

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Jacksonville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Bonita St Jacksonville, TX 75766	
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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on interview and record review the facility failed to ensure residents had the right to be treated with respect and dignity for 1 of 3 residents reviewed for resident rights. (Resident #1) The facility failed to ensure CNA A did not go through Resident #1's personal possessions without his permission or remove items from his room without his permission. This negative finding caused the resident to be distressed and could cause residents to feel disrespected. Findings included: Record review of Resident #1's face sheet, with no date, indicated he was a [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were depression and muscle wasting. Record review of Resident #1's Annual MDS assessment dated [DATE] indicated his cognition was intact with a BIMS (brief interview for mental status) score of 13. His assessment for mood and behaviors did not indicate any concerns. Record review of Resident #1's Care Plan dated 4/3/24 indicated a problem of General. The approaches were the resident preferred showers or baths once a day on Monday, Wednesday, and Friday on the 6 am to 2 pm shift. During an interview on 5/1/24 at 9: 45 a.m., Resident #1 said on 4/30/24, CNA A came into his room and started opening his nightstand drawers and rummaging through them. He said she continued to go through his things, and he asked her what she was doing, and she ignored him. Resident # 1 said he got mad and started yelling at her and told her to get out and leave his things alone. He said to make things worse, when he left his room to talk to the DON about CNA A going through his things without permission, CNA A and CNA B had gone in his room and taken all his towels. He said some of the towels were his own personal towels and they had taken those as well. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 10:14 a.m., CNA A said she was asked by the ADON to check resident rooms for towels. She was just doing what she was told. She was told to get the extra towels out of residents' rooms and that was what she was doing. She said Resident #1 took a shower every day and sometimes twice a day and felt he always needed extra towels. She said she did not have any problems with anyone else but Resident #1. CNA A said she had knocked on Resident #1's door and told him she was checking for towels. She told him she was going to check his dresser drawers and he appeared fine with that. However, when she had gone to his closet, he became upset and stated hollering, what are you doing? You have no business in there? She said she saw a bag in the closet that contained towels. She did not remove the bag because the resident was freaking out (hollering and upset.) She said she had told CNA B and they had gone back later to get the towels when the resident was not in the room. She said it was two large stacks of towels, and they had taken them to the Environmental Services Supervisor who said they were the facility's towel. CNA A said they were the facility's towels and he should not have had them. She said she was in-serviced on Resident Rights. During an interview on 5/1/24 at 10:23 a.m. the ADON said the Environmental Specialist Supervisor was doing inventory on his linens. He asked her to see if she could get the aides to do room search for towels. She said in some cases, hospice aides put towels in the rooms, so they had them when they wanted to do showers. She said she asked CNA A and CNA B to search the rooms for towels. The ADON said she did not think she had to tell them to knock on doors and ask for permission before looking for towels. She said she thought staff understood when the resident says no, that means no. During an interview on 5/1/24 at 10:44 a.m., the DON said the ADON asked CNA A to go to residents' rooms to see if they were hoarding towels. The DON said Resident #1 came to her and said CNA A had gone through his things without his permission. She said Resident #1 said he was upset that she went through his things. The DON said her interview with CNA A revealed she went to Resident #1's room and told him she was going to look for towels. The DON said that was not what they were supposed to do. The DON stated they were to ask for permission to go through the residents' things. She said she immediately started and an in-service on Resident rights. During an interview on 5/1/24 at 11:25 a.m., CNA B said the ADON had asked her and CNA A to check resident rooms for towels. She had to take care of another resident and CNA A had gone into Resident #1's room alone. She said the aide told her she knocked on his door and told him what she was doing. She said CNA A said Resident #1 got upset when she went into his closet. CNA B said CNA A came and told her Resident #1 had a lot of towels in his closet. CNA B said they had gotten the towels while Resident #1 was not in the room. During an interview on 5/1/24 at 12:30 p.m., the Administrator said they had started an in-service on yesterday regarding residents' rights and they had counseled CNA A. She said if things happened the way Resident #1 said, the aide should not have looked through his things without permission. During an interview on 5/1/24 at 12:40 p.m., Resident #1 said his main concern was that girl (CNA A) violated his rights by going through his things and he felt something needed to be done. (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an in-service dated 4/30/24 indicated Resident Rights and Privacy: You cannot go into a resident room and start looking through things without their permission. All staff must be mindful that this is their home, and we should respect that., at no point should they feel like they have no personal boundaries with staff, knock before you enter, let them know what you are in their room for, and ask permission before going forward with the task. The in service was signed by 8 staff. Attached to the in service was a copy of the facility Resident Rights policy. Record review of the facility's policy on Resident Rights revised February 2021 indicated Employees should treat all residents with kindness, respect, and dignity. The resident had the right to a dignified existence, to be treated with respect, kindness, and dignity, be informed of, and participate in his or her care planning and treatment, privacy, and confidentiality.		