STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675055	A. BUILDING _____ B. WING _____	03/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHILDRESS HEALTHCARE CENTER	1200 7TH ST NW CHILDRESS, TX 79201

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 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, it was determined the facility failed to implement its' written policies and procedures that prohibit and prevent neglect for 1 of 7 residents (Resident #1) reviewed for neglect when: Resident #1 received a fracture to her right hip and femur which required a trip to the emergency room and surgery but the facility failed to report the incident to State. The facility's failure to ensure suspicions of abuse/neglect were investigated and reported to State could place all residents at risk for poor self-esteem, poor self-worth, neglect, abuse, misappropriation of property, and continued contact with the perpetrator of the neglect. The evidence is as follows: Record review of the facility's policy on Abuse /Neglect revised date July,2017 reflects in part: Policy Statement All reports of abuse, neglect, injuries of unknown origin shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management . Reporting All alleged violations involving abuse, neglect .and injuries of unknown origin will be reported by the facility administrator or his designee to the state licensing agency . Record Review of Resident #1's clinical record revealed Resident #1 is a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#1 is non/verbal, incontinent, requires repositioning every 2 hours and is in bed most of the day except at meals. Resident was found with an injury to her right upper thigh on 3/13/20 at 6:40 AM. Resident #1 was assessed and found to have swelling on right upper thigh and thigh was tender to touch. Resident #1 was sent to the hospital. Resident #1 had surgery on 3/13/20 to repair the fracture. -Current Care Plan: has limited physical mobility and a communication deficit. -A quarterly MDS resident assessment, dated 1/24/20, documented Resident #1 is never understood and requires extensive assistance for bed mobility, dressing, toileting, personal hygiene,bathing and transfers. Record review of the hospital x ray report dated 3/13/20 for the pelvis documented there is a displaced subtrochanteric [MEDICAL CONDITION] hip with varus angulation. Additionally, a bony lesion is seen in the intertrochanteric region of the right hip raising the possibility of a pathological fracture. Record review of the hospital x ray report for the femur dated 3/13/20 documened there is a displaced subtrochanteric [MEDICAL CONDITION] femur with varus angulation. Additionally, a bony lesion is seen in the intertrochanteric region of the right hip raising the possibility of a pathological fracture. In an interview on 3/14/20 at 10:20 AM, ADM stated she did not call a report in to the state as she discussed the situation with the corporate office and the corporate office stated the incident was not reportable. Record review of Resident #1's facility nurses notes document the facility learned of the incident on 3/13/20 at 6:40 AM. The facility did not report the incident to the state.
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 involving abuse, neglect, and injuries of unknown source are reported in accordance with the state law for 1 of 7 residents reviewed for abuse/neglect. (Resident #1) The facility failed to report an abuse allegation of Resident #1 within 2 hours. This failure could place all residents in the facility at risk of injury related to abuse and neglect. Findings Include: Record Review of Resident #1's clinical record revealed Resident #1 is a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#1 is non/verbal, incontinent, requires repositioning every 2 hours and is in bed most of the day except at meals. Resident was found with an injury to her right upper thigh on 3/13/20 at 6:40 AM. Resident #1 was assessed and found to have swelling on right upper thigh and thigh was tender to touch. Resident #1 was sent to the hospital. Resident #1 had surgery on 3/13/20 to repair the fracture. -Current Care Plan: has limited physical mobility and a communication deficit. -A quarterly MDS resident assessment, dated 1/24/20, documented the resident is never understood and requires extensive assistance for bed mobility, dressing, toileting, personal hygiene,bathing and transfers. Record review of the hospital x ray report for the pelvis dated 3/13/20 documented there is a displaced subtrochanteric [MEDICAL CONDITION] hip with varus angulation. Additionally, a bony lesion is seen in the intertrochanteric region of the right hip raising the possibility of a pathological fracture. Record review of the hospital x ray report for the femur dated 3/13/20 documented there is a displaced subtrochanteric [MEDICAL CONDITION] femur with varus angulation. Additionally, a bony lesion is seen in the intertrochanteric region of the right hip raising the possibility of a pathological fracture. In an interview on 3/14/20 at 10:20 AM, ADM stated she did not call a report in to the state as she discussed the situation with the corporate office and the corporate office stated the incident was not reportable. Record review of Resident #1's facility nurses notes document the facility learned of the incident on 3/13/20 at 6:40 AM. The facility did not report the incident to the state. Record review of the facility's policy on Abuse /Neglect revised date July,2017 reflects in part: Policy Statement All reports of abuse, neglect, injuries of unknown origin shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management . Reporting All alleged violations involving abuse, neglect .and injuries of unknown origin will be reported by the facility administrator or his designee to the state licensing agency .

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.