at approximately 9:00 AM on 2/27/20. There were no obvious injuries. Nurses continued to monitor resident. On 2/27/20 at 7:35 PM further monitoring noted a possible contusion on the hip and X-Rays were ordered. It was reported on the night shift, CNA # 6, who knew about the fall, searched out LVN # 4 when Resident #2 moaned while CNA #6 moaned while changing his brief. LVN #6 reported Resident #2 did not moan while the two of them were performing perineal care together. X-Ray revealed [MEDICAL CONDITION] hip. Documents that were attached to the Provider Investigation Report include Fall Event Nurses Note dated 2/27/20 at 8:47 PM indicating Resident #2's fall, Nursing Progress Note dated 2/27/20 at 8:55 AM, Nursing Progress Note with effective date of 2/27/20 at 9:11 AM, but not created till 2/28/20 at 2:12 PM, indicating resident was transferred back to his recliner with no injuries noted. Nursing Progress Note dated 2/28/20 at 8:45 AM indicating Resident #2 complaining of pain to left hip from fall on 2/27/20, so portable X-Ray ordered. Nursing Progress Note dated 2/27/20 at 7:35 PM, but not created till 2/28/20 at 10:37 AM, documenting, X-ray tech to come in a.m. to take left hip x-ray. Transfer Notification note dated 2/28/20 at 2:31 PM indicating Resident #2 was transferred to the hospital on [DATE] at 3:00 PM related to intertrochanteric left femoral fracture. Nursing Progress Note dated 2/28/20 at 6:41 PM indicating Resident #2 returned to the facility from ER with discharge diagnose of Displaced articular fracture of head of left femur. New order for Tylenol #3 every 6 hours as needed for pain. Record Review of Intake information indicated the facility did not report the incident to the State Survey Agency until 2/28/2020 at 5:42 PM. During interview with Administrator on 3/6/20 at 8:30 AM when asked the time reporting requirements, He replied that if it didn't involve serious injury it's 24 hours. If it involves major injury, it's 2 hours. Surveyor showed Administrator the time the intake was received. He did not reply with any statement. Record Review of facility provided policy titled Abuse/Neglect from Nursing Policy and Procedure Manual 2003 with revision date 11/07/2016 Policy: Procedure D. Identification 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of [REDACTED]. The facility administrator or designee will report the allegation to the Texas Department of Aging and Disability (DADS). a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation b. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation. E. Investigation Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of [REDACTED]. 3. The written report with all information, must be sent to DADS no later than the fifth working day after the initial report. The facility will use the designated state reporting form. 7. The facility will report and cooperate with any and all investigations concerning reports of abuse, neglect, exploitations, mistreatment of [REDACTED].
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure treatment and care was provided in accordance with the comprehensive assessment and professional standards of practice that met the physical, mental and psychological needs for 1 of 5 residents (Resident #2) reviewed for Quality of Care in that: The facility failed to reassess Resident #2 following a fall and obtain an X-ray of Resident #2's left hip after resident was complaining of pain in a timely manner. On 2/27/20 at 4:00 PM resident's daughter went to front desk to notify the DON and ADON that something was wrong with his left leg and he was still in pain. The facility failed to medicate Resident #2 after complaint of pain was reported to LVN #2 by CNA #4 at 10:30 AM on 2/27/20. February Medication Administration Record [REDACTED]. There is an order for [REDACTED]. This deficient practice could affect all residents in the facility and put them at risk for falls and injury. The findings were: Record Review of Resident #2's clinical record revealed he was a [AGE] year old male that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #2's most recent quarterly MDS dated [DATE] indicates BIMS is unable to be completed due to the resident being rarely/never understood. Staff assessment of cognitive status indicates memory problems with both short and long-term memory, which indicates moderately impaired regarding daily decision making. Section G of the MDS indicates resident requires extensive assist with bed mobility, transfer, dressing, toileting, personal hygiene, and bathing. Limited assist with walking and eating. Record Review of Resident #'2 Significant Change MDS that is in process, dated 3/2/20 indicates staff assessment of cognitive status is severely impaired for daily decision making. Section G indicates extensive assist with bed mobility, transfer, dressing, eating, toileting, personal hygiene, and toileting, limited assist with walking. Review of a care plan entry dated 11/6/2018, revised on 1/15/20 indicates Resident #2 is at risk for falls related to unsteady gait due to lack of

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) coordination, generalized weakness, abnormalities of gait, and dementia. Review of care plan entry dated 2/27/20, revised on 2/28/20 indicating Resident had an actual fall. Intervention to monitor/document/report every shift and as needed x 72 hours to medical doctor for signs and symptoms of pain, bruises. Neuro-checks per protocol date initiated 2/27/20 with revision 2/28/20 Review of an Event Summary Report (incident report) by LVN #2 dated 2/27/2020 at 8:47 AM documents CNA's went to go make rounds/pick up breakfast tray, resident attempting to walk to bathroom without assist, fell to floor d/t (due to) losing his balance. No injuries noted. AROM/PROM (active range of motion/passive range of motion) wnl (within normal limits) x 4. Wife witnessed fall. Physician and responsible party notified at 8:45 AM Review of Nursing Progress Note by LVN #2 with effective date of 2/27/20 at 9:11 AM, but not created until 2/28/20 at 2:12 PM, indicating resident was transferred back to his recliner with no injuries noted. Review of Nursing Progress Note dated 2/28/20 at 8:45 AM indicating Resident #2 complaining of pain to left hip from fall on 2/27/20, so portable X-Ray ordered, resident unable to travel due to pain. Nursing Progress Note by LVN #2 dated 2/27/20 at 7:35 PM, but not created till 2/28/20 at 10:37 AM, documenting, X-ray tech to come in a.m. to take left hip x-ray. Responsible party notified. Review of Transfer Notification note by LVN #1 dated 2/28/20 at 2:31 PM documenting Resident #2 was transferred to hospital on [DATE] at 3:00 PM related to intertrochanteric left femoral fracture. The note text documents, This is intended to serve as notice of an emergency transfer. This notice was provided to (check all that apply) ___Resident ___Resident Representative Neither one is checked on this Transfer Notification. Review of Nursing Progress Note by LVN #5 with effective date of 2/28/20 at 6:41 PM, but not created until 2/28/20 at 9:01 PM documents, Resident returned to facility from SMMC ER (Scenic Mountain Medical Center emergency room) discharge dx (diagnosis) reads: displaced articular fx (fracture) of head of left femur, initial encounter for closed fx. Received prescription for Tylenol-[MEDICATION NAME] #3 every 6 hours prn (as needed) for pain. Order noted and carried out. Family in room and resident is resting quietly in bed at this time, call light is within reach. We will continue to monitor. The bottom of the note indicates this will be shown on Shift Report and shown on 24 Hour Report. Review of Pain Level Summary for 2/27/20 only show pain assessments of 0 for 2/27/20 at 8:49 AM and 0 at 8:50 AM. No further pain assessments recorded until 2/28/20 at 7:23 PM with pain level of 4. (This is based on numerical scale from 0-10. With 0 meaning no pain, one to three means mild pain, four to seven is considered moderate pain, and eight and above is severe pain.) Review of Resident #2' February 2020 MAR (Medication Administration Record) indicates Resident was not medicated for pain until 2/28/20 at 7:23 PM. Interview with D.O.N on 3/5/20 at 4:40 PM Asked D.O.N. about the q 30-minute checks following fall and every 2-hour interval monitoring as indicated in the Event Nurses Note dated 2/27/20. She stated, it was usually on paper. She went to find them. Interview with Administrator on 3/5/20 at 5:15 PM. Administrator entered room to bring me the monitoring chart that D.O.N. had gone to get regarding Resident #2, stating, she had to go pick up her kids. The paper is only initials with no explanation. Surveyor expressed concern for the gap in the nursing notes. LVN #2 did notify Physician with no new orders received, and family, but nothing till the following day. Administrator said, That bothered him too, but with the witness statements and evidence he didn't have enough to substantiate neglect. Stated LVN #2 is a new nurse. Administrator stated LVN #2 was here and asked if I would like to speak to her. Interview with LVN #2 on 3/5/20 at 5:36 PM. LVN #2 was the nurse on duty when Resident #2 fell . She stated after the CNA's notified her of his fall, she went to check on on him and did an assessment saying there was no pain noted. Stated he was joking around with CNA #5 like he always did. Surveyor asked if he was able to walk or bear weight. She said, No, he was full assistance to get him back to his recliner. He doesn't walk. Surveyor said apparently he was before he fell , per your documentation, and resident's wife who was a witness indicating that he got up from his recliner and walked really fast towards the restroom. LVN #2 stated she was sticking by her assessment. I asked her what is the first thing you learn in nursing school, she stated if not documented not done. Agreed she probably should have documented more. Interview with RN #1 on 3/6/20 at 6:15 AM. Surveyor asked RN as a professional, what are your expectations for charting for an incident like a fall. She replied you need to paint a picture, so anyone reading it would be able to know what happened. And then would need to chart in nursing progress notes. Surveyor asked if there needed to be follow- up. RN #1 responded absolutely. Pointed out the documentation in the chart and what was also attached to the Provider Invesitigation Report, that I had regarding Resident #2's fall. In agreement that documentation is open for questions. Interview with RN #2 Stated he had been an RN for 2 years. Asked his expectations of documentation for a change of condition such as a fall from a nurse and CNA's. He voiced that you would need to document assessment of resident. You wouldn't want to move them until you did full assessment, find out what might have caused fall. He stated he would want to do neurochecks. He would document in the nursing progress notes. Agreed that if CNA's were checking as well, it should be documented. Interview with Administrator on 3/6/20 at 8:30 AM. Surveyor talked again with Administrator about the lacking documentation of nursing. He stated I can't answer that. I understand where your are coming from. I also asked him the time for reporting for incidents. He stated if it didn't involve serious bodily injury its 24 hours. If involves major injury its 2 hours. The fall with Resident #2 occurred per Event Nurses Note at 8:47 AM on 2/27/20. Intake received 2/28/20 at 5:42 PM. X-Ray confirmed left [MEDICAL CONDITION], Nurse Note dated 2/28/20 2:31 PM, resident transferred to hospital. Administrator asked if I wanted to talk to D.O.N. Interview with D.O.N. on 3/6/20 at 8:50 PM Surveyor asked D.O.N. what her expectations were for her staff for documentation of events or change of condition of residents. She stated she expected a thorough assessment. Stated that this staff is not good with documentation. Surveyor asked if she went to assess Resident #2 after his fall. She stated no she didn't because LVN #2 reported no injuries. Surveyor asked how she determined if she needed to assess or not. D.O.N. stated that she will read the narrative summary on the event note, and this particular one indicated no injuries. She went to talk with resident #2's wife on 2/28/20 as resident was being prepared for transfer to find out what happened. D.O.N. stated they were going to start what was called a HUDDLE Fall Assessment, and it was going to require an RN to assess the resident after any fall. I asked if it was accurate that when an X-Ray was ordered that they came from Lubbock? She said, yes that is correct. The company they are contracted with is in Lubbock, but if they aren't here in 2 hours, I tell the staff to send them to the hospital. Surveyor asked it there was any other documentation that showed proof that Resident #2 was assessed after the fall. D.O.N. stated, No. Interview with ADON on 3/6/20 at 9:45 AM. Stated she had been an LVN since 2010, but that she had worked in long term care since she was [AGE] years old. She has been employed here for about a month. She stated she had lots of challenges to work on, These nurses don't chart. She was unaware of the Facility Self Report on Resident #2. We went through the documentation regarding the incident. She agreed that it was lacking and raised more questions. Stated she was working on trying to get systems in place to improve charting and communicaton between staff. She also expressed the frustration of staff not staying. She stated, I trained a wound care nurse yesterday and she has already quit. Surveyor asked what was the reason, ADON voiced because there aren't any tools to do their job. She said right now the tablets don't get a signal down the hall, and the nurses have to run back to the station to see what meds they are giving. No 24-hour report, no neurochecks. She did say that administration had ordered new tablets in hopes that things would improve. Interview with RN Corporate Compliance Reviewer on 3/6/20 at 10:05 AM. She stated that she had looked everywhere and couldn't find a policy for documentation that I had requested. I asked her about the fall incident regarding Resident #2. Surveyor asked if I was missing anything. She stated, No, I have looked through all the documentation as well. Agreed it wasn't there. Interview on 3/6/20 at 11:30 A.M. with CNA #4 who has been a CNA since 1981. He was on duty 2/27/20 on Hall 4. Asked him to go through his day regarding Resident #2. He stated that about 6:30 AM he got resident up and got him dressed for the day. He walked with him to the bathroom, and then got him to his recliner in preparation for breakfast. As he was passing out breakfast trays, when he opened the door Resident #2 was on the floor on his back. CNA #4 stated that he called to CNA #5 to go get the nurse. LVN #2 came to room and was asking resident if he had any pain. Resident is only Spanish speaking, so nurse asked CNA #5 to ask him in Spanish if he was hurting anywhere. Nurse was assessing resident, looking at skin and asking him if he could move arms and legs. They started getting him up, CNA #4 stated resident kind of moaned during the process. We got a chair and sat him in it then slid it to the recliner, then transferred him back to the recliner. CNA #4 stated he probably ate about 50% of breakfast. Surveyor asked how often he went back to check on resident following fall. CNA #4 stated every hour to hour . Surveyor asked if they documented their observations. He stated no. The next time he saw Resident #2 was about 10:30 AM to see if he needed to be changed. He stated resident's wife reported that he needed some Tylenol for pain. CNA #4 said he noticed that resident seemed more sleepy than he did earlier. He told the nurse that resident needed some Tylenol. Thought the nurse gave him some. At lunch, CNA #4 said he had to keep waking him up, he ate maybe 25%. CNA #4 said, I thought he might just be tired, but it seemed a little strange to me. It wasn't his usual. After lunch we always lay him down. When we were changing him he would stiffen up when we tried to roll him. The last time CNA #4 saw the resident was about 4:30 PM. He stated he went to get him ready for supper, but he was already in his recliner and his family was there. They were all eating chicken that the family had brought in. Family didn't say

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) anything about resident in pain. CNA #4 stated he gave report to the oncoming shift, and did report Resident #2 had a fall. Interview on 3/6/20 at 12:00 PM with CNA #5. She has been a CNA for [AGE] years, employeed here for two years. Surveyor asked CNA #5 to go through her day on 2/27/20 regarding Resident #2. She stated after they get report, they start getting residents ready for breakfast, starting at the front of the hall to the back. Stated it was probably around 7:00 AM when they got to Resident #2's room. They got him up and put him in his recliner. They were headed to start passing trays in the dining room. CNA #4 went back to check resident's in the room and Resident #2 was on the floor. She stated resident had his pants pulled down like he was getting ready to go to the bathroom. Stated he was kind of on his left side. She stayed with him while CNA #4 went to get the nurse. Nurse was asking him if he was hurting anywhere. She asked me to ask him, resident was just saying get me up We stood him up and got his pants pulled up. Surveyor asked if he was able to bear weight or walk. CNA #5 stated no he just picked his feet up, so we just picked him up by his belt loops and carried him to the recliner. Surveyor asked if she went to check on him after that. CNA #5 stated, yes about every 1-2 hours. Asked if she documented after her checks, she stated no. We changed him around 4:00 PM. Resident #4 seemed like he was in pain when rolling him. So we left him in bed. Around 5:30 PM checked on him, and he was still in bed. When we changed him I didn't want to turn him to the left, because that was the side he was laying on when he fell . She didn't see him after that. Change of shift. Attempted to call Physician on 3/6/20 at 1:35 PM with the number the facility gave surveyor. This was no longer the number for him, as he had moved offices. Attempted to call CNA #6 times 2 and left a message to call me. No return call received. Attempted to call LVN #4, the number provided is no longer a working number. Review of In-service Training Report dated 9/12/2019 with Subject: Professional Documentation REPEAT IN-SERVICE. Instructed by Corporate and D.O.N. Summary of Subject Matter: It is the expectation for all nursing staff, RN/LVN/CNA to complete any and all required documentation for their residents prior to the end of the shift every day. All required assessments and documentation by nursing staff will be reviewed for completeness and timeliness via the UDA tab in PCC. Check this for yourself each shift and complete what you can. If you note a red assessment and you can complete it then do so. Timely assessments of residents leads to increased quality of care. It is the charge nurse responsibility to check that POC (kiosk) is 100% prior to releasing your CNA staff at the end of the shift. If you need help understanding how to assess your charting on resident and how to complete, please see the D.O.N./ADON's. If you fail to complete your documentation during your shift and receive a telephone call to return to the facility to complete it that day, you will be expected to do so. This is a REPEAT in-service. Continued noncompliance with professional documentation will lead to progressive disciplinary action. The facility's CMS Resident Matrix printed on 3/6/20 documents 13 falls, 5 of those with injury.