STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675379	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare Nursing and Rehabilitation Center LLC	111 Ruthlynn Dr Longview, TX 75601

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 ased on interview and record review the facility failed to provide respect, dignity, and care in a manner and in an environment that promoted maintenance or enhancement of quality of life for 1 of 18 residents reviewed for resident rights. (Resident #178) The facility failed to treat Resident #178 with respect and dignity when staff told her to urinate in her brief. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. Findings included: Record review of the face sheet dated 07/17/24 revealed Resident #178 was [AGE] years old female and admitted on [DATE] with diagnoses including Unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), insomnia (persistent problems falling and staying asleep) and Parkinsonism (brain conditions that cause slowed movements, rigidity (stiffness) and tremors). Record review of the MDS dated [DATE] revealed Resident #178 BIMS was not performed and required maximal assistance for toilet use and moderate assistance for transfers, dressing, personal hygiene, and bathing. Record review of the care plan dated 04/04/24 revealed Resident #178 was at risk for skin breakdown/pressure injury related to decreased mobility and incontinence. Interventions included: Complete Braden assessment for early identification of risk factors and interventions. Nursing assistants to examine resident's skin daily for signs of redness or discoloration especially areas prone to breakdown such as boney prominences. Provide peri-care after each incontinent episode. Monitor labs per physician orders. (Especially albumin and pre-albumin) (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide nutritional assessment per RD and administer vitamins/supplements/medications as ordered by MD. Licensed Nurse to complete skin checks weekly. During an interview on 07/15/24 at 6:48 PM, Family Member #1 of Resident #178 said she was on the phone with Resident #178 when she heard a staff member told her to urinate on herself. Family Member #1 said she called the nursing station to get Resident #178 assistance to the bathroom when staff would not answer Resident #178's call light. Family Member #1 said Resident #178's roommate heard the staff tell her to urinate in her brief. Family Member #1 said she took Resident #178 home that night from the facility. During an interview on 07/16/24 1:45 PM, Resident #13 said she remembered Resident #178. Resident #13 said staff always tried to help her, but she refused their help. It depends on which time of day it waws with the accuracy of how long it would take for someone to come help her. Resident #13 said when Resident #178 told staff she had to use the bathroom, the staff would take her and she would not be able to urinate for about 30-45 minutes with staff waiting, so staff told her to go in her brief and they would change her. Resident #13 said one night Resident #178 called Family Member #1 and she came to get her, then took her home. Resident #13 said she thought the facility took care of Resident #178 while she was in the facility, but she was very difficult to take care of. During an interview on 07/16/24 at 1:59 PM, Family member #2 said Resident #178 called Family Member #1, because she had called for staff to assist her to the bathroom, but no one came. Family Member #2 said Family Member #1 told her that a staff member told Resident #178 to urinate in her brief. Family Member #2 stated she assisted Family Member #1 with transferring Resident #178 to the car, to go home. Family member #2 said Resident #178 cried when she got in the car, because she said the staff member told her to urinate in her brief. During an interview on 7/17/24 at 9:06 AM, RN L said he remembered Resident #178 leaving the facility. RN L said there was nothing the staff or the facility could do was satisfactory to the resident or the family. RN L said at night Resident #178 was on the call light nonstop, calling for items she could do on her own, like turn the light on and turn the light off. RN L said Family Member #1 told him she was taking Resident #178 home, because we could not provide adequate care for her at the facility. RN L said he remembered if she needed to go to the restroom the staff would take her. RN L said he does not recall telling Resident #178 to urinate in her brief. RN L said he did remember telling Resident #178 if she did wet her brief, he would change her brief. RN L said he remembered a couple times taking Resident #178 to the bathroom and she was very weak, so changing her brief was probably a safety precaution. During an interview on 7/17/24 at 2:57 PM, the DON said a staff member should never encourage a resident to urinate in their brief if they were aware of when they need to go to the bathroom. The DON said if a staff member told a resident to urinate on themselves, that was a dignity issue and potential for skin breakdown. During an interview on 7/17/24 at 3:15 PM, ADM said it is not ok for a staff member to tell a resident to urinate in their brief. We want the residents to stay independent as long as possible. If it were me, I would feel like they would not want to help me. I feel I am an adult, and it is a huge blow to your dignity, and it would make me feel like staff did not have time for me. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility resident admission agreement dated 12/1/23 revealed . the facility shall offer personal care . the facility will also offer nursing care, activities, restorative and rehabilitative services and psychosocial care as identified by the Resident's Plan of Care established by the Facility Standards and in accordance with the policies of the facility.

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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** 44933 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, including injuries of unknown source were reported immediately, but not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 18 residents (Resident #35) reviewed for abuse and neglect. The facility failed to report Resident #35's injury of unknown origin to her face, within 24 hours to the state agency. This failure could place residents at risk for continued abuse and neglect due to inappropriate interventions and failure to report the allegations of abuse timely. Findings included: Record review of a facility's Abuse Prevention and Prohibition Program policy revised 10/24/22, indicated .to ensure the facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse .the administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems .reporting/response .the facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown origin .immediately, but no later than 2 hours after forming suspicion. Record review of Resident #35's face sheet fated 07/16/24, indicated Resident #35 was a [AGE] year-old female admitted on [DATE] and 04/17/24 with diagnoses including anxiety disorder and dementia. Record review of Resident #35's significant change in status MDS assessment dated [DATE], indicated resident #35 usually understood and sometimes had the ability to understand others. Resident #35 was unable to complete the BIMS assessment. Resident #35 had short-and-long term memory recall problem and moderately impaired cognitive skills for daily decision making. Resident #35 had other behavioral symptoms not directed toward others and daily behavior of rejection of care. The MDS indicated her current behavior status have worsen compared to prior assessment. Resident #35 required moderate assistance for toileting and personal hygiene, dressing, putting on/taking off footwear and dependent for shower/bathe self. Record review of Resident #35's care plan dated 04/16/24, indicated Resident #35 had an alteration in thought process related to dementia with memory deficits, impaired decision making, confusion/disorientation, making self-understood: impaired, and understanding others: impaired. Intervention included always approach in a calm nurturing manner. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #35's care plan dated 05/02/24, indicated Resident #35 had a risk for bruises/discoloration related to fragile skin, restless movements, repeated falls, aspirin use. Intervention included monitor arms and legs during transfer and ADL care. Record review of Resident #35's weekly skin check dated 07/01/24 indicated no skin impairments found. Record review of Resident #35's accident/incident report dated 07/01/24, indicated .Resident #35 .resident's room .incident time: 6:30 p.m.reported by: family member (present in room) .reported to: LVN N .family member in room alerted nurse small bruise noted to Resident's [#35] right jaw .dime size bruise black/blue in color .no indication of pain .no pain voiced .level of consciousness: alert and oriented x1 .injury: bruise . Record review of Resident #35's accident/incident final disposition report completed by LVN N on 07/01/24, indicated .Resident #35 .date of incident: 07/01/24 .type: bruise/right jaw .outcome of interview with staff: spoke with all nurses, cnas, and hospice staff regarding bruise, upon interviewing it was discovered that resident sleeps with bed controller close to face and occasionally wakes up with remote under head/face also sleeps with a baby doll in bed that stays by her face/head and has hard hands and feet .state cause: unknown .did occurrence require notification of state agency .no .was equipment involved .unknown .LVN N . DON .ADM . Record review of Resident #35's hospice coordination notes report dated 07/02/24 indicated .call center-general .time of call:0756 .caller: ADON .the HHA gave the patient a bath last evening and the facility staff noted a bruise to the patient's jawline shortly after .the caller reports that because it is a suspicious bruise, they are conducting an investigation .they would like to know if the patient had been combative or if this bruise was noticed by the HHA during the shower .the patient has a history of being combative during care . During an interview on 07/17/24 at 3:29 p.m., the ADM said she was the abuse coordinator. She said Resident #35 had a history of sleeping with a baby doll and the bed controller remote. She said Resident #35 could not tell how she got the bruise to her jaw. She said after her, ADON, and DON talked about the incident, they did not think it was an injury of unknown origin due to history of sleeping with a baby doll and remote near her face. She said she did not know Resident #35 had a history of being resistive to cares and agitation. She said injury of unknown origin was supposed to be reported to HHSC. She said she was responsible for investigating and reporting. She said when injury of unknown origin was not reported the resident could get injured. She said it was important to report because better safe than sorry. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/24 at 5:07 p.m., the DON said Resident #35's family member was visiting on 07/01/24 and noticed the bruise on her jawline. She said Resident #35's bruise was dime sized. She said nurses reported they sometimes find Resident #35 laying on her remote and she slept with a baby doll too. She said we attributed the bruise to her bed remote or baby doll. She said Resident #35 was confused and could be confused about what staff are doing to her. She said after the incident, staff were supposed to ensure Resident #35 was not laying on the remote or baby doll. She said HHA R bathed Resident #35 the morning of or within a 24-hour period of when the bruise being found. She said she did not think it was an injury of unknown origin. She said Resident #35 could not say what happened. She said the ADM was the abuse coordinator. She said the ADM was responsible for investigating and reporting to HHSC within 2 hours for allegation of abuse. She said not reporting to HHSC placed resident at risk for harm if abuse or neglect was suspected. She said the facility had implemented a new abuse policy on July 1st, 2024.