STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455855	A. BUILDING _____ B. WING _____	03/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRACE CARE CENTER LUFKIN	504 N JOHN REDDITT DR LUFKIN, TX 75904

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their polices and procedures to prevent neglect for 1 of 6 residents reviewed for neglect. (Resident #62) The facility identified that Resident #49 had allegedly sexually assaulted Resident #62. While the facility was investigating the incident, they implemented one-on-one supervision for both residents. The facility failed to provide one-on-one supervision of Resident #49 for a period of 12 hours. An Immediate Jeopardy situation was identified on 03/19/14. The Immediate Jeopardy was removed on 03/20/14. The facility remained out of compliance at isolated actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place 21 residents, 12 of which were women, in the secured unit at risk for serious physical injury and psychological trauma. Findings included: 1.a. Physician orders [REDACTED]. Resident #62 resided on the secured unit. The most recent MDS dated [DATE] indicated Resident #62's cognition was severely impaired. She had unclear speech, disorganized thinking, [MEDICAL CONDITION],with physical and verbal behaviors directed toward others. Resident #62 was ambulatory and had a behavior of wandering daily. Care plans updated 01/15/14 indicated Resident #62 had socially inappropriate behaviors and cognitive deficits. The care plans did not address her wandering behaviors. 1.b. Physician orders [REDACTED]. The most recent MDS dated [DATE] indicted Resident #49's cognition was severely impaired. He had disorganized thinking and [MEDICAL CONDITION]. The assessment also indicated he had physical and verbal behaviors directed toward others and wandering. Care plans dated 12/23/13 indicated Resident #49 had impaired thought processes and episodes of confusion. The care plans did not address his physical, verbal, and wandering behaviors. During an interview on 03/19/14 at 12:42 p.m., CNA D said on 03/17/14 just before noon, she went in Resident #62's room to get her up for lunch. She saw scratches and a bruise to her neck and a scratch behind her left ear. She told the charge nurse, LVN H. During an interview on 03/19/14 at 12:55 p.m., LVN H said CNA D called her to Resident #62's room on 03/17/14 about noon to check the bruises on her neck. She said she was training a nurse and had not seen Resident #62 up close until that time. LVN H said she asked the secure unit manager, LVN J, and the LSW to come to the room because of the injuries. LVN H said Resident #62 was fully dressed when she came into the room. LVN H said when she assessed Resident #62, she also had a bruise on her knee. She did a head-to-toe assessment and did not see any bruises or lacerations to her perineal area. An incident report dated 03/17/14 at 12:00 noon for Resident #62 noted, .Called to residence room by CNA to report abrasions and bruising noted to resident. CNAs were unaware of cause of injuries. The report noted Resident #62 had the following injuries: abrasion to left chest that measured 4.0 cm x 1.0 cm x 0.5 cm, scratch noted to left cheek, behind left ear lobe, skin raw on left ear lobe, and superficial abrasion to left knee that measured 0.5 cm x 1.0 cm. During an interview on 03/19/14 at 1:00 p.m., CNA F said at approximately 4:00 p.m. on 03/17/14, she checked Resident #62 and she had scratches and bruises on her neck. She said the resident was having difficulty walking and the resident was grabbing her vaginal area. CNA F said she told the charge nurse, LVN K, and the administrator. CNA F said the administrator told her it was being investigated and Resident #62 was being sent to the emergency room . A nursing note for Resident #62 dated 03/17/14 indicated at 5:15 p.m. she was sent to the emergency room for complaint of vaginal pain. An Emergency Physician Record dated 03/17/14 timed 7:18 p.m. noted, .Patient found in room w/o (without) her underwear on noted abrasion to L (left) side neck and legs. Patient complained of vaginal pain. There was no documentation under the [MEDICAL CONDITION] examination section. The clinical impression noted, .Alleged Sexual Assault.multiple abrasions. The physician ordered Resident #62 be transferred to another hospital for SANE (sexually assaulted nurse examiner) exam. In further interview on 03/19/14 at 1:00 p.m. CNA F said she accompanied Resident #62 to the first emergency room . Resident #62 would not let the physician examine her. CNA F said she told the physician she did not know if Resident #62 was sexually assaulted or what. Since the resident would not let the physician her, that was why the resident was sent to another hospital for the SANE exam. During an interview on 03/19/14 at 4:58 p.m., the company president said the local police detective contacted him and said the SANE exam indicated Resident #62 had been raped. A nursing note dated 03/18/14 at 4:43 a.m. indicated Resident #62 .returned to facility with [DIAGNOSES REDACTED]. During an interview on 03/19/14 at 8:00 a.m., the administrator, DON, company president, and consultant identified Resident #49 as the person suspected for sexually assaulting Resident #62. They said Resident #49 and Resident #62 were placed on one on one supervision until Resident #49 could be transferred out of the facility. During an observation and interview on 03/19/14 at 9:00 a.m., Resident #49 was sitting in the dining room area. No staff were sitting with him. CNA A said she did not know if Resident #49 was on one on one supervision. During an interview on 03/19/14 at 9:02 a.m., Activity Director B said she did not know if Resident #49 was on one on one supervision. During an interview on 03/19/14 at 9:06 a.m., LVN C said there were no residents on one on one supervision. LVN C was working the 6:00 a.m.-2:00 p.m. (day) shift. During an interview on 03/19/14 at 9:07 a.m., CNA D said she did not know if Resident #49 was on one on one supervision. CNA D was working the 6:00 a.m.-2:00 p.m. (day) shift. During an interview on 03/19/14 at 10:57 a.m., LVN C said she clocked in at 5:50 a.m. and Resident #49 was in his room with no staff present. Resident #49 was in his room alone until approximately 8:00 a.m. when he came to the dining room for breakfast. An Elopement Risk/Behavior Monitoring Log dated 03/17/14 for Resident #49 indicated at 11:00 p.m. he was placed on monitoring and every fifteen minutes his location was documented. The Elopement Risk/Behavior Monitoring Log noted, .The resident will continue to be monitored until stated otherwise by the DON or Unit Supervisor. The last entry made on the monitoring sheet was on 03/18/14 at 9:00 p.m. There was no documentation Resident #49 was supervised after that time. During an interview on 03/19/14 at 9:20 a.m., LVN C acknowledged there was no other one on one sheets for Resident #49 and nothing had been documented since 03/18/14 at 9:00 p.m. LVN C said she was not told in report that Resident #49 was on one on one supervision. During an interview on 03/19/14 at 9:23 a.m., the DON acknowledged there were no other one on one sheets for Resident #49. During an interview on 03/19/14 at 9:18 a.m., CNA E, who worked 10:00 p.m. to 6:00 a.m. on 03/18/14 (night shift), said Resident #49 was watched closely, but stated, I can't answer that about the resident being monitored one on one. CNA E stated, What do you mean by one on one? and Why are you asking me all these questions? During an interview on 03/19/14 at 9:30 a.m., CNA G said she watched Resident #49 all the time, but nobody told me to sign papers. (document on a log). CNA G worked the 10:00 p.m.-6:00 a.m. (night) shift on 03/18/14. The charge nurse for 10:00 p.m. to 6:00 a.m. on 03/18/14 could not be reached by phone. The Abuse Prevention Policy dated December 2013 indicated, .3. If the alleged abuser is another resident, the two residents shall be separated and the alleged abusive resident shall be temporarily separated from other residents and monitored with one:one supervision as a therapeutic intervention to help lower the agitation, until a plan of care can be developed to meet the needs of the alleged abusive resident. The administrator, DON, company president, and consultant were notified on 03/19/14 at 1:43 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The facility's Plan of Removal was accepted on 03/19/14 5:53 p.m. and included: Plan

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) of Removal regarding IJ (Immediate Jeopardy) of 03/19/14 The following has and is being implemented to protect the residents of (facility name). Please review and inform us if acceptable or if additional action needed. Head-to-toe assessments preformed on all residents on South Wing (Dementia Unit) Secure Head-to-toe assessments preformed on all other residents Interviewed all staff working on South from Sunday 10 - 6 through Monday 2 - 10. Visually inspected nails and arms of all male staff on South Wing for marks Interviewed and checked arms and nails of rest of male staff for same reason Placed (Resident #62) and (Resident #49) on 24 hour observation with q15 minute checks Moved (Resident #62) out of unit keeping both residents apart and observed. Deep cleaned and Revamped (Resident #62's) room for her return Criminal background (public) on (Resident #49) found multiple non-violent arrests. Contracted and gained approval for (Resident #49's) family to take home and seek outpatient mental health care. Moved (Resident #49) to N-Step (another wing) and (Resident #62) back to South Wing(Resident #49) on one-on-one with q15 minute checks until removed from building Started in-services for all staff members on abuse policy, reporting, and monitoring. In-servicing all staff on definition and implementation of 1-on-1 monitoring and q15 minute checks (see attached). Installing closed circuit cameras on South Wing Secure unit (South Wing) door code will be changed monthly The surveyors confirmed the Plan of Removal had been implemented sufficiently to remove the Immediate Jeopardy by: Five LVNs were interviewed. All were able to identify and describe the types of abuse, when to report, and how to perform and document one on one resident monitoring. Four CNAs were interviewed. All were able to identify and describe the types of abuse, when to report, and how to perform and document one on one resident monitoring. One MA was interviewed. She was able identify and describe the types of abuse, when to report, and how to perform and document one on one resident monitoring. The one on one monitoring record for Resident #49 dated 03/19/14 beginning at 9:15 a.m. (following surveyor intervention) indicated staff monitored him until 8:15 p.m. until he was taken into custody by the local police department. On 03/20/14 at 10:10 a.m., the administrator, DON, company president, and consultant were informed the Immediate Jeopardy was removed; however, the facility remained out of compliance at isolated actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. The undated 802 provided 03/20/14 indicated there were 21 residents on the secured unit. Twelve of the 21 residents were women.
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their polices and procedures to prevent neglect for 1 of 6 residents reviewed for neglect. (Resident #62) The facility identified that Resident #49 had allegedly sexually assaulted Resident #62. While the facility was investigating the incident, they implemented one-on-one supervision for both residents. The facility failed to provide one-on-one supervision of Resident #49 for a period of 12 hours (from 3/18/14 at 9:00 p.m. - 3/19/14 at 9:00 a.m.). An Immediate Jeopardy situation was identified on 03/19/14. The Immediate Jeopardy was removed on 03/20/14. The facility remained out of compliance at isolated actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place 21 residents, 12 of which were women, in the secured unit at risk for serious physical injury and psychological trauma. Findings included: The Abuse Prevention Policy dated December 2013 indicated, .3. If the alleged abuser is another resident, the two residents shall be separated and the alleged abusive resident shall be temporarily separated from other residents and monitored with one:one supervision as a therapeutic intervention to help lower the agitation, until a plan of care can be developed to meet the needs of the alleged abusive resident. 1.a. Physician orders [REDACTED]. Resident #62 resided on the secured unit. The most recent MDS dated [DATE] indicated Resident #62's cognition was severely impaired. She had unclear speech, disorganized thinking, [MEDICAL CONDITION],with physical and verbal behaviors directed toward others. Resident #62 was ambulatory and had a behavior of wandering daily. Care plans updated 01/15/14 indicated Resident #62 had socially inappropriate behaviors and cognitive deficits. The care plans did not address her wandering behaviors. 1.b. Physician orders [REDACTED]. The most recent MDS dated [DATE] indicted Resident #49's cognition was severely impaired. He had disorganized thinking and [MEDICAL CONDITION]. The assessment also indicated he had physical and verbal behaviors directed toward others and wandering. Care plans dated 12/23/13 indicated Resident #49 had impaired thought processes and episodes of confusion. The care plans did not address his physical, verbal, and wandering behaviors. During an interview on 03/19/14 at 12:42 p.m., CNA D said on 03/17/14 just before noon, she went in Resident #62's room to get her up for lunch. 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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) closely, but stated, I can't answer that about the resident being monitored one on one. CNA E stated, What do you mean by one on one? and Why are you asking me all these questions? During an interview on 03/19/14 at 9:30 a.m., CNA G said she watched Resident #49 all the time, but nobody told me to sign papers. (document on a log). CNA G worked the 10:00 p.m.-6:00 a.m. (night) shift on 03/18/14. The charge nurse for 10:00 p.m. to 6:00 a.m. on 03/18/14 could not be reached by phone. The administrator, DON, company president, and consultant were notified on 03/19/14 at 1:43 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The facility's Plan of Removal was accepted on 03/19/14 5:53 p.m. and included: Plan of Removal regarding IJ (Immediate Jeopardy) of 03/19/14 The following has and is being implemented to protect the residents of (facility name). Please review and inform us if acceptable or if additional action needed. Head-to-toe assessments preformed on all residents on South Wing (Dementia Unit) Secure Head-to-toe assessments preformed on all other residents Interviewed all staff working on South from Sunday 10 - 6 through Monday 2 - 10. Visually inspected nails and arms of all male staff on South Wing for marks Interviewed and checked arms and nails of rest of male staff for same reason Placed (Resident #62) and (Resident #49) on 24 hour observation with q15 minute checks Moved (Resident #62) out of unit keeping both residents apart and observed. Deep cleaned and Revamped (Resident #62's) room for her return Criminal background (public) on (Resident #49) found multiple non-violent arrests. Contracted and gained approval for (Resident #49's) family to take home and seek outpatient mental health care. Moved (Resident #49) to N-Step (another wing) and (Resident #62) back to South Wing(Resident #49) on one-on-one with q15 minute checks until removed from building Started in-services for all staff members on abuse policy, reporting, and monitoring. In-servicing all staff on definition and implementation of 1-on-1 monitoring and q15 minute checks (see attached). Installing closed circuit cameras on South Wing Secure unit (South Wing) door code will be changed monthly The surveyors confirmed the Plan of Removal had been implemented sufficiently to remove the Immediate Jeopardy by: Five LVNs were interviewed. All were able to identify and describe the types of abuse, when to report, and how to perform and document one on one resident monitoring. Four CNAs were interviewed. All were able to identify and describe the types of abuse, when to report, and how to perform and document one on one resident monitoring. One MA was interviewed. She was able identify and describe the types of abuse, when to report, and how to perform and document one on one resident monitoring. The one on one monitoring record for Resident #49 dated 03/19/14 beginning at 9:15 a.m. (following surveyor intervention) indicated staff monitored him until 8:15 p.m. until he was taken into custody by the local police department. On 03/20/14 at 10:10 a.m., the administrator, DON, company president, and consultant were informed the Immediate Jeopardy was removed; however, the facility remained out of compliance at isolated actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. The undated 802 provided 03/20/14 indicated there were 21 residents on the secured unit. Twelve of the 21 residents were women.