STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675212	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HOMESTEAD OF DENISON	**1101 REBA MCENTIRE LN DENISON, TX 75020**

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 -** Immediate jeopardy **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 observation, interview and record review, the facility failed to ensure residents were free from abuse for one (Resident #1) of six residents reviewed for abuse. CNA A failed to ensure he was familiar with Resident #1's required level of assistance for ADLs and to provide the required two people for assistance. CNA A provided Resident #1 incontinent care with no assistance, resulting in the resident rolling off the bed onto the floor and disconnecting her ventilator. The resident required emergency CPR and was transferred to the hospital, where she was diagnosed with [REDACTED]. It was determined an Immediate Jeopardy (IJ) past non-compliance existed from [DATE] to [DATE]. The IJ was determined to have been removed on [DATE] due to the facility's implemented actions that corrected the non-compliance prior to the beginning of the investigation. This failure placed residents at risk for serious injuries, a decline in the resident's condition, hospitalization or death. Findings included: Review of Resident #1's Minimum Data Set (MDS) Admission Assessment, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her active [DIAGNOSES REDACTED]. She was in a persistent vegetative state/no discernible consciousness, was totally dependent and required assistance of two staff for bed mobility, was incontinent of bowel, had a Foley catheter and was on a ventilator. Review of Resident #1's comprehensive care plan, dated [DATE], reflected she had a self-care performance deficit and required two staff to reposition and turn in bed. Review of the Provider Investigation report dated [DATE] reflected, .Incident date [DATE] at 5:54 a.m. .description of incident .Resident rolled out of bed during incontinent care .Nurse assessed and found no pulse. CPR initiated. Pulse returned, and resident was transported to hospital by EMS in stable condition .CNA was suspended. MD and RP notified. Safe survey completed. In-service regarding abuse and neglect and fall prevention .Skin assessment performed on all resident who are unable to be interviewed. (CNA A) was terminated from employment. Staff educated regarding bed mobility . Review of the Witnessed Fall report completed by LVN D and dated [DATE] reflected, .Incident description .Entered residents room due to CNA calling for assistance. This nurse entered room resident lying parallel to right side of bed. Assessed resident vitals. Unable to feel pulse. Turned resident on back one round of CPR and being bagged by RT. Pulse picked up on pulse/O2 monitor .Immediate Action Taken .Assessed resident vitals. Unable to feel pulse. Turned resident on back and initiated a code. After one round of CPR/ RT. 911 notified. Pulse picked up on pulse/O2 monitor. BP ,[DATE] HR 86 O2 100% on vent. No visible injuries noted transported resident to (hospital name) ER for further evaluation .Witness statement .CNA A .I raised her bed and I rolled her on her back. I had her in the middle of the bed. I had a table with towels on it and I turned to get a towel and when I turned back around she was falling and I couldn't stop her . Review of Resident #1's hospital records, dated [DATE], reflected the following: .The patient present following fall .Per nursing home pt fell out of bed while being changed. Nurse couldn't find radio (sic) pulse and performed 1 min of CPR until pulse was detected .Differential Diagnosis: [REDACTED].Chest X-Ray .There is at least one right rib fracture of indeterminate age laterally .XR Pelvis .There is an abnormal appearance of the intertrochanteric region of the right hip, concerning for acute fracture . Review of the Resident #1's hospital discharge summary dated [DATE] reflected, .Diagnosis: [REDACTED].multiple fractures rib fractures .Comminuted right intertrochanteric [MEDICAL CONDITION] .The patient was not a good surgical candidate and was a high likelihood for mortality .Supportive care was continued .Present overall condition did not improve, she was evaluated by several people who recommended hospice placement. Today family has agreed on hospice arrangements. She will be transferred to hospice services . An interview with CNA A on [DATE] at 12:37 p.m. revealed he had worked on the ventilator hall for six months in the past but had been on other halls before [DATE]. He stated he was not familiar with Resident #1, as she was a new resident. He stated when he first rolled her she was in the rail, so he moved her toward the center of the bed and placed her on her back. He said he turned around to get a towel and she had flopped over on her side and started rolling and there was nothing he could do to stop her. He stated the resident could move her legs. He stated he did not ask for assistance when he went in to clean her up around the end of his shift. CNA A stated he had not checked the kiosk to determine what level of care Resident #1 required before providing care to her. He stated he had not done this because he only logged into the kiosk to complete his charting at the end of his shift. In an interview with LVN D on [DATE] at 6:15 p.m. she revealed on the morning of [DATE], she was down the hall making her last rounds, when she heard CNA A yell for help. She stated when she went to Resident #1's room, the resident was on the floor, detached from her vent. She assessed her and found no pulse and started CPR with assistance from the respiratory therapist. She stated they reconnected her vent, and after CPR and ventilation, were able to get a pulse and heart rhythm back. She stated the resident had no visible signs of injury. She stated 911 was called and the resident was transported to the hospital for evaluation. She stated CNA A had not asked her for any assistance with this resident. She stated they had two nurses to cover halls 100, 200, and 300, two CNAs and two RTs on duty that night, so he could have asked any one of those people for assistance. She stated she frequently assisted the CNAs, especially on the 200 hall, where almost all of the residents required two-person assistance. In an interview with the DON on [DATE] at 8:50 a.m. she revealed the incident occurred around the end of CNA A's shift on [DATE] and he had already clocked out when she had arrived at the facility. She stated she called him to ask about Resident #1's incident, and asked how a resident who could not move, lying on her back in the middle of the bed could roll of the bed. She stated CNA A insisted the resident could move her legs. She stated she asked CNA A if he had asked anyone to help him and he stated he did not. She stated she told the CNA he was suspended pending the investigation. She stated she had him come into the facility on [DATE] to re-enact exactly how the incident occurred. CNA A kept insisting he had the resident on her back, and he turned his back to get a towel and the next thing he knew, she was on the floor. The DON stated she had ADON B lay down on the bed on her back in the center of the bed and asked CNA A if this was the position he had Resident #1 in. He replied that it was. She stated ADON B crossed her right leg over her left and attempted to turn herself to the left side of the bed. She stated she was unable to turn herself without using her hands and arms to roll herself over. She said they immediately terminated CNA A for failure to ask for assistance in providing care to Resident #1. In an interview with LVN C on [DATE] at 2:00 p.m. she revealed Resident #1 was totally dependent for all care. She stated Resident #1 would not respond to verbal stimuli, open her eyes and her extremities were flaccid. She stated she had never seen Resident #1 move any of her limbs. Interviews conducted on [DATE] from 2:10 p.m. through 3:00 p.m. with CNA's K, M, N, I and O revealed all were aware each resident's level of care was found in the Kardex/plan of care system. They all stated they had been paired up with another CNA upon hire and were showed how to document in the care provided in the facility's Kardex/plan of care system. CNA M revealed on [DATE] at 2:30 p.m. if she had any question about a resident's level of care she would ask a co-worker or her charge nurse. Review of CNA A's training record reflected he had completed training on Position and Transfer Techniques and fall prevention on [DATE]. He had also signed an acknowledgment on [DATE] that he was to follow the resident's care plan to know

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) who required a Hoyer lift or who was to be lifted by two persons. He stated if there were any questions about how a resident was to be transferred, he was to clarify with the nurse. In an interview with the DON on [DATE] at 9:00 a.m. she stated after the incident on [DATE] they immediately put a corrective action plan into place that included: Review of the Plan reflected: 1. Suspension and later termination of CNA A on [DATE]. 2. Reported incident to the State within 2 hours of incident. 3. Thorough investigation of the incident, which included re-enactment of the event to determine the plausibility of how the incident occurred, interviews with staff members and safe surveys with four alert residents on the 200 hall, three residents from the 100 hall and seven residents from the 300 hall was concluded on [DATE] 4. In serviced staff on Abuse and Neglect and fall prevention, and repositioning residents in bed/bed mobility on [DATE]. 5. Skin assessments on all non-verbal residents and Safe Surveys of interviewable residents on halls 100, 200 and 300 completed on [DATE] 6. Audited all resident's Kardex/care plan on [DATE] to ensure all resident's level of care was updated and accurate. 7. Educated and validated all staff understood the use of the Kardex/care plan system on [DATE] 8. Ongoing monitoring will include: Select 2 staff members a week x six week to demonstrate competency in locating Kardex and demonstrate transfers as well as bed mobility. 9. Review plan in QAPI monthly until resolved. Review of In-service records revealed the facility had completed in-services on Abuse and Neglect, repositioning residents in bed/bed mobility and Fall precautions on [DATE] and Use of the Kardex/care on [DATE] Review of competency checks for bed mobility and the use of the Kardex/plan of care revealed the facility completed competency checks prior to working on: [DATE]- 20 staff members [DATE]- 11 staff members [DATE]- 3 staff members [DATE]- 5 staff members [DATE]-3 staff members [DATE]- 3 staff members [DATE]- 2 staff members [DATE]- 2- staff members [DATE]- 1 staff member. Review of the facility's monitoring plan revealed: Week One- February [DATE]: Seven staff members were monitored for knowledge on the use of the Kardex/plan of care and bed mobility. Week two- February [DATE]: Two staff members were monitored for knowledge on the use of the Kardex/plan of care and bed mobility. These systems were implemented prior to the state investigation on [DATE]. Interviews conducted on [DATE] from 10:45 a.m. to 8:15 p.m. with CNA E, CNA F, LVN G, CNA H, CNA I, LVN J and CNA K, which represented all shifts revealed they would check the Kardex system or ask thier nurse to determine what level of care a resident required. Review of inservice records revealed they had been in serviced on the use of the Kardex/Plan of Care system and on bed mobility and transfers. On [DATE] at 2:00 p.m. The Interim Administrator and DON was informed an Immediate Jeopardy was determined to have existed from [DATE] to [DATE]. Review of the facility's undated Abuse and Neglect policy, reflected, .No resident will be deprived by any individual of goods or services necessary to attain or maintaining physical, mental and psychosocial well-being . Review of the facility's undated policy, Comprehensive Resident Care Plans, reflected, .All items or services orders to be provided or withheld shall be included in each resident's plan of care .In accordance with each resident's plan of care, all services provided or arranged by the facility meet profession standard of quality and are provided by qualified persons. The care plan will be made available to all direct care staff.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for one (Resident #2) of three residents reviewed for pharmacy services. The facility failed to obtain Resident #2's [MEDICATION NAME] ER (Schedule II Narcotic) 15 mg on 12/29/19 which resulted in two missed doses. This failure placed residents at risk of not receiving their physician ordered medications to meet their individual needs. Findings included: Review of Resident #2's Quarterly MDS assessment, dated 01/11/20, reflected she was an [AGE] year-old female with a readmitted to the facility on [DATE]. Resident #2 was cognitively intact. Resident #2 had received scheduled and PRN pain medication in the last five days and had occasionally experienced pain over the past five days with the worst pain at a scale of 6 out of 10. Review of Resident #2's Physician order [REDACTED].[MEDICATION NAME] ER Tablet extended release 15 mg Give 1 tablet by mouth two times a day for pain . Tylenol with [MEDICATION NAME] #3 tablet 300-30 mg Give 1 tablet by mouth every 6 hours as needed for pain . Review of Resident #2's MAR for December 2019 reflected the resident received the following: [MEDICATION NAME] ER tablet 15 mg bid from 12/01/19 through the a.m. dose on 12/29/19. Resident #2 did not receive her p.m. dose on 12/29/20, or a.m. dose on 12/30/19. Review of the facility's Drug Record Book, reflected, Resident #2 .Order description: [MEDICATION NAME] ER Tablet Extended Release 15 mg .Re/Ordered Date: 12/28/19 . Review of Resident #2's Nurse's notes dated 12/30/19 reflected LVN G contacted Resident #2's MD for a triplicate for the resident's [MEDICATION NAME] sulfate. This was one day after the last dose of [MEDICATION NAME] was administered. Review of a Triplicate order signed by Resident #2's physician on 12/30/20 reflected it was for [MEDICATION NAME] 15 mg po bid 60 tablets. Review of the facility's prescription delivery ticket from the pharmacy, reflected, 60 Each [MEDICATION NAME] ER 15 mg tablet delivered 12/30/19. In an Interview with LVN G on 02/27/20 at 11:10 a.m. she stated the MA gave the routine narcotics and let her know when they needed to be re-ordered. She stated if they needed a triplicate then she had to call the MD and obtain that and fax it to the pharmacy. She stated she remembered calling the pharmacy to re-order Resident #2's medication and was told that it was too early to order. She stated she did not document that anywhere. She stated she did remember calling the doctor to get a triplicate but could not recall when that was. She stated they were supposed to re-order medications when the resident had five days' worth of medication left. She stated if they required a triplicate, then they must obtain that and send it to the pharmacy. She stated she was not sure how Resident #2's medication was missed. She stated Resident #2 did have Tylenol #3 PRN, which she was given during that time. Interview with LVN J on 12/27/20 at 12:45 p.m. revealed when she returned to work on 12/30/20 on the 2:00 p.m. to 10:00 p.m. shift she was told Resident #2 had been out of her [MEDICATION NAME]. She stated she was not sure how long she had been without her [MEDICATION NAME], but stated the resident was complaining of chest pain and nausea and wanted to go to the hospital. She stated she notified the MD and sent her out. She stated she told the paramedics she had been without her [MEDICATION NAME]. An interview with Resident #2 on 02/28/20 at 12:44 p.m. revealed she did not recall her hospital stay at the end of December 2019. She denied any problems with her pain medications. In an interview with ADON L on 02/28/20 at 11:15 a.m. she stated the procedure for re-ordering Narcotics was only the Nurses were allowed and would re-order when the resident had a 3-5-day supply on hand. The nurse called the pharmacy and if they did not have a refill, would obtain the triplicate from the MD. She stated the blister pack had a sticker that was to be placed on the re-order sheet when it had been ordered and faxed to the pharmacy. She stated they also placed it in the computer system to show that it had been re-ordered. She stated she was not sure how Resident #2's medication got missed but had not had any other resident's go without their medications due to late re-ordering. An interview with the facility Pharmacist Consultant on 02/28/20 at 11:25 a.m. revealed Resident #2's [MEDICATION NAME] 15 mg ER required a Triplicate each time it was filled. He stated even if the facility had re-ordered it on 12/28/19, they were not able to fill it until the triplicate was received from the physician. He stated their records reflected they had received the triplicate on 12/30/19 and had filled and delivered it to the facility on [DATE]. An interview with the DON on 02/28/20 at 12:15 p.m. revealed the facility had recently changed pharmacies and it appeared staff were not following the same procedure on how they tracked when medications were re-ordered. She stated the blister pack has and indicator on the pack that shows when they must re-order medications. She stated if for some reason they are not able to get medications they should notify her or the ADON and the physician. She stated she had not been made aware of Resident #2's missed medication in December 2019. An interview with Resident #2's MD on 02/28/20 at 12:52 p.m. revealed that Resident #2 was admitted to the hospital on [DATE] due to complaints of chest pain. He stated she was determined to have a UTI, which she received treatment for [REDACTED].#3 during that time. Review of the facility's undated policy Controlled Substance Prescriptions, reflected, .Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, completed, and signed written prescription from a person lawfully authorized to prescribe . Partial Fill Request for C11 (controlled 11 narcotics): if one or more refills .or a partial fill quaintly (C11) remains and medications are not automatically refilled by the pharmacy, it must be requested by the facility.