STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676218	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JEFFERSON NURSING AND REHABILITATION CENTER	**3840 POINTE PARKWAY BEAUMONT, TX 77706**

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate supervision and assistance to prevent an accident was provided for 1 of 5 residents reviewed for accidents. (Resident #1) The facility did not prevent Resident #1 from sustaining a [MEDICAL CONDITION]. CNA A dropped the resident from the bed during incontinent care. CNA A did not receive a skill check off until after the incident. This was determined to be past non-compliance with actual harm due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the investigation. This failure placed the residents at risk for injury. Findings included: Physician orders [REDACTED].#1 admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. The most recent MDS assessment dated [DATE] indicated Resident #1 was alert, confused, required extensive assist of one for bed mobility, and was totally dependent on one staff for personal care. The MDS indicated walking and surface to surface transfers did not occur during the lookback period. The resident had impairment to one side of the upper extremities and both sides of the lower extremities. A care plan updated 7/27/2020 indicated Resident #1 had an ADL self-care performance deficit and needs extensive to total assist from staff for all ADL care. The interventions indicated the resident was totally dependent on 1 to 2 staff for repositioning and turning in bed and for personal hygiene. A Fall Risk Evaluation dated 7/21/2020 indicated Resident #1 was disoriented, had 1 to 2 falls in the past 3 months, was regularly incontinent, and was at high risk for falls. During an interview on 8/19/2020 at 11:58 a.m., CNA A said Resident #1 was total care. She said on 7/24/20 she rolled Resident #1 to change dirty linens beneath the resident. She said she rolled the dirty linen under the resident, walked around to the other side of the bed, and then rolled the resident away from her to get the dirty linen out from under her. She said when she rolled the resident away from her, the resident's top leg went over the side of the bed propelling her over the edge and onto the floor. The CNA hollered out to the nurse for assistance. CNA A said she had not received skills check off upon hire and said she should have rolled the resident towards her instead of away from her. During an interview on 8/19/2020 at 10:00 a.m., LVN C said she walked in Resident #1's room and found CNA A sitting behind the resident on the floor. She said the resident was flaccid and totally dependent for care. She said the CNA should not have rolled the resident away from her while performing incontinent care. A Nursing-Change of Condition Communication Form dated 7/25/2020 indicated Resident #1 had a witnessed fall on 7/24/20 and was yelling out with movement/routine care, labored respirations. The document indicated the resident was supposed to be transferred with a mechanical lift. The nurse suggestion was to transfer to the hospital. An order dated 7/25/2020 indicated Resident #1 was to be sent to the hospital. A nursing note dated 7/25/2020 at 1:50 p.m. indicated Resident #1 was admitted to the hospital with [REDACTED].#1 had sustained a [MEDICAL CONDITION] and would not be coming back to the facility. The personnel file for CNA A did not contain documentation of skills check off upon hire on 6/2/2020. During an interview on 8/19/2020 at 1:18 p.m., ADON B said CNA A did not have skills check off in her file prior to Resident #1's fall on 7/24/20. ADON B said he did a skills check off with her on 7/30/2020. He said the resident was totally dependent for ADL care. The surveyor determined the facility was in non-compliance from 7/24/2020 to 7/30/2020. A Fall Risk policy revised December 2017, indicated Based on previous evaluations and current data, the staff will identify interventions related to resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff will identify appropriate interventions to reduce the risk of falls. The facility took the following actions to correct the non-compliance: During an interview on 8/19/2020 at 1:29 p.m., the administrator said after the incident occurred, she realized none of the new CNA staff had a skills check off in their file, including CNA A. She said she immediately put a plan in place on 7/30/2020 and had the nurses check off the new CNAs on their skills. She said the incident had not been brought to QA as of yet because they had not met since the incident occurred on 7/24/2020. On 8/19/2020, the surveyor determined interventions were completed by: *The skills check off dated 7/30/20 indicated CNA A received skill check off's covering transfers and bed mobility. *3 LVNs were interviewed and indicated they received training regarding, monitoring resident's care needs, fall precautions, abuse and neglect. *4 CNAs were interviewed and indicated they received training regarding resident safety, transfers, fall precautions and abuse and neglect.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE