STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676380	A. BUILDING _____ B. WING _____	**08/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BIG SPRING CENTER FOR SKILLED CARE	**3701 WASSON RD BIG SPRING, TX 79720**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, interview and record review the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced dignity and respect for 1 of 9 residents (2) in that: Resident #2's Representatives were not notified when resident #2 received a new roommate. This deficient practice could affect the other residents whose Representative(s) have the right to be notified when there is a change in roommates or receive a new roommate. The findings were: Record review on 8/24/20 of progress notes for resident #1 documented on 8/5/20 at 10:34 AM family was notified of resident #1 receiving new roommate and agreed. Record review on 8/24/20 of progress notes for resident #2 documented no notifications were made to resident or Power of Attorney contact for new roommate. Interview on 8/24/20 at 12:00 PM Social Worker, stated she had not made any notifications to resident #2 or his Power of Attorney contact before the facility placed a roommate in his room. Social Worker #1 stated she was not sure who was responsible for those types of notifications. Interview on 8/24/20 at 12:05 PM Admission's Coordinator, stated she had made notification of the roommate to resident #1's family on 8/5/20 because he was a recent admission and she had been in contact with his daughter. She stated she did not make any notifications to resident #2 or his family. Interview on 8/24/20 at 12:10 PM, Administrator, stated after reviewing our room changes policy we have realized we have not been following our policy and will start following it immediately. Record review of the facility policy titled Room Changes with a revision date of 12/13/16 reflected the following: Objective: To ensure that all room changes will be constructive and, in the resident's, best interest, whenever possible. The resident has the right to share a room with his or her roommate of choice when both residents live in the same facility, both residents consent to the agreement, if it is practicable. Procedure: The addition of a roommate will take place, whenever possible, after the resident and the family have been given twenty-four (24) hour notice and prepared for the change. The notice must be in writing and include the reason for change.
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.** Based on interview and record review, the facility failed to ensure all alleged violations involving of mistreatment, neglect, abuse or misappropriation of resident property were reported immediately, but not later than 24 hours after the allegation was made, to the administrator of the facility and to other officials (including to the State Agency) for 1 of 9 residents (Resident #3) reviewed for abuse and neglect in that: Staff failed to immediately report an allegation of rape involving Resident #3 to the Administrator on 7/17/20. This failure could place the facilities' 69 residents at risk for injury related to abuse and neglect. Findings included: Record review of progress notes for resident #3 dated 7/17/20, LVN # 1 documented the following: resident #3 came out of activities and saw resident #4 at nurses' station and started yelling rapist, he tried to rape me (referring to resident #4). Staff were able to distract resident #3 and walked her to her room. Interview on 8/12/20 at approximately 2:30 PM, the Administrator stated that incident was not reported to me. Administrator stated this was not reported to HHSC because this is the first I am learning of it looking over the progress notes now. Interview on 8/12/20 at approximately 2:30 PM, the DON stated, I do not recall that incident reported to me. DON stated there was not a risk management done or an incident report done in this incident from 7/17/20. Interview on 8/24/20 at 11:20 AM, LVN #1 stated she did not report the incident from 7/17/20 of resident #3 yelling rapist he tried to rape me because this was an ongoing thing with resident #3. Normally I would text the DON and Administrator what was going on, however there was no documentation that any notifications were made. This is an excuse, but you know how someone has an abnormal behavior that becomes normal because you get used to it, because it goes on day after day after day, that is how I felt with resident #3. Record review of progress notes for resident #3 dated 8/9/20, LVN #2 documented the following: Resident #3 pulled down her pants and yelled he has attacked me three times sexually. Record review of progress notes from Psychiatry Physician dated 8/8/20 documented the following: Subjective: Contacted after hours. LVN #2 called Physician to report resident #3 is delusional and states that she had been sexually assaulted. Anxiety, hostility towards caregivers, and verbal disruptions, Verbal aggression Delusions and paranoid ideations Anxiety, irritability, and hostility Plan: treatment plan: [REDACTED]. Refer to: inpatient psychiatric hospital if okayed by Primary Care Physician (PCP), Fax nurses notes and orders to my office. LVN #2 notified. Interview on 8/12/20 at approximately 2:45 PM, Administrator stated no one called me or the DON and reported resident #3 was stating she had been attacked three times sexually. I found out when I came to work on 8/10/20 and saw the police car in the parking lot and the police were in the facility. Interview on 8/12/20 at approximately 2:45 PM, DON stated I had been out of town over the weekend and was contacted by LVN #2 that resident #3 had an outburst and they had called the crisis line and the psychiatric physician, along with the medical director. I was not told resident #3 made allegations of being attacked sexually. I found out the resident made allegations of being attacked sexually when I arrived to work on 8/10/20. The facility's resident roster, dated 8/10/20, reflected the census was 69.
F 0836 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to operate and provide services in compliance with all applicable Federal, State and local laws, regulations, and codes, for 2 of 9 residents (Resident #1 and #2) in that: The Facility did not report a resident to resident altercation between Resident #1 and Resident #2 within the required time frame of the incident. This failure could place the census of 69 residents at risk of not having incidents and accidents reported appropriately. Findings included: Record review of progress notes for Resident#1 and Resident #2 documented a resident to resident altercation on 8/19/20. Documentation revealed Resident #2 was using his cane to assault Resident #1. Resident #1 did not fight back but did grab the cane to prevent resident#2 from striking him until help arrived. Interview on 8/24/20 at 12:10 PM, Administrator stated there was a resident to resident altercation recently and she did not report the incident to Health and Human Services because she thought it was not a reportable event since both residents have a [DIAGNOSES

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

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F 0836 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) REDACTED]. She stated she did report it however it was reported late. Record review of resident #2's discharge summary documented the following: A. Discharge Summary 3. Brief History: Resident #2 had an altercation with roommate, resident #1. Resident #2 hit resident #1 on the left arm and shin with his cane. Record review of the facility's policy Abuse and Neglect date revised 3/29/18 documented the following: C. Prevention 3. All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigation will be reviewed by the facility administrator/ and or Abuse Preventionist within 24 hours of complaint. Appropriate notifications to state and home office will be the responsibility of the administrator and per policy. E. Reporting 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of [REDACTED]. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider letter 17-18 dated 5/3/17. The facility provided Census List dated 8/10/20 indicated a census of 69 residents.