| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675717 | A. Building<br>B. Wing | 06/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| San Rafael Nursing and Rehabilitation Center | 3050 Sunnybrook Rd<br>Corpus Christi, TX 78415 |

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) |
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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737<br><br>Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 5 Residents (Resident #1) reviewed for medical records accuracy, in that:<br><br>Resident #1's clinical record was incomplete. Staff did not document Residents #1's fall that occurred on 06/21/24 in the shower room.<br><br>This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment.<br><br>The findings included:<br><br>Record review of Resident #1's face sheet, dated 06/30/24, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: Hemiplegia (paralysis to one side of body) and hemiparesis (weakness to one side of body) following cerebral infarction (ischemic stroke -occurs when the blood flow to brain is disrupted) affecting left dominant side.<br><br>Record review of Resident #1's annual Minimum Data Set assessment, dated 04/06/24, revealed Resident #1 had a BIMS score of 14, indicating no impaired cognition. The MDS revealed Resident #1 required substantial/maximal assistance (help does more than half the effort) for showers, upper body and lower body dressing and to put on and take off footwear. Resident #1's MDS revealed she required substantial/maximal assistance (help does more than half the effort) for chair to bed, toilet and tub/shower transfers, Resident #1's sit to stand had not been attempted to due to medical condition or safety concerns.<br><br>Record review of Resident #1's fall risk evaluation dated 06/19/24 revealed she was a low risk with a score of a 9.<br><br>(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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #1's care plan was retrieved on 06/30/24 but did not have a date on actual document revealed Resident #1 had a focus of, The resident is HIGH risk for falls r/t gait/balance problems, and interventions of, Anticipate and meet the Resident's needs., Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. and Educate the resident/family/caregiver about safety reminders and what to do if a fall occurs. All interventions had an initiation date of 10/06/22. Resident #1's care plan revealed no documentation related to a fall in the shower room on 06/21/24.<br><br>Record review of Resident #1's progress notes from 03/25/24 - 06/29/24 revealed no documentation related to a fall in the shower room on 06/21/24.<br><br>Record review of Resident #1's uploaded miscellaneous documents in the residents electronic record from 03/20/24 - 06/30/24 revealed no documentation related to a fall in the shower room on 06/21/24.<br><br>Record review of Resident #1's assessments from 03/28/24 - 06/29/24 revealed no documentation related to a fall in the shower room on 06/21/24.<br><br>Record review of the facility's incident history list dating back to 03/29/24 revealed no documentation related to a fall or incident with Resident #1 on 06/21/24 or any other date.<br><br>Record review of a statement dated 06/21/24 written by CNA A stated Resident #1 seemed kind of off and jittery to which CNA A asked Resident #1 if she was high and Resident #1 stated no. CNA A's statement stated Resident #1 slipped and had an assisted fall in the shower and was assisted off the floor and back to her chair by CNA A and CNA C. CNA A's statement stated Resident #1 stated she had not hurt herself and CNA A informed the nurse.<br><br>During a telephone interview with CNA A on 06/30/24 at 12:24pm CNA A stated weather a resident has a full or assisted fall they asked if the resident was okay and pulled the call light and waited for someone to come and call a nurse to assess the resident and tell them what to do. CNA A stated she was trained over falls often but could not provide a specific date for her last training. CNA A stated on 06/21/24 Resident #1 was seated in her shower chair after she had finished her shower. CNA A stated she was assisting Resident#1 to stand from her shower chair to get her dressed when Resident #1 started to go down after standing up. CNA A stated she assisted Resident #1 to the floor. CNA A stated before standing up Resident #1 looked off, like she was anxious. CNA A stated she pressed the call light and CNA C responded and entered the shower room. CNA A stated another aide also responded but she was not sure who it was and stated that aide went to call the nurse. CNA A stated she recalled a nurse assessing Resident #1 before CNA A and CNA C got her up off the floor but could not recall who the nurse was. CNA A stated Resident #1 did not voice any pain or injuries and said she was okay. CNA A stated once Resident #1 was back in the chair CNA C took her to her room to dress her. CNA A stated she emailed her statement to both ADON D and ADON E and stated she thought she had told ADON D about what happened with Resident #1. CNA A stated she had followed her accidents/incidents policy and stated she was not aware if the DON or Administrator had conducted an investigation to rule out neglect. CNA A stated not reporting, investigating, or documenting accidents and incidents could negatively impact residents because the situation would not be assessed properly and they would not get proper care, CNA A further stated if a resident were to break something, and if it is not reported you would not know If they were okay.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview with CNA C on 06/30/24 at 1:00pm CNA A stated when a resident had fallen, they asked if the resident was okay, called for the nurse and would wait till the nurse examined the resident before they would be picked up. CNA C stated she was last trained over falls within the last couple of weeks. CNA C stated she responded to an emergency call light in the shower when she entered and saw Resident #1 already on the floor. CNA C stated CNA A asked her to help pick up Resident #1. CNA C stated her, and CNA A picked up Resident #1 and placed her back in her chair and CNA C took Resident #1 back to her room to get her dressed. CNA C stated she did not witness Resident #1 fall and had not witnessed any nurse assess Resident #1. CNA C stated a nurse should have assessed Resident #1 before getting her up. CNA C stated she did not notify anybody of Resident #1's fall because she assumed since the fall occurred with CNA A that she would report it. CNA C stated Resident #1 had not voiced any pain and had stated she was okay. CNA C stated her accidents/incidents policy stated to report right away and notify a nurse. CNA C stated regarding reporting right away she had not followed the facility policy regarding accidents/incidents. CNA C stated she was not aware if the administrator or DON had investigated to rule out neglect. CNA C stated not reporting, investigation or documenting accidents/incidents could negatively impact residents because they would not know if a resident was injured.<br><br>During a telephone interview with the DON on 06/30/24 at 4:26pm he stated when a resident had a fall the nurse was to be notified, complete an assessment, and make a judgment call on if the resident was injured or in pain. The DON stated if a resident was in pain, they would send them out to hospital and if no pain they would assist them back up. The DON stated they would also make notification to the on-call person, or himself, come up with interventions to prevent a fall and complete an incident report along with the selected assessments. The DON stated they had completed in services over falls within the last 6 months. The DON stated he could not talk about Resident #1's fall because he did not know there was a fall until Surveyor intervention on 06/29/24. The DON stated he had talked to Resident #1 who stated she was guided down in the shower room by CNA A and had no pain and was okay. The DON stated he had not spoken to CNA A or LVN G. The DON stated there was no documentation of the incident and if there was, he would have caught it. The DON stated LVN G was the nurse who was responsible for completing the documentation that day and should have completed an incident report and made notifications. The DON stated he was just finding out there was an emailed statement from CNA A to ADON D. The DON stated regards to the facility policy for accidents/incidents staff did not follow the policy as far as paperwork and notification to the nurse managers. The DON stated he could not answer if there was an investigation conducted because he was just now finding out what was going on. The DON stated usually when an incident report is completed there is an investigation completed to make sure the resident was okay and to put proper intervention in place so it would not happen again. The DON stated the impact of not reporting, investigation or documenting would depend, and stated the resident would be negatively impacted if they were hurt.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the Administrator on 06/30/24 at 4:36pm he stated Resident #1 had a controlled descent, and stated with a true fall they would get the nurse and presumed they would complete an assessment, complete documentation, and incident report. The Administrator stated he had not seen anything about Resident #1 falling and was not aware she had any descents. The Administrator stated he had only spoken to Resident #1 and stated he had not specifically asked her if she was assessed before being picked up. The Administrator stated if Resident #1 had a real fall, then the nurse should have assessed her first and stated he would always get a nurse for himself because he was not trained clinically. The Administrator stated he did not know who was notified and stated he was unaware of the incident until Surveyor intervention. The Administrator stated he would not normally be notified of falls unless there was a fall with injury. The Administrator stated the nurse on shift was responsible for completing documentation. The Administrator stated he had not gone through the documentation. The Administrator stated Resident #1 stated she had no injury and no pain. The Administrator was asked if staff followed their accident/incident policy to which he stated to him Resident #1 had a controlled descent and that did not meet the definition of a fall. The Administrator stated generally falls were investigated but stated Resident #1 had a controlled descent and not a fall. The Administrator stated if they were not aware of an injury on somebody that could negatively impact a resident if it was not treated.<br><br>During an interview on 07/02/24 at 8:23pm with LVN G she stated when a resident had a fall a nurse needed to be called to assess the area, take vitals, and assess the resident to make sure they did not need to be sent out. LVN G stated it was protocol to always assess a resident for any trauma before they are moved. LVN G stated she was last trained over this topic within the last 2 months. LVN G stated on 06/21/24 CNA A was with Resident #1 in the shower room when Resident #1's strong side gave out during a transfer, and she was assisted by CNA A to the floor. LVN G stated no one assessed Resident #1 before she was picked up off the floor and stated she was not notified of fall until 5 or 10 minutes later. LVN G stated she assessed Resident #1 after she had already been taken to her room and placed back in bed and stated Resident #1 was alert and oriented with no bruising, cuts or pain identified or voiced. LVN G stated she was responsible for completing documentation of the incident and making the notifications. LVN G stated she contacted Resident #1's family member and the nurse practitioner but did not notify the DON or ADON and stated she should have. LVN G stated she had started the documentation for the incident and her assessment but had not finished it. LVN G stated because she did not make the notification to her ADON she had not followed the facility accident/incident policy. LVN G was not aware if the DON or Administrator had completed an investigation to rule out neglect. LVN G stated not reporting, investigating, or documenting accidents/incident could negatively impact residents because something could go unnoticed and if the resident was hurt then they may go without the clinical assessment that was needed.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with ADON D on 06/30/24 at 3:18pm she stated if a resident had a fall with an aide, then they would need to notify the nurse so they could assess for injuries. ADON D stated depending on assessment they would either call 911 or assist resident off the floor. ADON D stated an incident report would be completed and the appropriate notifications would be made to the MD, RP, ADON DON or on call. ADON D stated staff received trainings over falls regularly. ADON D stated from what she gathered CNA C responded to an emergency call light and assisted CNA A get Resident #1 off the floor. ADON D stated CNA C then took Resident #1 to her room and dressed her. ADON D stated LVN G stated she did assess Resident #1 however ADON D was not sure if that assessment occurred before or after Resident #1 was picked up off the floor but stated Resident #1 should have been assessed before being moved. ADON D stated LVN G did notify Resident #1's family member of the fall. ADON D stated nobody notified anyone of the fall that day and stated she was not aware of a statement that was emailed to her from CNA A until Surveyor F asked her about Resident #1's fall and she checked her email and found a statement from CNA A. ADON D stated LVN G should have notified the DON or ADON D or ADON E. ADON D stated per her conversation with LVN G on 06/29/24 Resident #1 did not have any injuries, pain or discomfort. The ADON D stated she would have to review documentation to see what LVN G did but stated it should have been documented. ADON D stated staff had not followed their accidents/incident policy. ADON D did not know if the DON or Administrator had conducted an investigation to rule out neglect. ADON D stated it would depend on the situation on how not reporting, investigating, or documenting accidents/incidents could negatively impact a resident.<br><br>During an interview with Resident #1 on 06/28/24 at 4:59pm she stated about a week ago she had fallen in the shower with CNA A. Resident #1 stated she was using the grab bars with CNA A behind her to get up and get dressed but stated she had gotten up on her weak side when getting up from the shower chair when she fell and was helped by CNA A to the floor. Resident #1 stated no nurse went to check her and she was picked up by CNA A and CNA C and taken back to her room. Resident #1 stated LVN G went to check her blood pressure in her room about an hour after. Resident #1 stated she had no injuries.<br><br>Record review of facility in-service dated 02/09/24 revealed LVN G had been trained on completing risk management forms which included completing all categories of an incident report (details, injuries, factors, witnesses, and action). The Inservice also covered completion of a change in condition to be completed with all incident reports and written statements from staff. This Inservice stated all pertinent documentation must be turned in at the end of shift and to the ADON office.<br><br>Record review of facility in-service dated 04/17/24 revealed CNA A, CNA C, ADON D and LVN G had been trained over falls.<br><br>Record review of facility in-service dated 05/09/24 revealed CNA A had been trained over the proper way to perform transfers with residents.<br><br>Record review of facility policy titled, Accidents and Incident - Investigating and Reporting with a revised date of July 2017 included a policy statement that stated, All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. The section titled Policy Interpretation and Implementation included verbiage that reflected, 1. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. |