STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455999	A. BUILDING _____ B. WING _____	**04/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PORT LAVACA NURSING AND REHABILITATION CENTER	**524 VILLAGE RD PORT LAVACA, TX 77979**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for fall assessments, in that: Resident #1's Fall Risk Assessment did not list falls sustained on 02/02/2020 and 04/02/2020. This deficient practice could place residents with high risk for falls at risk for not receiving proper care to prevent falls due to inaccurate documentation of fall assessments. The findings were: Record review of Resident #1's face sheet, dated 04/15/2020, revealed the resident was admitted to the facility on [DATE], and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #1's Comprehensive Care Plan, last revision date 04/12/2020, revealed the resident had falls on 02/02/2020, Witness fall, (Resident #1) attempted self-transfer without calling for assistance, and on 04/02/2020, Unwitnessed fall related to self-ambulation to restroom due to incontinence episode. Record review of Resident #1's Fall Risk Evaluation, dated 04/02/2020, revealed Resident #1 did not have any falls in past three months. Observation on 04/15/2020 at 1:06 p.m. revealed Resident #1 was sitting on the wheelchair in her room. Further observation revealed the resident's bed was in low position, call light was within reach, and the floor mat was on the floor at the bed side. During an interview with the DON on 04/15/2020 at 1:36 p.m., the DON confirmed Resident #1's Fall Risk Assessment, dated 04/02/2020, was incorrect. The DON confirmed Resident #1 had two falls in past three months, on 02/20/2020 and 04/02/2020, and the falls were not documented on the resident's assessment. Record review of the facility's policy and procedure titled Charting and Documentation, revision date 12/2017, revealed, all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

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.