STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675424	A. BUILDING _____ B. WING _____	09/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED REHABILITATION AND HEALTHCARE OF ATHENS	121 COMMONS DRIVE ATHENS, TX 75751

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 and assistance devices to prevent accidents were provided for 1 of 4 residents reviewed for accidents. (Resident #1) The facility did not implement effective interventions to prevent Resident # 1 from sustaining injuries from falling out of the bed. Resident #1 who had a history of [REDACTED]. This failure could place residents with history of falls at risk of injury. Findings included: 1. A face sheet printed 09/12/20 indicated Resident #1 was a [AGE] year-old female readmitted on [DATE]. Her [DIAGNOSES REDACTED]. Resident #1 was not available for interview as she was still in the hospital and visitation was not allowed due to COVID-19. A fall risk assessment dated [DATE] indicated Resident #1 had a score of 17 (a score above 10 represents high risk). The MDS dated [DATE] indicated Resident #1 had clear speech; usually made herself understood; had impaired vision; had moderately impaired cognition; required extensive assistance of 2 staff for bed mobility and transfers; was always incontinent of bladder and bowel; and had no falls since admission, reentry, or prior assessment. A care plan initiated on 07/01/20 indicated Resident #1 was at risk for falls related to a fall risk score of greater than 10 with goal to reduce the risk of injury related to falls over the next 90 days and the following interventions: * on 06/29/20-therapy to evaluate and treat, rearrange personal items in reach, and place grabber device at bedside; * on 07/01/20-anticipate and meet the resident's needs, place items frequently used by the resident within easy reach when in the room, ensure resident is wearing appropriate footwear when ambulating or mobilizing in her wheelchair, and Fall Risk Screening upon admission and quarterly to identify risk factors; * on 07/07/20-assist resident with all meals, resident up in chair for meals; and * on 07/21/20-floor mat. 1.An incident report dated 08/21/20 indicated Resident #1 was found lying on her stomach and right side on the floor next to her bed with a moderate amount of bleeding from her right forehead. She was not able to inform the facility and EMS staff of what exactly happened due to her mental status. She was transported to the local hospital and treated. An Interdisciplinary Post-Fall assessment dated [DATE] indicated Resident #1 rolled out of bed, she had a laceration to her forehead, and recommendations for ER evaluation and a fall mat at the bedside. A nursing note dated 08/21/20 indicated Resident #1 returned from the ER with a [DIAGNOSES REDACTED]. The note indicated she had 4 sutures to her right forehead. 2. An incident report dated 08/24/20 indicated Resident #1 was found sitting on the floor mat leaned against the bed, she was assessed, and no injuries noted. An Interdisciplinary Post-Fall assessment dated [DATE] indicated Resident #1 rolled out of the bed, she had no injuries, and recommendations for low bed and fall mat in place. A nursing note dated 08/24/20 indicated Resident #1 was found sitting on the floor mat leaned against the bed, she was assessed, and no injuries noted. The care plan initiated on 07/01/20 indicating Resident #1 was at risk for falls had a revision on 08/24/20 to include an intervention to keep her bed in the lowest position when not providing care. 3. An incident report dated 09/04/20 indicated at 01:00 p.m., the charge nurse noticed Resident #1 was lying in her bed with her trunk in her bed and her feet dangling off the side of the bed, at 01:30 p.m., it was reported by therapy to the charge nurse Resident #1 was on her fall mat beside the bed, she was assessed, and she had no injury. An Interdisciplinary Post-Fall assessment dated [DATE] indicated Resident #1 rolled out of the bed, she had no injuries, and recommendations for low bed, fall mat in place, and encourage activity. A nursing note dated 09/04/20 indicated it was reported by therapy to the charge nurse Resident #1 was on her fall mat beside the bed, she was assessed, and she had no injury. The care plan initiated on 07/01/20 indicated Resident #1 was at risk for falls had a revision on 09/04/20 to include an intervention to encourage her to participate in activities that promote exercise, physical activity for strengthening and improved mobility. A Fall Risk assessment dated [DATE] indicated Resident #1 had an increase in her score from 17 to 19 (a score above 10 represents high risk) due to 3 or more falls in the last 3 months. 4. An incident report dated 09/07/20 for Resident #1 indicated she was found on the floor on her left side with a large amount of blood coming from her nose, 911 was called, and she was transported to the ER. An Interdisciplinary Post-Fall assessment dated [DATE] indicated Resident #1 rolled out of the bed onto the floor, she had a nose bleed, and recommendations for ER evaluation and a scoop mattress (mattress with the sides slightly elevated to help prevent rolling out of the bed). A nursing note dated 09/07/20 indicated Resident #1 was found lying on the floor on her side with a large amount of blood coming from her nose; pressure was applied to the nose; 911 was notified; her vital signs were blood pressure 96/59 (low), pulse 112 (elevated), respirations 18 (normal), and oxygen saturation 99% (normal); and she was transferred to the ER. A hospital Trauma Admission History and Physical for Resident #1 dated 09/07/20 indicated Chief Complaint/HPI: .HPI (history of present illness) Patient presents to ER as transfer from (town) after GLF (ground level fall) at nursing home. Patient reported to have rolled out of bed and landed face down on floor. Unknown LOC (level of consciousness). Was evaluated by ER and found to have a very small SDH (subdural hemorrhage (brain bleed)), nasal bone fx (fracture) Assessment and Plan: 1) Subdural Hemorrhage, Present on Admit Yes, Clinical Status New, Admit to medical surgical unit 2) Closed Fracture of Nasal Bones, Present on Admit Yes, Clinical Status New A hospital Radiology Report dated 09/08/20 for Resident #1 indicated Procedure: CT Head (cat scan) WO (without) Contrast (a special dye) .REASON FOR EXAM: Trauma TBI ([MEDICAL CONDITION]) Additional Clinical Information: TRAUMA GLF SDH NASAL FX .COMPARISON: 09/07/20 FINDINGS: There is subdural hemorrhage layered on the tentorium (structure of the brain) on the left. There is no evidence of mass, mass effect, or midline shift. Ventricles (cavities filled with fluid in the brain) and sulci (indentation or depression in the brain) are normal. Basilar cisterns (space that surrounds the structures lying on the floor of the skull) are patent. Air-fluid level again seen at the left maxillary antrum (a sinus cavity). IMPRESSION: 1. Stable thin acute subdural hemorrhage layered on tentorium on the left. A written statement completed by MA A dated 09/08/20 indicated she was asked at approximately 02:00 p.m., to assist HA D to lay Resident #1 back into bed. She indicated PTA C assisted with laying Resident #1 down. She indicated HA B entered the room and she left. She indicated Resident #1's bed was elevated and there was no fall mat on the floor. An undated phone interview by the DON with HA B indicated she helped HA D with changing Resident #1. She indicated she left the room just prior to Resident #1's fall. She indicated the bed was in the raised position and no fall mat was in place. A written statement dated 09/08/20 PTA C indicated on 09/07/20 he transferred Resident #1 from her wheelchair to her bed with the assistance of MA A. He indicated he left the room leaving MA A with Resident #1. He indicated Resident #1's bed was in the low position, but the fall mat was not in place. An undated phone interview by the DON with HA D indicated he and HA B changed Resident #1. She indicated she left the room just prior to Resident #1's fall. He indicated the bed was in the low position and the fall mat was in place. During an interview on 09/12/20 at 01:54 p.m., the DON indicated from the investigation they were not sure if the bed was in the low position and the fall mat were in place. She said the scoop mattress was put into place after the incident on 09/07/20 when Resident #1 sustained the fractured nose and brain bleed. When asked if the scoop mattress should have been put into place prior to the incident on 09/07/20 due to Resident #1's four falls from rolling out of the bed, the

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) DON said probably. She said the resident was able to reposition herself in the bed from working with therapy. She said she was aware of the resident being found with her feet hanging off the bed at least one time. A Fall Management System policy revised 01/03/17 indicated Policy: It is the policy of this facility that each resident will be assessed to determine his/her risk for falls, and a plan of care implemented based on the resident's assessed needs Procedure: B. Analysis of Assessment and Implementation of Preventive Measures: 2. The identifying factors will be provided to staff, and the individualized resident care plan will be developed with appropriate goals and interventions utilizing the Fall Management 5. Preventive interventions are reviewed, evaluated, and implemented to reduce the reoccurrence of falls 6. Nursing Administration/designee will be responsible for validation and re-evaluation residents at risk for falls and effectiveness of interventions for Fall Management Program E. Investigation and follow-up of accidents involving falls 2. Interventions will be implemented in an attempt to prevent the resident from sustaining further falls. Based on the investigation results, the licensed nurse will initiate intervention measures as soon as practicable (e.g., placing a chair alarm, removing obstacles out of path to (bathroom), placing resident on a low bed, etc.). 3. Further investigation may be necessary and findings documented on the Investigation Synopsis by the Administrator or Director of Nursing
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents on the COVID-19 (coronavirus) isolation hall. The facility did not ensure staff wore PPE appropriately while on the COVID-19 isolation hall as mandated during the COVID-19 Pandemic. This failure could place residents, staff and visitors at risk for exposure to COVID-19 and other communicable diseases. Findings included: A resident roster dated 09/09/2020 indicated 2 residents resided on the COVID-19 Unit. During an observations on 09/09/20 at 3:40 p.m., LVN A was on the COVID-19 isolation hot hall wearing an isolation gown with the back open, exposing her clothes. During an interview on 09/09/20 at 3:44 p.m., LVN A said she thought her gown was pulled together but it must have pulled apart when she sat down. During an interview on 09/12/20 at 10:30 a.m., the DON and the ADM said LVN A should be covered all the way around in her gown. The DON said they have done training and in-services on how to wear the PPE properly. The ADM agreed staff have been trained. An inservice training signature log indicated LVN A was not present for the following in-services on the following dates: *08/14/2020 - Hall 500 Quarantine Unit - use of full PPE *08/06/2020 - COVID-19 Environmental Screening, Monitoring for Symptoms *08/05/2020, 08/06/2020 and 08/10/2020 - Mandatory Mask Fit Test *07/27/2020 - COVID-19, dress code, skin, empty trash/linen *07/23/2020 - Change your mask, Presumptive COVID-19, Staff transporting FULL PPE, Regular Nurse. *04/05/2020 - Isolation measures, signage to be posted, staff wearing mask . During interview 09/12/2020 at 10:36 a.m., the DON said the that LVN A had not been fit tested for an N95 because the agency nurse that was doing the testing was pulled from the facility before LVN A could be tested . A Coronavirus Management Plan Texas Phase 3 (Known Cases in Facility) Phase 3=Monitoring, Containment, & Rapid Identification of Cases policy dated 08/21/20 indicated: * on page 5: Monitor staff for proper PPE use and on suspect and confirmed cases to include gowns, gloves, N95 masks, and face shields/goggles * on pages 14 and 15- 4. Infection Control: Follow proper Transmission Based Precautions COVID-19 2. Step Down/Quarantine Unit and COVID Positive Unit all suggested PPE includes: N95 Respirators Eye protection, either face shield or goggles Gown Gloves 3. Negative/Cold Unit N95 Respirator Eye protection, either face shield or goggles Gown and gloves while performing personal care on the resident (do not need to wear gown and gloves in hallways) ; * on pages 17 and 18: For dedicating staff to care for residents on COVID Positive Unit or on the Step-Down/Quarantine Unit: (Example: staffing ratios depend on acuity and number of residents.) 1.Place a nurse who does complete care and add nursing aids as needed. Staff to stay on the unit and not go to other areas in the facility. When leaving and entering the unit: Directly after entering the isolation area and prior to donning PPE, perform hand hygiene Put on Proper PPE Perform hand hygiene before and after performing resident care Directly before exiting the isolation area, remove PPE Continue wearing N95 and face shield or goggles (Clean face shield or goggles before exiting) while in the facility Perform hand hygiene * on page 19: When Providing a dedicated area for donning and doffing of PPE 3. Only donning and doffing should occur at any given time in that area