STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675985	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOCUSED CARE AT MIDLAND	**2000 N MAIN MIDLAND, TX 79705**

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 allegations involving abuse, neglect, exploitation or mistreatment were reported immediately but not later than 2 hours if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) after the allegation was made in accordance with State law for 1 of 5 residents (Resident #1) reviewed for abuse and neglect. The facility failed to report to the State Survey Agency an unwitnessed fall and death involving Resident #1. This failure could affect residents by placing them at risk of not having incidents of abuse, neglect, exploitation, and misappropriation of resident property being reviewed and investigated in a timely manner by the facility and State Survey Agency. The Findings Include: Closed record review of Resident #1's Admission Record (Face Sheet) dated [DATE] indicated a [AGE] year old female with a current admission date of [DATE]. Her [DIAGNOSES REDACTED]. Closed record review of Resident #1's Quarterly MDS dated [DATE] indicated moderately impaired cognitive skills for daily decision making. Resident #1 required setup to extensive assist of one to two persons for activities of daily living. Resident #1 had a history of [REDACTED]. Scoring was defined at the bottom of the assessment in the following manner: Low risk: ,[DATE] Moderate risk: ,[DATE] High risk: 45 and higher Closed record review of Resident #1's Care Plan indicated the following: Focus: Date initiated [DATE] and revision date of [DATE] Resident has episodes of adverse behavior, will sit outside all day and is not easily redirected back indoors. Resident will begin to scream and cry out if staff tries to assist her back in building . Resident will yell out and bang on door until resident exhausts herself. Resident cannot be redirected at times . Goal: Date initiated [DATE] and revision [DATE] Resident will have no injury related to adverse behaviors through next quarter Interventions: Date initiated [DATE] and revision [DATE] Attempt to redirect resident to safe area when increased behaviors Focus: Date initiated [DATE] and revision [DATE] Resident is at risk for falls due to limited mobility, uses wheel chair, poor balance and weakness and poor safety awareness. Resident attempts to transfer self without calling for staff assistance. Is diabetic and is prone to hypoglycemic episodes which could lead to a fall. Resident lowers self to floor at times to adjust wheelchair. Goal: Date initiated [DATE] and revision [DATE] Resident will not obtain a major injury due to a fall through next quarter. Interventions: Date initiated [DATE] and revision [DATE] Resident likes to sit outside, encourage resident to sit by back glass door so that staff can see her. Closed record review of Nurse's Progress note written by the DON dated [DATE] at 10:30 am indicated the following: Alerted by staff resident was on ground on back patio (C Hall which was a secure unite) by Smoke Aide E at approximately 10:28 am. Upon arrival to resident she was laying on her left side, she had vomited her heart beat was faint and distant, respirations x4 then respiration stopped, CBG (capillary blood glucose) checked reading HI CPR initiated, [MED]gen applied, supportive respirations provided. LVN A began chest compressions RN B called 911. CPR continued AED applied, no shock advised continue CPR. EMS arrived at back patio. EMS took over CPR, after analyzing her cardiac function EMS sated that CPR needed to be stopped. This nurse called Dr. C, order received to stop CPR and RN to pronounce. Time of death pronounced by DON at 10:46 am, [DATE]. LVN D called guardian . Record review of weather.com (https://weather.com/weather/monthly/l/Midland+TX?canonicalCityId=4823f9a7f5815e79eb f695b9a9286d2fb183ef172c0d701bc2c55c62bd1) accessed on [DATE] indicated a low of 64 degrees Fahrenheit and a high of 80 degrees Fahrenheit. Record review of the facility's Incident log from [DATE] through [DATE] indicated no entry for Resident #1 on [DATE]. Record review of facility records on [DATE] revealed the incident was not reported to the State Agency. During an interview and observation on [DATE] at 10:49 am, the DON said she was called by LVN D went over to C hall patio. During observation of C Hall Patio the DON pointed to the area where resident was found on the floor which was about 4 steps from the glass door entrance to the patio. The patio floor was flat and appeared to have no hazards. She said Resident #1 had vomit on her chest and lap. She said she did not see any blood and the vomit was dark, not yellow, green, coffee ground or red. She said the resident loved to be outside and staff would monitor her frequently. She said the last person to see her was CNA G about 15 minutes before she was discovered on the floor by Smoke Aide E. She said she did not complete an incident report because she considered the incident a death with no unusual circumstances and not a fall. She said she assumed the death was cardiac related. During an interview on [DATE] at 8:45 am, Smoke Aide E said that he had finished supervising a group of residents smoke and Resident #1 was left outside per her request (Resident #1 was not a smoker). He said Resident #1 would stay out in the smoking area on her own because she enjoyed sleeping out there. He said he left her around 9:30 am and then returned about 10:,[DATE]:30 am and she was on the floor with what appeared to be blood. He said the wheelchair was beside her and she appeared to have fell out of the wheelchair. He said he checked her pulse and couldn't find a pulse and that is when he called the nurses. He said he was not sure of the nurse's name that responded. He said she was the head nurse at that time and the DON also responded. During an interview on [DATE] at 9:13 am, LVN D said she had just got on the hall to relieve a CNA for break and the Smoke Aide E notified her that Resident #1 was on the floor. She said she went outside and then called for help. She said that LVN F (C Hall nurse), DON, and both ADONs responded to the request for help. She said the nurses started emergency procedure. She said she was unsure how long the resident was outside for. She said she was a resident that was always outside by request and if you attempted to tell her she couldn't stay outside she would become agitated. She said you could not force her to do what she did not want to do. During an interview on [DATE] at 9:39 am, LVN F said she had last seen Resident #1 around 8:30 am. She said she always liked to be outside. She said she was discovered on the floor and could not tell if it was vomit or blood near her when she was discovered. She said she received health shakes and strawberry was one of the flavors. She said she checked her blood sugar earlier that morning and it was 189. She said the last time she observed the Resident #1 she seemed her normal self. She said when she was discovered LVN D, the DON, and the ADONS responded. EMS was in the building and the doctor was on the phone giving directions related to the code. During an interview on [DATE] at 9:53 am, CNA G said that Resident #1 had been her normal self the morning of [DATE]. She said the resident loved to go outside and had been checked on every 10 mins when she was outside. She said she would open the door to the back and check on her. She said it had been about 10 mins before she went on break last time she checked on Resident #1. She said about 30 mins into her break she saw the ambulance outside the facility and was told that Resident #1 had been discovered on the floor and worked on by the nurses and EMS. She said she was shocked because the last time she saw the Resident #1 she was baseline and did not see any changes. She said she had given her a chocolate health shake prior to going on her break at about 10:30 but was unsure of the exact time. During an interview and observation on [DATE] at 10:49 am, the DON said she was called by LVN D went over to C hall patio. During observation of C Hall Patio the DON pointed to the area where resident was found on the floor which was about 4 steps from the glass door entrance to the patio. The patio floor was flat and appeared to have no hazards. She said Resident #1 had

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) vomit on her chest and lap. She said she did not see any blood and the vomit was dark, not yellow, green, coffee ground or red. She said the resident loved to be outside and staff would monitor her frequently. She said the last person to see her was CNA G about 15 minutes before she was discovered on the floor by Smoke Aide E. She said she did not complete an incident report because she considered the incident a death with no unusual circumstances and not a fall. She said she assumed the death was cardiac related. During an interview on [DATE] at 11:29 am, RN D (also ADON) said that LVN D requested help and the DON and ADONs responded. She said Resident #1 appeared to have dark vomit near her head and she was on the ground on her left side. She said they started a code and their machine indicated no shock continue CPR. She said when EMS arrived they put their machine on and it read asystole (no electrical activity on the electrocardiogram monitor). She said that resident loved to be outside and was monitored by staff frequently when she was on the patio. She said as far as she was aware the resident had last been seen by CNA G 15 minutes prior to the incident. During an interview on [DATE] at 1:52 pm, the Administrator said that the incident with Resident #1 was not considered suspicious and that is why it was not reported to regulatory. She said that they had not considered it a fall and that is why an incident report had not been completed for the resident. The administrator said the facility followed Long-Term Care Regulatory Provider Letter ,[DATE] for reporting requirements and provided a copy of the provider letter. Record review of Long-Term Care Regulatory Provider Letter ,[DATE] with a date issued of [DATE] indicated the following: 1.0 Subject and purpose This letter provides guidance for reporting incidents to HHSC . A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Death due to unusual circumstances Type of incident Death under unusual circumstances When to report Immediately, but not later than 24 hours after the incident occurs or is suspected Record review of the facility's undated Incident and Accident Policy indicated the following: Policy: Accidents or incidents involving residents shall be investigated and reported to the administrator. Procedure: 1.Complete an incident/accident report when staff is aware that an incident occurred . 3. Complete a fall investigation report after every fall to include vital signs, pain assessment and environmental assessment . 7. If an injury of unknown origin occurs and the cause of the injury cannot be determined through an investigation notify DCO and report following to HHSC guidelines. 12. A fall is defined as unintentionally coming to rest on the floor, ground or lower level b. a resident found on floor is considered to have fallen
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation and injuries of unknown origin were thoroughly investigated for 1 of 5 residents reviewed for abuse and neglect. (Resident # 1) The facility did not thoroughly investigate Resident #1's unwitnessed fall and death. This failure could placed residents at risk for abuse, neglect, and a decreased quality of life. The Findings Include: Closed record review of Resident #1's Admission Record (Face Sheet) dated [DATE] indicated a [AGE] year old female with a current admission date of [DATE]. Her [DIAGNOSES REDACTED]. 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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) not yellow, green, coffee ground or red. She said the resident loved to be outside and staff would monitor her frequently. She said the last person to see her was CNA G about 15 minutes before she was discovered on the floor by Smoke Aide E. She said she did not complete an incident report because she considered the incident a death with no unusual circumstances and not a fall. She said she assumed the death was cardiac related. During an interview on [DATE] at 11:29 am, RN D (also ADON) said that LVN D requested help and the DON and ADONs responded. She said Resident #1 appeared to have dark vomit near her head and she was on the ground on her left side. She said they started a code and their machine indicated no shock continue CPR. She said when EMS arrived they put their machine on and it read asystole (no electrical activity on the electrocardiogram monitor). She said that resident loved to be outside and was monitored by staff frequently when she was on the patio. She said as far as she was aware the resident had last been seen by CNA G 15 minutes prior to the incident. During an interview on [DATE] at 1:52 pm, the Administrator said that the incident with Resident #1 was not considered suspicious and that is why it was not reported to regulatory. The Administrator said they did not do an investigation. She said that they had not considered it a fall and that is why an incident report had not been completed for the resident. The administrator said the facility followed Long-Term Care Regulatory Provider Letter ,[DATE] for reporting requirements and provided a copy of the provider letter. Record review of Long-Term Care Regulatory Provider Letter ,[DATE] with a date issued of [DATE] indicated the following: 1.0 Subject and purpose This letter provides guidance for reporting incidents to HHSC . A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Death due to unusual circumstances Type of incident Death under unusual circumstances When to report Immediately, but not later than 24 hours after the incident occurs or is suspected Attachment 2: How to Report Abuse, Neglect .other Incidents .Take immediate action to prevent further ANE (Abuse, Neglect, and Exploitation) pending investigation .Complete an internal investigation of the incident. Take appropriate corrective action. Report the investigation findings within 5 working days from the initial report to HHSC Record review of the facility's undated Incident and Accident Policy indicated the following: Policy: Accidents or incidents involving residents shall be investigated and reported to the administrator. Procedure: 1.Complete an incident/accident report when staff is aware that an incident occurred . 3. Complete a fall investigation report after every fall to include vital signs, pain assessment and environmental assessment . 7. If an injury of unknown origin occurs and the cause of the injury cannot be determined through an investigation notify DCO and report following to HHSC guidelines. 12. A fall is defined as unintentionally coming to rest on the floor, ground or lower level b. a resident found on floor is considered to have fallen