STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676209	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Medical Lodge	701 W Bennett Rd Decatur, TX 76234

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 0580 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on interview and record review the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention for one (Resident #1) of eight residents reviewed for notification. LVN A failed to notify Resident #1 physician after resident fell in her room on 04/17/24. LVN A failed to notify Resident #1's responsible party after Resident# 1had a fall in her room on 04/17/24. These failures could place residents at risk for delayed physician intervention and risk of families not receiving notification of change in condition of residents. Findings included: Record review of Resident #1 's admission record dated 04/17/24, revealed an [AGE] year-old female that was admitted to the facility on [DATE]. Her diagnoses included rheumatoid arthritis (a condition in which the body attacks its own tissues typically in joints especially hands and feet), atrial fibrillation (irregular heartbeat), pacemaker (a small device used to treat irregular heartbeat), unsteady on her feet, urinary tract infection, rheumatic fever without heart involvement (, contusion of left hip (skin and deep tissue bruising), and idiopathic peripheral automatic neuropathy (nerve damage). Record review of Resident #1's quartery MDS assessment dated [DATE] reflected a BIMS score of 14, which indicated the resident was cognitively intact. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Residents #1's care plan dated, 03/26/24, reflected .Focus: The resident was on anticoagulant therapy (resident takes blood thinner medication) related to (r/t) Atrial fibrillation. Date Initiated: 03/26/2024. Goal: The resident would be free from discomfort or adverse reactions related to anticoagulant use through the review date. Date Initiated: 03/26/2024. Interventions: Administer Xarelto ANTICOAGULANT medications as ordered by physician r/t atrial fibrillation. Monitor for side effects and effectiveness every shift. Daily skin inspection. CNA Report abnormalities to the nurse. Labs as ordered, report abnormal lab results to the MD. Monitor/document/report PRN adverse reactions of ANTICOAGULANT therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs (v/s) Date Initiated: 03/26/2024 The care plan also reflected that resident had an actual fall related to poor balance on 04/08/24. The goal was that Resident #1 would resume usual activities without further incidents throw the review date 07/02/24. Interventions were: .To order blood work and place a call don't fall sign in restroom, Check range of motion daily, Continue interventions on the at-risk plan, For no apparent acute injury, determine and address causative factors of the fall, Monitor/document /report PRN x 72h to MD for signs and symptoms of Pain, bruises, Change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Neuro-checks. Date Initiated: 04/08/2024 . Review of Residents #1's progress notes and MAR on 04/17/24 did not reflect notification to the physician of a fall or documentation of a fall that occurred 04/17/24. Interview with Resident #1 with her family in the room on 04/17/24 at 12:11 pm, revealed Resident #1 had a fall on 04/17/24. She said that she did not recall the exact time she fell , but it was around 7:00 AM. Resident #1 said that she did not call before going to bathroom by herself. She stated that she was transferring herself to the bed from the wheelchair when she lost her balance. She said she held onto the small bedside table, but it was not locked, and it slid from underneath her. She said she grabbed the privacy curtain as she fell to help break her fall to the ground. She said she landed on her bottom. The family stated that Resident #1 told her about the fall when they came to visit her around 10:00 AM. The family said that she was the responsible party and the first emergency contact, however, the facility did not notify her about Resident #1's fall. Resident #1 said her roommate pressed the call light and called for help. Resident #1 said that at the time she did not have much pain, so the nurse and CNA helped her into the bed. Resident #1 stated that the nurse did not assess her skin and did not do vitals. Resident #1 said she bruised easily due to blood thinners She said that the nurse gave her pain medication that was due at the time and applied a pain patch on her lower back . Interview with CNA B on 04/17/24 at 4:13 PM revealed that she found Resident #1 seated on the floor holding onto the privacy curtain. She said she immediately notified LVN A to come to the room. She said they asked the resident if she was hurt or in pain, but she denied new pain. She said after the nurse assessed Resident #1's pain, CNA B and LVN A then helped Resident #1 to the bed. CNA B said that she could not remember if LVN A checked her vitals or assessed Resident #1's skin because she had to leave the room after helping LVN A get Resident #1 back into the bed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN A on 04/17/24 at 2:01 PM, revealed Resident #1's fall happened between 06:45AM and 7:45 AM on 04/17/24. LVN A said Resident#1 was found on the floor holding the curtain. She said Resident #1 told her that after coming back from the bathroom she was transferring herself and she held onto the bedside table, but it slid from underneath her weight, and she grabbed the curtain as she sat to the ground. LVN A said her and CNA B helped Resident #1 up from the floor to the bed after a pain and range of motion assessment, which revealed no concerns as the resident did not express pain. LVN A said that she took Resident #1's vital signs but had not had time to input them in the MAR. LVN A said that she left a voicemail for Resident #1's family member and sent a text message to the physician. LVN A retrieved her text messages to show the surveyor, but she discovered that she forgot to notify the physician about Resident #1's fall. She said, I thought I included [Resident #1's] fall in the message together with another resident's physician notification. She said that she gave Resident #1 pain medication and applied a pain patch after the fall. LVN A said that the resident denied pain and stated that Resident #1 told her she was more embarrassed about the fall if anything. She did not see the risk because she did not consider what happened to have been a fall but that the resident let herself to the floor after beside table sled from under her hand. Interview with the ADON on 04/17/24 at 2:55 PM, revealed that she was not notified about Resident #1's fall prior to surveyor interviewing LVN A at 2PM. The ADON said that LVN A stated that she did not notify her of the incident because she did not consider Resident #1 had a fall because she lowered herself to the ground. The ADON said that the expectation was that LVN A should have notified her or upper management, the physician, and family about Resident #1 fall or any incident immediately. She said an incident report should have been created in the MAR to alert the IDT team. She said neuro checks should have been done because fall was unwitnessed, as the resident could have incurred a head injury. Staff should d not just go by what the resident said what happened alone. She said that she expected nursing staff to assess the patient, making sure nothing was wrong and check for bruising. She said the risk to the resident was an adverse effect and delay in treatment because if tomorrow she says she is hurt no one would know what happened. Interview with the Administrator on 04/17/24 at 5:49 PM, revealed he expected staff to follow facility policies and to treat an unwitnessed fall the same as the witnessed fall. He expected the nurse to perform neuro checks post fall and he expected the nurse to notify the ADON or DON, notify the doctor, and notify the family. Review of facility policy titles: Falls- Clinical Protocol, revision November 14, 2023, reflected in part the following: .The Nursing Staff with physician's assistance will also identify medical conditions affecting fall risk (for example, a recent stroke or medications that cause dizziness hypotension) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant) . The Nursing Staff will evaluate, and document falls that occur while the individual is in the facility, for example, when and where they happen, any observations of the events, etc .For an individual who has fallen, the Nursing Staff with physician's assistance will begin to try to identify possible causes within the first 24 hours of the fall . After a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on the preceding assessment, the Nursing Staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling .The Nursing Staff will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. The Charge Nurse will complete an assessment for seventy-two (72) hours post incident .The Nursing Staff will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling during the Standard of Care/High Risk Management Meetings .If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed; for example, if the problem that required the intervention has resolved by addressing the underlying cause . If the individual continues to fall, the Nursing Staff with the physician's assistance will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions .