

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S. Van Buren St. Amarillo, TX 79101	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854</p> <p>Based on interview and record review, the facility failed to maintain complete, accurate, readily accessible, and systemically organized records for 1 (Resident #1) of 8 residents reviewed for medical records.</p> <p>The facility failed to document the fall risk evaluation for Resident #1's history of falls within the last 90 days.</p> <p>This failure could place all residents at risk of not receiving appropriate care through inadequate documentation possibly resulting in deterioration in condition, exacerbation of disease process, and increased risk of harm or injury.</p> <p>Finding include:</p> <p>Record review of Resident #1's medical record revealed an [AGE] year-old-female admitted to the facility on [DATE]. Resident #1's current diagnoses include muscle weakness, history of falling, insomnia, unspecified dementia, unspecified severity, with other behavioral disturbance, hallucination, long term use of anticoagulants. Resident #1's last MDS, dated [DATE] was a quarterly with a BIMS of 13 indicating Resident #1 is cognitively intact. Resident #1 had a functionality of total dependency with mobility tasks while needing partial/moderate assistance with other self-care areas.</p> <p>Further record review of Resident #1's nurse's notes (NN) revealed that a fall risk evaluation dated 01/08/2024 stated the resident slid out of her raising lift recliner that resulted in a bruise to the left hip, no other injury noted. Fall Risk evaluation noted 1-2 falls in past 3 months.</p> <p>Record review of a NN note dated 02/16/2024 stated that Resident #1 was trying to toilet herself and slid from the bed, no injury s/t this fall, fall risk evaluation stated no Hx of falls in the last 3 months.</p> <p>Record review of a NN note dated 03/16/2024 stated that Resident #1 had a fall when she rolled out of her bed, resident hit her head on the floor, laceration to forehead and transfer to ER was performed. Fall risk evaluation stated no Hx of falls in the last 3 months.</p> <p>Record review of a NN note dated 03/17/2024 stated that Resident #1 received 3 stitches at local ER, no other injury noted.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</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 care plan reveals that resident is at risk for falls s/t to Resident 1's in ability to transfer alone.</p> <p>Observation and interview on 04/02/2024 at 11:11am with Resident #1 was on TBP for COVID, Resident #1 was lying in bed in a green night gown under her blankets. The left side of Resident #1's face was slightly bruised with bruising in different stages of healing. Resident did have a laceration to the left side of her forehead and was healing stages, no signs of infection present at site. Resident #1 was able to recall the night that she fell . She stated that she was lying in bed watching a ball game and was close to the edge of the bed. She stated that she went to push herself further back into the bed and just toppled right off the side of the bed. Resident #1 stated that staff came quickly to assist her and sent her to the ER very quickly since she hit her head and was bleeding a lot. No further concerns were voiced by Resident #1.</p> <p>Interview on 04/02/2024 at 12:49pm DON was asked why Resident #1's fall assessments after her falls in February and March indicated that the resident has had no falls in the last 3 months, when in fact she had. DON stated that she would get the nurse's contact information that performed those evaluations for the resident in question.</p> <p>Interview on 04/02/2024 at 1:55pm LVN A stated that she just didn't recall that the resident had fallen in January and that the assessment was made in error. LVN A stated that a negative outcome of not filling out the assessment correctly would be that there just isn't the right documentation for it.</p> <p>Interview on 04/02/2024 at 2:58pm LVN B stated that this was the first time in this building that she was filling out the assessment. LVN B was asked what a negative outcome would be with not filling out the assessment correctly. LVN B stated The next person that looked it up will have the incorrect information as well.</p> <p>Interview on 04/02/2024 at 4:31pm DON stated that a negative outcome to not having the correct documentation on a fall risk evaluation is that the next team member to come in would not have accurate information.</p> <p>Record review of facility provided policy titled Electronic Health Record, dated 06/07/2023, revealed the following:</p> <p>The purpose of the E.H.R. is to provide a basis for planning resident care as well as documenting the provision of such care and the outcomes relating to the evaluation, treatment, and changes in condition noted. Indiscriminate use of addenda, amendments, corrections, or deletions must be avoided. All reasonable attempts must be made by facility staff to assure documentation is accurate and complete prior to signing and saving the entries in the E.H.R. This facility recognizes the requirements of clinical providers to edit electronic health information in ta functional manner and protect the integrity of the E.H.R. simultaneously. In order to accommodate the needed functions, it is essential to define some terms.</p>		