| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675909 | A. Building<br>B. Wing | 10/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harker Heights Nursing & Rehabilitation | 415 Indian Oaks Dr<br>Harker Heights, TX 76548 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065<br><br>Based on observations, interviews, and record reviews, the facility failed to notify the resident representative(s) when there was an accident involving the resident which results in injury and had the potential for requiring physician intervention for 1 (Resident #1) of 5 residents RP's reviewed for incidents.<br><br>The facility failed to notify Resident #1's RP that staff observed Resident #1 had an injury of unknown origin. Staff observed Resident #1 had a black eye on 10/27/24 at 1:30 PM and didn't know how Resident #1 sustained the injury. Resident #1's RP was not notified until 10/27/24 at 7:39 PM.<br><br>The facility failed to notify Resident #1's RP that an incident happened with Resident #1 on 10/25/24. Resident #1's RP wasn't notified of any incidents on 10/25/24 until 10/27/24 at 7:39 PM<br><br>This deficient practice could place residents at risk of diminished quality of life, abuse, continuous incidents and accidents, and neglect.<br><br>Findings included:<br><br>Review of Resident #1's admission record, dated 10/29/24, reflected a [AGE] year-old female resident who was admitted to the facility on [DATE] with diagnoses including unspecified dementia, conversion disorder with seizures or convulsions, adjustment disorder with mixed anxiety and depressed mood, generalized muscle weakness, and other abnormalities of gait and mobility. Resident #1 also had an RP.<br><br>Review of Resident #1's quarterly MDS assessment, dated 09/11/24, reflected she had one fall with no injury, no skin issues, and was dependent on staff assistance with her ADLs except eating, in which she was independent.<br><br>Review of Resident #1's BIMS assessment, dated 10/29/24, reflected she had a BIMS score of 6, which indicated she had severe cognitive impairment.<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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675909 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/29/2024 |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #1's care plan, dated 09/25/24, reflected she didn't use the call light when she needed assistance or help and nursing staff were required to make frequent checks on her. The care plan also noted Resident #1 had a communication problem related to her Dementia/Alzheimer's and language barrier and had difficulty focusing due to her impaired cognition. There were no interventions in which staff were required to notify RP or FAM.<br><br>Review of Resident #1's progress notes reflected:<br><br>There were no progress notes from 10/25/24 through 10/26/24.<br><br>-A note by RN A on 10/27/24 at 3:31 PM, Head to toe assessment: left eye bruising around orbital bone. Some small old scabs to left elbow noted. No other skin concerns such as bruising; cuts or abrasions noted. DON notified.<br><br>-A note by LVN B on 10/27/24 at 7:49 PM, About 1:45 PM I was told by CNA that residents face was black and blue. Resident was sitting in the Hall with the bed side table in front of her. I assessed resident and noted resident had bruising to the left eye. I notified RN on duty who speaks Spanish, but resident was unable to tell her what had happened. NP was notified and Orbit x-ray of the eye ordered. All parties notified.<br><br>-A note by LVN C on 10/28/24 at 12:22 AM, Resident has bruising of unknown origin covering the left eye. Resident didn't display any signs of pain or discomfort at this time. At this time, it is very difficult to do neuro checks on the resident because she is being resistant to opening up her eyes.<br><br>-A note by the ADON on 10/28/24 at 12:51 PM, Contacted the RP to assist with sitting with the patient for the hospital visit. The RP stated that Resident #1's FAM will meet the resident at the hospital and stay with them the whole time. Advised the caregiver to be sure to bring the discharge paperwork with the resident when the resident returns.<br><br>Review of Resident #1's neurological checks on 10/27/24 reflected LVN B started the checks on 10/27/24 at 1:45 PM.<br><br>During an observation and interview on 10/29/24 at 10:08 AM, Resident #1 was sitting in her wheelchair outside her room. Resident #1 had a purple-colored bruise around her left eye and a yellow-colored bruise around the purple bruise and on the left side of her forehead. Attempted to interview Resident #1 using a Spanish Interpreter, but Resident #1 was unable to explain what happened to her left eye and answer any additional questions and maintain focus during the interview.<br><br>During an interview on 10/29/24 at 10:28 AM, the CE stated she worked from 6:00 AM through 2:00 PM. The CE stated on 10/27/24 around 12:00 PM-1:00 PM, she observed Resident #1 had a bruise around her eye. The CE stated she notified LVN V about Resident #1's eye bruise, who assessed Resident #1 and told her that she would file a report. The CE stated she didn't know if Resident #1's family was notified on 10/27/24, but she knew Resident #1's family was notified on 10/28/24 of Resident #1 being sent to the hospital.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675909 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/29/2024 |
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| NAME OF PROVIDER OR SUPPLIER Harker Heights Nursing & Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 415 Indian Oaks Dr Harker Heights, TX 76548 | |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/29/24 at 11:48 PM, the RP stated she was notified on 10/27/24 at 7:39 PM about Resident #1's black eye by a female unknown name night shift nurse. The RP stated the female night shift nurse also told him that she didn't know how Resident #1 got the black eye and that the incident happened a few days ago. The RP stated Resident #1's FAM visited Resident #1 on 10/27/24 around 8:00 PM and Resident #1 told them that the incident happened on 10/25/24. The RP stated he visited Resident #1 on 10/25/24 and didn't observe any bruises. The RP stated he was not notified of any incidents on 10/25/24.<br><br>During an interview on 10/29/24 at 11:50 AM, Resident #1's FAM stated she was not notified of any incidents on 10/25/24.<br><br>During an interview on 10/29/24 at 1:19 PM, RN A stated she worked every other weekend from 8:00 AM through 4:30 PM. RN A stated LVN B notified her about Resident #1's bruising on 10/27/24 around 2:00 PM. RN A stated when she did her report, she was hoping LVN B called Resident #1's RP, but she couldn't say if LVN B did or didn't notify Resident #1's RP. RN A stated the residents' RP or family was supposed to be notified immediately whenever staff observe an injury of unknown origin. RN A stated residents could have adverse effects, deterioration, and family not aware of any changes in condition if residents' families were not aware immediately.<br><br>During an interview on 10/29/24 at 1:39 PM, LVN B stated she worked from 6:00 AM through 6:00 PM. LVN B stated CNA E notified her that Resident #1's face was black and blue on 10/27/24 around 1:30 PM. LVN B stated she observed Resident #1's face had bruising that was light purple around her eye. LVN B stated she notified RN A after 2:00 PM and RN A assessed Resident #1. LVN B stated she didn't know how Resident #1 sustained the bruise on her eye. LVN B stated she notified Resident #1's family on 10/27/24 after 6:00 PM. LVN B stated she didn't know why she didn't notify Resident #1's family earlier. LVN B stated she didn't know when residents' families were supposed to be notified. LVN B stated she didn't know what could happen to a resident if their family wasn't notified within the required timeframes.<br><br>During an interview on 10/29/24 at 3:19 PM, the ADON stated she was notified and observed Resident #1 on 10/28/24. The ADON stated she didn't know what happened to Resident #1 at the time of the interview. The ADON stated she told Resident #1's family on 10/28/24 what information she was provided about Resident #1's incident. The ADON stated she didn't know if staff notified Resident #1's RP and family on 10/27/24. The ADON stated based on the conversation with Resident #1's RP on 10/28/24, she believed he was aware of Resident #1's bruise on 10/27/24. The ADON stated residents' families were supposed to be notified depending on the severity of the residents' injury, how it happened and where it's located. The ADON stated she expected staff to notify the NP, resident's family, and DON. The ADON stated residents' families were called last because the NP orders were priority to be completed. The ADON stated she would like for family to be notified and for the notifications to be documented in progress notes. The ADON stated residents could not be affected if their family was not notified within required timeframes.<br><br>(continued on next page) |

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 10/29/24 at 4:22 PM, CNA F stated she worked from 6:00 AM through 6:00 PM. CNA F stated she got Resident #1 up the morning of 10/27/24 and didn't observe anything. CNA F stated she was notified by CNA E around 12:00 PM-1:00 PM about Resident #1's eye bruise. CNA F stated she observed Resident #1 had red and puffiness around her eye. CNA F stated she didn't know how Resident #1 sustained a bruise. CNA F stated she notified LVN B. CNA F stated she didn't know if Resident #1's family was notified. CNA F stated residents' families should be notified immediately by a charge nurse after they notify the DON and ADM when something happens to the residents. CNA F stated resident could be affected and something could happen to the resident if their family was not notified by staff.

During an interview on 10/29/24 at 5:07 PM, the DON stated RN A notified him about Resident #1 having discoloration and bruising to her left eye and was already investigating the incident on 10/27/24 at around 1:30 PM-2:00 PM. The DON stated Resident #1's family was notified shortly after he was notified. The DON stated Resident #1's family notification was in her COC within a few hours. The DON reviewed Resident #1's EHR and couldn't locate Resident #1's COC. The DON stated LVN B told him that she notified Resident #1's family, made a progress note, and LVN B didn't tell him when she notified Resident #1's family. The DON stated all parties meant residents' RP, physician, and DON, when staff indicated notified all parties in progress notes. The DON stated LVN B was informed of adjusting the time of notification to Resident #1's family. The DON stated he expected staff to notify Resident #1's family after notifying him. The DON stated residents could not be impacted if their families weren't notified after him. The DON stated charge nurses (LVNs and RNs) were responsible for notifying families of injuries of unknown origin.

During an interview on 10/29/24 at 5:37 PM, the ADM stated she was notified by the DON on 10/27/24 around 2:00 PM-2:15 PM about Resident #1's incident and that there was discoloration in Resident #1's left eye area. The ADM stated CNA F found Resident #1's bruises on 10/27/24 around 12:00 PM-12:30 PM. The ADM stated Resident #1's family was notified. The ADM stated staff always completed assessments, took care of the resident, and then called the resident's family. The ADM stated she expected staff to notify residents' families immediately and sometimes after the assessments. The ADM stated residents could not have been impacted if their family was not notified within the required timeframes of the resident's incident.

Review of the facility's changes in resident condition policy, reviewed January 2023, reflected,

The resident, attending physician and resident representative or designated family member should be notified when changes in condition or certain events occur. Communication with the interdisciplinary team and caregivers is important to facilitate consistency and continuity of care.

1. The resident, attending physician and resident representative or designated family member should be notified when there is:

a. an accident involving the resident which results in injury and is treated in the community and/or has the potential for requiring physician

c. a significant change in the resident's physical, mental or psychosocial status;

d. a need to alter treatment significantly (i.e., a need form of treatment due to adverse consequences, or to commence a new form of treatment);

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | e. a decision to transfer the resident from the community; or<br><br>g. when laboratory, radiology or other diagnostic results fall outside the clinical reference ranges set by the contracted service provider or per physician orders.<br><br>Documentation:<br><br>1. Nursing Progress Notes:<br><br>o date, time and who was notified (physician/resident representative)<br><br>o information communicated<br><br>o response and/or orders received<br><br>Review of the facility's statement of resident rights policy, reviewed 10/2022, reflected,<br><br>Resident who has been deemed incompetent under state law will have his or her rights exercised by the person appointed under state law to act on the resident's behalf.<br><br>Residents have the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect their well-being.<br><br>The right to make informed decisions means that the resident or resident's representative is given the information needed to make informed decisions regarding his/her care.<br><br>Right to Notification of Changes<br><br>The community will immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is:<br><br>o an accident involving the resident that results in injury and has the potential for requiring physician intervention;<br><br>o a significant change In the resident's physical, mental, or psychosocial status (e.g., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>o a need to alter treatment significantly (e.g., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment);<br><br>o the decision to transfer or discharge the resident from the community.<br><br>Review of the facility's abuse guidance: preventing, identifying and reporting policy, reviewed 10/2022, reflected,<br><br>Investigative procedures related to allegations of abuse, neglect or exploitation<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Investigation should include, but is not limited to:<br><br>Immediate notification of the alleged victim's practitioner and the family or responsible party. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065<br><br>Based on observations, interviews, and record reviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 (Resident #1) of 5 residents reviewed for ADL care.<br><br>The facility failed to ensure Resident #1's wheelchair was clean.<br><br>This deficient practice could place residents at risk of neglect, infection, and a diminished quality of life.<br><br>Findings included:<br><br>Review of Resident #1's admission record, dated 10/29/24, reflected a [AGE] year-old female resident who was admitted to the facility on [DATE] with diagnoses including unspecified dementia, conversion disorder with seizures or convulsions, adjustment disorder with mixed anxiety and depressed mood, generalized muscle weakness, and other abnormalities of gait and mobility.<br><br>Review of Resident #1's quarterly MDS assessment, dated 09/11/24, reflected she was dependent on staff assistance with her ADLs except eating, in which she was independent.<br><br>Review of Resident #1's BIMS assessment, dated 10/29/24, reflected she had a BIMS score of 6, which indicated she had severe cognitive impairment.<br><br>Review of Resident #1's care plan, dated 09/25/24, reflected she didn't use the call light when she needed assistance or help and nursing staff were required to make frequent checks on her. The care plan also noted Resident #1 had a communication problem related to her Dementia/Alzheimer's and language barrier and had difficulty focusing due to her impaired cognition.<br><br>During an observation and interview on 10/29/24 at 10:08 AM, Resident #1 was sitting outside her room in her wheelchair. The left and right wheelchair arm rests of her wheelchair and wheelchair seat had brown-colored spots, had a foul odor, and were dried up. The right wheel of the wheelchair also had brown-colored dry spots. Attempted to interview Resident #1 using a Spanish Interpreter, but Resident #1 was unable to answer any additional questions and maintain focus during the interview.<br><br>During an interview on 10/29/24 at 10:28 AM, the CE stated they worked from 6:00 AM through 2:00 PM, CNAs cleaned wheelchairs. The CE stated the night shift CNAs didn't clean the residents' wheelchairs. The CE stated she didn't have enough time to clean residents' wheelchairs during the daytime. The CE stated odors could stain residents bodies and clothes if residents' wheelchairs were not cleaned. The CE stated there was no oversight of residents' wheelchair conditions.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/29/24 at 10:40 AM, the NAT stated she worked from 6:00 AM through 2:00 PM. The NAT stated CNAs cleaned residents' wheelchairs as they saw it. The NAT stated she didn't know how long Resident #1's arm rests and seat were like the condition the surveyor showed her. The NAT stated if residents' wheelchairs were not cleaned, it depended on what the mess was for whether or not it could impact the resident. The NAT stated she didn't know who oversaw to ensure residents' wheelchairs were clean.<br><br>During an interview on 10/29/24 at 11:07 AM, LVN H stated she worked from 6:00 AM through 6:00 PM. LVN H stated CNAs were responsible for cleaning residents' wheelchairs. LVN H stated Resident #1 usually spit out of nowhere and spilled stuff.<br><br>During an interview on 10/29/24 at 11:28 AM, WM stated the night shift staff cleaned residents' wheelchairs. WM stated the night shift CNAs previously cleaned residents wheelchairs quarterly.<br><br>During an interview on 10/29/24 at 11:31 AM, SW stated she didn't receive any concerns from Resident #1's family regarding her wheelchair.<br><br>During an interview on 10/29/24 at 11:48 AM, RP stated Resident #1's wheelchair was full of mold. RP stated Resident #1's FAM observed Resident #1's wheelchair and stated it was horrible, had mold, smelly, nasty, and had crust all over the handles, wheelchair seat, and wheels on 10/25/24. RP stated he didn't notify the staff about Resident #1's wheelchair condition.<br><br>During an interview on 10/29/24 at 11:50 AM, Resident #1's FAM stated she observed Resident #1's wheelchair was horrible and had mold, was smelly, and nasty crust all over the handles, wheelchair seat, and wheels on 10/28/24. Resident #1's FAM stated the staff were aware of Resident #1's wheelchair condition because it was noticeable.<br><br>During an interview on 10/29/24 at 12:59 PM, the WCN stated she didn't observe Resident #1's wheelchair condition. The WCN stated she knew the CNAs were assigned to clean residents' wheelchairs during the night shift because residents were not in their wheelchairs. The WCN stated most staff would stop and tend to residents' wheelchairs if they saw unkempt conditions. The WCN stated no one oversaw to ensure CNAs were cleaning residents' wheelchairs. The WCN stated residents' dignity could be impacted if wheelchairs were dirty and unkempt.<br><br>During an interview on 10/29/24 at 1:19 PM, RN A stated she worked every other weekend from 8:00 AM through 4:30 PM. RN A stated she didn't observe the condition of Resident #1's wheelchair. RN A stated CNAs were responsible for cleaning residents' wheelchairs. RN A stated she didn't know if anyone oversaw to ensure if residents' wheelchairs were cleaned. RN A stated residents could have adverse effects and infections if their wheelchairs were not cleaned.<br><br>During an interview on 10/29/24 at 1:39 PM, LVN B stated she worked from 6:00 AM through 6:00 PM. LVN B stated she observed Resident #1's wheelchair on 10/27/24 and couldn't recall the condition of the wheelchair. LVN B stated CNAs cleaned residents' wheelchairs during the night shift. LVN B stated residents' brakes could go bad, seating could be loose, arms could be tattered and torn, get an injury, and wheels could not lock and be damaged if wheelchairs were not cleaned. LVN B stated the nurses on duty were responsible for ensuring night shift CNAs were cleaning residents' wheelchairs.<br><br>(continued on next page) |

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|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observations and interviews with four other residents on 10/29/24 from 2:44 PM through 3:06 PM, residents' wheelchairs were clean and didn't have condition similar to Resident #1's wheelchair. Residents stated wheelchairs were cleaned at night by staff.<br><br>During an interview on 10/29/24 at 3:19 PM, the ADON stated she didn't observe Resident #1's wheelchair condition. The ADON stated she didn't know who was supposed to clean residents' wheelchairs. The ADON stated she expected CNAs to wipe residents' wheelchairs clean with sanitation wipes whenever a resident went down (slept) in bed. The ADON stated she expected the nurses to ensure the CNAs cleaned residents' wheelchairs. The ADON stated residents could be impacted due to their wheelchairs not being cleaned and the impact could depend on the stains, condition, and residents' status.<br><br>During an interview on 10/29/24 at 4:22 PM, CNA F stated she worked from 6:00 AM through 6:00 PM. CNA F stated she didn't observe Resident #1's wheelchair. CNA F stated the night shift CNAs cleaned residents' wheelchairs. CNA F stated nurses would oversee to ensure residents' wheelchairs were clean. CNA F stated if wheelchairs were dirty, stinky, and not cleaned, residents could get sick.<br><br>During an interview on 10/29/24 at 5:07 PM, the DON stated staff didn't report anything about Resident #1's wheelchair condition. The DON stated the night shift CNAs were responsible for cleaning residents' wheelchairs. The DON stated the facility didn't have a specific schedule for cleaning residents' wheelchairs at the time of the interview. The DON stated the charge nurses were responsible for ensuring CNAs cleaned residents' wheelchairs. The DON stated the ombudsman mentioned residents' wheelchair conditions as a concern last week. The DON stated residents' could not be impacted if their wheelchairs were not cleaned.<br><br>During an interview on 10/29/24 at 5:37 PM, the ADM stated she was not notified of Resident #1's physical environment conditions. The ADM stated the facility's policy stated environmental was responsible for cleaning residents' wheelchairs, but the night shift staff cleaned residents' wheelchairs. The ADM stated there was no one in particular from the night shift staff who cleaned residents' wheelchairs. The ADM stated the night shift staff as a whole were responsible for cleaning residents' wheelchairs. The ADM stated there was no oversight that she knew of who ensured residents' wheelchairs were cleaned. The ADM stated residents could not be impacted if their wheelchairs were not cleaned by the night shift staff. The ADM stated she hadn't followed-up with wheelchair cleaning being completed.<br><br>Review of the CNA position agreement, dated 07/01/20, reflected CNAs were required to perform other duties as assigned, address concerns immediately and report them to the supervisor.<br><br>Review of the charge nurse position agreement, dated 07/01/20, reflected charge nurses were required to provide supervision to CNAs providing direct resident care, make nursing assignments, identify residents problems, conduct resident rounds daily, report problems to nursing supervisor, and initiate corrective actions.<br><br>Review of the RN position agreement, dated 07/01/20, reflected RNs were required to direct, evaluate, and supervise all resident care and initiate appropriate actions and make daily resident rounds.<br><br>Review of the facility's cleaning and disinfection of environmental surfaces policy, revised June 2009, reflected,<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Environmental surfaces will be cleaned and disinfected.<br><br>1. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care and those in the resident's environment:<br><br>c. Non-critical items are those that come in contact with intact skin but not mucous membranes.<br><br>(I) Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors.<br><br>(2) Most non-critical items can be decontaminated where they are used (as opposed to being transported to a central processing location).<br><br>2. Non-critical surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and use directions.<br><br>Review of the facility's statement of resident rights policy, reviewed 10/2022, reflected,<br><br>Resident/Patient Rights include:<br><br>1. To all care necessary for them to have the highest possible level of health;<br><br>2. To safe, decent and clean conditions. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065<br><br>Based on observations, interviews and record reviews , the facility failed to ensure that all alleged violations were reported immediately or not later than 24 hours for 1 (Resident #1) of 5 residents reviewed for incidents.<br><br>The facility failed to report to the SA an incident where Resident #1 was found with a black eye on 10/27/24.<br><br>This deficient practice could place residents at risk of abuse and/or neglect.<br><br>Findings included:<br><br>Review of Resident #1's admission record, dated 10/29/24, reflected a [AGE] year-old female resident who was admitted to the facility on [DATE] with diagnoses including unspecified dementia, conversion disorder with seizures or convulsions, adjustment disorder with mixed anxiety and depressed mood, generalized muscle weakness, and other abnormalities of gait and mobility.<br><br>Review of Resident #1's quarterly MDS assessment, dated 09/11/24, reflected she had one fall with no injury, no skin issues, and was dependent on staff assistance with her ADLs except eating, in which she was independent.<br><br>Review of Resident #1's BIMS assessment, dated 10/29/24, reflected she had a BIMS score of 6, which indicated she had severe cognitive impairment.<br><br>Review of Resident #1's care plan, dated 09/25/24, reflected she didn't use the call light when she needed assistance or help and nursing staff were required to make frequent checks on her. The care plan also noted Resident #1 had a communication problem related to her Dementia/Alzheimer's and language barrier and had difficulty focusing due to her impaired cognition.<br><br>Review of Resident #1's progress notes reflected:<br><br>-A note by RN A on 10/27/24 at 3:31 PM, Head to toe assessment: left eye bruising around orbital bone. Some small old scabs to left elbow noted. No other skin concerns such as bruising; cuts or abrasions noted. DON notified.<br><br>-A note by LVN B on 10/27/24 at 7:49 PM, About 1:45 PM I was told by CNA that residents face was black and blue. Resident was sitting in the Hall with the bed side table in front of her. I assessed resident and noted resident had bruising to the left eye. I notified RN on duty who speaks Spanish, but resident was unable to tell her what had happened. NP was notified and Orbit x-ray of the eye ordered. All parties notified.<br><br>-A note by LVN C on 10/28/24 at 12:22 AM, Resident has bruising of unknown origin covering the left eye. Resident didn't display any signs of pain or discomfort at this time. At this time, it is very difficult to do neuro checks on the resident because she is being resistant to opening up her eyes.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #1's skin and wound evaluation, dated 10/29/24, reflected new bruise on face. The rest of the evaluation was incomplete and not signed by anyone.<br><br>During an observation and attempted interview on 10/29/24 at 10:08 AM, Resident #1 was sitting upright in her wheelchair with a bedside table in front of her in the hallway in front of her room. Resident #1 had a purple-colored bruise around her left eye and a yellow-colored bruise around the purple-colored bruise and on the left side of her forehead. Attempted to interview Resident #1 using a Spanish Interpreter, but Resident #1 was unable to explain what happened to her left eye or answer any additional questions and maintain focus during the interview.<br><br>During an interview on 10/29/24 at 10:24 AM, CNA D stated she worked from 6:00 AM through 6:00 PM. CNA D stated she was not given any in-services from 10/27/24 through 10/29/24 . CNA D stated she knew to report to the charge nurse if she observed an injury of unknown origin. CNA D stated she knew the ADM was the ANE coordinator and to immediately report ANE. CNA D stated if staff didn't immediately report ANE, then residents could continue to get abused or neglected. CNA D stated the ADM was responsible for reporting ANE to the SA. CNA D stated CNA E told her on 10/28/24 that Resident #1 had a black eye and didn't know how Resident #1 got the black eye. CNA D stated she notified a nurse on 10/28/24 about Resident #1's black eye, who told her that they were getting ready to send Resident #1 to the hospital.<br><br>During an interview on 10/29/24 at 10:28 AM, the CE stated they worked 6:00 AM through 2:00 PM. The CE stated they were not given any in-services from 10/27/24 through 10/29/24 . The CE stated they knew to report to the charge nurse if they observed any injuries of unknown origin. The CE stated they knew the ADM was the ANE coordinator and to immediately report ANE. The CE stated if staff didn't immediately report ANE, then that action was neglecting the resident. The CE stated the ADM was responsible for reporting ANE to the SA. The CE stated on 10/27/24 around 12:00 PM through 1:00 PM, they observed Resident #1 had a bruise. The CE stated they reported to LVN B, who worked from 6:00 AM through 6:00 PM, about Resident #1's bruise. The CE stated LVN B assessed Resident #1 and told them that she would file a report. The CE stated CNA F, who also worked from 6:00 AM through 6:00 PM, was also working on 10/27/24.<br><br>During an interview on 10/29/24 at 10:40 AM, the NAT stated she worked from 6:00 AM through 2:00 PM. The NAT stated she was not given any in-services from 10/27/24 through 10/29/24 . The NAT stated she knew the ADM was the ANE coordinator and to immediately report ANE. The NAT stated the resident could be neglected if staff didn't immediately report injury of unknown origin. NAT stated if she observed an injury of unknown origin, she would report to the nurse. The NAT stated the ADM was responsible for reporting ANE to the SA. The NAT stated she last worked with Resident #1 two weeks ago and didn't observe any bruises.<br><br>During an interview on 10/29/24 at 10:50 AM, CNA G stated she worked from 6:00 AM through 10:00 PM. CNA G stated she was not given any in-services from 10/27/24 through 10/29/24 . CNA G stated she knew the ADM was the ANE coordinator and to immediately report ANE. CNA G stated the ADM was responsible for reporting ANE to the SA. CNA G stated she would report ANE to an RN or charge nurse. CNA G stated if she observed an injury of unknown origin, then she would report to the charge nurse. CNA G stated she last worked with Resident #1 last week and didn't observe any bruises.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/29/24 at 11:07 AM, LVN H stated she worked from 6:00 AM through 6:00 PM. LVN H stated she was not given any in-services from 10/27/24 through 10/29/24 . LVN H stated she knew the ADM was the ANE coordinator and to immediately report ANE. LVN H stated the ADM was responsible for reporting ANE to the SA. LVN H stated residents could be neglected and abused if staff didn't immediately report ANE. LVN H stated she last worked with Resident #1 on 10/24/24 and didn't observe any bruise on Resident #1's face.<br><br>During an interview on 10/29/24 at 11:48 AM, the RP stated he was notified by a female night shift nurse on 10/27/24 at 7:39 PM about Resident #1's black eye. The RP stated the female night shift nurse told him that she didn't know how Resident #1 got the black eye. RP stated the female night shift nurse told him that the incident happened on 10/25/24. The RP stated he last visited Resident #1 on 10/25/24 and he didn't observe any bruises on Resident #1.<br><br>During an interview on 10/29/24 at 11:50 AM, Resident #1's FAM stated her and the RP were not notified of any incident involving Resident #1 on 10/25/24 . Resident #1's FAM stated Resident #1's bruise on her head was already starting to go away and face was lightening on 10/28/24.<br><br>During an interview on 10/29/24 at 12:59 PM, the WCN stated she last worked with Resident #1 on 10/18/24 and didn't observe any bruises to Resident #1's eye. The WCN stated she was not given any in-services from 10/27/24 through 10/29/24 . The WCN stated she knew the ADM was the ANE coordinator and to immediately report. The WCN stated the ADM was responsible for reporting ANE to the SA and anyone could report ANE to the SA. WCN stated if a resident had a new bruise that she didn't know how it was acquired, she would report the injury of unknown origin to the ADM. The WCN stated residents could be left in pain or discomfort if staff didn't immediately report injury of unknown origin.<br><br>Attempted to contact CNA I, who performed personal hygiene on Resident #1 on 10/27/24 at 5:57 AM, on 10/29/24 at 1:17 PM. A voicemail and call back number was left. CNA I didn't return the call before exit.<br><br>During an interview on 10/29/24 at 1:19 PM, RN A stated she worked every other weekend from 8:00 AM through 4:30 PM. RN A stated LVN B was the one who notified her about Resident #1's bruises on 10/27/24. RN A explained LVN B noticed Resident #1's bruises on 10/27/24 and notified her around 2:00 PM. RN A stated CNAs were responsible for reporting injuries of unknown origin to the charge nurse. RN A stated charge nurses were responsible for notifying the nursing supervisor. RN A stated the nursing supervisor was responsible for notifying the DON and ADM. RN A stated she observed Resident #1's bruise was really dark black and purple to the left eye around 3:31 PM, notified the DON, and the DON instructed her to conduct a head to toe assessment on Resident #1. RN A stated she had not been in-serviced on anything new from 10/27/24 through 10/29/24 . RN A stated she was given orientation training on ANE. RN A stated she knew the ADM was the abuse and neglect coordinator and to immediately report ANE. RN A stated residents could deteriorate, have adverse effects and be in danger if staff didn't immediately report ANE. RN A stated she assumed the ADM was responsible for reporting ANE to the SA.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/29/24 at 1:39 PM, LVN B stated she worked from 6:00 AM through 6:00 PM. LVN B stated on 10/27/24 after lunch, which she believed was around 1:30 PM, CNA E notified her that Resident #1's face was black and blue. LVN B stated she observed Resident #1's face had bruising that was light purple around her eye. LVN B stated she notified RN A at an unknown time, but she believed was possibly after 2:00 PM and RN A assessed Resident #1. LVN B stated she didn't know how Resident #1 sustained the bruise on her eye. LVN B stated she didn't receive any new in-services from 10/27/24 through 10/29/24 . LVN B stated she knew the ADM was the abuse and neglect coordinator and to immediately report ANE. LVN B stated she didn't know who was responsible for reporting ANE to SA. LVN B stated she knew to report injury of unknown origin to SA, but she didn't know when injury of unknown origin must be reported to SA. LVN B stated residents could die and have brain bleed if staff didn't immediately report ANE.<br><br>During interviews with four residents on 10/29/24 from 2:44 PM through 3:06 PM, the residents stated they felt safe and knew who to report abuse and neglect to.<br><br>During an interview on 10/29/24 at 3:19 PM, the ADON stated she was not working the weekend of Resident #1's incident, but she was notified on 10/28/24. The ADON stated she observed Resident #1 on 10/28/24. The ADON stated she reviewed the nursing notes to find out what happened to Resident #1 and the notes didn't tell her what happened. The ADON stated Resident #1's face wounds looked like Resident #1 hit her head. The ADON stated she didn't know what happened to Resident #1 as of 10/29/24 and it was hard to tell because the bruise was purple or green and yellow, which indicated to her that it could've happened days ago. The ADON explained Resident #1 may have not gotten bruises immediately, she didn't know the incident that could've caused the bruising to be definite. ADON stated staff received classroom training, electronic training, and training by email. The ADON stated since Sunday (10/27/24), she received four in-services and didn't know what they were regarding. The ADON stated she knew the ADM was the abuse and neglect coordinator and to immediately report ANE. The ADON stated the ADM was responsible for reporting ANE to SA. The ADON stated the resident could get abused and the abuse could continue if staff didn't report ANE to SA.<br><br>During an interview on 10/29/24 at 3:57 PM, the NP stated she was notified the morning of 10/28/24 about Resident #1's eye. The NP stated she had an on-call NP work on 10/27/24. The NP stated she reviewed the on-call NP's notes, who indicated an unknown name nurse discovered and notified them about Resident #1's eye bruise. The NP reviewed the on-call NP's note from 10/27/24 at 5:31 PM, which indicated, NP On-Call reported, 'Nurse reports that patient had bruising surrounding left eye. Same nurse reported patient able to move eye socket. No redness to sclera (white of the eye). No witnesses to event. No known fall. Also reported unable to verbalize how bruising occurred because of AMS. Neuros at baseline. Pupils equal. Vitals stable. DON request x-ray. New order. Left orbital x-ray. Continue neuros. Vitals signs per facility. Post-fall protocol and call back for any further concerns or patient change in condition.' The NP stated she suspected Resident #1's bruise could've originated from different events, but she didn't have the slightest idea.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/29/24 at 4:22 PM, CNA F stated she worked from 6:00 AM through 6:00 PM. CNA F stated she didn't observe anything when she got Resident #1 up and out of bed on 10/27/24. CNA F stated CNA E notified her around 12:00 PM-1:00 PM about Resident #1's eye bruise. CNA F stated she observed Resident #1 had a red and puffy eye. CNA F stated she didn't know how Resident #1 sustained a bruise. CNA F stated she notified the LVN B. CNA F stated she hasn't received any in-services from 10/27/24 through 10/29/24 . CNA F stated she knew the ADM was the abuse and neglect coordinator and to immediately report ANE. CNA F stated residents could die if staff didn't immediately report ANE.<br><br>During an interview on 10/29/24 at 5:07 PM, the DON stated he was notified on 10/27/24 around 1:30 PM-2:00 PM by RN A. The DON stated RN A notified him that Resident #1 had discoloration and bruising to her left eye and that she was already investigating the incident. The DON stated RN A also told him that she believed something had happened and suspected Resident #1 might've sustained her bruise by her bedside table because Resident #1 fell asleep and would nod her head down. The DON stated he assumed the bedside table as the injury of origin because of Resident #1's history of nodding her head down at her bedside table. The DON stated according to the facility's provider letter, the facility didn't report injury of unknown origin unless abuse or neglect occurred. The DON stated due to having assumptions that could have likely occurred, the facility didn't report Resident #1's incident to the SA. The DON stated he, the ADON, and the ADM also interviewed Resident #1 on 10/28/24 and Resident #1 told them that she rolled out of bed, fell , and hit her head . The DON also stated he and the ADM interviewed Resident #1 again and she told them that she fell . The DON stated he couldn't believe that Resident #1 fell . The DON stated Resident #1 had a history of falls . The DON stated he didn't have any correlation of the bedside table to Resident #1's injury and didn't know if Resident #1 had a significant injury on 10/27/24. The DON stated he didn't believe not reporting allegations to the SA within the required timeframe could impact the residents. The DON stated staff didn't report to him about any yellow-colored discoloration observed on Resident #1. The DON stated the yellow-discoloration likely could've been caused by Resident #1's bedside table.<br><br>During an interview on 10/29/24 at 5:37 PM, the ADM stated she was notified by the DON on 10/27/24 around 2:00 PM-2:15 PM about Resident #1's incident. The ADM stated the DON reported to her that there was discoloration in Resident #1's left eye area. The ADM stated she observed there was a ring around Resident #1's eye and more towards the top of the eye . The ADM stated she did a timeline with the night and morning shift staff and involved CNAs, who all indicated they didn't see anything with Resident #1. The ADM stated CNA E found Resident #1's bruises around 12:00 PM-12:30 PM. The ADM stated Resident #1 was in front of her bedside table when discovered by CNA E. The ADM stated the injury wasn't unknown to her because Resident #1 had a history of eating at her bedside table and she couldn't say Resident #1 fell . The ADM stated the unknown source really was what she went by when determining whether she needed to report the incident to the SA or not. The ADM stated she didn't report Resident #1's incident because of the facility's provider letter, she waited for Resident #1's x-rays to see if Resident #1 had any injuries and then determined if Resident #1's incident was reportable due to Resident #1's x-rays. The ADM stated she obtained statements from staff about Resident #1's incident because that was routine to rule out if it was a reportable incident or not. The ADM stated if the injury was unknown, how could the facility speculate the origin source of the injury. The ADM stated there were no in-services were given to staff from what she recalled following Resident #1's incident because staff followed through with investigating the source of the injury and trying to determine if the incident was reportable.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's incident logs from 09/01/24 through 10/29/24, reflected Resident #1 had a skin incident on 10/27/24 at 1:30 PM and fall incident on 10/03/24 at 9:00 PM.<br><br>Review of the facility's abuse and neglect investigations, from 10/01/24 through 10/29/24, reflected there were no self-reports submitted to the SA regarding Resident #1's incident.<br><br>Review of the facility's accidents and incidents reporting/investigation policy, dated January 2023, reflected,<br><br>a. An accident or incident will be reported to the department supervisor/administrator/designee as soon as such accident/incident is discovered or when information of such accident/incident is learned.<br><br>e. An incident involving an allegation of abuse (verbal, physical, emotional) or exploitation should report as soon possible to the community abuse coordinator/DON/RN Supervisor/designee.<br><br>f. The community abuse coordinator should follow state and federal requirements in regard to what is state reportable and within the required timeframe.<br><br>Review of the facility's resident abuse policy, revised July 2018, reflected,<br><br>4. When an alleged or suspected case of exploitation, mistreatment, neglect, injuries of an unknown source, or abuse is reported, the Community Administrator, or his/her designee, will notify the following persons or agencies per the current state/federal reporting requirements of such incident, if appropriate:<br><br>a) The State licensing/certification agency responsible for surveying/licensing the Community;<br><br>All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities are individuals as may be required by law and per the current state/federal reporting requirements.<br><br>1. Should an alleged/suspected violation of mistreatment, neglect, or abuse be reported, the Community Abuse Coordinator Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident:<br><br>a) The State licensing/certification agency responsible for surveying/licensing the Community;<br><br>An investigation of all unexplained injuries (including bruises, operations, and injuries of an unknown source) will be conducted by the Director of Nursing Services, and/or other individuals appointed by the Administrator, to ensure that the safety of our residents has not been jeopardized.<br><br>Procedures for reporting/investigating incidents of abuse are outlined in separate policies. (See policy entitled Abuse investigations, Reporting Abuse to Community Management, Reporting Abuse to State Agencies and Other Entities/Individuals and the most current TOADS/HHS Reporting Guidelines Provider Letters.<br><br>Review of the facility's provider letter, issued 08/29/24, reflected,<br><br>(continued on next page) |

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| (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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A NF must report to CII the following types of incidents, in accordance with applicable state and federal requirements: Suspicious injuries of unknown source.<br><br>Events that a NF Does Not Need to Report to CII<br><br>A NF is not required to report to CII: injury that is not suspicious or of unknown source. |