

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER Country View Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 N Frances St Terrell, TX 75160	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527</p> <p>33249</p> <p>Based on observation, interview, and record review, the facility failed to implement their written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident's property of 1 of 1 resident reviewed for abuse, neglect, and exploitation. (Resident #17)</p> <p>The facility did not implement their policy to report to HHSC when Resident #17 sustained a severe coffee burn on 8/16/23.</p> <p>This failure could place the residents at risk for further potential abuse, neglect, and injuries of unknown origin.</p> <p>Findings included:</p> <p>Record review of an Abuse/Neglect policy dated 2003 and revised on 5/09/2017 indicated the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals . 2. Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof C. Prevention 4. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. The facility has in place a method to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. All occurrences of potential abuse or criminal behavior will be investigated by the abuse preventionist and/or designee E. Reporting 3. Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown sources to the facility administrator. The facility administrator or designee will report the allegation to HHSC. A. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation F. Investigation Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated.</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a face sheet dated 7/30/2024 indicated Resident #17 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses heart failure, quadriplegia (paralysis of all four limbs), and other muscle spasms, contractures of the left and right hands (a condition where the one or more fingers bend toward the palm of the hand), lack of coordination, muscle weakness, muscle wasting and atrophy.</p> <p>Record review of the Comprehensive Care Plan dated 11/02/2023 indicated Resident #17 was at risk for burns due to hot liquids. The goal of Resident #17's care plan was he would not suffer any injury related to hot liquids. The interventions included coffee and other hot liquids should not be served if over 140 degrees, if hot liquid was spilled on self, staff should pour room temperature or lower temperature liquid over the affected area, he was to use his dominant hand for drinking, and should be seated in upright position with table or overbed table when hot liquids were being consumed. The Comprehensive Care Plan failed to indicate there was a hot liquid deficit prior to 11/02/2023.</p> <p>Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #17 understood and was understood by others. The MDS indicated Resident #17's BIMS score was 15 indicating he had no cognitive deficits.</p> <p>Record review of a nursing progress note dated 8/16/2023 at 12:31p.m., RN F documented Resident #17 said he had a dry area to his right thigh. RN F documented upon assessment she noted a dry scabbed area measuring about 3.5 x 5 (no documented measurement system). The note indicated Resident #17 indicated he had a coffee cup sitting by the side of his wheelchair and it poured on him while he was trying to sit up. The note indicated RN F notified the nurse practitioner, and a new order was received to apply triple antibiotic ointment and cover with a dressing daily until resolved.</p> <p>Record review of a Nurse Practitioner Progress Note dated 8/21/2023 at 10:20 a.m., the nurse practitioner documented the chief complaint was a burn to the right upper thigh. The History of Present Illness section indicated Resident #17 was a [AGE] year old male The nurse practitioner note indicated Resident #17 was seen as requested by the DON due to a new wound to upper thigh. The note indicated Resident #17 said he spilled hot coffee and got burned. The note indicated Resident #17 said it was excruciating. The note indicated the burn was treated with the over-the-counter triple antibiotic cream and covered with a dressing daily. The note in the Section Current Problems: Burn of third degree of right thigh . Review of Systems section labeled Wounds: complaints of wound redness, discharge, pain, and opening of the wound. The note in Section Wound indicated: Traumatic burn to upper thigh right leg with the onset date of 8/14/2023, measuring 5.5 centimeters, 2.5 centimeters width, 0.3 centimeters depth. The note indicated the wound base was slough, with a small amount of serosanguinous drainage. The note indicated Resident #17's burn exposed the adipose tissue and was considered a full thickness wound. The note indicated Resident #17's burn was 51-75% slough; and 25-50% epithelialization and erythema present. The nurse practitioner note indicated Resident #17 was ordered cleanse the wound with normal saline, apply Silvadene, cover with a foam dressing twice daily. The note indicated the nurse practitioner applied a topical anesthetic, after explaining the risks and benefits of debridement (removal of dead tissue using a sharp instrument), debridement was performed without complications.</p> <p>During an attempted interview on 7/29/2024 at 11:36 a.m., the previous DON was called but she had her telephone going to voice mail and a message was left to return the call related to the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 7/29/2024 at 11:45 a.m., Resident #17 said he had previously had a coffee spill that caused a burn to his leg. Resident #17 said he had received treatment for the burn. Resident #17 was drinking coffee from a spill proof coffee cup with a lid and a straw. Resident #17 said he had not had any other burns.</p> <p>Record review of the state agency reporting system for abuse and neglect revealed from 8/16/2023 -8/21/2023 there were no reported incidents regarding Resident #17's burn.</p> <p>During an interview on 7/30/2024 at 6:57 p.m., the ADON said she was not a staff member at the facility when Resident #17 had the coffee burn. The ADON said a burn was a reportable incident to the state agency. The ADON said the Administrator was the abuse coordinator and was responsible for reporting to the state agency. The ADON said she expected the facility abuse policy to be followed and report according to the required time frame of within 2 hours. The ADON said monitoring for incidents and accidents requiring reporting was done through morning meeting and review of the 24-hour report in the computer system.</p> <p>During an interview on 7/30/2024 at 8:02 p.m., the RNC said she was not an employee of the facility when the incident occurred with Resident #17. The RNC said she was unable to comment why the incident was not reported to the state agency, but she agreed the incident should have been reported. The RNC said the state agency should have been made aware of the incident within the two-hour time frame for reporting abuse. The RNC said when an abuse allegation was not reported timely then abuse could continue. The RNC said in morning meeting the incidents and accidents were reviewed. The RNC indicated this incident was not documented on an incident report but should have been. The RNC said in morning meeting the team also reviews the computerized documentation that flows to the 24-hour report.</p> <p>During an interview on 7/30/2024 at 8:51 p.m., the Administrator said when Resident #17 had his coffee burn, he was not the Administrator. The Administrator said he was the abuse coordinator, and the incident required reporting within 2 hours. The Administrator said the incident was not reported through his review. The Administrator said when abuse was not reported timely this could delay the care and services the resident would receive.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527</p> <p>33249</p> <p>Based on observation, interview and record review, 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 caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to the State Survey Agency for 1 of 8 residents (Resident #17) reviewed for abuse and neglect.</p> <p>The facility failed to report to the State Survey Agency on 8/16/2023 immediately but no later than 2 hours after becoming aware Resident #17 sustained a severe coffee burn to his right thigh.</p> <p>This failure could place residents at risk of further potential abuse or neglect.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 7/30/2024 indicated Resident #17 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses heart failure, quadriplegia (paralysis of all four limbs), and other muscle spasms, contractures of the left and right hands (a condition where the one or more fingers bend toward the palm of the hand), lack of coordination, muscle weakness, muscle wasting and atrophy.</p> <p>Record review of the Comprehensive Care Plan dated 11/02/2023 indicated Resident #17 was at risk for burns due to hot liquids. The goal of Resident #17's care plan was he would not suffer any injury related to hot liquids. The interventions included coffee and other hot liquids should not be served if over 140 degrees, if hot liquid was spilled on self, staff should pour room temperature or lower temperature liquid over the affected area, he was to use his dominant hand for drinking, and should be seated in upright position with table or overbed table when hot liquids were being consumed. The Comprehensive Care Plan failed to indicate there was a hot liquid deficit prior to 11/02/2023.</p> <p>Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #17 understood and was understood by others. The MDS indicated Resident #17's BIMS score was 15 indicating he had no cognitive deficits.</p> <p>Record review of a nursing progress note dated 8/16/2023 at 12:31p.m., RN F documented Resident #17 said he had a dry area to his right thigh. RN F documented upon assessment she noted a dry scabbed area measuring about 3.5 x 5 (no documented measurement system). The note indicated Resident #17 indicated he had a coffee cup sitting by the side of his wheelchair and it poured on him while he was trying to sit up. The note indicated RN F notified the nurse practitioner, and a new order was received to apply triple antibiotic ointment and cover with a dressing daily until resolved.</p> <p>(continued on next page)</p>		

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