STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675606	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARLINGEN NURSING AND REHABILITATION CENTER	**3810 HALE ST HARLINGEN, TX 78550**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of each resident's needs, for one Resident (R#1), of six residents reviewed for call light access. Facility staff did not place R#1's call light within her reach. This failure could place dependent residents at risk for not being able to call for assistance from staff. The findings were: Record review of R#1's Admission Record revealed R#1 was a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Significant Change MDS assessment, dated 06/30/20, revealed R#1: -had independent cognitive status, -required extensive assistance by two staff for bed mobility, dressing, and toilet use, and -required limited assistance by one staff for personal hygiene. Record review of R#1's Comprehensive care plan, initiated 05/19/20, revealed R#1: -was at risk for falls, related to history of falls at home with fracture to left femur prior to admission to nursing home. Intervention created on 09/02/20 included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. -had an ADL self-care performance deficit r/t [MEDICAL CONDITION] weakness and ADL decline, created 05/19/20. Interventions included: Encourage the resident to use bell for assistance, created 09/02/20. Observation on 09/01/20 at 9:21 a.m. revealed R#1 lying on the rights side of her bed with her head elevated on a pillow. R#1's call light cord was clipped on the resident's left side, on the edge of the bed, with the call light cord hanging off the bed. R#1's bed had two quarter-size side rails up, one on each side of the bed. Observation of R#1 trying to search for or reach the call light with her left arm revealed she could not reach to find the call light. In an interview on 09/02/20 at 9:21 a.m., R#1 said she needed to call the nurse to ask for pain medication for her left heel that was hurting. R#1 said she could not find or reach the call light on her bed. R#1 said she needed assistance with all her ADLs and she could not get out of bed by herself. R#1 said staff would come in and provide wound care, brief change, medications. R#1 said she did not remember who had clipped the call light out of her sight and reach. R#1 said she wanted to ask the nurse for pain medications because she had pain in her left heel wound and she could not reach the call light. R#1 said sometimes she had to ask her roommate to call someone when she needed help from the nurses. In an interview on 09/02/20 at 9:22 a.m., CNA A said she did not know who had placed the call light where R#1 could not reach or see it. CNA A said the call light needed to be placed where R#1 could see and reach it. CNA A said the call light needed to be clipped to R#1's nightgown, with the call light cord placed on her chest or stomach. In an interview on 09/02/20 at 9:25 a.m., LVN B said she was R#1's Charge Nurse. LVN B said she was not aware that R#1's call light was not within R#1's reach. In an interview on 09/02/20 at 9:45 a.m., LVN C said she was the Wound Treatment nurse. LVN C said she provided wound care to R#1 before 6:00 a.m. LVN C said R#1's call light was clipped to the left shoulder of her gown at that time. LVN C said R#1 would tell staff to clip the call light close to her gown where she could reach it. In an interview on 09/02/20 at 9:48 a.m., R#2 said she had just been living in the same room as R#1 about a week before. R#2 said she would go out to the nurse's station to get help for R#1 when R#1 asked her for help with a brief change. R#2 said she did not notice where R#1's call light was placed. In an interview on 09/02/20 at 10:37 a.m., CNA D said R#1 could not move herself completely onto her left side. CNA D said R#1 would tell her and other staff to clip her call light to her gown, on her left shoulder, and to place the call light cord across her chest so she could see and reach it. In an interview on 09/02/20 at 11:08 a.m., the Administrator said call lights should be placed within reach of the residents. Staff had been instructed to do rounds every two hours and to check for call light placement. In an interview on 09/02/20 at 1:43 p.m., the DON said R#1's call light could have been moved out of reach by staff. The DON said she was going to ask staff and R#1 about the concern. The DON said R#1's call light and all residents's call lights should be placed within reach and within eyesight. The DON said the facility did not have a specific written policy on the use of call lights or ADLs, but she would provide a written statement. Record review of the written statement provided by the DON included no title, signature or date. Written statement revealed: Although there is no set policy on Call Lights, we do have the NO PASS ZONE concept as a patient experience initiative to provide quick and effective responses to patient's needs.

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