STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675361	A. BUILDING _____ B. WING _____	**07/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHARTON NURSING AND REHABILITATION CENTER	**1220 SUNNY LANE WHARTON, TX 77488**

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 -** Minimal harm or potential for 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 observation, interview, and record review, the facility failed to ensure that resident's environment remains as free of accident hazards as is possible, and residents received adequate supervision and assistance devices to prevent accidents for 1 of 8 residents (Resident #1) reviewed for accidents and hazards. -The facility failed to ensure Resident #1 who was at risk for falls, had a fall mat in her room by her bed. This failure could affect all residents at risk for falls and place them at risk of injury and hospitalization . Findings include: Record review of the face sheet for Resident #1 revealed a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's Fall risk evaluation with effective date 01/04/20 revealed that she was a high risk for falls. Record review of Resident #1's undated care plan read in part, . Resident #1 has had an actual fall .1/04/20 unwitnessed fall from air mattress, no injury noted .1/04/20 .wedges to be placed while resident in bed to aid in resident safety. Fall mat x 2 .fall mat at beside . Record review of Resident #1's quarterly MDS dated [DATE] revealed that her BIMS was 99 indicating that she was cognitively impaired. Further review of her MDS revealed that she required total assistance from two staff for bed mobility. She was coded as not having any falls since reentry or prior assessment. Record review of Resident #1's physican order's for June 2020 revealed order for [MEDICATION NAME] tablet 75 mg (anticoagulant), give one tablet one time a day, with start date 06/01/18. Record review of Resident #1's progress notes dated 06/11/20 by RN A read in part, .At 4:30 am, the 300 CNA approached the nurses station to report that this resident was found on the floor by her. This nurse went to the resident's room at this time. The patient is noted lying on the floor in a supine position, awake next to her bed. Bed noted in lowest position. Large amount of blood coming from patient's head. This nurse stayed with patient, continued to assess .patient transferred out via stretcher to ER . Record review of Resident #1's progress notes dated 06/16/20 revealed Resident #1 was readmitted back to the facility with head staples. Interview with Resident #2, the roommate of Resident #1, on 6/12/20 at 2:23 pm, she said,My roommate fell ! When asked what happened, she said she got up in the middle of the night go to check something in her closet and that was when she saw Resident #1 on the floor. She said Resident #1 was bleeding and she was laying on her back. She said she did not hear the resident fall or her screaming or anything. When asked if her bed was in the low position, she said that she did not remember. When asked if there was a floor mat, she said it was not there and that she knew for a fact that it was not there. She said, Ima say the truth because I got nothing to hide and there was no fall mat there. Phone interview with CNA A on 6/12/20 at 2:33 pm, when asked about Resident #1's fall she said she and another aide did incontinent care for Resident #1, put her in the middle of the bed, and placed a wedge behind her to keep her on her side. She said she put the bed in a position low to the ground and there was no fall mat in place. She said Resident #1 did usually have a fall mat but that day she did not have a fall mat. She said then around 4:30 am Resident #1's roommate came and told her she was on the floor. She said she went and checked on the resident and found her laying on her back and was bleeding from her head. She said she could not tell where Resident #1 hit her head, there was just blood on the floor. Phone interview with Nurse Aide on 6/12/20 at 2:40 pm, when asked about Resident #1's fall, she said she and another CNA went into Resident #1's room around 4 am. She said they changed her brief and repositioned her. She said when they were done, they put Resident #1 on the middle of the bed with a wedge on one side and pillow on the other side. She said they put the bed to the lowest but there was no fall mat in the room. Then later Resident #2 came out of the room and told them Resident #1 was on the floor. Phone interview with RN A on 6/12/20 at 2:50 pm, she said that one of the CNA's came and told her Resident #1 had fallen. She said she went down to see what was going on and saw Resident #1 was on the floor. She said she could not recall if there was a fall mat in the room. She said she assessed the resident, notified the physician who gave her an order to send Resident #1 out to the hospital, so she did right away. Interview with Administrator on 6/12/20 at 3:26 pm, she said she started investigating the incident with Resident #1. She said she learned so far that at roughly 4 am the aides went in to provide incontinent care, they repositioned her semi facing door, placed wedge behind her, and pillow between her legs and she was in the center of the bed. The bed was in the lowest position and call light was in place. She said she asked CNA A about a fall mat and per CNA A the fall mat was not in place. She said she then asked CNA A if she knew how to read the Kardex because it tells you individual assessment of a resident according to what is in PCC. She said the CNA's were supposed to be looking at that when they are caring for the resident. She said when they went back to audit they did see where it said Resident #1 needed a fall mat and it should have been in place. She said since this incident, they had started to audit all residents' care plans, to ensure all interventions were implemented. She said, We started to audit to check and make sure there is no glitch and whatever is in their plan of care is what's in there Kardex. Observation made from the hallway on 07/21/20 at 8:43 a.m revealed Resident #1's door was open. Resident#1 was resting in bed on a scoop mattress. Resident's bed was in low position with a fall matt on floor at resident bedside. A policy for Accidents and hazards was requested from the Administrator on 07/21/20 at 10:30 am, she said they did not have a policy for it. Record review of the facility's policy for fall risk revised December 2017 read in part, .staff will identify appropriate interventions to reduce the risk of falls .

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