

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675712	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/18/2024
NAME OF PROVIDER OR SUPPLIER  Homestead Nursing and Rehabilitation of Itasca		STREET ADDRESS, CITY, STATE, ZIP CODE  409 S Files St Itasca, TX 76055	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654</b></p> <p>Based on interview and record review, the facility failed to notify the Resident representative when the Resident experienced a significant change in condition for 1 (Resident #1) of 7 Residents reviewed for Resident rights.</p> <p>The facility failed to notify Resident #1's Family Member or Hospice Agency of his x-ray results that showed he had a left hip fracture on 05/15/24 due to Resident #1 falling on 05/14/24.</p> <p>The facility failed to notify Resident #1's Family Member or Hospice Agency that he was transferred to the hospital on 05/15/24 due to the left hip fracture which was revealed from an x-ray taken on 05/15/24 due to Resident #1 falling on 05/14/24.</p> <p>This failure could result in the Resident representative not being aware of conditions that may require them to make medical decisions.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 07/18/24 reflected an [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses included: dementia (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities), diabetes (a group of diseases that result in too much sugar in the blood), left femur fracture (a serious injury that requires immediate medical attention), and repeated falls (frequent falling). Resident #1's face sheet revealed FM was 1st in line to be called.</p> <p>Record review of Resident #1's initial MDS assessment dated [DATE] reflected Resident #1 had a BIMS of 06 indicating Resident #1 had severe cognitive impairment. Section GG-Functional Abilities and Goals revealed Resident #1 required partial/moderate assistance with bathing and personal hygiene and required set-up or touching assistance with toileting hygiene.</p> <p>Record review of Resident #1's progress notes dated 05/16/24 at 11:16 AM and signed by LVN A reflected [Recorded as Late Entry on 05/17/2024 11:22] Daughter called and said that they did not know that her father was sent to the hospital. She said, I wouldn't have sent him to the hospital. He wouldn't be able to go thru surgery anyway. I apologized for not calling her myself thinking the nurse on duty was going to call.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's SBAR/Change in Condition form dated 05/17/2024 at 1:53 PM reflected when asked for Name of Responsible Party/Health Care Agent Notified the answer was none. Form was created due to Resident #1 previously falling and x-ray reports revealed resident had a fractured left hip.</p> <p>In an interview on 07/18/2024 at 12:58 PM, LVN A stated Resident #1 had the x-ray done due to the change in condition after the fall he had on 05/14/24. She stated she had gotten the results from the x-ray and called and informed the doctor that resident had a left hip fracture. She stated the doctor gave orders to transfer Resident #1 to the emergency room for evaluation and treatment. She stated she sent Resident #1 to the hospital and was going to call the RP the next morning because it was late in the evening when Resident #1 went out to the hospital. She stated she did not notify the family or hospice when resident was transferred to the hospital. She stated she sent the Resident #1's face sheet to the hospital when he transferred there via care flight. She stated residents family and hospice was in the facility when the x-ray was ordered but not when the results came back in. She stated she would normally call and inform the family and hospice, if a resident had been receiving hospice services, if a resident was transferred to the hospital, but because the family member and HRN already knew Resident #1 had a possible fracture and the family member worked in a hospital, family member knew they would possibly have to send resident out. She stated she had been trained on notifying RP's, families, and hospice agencies for any change with the residents, including x-ray results and sending resident to the hospital. She stated if she did not notify the family or hospice agency of a resident transferring out of the facility, the family or hospice agency would not have known where the resident was and a wreck with the ambulance or anything could have happened.</p> <p>In an interview on 07/18/2024 at 1:10 PM, the ADM stated it was her expectation that staff would notify family, responsible parties, or hospice when there was any change in condition, new orders received, or transfer to hospital. She stated staff had been trained on notifying families of residents and hospice, if a resident was receiving hospice services, of any emergency transfers. She stated there could have been a delay in treatment if a residents family member or hospice was not notified of a resident transferring to the hospital. She stated she had not been aware that Resident #1's family or hospice agency had not been notified of his transfer to the hospital.</p> <p>In an interview on 07/18/2024 at 2:09 PM with FM, she stated she had initially been informed by the facility that Resident #1 had fallen and had been assessed with no injuries found. She stated the following day she went to the facility and when she tried to get Resident #1 up out of bed, she could tell something was wrong with him. She stated she had brought something to eat for Resident #1, and after they ate, she asked the nurse on duty to help her get Resident #1 back into bed. She stated the HRN came to the facility about 30 minutes later and ordered an x-ray due to Resident #1's foot being turned outward. She stated the facility nurse told HRN she would notify her and the family of the x-ray results when they came in. She stated she or the HRN was not notified of the x-ray results or Resident #1's transfer to hospital.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/18/2024 at 3:49 PM, the HRN stated she was informed by the facility that Resident #1 had a fall, and she went out to the facility to assess Resident #1. She stated upon her assessment she found that Resident #1's left ankle was turned outward which was a sign of a possible fracture, so she ordered an x-ray. She stated Resident #1 only complained of pain when he was moved but when asked if he was in pain, he said no. She stated Resident #1 had a diagnoses of dementia. She stated the staff at the facility had medicated resident with his PRN pain medication as ordered and the medication appeared to be effective. She stated the x-ray was done but she was not notified of the results. She stated when Resident#1's FM called her the following morning to ask for results, she could not reach the facility. She stated she went back to the facility and found that Resident #1 had a fractured left hip and had been transferred to the hospital. She stated she informed the Resident #1's FM and they called the hospital where Resident #1 had been sent. She stated Resident #1 had not received any treatment besides his regularly ordered medication and the hospital had been waiting on the doctor to see Resident #1 for any possible treatment. She stated it was usually up to the family if they want to send a resident out to the hospital for treatment or not, but because this family had not been made aware, they could not make that decision.</p> <p>Record review of facility's policy dated 2001 and revised September 2012 titled Transfer or Discharge, Emergency reflected Policy Statement: Our facility shall make an emergency transfer or discharge when it is in the best interest of the resident. Policy Interpretation and Implementation: 1. Should it become necessary to make and emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: e. Notify the representative (sponsor) or other family member.</p>		