STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676177	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARRISON NURSING HOME & REHABILITATION CENTER	333 NORTH FM 95 GARRISON, TX 75946

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 -** 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 adequate supervision was provided for 1 of 4 residents reviewed for abuse. (Resident #1) The facility did not transfer Resident #1 according to the MDS and care plan. CNA A transferred the resident without assistance, and the resident had a fall which resulted in a [MEDICAL CONDITION] femur (leg bone just above the knee joint) with soft tissue prominence of the mid thigh, possibly representing a hematoma (bruising). This failure could place residents who were dependent on staff during transfers at risk of injury during transfers. Findings included: A face sheet dated 03/03/20 indicated Resident #1 was [AGE] years old and re-admitted on [DATE] with [DIAGNOSES REDACTED]. A physician's note dated 08/11/15 by MD F indicated Resident #1's left hip and groin area could not be flexed or extended, and the physician noted he could not straighten the resident's leg, and her knee felt tight. The physician noted palpation (feeling of the area to assist with diagnosing) over the left hip and groin, and stiffness in the resident's hip. The physician's note indicated x-rays of the left hip showed [MEDICAL CONDITION] changes, bone spurs and it appeared [MEDICAL CONDITION], but no fracture was noted. MD F noted Resident #1 had significant osteopenia and severe arthritis in the left hip and she was not a candidate for surgery. An x-ray report of the left hip dated 09/17/15 indicated Resident #1 had generalized osteopenia and [MEDICAL CONDITION] osteoarthritic change with no fracture. A physical medicine and rehabilitation consultation dated 10/12/15 by MD G indicated Resident #1 had severe [MEDICAL CONDITION] of the left hip and knee. An x-ray report of Resident #1's left foot dated 02/23/18 indicated the resident had mild [MEDICAL CONDITION] joint disease with no fracture or dislocation. An x-ray report of the left hip dated 08/15/19 indicated Resident #1 had marked [MEDICAL CONDITION] arthritis in the left hip joint with possible avascular necrosis (death of the bone) of the femoral head (highest part of the thigh bone). An MDS dated [DATE] indicated Resident #1 sometimes understood and sometimes made herself understood. The MDS noted the resident had significant impaired cognition, was dependent on two or more staff for transfers and she had no falls since her prior assessment. A care plan dated 01/16/20 indicated Resident #1 had chronic pain due to [MEDICAL CONDITIONS] joint disease in her hip. The plan noted she required transfer using a mechanical lift, but it caused too much pain to the resident, so she was to be transferred by 2 CNAs. The plan noted she was total care. An incident/accident report dated 02/24/20 at 8:15 a.m. indicated LVN C was called to the room by the CNA who said she eased Resident #1 to the floor during a transfer. The resident was assessed by the nurse and had no swelling, abrasions, skin tears, or complaints of pain. A skin communication sheet dated 02/24/20 completed by LVN C indicated Resident #1 had no redness, swelling, bruising, abrasions, or skin tears. A nurse's note dated 02/24/20 at 8:15 a.m. completed by LVN C indicated she was called to Resident #1's room. The note indicated CNA A said she eased the resident to the floor and the resident did not have pain, swelling, bruising, abrasions, or redness. The note indicated Resident #1 requested to be put back into bed so 2 staff assisted the resident back to bed. A nurse's note dated 02/24/20 at 8:30 a.m. completed by LVN C indicated when she went back to Resident #1's room she complained of pain to her left hip. The note indicated she reported this to the physician, medicated the resident, and received an order for [REDACTED].#1's left hip and pelvis dated 02/24/20 at 1:16 p.m. indicated no acute osseous abnormality (irregularities in the resident's bone that needed to be addressed) but noted there were [MEDICAL CONDITION] changes. The x-ray did not include the femur. A nurse's note dated 02/24/20 at 2:14 p.m. completed by LVN C indicated Resident #1's left hip x-ray was negative for a fracture, and the resident had no complaint of pain. A nurse's note dated 02/25/20 at 12:30 a.m. completed by LVN D indicated Resident #1 did not have any swelling or bruising to her left hip and did not show any signs of pain or discomfort. An incident/accident statement dated 02/26/20 indicated CNA B said Resident #1 was not complaining of any pain and did not have joint swelling to her left leg when she checked on her at 10:30 p.m. on 2/25/20. She said at 1:30 a.m. on 2/26/20 she noticed Resident #1's left hip and leg were swollen, so she notified the charge nurse. An x-ray report dated 02/26/20 at 4:45 a.m. indicated Resident #1 had [MEDICAL CONDITION] changes to her left hip. The left femur x-ray showed a [MEDICAL CONDITION] femur with soft tissue prominence of the mid-thigh possibly representing a hematoma (bruising) . A nurse's note dated 02/26/20 at 1:30 a.m. completed by LVN D indicated Resident #1's left leg from her knee down was turned outward with her foot laying inward. The note indicated Resident #1 had swelling to her left hip and the resident denied pain, but mild discomfort was noted when the resident's left leg was moved. The note indicated the resident denied the need for pain medication. The note indicated LVN D notified the physician who ordered an x-ray of the left hip and femur. A nurse's note dated 02/26/20 at 6:10 a.m. completed by LVN D said Resident #1's x-rays showed a [MEDICAL CONDITION] femur. The note indicated the physician ordered the resident to be transferred to the hospital for further evaluation and treatment. An Emergency Department Summary dated 02/26/20 indicated Resident #1 had a moderately displaced acute post traumatic oblique fracture (a slanted, complete fracture from trauma) involving the distal diaphysis/metadiaphysis (the main section of the bone/ narrow section of the bone) of the left femur, [MEDICAL CONDITION], and multifocal moderate to severe primary [MEDICAL CONDITION]. A nurse's note dated 02/26/20 at 12:30 p.m. completed by LVN C indicated Resident #1 returned from the hospital with a brace to her left leg. She said the resident was assisted over to the bed by 2 staff. She said the resident had new orders to keep the brace on the left leg all the time except to bathe and to do skin assessments. During an observation and interview on 03/12/20 at 12:56 p.m. Resident #1 was lying in bed and did not appear to have pain or discomfort. She said something was wrong with her left hip, but she was not sure what it was. She said she always hurts in her left hip. A progress note dated 03/06/20 completed by MD E indicated Resident #1 had been non-ambulatory for several years and had severe [MEDICAL CONDITION]. He wrote to continue with non-surgical treatment with a knee immobilizer and to return in a month for another x-ray and an update. During a phone interview on 03/12/20 at 4:22 p.m. CNA A said she transferred Resident #1 by herself on 2/24/20. She said she had to ease the resident to the floor because she could not get her from the bed to her chair. She said she did not know at the time of the transfer Resident #1 required 2 staff during transfer. She said after the transfer she found out the information on how many staff it took to transfer a resident could be found in the front of a notebook at the CNA desk. She said she had only seen Resident #1 out of bed about two times, so she was not sure how the resident needed to be transferred. She said the resident did not have a right leg, so the resident was not able to help with the transfer. During a phone interview on 03/12/20 at 2:00 p.m. LVN C said she was the charge nurse the day Resident #1 was eased to the floor by CNA A (on 2/24/20). She said she was called to Resident #1's room by CNA A. She said when she arrived in the room there was nobody with the resident. LVN C did not know if anyone assisted CNA A in transferring Resident #1. LVN C said Resident #1 was sitting on the floor with her back against the side of her bed. She said she assessed the resident for redness, swelling, or bruising and found none. She said she and CNA A assisted Resident #1 back to bed. She said the resident denied pain when they assisted her back to bed. LVN C said later on 2/24/20 in her shift Resident #1 complained of pain to her hip, so she notified the doctor and gave the resident some pain

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) medication. She said the doctor ordered an x-ray of the left hip. She said the hip x-ray on 02/24/20 was negative for any fractures. She said Resident #1 did not have any redness, swelling, or bruising throughout that shift or the next day. She denied knowledge of any other assists to the floor or falls for Resident #1. She denied knowledge of Resident #1 having fractures in the past. During an interview on 03/12/20 at 5:05 p.m. the DON said CNA A attempted to transfer Resident #1 without assistance on 2/24/20 and had to assist the resident to the floor because she was not able to transfer her from the bed to the chair by herself. She said aides have a notebook at their stations on each hall that have information on how the resident is to be transferred and how many staff are required for the transfer. She said Resident #1 had brittle bones for years. She said the doctor said Resident #1's bones could break in every day care such as turning the resident in bed.