STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455618	A. BUILDING _____ B. WING _____	**06/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDEN HOME INC	**631 LAKEVIEW BLVD NEW BRAUNFELS, TX 78130**

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 Observation, Interview and Record Review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and investigate any such allegations for 1 of 5 residents (Resident #1) reviewed for neglect and abuse, in that: The facility did not implement their policy in reporting to the State Survey Agency (HHSC) Resident #1's death after an unwitnessed fall. This deficient practice could place residents who had a fall at risk for abuse and/or neglect. The findings were: Record review of the facility's policy titled, Abuse, Neglect, Exploitation dated [DATE], revealed in part, It is the facility policy to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property V Investigation of Alleged Abuse, Neglect and Exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur VII. Reporting /Response A.1. Reporting of all alleged violations to the Administrator, state agency, and to all other required agencies Within specified timeframes. A. Immediately, but not later then 2 hours after the allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . Record review of Resident #1's face sheet, dated [DATE], revealed an admission date of [DATE], with [DIAGNOSES REDACTED].). Record review of Resident #1's Care Plan, dated [DATE], revealed the resident was high risk for falls due to weakness, [MEDICAL CONDITION] meds, history of falls and diuretics. Further review revealed the goal of the focus area was, The resident will remain free from injury due to falls through next review date [DATE]. One of the interventions included to monitor the resident for increase in ability to transfer himself. Record review of the facility's Incident Reports revealed Resident #1 had suffered falls on [DATE] at 10:00 p.m., [DATE] at 9:30 p.m. without injury and then fell on [DATE] at 9:35 p.m. with 2 skin tears to his left hand. Record review of an Incident Report, dated [DATE] at 9:35 p.m., revealed, Resident #1 had an unwitnessed fall in the large dining room and had 2 skin tears on his left hand. Further documentation stated the resident was assessed from head to toe. Resident transferred to his room to complete wound care and prepare the resident for bed and obtain vitals signs for neuro checks when Resident #1 began drooling and unresponsive. The Nurse Manager was notified at 9:37 p.m., Physician at 10:14 p.m. and the RP at 11:00 p.m. Record review of the electronic nursing progress notes dated [DATE] at 11:24 p.m., revealed the documentation indicating at 10:40 p.m. LVN C contacted the physician and had an order for [REDACTED]. Further review of another nursing progress note, dated [DATE] at 4:08 am from LVN C, revealed in part Resident #1 was in the dining room transferring himself from the wheelchair to a chair at the table and slipped out of his wheelchair onto the floor on his right side .No other injuries noted at this time taken to his room for privacy to complete wound care and prepare the resident for bed Head to toe assessment performed, Neuro checks initiated, encouraged resident to ask for assistance . Contacted pertinent parties Will continue to monitor for any delayed injuries or change in condition. During an interview with the DON on [DATE] at 9:44 a.m. revealed Resident #1 had a fall, he was assessed and then became unresponsive and later expired. The DON stated when they began to look at the nurses' notes and information provided, they started to investigate because the documentation did not line up. The DON stated LVN C was suspended until the investigation was completed. The DON stated Resident #1 had a Do Not Resuscitate (DNR). The DON stated on [DATE] Resident #1 had a fall and then became unresponsive. The DON stated the following day she pulled the documentation concerning Resident #1 and noted there was no time line and the notes were hard to follow and she was not sure if LVN C had done any neuro checks. The DON stated LVN C was able to show the documentation and the time lines, but it needed to be on the Nurses' Notes and since the electronic notes were locked she had LVN C place the notes on a paper Nurses' Notes Form. The DON confirmed the State was not notified as required when there was a question concerning possible neglect. During an Interview with LVN C on [DATE] at 11:12 a.m. revealed she had the notes about Resident #1 on her scratch paper, but not on the neuro check sheet and in the Nurses' Notes. The DON asked me to transfer the information to the paper Nurses' Notes since the computer Nurses' Notes was locked and she could not add them to the electronic notes. LVN C revealed she had completed neuro checks on Resident #1. LVN C stated she had worked Wednesday and Thursday and was getting off on Friday morning, and RN B called her on Thursday evening when she was at work to not go home before she had met with the DON. LVN C confirmed she had not placed the notes in Resident #1's electronic nurses' notes the day the incident had taken place. During an interview with CNA D on [DATE] at 1:11 p.m. revealed he was the CNA who took Resident #1 to his room and began to undress the resident. CNA D stated LVN C accompanied him to Resident #1's room. CNA D stated Resident #1 had 3 shirts on (2 long sleeve and a T shirt). CNA D stated the resident proceeded to get up out of his wheelchair when he began to drool out of both sides of his mouth and became unresponsive and informed LVN C who had the treatment cart in the room and had her back to him and Resident #1. CNA D stated LVN C helped him get Resident #1 in bed. CNA D revealed LVN C was on the phone calling someone, but he did not know who it was. He confirmed LVN C did check Resident #1 out, place oxygen on Resident #1, CNA D stated LVN C did have a pulse oximeter on Resident #1's finger and LVN C was checking his vital signs. Later another CNA came into the room and he left.
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 Observation, Interview and Record Review, the facility failed to report alleged violations related to neglect or abuse, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) for 1 of 5 residents (Resident #1) reviewed for neglect and abuse, in that: The facility did not report to State Survey Agency (HHSC) Resident #1's death after an unwitnessed fall. This deficient practice could place residents who had a fall at risk for abuse and/or neglect. The findings were: Record review of Resident #1's face sheet, dated [DATE], revealed an admission date of [DATE], with [DIAGNOSES REDACTED].). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed the resident's cognition had to be evaluated by staff. The resident had long and short term memory problems, cognition is moderately impaired indicating the residents' decisions were poor and had to be cued and supervision was required. Record review of Resident #1's Care Plan, dated [DATE], revealed the resident was high risk for falls due to weakness, [MEDICAL CONDITION] meds, history of falls and diuretics. Further review revealed the goal of the focus area was, The resident will remain free from injury due to falls through next review date [DATE]. One of the interventions included to monitor the resident for increase in ability to transfer himself. Record review of the facility's Incident Reports revealed Resident #1 had suffered falls on [DATE] at

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

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