STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675231**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/13/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JACINTO CITY HEALTHCARE CENTER	**1405 HOLLAND HOUSTON, TX 77029**

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 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F223 Based on interview and record review, the facility failed to ensure the right to be free from physical and verbal abuse was provided for 5 of 8 residents reviewed for abuse (Residents #6, #8, #5, #3 and #7) as evidenced by: Resident #6 was grabbed by her wrist/ arm and hand by Medication Aide (MA) B and Resident Care Specialist (RCS) K to prevent her from entering her room. RSC I handled Resident #8 roughly when she changed his brief by pulling him by one leg to reposition him in bed. RCS M verbally abused Resident #5. He took her call light away and told her that it would not help her get water. Resident #5 was scared of RCS M. RCS G was rude and mean to Resident #3. RCS G was rude and refused to tell Resident #7 her name. An IJ was identified on 01/08/2016. While the IJ was removed on 01/13/2016, the facility remained out of compliance at a scope of pattern and a severity level of actual harm due to the facility needing more time to monitor the plan of removal for effectiveness. These failures affected five residents and placed 105 residents at risk for mistreatment, abuse and neglect. Intake #: 8, 0, 8, 2 Findings Include: Resident #6 Record review of Resident #6 ' s face sheet revealed resident is a [AGE] year old female with an admission date of [DATE]. Diagnoses: [REDACTED]. Record review of Resident # 6 ' s Care Plan dated 7/02/2014 with a review date of 10/15/2015 revealed: Resident #6 had moderate cognitive impairment due to short-term and long-term memory loss. Approach: Staff will offer options in simple terms regarding care for resident to choose, Provide time to think/react. Resident #6 was care planned for falls. Approach: Falling Star Program, Encourage resident to ask for assist, orient resident to environment, bed alarm, chair alarm, place call light in reach, observe for `potential patterns of falls to identify possible causes, Offer/assist to toilet frequently and as accepted, place frequently used items within reach, and observe for potential medication related causes. Resident #6 had [DIAGNOSES REDACTED]. Approach: Administer medication as ordered, fall risk assessment, fall prevention protocol as indicated, call bell within reach, notify MD as indicated. Observation on 1/06/2016 at 2:59pm revealed that there was no Falling Star above the Resident ' s door or above her bed to identify her as a fall risk. Observation on 1/06/2016 at 3:15pm revealed Resident #6 sitting in wheelchair attempting to enter her room but was not able to as medication cart was blocking the entrance to her room. Surveyor intervened and informed MA B that Resident #6 was trying to enter her room but could not due to the medication cart blocking entrance to room. MA B said he was aware she wanted in the room and that is why he had the cart there to block the entrance to prevent her from going in the room. He further revealed she was a fall risk and did not want her in the room. Observation on 1/06/2016 at 3:19pm revealed Resident #6 in her wheelchair wedged between medication cart and door to her room. Surveyor intervened and informed MA B and RCS K that Resident #6 was wedged between medication cart and door to her room. MA B and RCS K went over to Resident #6 and moved the cart and told Resident #6 she could not go to her room at this time. Resident #6 grabbed the handrail and tried to wheel herself into her room. Resident #6 said she wanted to look at the box in her closet. MA B and RCS K told her she was not able to go into her room at this time. Resident #6 would not release handrail as she continued to try and wheel herself into her room. MA B grabbed Resident #6 ' s wrist/arm and tried to pull her hand off the railing. RCS K then began prying Resident #6 ' s fingers from the handrail. The DON walked by and quickly removed MA B and RCS K from Resident #6. MA B and RCS K told the DON that they did not want Resident #6 in her room because she would make a mess and take things out of her closet and she was a fall risk. DON informed MA B and RCS K that Resident #6 had the right to enter her room. Interview on 1/06/2016 at 3:30pm with the DON revealed that she performed an assessment on Resident #6 and found no injuries. She further revealed that MA B and RCS K acted inappropriately and should have allowed her to enter her room or they could have tried redirecting her. The DON said they should not have grabbed Resident #6's hand or arm. The DON said staff would be in-serviced in Abuse/Neglect. The DON revealed that she was sure staff had training on Dementia but was not sure of the date. In an interview with RCS K on 1/06/2016 at 3:35pm she said that she was trying to re-direct Resident #6 because she did not want her in the room because Resident #6 was a fall risk. In an interview with Resident #6 at 3:45pm she said that MA B and RCS K hurt her wrist. Resident #6 said no one had ever grabbed her arm like that before. She said she just wanted to look in the box in her closet. Observation on 1/06/2016 at 3:45 pm revealed redness to Resident #6 ' s right wrist. Record review of MA B ' s written statement dated 1/06/2016 revealed at about 3pm, he was by the Med Aid Cart, and was about to move it. He was told by the RCS K not to move it because Resident #6 was a fall risk. Resident #6 tried to wheel herself in her room. As she tried to go inside, the RCS K grabbed her hand, telling her not to go in her room for her safety. He only touched the resident and nothing more. Record review of RCS K ' s written statement dated 1/06/2016 revealed that Resident #6 was trying to enter her room and RCS K intervened by trying to stop her because she was a fall risk. RCS K's written statement further revealed that she spoke to Resident #6, and touched her hand trying to redirect her away from the door because she was a fall risk. In an observation and interview with Resident #6 on 1/07/2016 at 9:40am she revealed she had three small bruises on her right wrist purple in color and in the shape of finger prints. Resident #6 said she had pain to her right wrist. In an interview with the Director of Nursing (DON) on 1/07/2016 at 9:45am she revealed she was aware not aware of bruising. The DON said she would assess Resident #6 and administer Tylenol per orders for her pain to her right wrist. In an interview with DON on 1/07/2016 at 10:00am she verified that there were 3 small bruises to Resident #6 ' s right wrist. The DON said she had not noticed them before because they were under the wander guard. Record review of Provider Investigation Report dated 1/07/2016 completed by DON read: Description of Allegation- The DON was walking down the hall towards room. Resident #6 was grabbing onto the door frame trying to pull herself into the room, RCS

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 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1)

K was asking the resident where she was going, and reached towards residents hand, The DON could not see what RCS K did with the resident's hand because the resident's body and wheelchair were blocking my view. However, MA B then reached over and put his hand around the resident ' s wrist to prevent her from grabbing onto the other door frame, causing resident to become agitated. The DON intervened with the staff explaining to them resident ' s rights and allowed resident into her room to access items in her closet and then redirected her back to into the activity room. The DON removed both staff members from the floor, began education, and notified the administrator of the incident.
Resident #8
Record review of Resident #8 ' s face sheet revealed a [AGE] year old male with an admission date of [DATE]. Diagnoses: [REDACTED].
Record review of Resident #8 ' s MDS dated [DATE] revealed resident was moderately impaired for cognitive skills for daily decision making. He was assessed as not having problems with moods or behaviors, needed extensive assistance of one to two staff members for all activities of daily living (ADL) except eating for which he required supervision only. Under the section for functional limitation in range of motion he was assessed as impairment on both sides for upper and lower extremities.
Record review of Resident #8 ' s Care Plan dated 6/30/2015 with a review date of 10/29/2015 revealed resident was at risk for falls. Approach: Falling Star program, encourage resident to ask for assistance, place call light in reach, place frequently used items within reach.
In an interview on 1/10/2015 at 1:40pm with Administrator revealed Resident #8 was identified as having concerns with caregivers. Administrator said resident was not able to understand the RCS ' s in his room because they were speaking Spanish. Administrator said that Resident #8 ' s roommate spoke Spanish and told the RCS in Spanish not to hurt Resident #8 or he would report them.
In an interview with Resident #8 at 3:00pm he said that one of the RCS ' s was rough with him while trying to change his brief. Resident #8 said RCS grabbed him by one leg and spun him around in bed so she could change his brief. Resident #8 further revealed that same RCS had pushed him into the bed before. Resident #8 was not sure of RCS ' s name. He said he had not seen her in about 4 days.
In an interview with the DON on 1/10/2016 at 3:30pm she said we was not sure who the RCS was that Resident #8 was talking about, but she would find out.
In an interview with the DON on 1/11/2016 at 11:40am she revealed that RCS G, RSC I and RCS H were all in Resident #8 ' s room when incident occurred and RSC H had provided a written statement.
In a telephone interview on 1/13/2016 at 12:15pm with RCS H she said she was passing by Resident #8 ' s room and heard noise. RCS H said she opened the door and the curtain was drawn. She said RCS I was turning Resident #8 and moved his leg. She said she told RCS I to move Resident #8 slowly. RCS H said RCS I responded with That ' s not how I do it . When RCS H was asked if she did anything regarding the treatment of [REDACTED].
In a telephone interview on 1/13/2016 at 1:00pm with RCS G she said RCS I was changing Resident #8 and she was in the room to assist. RCS G said Resident #8 hollers every time he was changed. RCS G said that when RCS I turned Resident # 8 he screamed that something was wrong with his leg RCS G further revealed that the Resident #8 ' s roommate heard Resident #8 screaming and roommate told them he was going to report them for being mean to Resident #8.
In a telephone interview on 1/13/2016 at 1:20pm with RCS I she said she was in the room with RCS G who was giving Resident #8 a bed bath. RCS I said RCS H was also in the room to translate for Resident #8 ' s Spanish speaking roommate. RCS I said the roommate said in Spanish that he was going to report them for being mean to Resident #8 if they didn ' t stop.
Resident #3
Record review of Resident #3 ' s face sheet revealed a [AGE] year old female with an admitted [DATE]. Diagnoses: [REDACTED]. Face sheet further revealed Resident #3 was her own legal guardian.
Record review of care plan dated 7/15/15 with a review date of 10/15/15 revealed resident was care planned for Depression/Anxiety. Approach: Provide calm, reassuring environment, encourage resident and staff to be alert to events or situations that precipitate episodes of restlessness or anxiety, calm and reassure as needed, modify environment to promote calm and comfort.
In an interview with Resident #3 on 1/08/2016 at 1:40pm she said that RCS M was rude and mean to her. She further revealed that she doesn ' t put up with it and takes care of it herself by telling him off. Resident #3 further revealed she did not like it when RCS M was assigned to her hall and she was scared of him. Resident #3 had witnessed RCS M speak rudely to her roommate (Resident #5) and take her call light away so she would not be able to use it and stated her roommate was also scared of RCS M. Resident #3 said she had mentioned it to previous administrator and RCS M was moved to a different hall but now he was working on her hall again andshe was worried he might come into her room.
In an interview with the DON on 1/08/2016 at 1:50pm she said she was aware of the incident involving Resident #3 and RCS M. She said RCS M had been removed from the floor and suspended pending investigation.
Resident #5
Record review of face sheet for Resident #5 revealed an [AGE] year old female who was admitted to facility on 12/02/2015. Diagnoses: [REDACTED].
Record review of MDS dated [DATE] revealed a BIMS score of 8. MDS further revealed that Resident #5 required extensive assistance with bed mobility and dressing. MDS revealed Resident #5 was total dependence for toileting.
Record review of Resident #5 ' s care plan dated 12/2/15 with a reviewed date of 12/17/15 revealed Resident #5 was care planned for falls. Approach: Place call light in reach, full body lift-hoyer, use calm, patient approach when using mechanical lift.
Record review of Resident #5 ' s care plan dated 12/4/15 with a reviewed date of 12/17/15 revealed Resident #5 was care planned for falls. Approach: Falling Star Program, place call light in reach, place frequently used items in reach, offer/assist to toilet frequently and as accepted.
Record review of Resident #5 ' s care plan dated 12/8/15 with a reviewed date of 12/17/15 revealed resident was care planned for anxiety. Approach: Administer medication as ordered, Monitor for side effects to medication, notify MD as indicated, monitor for effectiveness, refer to social services as indicated, and refer to psych services as indicated.
Interview on 01/06/16 at 1:30pm, Resident #5 said RCS M came into her room (date and time not provided) and told her, Here is your damn soup. He then told her he was not going to get her out of this damn bed.
In an interview on 1/06/2016 at 1:45pm Resident #5 said she didn ' t like it when that mean man would come into her room. She said that whenever she used her call light he would come in the room and take it away. She said that RCS M told her This call light won ' t get you water and then took the call light away and placed it out of her reach. Resident #5 said she told the previous administrator and RCS M was moved to another hall but she sometimes will see him on her hall and is very worried he might hurt her.
In an interview on 1/06/2015 at 1:50pm Resident #5 ' s roommate (Resident #3) said that everything Resident #5 said was true. Resident #3 said she had witnessed him speaking rudely to Resident #5 and had witnessed him take her call light away.
In an interview with the DON on 1/08/2016 at 1:50pm she said she was aware of the incident involving Resident #5 and RCS M. She said RCS M had been removed from the floor and suspended pending investigation.
Resident #7
Record review of Resident #7 ' s clinical record revealed a [AGE] year old male with an admission date of [DATE]. Diagnoses: [REDACTED].
Record review of Resident #7 ' s MDS dated [DATE] revealed a BIMS score of 13 which indicated no cognitive impairment. The MDS assessment further revealed that Resident #7 required extensive assistance for bed mobility and personal hygiene. Resident #7 was total dependence for transfer and toilet use.
Record review of care plan dated 12/21/15 with a reviewed date of 1/7/16 revealed resident was care planned for falls. Approach: Falling Star Program, encourage resident to ask for assistance, place call light in reach, place frequently used items within reach, offer/assist to toilet frequently and as accepted.
In an interview with Resident #7 on 1/11/ at 11:25am he revealed that RCS G was rude and spoke aggressively towards him. He also said that when RCS G enters the room she refused to give her name. Resident #7 also said that when he used the call light for pain medication RCS G just entered the room, turns off the call light and leaves the room. Resident #7 said she never returns to let him know if she told the nurse he needed something for pain.

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) In an interview with DON on 1/11/2016 at 11:35am she said she was aware of the incident involving RCS G and incident was being investigated. The DON further said that she double checked the Medication Administration Record [REDACTED]. The DON also said staff would be receiving sensitivity training now and quarterly. In a telephone interview with RCS G on 1/13/2016 at 1:00pm she said that she took care of Resident #7 on Friday. She asked the nurse to tell Resident #7 that she was the only RCS on his hall. RCS G said that Resident #7 reported that she did not let him know when she tells the nurse he needs medicine for pain. She said she was not aware that she had to report back to him. She stated My tone is high sometimes, maybe I come off rude Record review of in-service dated 12/22/2015 revealed staff was in-service on reporting abuse and able to assess the need to report. Record review of in-service dated 12/31/2015 revealed staff was in-service on understanding abuse. Record review of in-service dated 1/06/2016 revealed staff was in-serviced on Dementia care and communicating with dementia residents. Record review of Dementia, resident communication, long term care policy with revised date of October 02, 2015 provided by facility read: -Visual strategies; Approach the resident from the front, in his vision field, smile, present objects or written cues to focus attention on the communication topic, provide contextual and environmental cues; use colors, highlighting, enlargement, pictures, drawings, and symbols. -Auditory strategies; use calm, positive, unhurried speech, state the person ' s name and yours to increase a sense of familiarity, use praise and compliments befitting an adult. -Tactile Strategies; use touch to reassure, use touch to guide, lead, redirect, and prompt desired behavior, use familiar objects as reminders. In an interview on 01/06/16 at 11:30 am with RCS N revealed that she was not sure if she had been trained on working with residents with dementia. In an interview with Housekeeper F on 01/09/16 at 8:50am revealed that he had been working at the facility for two weeks and had not been trained on abuse or neglect. He was not sure who the abuse prohibition coordinator was and had not been trained on residents with dementia. Interview on 01/09/16 at 9:10am with Licensed Vocational Nurse (LVN) D revealed she had worked at the facility for three weeks and had not been trained or in-serviced on abuse and neglect or working with residents with dementia. Record review of Suspected resident abuse assessment, long-term care dated October 02, 2015 provided by facility read: -Residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. -The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. -The facility must not employ individuals who have been found guilty by court of law of abusing, neglecting, or mistreating residents or who have had a finding entered into the state nursing assistant registry concerning abuse, neglect, or mistreatment of [REDACTED]. -The facility must report to the state ' s nursing assistant registry or licensing authorities any knowledge it has of actions by a court of law against an employee that would indicate unfitness for service as a nursing assistant or other facility staff member. -The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of a resident ' s property, are reported immediately, through established procedures, to the facility administrator and to other officials in accordance with state law. -The facility must have evidence that all alleged violations have been thoroughly investigated and must take precautions to prevent further potential abuse while the investigation is in process. An immediate jeopardy (IJ) was identified on 01/08/16 at 2:13 pm and the Administrator was informed at that time. A Plan of Removal (POR) for the IJ was submitted on 01/09/16 at 12:40pm and after several revisions were made it was accepted on 01/12/16 at 4:13pm. The POR included in part: Immediate Action: 1.The Interdiscplinary Team interviewed 69 interviewable residents, provided a copy of Resident ' s Rights to voice concerns and to be free of retaliation. copy of the DADS Hotline phone number and Compliance Hotline phone numbers to report any concerns. They were re-educated regarding where the phone numbers were posted in the facility for DADS Hotline and Compliance Hotlines. 2. The DON and Charge Nurses conducted Head to Toe skin checks on 37 non-interviewable residents and found no concerns following the completion of the assessment. 3. The facility mailed copies of the Resident Rights, DADS Hotline phone number and the company ' s Compliance Hotline phone numbers to the resident ' s responsible party / family member. 4. To protect non-interviewable residents from abuse included the following actions: Certified Nursing Assistants will utilize the Stop & Watch tool following all ADL care to alert the charge nurse of any changes they observe. Charge nurses will conduct weekly head to toes skin checks. Charge nurses will monitor residents for changes in behavior and complete the SBAR if they have a concern and notify the family and physician. 5. Using the care path \interact process on Fall Do Not Move Resident From The Floor Until Complete Assessment Is Done and visual assessment is done. The assessments include AROM and PROM and visual observation of any limb shortening or internal or external rotation of any obvious sign of fracture. The staff will do the following: a. Take vital signs - temperatures, BP, pulse, b. If vital signs- critical is not met per (care path) then proceed with initial nursing evaluation for injuries and \ or mental status change. Do not move off the floor until complete exam has been performed. c. Determine if suspected fracture or new bone deformity, head trauma, altered manta, (decrease LOC, unresponsiveness, suspicious of [MEDICAL CONDITION] new or worsen cognitive impairment), laceration required sutures\staples if yes notify MD\NP\PA and transfer via EMS. 6. If resident falls and has any complaints of [MEDICAL CONDITION] or spinal injury, head trauma, perform Neurological assessment at the scene of fall If any abnormalities call EMS and send resident out. Do not move resident. A complete report and notify MD via telephone. If no answer within one hour,, the Medical Director will be contacted. The RP\facility will be notified Training: The DON and the District Director of Clinical Services conducted re-education training for all Nursing, Dietary, Housekeeping, Laundry and Department Manager personnel January 8, 9 and 10, 2016. Training topics included were : Abuse and Neglect Prohibition Assessment of discomfort in Dementia Protocol Change in Condition Emergency Transports via 911 versus Non-emergency transfers. Abuse and Neglect Prohibition training included a review of the facility ' s policy on abuse and neglect prohibition. The training was provided by the Director of Nursing Services and the District Director of Clinical Services. The training was presented in an oral fashion with examples provided of how abuse and neglect are defined, prevention techniques, identification, investigation, protection and reporting responsibilities. Abuse and Neglect Prohibition training began January 8, 2016 and ended for all staff that were scheduled to work thru January 10, 2016 including RN ' s, LVN ' s, Certified Nursing Assistants, Certified Medication Aides, Staff Development, Nurse Managers, Rehab Staff, Dietary, Housekeeping and Laundry Staff and Department Managers. Staff that were not able to attend any of the training offered between January 8 thru January 10, 2016 will not be allowed to work with residents until they have been re-educated on the facility ' s Abuse and Neglect Prohibition policy. The Assessment of discomfort in Dementia Protocol training included a review of how physical pain and affective discomfort

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F 0223

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 3)
experienced by people with dementia can be managed. The training was provided by the Director of Nursing Services and the District Director of Clinical Services. The training was presented in an oral fashion with examples provided of how the Assessment of Discomfort protocol should be applied when staff encounter situations with affected residents. Staff were trained on the steps they should follow which include:
Conducting a physical evaluation
Review residents history for potentially painful conditions
Evaluating the discomfort and initiating non-pharmacologic comfort interventions
Evaluate for pharmacologic interventions that are not [MEDICAL CONDITION]
The Assessment of discomfort in Dementia Protocol training began January 8, 2016 and ended January 10, 2016 for RN ' s, LVN ' s, Certified Nursing Assistants, Certified Medication Aides, Physical Therapy, Occupational Therapy and Speech Therapy staff. Staff that were not able to attend any of the training offered between January 8 thru January 10, 2016 will not be allowed to work with residents until they have been re-educated on The Assessment of Discomfort in Dementia Protocol program.
The facility ' s policy for identification of change of condition requires the implementation of the Stop & Watch tool as well as Interact 4.0. These decision support tools provide reporting guidance to licensed nurses on whether specific symptoms, signs, and lab results are immediate versus non-immediate, or next day, for reporting purposes to the primary care clinician. Using the Interact 4.0 tool the licensed nurse can determine immediacy of reporting for vital signs, laboratory results and diagnostic procedures.
The Director of Nursing Services was re-educated on Stop & Watch and Interact 4.0 on January 9, 2016 by the District Director of Clinical Services.
The Director of Clinical Services and the Director of Nursing Services re-educated RN ' s, LVN ' s, Unit Managers, ADON ' s, Staff Development, Certified Nursing Assistants, Certified Medication Aides, Physical Therapy, Occupational Therapy, Speech Therapy and MDS nurses January 9 and 10, 2016 on the Stop & Watch and Interact 4.0 programs. Staff that were not able to attend any of the training offered between January 8 and 9, 2016 will not be allowed to work with residents until they have been re-educated on the facility ' s Stop & Watch and Interact 4.0 programs.
The licensed nurse will evaluate each situation based on individual resident condition at the time of the event. Once a medical emergency is identified, qualified staff evaluate the resident; initiate the appropriate emergency procedure(s), and calls 911. The licensed staff continues to provide care and monitor the resident until the emergency personnel arrive.
The surveyors confirmed the POR had been implemented sufficiently to remove the IJ by:
Record Review of the In-Service sign-in sheet revealed that staff from the nursing department representing all three shifts had been in-serviced from 01/08/16 until 01/10/16. The topics included in part: Abuse and Neglect, Dementia Resident.
Observations were made from 01/08/06 until 01/10/16 to that staff -resident interaction was appropriate, for any residents that have a change in condition/falls and care of residents with dementia.
Interviews conducted from 01/08/16-01/10/16 between 4:30am to 4:00 pm daily with RCSs and Nurses on various shifts revealed staff were able to verbalize the information from the recent in-services regarding abuse and neglect and care of a resident with dementia.
The Administrator and DON were informed on 01/13/16 at 1:35pm that the IJ was lowered; however the facility remained out of compliance at a pattern level and a severity of actual harm that is not immediate jeopardy due to facility needing more time to monitor the plan of removal for effectiveness.
Facility 672 dated 1/06/2016 revealed a census of 110.

F 0224

Level of harm - Immediate jeopardy

Residents Affected - Many

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 observations, interviews and record review the facility failed to implement their policy and procedures that prohibit mistreatment, neglect and abuse for two (Resident #1,and #4) of eight residents reviewed for neglect and abuse.
Resident #4 suffered a fall with lacerations to the head on 1/6/2016 and was not assessed appropriately after change in condition. He became non-responsive on 01/08/16 around 11:00am, the facility did not assess the resident appropriately and called for a non-emergency ambulance versus calling 911. The resident remained in the facility uintil 4:11pm.
Resident #1 had an un-witnessed fall while out on pass. He was not assessed upon return to the facility. After the Hospital Nurse assessed the resident and told the facility he had the fall and injuries he was sent to the hospital. He was found to have a fracture to his cervical spine.
An IJ was identified on 01/08/2016. While the IJ was removed on 01/13/2016, the facility remained out of compliance at a scope of pattern and a severity level of actual harm due to the facility needing more time to monitor the plan of removal for effectiveness.
These failures affected two residents and placed 108 residents at risk for mistreatment, abuse and neglect.
Intake #: 8, 0, 8, 2,
Findings Include:
Resident #4
Record review of Resident #4 ' s face sheet revealed a [AGE] year old male with an admission date of [DATE]. Diagnoses: [REDACTED].
Record review of Resident #4 ' s MDS dated [DATE] revealed a BIMS score of 12 which indicated moderate cognitive impairment, required one person assist with bed mobility, dressing, and toilet use.
Record review of Resident #4 ' s Care Plan dated 12/14/2015 with a reviewed date of 12/23/15 revealed:
Resident #4 had Cognitive Deficit; Resident had moderate independence with decision making. Resident had difficulty with making decisions in new situations. Approach: Provide clear choices and adequate information for resident to make decisions, Point out consequences of bad decisions, involve family members in decisions regarding important matters.
Resident #4 was at risk for falls due to: history of previous falls, non-ambulation, blood pressure changes, and [MEDICAL CONDITION]. Approach: Falling star program, encourage resident to ask for assistance, physical therapy, occupational therapy, provide assistive devices such as wheelchair, place call light in reach, observe for potential patterns of falls to identify possible causes, and place frequently used items within reach.
Resident #4 was care planned for, [DIAGNOSES REDACTED]. Approach: Administer medication as ordered, fall risk assessment, fall prevention protocol as indicated, call bell within reach, notify MD as indicated.
In an interview with Resident #4 on 1/6/16 at 9:40am he said he was at the facility for therapy and was feeling alright today. Observation at the same time revealed resident was well groomed, very talkative and alert, lying in bed with head of bed elevated. His call light was within reach. There were no falling star above the bed or doorway entrance to signify that Resident #4 was a fall risk.
Record review of Interdisciplinary Post Fall Report dated 1/6/2016 revealed Resident #4 suffered a fall at 11:00am on 1/6/2016. Record further revealed that Resident #4 ' s fall occurred in the dining room and LVN A was called to the dining room where she found resident lying on floor on his right side. Resident #4 was assessed by LVN A and assisted to wheelchair and then to bed. Record further revealed Resident #4 sustained an open area to the back of the head and right wrist.
Record review of Incident/Accident Investigation Follow-up dated 1/6/16 revealed Resident #4 fell in dining room and LVN A was called to dining room by staff where LVN A found Resident #4 on the floor on his right side. Summary of investigation read: Resident stated he leaned forward to get up and fell to the floor. Past Interventions read: New resident to facility, no history of falls. Recommendations: encourage resident to ask for assistance avoid attempting to get up on his own.
Record review of Resident #4 ' s Interdisciplinary Post Fall Review completed by LVN A and dated 1/6/16 read: Predisposing Diseases: Dementia.
In an interview on 1/6/16 at 2:20pm with LVN A she said she was called to dining room and found Resident #4 lying on his side on the floor. LVN A said she assessed Resident #4 and found 2 lacerations to the back of his head and he had a skin tear to his right arm. Resident #4 was assisted to the wheelchair and then assisted to his bed. LVN A said she started

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JACINTO CITY HEALTHCARE CENTER	**1405 HOLLAND HOUSTON, TX 77029**

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(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 - Many

(continued... from page 4)
neuro vitals and notified the physician of the fall. She further said that orders were received for Tylenol 650mg for discomfort, wound care orders for skin tear of right arm and both wounds to head. LVN A said no orders were received for CT (cat scan).
Record review of Resident #4's physician's orders [REDACTED].monitor neuro checks every 15 minutes for one hour, every hour for four hours and then every four hours for 24 hours and every eight hours for 72 hours.
Record review of Resident #4's Neurological Record read in part: frequency every 30 minutes for four hours, every one hour for four hours, every four hours for 24 hours, every eight hours for remaining 72 hours or as ordered by physician .neuro vital signs were done starting on 01/6/16 at 11:15am and ended on 01/07/16 at 10:30am.
Record review of Resident #4's Neurological record dated 01/6/16-01/7/16 revealed neither the physican's order nor the instructions on the Neurological Record in regards to frequency was followed.
In an interview on 01/7/16 at 9:30am with Resident #4, he said he was not feeling well and that he was hurting all over.
In an interview with Resident #1 (Resident #4 ' s roommate) on 01/7/16 at 9:30am he said that immediately after hitting his head Resident #4 was not the same. He said Resident #4 did not act the same and he stayed in bed and did not eat.
Interview on 01/7/16 at 9:40am LVN A when it was reported to her that Resident #4 was hurting all over she said she would assess him.
Interview on 01/7/16 at 10:00am LVN A said Resident #4 was fine he was just tired.
Interview on 01/7/16 at 10:15am with Resident #1 he said Resident #4 was not fine. He said Resident #4 had been tossing and turning all night and was in pain and did not sleep.
Observation on 01/7/16 12:00pm revealed Resident was resting with his eyes closed.
Observation and interview on 01/7/16 at 4:00pm revealed Resident #4 was in bed and not feeling well. He said he did not feel like getting out of bed.
Observation on 01/8/16 at 8:00am revealed Resident #4 was in bed with his eyes closed. His breakfast tray was beside his bed untouched.
Record review of nurse ' s notes dated 1/8/2016 at 12:15pm read: placed call to hospital, spoke to emergency room nurse. Report given. Went to Resident #4 ' s room, made resident aware he would be transferred to hospital.
Observation and interview on 01/08/16 at 1:00pm revealed Resident #4 was in bed with eyes closed and did respond to verbal stimuli. His RP was at his bedside and said he would not wake up and shook his shoulder, Resident #4 did not respond. His lunch tray was at his bedside untouched. The RP said the Hospital Nurse told him that she would inform the Nurse at the facility that Resident #4 needed to be sent back to the hospital for evaluation.
In an interview on 1/8/16 at 3:14pm with Resident #4 ' s Responsible Party (RP) revealed that Resident #4 did not have a [DIAGNOSES REDACTED]. Resdident #4's RP further revealed that he was not notified of Resident #4 ' s fall until he arrived at facility on 1/06/2016 after lunch time. He said LVN H told him they did not have his phone number in Resident #4 ' s chart. The RP said that Resident #4 was not acting like his self and had been acting different since the fall. The RP said that he arrived at facility at 11:00am today and Resident #4 would not wake up and his breakfast had not been eaten. He said he informed the nurse of Resident #4 ' s condition and she assessed him and said she would call the physician. The RP said LVN H told him that Resident #4 would be transferred to hospital for evaluation but that was over 3 hours ago and Resident #4 still had not woken up.
Observation on 1/8/ at 3:14pm of Resident #4 revealed he was lying in bed with head of bed elevated. Resident ' s lips were dry and cracked and lunch was at bedside and had not been eaten. Resident #4 did not respond to verbal stimuli. The RP shook Resident #4 by the shoulder and Resident #4 did not respond.
In an interview with LVN H on 1/8/16 at 3:30pm she said that she had notified physician of change in mental status and Resident #4 was to be transferred to hospital. She further revealed that she contacted several ambulance companies and chose the one with the least estimated time of arrival. When asked if she called 911 for Resident #4 due to non-responsiveness, she said no. She said this was not an emergency situation.
In an interview with the DON on 1/8/16 at 3:35pm she revealed she was unaware that LVN H had not called 911. She was aware of change in condition on 1/7/16 and had requested an order from physician for x-ray of skull on 1/7/16. She further revealed that Resident #4 did not become unresponsive until 1:00pm on 1/8/16. DON said she would have ADON call 911 immediately for transfer.
Record review of nurse ' s notes dated 1/8/16 at 12:00pm said hospital nurse was visiting with Resident #4 and family. Hospital nurse requested that nurse on duty to assess Resident #4. Resident #4 said he was not feeling well. VA Nurse remained at bedside. Call was placed to physician regarding assessment and Resident #4 not feeling well and also made aware of recent fall from wheelchair.
Record review of nurse ' s note dated 1/8/16 at 12:25pm read: placed call to ambulance service. The above report given to dispatcher. Stated will send ambulance right away. Made charge nurse aware.
Record review of nurse ' s note dated 1/8/16 at 12:30pm read: Resident in room. Son at bedside. Blood sugar (BS)=69. Call placed to MD. New order to give glucacon 1mg IM (intra-muscular)if resident not awake.
Record review of nurse ' s note dated 1/8/16 at 1:00pm read: BS=100. Resident responds to painful stimuli. Awaiting on transportation. Son at bedside. Vital signs: Blood pressure-138/76, respirations-20, pulse- 78.
Record review of nurse ' s note dated 1/8/16 at 2:00pm read: Responds to painful stimuli and moves all extremities. No sign or symptoms of pain or discomfort.
Record review of nurse ' s note dated 1/8/16 at 2:30pm read: Awaiting on transportation. Resident denies pain. Respirations even and unlabored. Vital signs: blood pressure-140/78, 80, 20, 97%.
Record review of nurse ' s note dated 1/8/16 at 3:00pm read: Resident responding to painful stimuli. No signs of distress. Respirations 20 per minute. Son at bedside and aware of change of condition.
Record review of nurse ' s note dated 1/8/16 at 4:50pm read: EMS personnel arrived. Blood sugar at this time is 71. Blood pressure 140/79, pulse 79, respirations 20, and temperature 97.8.
In an interview with DON on 1/8/16 at 5:10pm she said that ADON and LVN H both will be counseled on assessment, the depth of assessment, and starting interventions. She stated They both failed to assess with urgency .
Record review of emergency room visit dated 1/08/2016 revealed resident was [AGE] years old and presented to emergency department post fall 3 days ago. Patient is non-responsive. Per EMS, family says patient was not his normal self after fall. Primary Impression: Urinary Tract Infection. Secondary Impressions: Altered mental status, [DIAGNOSES REDACTED].
In an interview with Resident #4 ' s RP on 1/9/16 at 2:00pm he revealed that Resident #4 was diagnosed with [REDACTED]. RP said Resident #4 was still not alert.
In an interview on 1/11/16 at 3:00pm with Resident #4 at hospital, resident responded to verbal stimuli. Resident #4 said he was not feeling well and hasn ' t felt well since the fall. He said he is hoping to get better so he can return to his home.
Resident#1
Record review of Resident #1 ' s clinical record revealed a [AGE] year old male with an admission date of [DATE]. Diagnoses: [REDACTED].
Record review of Resident #1 ' s Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment.
Record review of Resident #1 ' s Care Plan dated 12/15/2015 revealed that he was at risk for falls. Approach: Falling Star Program, encourage resident to ask for assistance, place call light in reach, observe for potential patterns of falls to identify possible causes, offer/assist to toilet frequently and as accepted, place frequently used items within reach, observe for potential medication related causes.
In an interview on 1/06/2016 at 11:00am with Resident #1 he revealed that he had a fall while he was out on pass. He said he hit his head when he fell down 4-5 steps. Resident #1 said he fell on [DATE] and when he returned to the facility that same day, he did not tell any staff and the staff didn ' t ask about the bump and scratches to his forehead. Resident #1 said no one noticed the bump on his head and scratches until the hospital nurse came to visit him at the facility on 12/23/2015 . Resident #1 said the hospital nurse noticed immediately and she told the facility of the fall and his injuries. Resident further revealed that CT (cat scan) revealed a fracture to his neck and he needed to wear a neck brace. Observation at same time revealed resident was wearing neck brace per physician order.
In a telephone interview on 1/06/2016 at 10:00am with the VA Nurse she said that she was very concerned about Resident #1 ' s care and the assessment skills of the nurses at the facility. The VA Nurse said she noticed immediately that Resident #1

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 5)
had a large bump to his forehead along with scratches. She said she asked Resident #1 about the bump and scratches and he said he fell down some stairs while he was out on pass. The Hospital nurse said the facility was not aware of Resident #1's fall until she notified them on 12/23/2015.
Record review of nursing notes dated 12/23/2015 at 1:00pm revealed Resident #1 said he fell at home on 12/22/2015. Head to toe assessment performed. Resident #1 was alert and oriented. Small laceration on the forehead observed, scratch to the tip of nose. No bruising noted. Call placed to physician. No new orders received. Continue with Neuro vital signs, monitor for pain, bruising, redness or neurological change.
Record review of Neurological record dated 12/23/2015 revealed that Neurological checks were started at 12:45am on 12/23/2015 and continued to 5:30pm on 12/23/2015.
Record review of nurses note dated 12/23/2015 at 4:30pm revealed facility called VA Nurse regarding Resident #1 and his fall. Hospital nurse voiced concern regarding documentation of facility nurse and requested that hospital protocol be followed for falls with suspected head injuries.
Record review of the Situation, Background, Assessment and Recommendation (SBAR) Communication Form dated 12/23/2015 at 6:05pm revealed that Resident #1's physician was notified of fall while Resident #1 was out on pass 12/22/2015. Orders received from physician to send Resident #1 to emergency room for evaluation and treatment for [REDACTED].
Record review of CT report dated 12/24/2015 read: Diagnostic Impression; C3 cervical [MEDICATION NAME] process fracture: acute
Record review of physician order [REDACTED].
In an interview with the Director of Nursing (DON) on 1/8/2016 at 5:00pm she was unsure of policy regarding assessments of residents who go out on pass and how residents were monitored when they returned. The DON said she would find out.
In an interview with DON on 1/11/2016 at 3:30pm she said that residents should be assessed before going out on pass and when they return. She further said that when residents go out on pass that the residents must inform the nurse and sign out on the Out of Facility Release of Responsibility form and they sign in when they return so that they know the resident has returned. She further revealed that the nurse on duty signs the form as well.
Record review of Out of Facility Release of Responsibility form in Resident #1 ' s chart revealed Resident #1 signed himself out on pass on 12/18/15, 12/24/15, 12/28/15, 1/03/16, 1/04/16, and 1/07/16. There were no signatures by nurse or resident indicating that Resident #1 returned to facility on those days.
Record review of in-service dated 12/22/2015 revealed staff was in-service on reporting abuse and able to assess the need to report.
Record review of in-service dated 12/31/2015 revealed staff was in-service on understanding abuse.
Record review of in-service dated 1/06/2016 revealed staff was in-serviced on Dementia care and communicating with dementia residents.
Record review of Dementia, resident communication, long term care policy with revised date of October 02, 2015 provided by facility read:
-Visual strategies; Approach the resident from the front, in his vision field, smile, present objects or written cues to focus attention on the communication topic, provide contextual and environmental cues; use colors, highlighting, enlargement, pictures, drawings, and symbols.
-Auditory strategies; use calm, positive, unhurried speech, state the person ' s name and yours to increase a sense of familiarity, use praise and compliments befitting an adult.
-Tactile Strategies; use touch to reassure, use touch to guide, lead, redirect, and prompt desired behavior, use familiar objects as reminders.
In an interview on 01/06/16 at 11:30 am with RCS N revealed that she was not sure if she had been trained on working with residents with dementia.
In an interview with Housekeeper F on 01/09/16 at 8:50am revealed that he had been working at the facility for two weeks and had not been trained on abuse or neglect. He was not sure who the abuse prohibition coordinator was and had not been trained on residents with dementia.
Interview on 01/09/16 at 9:10am with Licensed Vocational Nurse (LVN) D revealed she had worked at the facility for three weeks and had not been trained or in-serviced on abuse and neglect or working with residents with dementia.
Record review of Suspected resident abuse assessment, long-term care dated October 02, 2015 provided by facility read:
-Residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
-The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
-The facility must not employ individuals who have been found guilty by court of law of abusing, neglecting, or mistreating residents or who have had a finding entered into the state nursing assistant registry concerning abuse, neglect, or mistreatment of [REDACTED].
-The facility must report to the state ' s nursing assistant registry or licensing authorities any knowledge it has of actions by a court of law against an employee that would indicate unfitness for service as a nursing assistant or other facility staff member.
-The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of a resident ' s property, are reported immediately, through established procedures, to the facility administrator and to other officials in accordance with state law.
-The facility must have evidence that all alleged violations have been thoroughly investigated and must take precautions to prevent further potential abuse while the investigation is in process.
An immediate jeopardy (IJ) was identified on 01/08/16 at 2:13 pm and the Administrator was informed at that time.
A Plan of Removal (POR) for the IJ was submitted on 01/09/16 at 12:40pm and after several revisions were made it was accepted on 01/12/16 at 4:13pm.
The POR included in part:
Immediate Action:
1.The Interdiscplinary Team interviewed 69 interviewable residents, provided a copy of Resident ' s Rights to voice concerns and to be free of retaliation. copy of the DADS Hotline phone number and Compliance Hotline phone numbers to report any concerns. They were re-educated regarding where the phone numbers were posted in the facility for DADS Hotline and Compliance Hotlines.
2. The DON and Charge Nurses conducted Head to Toe skin checks on 37 non-interviewable residents and found no concerns following the completion of the assessment.
3. The facility mailed copies of the Resident Rights, DADS Hotline phone number and the company ' s Compliance Hotline phone numbers to the resident ' s responsible party / family member.
4. To protect non-interviewable residents from abuse included the following actions:
Certified Nursing Assistants will utilize the Stop & Watch tool following all ADL care to alert the charge nurse of any changes they observe.
Charge nurses will conduct weekly head to toes skin checks.
Charge nurses will monitor residents for changes in behavior and complete the SBAR if they have a concern and notify the family and physician.
5. Using the care path \interact process on Fall Do Not Move Resident From The Floor Until Complete Assessment Is Done and visual assessment is done. The assessments include AROM and PROM and visual observation of any limb shortening or internal or external rotation of any obvious sign of fracture. The staff will do the following:
a. Take vital signs - temperatures, BP, pulse,
b. If vital signs- critical is not met per (care path) then proceed with initial nursing evaluation for injuries and \ or mental status change. Do not move off the floor until complete exam has been performed.
c. Determine if suspected fracture or new bone deformity, head trauma, altered manta, (decrease LOC, unresponsiveness, suspicious of [MEDICAL CONDITION] new or worsen cognitive impairment), laceration required sutures\staples if yes notify MD\NP\PA and transfer via EMS.
6. If resident falls and has any complaints of [MEDICAL CONDITION] or spinal injury, head trauma, perform Neurological

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 6)
assessment at the scene of fall If any abnormalities call EMS and send resident out. Do not move resident. A complete report and notify MD via telephone. If no answer within one hour,, the Medical Director will be contacted. The RP\facility will be notified
Training:
The DON and the District Director of Clinical Services conducted re-education training for all Nursing, Dietary, Housekeeping, Laundry and Department Manager personnel January 8, 9 and 10, 2016. Training topics included were :
Abuse and Neglect Prohibition
Assessment of discomfort in Dementia Protocol
Change in Condition
Emergency Transports via 911 versus Non-emergency transfers.
Abuse and Neglect Prohibition training included a review of the facility ' s policy on abuse and neglect prohibition. The training was provided by the Director of Nursing Services and the District Director of Clinical Services. The training was presented in an oral fashion with examples provided of how abuse and neglect are defined, prevention techniques, identification, investigation, protection and reporting responsibilities.
Abuse and Neglect Prohibition training began January 8, 2016 and ended for all staff that were scheduled to work thru January 10, 2016 including RN ' s, LVN ' s, Certified Nursing Assistants, Certified Medication Aides, Staff Development, Nurse Managers, Rehab Staff, Dietary, Housekeeping and Laundry Staff and Department Managers. Staff that were not able to attend any of the training offered between January 8 thru January 10, 2016 will not be allowed to work with residents until they have been re-educated on the facility ' s Abuse and Neglect Prohibition policy.
The Assessment of discomfort in Dementia Protocol training included a review of how physical pain and affective discomfort experienced by people with dementia can be managed. The training was provided by the Director of Nursing Services and the District Director of Clinical Services. The training was presented in an oral fashion with examples provided of how the Assessment of Discomfort protocol should be applied when staff encounter situations with affected residents. Staff were trained on the steps they should follow which include:
Conducting a physical evaluation
Review residents history for potentially painful conditions
Evaluating the discomfort and initiating non-pharmacologic comfort interventions
Evaluate for pharmacologic interventions that are not [MEDICAL CONDITION]
The Assessment of discomfort in Dementia Protocol training began January 8, 2016 and ended January 10, 2016 for RN ' s, LVN ' s, Certified Nursing Assistants, Certified Medication Aides, Physical Therapy, Occupational Therapy and Speech Therapy staff. Staff that were not able to attend any of the training offered between January 8 thru January 10, 2016 will not be allowed to work with residents until they have been re-educated on The Assessment of Discomfort in Dementia Protocol program.
The facility ' s policy for identification of change of condition requires the implementation of the Stop & Watch tool as well as Interact 4.0. These decision support tools provide reporting guidance to licensed nurses on whether specific symptoms, signs, and lab results are immediate versus non-immediate, or next day, for reporting purposes to the primary care clinician. Using the Interact 4.0 tool the licensed nurse can determine immediacy of reporting for vital signs, laboratory results and diagnostic procedures.
The Director of Nursing Services was re-educated on Stop & Watch and Interact 4.0 on January 9, 2016 by the District Director of Clinical Services.
The Director of Clinical Services and the Director of Nursing Services re-educated RN ' s, LVN ' s, Unit Managers, ADON ' s, Staff Development, Certified Nursing Assistants, Certified Medication Aides, Physical Therapy, Occupational Therapy, Speech Therapy and MDS nurses January 9 and 10, 2016 on the Stop & Watch and Interact 4.0 programs. Staff that were not able to attend any of the training offered between January 8 and 9, 2016 will not be allowed to work with residents until they have been re-educated on the facility ' s Stop & Watch and Interact 4.0 programs.
The licensed nurse will evaluate each situation based on individual resident condition at the time of the event. Once a medical emergency is identified, qualified staff evaluate the resident; initiate the appropriate emergency procedure(s), and calls 911. The licensed staff continues to provide care and monitor the resident until the emergency personnel arrive.
The surveyors confirmed the POR had been implemented sufficiently to remove the IJ by:
Record Review of the In-Service sign-in sheet revealed that staff from the nursing department representing all three shifts had been in-serviced from 01/08/16 until 01/10/16. The topics included in part: Abuse and Neglect, Dementia Resident.
Observations were made from 01/08/06 until 01/10/16 to that staff -resident interaction was appropriate, for any residents that have a change in condition/falls and care of residents with dementia.
Interviews conducted from 01/08/16-01/10/16 between 4:30am to 4:00 pm daily with RCSs and Nurses on various shifts revealed staff were able to verbalize the information from the recent in-services regarding abuse and neglect and care of a resident with dementia.
The Administrator and DON were informed on 01/13/16 at 1:35pm that the IJ was lowered; however the facility remained out of compliance at a pattern level and a severity of actual harm that is not immediate jeopardy due to facility needing more time to monitor the plan of removal for effectiveness.
Facility 672 dated 1/06/2016 revealed a census of 110.

F 0226

Level of harm - Immediate jeopardy

Residents Affected - Many

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 observations, interviews and record review the facility failed to implement their policy and procedures that prohibit mistreatment, neglect and abuse for seven (Resident #1, #4, #6, #8, #5, #3 and #7) of eight residents reviewed for neglect and abuse.
Resident #6 was grabbed by her wrist/ arm and hand by Medication Aide (MA) B and Resident Care Specialist (RCS) K to prevent her from entering her room.
Resident #4 suffered a fall with lacerations to the head on 1/6/2016 and was not assessed appropriately after change in condition. He became non-responsive on 01/08/16 around 11:00am, the facility did not assess the resident appropriately and called for a non-emergency ambulance versus calling 911. The resident remained in the facility uintil 4:11pm.
RSC I handled Resident #8 roughly when she changed his brief by pulling him by one leg to reposition him in bed.
RCS M verbally abused Resident #5. He took her call light away and told her that it would not help her get water. Resident #5 was scared of RCS M.
Resident #3 said RCS G was rude and mean to her.
Resident #7 said RCS G was rude and refused to tell him her name.
Resident #1 had an un-witnessed fall while out on pass. He was not assessed upon return to the facility. After the VA Nurse assessed the resident and told the facility he had the fall and injuries he was sent to the hospital. He was found to have a fracture to his cervical spine.
An IJ was identified on 01/08/2016. While the IJ was removed on 01/13/2016, the facility remained out of compliance at a scope of pattern and a severity level of actual harm due to the facility needing more time to monitor the plan of removal for effectiveness.
These failures affected seven residents and placed 103 residents at risk for mistreatment, abuse and neglect.
Intake #: 8, 0, 8, 2,
Findings Include:
Record review of Suspected resident abuse assessment, long-term care dated October 02, 2015 provided by facility read:
-Residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
-The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675231**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/13/2016**
NAME OF PROVIDER OF SUPPLIER **JACINTO CITY HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1405 HOLLAND** **HOUSTON, TX 77029**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 7) -The facility must not employ individuals who have been found guilty by court of law of abusing, neglecting, or mistreating residents or who have had a finding entered into the state nursing assistant registry concerning abuse, neglect, or mistreatment of [REDACTED]. -The facility must report to the state ' s nursing assistant registry or licensing authorities any knowledge it has of actions by a court of law against an employee that would indicate unfitness for service as a nursing assistant or other facility staff member. -The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of a resident ' s property, are reported immediately, through established procedures, to the facility administrator and to other officials in accordance with state law. -The facility must have evidence that all alleged violations have been thoroughly investigated and must take precautions to prevent further potential abuse while the investigation is in process. Resident #6 Record review of Resident #6 ' s face sheet revealed resident is a [AGE] year old female with an admission date of [DATE]. Diagnoses: [REDACTED]. Record review of Resident # 6 ' s Care Plan dated 7/02/2014 with a review date of 10/15/2015 revealed: Resident #6 had moderate cognitive impairment due to short-term and long-term memory loss. Approach: Staff will offer options in simple terms regarding care for resident to choose, Provide time to think/react. Resident #6 was care planned for falls. Approach: Falling Star Program, Encourage resident to ask for assist, orient resident to environment, bed alarm, chair alarm, place call light in reach, observe for potential patterns of falls to identify possible causes, Offer/assist to toilet frequently and as accepted, place frequently used items within reach, and observe for potential medication related causes. Resident #6 had a [DIAGNOSES REDACTED]. Approach: Administer medication as ordered, fall risk assessment, fall prevention protocol as indicated, call bell within reach, notify MD as indicated. Observation on 1/06/2016 at 2:59pm revealed that there was no Falling Star above residents door or above her bed to identify her as a fall risk. Observation on 1/06/2016 at 3:15pm revealed Resident #6 sitting in wheelchair attempting to enter her room but was not able to as medication cart was blocking the entrance to her room. Surveyor intervened and informed MA B that Resident #6 was trying to enter her room but could not due to the medication cart blocking entrance to room. MA B said he was aware she wanted in the room and that is why he had the cart there to block the entrance to prevent her from going in the room. He further revealed she was a fall risk and did not want her in the room. Observation on 1/06/2016 at 3:19pm revealed resident #6 in her wheelchair wedged between medication cart and door to her room. Surveyor intervened and informed MA B and RCS K that Resident #6 was wedged between medication cart and door to her room. MA B and RCS K went over to Resident #6 and moved the cart and told Resident #6 she could not go to her room at this time. Resident #6 grabbed handrail and tried to wheel herself into her room. Resident #6 said she wanted to look at the box in her closet. MA B and RCS K told her she was not able to go into her room at this time. Resident #6 would not release handrail as she continued to try and wheel herself into her room. MA B grabbed Resident #6 ' s wrist/arm and tried to pull her hand off railing. RCS K then began prying Resident #6 ' s fingers from the handrail. The DON walked by and quickly removed MA B and RCS K from Resident #6. MA B and RCS K told the DON that they did not want Resident #6 in her room because she would make a mess and takes things out of her closet and she was a fall risk. DON informed MA B and RCS K that Resident #6 had the right to enter her room. Interview on 1/06/2016 at 3:30pm with the DON revealed that she performed an assessment on Resident #6 and found no injuries. She further revealed that MA B and RCS K acted inappropriately and should have allowed her to enter her room or they could have tried redirecting. The DON said they should not have grabbed Resident #6's hand or arm. The DON said staff would be in-serviced in Abuse/Neglect. The DON revealed that she was sure staff had training on Dementia but was not sure of the date. In an interview with RCS K on 1/06/2016 at 3:35pm she said that she was trying to re-direct Resident #6 because she did not want her in the room because Resident #6 was a fall risk. In an interview with Resident #6 at 3:45pm she said that MA B and RCS K hurt her wrist. Resident #6 said no one had ever grabbed her arm like that before. She said she just wanted to look in the box in her closet. Observation on 1/06/2016 at 3:45 pm revealed redness to Resident #6 ' s right wrist. Record review of MA B ' s written statement dated 1/06/2016 revealed at about 3pm, he was by the Med Aid Cart, and was about to move it. He was told by the CNA not to move it because the resident was a fall risk. Resident #6 tried to wheel herself in her room. As she tried to go inside, the CNA grabbed her hand, telling her not to go in her room for her safety. He only touched the resident and nothing more. Record review of RCS K ' s written statement dated 1/06/2016 revealed that Resident #6 was trying to enter her room and RCS K intervened by trying to stop her because she was a fall risk. RCS K's written statement further revealed that shespoke to Resident #6, and touched her hand trying to redirect her away from the door because she was a fall risk. In an interview with Resident #6 on 1/07/2016 at 9:40am she revealed that she had pain to her right wrist. Observation at same time revealed 3 small round bruises with purple hue to right wrist. In an interview with the DON on 1/07/2016 at 9:45am she revealed she was aware not aware of bruising. The DON said she would assess resident and administer Tylenol per orders for pain to resident ' s right wrist. In an interview with DON on 1/07/2016 at 10:00am she verified that there were 3 small bruises to Resident #6 ' s right wrist. The DON said she had not noticed them before because they were under the wander guard. Record review of Provider Investigation Report dated 1/07/2016 completed by DON read: Description of Allegation- The DON was walking down the hall towards room. Resident #6 was grabbing onto the door frame trying to pull herself into the room, RCS K was asking the resident where she was going, and reached towards residents hand, The DON could not see what RCS K did with the resident's hand because the resident's body and wheelchair were blocking my view. However, MA B then reached over and put his hand around the resident ' s wrist to prevent her from grabbing onto the other door frame, causing resident to become agitated. The DON intervened with the staff explaining to them residents rights and allowed resident into her room to access items in her closet and then redirected her back to into the activity room. The DON removed both staff members from the floor, began education, and notified the administrator of the incident. After following up that employee ' s need to be suspended pending investigation,she followed back up with administrator. Record review of in-service dated 12/22/2015 revealed staff was in-service on reporting abuse and able to assess the need to report. Record review of in-service dated 12/31/2015 revealed staff was in-service on understanding abuse. Record review of in-service dated 1/06/2016 revealed staff was in-serviced on Dementia care and communicating with dementia residents. Record review of Dementia, resident communication, long term care policy with revised date of October 02, 2015 provided by facility read: -Visual strategies; Approach the resident from the front, in his vision field, smile, present objects or written cues to focus attention on the communication topic, provide contextual and environmental cues; use colors, highlighting, enlargement, pictures, drawings, and symbols. -Auditory strategies; use calm, positive, unhurried speech, state the person ' s name and yours to increase a sense of familiarity, use praise and compliments befitting an adult. -Tactile Strategies; use touch to reassure, use touch to guide, lead, redirect, and prompt desired behavior, use familiar objects as reminders. Resident #4 Record review of Resident #4 ' s face sheet revealed a [AGE] year old male with an admission date of [DATE]. Diagnoses: [REDACTED]. Record review of Resident #4 ' s MDS dated [DATE] revealed a BIMS score of 12 which indicated moderate cognitive impairment, required one person assist with bed mobility, dressing, and toilet use. Record review of Resident #4 ' s Care Plan dated 12/14/2015 with a reviewed date of 12/23/15 revealed: Resident #4 had Cognitive Deficit; Resident had moderate independence with decision making. Resident had difficulty with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675231**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/13/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JACINTO CITY HEALTHCARE CENTER	**1405 HOLLAND HOUSTON, TX 77029**

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 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 8) making decisions in new situations. Approach: Provide clear choices and adequate information for resident to make decisions, Point out consequences of bad decisions, involve family members in decisions regarding important matters. Resident #4 was at risk for falls due to: history of previous falls, non-ambulation, blood pressure changes, and [MEDICAL CONDITION]. Approach: Falling star program, encourage resident to ask for assistance, physical therapy, occupational therapy, provide assistive devices such as wheelchair, place call light in reach, observe for potential patterns of falls to identify possible causes, and place frequently used items within reach. Resident #4 was care planned for, [DIAGNOSES REDACTED]. Approach: Administer medication as ordered, fall risk assessment, fall prevention protocol as indicated, call bell within reach, notify MD as indicated. In an interview with Resident #4 on 1/6/16 at 9:40am he said he was at the facility for therapy and was feeling alright today. Observation at the same time revealed resident was well groomed, very talkative and alert, lying in bed with head of bed elevated. His call light was within reach. There were no falling star above the bed or doorway entrance to signify that Resident #4 was a fall risk. Record review of Interdisciplinary Post Fall Report dated 1/6/2016 revealed Resident #4 suffered a fall at 11:00am on 1/6/2016. Record further revealed that Resident #4 ' s fall occurred in the dining room and LVN A was called to the dining room where she found resident lying on floor on his right side. Resident #4 was assessed by LVN A and assisted to wheelchair and then to bed. Record further revealed Resident #4 sustained an open area to the back of the head and right wrist. Record review of Incident/Accident Investigation Follow-up dated 1/6/16 revealed Resident #4 fell in dining room and LVN A was called to dining room by staff where LVN A found Resident #4 on the floor on his right side. Summary of investigation read: Resident stated he leaned forward to get up and fell to the floor. Past Interventions read: New resident to facility, no history of falls. Recommendations: encourage resident to ask for assistance avoid attempting to get up on his own. Record review of Resident #4 ' s Interdisciplinary Post Fall Review completed by LVN A and dated 1/6/16 read: Predisposing Diseases: Dementia. In an interview on 1/6/16 at 2:20pm with LVN A she said she was called to dining room and found Resident #4 lying on his side on the floor. LVN A said she assessed Resident #4 and found 2 lacerations to the back of his head and he had a skin tear to his right arm. Resident #4 was assisted to the wheelchair and then assisted to his bed. LVN A said she started neuro vitals and notified the physician of the fall. She further said that orders were received for Tylenol 650mg for discomfort, wound care orders for skin tear of right arm and both wounds to head. LVN A said no orders were received for CT (cat scan). Record review of Resident #4's physician's orders [REDACTED].monitor neuro checks every 15 minutes for one hour, every hour for four hours and then every four hours for 24 hours and every eight hours for 72 hours. Record review of Resident #4's Neurological Record read in part: frequency every 30 minutes for four hours, every one hour for four hours, every four hours for 24 hours, every eight hours for remaining 72 hours or as ordered by physician .neuro vital signs were done starting on 01/6/16 at 11:15am and ended on 01/07/16 at 10:30am. Record review of Resident #4's Neurological record dated 01/6/16-01/7/16 revealed neither the physican's order nor the instructions on the Neurological Record in regards to frequency was followed. In an interview on 01/7/16 at 9:30am with Resident #4, he said he was not feeling well and that he was hurting all over. In an interview with Resident #1 (Resident #4 ' s roommate) on 01/7/16 at 9:30am he said that immediately after hitting his head Resident #4 was not the same. He said Resident #4 did not act the same and he stayed in bed and did not eat. Interview on 01/7/16 at 9:40am LVN A when it was reported to her that Resident #4 was hurting all over she said she would assess him. Interview on 01/7/16 at 10:00am LVN A said Resident #4 was fine he was just tired. Interview on 01/7/16 at 10:15am with Resident #1 he said Resident #4 was not fine. He said Resident #4 had been tossing and turning all night and was in pain and did not sleep. Observation on 01/7/16 12:00pm revealed Resident was resting with his eyes closed. Observation and interview on 01/7/16 at 4:00pm revealed Resident #4 was in bed and not feeling well. He said he did not feel like getting out of bed. Observation on 01/8/16 at 8:00am revealed Resident #4 was in bed with his eyes closed. His breakfast tray was beside his bed untouched. Record review of nurse ' s notes dated 1/8/2016 at 12:15pm read: placed call to hospital, spoke to emergency room nurse. Report given. Went to Resident #4 ' s room, made resident aware he would be transferred to hospital. Observation and interview on 01/08/16 at 1:00pm revealed Resident #4 was in bed with eyes closed and did respond to verbal stimuli. His RP was at his bedside and said he would not wake up and shook his shoulder, Resident #4 did not respond. His lunch tray was at his bedside untouched. The RP said the Hospital Nurse told him that she would inform the Nurse at the facility that Resident #4 needed to be sent back to the hospital for evaluation. In an interview on 1/8/16 at 3:14pm with Resident #4 ' s Responsible Party (RP) revealed that Resident #4 did not have a [DIAGNOSES REDACTED]. Resdident #4's RP further revealed that he was not notified of Resident #4 ' s fall until he arrived at facility on 1/06/2016 after lunch time. He said LVN H told him they did not have his phone number in Resident #4 ' s chart. The RP said that Resident #4 was not acting like his self and had been acting different since the fall. The RP said that he arrived at facility at 11:00am today and Resident #4 would not wake up and his breakfast had not been eaten. He said he informed the nurse of Resident #4 ' s condition and she assessed him and said she would call the physician. The RP said LVN H told him that Resident #4 would be transferred to hospital for evaluation but that was over 3 hours ago and Resident #4 still had not woken up. Observation on 1/8/ at 3:14pm of Resident #4 revealed he was lying in bed with head of bed elevated. Resident ' s lips were dry and cracked and lunch was at bedside and had not been eaten. Resident #4 did not respond to verbal stimuli. The RP shook Resident #4 by the shoulder and Resident #4 did not respond. In an interview with LVN H on 1/8/16 at 3:30pm she said that she had notified physician of change in mental status and Resident #4 was to be transferred to hospital. She further revealed that she contacted several ambulance companies and chose the one with the least estimated time of arrival. When asked if she called 911 for Resident #4 due to non-responsiveness, she said no. She said this was not an emergency situation. In an interview with the DON on 1/8/16 at 3:35pm she revealed she was unaware that LVN H had not called 911. She was aware of change in condition on 1/7/16 and had requested an order from physician for x-ray of skull on 1/7/16. She further revealed that Resident #4 did not become unresponsive until 1:00pm on 1/8/16. DON said she would have ADON call 911 immediately for transfer. Record review of nurse ' s notes dated 1/8/16 at 12:00pm said hospital nurse was visiting with Resident #4 and family. Hospital nurse requested that nurse on duty to assess Resident #4. Resident #4 said he was not feeling well. VA Nurse remained at bedside. Call was placed to physician regarding assessment and Resident #4 not feeling well and also made aware of recent fall from wheelchair. Record review of nurse ' s note dated 1/8/16 at 12:25pm read: placed call to ambulance service. The above report given to dispatcher. Stated will send ambulance right away. Made charge nurse aware. Record review of nurse ' s note dated 1/8/16 at 12:30pm read: Resident in room. Son at bedside. Blood sugar (BS)=69. Call placed to MD. New order to give glucacon 1mg IM (intra-muscular)if resident not awake. Record review of nurse ' s note dated 1/8/16 at 1:00pm read: BS=100. Resident responds to painful stimuli. Awaiting on transportation. Son at bedside. Vital signs: Blood pressure-138/76, respirations-20, pulse- 78. Record review of nurse ' s note dated 1/8/16 at 2:00pm read: Responds to painful stimuli and moves all extremities. No sign or symptoms of pain or discomfort. Record review of nurse ' s note dated 1/8/16 at 2:30pm read: Awaiting on transportation. Resident denies pain. Respirations even and unlabored. Vital signs: blood pressure-140/78, 80, 20, 97%. Record review of nurse ' s note dated 1/8/16 at 3:00pm read: Resident responding to painful stimuli. No signs of distress. Respirations 20 per minute. Son at bedside and aware of change of condition. Record review of nurse ' s note dated 1/8/16 at 4:50pm read: EMS personnel arrived. Blood sugar at this time is 71. Blood pressure 140/79, pulse 79, respirations 20, and temperature 97.8. In an interview with DON on 1/8/16 at 5:10pm she said that ADON and LVN H both will be counseled on assessment, the depth of

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NAME OF PROVIDER OF SUPPLIER **JACINTO CITY HEALTHCARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP **1405 HOLLAND** **HOUSTON, TX 77029**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0226

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 9)
assessment, and starting interventions. She stated They both failed to assess with urgency .
Record review of emergency room visit dated 1/08/2016 revealed resident was [AGE] years old and presented to emergency department post fall 3 days ago. Patient is non-responsive. Per EMS, family says patient was not his normal self after fall. Primary Impression: Urinary Tract Infection. Secondary Impressions: Altered mental status, [DIAGNOSES REDACTED].
In an interview with Resident #4 ' s RP on 1/9/16 at 2:00pm he revealed that Resident #4 was diagnosed with [REDACTED]. RP said Resident #4 was still not alert.
In an interview on 1/11/16 at 3:00pm with Resident #4 at hospital, resident responded to verbal stimuli. Resident #4 said he was not feeling well and hasn ' t felt well since the fall. He said he is hoping to get better so he can return to his home.
Resident #3
Record review of Resident #3 ' s face sheet revealed a [AGE] year old female with an admitted [DATE]. Diagnoses: [REDACTED]. Face sheet further revealed Resident #3 was her own legal guardian.
Record review of care plan dated 7/15/15 with a review date of 10/15/15 revealed resident was care planned for Depression/Anxiety. Approach: Provide calm, reassuring environment, encourage resident and staff to be alert to events or situations that precipitate episodes of restlessness or anxiety, calm and reassure as needed, modify environment to promote calm and comfort.
In an interview with Resident #3 on 1/08/2016 at 1:40pm she said that RCS M was rude and mean to her. She further revealed that she doesn ' t put up with it and takes care of it herself by telling him off. Resident #3 further revealed she did not like it when RCS M was assigned to her hall and she was scared of him. Resident #3 had witnessed RCS M speak rudely to her roommate (Resident #5) and take her call light away so she would not be able to use it and stated her roommate was also scared of RCS M. Resident #3 said she had mentioned it to previous administrator and RCS M was moved to a different hall but now he was working on her hall again andshe was worried he might come into her room.
In an interview with the DON on 1/08/2016 at 1:50pm she said she was aware of the incident involving Resident #3 and RCS M. She said RCS M had been removed from the floor and suspended pending investigation.
Resident #7
Record review of Resident #7 ' s clinical record revealed a [AGE] year old male with an admission date of [DATE]. Diagnoses: [REDACTED].
Record review of Resident #7 ' s MDS dated [DATE] revealed a BIMS score of 13 which indicated no cognitive impairment. The MDS assessment further revealed that Resident #7 required extensive assistance for bed mobility and personal hygiene. Resident #7 was total dependence for transfer and toilet use.
Record review of care plan dated 12/21/15 with a reviewed date of 1/7/16 revealed resident was care planned for falls. Approach: Falling Star Program, encourage resident to ask for assistance, place call light in reach, place frequently used items within reach, offer/assist to toilet frequently and as accepted.
In an interview with Resident #7 on 1/11/2016 at 11:25am he revealed that RCS G was rude and speaks aggressively towards him. He also said that when RCS G enters the room she refuses to give her name. Resident #7 also said that when he used the call light for pain medication RCS G just enters the room, turns off the call light and leaves the room. Resident #7 said she never returns to let him know if she told the nurse he needed something for pain.
In an interview with DON on 1/11/2016 at 11:35am she said she was aware of the incident involving RCS G and incident was being investigated. The DON further said that she double checked the Medication Administration Record [REDACTED]. The DON also said staff would be receiving sensitivity training now and quarterly.
In a telephone interview with RCS G on 1/13/2016 at 1:00pm she said that she took care of Resident #7 on Friday. She asked the nurse to tell Resident #7 that she was the only RCS on his hall. RCS G said that Resident #7 reported that she does not let him know when she tells the nurse he needs medicine for pain. She said she was not aware that she had to report back to him. She stated My tone is high sometimes, maybe I come off rude .
Resident#1
Record review of Resident #1 ' s clinical record revealed a [AGE] year old male with an admission date of [DATE]. Diagnoses: [REDACTED].
Record review of Resident #1 ' s Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment.
Record review of Resident #1 ' s Care Plan dated 12/15/2015 revealed that he was at risk for falls. Approach: Falling Star Program, encourage resident to ask for assistance, place call light in reach, observe for potential patterns of falls to identify possible causes, offer/assist to toilet frequently and as accepted, place frequently used items within reach, observe for potential medication related causes.
In an interview on 1/06/2016 at 11:00am with Resident #1 he revealed that he had a fall while he was out on pass. He said he hit his head when he fell down 4-5 steps. Resident #1 said he fell on [DATE] and when he returned to the facility that same day, he did not tell any staff and the staff didn ' t ask about the bump and scratches to his forehead. Resident #1 said no one noticed the bump on his head and scratches until the hospital nurse came to visit him at the facility on 12/23/2015 . Resident #1 said the hospital nurse noticed immediately and she told the facility of the fall and his injuries. Resident further revealed that CT (cat scan) revealed a fracture to his neck and he needed to wear a neck brace. Observation at same time revealed resident was wearing neck brace per physician order.
In a telephone interview on 1/06/2016 at 10:00am with the VA Nurse she said that she was very concerned about Resident #1 ' s care and the assessment skills of the nurses at the facility. The VA Nurse said she noticed immediately that Resident #1 had a large bump to his forehead along with scratches. She said she asked Resident #1 about the bump and scratches and he said he fell down some stairs while he was out on pass. The Hospital nurse said the facility was not aware of Resident #1's fall until she notified them on 12/23/2015.
Record review of nursing notes dated 12/23/2015 at 1:00pm revealed Resident #1 said he fell at home on 12/22/2015. Head to toe assessment performed. Resident #1 was alert and oriented. Small laceration on the forehead observed, scratch to the tip of nose. No bruising noted. Call placed to physician. No new orders received. Continue with Neuro vital signs, monitor for pain, bruising, redness or neurological change.
Record review of Neurological record dated 12/23/2015 revealed that Neurological checks were started at 12:45am on 12/23/2015 and continued to 5:30pm on 12/23/2015.
Record review of nurses note dated 12/23/2015 at 4:30pm revealed facility called VA Nurse regarding Resident #1 and his fall. Hospital nurse voiced concern regarding documentation of facility nurse and requested that hospital protocol be followed for falls with suspected head injuries.
Record review of the Situation, Background, Assessment and Recommendation (SBAR) Communication Form dated 12/23/2015 at 6:05pm revealed that Resident #1's physician was notified of fall while Resident #1 was out on pass 12/22/2015. Orders received from physician to send Resident #1 to emergency room for evaluation and treatment for [REDACTED].
Record review of CT report dated 12/24/2015 read: Diagnostic Impression; C3 cervical [MEDICATION NAME] process fracture: acute
Record review of physician order [REDACTED].
In an interview with the Director of Nursing (DON) on 1/8/2016 at 5:00pm she was unsure of policy regarding assessments of residents who go out on pass and how residents were monitored when they returned. The DON said she would find out.
In an interview with DON on 1/11/2016 at 3:30pm she said that residents should be assessed before going out on pass and when they return. She further said that when residents go out on pass that the residents must inform the nurse and sign out on the Out of Facility Release of Responsibility form and they sign in when they return so that they know the resident has returned. She further revealed that the nurse on duty signs the form as well.
Record review of Out of Facility Release of Responsibility form in Resident #1 ' s chart revealed Resident #1 signed himself out on pass on 12/18/15, 12/24/15, 12/28/15, 1/03/16, 1/04/16, and 1/07/16. There were no signatures by nurse or resident indicating that Resident #1 returned to facility on those days.
Record review of in-service dated 12/22/2015 revealed staff was in-service on reporting abuse and able to assess the need to report.
Record review of in-service dated 12/31/2015 revealed staff was in-service on understanding abuse.
Record review of in-service dated 1/06/2016 revealed staff was in-serviced on Dementia care and communicating with dementia residents.

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NAME OF PROVIDER OF SUPPLIER **JACINTO CITY HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1405 HOLLAND** **HOUSTON, TX 77029**	

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 10) Record review of Dementia, resident communication, long term care policy with revised date of October 02, 2015 provided by facility read: -Visual strategies; Approach the resident from the front, in his vision field, smile, present objects or written cues to focus attention on the communication topic, provide contextual and environmental cues; use colors, highlighting, enlargement, pictures, drawings, and symbols. -Auditory strategies; use calm, positive, unhurried speech, state the person ' s name and yours to increase a sense of fami
F 0251 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Hire a qualified full-time social worker in a facility with more than 120 beds.** Based on observation, interview and record review the facility failed to ensure a qualified Social Worker was employed on a full-time basis for a facility with more than 120 beds. The facility failed to employ a full time Social Worker since the last licensed Social Worker resigned from employment on 12/5/2015. This deficient practice placed a census of 110 residents at risk for not having needs met including ancillary services, medical appointments, psychosocial needs or timely discharge planning. Findings Included: Observations conducted during the survey from 1/6/2016 to 1/13/2016 revealed no Social Worker was present in the facility during the survey conducted by DADS. Interview on 1/6/2016 at 10:30 AM with Resident #11asked about the new Social Worker. Resident #11 stated she wanted to speak with the social worker and that she has been waiting to do so. Resident #11 was at the facility for rehabilitation only and then to return home, but was unsure on how the process worked. Interview on 1/6/2016 at 10:35 AM with MA J revealed there was currently no social worker at the facility. MA J stated she was unsure how long the facility has been without a Social Worker or when there would be a Social Worker. Interview on 1/6/2016 at 10:40 AM, the Administrator stated they did not have a Social Worker yet. Observation on 1/7/2016 at 9:36 AM of Resident #8 lying in bed. Resident #8 ' s feet were dry and his toe nails were long and thick. Interview on 1/7/2016 at 9:38 AM with LVN L that residents who need a podiatrist were put on a list and the podiatrist checks the list on each station when she comes to the facility. LVN L stated since there was no Social Worker, she was unsure as to when the next time the podiatrist would be in; but she knows that the podiatrist rounds early mornings around 5 AM. LVN L stated Resident #8 was added to the podiatry list in December. Interview on 1/7/2016 at 1:40 PM with Resident # 9 regarding his discharge. Resident #9 asked if could get help for him to go home. Resident #9 stated he did not want to pay for here and for his house and that he would rather go home but did not know who to talk to about going home. Interview on 1/7/2016 at 1:45 PM with the ADON revealed that Resident #9 was here for long-term care. In an interview on 1/13/2015 at 10:15 AM with the Administrator revealed the facility had not had a full time social worker as long as she has been working at the facility; which has been two weeks. Interview on 1/13/2015 with LVN A revealed that since there has been no Social Worker, each station has been in charge of their own residents discharges and getting residents seen for ancillary services. LVN A also stated that she was not sure as to what all it takes for discharges, but she gets with the residents physicians to ensure that everything is set up. The CMS form 672 reflected 110 residents resided at the facility.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide the necessary care and services to ensure 2 of 4 residents (Resident #4 and Resident #1) reviewed attained the highest practicable, physical, mental and psychosocial well-being when the facility failed to properly assess residents after a fall. -Resident #4 suffered a fall with lacerations to the head on 1/6/2016 and was not assessed appropriately after change in condition. He became non-responsive on 01/08/16 around 11:00am, the facility did not assess the resident appropriately and called for a non-emergency ambulance versus calling 911. The resident remained in the facility from 11:00am until 4:11pm when he was transferred to the hospital via ambulance. Resident #1 had an un-witnessed fall while out on pass on 12/22/2015 . He was not assessed upon return to the facility the same day. After the Veterans Admistration (VA) Nurse assessed the resident on 12/23/15 and told the facility he had fallen and had injuries he was sent to the hospital. He was found to have a fracture to his cervical spine. An IJ was identified on 01/08/2016. While the IJ was removed on 01/13/2016, the facility remained out of compliance at a scope of pattern and a severity level of actual harm due to the facility needing more time to monitor the plan of removal for effectiveness. These failures affected two residents and placed 102 residents as needing assistance or dependent on staff for mobility at risk for not having their needs met, injury and a decline in health status. Intake #: 8, 0, 8, 2, Findings Include: Resident #4 Record review of Resident #4 ' s face sheet revealed a [AGE] year old male with an admission date of [DATE]. Diagnoses: [REDACTED]. Record review of Resident #4 ' s MDS dated [DATE] revealed a BIMS score of 12 which indicated moderate cognitive impairment, required one person assist with bed mobility, dressing, and toilet use. Record review of Resident #4 ' s Care Plan dated 12/14/2015 with a reviewed date of 12/23/15 revealed: Resident #4 had Cognitive Deficit; Resident had moderate independence with decision making. Resident had difficulty with making decisions in new situations. Approach: Provide clear choices and adequate information for resident to make decisions, Point out consequences of bad decisions, involve family members in decisions regarding important matters. Resident #4 was at risk for falls due to: history of previous falls, non-ambulation, blood pressure changes, and [MEDICAL CONDITION]. Approach: Falling star program, encourage resident to ask for assistance, physical therapy, occupational therapy, provide assistive devices such as wheelchair, place call light in reach, observe for potential patterns of falls to identify possible causes, and place frequently used items within reach. Resident #4 was care planned for, [DIAGNOSES REDACTED]. Approach: Administer medication as ordered, fall risk assessment, fall prevention protocol as indicated, call bell within reach, notify MD as indicated. In an interview with Resident #4 on 1/6/16 at 9:40am he said he was at the facility for therapy and was feeling alright today. Observation at the same time revealed resident was well groomed, very talkative and alert, lying in bed with head of bed elevated. His call light was within reach. There were no falling star above the bed or doorway entrance to signify that Resident #4 was a fall risk. Record review of Interdisciplinary Post Fall Report dated 1/6/2016 revealed Resident #4 suffered a fall at 11:00am on 1/6/2016. Record further revealed that Resident #4 ' s fall occurred in the dining room and LVN A was called to the dining room where she found resident lying on floor on his right side. Resident #4 was assessed by LVN A and assisted to wheelchair and then to bed. Record further revealed Resident #4 sustained an open area to the back of the head and right wrist. Record review of Incident/Accident Investigation Follow-up dated 1/6/16 revealed Resident #4 fell in dining room and LVN A was called to dining room by staff where LVN A found Resident #4 on the floor on his right side. Summary of investigation read: Resident stated he leaned forward to get up and fell to the floor. Past Interventions read: New resident to facility, no history of falls. Recommendations: encourage resident to ask for assistance avoid attempting to get up on his own. Record review of Resident #4 ' s Interdisciplinary Post Fall Review completed by LVN A and dated 1/6/16 read: Predisposing Diseases: Dementia. In an interview on 1/6/16 at 2:20pm with LVN A she said she was called to dining room and found Resident #4 lying on his side on the floor. LVN A said she assessed Resident #4 and found 2 lacerations to the back of his head and he had a skin tear to his right arm. Resident #4 was assisted to the wheelchair and then assisted to his bed. LVN A said she started neuro vitals and notified the physician of the fall. She further said that orders were received for Tylenol 650mg for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675231**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/13/2016**

NAME OF PROVIDER OF SUPPLIER **JACINTO CITY HEALTHCARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP **1405 HOLLAND HOUSTON, TX 77029**

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 0309

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 11)
discomfort, wound care orders for skin tear of right arm and both wounds to head. LVN A said no orders were received for CT (cat scan).
Record review of Resident #4's physician's orders [REDACTED].monitor neuro checks every 15 minutes for one hour, every hour for four hours and then every four hours for 24 hours and every eight hours for 72 hours.
Record review of Resident #4's Neurological Record read in part: frequency every 30 minutes for four hours, every one hour for four hours, every four hours for 24 hours, every eight hours for remaining 72 hours or as ordered by physician .neuro vital signs were done starting on 01/6/16 at 11:15am and ended on 01/07/16 at 10:30am.
Record review of Resident #4's Neurological record dated 01/6/16-01/7/16 revealed neither the physican's order nor the instructions on the Neurological Record in regards to frequency was followed.
In an interview on 01/7/16 at 9:30am with Resident #4, he said he was not feeling well and that he was hurting all over.
In an interview with Resident #1 (Resident #4 ' s roommate) on 01/7/16 at 9:30am he said that immediately after hitting his head Resident #4 was not the same. He said Resident #4 did not act the same and he stayed in bed and did not eat.
Interview on 01/7/16 at 9:40am LVN A when it was reported to her that Resident #4 was hurting all over she said she would assess him.
Interview on 01/7/16 at 10:00am LVN A said Resident #4 was fine he was just tired.
Interview on 01/7/16 at 10:15am with Resident #1 he said Resident #4 was not fine. He said Resident #4 had been tossing and turning all night and was in pain and did not sleep.
Observation on 01/7/16 12:00pm revealed Resident was resting with his eyes closed.
Observation and interview on 01/7/16 at 4:00pm revealed Resident #4 was in bed and not feeling well. He said he did not feel like getting out of bed.
Observation on 01/8/16 at 8:00am revealed Resident #4 was in bed with his eyes closed. His breakfast tray was beside his bed untouched.
Record review of nurse ' s notes dated 1/8/2016 at 12:15pm read: placed call to hospital, spoke to emergency room nurse. Report given. Went to Resident #4 ' s room, made resident aware he would be transferred to hospital.
Observation and interview on 01/08/16 at 1:00pm revealed Resident #4 was in bed with eyes closed and did respond to verbal stimuli. His RP was at his bedside and said he would not wake up and shook his shoulder, Resident #4 did not respond. His lunch tray was at his bedside untouched. The RP said the Hospital Nurse told him that she would inform the Nurse at the facility that Resident #4 needed to be sent back to the hospital for evaluation.
In an interview on 1/8/16 at 3:14pm with Resident #4 ' s Responsible Party (RP) revealed that Resident #4 did not have a [DIAGNOSES REDACTED]. Resdident #4's RP further revealed that he was not notified of Resident #4 ' s fall until he arrived at facility on 1/06/2016 after lunch time. He said LVN H told him they did not have his phone number in Resident #4 ' s chart. The RP said that Resident #4 was not acting like his self and had been acting different since the fall. The RP said that he arrived at facility at 11:00am today and Resident #4 would not wake up and his breakfast had not been eaten. He said he informed the nurse of Resident #4 ' s condition and she assessed him and said she would call the physician. The RP said LVN H told him that Resident #4 would be transferred to hospital for evaluation but that was over 3 hours ago and Resident #4 still had not woken up.
Observation on 1/8/ at 3:14pm of Resident #4 revealed he was lying in bed with head of bed elevated. Resident ' s lips were dry and cracked and lunch was at bedside and had not been eaten. Resident #4 did not respond to verbal stimuli. The RP shook Resident #4 by the shoulder and Resident #4 did not respond.
In an interview with LVN H on 1/8/16 at 3:30pm she said that she had notified physician of change in mental status and Resident #4 was to be transferred to hospital. She further revealed that she contacted several ambulance companies and chose the one with the least estimated time of arrival. When asked if she called 911 for Resident #4 due to non-responsiveness, she said no. She said this was not an emergency situation.
In an interview with the DON on 1/8/16 at 3:35pm she revealed she was unaware that LVN H had not called 911. She was aware of change in condition on 1/7/16 and had requested an order from physician for x-ray of skull on 1/7/16. She further revealed that Resident #4 did not become unresponsive until 1:00pm on 1/8/16. DON said she would have ADON call 911 immediately for transfer.
Record review of nurse ' s notes dated 1/8/16 at 12:00pm said hospital nurse was visiting with Resident #4 and family. Hospital nurse requested that nurse on duty to assess Resident #4. Resident #4 said he was not feeling well. VA Nurse remained at bedside. Call was placed to physician regarding assessment and Resident #4 not feeling well and also made aware of recent fall from wheelchair.
Record review of nurse ' s note dated 1/8/16 at 12:25pm read: placed call to ambulance service. The above report given to dispatcher. Stated will send ambulance right away. Made charge nurse aware.
Record review of nurse ' s note dated 1/8/16 at 12:30pm read: Resident in room. Son at bedside. Blood sugar (BS)=69. Call placed to MD. New order to give glucacon 1mg IM (intra-muscular)if resident not awake.
Record review of nurse ' s note dated 1/8/16 at 1:00pm read: BS=100. Resident responds to painful stimuli. Awaiting on transportation. Son at bedside. Vital signs: Blood pressure-138/76, respirations-20, pulse- 78.
Record review of nurse ' s note dated 1/8/16 at 2:00pm read: Responds to painful stimuli and moves all extremities. No sign or symptoms of pain or discomfort.
Record review of nurse ' s note dated 1/8/16 at 2:30pm read: Awaiting on transportation. Resident denies pain. Respirations even and unlabored. Vital signs: blood pressure-140/78, 80, 20, 97%.
Record review of nurse ' s note dated 1/8/16 at 3:00pm read: Resident responding to painful stimuli. No signs of distress. Respirations 20 per minute. Son at bedside and aware of change of condition.
Record review of nurse ' s note dated 1/8/16 at 4:50pm read: EMS personnel arrived. Blood sugar at this time is 71. Blood pressure 140/79, pulse 79, respirations 20, and temperature 97.8.
In an interview with DON on 1/8/16 at 5:10pm she said that ADON and LVN H both will be counseled on assessment, the depth of assessment, and starting interventions. She stated They both failed to assess with urgency .
Record review of emergency room visit dated 1/08/2016 revealed resident was [AGE] years old and presented to emergency department post fall 3 days ago. Patient is non-responsive. Per EMS, family says patient was not his normal self after fall. Primary Impression: Urinary Tract Infection. Secondary Impressions: Altered mental status, [DIAGNOSES REDACTED].
In an interview with Resident #4 ' s RP on 1/9/16 at 2:00pm he revealed that Resident #4 was diagnosed with [REDACTED]. RP said Resident #4 was still not alert.
In an interview on 1/11/16 at 3:00pm with Resident #4 at hospital, resident responded to verbal stimuli. Resident #4 said he was not feeling well and hasn ' t felt well since the fall. He said he is hoping to get better so he can return to his home.
Resident#1
Record review of Resident #1 ' s clinical record revealed a [AGE] year old male with an admission date of [DATE]. Diagnoses: [REDACTED].
Record review of Resident #1 ' s Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment.
Record review of Resident #1 ' s Care Plan dated 12/15/2015 revealed that he was at risk for falls. Approach: Falling Star Program, encourage resident to ask for assistance, place call light in reach, observe for potential patterns of falls to identify possible causes, offer/assist to toilet frequently and as accepted, place frequently used items within reach, observe for potential medication related causes.
In an interview on 1/06/2016 at 11:00am with Resident #1 he revealed that he had a fall while he was out on pass. He said he hit his head when he fell down 4-5 steps. Resident #1 said he fell on [DATE] and when he returned to the facility that same day, he did not tell any staff and the staff didn ' t ask about the bump and scratches to his forehead. Resident #1 said no one noticed the bump on his head and scratches until the hospital nurse came to visit him at the facility on 12/23/2015 . Resident #1 said the hospital nurse noticed immediately and she told the facility of the fall and his injuries. Resident further revealed that CT (cat scan) revealed a fracture to his neck and he needed to wear a neck brace. Observation at same time revealed resident was wearing neck brace per physician order.
In a telephone interview on 1/06/2016 at 10:00am with the VA Nurse she said that she was very concerned about Resident #1 ' s care and the assessment skills of the nurses at the facility. The VA Nurse said she noticed immediately that Resident #1 had a large bump to his forehead along with scratches. She said she asked Resident #1 about the bump and scratches and he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675231**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/13/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JACINTO CITY HEALTHCARE CENTER	**1405 HOLLAND HOUSTON, TX 77029**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0309

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 12)
said he fell down some stairs while he was out on pass. The Hospital nurse said the facility was not aware of Resident #1's fall until she notified them on 12/23/2015.
Record review of nursing notes dated 12/23/2015 at 1:00pm revealed Resident #1 said he fell at home on 12/22/2015. Head to toe assessment performed. Resident #1 was alert and oriented. Small laceration on the forehead observed, scratch to the tip of nose. No bruising noted. Call placed to physician. No new orders received. Continue with Neuro vital signs, monitor for pain, bruising, redness or neurological change.
Record review of Neurological record dated 12/23/2015 revealed that Neurological checks were started at 12:45am on 12/23/2015 and continued to 5:30pm on 12/23/2015.
Record review of nurses note dated 12/23/2015 at 4:30pm revealed facility called VA Nurse regarding Resident #1 and his fall. Hospital nurse voiced concern regarding documentation of facility nurse and requested that hospital protocol be followed for falls with suspected head injuries.
Record review of the Situation, Background, Assessment and Recommendation (SBAR) Communication Form dated 12/23/2015 at 6:05pm revealed that Resident #1's physician was notified of fall while Resident #1 was out on pass 12/22/2015. Orders received from physician to send Resident #1 to emergency room for evaluation and treatment for [REDACTED].
Record review of CT report dated 12/24/2015 read: Diagnostic Impression; C3 cervical [MEDICATION NAME] process fracture: acute
Record review of physician order [REDACTED].
In an interview with the Director of Nursing (DON) on 1/8/2016 at 5:00pm she was unsure of policy regarding assessments of residents who go out on pass and how residents were monitored when they returned. The DON said she would find out.
In an interview with DON on 1/11/2016 at 3:30pm she said that residents should be assessed before going out on pass and when they return. She further said that when residents go out on pass that the residents must inform the nurse and sign out on the Out of Facility Release of Responsibility form and they sign in when they return so that they know the resident has returned. She further revealed that the nurse on duty signs the form as well.
Record review of Out of Facility Release of Responsibility form in Resident #1 ' s chart revealed Resident #1 signed himself out on pass on 12/18/15, 12/24/15, 12/28/15, 1/03/16, 1/04/16, and 1/07/16. There were no signatures by nurse or resident indicating that Resident #1 returned to facility on those days.
An immediate jeopardy (IJ) was identified on 01/08/16 at 2:13 pm and the Administrator was informed at that time.
A Plan of Removal (POR) for the IJ was submitted on 01/09/16 at 12:40pm and after several revisions were made it was accepted on 01/12/16 at 4:13pm.
The POR included in part:
Immediate Action:
1.The Interdiscplinary Team interviewed 69 interviewable residents, provided a copy of Resident ' s Rights to voice concerns and to be free of retaliation. copy of the DADS Hotline phone number and Compliance Hotline phone numbers to report any concerns. They were re-educated regarding where the phone numbers were posted in the facility for DADS Hotline and Compliance Hotlines.
2. The DON and Charge Nurses conducted Head to Toe skin checks on 37 non-interviewable residents and found no concerns following the completion of the assessment.
3. The facility mailed copies of the Resident Rights, DADS Hotline phone number and the company ' s Compliance Hotline phone numbers to the resident ' s responsible party / family member.
4. To protect non-interviewable residents from abuse included the following actions:
· Certified Nursing Assistants will utilize the Stop & Watch tool following all ADL care to alert the charge nurse of any changes they observe.
· Charge nurses will conduct weekly head to toes skin checks
· Charge nurses will monitor residents for changes in behavior and complete the SBAR if they have a concern and notify the family and physician.
5. Using the care path \interact process on Fall Do Not Move Resident From The Floor Until Complete Assessment Is Done and visual assessment is done. The assessments include AROM and PROM and visual observation of any limb shortening or internal or external rotation of any obvious sign of fracture. The staff will do the following:
a. Take vital signs - temperatures, BP, pulse,
b. If vital signs- critical is not met per (care path) then proceed with initial nursing evaluation for injuries and \ or mental status change. Do not move off the floor until complete exam has been performed.
c. Determine if suspected fracture or new bone deformity, head trauma, altered manta, (decrease LOC, unresponsiveness, suspicious of [MEDICAL CONDITION] new or worsen cognitive impairment), laceration required sutures\staples if yes notify MD\NP\PA and transfer via EMS.
6. If resident falls and has any complaints of [MEDICAL CONDITION] or spinal injury, head trauma, perform Neurological assessment at the scene of fall If any abnormalities call EMS and send resident out. Do not move resident. A complete report and notify MD via telephone. If no answer within one hour,, the Medical Director will be contacted. The RP\facility will be notified
Training:
The DON and the District Director of Clinical Services conducted re-education training for all Nursing, Dietary, Housekeeping, Laundry and Department Manager personnel January 8, 9 and 10, 2016. Training topics included were :
· Abuse and Neglect Prohibition
· Assessment of discomfort in Dementia Protocol
· Change in Condition
· Emergency Transports via 911 versus Non-emergency transfers.
Abuse and Neglect Prohibition training included a review of the facility ' s policy on abuse and neglect prohibition. The training was provided by the Director of Nursing Services and the District Director of Clinical Services. The training was presented in an oral fashion with examples provided of how abuse and neglect are defined, prevention techniques, identification, investigation, protection and reporting responsibilities.
Abuse and Neglect Prohibition training began January 8, 2016 and ended for all staff that were scheduled to work thru January 10, 2016 including RN ' s, LVN ' s, Certified Nursing Assistants, Certified Medication Aides, Staff Development, Nurse Managers, Rehab Staff, Dietary, Housekeeping and Laundry Staff and Department Managers. Staff that were not able to attend any of the training offered between January 8 thru January 10, 2016 will not be allowed to work with residents until they have been re-educated on the facility ' s Abuse and Neglect Prohibition policy.
The Assessment of discomfort in Dementia Protocol training included a review of how physical pain and affective discomfort experienced by people with dementia can be managed. The training was provided by the Director of Nursing Services and the District Director of Clinical Services. The training was presented in an oral fashion with examples provided of how the Assessment of Discomfort protocol should be applied when staff encounter situations with affected residents. Staff were trained on the steps they should follow which include:
· Conducting a physical evaluation
· Review residents history for potentially painful conditions
· Evaluating the discomfort and initiating non-pharmacologic comfort interventions
· Evaluate for pharmacologic interventions that are not [MEDICAL CONDITION]
The Assessment of discomfort in Dementia Protocol training began January 8, 2016 and ended January 10, 2016 for RN ' s, LVN ' s, Certified Nursing Assistants, Certified Medication Aides, Physical Therapy, Occupational Therapy and Speech Therapy staff. Staff that were not able to attend any of the training offered between January 8 thru January 10, 2016 will not be allowed to work with residents until they have been re-educated on The Assessment of Discomfort in Dementia Protocol program.
The facility ' s policy for identification of change of condition requires the implementation of the Stop & Watch tool as well as Interact 4.0. These decision support tools provide reporting guidance to licensed nurses on whether specific symptoms, signs, and lab results are immediate versus non-immediate, or next day, for reporting purposes to the primary care clinician. Using the Interact 4.0 tool the licensed nurse can determine immediacy of reporting for vital signs, laboratory results and diagnostic procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675231**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/13/2016**
NAME OF PROVIDER OF SUPPLIER **JACINTO CITY HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1405 HOLLAND HOUSTON, TX 77029**	

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 0309

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 13)
The Director of Nursing Services was re-educated on Stop & Watch and Interact 4.0 on January 9, 2016 by the District Director of Clinical Services.
The Director of Clinical Services and the Director of Nursing Services re-educated RN ' s, LVN ' s, Unit Managers, ADON ' s, Staff Development, Certified Nursing Assistants, Certified Medication Aides, Physical Therapy, Occupational Therapy, Speech Therapy and MDS nurses January 9 and 10, 2016 on the Stop & Watch and Interact 4.0 programs. Staff that were not able to attend any of the training offered between January 8 and 9, 2016 will not be allowed to work with residents until they have been re-educated on the facility ' s Stop & Watch and Interact 4.0 programs.
The licensed nurse will evaluate each situation based on individual resident condition at the time of the event. Once a medical emergency is identified, qualified staff evaluate the resident; initiate the appropriate emergency procedure(s), and calls 911. The licensed staff continues to provide care and monitor the resident until the emergency personnel arrive.
The surveyors confirmed the POR had been implemented sufficiently to remove the IJ by:
Record Review of the In-Service sign-in sheet revealed that staff from the nursing department representing all three shifts had been in-serviced from 01/08/16 until 01/10/16. The topics included in part: Abuse and Neglect, Dementia Resident Change in Condition and assessments and Emergency transport versus non-emergency transport
Observations were made from 01/08/06 until 01/10/16 , for any residents that have a change in condition/falls and care of residents with dementia.
Interviews conducted from 01/08/16-01/10/16 between 4:30am to 4:00 pm daily with CNAs and Nurses on various shifts revealed staff were able to verbalize the information from the recent in-services.
The Administrator and DON were informed on 01/13/16 at 1:35pm that the IJ was lowered; however the facility remained out of compliance at a pattern level and a severity of actual harm that is not immediate jeopardy due to facility needing more time to monitor the plan of removal for effectiveness.
The Form CMS 672 listed 104 residents as needing assistance or dependent on staff for mobility.

F 0490

Level of harm - Immediate jeopardy

Residents Affected - Many

Be administered in an acceptable way that maintains the well-being of each resident .
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview and record review the Administrator and DON failed to administer the facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical physical, mental and psychosocial well-being for 7 of 8 residents reviewed for abuse and neglect and quality of care. (Residents #6, #4, #8, #5, #3, #7and #1).
The Administrator failed to:
-- implement the facility Abuse, Neglect, and Exploitation (ANE) Policy to prevent abuse and neglect.
--supervise the DON to ensure nursing staff conducted accurate assessmnets of residents when they had a change in condition and a fall.
The DON failed to:
-Train and monitor the staff on management of Residents with Dementia.
-Train and monitor the nursing staff on assessing Residents when they had a change in condition and after a fall.
These failures affected 7 residents and placed 103 residents at risk for inadequate care and diminishing health conditions.
Intake #: 8, 0, 8, 2,
An IJ was identified on 01/08/2016. While the IJ was removed on 01/13/2016, the facility remained out of compliance at a scope of pattern and a severity level of actual harm due to the facility needing more time to monitor the plan of removal for effectiveness.
Findings Include:
In an interview on 01/08/16 at 2:13pm the Administrator said she monitored the DON by in-service of staff and monitoring her. She also said she was not aware of the situation regarding the abuse, neglect and quality of care.
In an interview at 01/08/16 at 2:30pm the DON said she ensured the nurses were competent in their skills by having a policy and procedure, in-services and skill check-off sheets.
In an interview on 1/09/2016 at 8:30am, Administrator said staff were going to be in-serviced on how to handle residents with Dementia. She said she knows that the staff was in-serviced on Dementia care by the state but was not sure how long ago as she is new to the facility and she would have to find out about the in-services. She also said that staff will be sent to Alzheimer ' s/Dementia training to be certified.
In an interview with the DON 1/09/2016 at 2:30pm she said that the facility has policies on abuse and neglect. Staff is in-serviced monthly. DON said she had not held an in-service prior to the IJ as today was her third day at the facility. DON said staff will all be educated on Stop and Watch . DON also said that all employees will be in-serviced on falls, dementia, and abuse and neglect before the start of their shift.
In an interview on 1/09/2016 at 9:10am with LVN D she said that she had only been with the facility for 3 weeks. LVN D was able to name the Administrator as the Abuse Coordinator but said she had not been in-serviced on Abuse and neglect, falls or dementia. LVN D said she did watch a new hire video but was not sure if the new hire video mentioned dementia or how to care for residents with dementia.
In an interview on 01/09/2016 at 9:15am with Housekeeping P, she said she was new to the facility and had only been there a few days. When Housekeeping P was asked about abuse and neglect training, she said I ' m not sure .
In an interview on 01/09/2016 at 8:53am with RCS Q, she was able to name the Administrator as abuse coordinator. RCS Q said she was in-serviced this morning on abuse and neglect as well as falls. RCS Q was not sure of when she had dementia training but knows that the facility provided it some time ago.
In an interview on 1/09/2016 at 8:50am with Housekeeping F, he said that he was new to the facility and had only been employed for 2 weeks. Housekeeping F said he has not had abuse or neglect training, falls or dementia training and was not sure who the abuse coordinator was.
In an interview with LVN S on 1/09/2016 at 8:55am she said that this was her second day working at the facility. She said she was in-serviced on falls, abuse and neglect this morning before her shift. LVN S was able to name the Administrator as the abuse coordinator. LVN S said she had not been in-serviced on residents with dementia or how to care for them.
In an interview on 1/12/2016 with LVN C, she said she had recently been in-serviced on abuse and neglect. She named facility Administrator as the abuse coordinator. LVN C said she had training on dementia and residents with dementia was not sure when.
In an interview on 1/12/2016 with ADON, she said that she was in-serviced on falls and abuse and neglect. She knows she had training on dementia and redirecting residents but was not sure how long ago.
Resident #6
Record review of Resident # 6 ' s Care Plan dated 7/02/2014 with a review date of 10/15/2015 revealed:
Resident #6 had moderate cognitive impairment due to short-term and long-term memory loss. Approach: Staff will offer options in simple terms regarding care for resident to choose, Provide time to think/react.
Resident #6 was care planned for falls. Approach: Falling Star Program, Encourage resident to ask for assist, orient resident to environment, bed alarm, chair alarm, place call light in reach, observe for `potential patterns of falls to identify possible causes, Offer/assist to toilet frequently and as accepted, place frequently used items within reach, and observe for potential medication related causes.
Observation on 1/06/2016 at 3:15pm revealed Resident #6 sitting in wheelchair attempting to enter her room but was not able to as medication cart was blocking the entrance to her room. Surveyor intervened and informed MA B that Resident #6 was trying to enter her room but could not due to the medication cart blocking entrance to room. MA B said he was aware she wanted in the room and that is why he had the cart there to block the entrance to prevent her from going in the room. He further revealed she was a fall risk and did not want her in the room.
Observation on 1/06/2016 at 3:19pm revealed Resident #6 in her wheelchair wedged between medication cart and door to her room. Surveyor intervened and informed MA B and RCS K that Resident #6 was wedged between medication cart and door to her room. MA B and RCS K went over to Resident #6 and moved the cart and told Resident #6 she could not go to her room at this time. Resident #6 grabbed the handrail and tried to wheel herself into her room. Resident #6 said she wanted to look at the box in her closet. MA B and RCS K told her she was not able to go into her room at this time. Resident #6 would not release handrail as she continued to try and wheel herself into her room. MA B grabbed Resident #6 ' s wrist/arm and tried to pull

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JACINTO CITY HEALTHCARE CENTER	**1405 HOLLAND** **HOUSTON, TX 77029**

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 14) her hand off the railing. RCS K then began prying Resident #6 ' s fingers from the handrail. The DON walked by and quickly removed MA B and RCS K from Resident #6. MA B and RCS K told the DON that they did not want Resident #6 in her room because she would make a mess and take things out of her closet and she was a fall risk. DON informed MA B and RCS K that Resident #6 had the right to enter her room. Interview on 1/06/2016 at 3:30pm with the DON revealed that she performed an assessment on Resident #6 and found no injuries. She further revealed that MA B and RCS K acted inappropriately and should have allowed her to enter her room or they could have tried redirecting her. The DON said they should not have grabbed Resident #6's hand or arm. The DON said staff would be in-serviced in Abuse/Neglect. The DON revealed that she was sure staff had training on Dementia but was not sure of the date. In an interview with RCS K on 1/06/2016 at 3:35pm she said that she was trying to re-direct Resident #6 because she did not want her in the room because Resident #6 was a fall risk. In an interview with Resident #6 at 3:45pm she said that MA B and RCS K hurt her wrist. Resident #6 said no one had ever grabbed her arm like that before. She said she just wanted to look in the box in her closet. Observation on 1/06/2016 at 3:45 pm revealed redness to Resident #6 ' s right wrist. Record review of MA B ' s written statement dated 1/06/2016 revealed at about 3pm, he was by the Med Aid Cart, and was about to move it. He was told by the RCS K not to move it because Resident #6 was a fall risk. Resident #6 tried to wheel herself in her room. As she tried to go inside, the RCS K grabbed her hand, telling her not to go in her room for her safety. He only touched the resident and nothing more. In an observation and interview with Resident #6 on 1/07/2016 at 9:40am she revealed she had three small bruises on her right wrist purple in color and in the shape of finger prints. Resident #6 said she had pain to her right wrist. In an interview with the DON on 1/07/2016 at 9:45am she revealed she was aware not aware of bruising. The DON said she would assess Resident #6 and administer Tylenol per orders for her pain to her right wrist. In an interview with DON on 1/07/2016 at 10:00am she verified that there were 3 small bruises to Resident #6 ' s right wrist. The DON said she had not noticed them before because they were under the wander guard. Resident #4 Record review of Resident #4 ' s Care Plan dated 12/14/2015 with a reviewed date of 12/23/15 revealed: Resident #4 had Cognitive Deficit; Resident had moderate independence with decision making. Resident had difficulty with making decisions in new situations. Approach: Provide clear choices and adequate information for resident to make decisions, Point out consequences of bad decisions, involve family members in decisions regarding important matters. Resident #4 was at risk for falls due to: history of previous falls, non-ambulation, blood pressure changes, and [MEDICAL CONDITION]. Approach: Falling star program, encourage resident to ask for assistance, physical therapy, occupational therapy, provide assistive devices such as wheelchair, place call light in reach, observe for potential patterns of falls to identify possible causes, and place frequently used items within reach. Resident #4 was care planned for, [DIAGNOSES REDACTED]. Approach: Administer medication as ordered, fall risk assessment, fall prevention protocol as indicated, call bell within reach, notify MD as indicated. In an interview with Resident #4 on 1/06/2016 at 9:40am he said he was at the facility for therapy and was feeling alright today. Observation at the same time revealed resident was well groomed, lying in bed with head of bed elevated. His call light was within reach. There were no falling star above the bed or doorway entrance to signify that Resident #4 was a fall risk. In an interview on 1/06/2016 at 2:20pm with LVN A she said she was called to dining room and found Resident #4 lying on his side on the floor. LVN A said she assessed Resident #4 and found 2 lacerations to the back of his head and he had a skin tear to right arm. Resident #4 was assisted to wheelchair and then assisted to his bed. LVN A said she started neuro vitals and notified physician of fall. She further said that orders were received for Tylenol 650mg for discomfort, wound care orders for skin tear of right arm and both wounds to head. LVN A said no orders were received for CT (cat scan). Record review of Interdisciplinary Post Fall Report dated 1/6/2016 revealed Resident #4 suffered a fall at 11:00am on 1/6/2016. Resident #4 was assessed by LVN A and assisted to wheelchair and then to bed. Record further revealed Resident #4 sustained an open area to the back of the head and right wrist. Record review of Resident #4 ' s Interdisciplinary Post Fall Review completed by LVN A and dated 1/06/16 read: Predisposing Diseases: Dementia. In an interview on 1/08/16 at 3:14pm with Resident #4 ' s RP revealed that Resident #4 did not have a [DIAGNOSES REDACTED].#4 ' s fall until he arrived at facility on 1/06/2016 after lunch time. He said LVN H told him they did not have his phone number in Resident #4 ' s chart. The RP said that Resident #4 is not acting like his self and had been acting different since the fall. The RP said that he arrived at facility at 11:00am today and Resident #4 would not wake up and his breakfast had not been eaten. He said he informed the nurse of Resident #4 ' s condition and she assessed him and said she would call the physician. The RP said LVN H told him that Resident #4 would be transferred to hospital for evaluation but that was over 3 hours ago and Resident #4 still had not woken up. Observation on 1/08/ at 3:14pm of Resident #4 revealed he was lying in bed with head of bed elevated. Resident ' s lips were dry and cracked and lunch was at bedside and had not been eaten. Resident #4 did not respond to verbal stimuli. The RP shook Resident #4 by the shoulder and Resident #4 did not respond. In an interview with LVN H on 1/08/2016 at 3:30pm she said that she had notified physician of change in mental status and Resident #4 was to be transferred to hospital. She further revealed that she contacted several ambulance companies and chose the one with the least estimated time of arrival. When asked if she called 911 for Resident #4 due to non-responsiveness, she said no. In an interview with the DON on 1/08/2016 at 3:35pm she revealed she was unaware that LVN H had not called 911. She was aware of change in condition on 1/07/2016 and had requested an order from physician for x-ray of skull on 1/07/2016. She further revealed that Resident #4 did not become unresponsive until 1:00pm on 1/08/2016. DON said she would have ADON call 911 immediately for transfer. Record review of nurse ' s notes dated 1/8/2016 at 12:00pm said hospital nurse was visiting with Resident #4 and family. Hospital nurse requested that nurse on duty to assess Resident #4. Resident #4 said he was not feeling well. Hospital nurse remained at bedside. Call was placed to physician regarding assessment and Resident #4 not feeling well and also made aware of recent fall from wheelchair. Record review of nurse ' s notes dated 1/8/2016 at 12:15pm read: placed call to hospital, spoke to emergency room nurse. Report given. Went to Resident #4 ' s room, made resident aware he would be transferred to hospital. Record review of nurse ' s note dated 1/08/2016 at 12:25pm read: placed call to ambulance service. The above report given to dispatcher. Stated will send ambulance right away. Made charge nurse aware. Record review of nurse ' s note dated 1/08/2016 at 12:30pm read: Resident in room. Son at bedside. Blood sugar (BS)=69. Call placed to MD. New order to give glucacon 1mg IM (intra-muscular)if resident not awake. Record review of nurse ' s note dated 1/08/2016 at 1:00pm read: BS=100. Resident responds to painful stimuli. Awaiting on transportation. Record review of nurse ' s note dated 1/08/2016 at 2:00pm read: Responds to painful stimuli and moves all extremities. No sign or symptoms of pain or discomfort. Record review of nurse ' s note dated 1/08/2016 at 2:30pm read: Awaiting on transportation. Resident denies pain. Respirations even and unlabored. Vital signs: blood pressure-140/78, 80, 20, 97%. Record review of nurse ' s note dated 1/08/2016 at 3:00pm read: Resident responding to painful stimuli. No signs of distress. Respirations 20 per minute. Son at bedside and aware of change of condition. Record review of nurse ' s note dated 1/08/2016 at 4:50pm read: EMS personnel arrived. Blood sugar at this time is 71. Blood pressure 140/79, pulse 79, respirations 20, and temperature 97.8. In an interview with DON on 1/08/2016 at 5:10pm she said that ADON and LVN H both will be counseled on assessment, the depth of assessment, and starting interventions. She stated They both failed to assess with urgency . Record review of emergency room visit dated 1/08/2016 revealed Patient is non-responsive. Per EMS, family says patient was not his normal self after fall. In an interview with Resident #4 ' s RP on 1/09/2016 at 2:00pm he revealed that Resident #4 was still not alert. In an interview on 1/11/2016 at 3:00pm with Resident #4 at hospital, resident responded to verbal stimuli. Resident #4 said

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 15) he was not feeling well and hasn ' t felt well since the fall. He said he is hoping to get better so he can return to his home. Resident #8 Record review of Resident #8 ' s Care Plan dated 6/30/2015 with a review dated of 10/29/2015 revealed resident was at risk for falls. Approach: Falling Star program, encourage resident to ask for assistance, place call light in reach, place frequently used items within reach. In an interview on 1/10/2015 at 1:40pm with Administrator revealed Resident #8 was identified as having concerns with caregivers. Administrator said resident was not able to understand the RCS ' s in his room because they were speaking Spanish. Administrator said that Resident #8 ' s roommate spoke Spanish and told the RCS in Spanish not to hurt Resident #8 or he would report them. In an interview with Resident #8 at 3:00pm he said that one of the RCS ' s was rough with him while trying to change his brief. Resident #8 said RCS grabbed him by one leg and spun him around in bed so she could change his brief. Resident #8 further revealed that same RCS had pushed him into the bed before. Resident #8 was not sure of RCS ' s name. He said he had not seen her in about 4 days. In an interview with the DON on 1/10/2016 at 3:30pm she said we was not sure who the RCS was that Resident #8 was talking about, but she would find out. In an interview with the DON on 1/11/2016 at 11:40am she revealed that RCS G, RSC I and RCS H were all in Resident #8 ' s room when incident occurred and RSC H had provided a written statement. In a telephone interview on 1/13/2016 at 12:15pm with RCS H she said she was passing by Resident #8 ' s room and heard noise. RCS H said she opened the door and the curtain was drawn. She said RCS I was turning Resident #8 and moved his leg. She said she told RCS I to move Resident #8 slowly. RCS H said RCS I responded with That ' s not how I do it . When RCS H was asked if she did anything regarding the treatment of [REDACTED]. In a telephone interview on 1/13/2016 at 1:00pm with RCS G she said RCS I was changing Resident #8 and she was in the room to assist. RCS G said Resident #8 hollers every time he was changed. RCS G said that when RCS I turned Resident # 8 he screamed . RCS G further revealed that the Resident #8 ' s roommate heard Resident #8 screaming and roommate told them he was going to report them for being mean to Resident #8. In a telephone interview on 1/13/2016 at 1:20pm with RCS I she said she was in the room with RCS G who was giving Resident #8 a bed bath. RCS I said RCS H was also in the room to translate for Resident #8 ' s Spanish speaking roommate. RCS I said the roommate said in Spanish that he was going to report them for being mean to Resident #8 if they didn ' t stop. Resident #3 Record review of care plan dated 7/15/15 with a review date of 10/15/15 revealed resident was care planned for Depression/Anxiety. Approach: Provide calm, reassuring environment, encourage resident and staff to be alert to events or situations that precipitate episodes of restlessness or anxiety, calm and reassure as needed, modify environment to promote calm and comfort. In an interview with Resident #3 on 1/08/2016 at 1:40pm she said that RCS M was rude and mean to her. She further revealed that she doesn ' t put up with it and takes care of it herself by telling him off. Resident #3 further revealed she did not like it when RCS M was assigned to her hall and she was scared of him. Resident #3 had witnessed RCS M speak rudely to her roommate (Resident #5) and take her call light away so she would not be able to use it and stated her roommate was also scared of RCS M. Resident #3 said she had mentioned it to previous administrator and RCS M was moved to a different hall but now he was working on her hall again andshe was worried he might come into her room. In an interview with the DON on 1/08/2016 at 1:50pm she said she was aware of the incident involving Resident #3 and RCS M. She said RCS M had been removed from the floor and suspended pending investigation. Resident #5 Record review of Resident #5 ' s care plan dated 12/2/15 with a reviewed date of 12/17/15 revealed Resident #5 was care planned for falls. Approach: Place call light in reach, full body lift-hoyer, use calm, patient approach when using mechanical lift. Record review of Resident #5 ' s care plan dated 12/4/15 with a reviewed date of 12/17/15 revealed Resident #5 was care planned for falls. Approach: Falling Star Program, place call light in reach, place frequently used items in reach, offer/assist to toilet frequently and as accepted. Record review of Resident #5 ' s care plan dated 12/8/15 with a reviewed date of 12/17/15 revealed resident was care planned for anxiety. Approach: Administer medication as ordered, Monitor for side effects to medication, notify MD as indicated, monitor for effectiveness, refer to social services as indicated, refer to psych services as indicated. In an interview on 1/06/2016 at 1:45pm Resident #5 said she didn ' t like it when that mean man would come into her room. She said that whenever she used her call light he would come in the room and take it away. She said that RCS M told her This call light won ' t get you water and then took the call light away and placed it out of her reach. Resident #5 said she told the previous administrator and RCS M was moved to another hall but she sometimes will see him on her hall and is very worried he might hurt her. Observation at same time revealed no Falling Star over bed or outside of door to identify resident as a fall risk. In an interview on 1/06/2015 at 1:50pm Resident #5 ' s roommate (Resident #3) said that everything Resident #5 said was true. Resident #3 said she had witnessed him speaking rudely to Resident #5 and had witnessed him take her call light away. In an interview with DON on 1/08/2016 at 1:50pm she said she was aware of the incident involving Resident #5 and RCS M. She said RCS M has been removed from the floor and suspended pending investigation. DON said all employees will be in-serviced on abuse and neglect when they come in for their shifts. She said they would not be able to care for residents until they had been in-serviced. Resident #7 Record review of care plan dated 12/21/15 with a reviewed date of 1/7/16 revealed resident was care planned for falls. Approach: Falling Star Program, encourage resident to ask for assistance, place call light in reach, place frequently used items within reach, offer/assist to toilet frequently and as accepted. In an interview with Resident #7 on 1/11/ at 11:25am he revealed that RCS G was rude and speaks aggressively towards him. He also said that when RCS G enters the room she refuses to give her name. Resident #7 also said that when he used the call light for pain medication RCS G just enters the room, turns off the call light and leaves the room. Resident #7 said she never returns to let him know if she told the nurse he needed something for pain. In an interview with DON on 1/11/2016 at 11:35am she said she was aware of the incident involving RCS G and incident was being investigated. The DON further said that she double checked the Medication Administration Record [REDACTED]. The DON also said staff would be receiving sensitivity training now and quarterly. In a telephone interview with RCS G on 1/13/2016 at 1:00pm she said that she took care of Resident #7 on Friday. She asked the nurse to tell Resident #7 that she was the only RCS on his hall. RCS G said that Resident #7 reported that she does not let him know when she tells the nurse he needs medicine for pain. She said she was not aware that she had to report back to him. She stated My tone is high sometimes, maybe I come off rude . Resident#1 Record review of Resident #1 ' s Care Plan dated 12/15/2015 revealed that he was at risk for falls. Approach: Falling Star Program, encourage resident to ask for assistance, place call light in reach, observe for potential patterns of falls to identify possible causes, offer/assist to toilet frequently and as accepted, place frequently used items within reach, observe for potential medication related causes. In an interview on 1/06/2016 at 11:00am with Resident #1 he revealed that he had a fall while he was out on pass. He said he hit his head when he fell down 4-5 steps. Resident #1 said he fell on [DATE] and when he returned to the facility that same day, he did not tell any staff and the staff didn ' t ask about the bump and scratches to his forehead. Resident #1 said no one noticed the bump on his head and scratches until the hospital nurse came to visit him at the facility on 12/23/2015 . Resident #1 said the hospital nurse noticed immediately and she told the facility of the fall and his injuries. Resident further revealed that CT (cat scan) revealed a fracture to his neck and he needed to wear a neck brace. Observation at same time revealed resident was wearing neck brace per physician order. In a telephone interview on 1/06/2016 at 10:00am with hospital nurse she said that she was very concerned about Resident #1 ' s care and the assessment skills of the nurses at the facility. The hospital nurse said she noticed immediately that

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 16)

Resident #1 had a large bump to his forehead along with scratches. She said she asked Resident #1 about the bump and scratches and he said he fell down some stairs while he was out on pass. The Hospital nurse said the facility was not aware of Resident #1's fall until she notified them on 12/23/2015.
Record review of nursing notes dated 12/23/2015 at 1:00pm revealed Resident #1 said he fell at home on 12/22/2015. Head to toe assessment performed. Resident #1 was alert and oriented. Small laceration on the forehead observed, scratch to the tip of nose. No bruising noted. Call placed to physician. No new orders received. Continue with Neuro vital signs, monitor for pain, bruising, redness or neurological change.
Record review of Neurological record dated 12/23/2015 revealed that Neurological checks were started at 12:45am on 12/23/2015 and continued to 5:30pm on 12/23/2015.
Record review of nurses note dated 12/23/2015 at 4:30pm revealed facility called hospital nurse regarding Resident #1 and his fall. Hospital nurse voiced concern regarding documentation of facility nurse and requested that hospital protocol be followed for falls with suspected head injuries.
Record review of SBAR Communication Form dated 12/23/2015 at 6:05pm revealed that Resident #1's physician was notified of fall while Resident #1 was out on pass 12/22/2015. Orders received from physician to send Resident #1 to emergency room for evaluation and treatment for [REDACTED].
Record review of CT report dated 12/24/2015 read: Diagnostic Impression; C3 cervical [MEDICATION NAME] process fracture: acute
Record review of physician order [REDACTED].
In an interview with the Director of Nursing (DON) on 1/8/2015 at 5:00pm she was unsure of policy regarding assessments of residents who go out on pass and how residents were monitored when they returned. The DON said she would find out.
In an interview with DON on 1/11/2015 at 3:30pm she said that residents should be assessed before going out on pass and when they return. She further said that when residents go out on pass that the residents must inform the nurse and sign out on the Out of Facility Release of Responsibility form and they sign in when they return so that they know the resident has returned. She further revealed that the nurse on duty signs the form as well.
Record review of Out of Facility Release of Responsibility form in Resident #1 ' s chart revealed Resident #1 signed himself out on pass on 12/18/15, 12/24/15, 12/28/15, 1/03/16, 1/04/16, and 1/07/16. There were no signatures by nurse or resident indicating that Resident #1 returned to facility on those days.
Record review of Suspected resident abuse assessment, long-term care dated October 02, 2015 provided by facility read:
-Residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
-The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
-The facility must not employ individuals who have been found guilty by court of law of abusing, neglecting, or mistreating residents or who have had a finding entered into the state nursing assistant registry concerning abuse, neglect, or mistreatment of [REDACTED].
-The facility must report to the state ' s nursing assistant registry or licensing authorities any knowledge it has of actions by a court of law against an employee that would indicate unfitness for service as a nursing assistant or other facility staff member.
-The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of a resident ' s property, are reported immediately, through established procedures, to the facility administrator and to other officials in accordance with state law.
-The facility must have evidence that all alleged violations have been thoroughly investigated and must take precautions to prevent further potential abuse while the investigation is in process.
An immediate jeopardy (IJ) was identified on 01/08/16 at 2:13 pm and the Administrator was informed at that time.
A Plan of Removal (POR) for the IJ was submitted on 01/09/16 at 12:40pm and after several revisions were made it was accepted on 01/12/16 at 4:13pm.
The POR included in part:
Immediate Action:
1.The Interdiscplinary Team interviewed 69 interviewable residents, provided a copy of Resident ' s Rights to voice concerns and to be free of retaliation. copy of the DADS Hotline phone number and Compliance Hotline phone numbers to report any concerns. They were re-educated regarding where the phone numbers were posted in the facility for DADS Hotline and Compliance Hotlines.
2. The DON and Charge Nurses conducted Head to Toe skin checks on 37 non-interviewable residents and found no concerns following the completion of the assessment.
3. The facility mailed copies of the Resident Rights, DADS Hotline phone number and the company ' s Compliance Hotline phone numbers to the resident ' s responsible party / family member.
4. To protect non-interviewable residents from abuse included the following actions:
· Certified Nursing Assistants will utilize the Stop & Watch tool following all ADL care to alert the charge nurse of any changes they observe.
· Charge nurses will conduct weekly head to toes skin checks
· Charge nurses will monitor residents for changes in behavior and complete the SBAR if they have a concern and notify the family and physician.
5. Using the care path \interact process on Fall Do Not Move Resident From The Floor Until Complete Assessment Is Done and visual assessment is done. The assessments include AROM and PROM and