STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676139	A. BUILDING _____ B. WING _____	**10/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SENIOR CARE OF GREEN OAKS	**3033 W GREEN OAKS BLVD ARLINGTON, TX 76016**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Criteria 1: what did the facility's investigation consist of once they were notified of what occurred? Was CNA B and/or other staff re-educated on reviewing resident care plans prior to providing care to ensure they know the type and how much assist the resident needs? Was only RN A re-educated on the process of incident/accident/change in condition? Did surveyor ever find out about x-ray being conducted at the hospital? Was it related to the resident's swollen leg and was the x-ray done if so? If the x-ray was done what were the results (injury, etc)? If CNA B was not re-educated on following resident care plan this could possibly be F689. The nurse and aide admit they do not look at the plan of care. I did not see where they were in-serviced on this issue. Did other aides know to look a the resident's POC prior to providing care and/or were they following the POC? Based on interview and record review, the facility failed to immediately consult with the resident's physician and family when there was a significant change in the resident's condition or need to alter treatment significantly for one (Resident #1) of four residents reviewed for notification of changes. The facility failed to notify Resident #1's physician and family after a witnessed fall. This failure placed residents at risk of not having their physician and family notified of changes, resulting in a delay in medical intervention and decline in health. Findings included: Review of Resident #1's face sheet, dated 10/15/20, revealed she was a [AGE] year-old female with an admission date of [DATE] and re-admission date of [DATE]. Resident #1's [DIAGNOSES REDACTED]. The Admission Record identified Resident #1's emergency contact with phone numbers. Interview with Resident #1's family member on 10/15/20 at 3:18 p.m. revealed they were not notified by the facility of Resident #1's fall. The family member stated Resident #1 called and reported the fall to her. She stated Resident #1 reported a nurse had to assist her (Resident #1) off of the floor using a Hoyer lift. The family member stated they called the facility and reported the incident to the BOM. She stated the BOM gave the message to the ADON. The family member stated an incident report was not completed, and the incident was not reported to the Administrator and DON. She stated she spoke to the ADON and the ADON was not aware of the situation. An interview with Resident #1 on 10/15/20 at 3:50 p.m. revealed she was currently in the hospital on her way to obtain x-rays. Resident #1 requested to be called back after obtaining her x-ray. Review of Resident #1's care plans initiated on 10/14/20, revealed, self-reported fall on 10/14/20. There will be no major injuries from a fall over the next 90 days. Interventions: notify MD/NP and responsible party of fall and resulting assessment and interventions. Evaluate for grab bar/quarter rails for repositioning. ADL/ROM Performance- Resident #1 requires assistance with ADLs/ROMs related to DM, [MEDICAL CONDITION], weakness, and decreased mobility. Interventions: may have siderails for repositioning purposes. Requires extensive to total assist with ADL care. Uses a Hoyer x2 staff with transfers, amount of care needed can change moment to moment depending on how resident feels at any given time. Review of Resident #1's care plan, initiated on 10/13/20, revealed, Resident #1 is at risk for falls related to decreased mobility, weakness and need for extensive assist. Continence: Resident #1 is at risk for incontinence related to DM, [MEDICAL CONDITION], weakness, and decreased mobility. Interventions: assist to toilet as needed. Provide incontinent care as needed. An interview with the Administrator on 10/15/20 at 10:53 AM revealed Resident #1 reported to the ADON that CNA B was performing incontinent care and Resident #1 fell out of the bed . The Administrator stated Resident #1 was asked if the fall was intentional and Resident #1 reported she did not think it was intentional, but CNA B should have retrieved help from another staff. The Administrator stated the ADON informed the DON and the Administrator of the incident the following shift. The Administrator stated CNA B was currently suspended pending investigation. She stated the facility called in the report the state agency . She stated RN A was on duty and the incident occurred on the night shift 10:00 PM-6:00 AM. The Administrator stated RN A had to assist Resident #1 off of the floor. She stated RN A said he assessed Resident #1 but did not report the incident nor fill out an incident report. The Administrator stated RN A was in-serviced on failure to notify the family and physician and completing an incident report. She stated RN A was given disciplinary action. The Administrator Resident #1 had swelling in her right leg after the fall and an x-ray was ordered with pending results but Resident #1 was sent out to [MEDICAL TREATMENT] before the x-ray was performed. She stated the facility was notified by the [MEDICAL TREATMENT] clinic that the Resident #1 was sent to the ER from the [MEDICAL TREATMENT] center but she was unsure of why Resident #1 was transferred to the ER. An interview with the DON on 10/15/20 at 11:21 a.m. revealed yesterday morning (10/14/20) on her way to work the ADON asked her if she was informed of Resident #1's fall. The DON stated the family called the facility upset and would not say what happened. She stated she instructed the ADON to look at Resident #1's nurse's notes and there were no notes regarding the incident. The DON stated the Administrator and she went to Resident #1's room to interview her. She stated Resident #1 reported CNA B rolled Resident #1 off of the bed while providing incontinent care. She stated the Administrator asked Resident #1 if she felt the fall was intentional and Resident #1 responded no. The DON stated after interviewing Resident #1 the RN A and CNA B were interviewed about the incident. She stated RN A reported the fall was an assisted fall. She stated RN A reported Resident #1 was on the floor when he entered the room. She stated CNA B reported she tried to change Resident #1 and when she rolled the Resident #1 to her side Resident #1 was sliding out of the bed, so CNA B figured it would be easier to lower Resident #1 to the floor. She stated CNA B was suspended pending the investigation. The DON stated RN A was not suspended, was currently working, was in-serviced and given a disciplinary action. She stated RN A failed to report the incident to Resident #1's family and physician and an incident report was not generated. The DON stated the policy and procedure regarding falls was the resident must be assessed, and the family, physician and facility management should be notified. The DON stated an incident report must be completed. The DON stated Resident #1 later complained of right knee pain on the next shift and an x-ray was ordered. She stated the x-ray was not obtained because Resident #1 had left the facility for [MEDICAL TREATMENT]. She stated Resident #1 did not return from [MEDICAL TREATMENT]. The DON stated the [MEDICAL TREATMENT] center transferred the Resident #1 to the ER related to SOB. She stated during interview with CNA B the aide admitted she did not look in POC before giving care. She stated RN A did not report the incident but the family reported the incident to the facility. She stated the situation could have been avoided if RN A would have reported the incident instead of the family reporting the incident. An interview with RN A on 10/15/20 at 11:51 a.m. revealed he was on 10/13/20 on the night shift (10 PM-6AM) break when CNA B called for his help. RN A stated CNA B told him while changing Resident #1 the resident began to slide off of the edge of the bed. He stated Resident #1 was larger than CNA B, so CNA B helped Resident #1 to the floor. RN A stated when he entered the room Resident #1 was on the floor with a pillow to the side of her head while lying down. He stated he assessed Resident #1 and the resident denied pain. He stated he obtained vital signs on Resident #1. RN A stated he assisted CNA B with transferring Resident #1 back to bed using a Hoyer lift. RN A stated the aides would determine if they could assist a resident alone unless the aide felt like they needed assistance from other staff. RN A described Resident #1 as incontinent of bowel/bladder. He believes one staff member can do incontinent care on

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

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident #1 alone. He stated he did not fill out an incident report because it was a witnessed fall. RN A stated an incident report should be completed as soon as the incident happened. He stated he did not think the assisted fall was considered a fall. He stated he did not report the incident to family, physician, and management. RN A did not report the fall to the oncoming shift. He stated he received a disciplinary action. Review of employee corrective action form dated 10/14/20 revealed: RN A was counseled on failure to provide accurate documentation. After Resident #1 fell RN A failed to provide an incident report and failed to report it to management, family and physician. Moving forward RN A must document all incidents and report them immediately to management. An interview with the ADON on 10/15/20 at 1:38 p.m. revealed Resident #1's family called on the morning of 10/14/20 to get information about an incident that happened the night prior. The ADON stated the family member spoke with the BOM who gave him (ADON) the message to call the family back. The ADON stated he called the family member to find out what happened to Resident #1 on the night shift. He stated he did not see an incident report regarding Resident #1's fall. The ADON stated Resident #1 told her family she had fallen out of bed and was put back in bed by a Hoyer lift. The ADON stated the DON, Administrator, and he interviewed Resident #1. He stated Resident #1 told them when CNA B turned her she fell out of the bed. He stated Resident #1 told them she asked CNA B if she needed help and CNA B told her no. He stated he believed Resident #1 was a two person assist. The ADON stated RN A was working the night of the fall. He stated RN A did not report the incident nor filled out an incident report. He stated there was no documentation in the computer related to the incident like nurse's notes or incident report. The ADON stated in the event of a fall whether unwitnessed or witnessed staff must notify the DON and perform an assessment immediately. He stated the staff should notify nursing management, the Administrator, family and the physician after an incident immediately. The ADON stated vital signs should be taken at initial assessment. He stated for a witnessed fall the aide would inform nurse, nurse would perform assessment, nurse would contact family and the physician, and fill out an incident report. The ADON stated Resident #1 complained of right leg pain when they interviewed her and an x-ray was ordered. He stated Resident #1 did not received the x-ray at the facility before being transported to [MEDICAL TREATMENT]. He stated Resident #1 was currently in the hospital due to SOB. The ADON stated CNA B was suspended pending the investigation. He stated the care plan and POC would indicate what type of care was required for a resident. He stated before the beginning of shift aides should round and find out if there are any changes to a resident's plan of care. An interview with the Administrator on 10/15/20 at 2:36 p.m. revealed LVN C filled out the incident report on the following shift 6AM-2PM shift with the information given from RN A after interviewing. An interview with CNA B on 10/15/20 at 3:35 p.m. revealed she went to change Resident #1 and she asked Resident #1 to roll over and Resident #1 slid out of the bed on same night the resident was admitted [DATE] on 10PM-6AM shift. She stated Resident #1 slid out the bed onto her right side onto the floor. CNA B stated she tried to put Resident #1 back in the bed but needed a Hoyer lift to get Resident #1 off of the floor. She stated she was alone and usually cared for Resident #1 alone. CNA B stated Resident #1 did not hit her head. She stated if she was assigned a new resident she would ask the resident how much care was needed. S he stated incident reports were filled out by nurses. CNA B stated she was suspended pending the investigation. She stated Resident #1 did not complain of any pain when the incident occurred. Review of witness statement from CNA B, dated 10/14/20, revealed: Went to ask if Resident #1 needed to be changed and Resident #1 responded she did not. Resident #1 put on the call light to ask for ice. CNA B got Resident #1 a cup of ice. CNA B went to change Resident #1, asked Resident #1 to roll over and Resident #1 slid off of the side of the bed. CNA B went to get RN A to help her get Resident #1 off of the floor with a Hoyer lift. RN A assisted CNA B with incontinent care once Resident #1 was in bed. The statement did not include date and time. An interview with the BOM on 10/15/20 at 3:54 p.m. revealed she answered the phone and spoke with family of Resident #1 on the morning of 10/14/20. The BOM stated the family of Resident #1 asked her if the facility reported to families if a resident had a fall. She stated she took down the name and number of the family member and gave the complaint to the ADON because she did not know who Resident #1's nurse was at the time. She stated she was informed if a resident fell or sustained an injury that the family is notified. The BOM stated the physician was notified of a fall. An interview with the DON on 10/15/20 at 4:27 p.m. revealed the timeframe for reporting to the family and physician of any changes/incident was immediately and that was what the staff were educated on. An interview with the family member of Resident #1 on 10/21/20 at 1:56 p.m. revealed Resident #1 passed away on Sunday, 10/18/20, and she did not know the cause of death. Review of Resident #1's Progress Note completed by LVN C on 10/14/20 at 10:15 AM revealed Resident #1 complained of right knee pain. The nurse assessed and no swelling was noted. The MD was notified and an order was received for x-ray to the right knee. There was no documentation reflecting the resident's family was notified of the resident experiencing a fall. Review of Resident #1's Progress Note completed by LVN C on 10/14/20 at 11:07 a.m. revealed LVN C called for x-ray confirmation. Review of Resident #1's Progress Note completed by Charge Nurse E on 10/15/20 at 6:19 a.m. revealed Resident #1 was not in the building upon start of shift. The off-going nurse stated the resident went to [MEDICAL TREATMENT] and had not yet returned to the facility. At the end of shift Resident #1 had not yet returned. The DON was notified and the on-coming nurse was notified. Review of Resident #1's Progress Note completed by ADON D on 10/15/20 at 8:09 a.m. revealed Resident #1 was sent to hospital from [MEDICAL TREATMENT]. Family confirmed the [MEDICAL TREATMENT] center notified them of transport to hospital. Review of Resident #1's Progress Note completed by ADON D on 10/15/20 at 9:39 a.m. revealed x-ray was not done because Resident #1 had left for [MEDICAL TREATMENT] when the x-ray tech came for the order. Review of Resident #1's incident report of witnessed fall dated 10/14/20 at 10:11 a.m. by LVN C revealed: Nursing description: Resident #1 told RN A she fell last night when CNA B was performing incontinent care. Resident #1 reported no distress, discomfort, and no complaint of pain. Resident #1 was alert and oriented times 4. Resident #1 description: Resident #1 stated when CNA B rolled her over she found herself to the floor. Resident taken to hospital? No No witnesses found No notifications found Review of an email, dated 10/14/20 at 12:05 p.m., from RN A to the DON revealed CNA B stated during bedding and clothing change, Resident #1 sild onto the side of the bed and to prevent a fall she put pillow on the floor and helped Resident #1 to the floor so that CNA B could come and call RN A to help with putting Resident #1 back into the bed. RN A rushed to the room, assessed Resident #1 but identified no obvious injuries. Resident #1 denied any pain or discomfort, was oriented x3. Monitoring continued. Review of the facility's current Assessing Falls and their Causes, policy and procedure, revised March 2018, reflected the following: .Steps in the Procedure 5. Notify the resident's attending physician and family in an appropriate time frame. a. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone. B. When a fall does not result in significant injury or a change of condition notify the practitioner routinely. .8. Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report from should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services. Defining details of falls: 1. After an observed or probable fall, clarify details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. Documentation When a resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found 2. Assessment data, including vital signs and any obvious injuries. 3. Interventions, first aid, or treatment administered. 4. Notification of the physician and family as indicated 5. Completion of a falls risk assessment. 6. Appropriate interventions taken to prevent future falls. 7. The signature and title of the person recording the data. Reporting 1. Notify the following individuals when a resident falls: a. The resident's family b. The attending physician c. The DON d. The nursing supervisor on duty 2. Report other information in accordance with facility policy and professional standards of practice.