STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676157	A. BUILDING _____ B. WING _____	**08/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
USSERY ROAN TEXAS STATE VETERANS HOME	**1020 TASCOSA RD AMARILLO, TX 79124**

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 9 residents (Resident #1) reviewed for neglect. The facility failed to report an allegation of neglect that occurred when CNA B and CNA C failed to transfer Resident #1 using two people and failed to use a gait belt for the transfers which resulted in Resident #1 receiving a laceration to her right lower calf that required stiches. 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 evidence is as follows: Record review of facility provided policy titled Resident Abuse Policy documented the following: A. Reporting Abuse to Community Management Policy Statement It is the responsibility of our team members, Community consultants, attending physicians, family members, visitors, etc. to promptly report any incident of suspected neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to Community Management. 4. When an alleged or suspected case of expolitation, mistreatment, neglect, injuries of an unknown source, or abuse is reported, the Community Administrator, or his/her designee, will notify the following persons or agencies per the current state/federal reporting requirements of such incident, if appropriate: a. The State licensing/certification agency responsible for surveying/licensing the Community. Record review of Resident #1's clinical record revealed she admitted to the facility on [DATE], was [AGE] years old with the following Diagnoses: [REDACTED]. -A quarterly MDS resident assessment, dated 6/21/2020, documented the resident scored 4 of 15 on a mini-mental exam, required extensive assistance by two staff for bed mobility, transfers, toileting, personal hygiene and bathing, required extensive assistance by one staff for dressing, frequently incontinent of bladder, occasionally incontinent of bowel, 69 inches tall and 164 pounds. -Care Plan: have ADL self-care performance deficit related to left sided weakness, gait/balance problems and cognitive impairment. Record Review of the Incident/Accident Report, dated 8/12/2020 at 11:00 a.m., documented the following: The CNA called this charge nurse to resident room stating resident has a skin tear to her leg. Upon entering resident room, resident was sitting up in her wheelchair on the left side of her bed with CNA holding her right leg. This nurse walked around the bed to the left side and looked at resident's right lower calf in side of the leg. Assessed a wound with bleeding noted. This nurse instructed the CNA to assist with moving the wheelchair around the bed so this nurse can assess the wound to right lower leg. Wound measures 6.3 cm x 2.0 cm. Resident is fully clothed with gripper socks on at this time. Resident is clean and dry. Action taken - applied a Vaseline dressing covered with ABD pad and wrapped with coban. Sent to VA ER. Predisposing Environmental Factors: furniture was checked Presdiposing Physiologial Factors: lower extremity weakness was checked Predisposing Situation Factors: ambulating with assist was checked No documentation was found regarding the use of gait belts During an interview on 8/20/20 at 8:20 a.m., the Administrator stated Resident #1 had to go out to the emergency room to have stitches in her leg. The Administrator stated she asked staff when Resident #1 was sent out to the emergency room if the injury was the facility'sfault and she was told no it was not so the incident did not need to be reported. During an interview on 8/20/2020 at 10:35 a.m., LVN A stated she was working the day Resident #1 was injured during a transfer. LVN A stated two CNAs were transferring Resident #1 as she can stand and pivot. LVN A stated one of the CNAs called for her to come to Resident #1's room because she received a skin tear. LVN A stated Resident #1 had more than a skin tear as it was bleeding a lot. LVN A stated she had to put a pressure dressing on the laceration and Resident #1was sent out to the hospital and got 9 stitches in her leg. LVN A stated the CNAs were not using a gait belt. LVN A stated as soon as she saw Resident #1's leg, she knew Resident #1 was going to be sent out to the hospital. During an interview on 8/20/20 at 1:00 p.m., CNA B stated they got Resident #1 dressed and sat her on the side of the bed. CNA B stated Resident #1 helped with the transfer and when Resident #1 sat down in the wheelchair, she saw a lot of blood on the floor. CNA B told CNA C to go get the nurse (LVN A). CNA B stated she did not know how Resident #1 injured herself or what happened. CNA B stated she did not have a gait belt on Resident #1. CNA B stated she knew she was supposed to use her gait belt for transfers but she didn't that time. During an interview on 8/2020 at 1:58 p.m., CNA C stated she was holding the locked wheelchair in place when CNA B transferred Resident #1 by herself. CNA C stated CNA B transferred Resident #1 to her wheelchair and that was when they both noticed blood on the floor. CNA C stated CNA B pulled up Resident #1's pant leg and that was when they saw the skin tear. CNA C stated she went and got the nurse (LVN A) to look at Resident #1's leg. CNA C stated CNA B was not using a gait belt when she transferred Resident #1 unassisted.
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 alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, 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 9 residents (Resident #1) reviewed for abuse/neglect. The facility failed to report an allegation of neglect involving Resident #1 to the State Survey Agency that occurred when CNA B and CNA C failed to transfer Resident #1 using two people and failed to use a gait belt for the transfer which resulted in Resident #1 receiving a laceration to her right lower calf that required stiches. 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 Evidence is as follows: Record review of Resident #1's clinical record revealed she admitted to the facility on [DATE], was [AGE] years old with the following Diagnoses: [REDACTED]. -A quarterly MDS resident assessment, dated 6/21/2020, documented the resident scored 4 of 15 on a mini-mental exam, required extensive assistance by two staff for bed mobility, transfers, toileting, personal hygiene and bathing, required extensive assistance by one staff for dressing, frequently incontinent of bladder, occasionally incontinent of bowel, 69 inches tall and 164 pounds. -Care Plan: have ADL self-care performance deficit related to left sided weakness, gait/balance problems and cognitive impairment. During an interview on 8/20/20 at 8:20 a.m., the Administrator stated Resident #1 had to go out to the emergency room to have stitches in her leg. The Administrator stated she asked staff when Resident #1 was sent out to the emergency room if the injury was the facility's fault and she was told no it was not. The Administrator stated the girls always have their gait belts and use them every time and she was sure the CNAs used their gait belts to transfer Resident #1. During an interview on 8/20/20 at 8:50 a.m., the DON, stated two CNAs were transferring Resident #1 from her bed to her wheelchair and the wheelchair got her on the

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

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) inside of her right leg. The DON stated Resident #1 helps staff with transfers and was hard to keep in one place. The DON stated staff were supposed to use gait belts for transfers and they should have used them for Resident #1's transfer. The DON stated the two CNAs that were transferring Resident #1 always have a gait belt on them so she would think they would use have used them. During an interview on 8/20/2020 at 10:35 a.m., LVN A stated she was working the day Resident #1 was injured during a transfer. LVN A stated two CNAs were transferring Resident #1 as she can stand and pivot. LVN A stated one of the CNAs called for her to come to Resident #1's room because she received a skin tear. LVN A stated Resident #1 had more than a skin tear as it was bleeding a lot. LVN A stated she had to put a pressure dressing on the laceration and Resident #1was sent out to the hospital and got 9 stitches in her leg. LVN A stated the CNAs were not using a gait belt. LVN A stated as soon as she saw Resident #1's leg, she knew Resident #1 was going to be sent out to the hospital. During an interview on 8/20/20 at 1:00 p.m., CNA B stated they got Resident #1 dressed and sat her on the side of the bed. CNA B stated Resident #1 helped with the transfer and when Resident #1 sat down in the wheelchair, she saw a lot of blood on the floor. CNA B told CNA C to go get the nurse (LVN A). CNA B stated she did not know how Resident #1 injured herself or what happened. CNA B stated she did not have a gait belt on Resident #1. CNA B stated she knew she was supposed to use her gait belt for transfers but she didn't that time. During an interview on 8/2020 at 1:58 p.m., CNA C stated she was holding the locked wheelchair in place when CNA B transferred Resident #1 by herself. CNA C stated CNA B transferred Resident #1 to her wheelchair and that was when they both noticed blood on the floor. CNA C stated CNA B pulled up Resident #1's pant leg and that was when they saw the skin tear. CNA C stated she went and got the nurse (LVN A) to look at Resident #1's leg. CNA C stated CNA B was not using a gait belt when she transferred Resident #1 unassisted. Record Review of the Incident/Accident Report, dated 8/12/2020 at 11:00 a.m., documented the following: The CNA called this charge nurse to resident room stating resident has a skin tear to her leg. Upon entering resident room, resident was sitting up in her wheelchair on the left side of her bed with CNA holding her right leg. This nurse walked around the bed to the left side and looked at resident's right lower calf in side of the leg. Assessed a wound with bleeding noted. This nurse instructed the CNA to assist with moving the wheelchair around the bed so this nurse can assess the wound to right lower leg. Wound measures 6.3 cm x 2.0 cm. Resident is fully clothed with gripper socks on at this time. Resident is clean and dry. Action taken - applied a Vaseline dressing covered with ABD pad and wrapped with coban. Sent to VA ER. Predisposing Environmental Factors: furniture was checked Presdiposing Physiologial Factors: lower extremity weakness was checked Predisposing Situation Factors: ambulating with assist was checked No documentation was found regarding the use of gait belts Record review of facility provided policy titled Resident Abuse Policy documented the following: A. Reporting Abuse to Community Management Policy Statement It is the responsibility of our team members, Community consultants, attending physicians, family members, visitors, etc. to promptly report any incident of suspected neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to Community Management. 4. When an alleged or suspected case of expolitation, mistreatment, neglect, injuries of an unknown source, or abuse is reported, the Community Administrator, or his/her designee, will notify the following persons or agencies per the current state/federal reporting requirements of such incident, if appropriate: a. The State licensing/certification agency responsible for surveying/licensing the Community
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 interviews and record review, it was determined the facility failed to ensure the resident environment remains as free from accidents hazards as is possible, and each resident received adequate supervision and assistance to prevent accidents for 1 of 9 residents (Resident #1) reviewed for accident/hazards and supervision. CNA B and CNA C failed to transfer Resident #1 using two people and failed to use a gait belt for the transfer which resulted in Resident #1 receiving a laceration to her right lower calf that required stiches. This deficient practice has the potential to affect all residents in the building who required extensive assistance which could result in residents having falls, lacerations, fractures, and even death. The evidence is as follows: Record review of Resident #1's clinical record revealed she admitted to the facility on [DATE], was [AGE] years old with the following Diagnoses: [REDACTED]. -A quarterly MDS resident assessment, dated 6/21/2020, documented the resident scored 4 of 15 on a mini-mental exam, required extensive assistance by two staff for bed mobility, transfers, toileting, personal hygiene and bathing, required extensive assistance by one staff for dressing, frequently incontinent of bladder, occasionally incontinent of bowel, 69 inches tall and 164 pounds. -Care Plan: have ADL self-care performance deficit related to left sided weakness, gait/balance problems and cognitive impairment. During an interview on 8/20/20 at 8:20 a.m., the Administrator stated Resident #1 had to go out to the emergency room to have stitches in her leg. The Administrator stated she asked staff when Resident #1 was sent out to the emergency room if the injury was the facility's fault and she was told no it was not. The Administrator stated the girls always have their gait belts and use them every time and she was sure the CNAs used their gait belts to transfer Resident #1. During an interview on 8/20/20 at 8:50 a.m., the DON stated two CNAs were transferring Resident #1 from her bed to her wheelchair and the wheelchair got her on the inside of her right leg. The DON stated Resident #1 helps staff with transfers and was hard to keep in one place. The DON stated staff were supposed to use gait belts for transfers and they should have used them for Resident #1's transfer. The DON stated the two CNAs that were transferring Resident #1 always have a gait belt on them so she would think they would use have used them. During an interview on 8/20/2020 at 10:35 a.m., LVN A stated she was working the day Resident #1 was injured during a transfer. LVN A stated two CNAs were transferring Resident #1 as she can stand and pivot. LVN A stated one of the CNAs called for her to come to Resident #1's room because she received a skin tear. LVN A stated Resident #1 had more than a skin tear as it was bleeding a lot. LVN A stated she had to put a pressure dressing on the laceration and Resident #1was sent out to the hospital and got 9 stiches in her leg. LVN A stated the CNAs were not using a gait belt. LVN A stated as soon as she saw Resident #1's leg, she knew Resident #1 was going to be sent out to the hospital. During an interview on 8/20/20 at 1:00 p.m., CNA B stated they got Resident #1 dressed and sat her on the side of the bed. CNA B stated Resident #1 helped with the transfer and when Resident #1 sat down in the wheelchair, she saw a lot of blood on the floor. CNA B told CNA C to go get the nurse (LVN A). CNA B stated she did not know how Resident #1 injured herself or what happened. CNA B stated she did not have a gait belt on Resident #1. CNA B stated she knew she was supposed to use her gait belt for transfers but she didn't that time. During an interview on 8/2020 at 1:58 p.m., CNA C stated she was holding the locked wheelchair in place when CNA B transferred Resident #1 by herself. CNA C stated CNA B transferred Resident #1 to her wheelchair and that was when they both noticed blood on the floor. CNA C stated CNA B pulled up Resident #1's pant leg and that was when they saw the skin tear. CNA C stated she went and got the nurse (LVN A) to look at Resident #1's leg. CNA C stated CNA B was not using a gait belt when she transferred Resident #1 unassisted. Record review of a policy titled Gait Belt Issue and Return Acknowledgment, undated, documented the following: Policy: It is the policy of this company that resident transfers should be made with the use of a gait belt to help avoid incidents to the resident and team member. This community is committed to the safety of residents and team members. As one means to promote our safety policy, you are being issued a gait belt to be used for all transfers of residents. It is proven that transfers with gait belts reduce skin tears and other injuries to residents.