STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND PINES NURSING HOME	1100 N 4TH ST LONGVIEW, TX 75601

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 5 of 9 residents reviewed for ADLs. (Residents #1, #2, #3, #4 and #5) The facility did not provide Resident #1 with incontinent care in a timely manner. The facility did not provide Residents #2, #3, #4, and #5 with showers as indicated in their care plans. This failure could place residents who were dependent on staff for toileting and shower care at risk for embarrassment, rashes, infections, discomfort, and skin break down. Findings included: 1. A face sheet dated 03/05/20 indicated Resident #1 was a [AGE] year old male admitted on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] indicated Resident #1 had severely impaired cognition. He required extensive 2-person assistance in most activities of daily living (ADLs). He was dependent on 2-persons for toileting and personal hygiene. Resident #1 was always incontinent of bladder and bowel. The care plan for Resident #1 dated 12/18/19 indicated Resident #1 had a communication problem related to his impaired cognition. Resident #1 had a history of [REDACTED]. Resident #1 had an ADL self-care performance deficit. A provider investigation report dated 03/02/20 indicated on 02/26/20, the quality monitor observed Resident #1 with dried emesis (vomit) on his gown and appeared to be in pain and neglected. The report indicated staff changed the resident's brief, linens, gown, and mattress and noted no skin breakdown, or distress. Skin ointment was applied to Resident #1's sacrum area. During an interview on 3/04/20 at 9:30 a.m., CNA A said on 2/26/20 between 9:30 a.m. and 10:00 a.m., she observed Resident #1 in his bed, with a blanket under him and not a draw sheet. CNA A said typically Resident #1 frequently was incontinent of urine and/or had bowel movements. CNA A said Resident #1's gown was soiled, his bed was soiled, and he was still on the blanket. She said the blanket had yellow, brown and pink stained colors on it from the urine which indicated to her he had been left soiled for a while. CNA A said Resident #1 was unable to communicate. CNA A said she had not performed incontinent care for Resident #1 that morning (2/26/20) because she had not gotten to him. CNA A said every resident needed bed changes and a full bed bath. CNA A said staff were running out of linens because they were changing all beds. 2. A face sheet dated 03/05/20 indicated Resident #2 was [AGE] year-old male admitted on [DATE] with [DIAGNOSES REDACTED]. A care plan dated 01/08/20 indicated Resident #2 had a communication problem related to his [MEDICAL CONDITION]. Resident #2 had an ADL self -care performance deficit related to [MEDICAL CONDITION] (paralysis of all four limbs). Resident # 2 was totally dependent on two staff to provide a scheduled bath and as necessary. An MDS dated [DATE] indicated Resident #2 had intact cognition. He was totally dependent on staff for assistance with all ADLs. He had an indwelling catheter. An ADL bathing sheet dated 2/20/20 through 3/05/20, (a period of 15 days) indicated Resident #2 received a bath on 2/28/20. No other bath was documented. During an observation on 3/4/20 at 3:00 p.m., Resident # 2 was in bed. He told the DON he had not had a bath since last week and would like one between 10 a.m. and noon on 03/05/20. 3. A face sheet dated 03/05/20 indicated Resident #3 was a 62, year old female admitted on [DATE] with [DIAGNOSES REDACTED]. The care plan for Resident #3 dated 01/08/20 indicated an ADL self care performance deficit related to her impaired mobility, [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #3 had intact cognition. She required, extensive1-person assistance with hygiene, and was totally dependent on 2 staff for toileting. Resident #3 was always incontinent to bladder and bowel. An ADL bathing sheet dated from 02/21/20 through 03/02/20 (an 11 day period) indicated Resident #3 received a bath on 2/28/20. No other bath was documented. No refusal was documented. During an interview on 3/4/20 at 3:17 p.m., Resident # 3 said she was ashamed because she had not had a bath in a week. Resident #3 said she was unable to transfer without assistance. 4. A face sheet dated 03/05/20 indicated Resident #4 was a 64, year old male admitted on [DATE] with [DIAGNOSES REDACTED]. The care plan for Resident #4 dated 02/11/20 indicated Resident #4 had an ADL self-care performance deficit related to his amputation. Interventions included: Bathing: Check nail length and trim and clean on bath day and as necessary. Resident #4 required 1 staff participation with bathing. An MDS dated [DATE] indicated Resident #4 had intact cognition. He required 1- person assistance with hygiene and extensive 1-person assistance with toilet use. He had an indwelling catheter and was always incontinent to bowel. An ADL Bathing sheet indicated Resident #4 did not receive a bath on the designated bath days 2/23/20, 2/24/20, 2/28/20, and 3/01/20. No refusal was documented. During an observation and interview on 3/4/20 at 3:32 p.m., Resident # 4 was sitting in his wheelchair in the hallway. Resident #4 approached the investigator and said he had not had a shower in weeks although he has been asking for assistance with a shower. 5. A face sheet dated 03/05/20 indicated Resident #5 was an [AGE] year-old female admitted [DATE] with [DIAGNOSES REDACTED]. A care plan dated 12/10/19 indicated Resident #5 had a communication problem related to language barrier. She primarily spoke Spanish and only a few words of English. Resident #5 had an ADL self-care performance deficit related to her disease process, history of [MEDICAL CONDITIONS], and heart failure. The ADL interventions included a requirement for 1 staff maximum participation with bathing. An MDS dated [DATE] indicated Resident #5 had severely impaired cognition. She required, extensive assistance in performing all activities of daily living (ADLs). She was occasionally incontinent to bladder and always to bowel. An ADL bathing sheet dated 02/05/20 through 03/05/20 (a 30 day period) indicated Resident #5 received a bath on 02/14/20 and 2/21/20. No refusal was documented. During an interview with a translator and observation on 3/5/20 at 9:40 a.m., Resident # 5 was in her room in bed. She said she had not had a shower in a month. Resident #5 said she had not been offered a shower and would like one. During an interview with the DON on 3/04/20 at 4:58 p.m., she said they were in the process of hiring shower aides to assist residents who might be missing their showers. During an interview with the administrator on 3/04/20 at 1:40 p.m., he said they were working to eliminate complaints regarding response time to residents' request for assistance. He said they were processing applications for new staff and were using agency staff to minimize any problem. During an interview on 3/05/20 at 9:30 a.m., CNA A said residents were supposed to get showers three times a week. CNA A said residents were not getting showers three times a week because of staff shortage and, staff have been trying to do what they can to keep everyone safe and clean. During an interview on 3/05/20 at 1:45 p.m., CNA B said she had not been giving showers because there had not been enough staff. CNA B said she and the other aides concentrated on keeping residents dry and turned, and not showers. During an interview on 3/05/20 at 1:52 p.m., CNA C said she did not give residents showers because there were not enough staff. She said last week, the DON asked her when the residents last had baths and she told the DON for some residents, it was back in February. A policy dated 05/2017 titled Bath, Bed, Tub or Shower indicated It is the policy of this home that residents be assisted with their bathing needs and will be bathed on a routine basis.

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.