STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. BUILDING _____ B. WING _____	**06/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND PINES NURSING HOME	**1100 N 4TH ST LONGVIEW, TX 75601**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records that were complete and/or accurate for 1 of 3 residents reviewed for clinical records. (Resident #1) The facility did not have accurate contact information listed for the responsible party for Resident #1. This failure could place residents at risk for not having accurate contact information documented in their clinical records. Findings included: An admission record dated [DATE] indicated Resident #1 was [AGE] years old, admitted [DATE] and discharged [DATE]. His [DIAGNOSES REDACTED]. The record indicated the primary responsible party was himself with a phone number provided. An undated resident admission information sheet indicated Resident #1's responsible party contact was his sister with a phone number listed. An undated report sheet indicated Resident #1's responsible party contact was his sister, there was a phone number provided. A hospital face sheet dated [DATE] indicated Resident #1's responsible party contact was his sister, there was a phone number provided. During an interview on [DATE] at 9:35 a.m., Resident #1's family member said the facility did not notify them when Resident #1 was sent to the emergency room for a medical emergency where he later died . She said the number the facility had listed on Resident #1's admission record dated [DATE] was a number for Resident #1's father he had several years ago and was no longer accurate. She said she contacted the facility previously about the contact information and all calls would have to be made to Resident #1's sister with the contact information listed on the report sheet and hospital face sheet. She said she informed the facility Resident #1's father was unavailable to oversee his care at this time and to call her or the other sister. During a record review on [DATE] at 10:46 a.m., Resident #1's paper clinical records contained 3 separate sheets with contact information for Resident #1's sister. The sheets indicated that Resident #1's sister was his responsible party. During an interview on [DATE] at 12:53 p.m., Registered Nurse (RN) A indicated she worked on [DATE] during the evening shift when Resident #1 experienced a medical emergency and needed to be sent to the emergency room . She said she located a number in Resident #1s medical records for his father. She said she called the number listed both in the paper chart and in the electronic records and was informed she had the wrong number. She said she knew Resident #1's father was unable to manage his care and decisions at the time of his admission, she said there was no other contact information she could find for any other family members. RN A said another staff member informed her later in the evening Resident #1's sister was to be contacted in the event of any changes, she said she updated the contact information in the electronic clinical records but did not notify the family of the event after the hospital told her Resident #1 had expired and they (hospital) notified the family. During an interview on [DATE] at 3:00 p.m., the Director of Nurses (DON) said she expected all information for resident contact information to be in the electronic health records and be accurate. She said the admission team was responsible for getting the contact information into the records. She said Resident #1's contact information should have been listed and verified prior to his admission into the facility. She said staff should not have to look through a chart at multiple pages to get information in the event of an emergency and should be easily accessible. A policy dated [DATE], titled Admission of a Resident did not address resident contact information.

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.