STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675931	A. BUILDING _____ B. WING _____	03/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CEDAR HILLS GERIATRIC CENTER	710 HWY 55 CAMP WOOD, TX 78833

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 1of 4 residents (Resident #3) reviewed for resident rights, in that: Resident #3 did not have signed informed consents for psychoactive medications [MEDICATION NAME] and [MEDICATION NAME]. This failure could affect residents who received psychoactive medications without informed consents and place them at risk of receiving treatments without informed consent. Findings included: Review of Resident #3's face sheet (undated) revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further record review revealed Resident #3 was her own RP (responsible party). Review of Resident #3's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident was cognitively intact. Review of the mood score indicated the resident was feeling down or depressed nearly every day and had rejection of care behaviors 1-3 days a week. Review of Resident #3's Care Plan dated 12/9/19 revealed Resident #3 was non-compliant with the medication regimen. The plan of care included interventions which included: encourage resident to follow physician orders, listen to reasons for non-compliance, emphasize negative aspects of non-compliance, give choices in daily care, offer psychological services, acknowledge residents right to refuse treatment and educate staff concerning resident right. Review of Resident #3's Consolidated physician's orders [REDACTED].#3's physician's orders [REDACTED]. Review of Resident #3's Informed Consent Form for [MEDICATION NAME] dated 9/6/19 revealed Resident #3 had not signed the consent form. Further review of the document revealed the consent had been written for prolonged treatment for [REDACTED]. Review of Resident #3's Informed Consent Form for [MEDICATION NAME] dated 9/16/19 revealed Resident #3 had not signed the consent form. Further review of the document revealed the consent had been written for prolonged treatment for [REDACTED]. Review of Resident #3's medication record revealed Resident #3 did not have an Informed Consent Form for the use of [MEDICATION NAME]. In an interview on 3/19/20 at 10:07 AM, Resident #3 revealed she was scared to take any medication given by the staff. The resident stated the staff gave her tiny white pills that made her dizzy and feel sick and made her go to sleep. Resident #3 stated the staff gets upset with her when she doesn't want to take the medication or asks too many questions. Resident #3 said she doesn't know what the medication is for and she doesn't know what to do. In an interview on 3/19/20 at 12:22 PM, RN D confirmed Resident #3 had consents for [MEDICATION NAME] and [MEDICATION NAME] that were not signed by the resident. RN D revealed Resident #3 was cognitively intact and capable of making informed decisions for herself and capable of signing her own consents. RN D further confirmed Resident #3 was currently taking [MEDICATION NAME] and confirmed there was no signed consent for the [MEDICATION NAME]. In an interview on 3/19/20 at 2:30 PM, the DON stated Informed Consent should be obtained prior to administration of psychoactive medications. Review of a facility policy, titled Consent, Informed (undated) revealed Purpose: 1. to assure residents and/or family are aware of recommended treatment and non-compliance issues 2. Allow resident or resident's family to accept or decline treatment recommended. Procedure: 1. Recommend treatment needed 2. Inform resident and/or family of the associated risks and alternatives 3. Answer any questions resident and/or family may have about treatment 4. Have informed consent formed signed by resident and/or family. Review of a facility policy, titled Psychoactive Medications Procedure, Consent to Administer (undated) revealed, A person may not administer a psychoactive medication to a resident who does not consent to the prescribed medication unless: 1. the resident is having a medication-related emergency or 2. the person authorized by law to consent on behalf of the resident has consented to the prescription.
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 implement their written policies and procedures for 2 of 3 residents (Resident #1 and #2) reviewed for allegations of abuse and misappropriation of resident property, in that: 1. The facility did not report immediately to the State agency or thoroughly investigate when Resident #3 alleged CNA A hit him in the chest and CNA B hit him in the testicles. 2. The facility did not report within 24 hours to the State agency or thoroughly investigate when Resident #2 alleged that $700 had been stolen from her while she showered. These failures could place residents at risk for abuse and misappropriation of property. Findings Included: Review of a facility policy titled Abuse Policy dated 10/17/14 revealed Investigation: All allegations, no matter what types of incidents reported will be investigated fully .The Administrator or his/her designees will report this allegation of abuse immediately to the state agency and to the proper local authorities. An immediate investigation will be instigated . 1. Review of Resident #1's face sheet (undated) revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 12 which indicated the resident was cognitively intact. Further review of the MDS revealed Resident #1 had inattention and difficulty paying attention and had verbal behaviors that occurred 1-3 days a week. Review of Resident #1's Care Plan dated 2/4/20 revealed Resident #1 had verbal behaviors which included using profanity towards staff members when they attempted to provide care. Further review of the Care Plan revealed Resident #1 had an alteration in mood/behavior which included physical aggression, verbal aggression, yelling and screaming for no reason, throwing objects, episodes of resisting care, history of wandering (initiated 4/[DATE]7). Review of a facility grievance dated 12/3/19 revealed Resident #1 alleged CNA A hit him. Resident #1 was quoted as saying He (CNA A) hit me right here. While pointing to his chest. CNA A hit me in the hallway yesterday. He hit me hard. Resident #1 further alleged CNA B hit his testicles. Resident #1 stated, CNA B hit me in the balls this morning. He hit me in the bedroom. Further review of the grievance revealed a type written note that read, Assessment showed no bruising or other signs of trauma. A handwritten statement was written on the grievance which stated, camera was examined for the date stated. There were no incidents in the hallway. 2. Review of Resident #2's face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident was cognitively intact. Further review of the MDS revealed Resident #2 had a evidence of depression or [MEDICAL CONDITION]. The resident had a behavior of rejection of care 1-3 days a week and no other documented behaviors. Review of Resident #2's Care Plan dated 12/16/19 revealed Resident #2 had a behavior of hoarding cutlery and cups and soliciting alcohol from visitors. The Care Plan did not address any other behaviors or behaviors of making false allegations. Review of a facility grievance, dated 1/30/20 revealed Resident #2 made the allegation to the Administrator that 2 weeks ago she had $500 dollars that was missing and $200 that was missing while she showered for a total of $700 that was stolen from her. Resident #2 requested that law enforcement be contacted and indicated she wanted to file a police report. Further review of the grievance revealed that a search of the resident's room was performed and no money was found. Pending police investigation was documented on the grievance. Review of a Grievance Summary dated 1/30/20 given to this surveyor by the Administrator revealed, Resident #2 has a history of accusing others of stealing her things. She is sometimes forgetful. Resident #2 is

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) very determined that someone stole her money. However, she has accused staff of stealing her things multiple times in the past .At this time, it is impossible to discern if there was money taken and if money was taken, who took it. Resident #2 is aware that the facility is not responsible for loss of property and she signed a form when she was admitted to the facility in that regard. In an interview on 3/19/20 at 11:19 AM, the Administrator confirmed she did not notify the State agency of either grievance which included allegations of abuse and misappropriation of property. The Administrator indicated she believed both grievances were the result of resident behaviors and she did not believe either one of the allegations actually happened. In an interview on 3/19/20 at approximately 1:45 PM, the Administrator stated she had watched the security cameras in the hallway related to Resident #1 and did not see any abuse. The Administrator also indicated Resident #2 did not have $700 dollars. The Administrator indicated the Social Worker had called the police at Resident #2's request but the police never showed up at the facility. The Administrator confirmed she did not suspend any employees pending an investigation of the allegations because none of the employees were at work when the allegations were made. The Administrator confirmed she did not complete an investigative report or have documentation of a complete investigation for either of the allegations. In an interview on 3/19/20 at 3:29 PM, Corporate Nurse LVN C stated the facility did not notify the State agency of the allegations of abuse or misappropriation of property because the incidents were investigated, and the allegations were not true.
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, the facility failed to ensure all allegations of abuse and misappropriation of property were reported immediately to the State agency, thoroughly investigated, and residents were protected during investigation for 2 of 3 residents (Residents #1 and #2) reviewed for abuse and neglect, in that: 1. The facility did not report immediately to the State agency or thoroughly investigate when Resident #3 alleged CNA A hit him in the chest and CNA B hit him in the testicles. 2. The facility did not report within 24 hours to the State agency or thoroughly investigate when Resident #2 alleged that $700 had been stolen from her while she showered. 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