STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NOLAN NURSING AND REHABILITATION LP	705 NE GEORGIA AVENUE SWEETWATER, TX 79556

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 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an allegation of neglect for 1 of 4 residents reviewed for falls (Resident #1) as evidenced by failure to interview the staff on duty, including the staff assigned to work with him on the night shift of 10/11/14 when he fell and sustained a broken hip. The failure to conduct a thorough investigation of accidents and injuries to rule out neglect could result in ongoing neglect of residents and could affect the 23 residents who required close supervision to prevent accidents. Findings included: 1. An undated Resident Admission Record for Resident #1 documented he was an [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A fall risk assessment form dated 10/7/14 documented that Resident #1 scored 17. A score of 10 or more indicated a high risk for falls. An Admission Care Plan for Resident #1 dated 10/7/14 documented that Resident #1 had cognitive loss and intermittent confusion. The care plan documented he needed the assistance of two staff for ambulation, transferring, toilet use and bathing. He required the assistance of one staff for grooming, dressing, and eating. Resident #1 had a catheter. He required oxygen continuously and took breathing treatments as needed. The care plan documented that Resident #1 was a fall risk and interventions included a sensor pad alarm. Physician's start up orders for Resident #1 dated 10/7/14 documented a fall alarm to bed and wheelchair due to fall risk. 2. A Provider Investigation Report dated 10/17/14 documented that CNA A found Resident #1 on the floor of his room on 10/11/14 at 5:55 a.m. The report documented that Resident #1 was moaning and complaining of pain, so he was sent to the hospital by ambulance for a suspected [MEDICAL CONDITION], which was confirmed at the hospital. The report documented that Resident #1 was determined to be at high risk for falls when he was admitted , thus fall interventions of a bed alarm and low bed were ordered by the physician, but were not implemented. The Provider Investigation report included statements from three nurses that indicated that the sensor alarm was not implemented on admission as the nurses could not locate an alarm in the building. The report included a statement from CNA A, stating that she was going down hall #2 (where Resident #1 resided) to take out trash and heard Resident #1 moaning. She said she found him on the floor, sitting in an upright position with his hand on his right hip, groaning in pain. She said there was no fall mat or sensor alarm in place. She said Resident #1 told her he rolled from the bed to the floor. The report concluded that administrative staff had counseled the nursing staff regarding failure to implement the alarm, implemented the fall alarm and measures to monitor all fall alarms in the building, and in-serviced staff accordingly. The provider investigation report did not include any interviews with staff that were on duty at the time the injury occurred. The provider investigation report did not identify who was assigned to work with, or supervise Resident #1's care at the time of his injury. 3. During an interview on 10/22/14 at 10:10 a.m., Resident #1 was in his room with two of his daughters (Daughter A and B). Resident #1 and his sisters were spanish speaking only, so Housekeeper A interpreted the interview. Resident #1 was observed to be lying on his bed with oxygen in place. Daughter A said that they visit him multiple times a day at the facility. She said that the family had been having concerns about the staff's supervision of Resident #1, and their english speaking sister had spoken with the Administrator or Director of Nurses about it several times, but it did not seem to improve. Daughter A said that Resident #1 used his call light for help, but they had noticed it took a long time for staff to answer the call light, and sometimes they had to go look for staff after waiting too long. She said that when she arrived to see Resident #1 yesterday, He was trying to get up and the alarm was sounding, but, Nobody ever came. She said that she put him back in bed. She said that Resident #1 had surgery on his hip at the hospital but he was not totally oriented and would forget he had surgery and still try to get up. She said that he did not have an alarm until he came back from the hospital after surgery. Daughter A said that when she spoke with Resident #1 after the fall, he told her that he turned on his call light and no one ever came. He told her he then started yelling for help. She was not sure if he meant that he activated the call light before falling or after falling. Daughter A said that Resident #1 had been in the hospital immediately prior to his admission to this facility, and had fallen at the hospital and sustained a hematoma to his forehead. An attempt was made to interview Resident #1. He could not recall the details of his fall. He stated, I just fell . 4. During an interview on 10/22/14 at 10:30 a.m., CNA A said that she was the person who found Resident #1 on the floor of his room on 10/11/14. She was not the nurse aide assigned to Resident #1's hall that night, as Resident #1 resided on hall two and she was assigned to hall three. She said that CNA B was assigned to Resident #1. CNA A said it was nearing the end of her shift and she was taking out the trash. She said that as she walked past the foyer that separates hall two and three, she saw CNA B sitting on the couch. She said she heard loud moaning before she ever reached hall two and followed the sound to Resident #1's room. She said that she found him on the floor in pain and informed the nurse. CNA A said that the bed was not in a low position, there was no fall matt in the room, and there was no sensor alarm in place. CNA A said that she had worked on Resident #1's hall after he came in to the facility. She said that she remembered walking in and finding him there, but no one had informed her she had a new resident on her hall or that he was a fall risk. She said sometimes the only way the CNA's knew a new resident was a fall risk the first time they met them was if they observed an alarm or a mat beside the bed. She said that prior to his fall, Resident #1 did very well and only required one staff to assist him as he could bear some weight and followed instructions well. She said that although he had a catheter, Resident #1 was continent of bowel and they assisted him to the restroom when needed. CNA A said that she was never interviewed by the Administrator or Director of Nurses regarding her knowledge of the incident. She said she had not told anyone about seeing CNA B in the sitting room, because no one had asked her. She said she was only asked to write a statement and give it to them. 5. During a telephone interview on 10/22/14 at 12:10 p.m., CNA B said that she was on duty from 10:00 p.m. to 6:00 a.m. and assigned to Resident #1's hall on 10/11/14. When discussing her monitoring of Resident #1 that night, she said that she was in his room many times that night because he was constantly putting his legs down over the side of the bed trying to get up. She said she just put him back to bed each time. She said she did not know what he wanted because she could not understand spanish. When discussing whether she could get assistance from a peer to talk to the resident, she said that she asked a spanish speaking peer to find out what he needed and they talked but she never asked the peer what Resident #1 had said. When discussing when she last saw Resident #1, she said that she started her last rounds of the night about 4:00 a.m. and ended them between 5:00 a.m. and 5:30 a.m. She said she saw him some time during that window, and that she was standing at the nurse's station when he fell . She said she was with CNA A. She said she had not been interviewed by anyone regarding the incident. 6. An observation of the facility 10/22/14 at 2:00 p.m. revealed the nurse's station was situated in a large area in the center of the building with halls one, two, three, and four splitting off of that main area in a wagon wheel like fashion. Halls two and three split off the back side of the room. Between halls

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 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) two and three was a sitting area for residents with a television, couches, and chairs. (This was the area that CNA A described as where she had seen CNA B sitting when Resident #1 was found on the floor). Behind the sitting area was the dining room. Observation of the sitting area revealed that none of the hallways were visible from any location in the sitting area. Call lights on the doorways of the rooms could not be seen from the sitting area. Observation revealed that in order to be on hall two and see what was going on in hall two, one would be required to leave the sitting area and turn a corner to the left to be on hall two. 7. During an interview on 10/22/14 at 3:45 p.m., CNA C said she did not have direct knowledge about Resident #1's fall, but she had worked with him prior to, and since his fall. She said that prior to the [MEDICAL CONDITION], Resident #1 could assist in his transfer. She said that he could sit up and put his legs over the side of the bed and stand up with assistance. She said that now when he tried to do that, he yelled out in pain and would just lie back down. CNA C said Resident #1 was not the type of resident that was so confused that he just tried to get out of bed for no reason. She said she believed he only tried to get out of bed when he wanted something, and most of the time that was to go to the restroom, and otherwise, He doesn't budge. She said that prior to the fall, Resident #1 was good to use his call light when he needed help, but if staff did not respond to the light in a relatively short time, he would always try to get himself up. She said that Resident #1 was not the type of resident that you could ask to wait. 8. During an interview on 10/23/14 at 10:10 a.m., CNA D said she came to work the morning of 10/11/14 at 5:50 a.m. She said that it could have been 5:45 a.m. but it was no later than 5:50 a.m. She said that she parked her car outside hall two, and had to travel down hall two to get to her work station. She said that she walked by Resident #1's room and noticed he was not in. She said she asked someone where he was and was told that he had already left the facility in an ambulance after a fall. 9. During an interview on 10/23/14 at 2:30 p.m., the Director of Nurses (DON) said that the charge nurse generally gathered information regarding how a fall occurred at the time of the incident. She said that since there was an injury involved in Resident #1's case the Administrator conducted an investigation regarding the fall. When discussing that the facility's documentation regarding this incident did not include identifying or addressing that CNA B was not providing supervision to Resident #1 when his accident occurred, the DON said that she was only aware of the issues related to the fall precautions not being in place and the corrective measures taken to address them. 10. During an interview on 10/23/14 at 2:45 p.m., the Administrator said that the only person that she talked to that was on duty when Resident #1 fell was the charge nurse. She said she did not talk to CNA A. She said she did not ask where CNA B was at the time Resident #1 fell and did not talk to CNA B at all. She said she guessed she could have talked to more people. 11. A review of the facility's policy, titled Abuse-Reportable Events dated 01/2008 and revised 05/2014 revealed it included the following: All incidents/accidents of unknown origin will be investigated. .Begin taking written statements from the person reporting the allegation or suspicion and any witnesses including staff, family, and/or residents. In certain situations, the person writing the information, along with the person making the statement, if at all possible, and a witness to the dictated statement should all sign the completed form. Ask any witness to wait for the Administrator or the person on call to arrive at the home. If an employee is involved, the employee will be detained and removed from their assigned duties until they are interviewed by the Administrator or person on-call or other appropriate staff. 12. The DON provided a list of residents at high risk for falls on 10/22/14 at 2:00 p.m. The list contained 23 residents.
F 0226 **Level of harm** - Minimal harm or potential for actual harm **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 interview and record review, the facility failed to implement written policies that prohibit mistreatment, neglect, and abuse of residents when they failed to thoroughly investigate an allegation of neglect for 1 of 4 residents reviewed for falls (Resident #1) as evidenced by failure to interview the staff on duty, including the staff assigned to work with Resident #1, on the night shift of 10/11/14 when he fell and sustained a broken hip. The failure to conduct a thorough investigation of accidents and injuries to rule out neglect could result in ongoing neglect of residents and could affect the 23 residents who required close supervision to prevent accidents. Findings included: 1. A review of the facility's policy, titled Abuse-Reportable Events dated 01/2008 and revised 05/2014 revealed it included the following: All incidents/accidents of unknown origin will be investigated. .Begin taking written statements from the person reporting the allegation or suspicion and any witnesses including staff, family, and/or residents. In certain situations, the person writing the information, along with the person making the statement, if at all possible, and a witness to the dictated statement should all sign the completed form. Ask any witness to wait for the Administrator or the person on call to arrive at the home. If an employee is involved, the employee will be detained and removed from their assigned duties until they are interviewed by the Administrator or person on-call or other appropriate staff. 2. An undated Resident Admission Record for Resident #1 documented he was an [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A fall risk assessment form dated 10/7/14 documented that Resident #1 scored 17. A score of 10 or more indicated a high risk for falls. An Admission Care Plan for Resident #1 dated 10/7/14 documented that Resident #1 had cognitive loss and intermittent confusion. The care plan documented he needed the assistance of two staff for ambulation, transferring, toilet use and bathing. He required the assistance of one staff for grooming, dressing, and eating. Resident #1 had a catheter. He required oxygen continuously and took breathing treatments as needed. The care plan documented that Resident #1 was a fall risk and interventions included a sensor pad alarm. Physician's start up orders for Resident #1 dated 10/7/14 documented a fall alarm to bed and wheelchair due to fall risk. 3. A Provider Investigation Report dated 10/17/14 documented that CNA A found Resident #1 on the floor of his room on 10/11/14 at 5:55 a.m. The report documented that Resident #1 was moaning and complaining of pain, so he was sent to the hospital by ambulance for a suspected [MEDICAL CONDITION], which was confirmed at the hospital. The report documented that Resident #1 was determined to be at high risk for falls when he was admitted , thus fall interventions of a bed alarm and low bed were ordered by the physician, but were not implemented. The Provider Investigation report included statements from three nurses that indicated that the sensor alarm was not implemented on admission as the nurses could not locate an alarm in the building. The report included a statement from CNA A, stating that she was going down hall #2 (where Resident #1 resided) to take out trash and heard Resident #1 moaning. She said she found him on the floor, sitting in an upright position with his hand on his right hip, groaning in pain. She said there was no fall mat or sensor alarm in place. She said Resident #1 told her he rolled from the bed to the floor. The report concluded that administrative staff had counseled the nursing staff regarding failure to implement the alarm, implemented the fall alarm and measures to monitor all fall alarms in the building, and in-serviced staff accordingly. The provider investigation report did not include any interviews with staff that were on duty at the time the injury occurred. The provider investigation report did not identify who was assigned to work with, or supervise Resident #1's care at the time of his injury. 4. During an interview on 10/22/14 at 10:10 a.m., Resident #1 was in his room with two of his daughters (Daughter A and B). Resident #1 and his sisters were spanish speaking only, so Housekeeper A interpreted the interview. Resident #1 was observed to be lying on his bed with oxygen in place. Daughter A said that they visit him multiple times a day at the facility. She said that the family had been having concerns about the staff's supervision of Resident #1, and their english speaking sister had spoken with the Administrator or Director of Nurses about it several times, but it did not seem to improve. Daughter A said that Resident #1 used his call light for help, but they had noticed it took a long time for staff to answer the call light, and sometimes they had to go look for staff after waiting too long. She said that when she arrived to see Resident #1 yesterday, He was trying to get up and the alarm was sounding, but, Nobody ever came. She said that she put him back in bed. She said that Resident #1 had surgery on his hip at the hospital but he was not totally oriented and would forget he had surgery and still try to get up. She said that he did not have an alarm until he came back from the hospital after surgery. Daughter A said that when she spoke with Resident #1 after the fall, he told her that he turned on his call light and no one ever came. He told her he then started yelling for help. She was not sure if he meant that he activated the call light before falling or after falling. Daughter A said that Resident #1 had been in the hospital immediately prior to his admission to this facility, and had fallen at the hospital and sustained a hematoma to his forehead. An attempt was made to interview Resident #1. He could not recall the details of his fall. He stated, I just fell . 5. During an interview on 10/22/14 at 10:30 a.m., CNA A said that she was the person who found Resident #1 on the floor of his room on 10/11/14. She was not the nurse aide assigned to Resident #1's hall that night, as Resident #1 resided on hall two and she was assigned to hall three. She said that CNA B was assigned to Resident #1. CNA A said it was nearing the end of her shift and she was taking out the trash. She said that as she walked past the foyer that separates hall two

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F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) and three, she saw CNA B sitting on the couch. She said she heard loud moaning before she ever reached hall two and followed the sound to Resident #1's room. She said that she found him on the floor in pain and informed the nurse. CNA A said that the bed was not in a low position, there was no fall matt in the room, and there was no sensor alarm in place. CNA A said that she had worked on Resident #1's hall after he came in to the facility. She said that she remembered walking in and finding him there, but no one had informed her she had a new resident on her hall or that he was a fall risk. She said sometimes the only way the CNA's knew a new resident was a fall risk the first time they met them was if they observed an alarm or a mat beside the bed. She said that prior to his fall, Resident #1 did very well and only required one staff to assist him as he could bear some weight and followed instructions well. She said that although he had a catheter, Resident #1 was continent of bowel and they assisted him to the restroom when needed. CNA A said that she was never interviewed by the Administrator or Director of Nurses regarding her knowledge of the incident. She said she had not told anyone about seeing CNA B in the sitting room, because no one had asked her. She said she was only asked to write a statement and give it to them. 6. During a telephone interview on 10/22/14 at 12:10 p.m., CNA B said that she was on duty from 10:00 p.m. to 6:00 a.m. and assigned to Resident #1's hall on 10/11/14. When discussing her monitoring of Resident #1 that night, she said that she was in his room many times that night because he was constantly putting his legs down over the side of the bed trying to get up. She said she just put him back to bed each time. She said she did not know what he wanted because she could not understand spanish. When discussing whether she could get assistance from a peer to talk to the resident, she said that she asked a spanish speaking peer to find out what he needed and they talked but she never asked the peer what Resident #1 had said. When discussing when she last saw Resident #1, she said that she started her last rounds of the night about 4:00 a.m. and ended them between 5:00 a.m. and 5:30 a.m. She said she saw him some time during that window, and that she was standing at the nurse's station when he fell . She said she was with CNA A. She said she had not been interviewed by anyone regarding the incident. 7. An observation of the facility 10/22/14 at 2:00 p.m. revealed the nurse's station was situated in a large area in the center of the building with halls one, two, three, and four splitting off of that main area in a wagon wheel like fashion. Halls two and three split off the back side of the room. Between halls two and three was a sitting area for residents with a television, couches, and chairs. (This was the area that CNA A described as where she had seen CNA B sitting when Resident #1 was found on the floor). Behind the sitting area was the dining room. Observation of the sitting area revealed that none of the hallways were visible from any location in the sitting area. Call lights on the doorways of the rooms could not be seen from the sitting area. Observation revealed that in order to be on hall two and see what was going on in hall two, one would be required to leave the sitting area and turn a corner to the left to be on hall two. 8. During an interview on 10/22/14 at 3:45 p.m., CNA C said she did not have direct knowledge about Resident #1's fall, but she had worked with him prior to, and since his fall. She said that prior to the [MEDICAL CONDITION], Resident #1 could assist in his transfer. She said that he could sit up and put his legs over the side of the bed and stand up with assistance. She said that now when he tried to do that, he yelled out in pain and would just lie back down. CNA C said Resident #1 was not the type of resident that was so confused that he just tried to get out of bed for no reason. She said she believed he only tried to get out of bed when he wanted something, and most of the time that was to go to the restroom, and otherwise, He doesn't budge. She said that prior to the fall, Resident #1 was good to use his call light when he needed help, but if staff did not respond to the light in a relatively short time, he would always try to get himself up. She said that Resident #1 was not the type of resident that you could ask to wait. 9. During an interview on 10/23/14 at 10:10 a.m., CNA D said she came to work the morning of 10/11/14 at 5:50 a.m. She said that it could have been 5:45 a.m. but it was no later than 5:50 a.m. She said that she parked her car outside hall two, and had to travel down hall two to get to her work station. She said that she walked by Resident #1's room and noticed he was not in. She said she asked someone where he was and was told that he had already left the facility in an ambulance after a fall. 10. During an interview on 10/23/14 at 2:30 p.m., the Director of Nurses (DON) said that the charge nurse generally gathered information regarding how a fall occurred at the time of the incident. She said that since there was an injury involved in Resident #1's case the Administrator conducted an investigation regarding the fall. When discussing that the facility's documentation regarding this incident did not include identifying or addressing that CNA B was not providing supervision to Resident #1 when his accident occurred, the DON said that she was only aware of the issues related to the fall precautions not being in place and the corrective measures taken to address them. 11. During an interview on 10/23/14 at 2:45 p.m., the Administrator said that the only person that she talked to that was on duty when Resident #1 fell was the charge nurse. She said she did not talk to CNA A. She said she did not ask where CNA B was at the time Resident #1 fell and did not talk to CNA B at all. She said she guessed she could have talked to more people. 12. The DON provided a list of residents at high risk for falls on 10/22/14 at 2:00 p.m. The list contained 23 residents.
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that three residents (Residents #1, 2, and 3) of four reviewed for high fall risk received adequate supervision and assistance devices to prevent accidents as evidenced by: a) failure to ensure fall prevention measures of a sensor alarm and low bed were in place as ordered by the physician from 10/7/14 through 10/11/14 and failure of CNA (certified nurse's aide) B to provide supervision to Resident # 2 when she left her hall and was sitting in the sitting room when Resident #2 fell on [DATE] at approximately 5:55 a.m. and sustained a fractured hip requiring surgical repair. CNA B reported Resident #2 had been trying to get out of bed unassisted throughout the night; b) failure to ensure that staff were implementing fall prevention measures for Resident #2 including the sensor pad alarm, a matt by her bed, and constant supervision in the restroom. Resident #2 had six falls that included two trips to the emergency room , injury to her coccyx and two falls from the toilet when staff were reportedly in the room to supervise her, occurring between 9/2/14 and 10/8/14; c) failure to ensure fall prevention measures were implemented for Resident #3. Observation on 10/23/14 revealed her sensor alarm was off while she was sitting in her wheelchair and needed items were out of her reach. These failures resulted in Resident #1's fall and broken hip that resulted in lasting pain and the need for surgical repair. These failures could result in increased falls for the 23 residents at high risk for falls and result in pain, decreased functional abilities, serious injury or death. Findings included: Resident #1 1. An undated Resident Admission Record for Resident #1 documented he was an [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A fall risk assessment form dated 10/7/14 documented that Resident #1 scored 17. A score of 10 or more indicated a high risk for falls. An Admission Care Plan for Resident #1 dated 10/7/14 documented that Resident #1 had cognitive loss and intermittent confusion. The care plan documented he needed the assistance of two staff for ambulation, transferring, toilet use and bathing. He required the assistance of one staff for grooming, dressing, and eating. Resident #1 had a catheter. He required oxygen continuously and took breathing treatments as needed. The care plan documented that Resident #1 was a fall risk and interventions included a sensor pad alarm. Physician's start up orders for Resident #1 dated 10/7/14 documented a fall alarm to bed and wheelchair due to fall risk. 2. A Provider Investigation Report dated 10/17/14 documented that CNA A found Resident #1 on the floor of his room on 10/11/14 at 5:55 a.m. The report documented that Resident #1 was moaning and complaining of pain, so he was sent to the hospital by ambulance for a suspected hip fracture, which was confirmed at the hospital. The report documented that Resident #1 was determined to be at high risk for falls when he was admitted , thus fall interventions of a bed alarm and low bed were ordered by the physician, but were not implemented. The Provider Investigation report included statements from three nurses that indicated that the sensor alarm was not implemented on admission as the nurses could not locate an alarm in the building. The report included a statement from CNA A, stating that she was going down hall #2 (where Resident #1 resided) to take out trash and heard Resident #1 moaning. She said she found him on the floor, sitting in an upright position with his hand on his right hip, groaning in pain. She said there was no fall mat or sensor alarm in place. She said Resident #1 told her he rolled from the bed to the floor. The report concluded that administrative staff had counseled the nursing staff regarding failure to implement the alarm, implemented the fall alarm and measures to monitor all fall alarms in the building, and in-serviced staff accordingly. 3. During an interview on 10/22/14 at 10:10 a.m., Resident #1 was in his room with two of his daughters (Daughter A and B). Resident #1 and his sisters were spanish speaking only, so Housekeeper A interpreted the interview. Resident #1 was observed to be lying on his bed with oxygen in place. Daughter A said that they visit him multiple times a day at the facility. She said that the family had been having concerns about the

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) staff's supervision of Resident #1, and their english speaking sister had spoken with the Administrator or Director of Nurses about it several times, but it did not seem to improve. Daughter A said that Resident #1 used his call light for help, but they had noticed it took a long time for staff to answer the call light, and sometimes they had to go look for staff after waiting too long. She said that when she arrived to see Resident #1 yesterday, He was trying to get up and the alarm was sounding, but, Nobody ever came. She said that she put him back in bed. She said that Resident #1 had surgery on his hip at the hospital but he was not totally oriented and would forget he had surgery and still try to get up. She said that he did not have an alarm until he came back from the hospital after surgery. Daughter A said that when she spoke with Resident #1 after the fall, he told her that he turned on his call light and no one ever came. He told her he then started yelling for help. She was not sure if he meant that he activated the call light before falling or after falling. Daughter A said that Resident #1 had been in the hospital immediately prior to his admission to this facility, and had fallen at the hospital and sustained a hematoma to his forehead. An attempt was made to interview Resident #1. He could not recall the details of his fall. He stated, I just fell . 4. During an interview on 10/22/14 at 10:30 a.m., CNA A said that she was the person who found Resident #1 on the floor of his room on 10/11/14. She was not the nurse aide assigned to Resident #1's hall that night, as Resident #1 resided on hall two and she was assigned to hall three. She said that CNA B was assigned to Resident #1. CNA A said it was nearing the end of her shift and she was taking out the trash. She said that as she walked past the foyer that separates hall two and three, she saw CNA B sitting on the couch. She said she heard loud moaning before she ever reached hall two and followed the sound to Resident #1's room. She said that she found him on the floor in pain and informed the nurse. CNA A said that the bed was not in a low position, there was no fall matt in the room, and there was no sensor alarm in place. CNA A said that she had worked on Resident #1's hall after he came in to the facility. She said that she remembered walking in and finding him there, but no one had informed her she had a new resident on her hall or that he was a fall risk. She said sometimes the only way the CNA's knew a new resident was a fall risk the first time they met them was if they observed an alarm or a mat beside the bed. She said that prior to his fall, Resident #1 did very well and only required one staff to assist him as he could bear some weight and followed instructions well. She said that although he had a catheter, Resident #1 was continent of bowel and they assisted him to the restroom when needed. 5. During a telephone interview on 10/22/14 at 12:10 p.m., CNA B said that she was on duty from 10:00 p.m. to 6:00 a.m. and assigned to Resident #1's hall on 10/11/14. When discussing her monitoring of Resident #1 that night, she said that she was in his room many times that night because he was constantly putting his legs down over the side of the bed trying to get up. She said she just put him back to bed each time. She said she did not know what he wanted because she could not understand spanish. When discussing whether she could get assistance from a peer to talk to the resident, she said that she asked a spanish speaking peer to find out what he needed and they talked but she never asked the peer what Resident #1 had said. When discussing when she last saw Resident #1, she said that she started her last rounds of the night about 4:00 a.m. and ended them between 5:00 a.m. and 5:30 a.m. She said she saw him some time during that window, and that she was standing at the nurse's station when he fell . She said she was with CNA A. 6. An observation of the facility 10/22/14 at 2:00 p.m. revealed the nurse's station was situated in a large area in the center of the building with halls one, two, three, and four splitting off of that main area in a wagon wheel like fashion. Halls two and three split off the back side of the room. Between halls two and three was a sitting area for residents with a television, couches, and chairs. (This was the area that CNA A described as where she had seen CNA B sitting when Resident #1 was found on the floor). Behind the sitting area was the dining room. Observation of the sitting area revealed that none of the hallways were visible from any location in the sitting area. Call lights on the doorways of the rooms could not be seen from the sitting area. Observation revealed that in order to be on hall two and see what was going on in hall two, one would be required to leave the sitting area and turn a corner to the left to be on hall two. 7. During an interview on 10/22/14 at 3:45 p.m., CNA C said she did not have direct knowledge about Resident #1's fall, but she had worked with him prior to, and since his fall. She said that prior to the fractured hip, Resident #1 could assist in his transfer. She said that he could sit up and put his legs over the side of the bed and stand up with assistance. She said that now when he tried to do that, he yelled out in pain and would just lie back down. CNA C said Resident #1 was not the type of resident that was so confused that he just tried to get out of bed for no reason. She said she believed he only tried to get out of bed when he wanted something, and most of the time that was to go to the restroom, and otherwise, He doesn't budge. She said that prior to the fall, Resident #1 was good to use his call light when he needed help, but if staff did not respond to the light in a relatively short time, he would always try to get himself up. She said that Resident #1 was not the type of resident that you could ask to wait. 8. During an interview on 10/23/14 at 10:10 a.m., CNA D said she came to work the morning of 10/11/14 at 5:50 a.m. She said that it could have been 5:45 a.m. but it was no later than 5:50 a.m. She said that she parked her car outside hall two, and had to travel down hall two to get to her work station. She said that she walked by Resident #1's room and noticed he was not in. She said she asked someone where he was and was told that he had already left the facility in an ambulance after a fall. 9. During an interview on 10/23/14 at 2:30 p.m., the Director of Nurses (DON) said that the charge nurse generally gathered information regarding how a fall occurred at the time of the incident. She said that since there was an injury involved in Resident #1's case the Administrator conducted an investigation regarding the fall. When discussing that the facility's documentation regarding this incident did not include identifying or addressing that CNA B was not providing supervision to Resident #1 when his accident occurred, the DON said that she was only aware of the issues related to the fall precautions not being in place and the corrective measures taken to address them. 10. During an interview on 10/23/14 at 2:45 p.m., the Administrator said that the only person that she talked to that was on duty when Resident #1 fell was the charge nurse. She said she did not ask where CNA B was at the time Resident #1 fell . She said she guess she could have talked to more people. Resident #2 11. An undated admission record documented Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set Assessment for Resident #2 dated 8/25/14 documented that she required extensive assistance of one staff for transfers, dressing, bed mobility, and toilet use. She had impaired range of motion to one side of her upper extremity and both lower extremities. She used a wheelchair for mobility. She was occasionally incontinent of bowel and bladder. A fall risk assessment dated [DATE] documented a score of 16. A score of 10 or more indicated high risk for falls. 12. Incident reports for Resident #2 revealed the following: 10/8/14 at 6:10 p.m.: Resident on toilet- lost balance. (There were no statements or description of how Resident #2 fell off the toilet). Resident #2 was sent to the emergency room due to pain and bruising on her hand. Discharge instructions from the hospital that were attached to the incident report documented, left hand/elbow contusions. Under, what measures were put in place or what systemic changes were made? the facility documented, Will continue to check sensor pad at least bid (twice daily) and low bed with mat at bedside. 10/4/14 at 12:15 p.m.: Lowered to floor in restroom while on toilet, skin tear to top left wrist. Cause documented as Res on commode and staring leaning-lost balance. A brief summary documented that the CNA (CNA F) turned her back briefly to move an object in the resident's room and when the resident started leaning the CNA lowered her to the floor. Immediate action taken was in-service with staff not to leave resident alone or unattended while on commode. Attached to the incident was a statement by CNA G confirming CNA F's report. An attached in-service signed by staff and dated 10/4/14 documented, Do not leave resident on commode alone/unassisted.) 9/23/14 at 7:00 p.m.: Resident went to restroom after evening meal with assist from CNA. Assist off and back into wheelchair from toilet. Resident in room, did not put brakes on wheelchair and attempted to ambulate independently without assistance. Sat on floor. The report documented that visitor and CNA reported that the alarm sounded for greater than one minute. The facility's documented interventions/measures put in place were, Given call light/ BR (bathroom) q (every) 2 hours, repositioned every 2 hours with assistance. Offered water/ice with rounds. CNA to frequently assist and ensure call light in place and in reach of resident and personal alarm in place and responded to. An attached witness statement to this incident included the following statement: My name is ( ). I'm a witness. I was taking my mom to her room last night when (resident name) called me to her room to tell me she needed help. I asked her what kind of help she needed and she said Resident #2 had fell . (resident name) said she went to the nurse's station to ask for some help and that the three nurses that were standing there did not pay attention to her. I then see a staff member coming out of a room from picking up trays and we picked her up and put her on her bed. I stayed with her til (staff member, CNA E) got back then finally after about 20 minutes the nurse finally showed up and I left. 9/14/14 at 12:40 p.m.: Resident with sensor alarm on and in place said she lost her balance on side of the bed and let herself down on the floor. The facility documented interventions that Resident #1 was not to be left alone in room and she had wheeled herself from the hallway into her room. 9/6/14 at 9:55 a.m.: CNA reports alarm sounded and noted resident on the floor when entering room. Resident #2 was complaining of tailbone pain and sent to the emergency room . The incident report documented that Resident #2 had been in her wheelchair and attempted to transfer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455509	A. BUILDING _____ B. WING _____	**10/23/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NOLAN NURSING AND REHABILITATION LP	**705 NE GEORGIA AVENUE SWEETWATER, TX 79556**

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) herself. The disposition documented a fractured coccyx. The facility documented that interventions included that resident was to be out of her room when not in bed unless supervised. 9/2/14 at 9:20 a.m.: Another resident reported Resident #2 was sitting on the floor in her room. Resident #2 was reportedly sitting in her wheelchair and attempted to transfer herself out of the wheelchair when she fell . The facility documented interventions as: In-service (that alarm was to be on in bed and wheelchair and a matt at bedside when in bed), reviewed safety measures with resident, and physical therapy screening. 13. During an interview on 10/22/14 at 9:55 a.m., Resident #2's daughter said that she was told that Resident #2 fell in the bathroom because the staff member left her on the toilet and went to retrieve an item from the room. Resident #2's daughter said she had observed that it took a long time for staff to answer her mother's call light. She also stated the staff did not consistently implement fall prevention measures as sometimes her mat was by her bed and sometimes it was not. She said that she has observed the sensor pad alarm not even turned on and she has to turn it on. She said that Resident #2 gets tired of waiting on the staff to come and help her and she will always try to get up and go to the bathroom or try to get in bed from her wheelchair. Resident #2's daughter said that she and her sister have made complaints to the DON. She said they always say they will take care of it, but there had not been improvement. 14. During an interview on 10/22/14 at 3:45 p.m., CNA C said that she worked with Resident #2 but was not involved in the incidents when Resident #2 fell in the restroom. CNA C said that Resident #2 was known to get up and try to transfer herself when not supervised closely. She said that most of the time, Resident #2 tried to do this when she wanted to go to the restroom or if she wanted to get back in bed from her wheelchair. She said Resident #2 did not just randomly try to get out of bed for no reason. She said that Resident #2 must be closely supervised on the toilet because as soon as she is finished she will stand and try to pull her pants up. She said Resident #2 had only one good arm, so this would always throw her off balance. CNA C said Resident #2 did use her call light. 15. During an interview on 10/23/14 at 9:40 a.m., CNA H said she worked with Resident #2 but was not involved in either of the incidents that occurred in the restroom recently. She said that when taking Resident #2 to the restroom, she assists the caregiver and follows instructions. CNA H said, She's not hard to assist or monitor. She said that Resident #2 would hold on to the rail in the bathroom and would stand while the CNA lowered her pants. Then Resident #2 would sit on the toilet. CNA H stated she stands right next to Resident #2 and assists her off the toilet. CNA H said Resident #2 had not been observed leaning to the side while on the toilet when she had worked with her. CNA H stated she believed that the CNAs had to have left Resident #2 in the restroom alone, because there was no way Resident #2 could fall off the toilet if the CNA was beside her. CNA H said, Somebody's lying, I'm sorry. 16. During an interview on 10/23/14 at 10:35 a.m., CNA I said she had lowered Resident #2 to the floor in the restroom on 10/4/14. She said she had placed Resident #2 on the toilet and turned her back to move a fall matt that had been propped against the wall because it was in her way. She said that while turned around, Resident #2 began leaning on the toilet, and could not be kept from falling so CNA I had lowered her to the floor. An observation in Resident #2's room (accompanied by CNA I) on 10/23/14 at 10:45 a.m. revealed Resident #2's restroom was very spacious, with room for a chair situated next to the toilet. The resident's fall mat was beside her bed and it was a very large thick mat. CNA I acknowledged this mat would not have fit in the restroom against the wall and she said it must have been one of the gray mats that was in the bathroom at that time. CNA I pointed out where she was standing and turned around to move the mat. Based on this observation, CNA I would have remained within arms' length distance to the resident when she turned from facing the resident. 17. During an interview 10/23/14 at 2:30 p.m., the Director of Nursing said that they had just in-serviced the staff to be sure and stay with the resident in the restroom, and continued previous interventions of fall alarm, mat, low bed, and not leaving the resident in her room unless she was put to bed. She did not identify how the facility addressed the problem that Resident #2 continued to fall despite these interventions and the in-service. Resident #3 18. An undated admission record documented Resident #3 was a [AGE] year-old female admitted to the facility on [DATE] with intracranial hemmorhage, depression, hypertention, aphasia, dysphagia, anxiety, [DIAGNOSES REDACTED] dominant side, history of stroke, diabetes, and abnormal gait. A physician's note dated 1/14/14 also documented [DIAGNOSES REDACTED]. A care plan problem dated 9/4/14 documented that Resident #3 had cognitive deficits with poor safety awareness, unsteady gait, attempts to stand unassisted, history of previous falls, impulsiveness, and right [DIAGNOSES REDACTED]. Interventions included a sensor pad alarm in her chair and bed, fall mats while in bed, and to keep commonly used items within her reach. A fall risk assessment dated [DATE] documented a score of 19 which indicated Resident #3 was at high risk of falls. 19. an incident report dated 10/8/14 documented that Resident #3 was found laying on the floor directly next to her bed and she fell while leaning for something on her bedside table. 20. During an observation and interview with Resident #3 in her room on 10/23/14 at 2:10 p.m., she was observed sitting in her wheelchair next to her bed. Her light was not on and the room was very dim. Resident #3 spoke in short sentences and when asked if she was okay, she said, nope. When asked what she needed, she said she needed a drink and pointed to an over-bed table that was just out of her reach. A plastic water bottle was sitting on the table. There was a sensor pad alarm attached to her wheelchair and observation revealed the green light was not blinking and the alarm did not appear to be activated. Resident #3's call light was turned on. Ten minutes later, CNA J entered the room. He gave Resident #3 the water bottle. His attention was called to the sensor alarm. He looked at it and said it was turned off. He turned a switch on the alarm and the alarm showed a green blinking light. CNA J said that he had just come on duty for the 2:00 to 10:00 p.m. shift, and the off-going CNA must have left the alarm off. 21. A policy and procedure titled Falls-Evaluation and Prevention effective 1/2008 and revised 3/2012 which was provided by the DON 10/23/14 at 1:15 p.m. included the following: A fall is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. Following a fall.Review the plan of care and update the interventions as appropriate. Intervention suggestions for fall prevention .evaluate and implement toileting program if indicated .provide adequate lighting. .Ensure personal items and water is within easy reacy 22. The DON provided a list of residents at high risk for falls on 10/22/14 at 2:00 p.m. The list contained 23 residents.