STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675098	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FARWELL CARE AND REHABILITATION CENTER	**305 FIFTH ST FARWELL, TX 79325**

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 it's own written policy and procedures that prohibit abuse and neglect for 1 of 6 residents (Resident #1) reviewed for neglect. The facility failed to report an allegation of neglect involving Resident #1 to the State Survey Agency within 2 hours of the allegation being made. This failure could affect residents by placing them at risk of not having incidents of abuse, neglect, exploitation, and misappropriation of resident property being reviewed and investigated in a timely manner by the facility and State Survey Agency. The Findings Include: Record review of facility provided policy titled Abuse, Neglect, and Exploitation, dated 2-1-2019, reflected in part: VIII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury Record review of Resident #1's clinical record revealed a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS section C, dated, 7-5-2020, revealed a BIMS that could not be assessed. The staff assessment revealed that the resident was severely cognitively impaired. Section G of the MDS revealed that Resident #1 required limited to extensive 2 person assist with all ADLs. Record review of the Provider Investigation Report of the incident involving Resident #1 revealed that the resident fell and experienced a significant injury around 8:50 PM on 7-5-2020. The report indicated that the state agency was not alerted of the fall until 7-6-2020 at 10:00 AM, more than 11 hours after the 2-hour requirement. During an interview with the DON on 7-28-2020 at 12:30 PM, she was asked if it was her expectation that falls with significant injuries be reported to the state agency within 2 hours. She responded that it was her expectation to report within the specified time frames. She was then asked if the staff was aware that they were required to report significant injuries to the abuse coordinator and to the state within 2 hours. She responded that the staff was aware. The DON was then asked why the incident was not reported in a timely manner. She replied that she was unclear on the wording of the regulation.
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, it was determined the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) after the allegation was made in accordance with State law for 1 of 1 residents (Resident #1) reviewed for neglect. The facility failed to report an allegation of neglect involving Resident #1 to the State Survey Agency within 2 hours of the allegation being made. This failure could affect residents by placing them at risk of not having incidents of abuse, neglect, exploitation, and misappropriation of resident property being reviewed and investigated in a timely manner by the facility and State Survey Agency. The Findings Include: Record review of Resident #1's clinical record revealed a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS section C, dated, 7-5-2020, revealed a BIMS that could not be assessed. The staff assessment revealed that the resident was severely cognitively impaired. Section G of the MDS revealed that Resident #1 required limited to extensive 2 person assist with all ADLs. Record review of the Provider Investigation Report of the incident involving Resident #1 revealed that the resident fell and experienced a significant injury around 8:50 PM on 7-5-2020. The report indicated that the state agency was not alerted of the fall until 7-6-2020 at 10:00 AM, more than 11 hours after the 2-hour requirement. During an interview with the DON on 7-28-2020 at 12:30 PM, she was asked if it was her expectation that falls with significant injuries be reported to the state agency within 2 hours. She responded that it was her expectation to report within the specified time frames. She was then asked if the staff was aware that they were required to report significant injuries to the abuse coordinator and to the state within 2 hours. She responded that the staff was aware. The DON was then asked why the incident was not reported in a timely manner. She replied that she was unclear on the wording of the regulation. Record review of facility provided policy titled Abuse, Neglect, and Exploitation, dated 2-1-2019, reflected in part: VIII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury

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.