DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:7/19/2016 FORM APPROVED OMB NO. 0938-0391
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 SU JACINTO CITY HEALTHC		1405 HOLLANI	
For information on the nursing	home's plan to correct this deficient	HOUSTON, TX cy, please contact the nursing home or the state surv	
(X4) ID PREFIX TAG	1	EFICIENCIES (EACH DEFICIENCY MUST BE	
F 0223	Protect each resident from all al	ouse, physical punishment, and being separated f	from
Level of harm - Immediate jeopardy	others. **NOTE- TERMS IN BRACKET F223	S HAVE BEEN EDITED TO PROTECT CONFID	DENTIALITY**
Residents Affected - Many	Based on interview and record rev provided for 5 of 8 residents revie Resident #6 was grabbed by her w her from entering her room. RSC I handled Resident #8 roughl RCS M verbally abused Resident # #5 was scared of RCS M. RCS G was rude and mean to Resi RCS G was rude and mean to Resi RCS G was rude and refused to tel An IJ was identified on 01/08/201 scope of pattern and a severity lex for effectiveness. These failures affected five residen Intake #: 8, 0, 8, 2 Findings Include: Record review of Resident #6 ' s fi Diagnoses: [REDACTED]. Record review of Resident #6 ' s fi Record review of Resident #6 ' s fi Resident #6 had moderate cogniti options in simple terms regarding Resident #6 was care planned for 1 resident to environment, bed alarr identify possible causes, Offer/ass observe for potential medication n Resident #6 had [DIAGNOSES R protocol as indicated, call bell wii Observation on 1/06/2016 at 3:15 to as medication cart was blockin, trying to enter her room but could wanted in the room and that is wh further revealed she was a fall risis Observetion on 1/06/2016 at 3:15 proom. Surveyor intervened and in room. MA B and RCS K went ov time. Resident #6 grabbed the har	I Resident #7 her name. 6. While the IJ was removed on 01/13/2016, the fac (e) of actual harm due to the facility needing more t its and placed 105 residents at risk for mistreatmen ace sheet revealed resident is a [AGE] year old fem Care Plan dated 7/02/2014 with a review date of 10, ve impairment due to short-term and long-term mer care for resident to choose, Provide time to think/rr falls. Approach: Falling Star Program, Encourage re n, chair alarm, place call light in reach, observe for sist to toilet frequently and as accepted, place freque elated causes. EDACTED]. Approach: Administer medication as of hin reach, notify MD as indicated. m revealed Resident #6 sitting in wheelchair attem g the entrance to her room. Surveyor intervened and not due to the medication cart blocking entrance to y he had the cart there to block the entrance to prev cand did not want her in the room. m revealed Resident #6 in her wheelchair wedged formed MA B and RCS K that Resident #6 dat Resident where it means the server in the room. Resident #6 and moved the cart and told Resid dirail and tried to wheel herself into her room. Resident	evidenced by: I Resident Care Specialist (RCS) K to prevent e leg to reposition him in bed. vould not help her get water. Resident solution of the plan of removal tility remained out of compliance at a ime to monitor the plan of removal t, abuse and neglect. ale with an admission date of [DATE]. /15/2015 revealed: mory loss. Approach: Staff will offer eact. esident to ask for assist, orient `potential patterns of falls to ently used items within reach, and ordered, fall risk assessment, fall prevention e Resident 's door or above her bed to upting to enter her room but was not able d informed MA B that Resident #6 was o room. MA B said he was aware she yent her from going in the room. He between medication cart and door to her dged between medication cart and door to her dged between medication cart and door to her dget #6 said she wanted to look at the
	handrail as she continued to try ar her hand off the railing. RCS K the removed MA B and RCS K from because she would make a mess and take t #6 had the right to enter her room interview on 1/06/2016 at 3:30pm injuries. She further revealed that they could have tried redirecting 1 staff would be in-serviced in Abu sure of the date. In an interview with RCS K on 1/0 want her in the room because Res In an interview with RCS K on 1/0 want her in the room because Res In an interview with Resident #6 at grabbed her arm like that before. : Observation on 1/06/2016 at 3:45 Record review of MA B 's writter to move it. He was told by the RC in her room. As she tried to go im only touched the resident and not Record review of RCS K 's writter to Resident #6, and touched her h In an observation and interview wit right wrist purple in color and in to In an interview with DON on 1/07 wrist. The DON said she would assess F In an interview with DON on 1/07 wrist. The DON said she had not	with the DON revealed that she performed an asset MA B and RCS K acted inappropriately and shoul rer. The DON said they should not have grabbed R se/Neglect. The DON revealed that she was sure sta 06/2016 at 3:35pm she said that she was trying to re ident #6 was a fall risk. 1 3:45pm she said that MA B and RCS K hurt her v She said she just wanted to look in the box in her cl pm revealed redness to Resident #6 's right wrist. 1 statement dated 1/06/2016 revealed at about 3pm, 'S K not to move it because Resident #6 was a fall r ide, the RCS K grabbed her hand, telling her not to	ident #6's wrist/arm and tried to pull- undrail. The DON walked by and quickly they did not want Resident #6 in her room Vinformed MA B and RCS K that Resident ssment on Resident #6 and found no d have allowed her to enter her room or esident #6's hand or arm. The DON said aff had training on Dementia but was not e-direct Resident #6 because she did not vrist. Resident #6 bad no one had ever loset. he was by the Med Aid Cart, and was about risk. Resident #6 tried to wheel herself o go in her room for her safety. He #6 was trying to enter her room and RCS nent further revealed that she spoke use she was a fall risk. d she had three small bruises on her pain to her right wrist. all bruises to Resident #6 's right ander guard. read: Description of Allegation- The DON was
	S OR PROVIDER/SUPPLIER	TITLE	(X6) DATE

REPRESENTATIVE'S SIGNATURE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1O11

Facility ID: 675231

If continuation sheet Page 1 of 17

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:7/19/2016 FORM APPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 01/13/2016		
	675231				
NAME OF PROVIDER OF SU IACINTO CITY HEALTHC.		STREET ADDRESS, 1405 HOLLAND	CITY, STATE, ZIP		
		HOUSTON, TX 770			
(X4) ID PREFIX TAG	· ·	cy, please contact the nursing home or the state survey a DEFICIENCIES (EACH DEFICIENCY MUST BE PRE	° '		
E 0222	OR LSC IDENTIFYING INFORM				
F 0223 Level of harm - Immediate jeopardy	with the resident's hand because t and put his hand around the reside	she was going, and reached towards residents hand, The he resident's body and wheelchair were blocking my vie ent 's wrist to prevent her from grabbing onto the other vened with the staff explaining to them resident 's rights	ew. However, MA B then reached over door frame, causing resident to		
Residents Affected - Many	room to access items in her closet	t and then redirected her back to into the activity room. ' Jucation, and notified the administrator of the incident.			
		ace sheet revealed a [AGE] year old male with an admis	ssion date of [DATE]. Diagnoses:		
	Record review of Resident #8 's M decision making. He was assessed staff members for all activities of	MDS dated [DATE] revealed resident was moderately in d as not having problems with moods or behaviors, need daily living (ADL) except eating for which he required n range of motion he was assessed as impairment on bot	led extensive assistance of one to two supervision only. Under the		
	Record review of Resident #8 's C for falls. Approach: Falling Star p frequently used items within reac		call light in reach, place		
	caregivers. Administrator said res	40pm with Administrator revealed Resident #8 was iden ident was not able to understand the RCS 's in his room Resident #8 's roommate spoke Spanish and told the RC	n because they were speaking		
	brief. Resident #8 said RCS grabl	tt 3:00pm he said that one of the RCS 's was rough with bed him by one leg and spun him around in bed so she c ad pushed him into the bed before. Resident #8 was not	ould change his brief. Resident #8		
	In an interview with the DON on about, but she would find out.	1/10/2016 at 3:30pm she said we was not sure who the F 1/11/2016 at 11:40am she revealed that RCS G, RSC I a	C C		
	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 dwitnessed RCS M was 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.				
	Diagnoses: [REDACTED]. Record review of MDS dated [DA	esident #5 revealed an [AGE] year old female who was TE] revealed a BIMS score of 8. MDS further revealed	that Resident #5 required extensive		
	Record review of Resident #5 's c planned for falls. Approach: Place mechanical lift.	dressing. MDS revealed Resident #5 was total depender are plan dated 12/2/15 with a reviewed date of 12/17/15 e call light in reach, full body lift-hoyer, use calm, patier	5 revealed Resident #5 was care nt approach when using		
	planned for falls. Approach: Falli offer/assist to toilet frequently and Record review of Resident #5 's c	are plan dated 12/8/15 with a reviewed date of 12/17/15	tly used items in reach, 5 revealed resident was care planned		
	monitor for effectiveness, refer to Interview on 01/06/16 at 1:30pm, is your damn soup. He then told h	r medication as ordered, Monitor for side effects to mec social services as indicated, and refer to psych services Resident #5 said RCS M came into her room (date and the her he was not going to get her out of this damn bed.	as indicated. time not provided) and told her, Here		
	She said that whenever she used I This call light won 't get you wat	45pm Resident #5 said she didn ' t like it when that mea her call light he would come in the room and take it awa er and then took the call light away and placed it out of or and RCS M was moved to another hall but she someti	y. She said that RCS M told her her reach. Resident #5 said		
	In an interview on 1/06/2015 at 1: true. Resident #3 said she had wit In an interview with the DON on	50pm Resident #5 's roommate (Resident #3) said that ( tnessed him speaking rudely to Resident #5 and had with 1/08/2016 at 1:50pm she said she was aware of the incid ed from the floor and suspended pending investigation.	nessed him take her call light away.		
	Record review of Resident #7 ' s c [REDACTED]. Record review of Resident #7 ' s M	ilinical record revealed a [AGE] year old male with an a MDS dated [DATE] revealed a BIMS score of 13 which that Resident #7 required extensive assistance for bed	indicated no cognitive impairment. The		
	Resident #7 was total dependence Record review of care plan dated Approach: Falling Star Program,	12/21/15 with a reviewed date of 1/7/16 revealed resident encourage resident to ask for assistance, place call light	nt was care planned for falls.		
	In an interview with Resident #7 of also said that when RCS G enters light for pain medication RCS G	toilet frequently and as accepted. on $1/11/$ at 11:25am he revealed that RCS G was rude an the room she refused to give her name. Resident #7 als just entered the room, turns off the call light and leaves he told the nurse he needed something for pain.	o said that when he used the call		

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	ME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CINTO CITY HEALTHCARE CENTER 1405 HOLLAND						
For information on the nursing	home's plan to correct this deficien		HOUSTON, TX 77029 e or the state survey agency.				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D	DEFICIENCIES (EACH DEFICIEN		FULL REGULATORY			
F 0223 Level of harm - Immediate	being investigated. The DON furt	/2016 at 11:35am she said she was her said that she double checked th sensitivity training now and quart	ne Medication Administration Re				
jeopardy Residents Affected - Many	In a telephone interview with RCS the nurse to tell Resident #7 that s let him know when she tells the n him. She stated My tone is high s Record review of in-service dated report.	G on 1/13/2016 at 1:00pm she sai she was the only RCS on his hall. Furse he needs medicine for pain. Sl ometimes, maybe I come off rude 12/22/2015 revealed staff was in-s	id that she took care of Resident # CCS G said that Resident #7 repo he said she was not aware that sh service on reporting abuse and ab	rted that she did not had to report back to			
	Record review of in-service dated residents. Record review of Dementia, reside facility read: -Visual strategies; Approach the r	12/31/2015 revealed staff was in-se 1/06/2016 revealed staff was in-se ent communication, long term care esident from the front, in his vision tion topic, provide contextual and	rviced on Dementia care and con policy with revised date of Octo field, smile, present objects or w	ber 02, 2015 provided by written cues to			
	enlargement, pictures, drawings, -Auditory strategies; use calm, po familiarity, use praise and compli -Tactile Strategies; use touch to re objects as reminders. In an interview on 01/06/16 at 11:	and symbols. sitive, unhurried speech, state the p	person's name and yours to incre direct, and prompt desired behavi	case a sense of ior, use familiar			
	had not been trained on abuse or trained on residents with dementi Interview on 01/09/16 at 9:10am weeks and had not been trained o	vith Licensed Vocational Nurse (L r in-serviced on abuse and neglect	buse prohibition coordinator was VN) D revealed she had worked or working with residents with de	and had not been at the facility for three ementia.			
	<ul> <li>-Residents have the right to be fre seclusion.</li> <li>-The facility must develop and im residents and misappropriation of</li> </ul>	ent abuse assessment, long-term ca e from verbal, sexual, physical, and plement written policies and proce- resident property. viduals who have been found guilt	d mental abuse, corporal punishm dures that prohibit mistreatment,	nent, and involuntary neglect, and abuse of			
	mistreatment of [REDACTED]. -The facility must report to the sta actions by a court of law against a	ng entered into the state nursing as: te 's nursing assistant registry or li an employee that would indicate ur	censing authorities any knowledg	ge it has of			
	unknown source and misappropri to the facility administrator and to -The facility must have evidence t	lleged violations involving mistrea ation of a resident 's property, are o other officials in accordance with hat all alleged violations have beer	reported immediately, through es state law. h thoroughly investigated and mu	stablished procedures,			
	An immediate jeopardy (IJ) was id A Plan of Removal (POR) for the accepted on 01/12/16 at 4:13pm. The POR included in part: Immediate Action:	hile the investigation is in process. lentified on 01/08/16 at 2:13 pm at IJ was submitted on 01/09/16 at 12	nd the Administrator was informe 2:40pm and after several revision:	s were made it was			
	and to be free of retaliation. copy concerns. They were re-educated Compliance Hotlines.	viewed 69 interviewable residents, of the DADS Hotline phone numb regarding where the phone number	er and Compliance Hotline phone rs were posted in the facility for I	e numbers to report any DADS Hotline and			
	following the completion of the a 3. The facility mailed copies of the numbers to the resident 's respon 4. To protect non-interviewable re	e Resident Rights, DADS Hotline p	phone number and the company ' llowing actions:	s Compliance Hotline phone			
	<ul> <li>changes they observe.</li> <li>Charge nurses will conduct weekly head to toes skin checks.</li> <li>Charge nurses will conduct weekly head to toes skin checks.</li> <li>Charge nurses will monitor residents for changes in behavior and complete the SBAR if they have a concern and notify the family and physician.</li> <li>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: <ul> <li>a. Take vital signs - temperatures, BP, pulse,</li> <li>b. If vital signs - critical is not met per (care path) then proceed with initial nursing evaluation for injuries and \ or</li> </ul> </li> </ul>						
	mental status change. Do not mov c. Determine if suspected fracture suspicious of [MEDICAL COND MD\NP\PA and transfer via EMS	e off the floor until complete exan or new bone deformity, head traun ITION] new or worsen cognitive in	n has been performed. na, altered manta, ( decrease LOO mpairment), laceration required s	C, unresponsiveness, sutures\staples if yes notify			
	assessment at the scene of fall If a	nplaints of [MEDICAL CONDITIOn abnormalities call EMS and senter. If no answer within one hour,, t	nd resident out. Do not move resi	ident. A complete			
	Housekeeping, Laundry and Depa Abuse and Neglect Prohibition Assessment of discomfort in Den Change in Condition						
	training was provided by the Dire presented in an oral fashion with identification, investigation, prote Abuse and Neglect Prohibition tra January 10, 2016 including RN <sup>-1</sup> Nurse Managers, Rehab Staff, Di attend any of the training offered	ining included a review of the facil ctor of Nursing Services and the D examples provided of how abuse a cction and reporting responsibilities ining began January 8, 2016 and et s, LVN's, Certified Nursing Assiss etary, Housekeeping and Laundry's between January 8 thru January 10	vistrict Director of Clinical Servic nd neglect are defined, prevention s. nded for all staff that were schedu tants, Certified Medication Aides Staff and Department Managers. ), 2016 will not be allowed to woo	res. The training was n techniques, uled to work thru s, Staff Development, Staff that were not able to			
		e facility 's Abuse and Neglect Pro Dementia Protocol training include		and affective discomfort			

STATEMENT OF     (X1) PROVIDER / SUPPLIER     (X2) MULTIPLE CONSTRUCTION     (X3) DATE SURVEY       DEFICIENCIES     / CLIA     A. BUILDING     COMPLETED       AND PLAN OF     IDENNTIFICATION     B. WING     01/13/2016	DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:7/19/2016 FORM APPROVED
AME OF PROVIDER OF SUPPLIER AMENOT CITY ILLENATION AND ALL AN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	Ì CLÍA IDENNTIFICATION NUMBER	A. BUILDING	COMPLETED
HONGTON, TX 7099           CVA 1D RETEX TVA         SUMMARY STATEMENT OF DETECTINCY GLACIE DETECTIONY MIST REPERCEMENT AND STATEMENT OF DETECTION OF ADDRESS STATEMENT OF DETECTION STATEMENT OF DETECTION OF ADDRESS STATEMENT OF DETECTION STATEMENT OF DETECTION OF ADDRESS STATEMENT OF DETE		PPLIER		
<ul> <li>(4) DI PRITY T-G</li> <li>SIMMARY STATTMENT OF DETERDINGUE (GALD DIFICURNCY MUST BLEPRETIDE BY FULL BUGHLATORY OLD SCIENTRY/NOR INCOMMATION)</li> <li>F023</li> <li>F023</li> <li>Card of Damm INTERNA Sectors of The Control of Problem of Sectors in the statings of a provided by the Detector of Maning Sectors and the Department of Problem of Sectors in the stating of a provided by the Detector of Maning Sectors and the Department of Decomposition of The Control of Sectors in the stating of the provided by the Detector of Maning Sectors and the Department of Decomposition of the octor of Maning Sectors and the Sectors in the stating of the Sectors in the stating of the Sectors in the Sectors</li></ul>			HOUSTON, TX	77029
FOID         Continue Type 201           Level of human - Instancial (populy)         Continue Type 201         Section 201         Section 201           Residents Alliced - Mark         Section 201         Section 201         Section 201           Residents Alliced - Mark         Section 201         Section 201         Section 201           Residents Alliced - Mark         Section 201         Section 201         Section 201         Section 201           Residents Alliced - Mark         Section 201	ŭ	· ·		
Full         Experienced by people with dementia cub termanged. The training was provided by the Director of Numice Services and the Director	E 0222		MATION)	
Interviews conducted from 01.08/16-01/10/16 between 4.30m to 4.00 pm daly with RCSs and Nurse on various shifts revealed still with dementia.         F0224       The Administrator and DON were informed on 01/13/16 at 1:35pm that the U was lowered; however the facility meeding more Facility of 72 dated 1.06/2016 revealed a census of 110.         F0224       The Administrator and DON were informed on 01/13/16 at 1:35pm that the U was lowered; however the facility ineeding more Facility 072 dated 1.06/2016 revealed a census of 110.         Fued of Farm - Immediate jeopardy date to facility for and use policies that forbid mistreatment, neglect and base of residents and theft of resident P property.         Residents Affected - Mary       ONTE: 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 adjust of policy resident appropriately affer change in contained. The Lower on 0108/16 around 11400m. the facility dation assess the resident appropriately and called for a non-emergency ambulance versus calling 911. The resident remained in the hospital. He was found to four select and a secority level of actual harm due to the facility needing more time to momitor the plan of removal for feetiveness.         These failures affected two residents and placed 108 resident set of 12/23/16, the facility remained out of compliance at a scope of pattern to his cervical spine.         An U was identified to on 108/16/2000. While the U was removed on 01/12/2016, the facility remained out of compliance at a scope of reletiveness.         These failures affected two resident and onthick of 100 more facility termined by the resident 14	Level of harm - Immediate jeopardy	experienced by people with deme District Director of Clinical Servi Assessment of Discomfort protoc trained on the steps they should f Conducting a physical evaluation Review residents history for pote Evaluate for pharmacologic inter The Assessment of discomfort and ini Evaluate for pharmacologic inter The Assessment of discomfort in 's, Certified Nursing Assistants, 0 staff, Staff that were not able to a allowed to work with residents un program. The facility 's policy for identific well as Interact 4.0. These decisic symptoms, signs, and lab results care clinician. Using the Interact laboratory results and diagnostic The Director of Clinical Services. Staff Development, Certified Nur Therapy and MDS nurses Januar attend any of the training offered been re-educated on the facility ' The licensed nurse will evaluate e medical emergency is identified, and calls 911. The licensed staff, The surveyors confirmed the POR Record Review of the In-Services had been in-serviced from 01/08/	ices. The training was presented in an oral fashion we ol should be applied when staff encounter situations ollow which include: ntially painful conditions titating non-pharmacologic comfort interventions ventions that are not [MEDICAL CONDITION] Dementia Protocol training began January 8, 2016 a Certified Medication Aides, Physical Therapy, Occu ttend any of the training offered between January 8 till they have been re-educated on The Assessment of ation of change of condition requires the implement on support tools provide reporting guidance to licems are immediate versus non-immediate, or next day, ff 4.0 tool the licensed nurse can determine immediacy procedures. was re-educated on Stop & Watch and Interact 4.0 of and the Director of Nursing Services re-educated R1 rsing Assistants, Certified Medication Aides, Physic y 9 and 10, 2016 on the Stop & Watch and Interact 4 between January 8 and 9, 2016 will not be allowed s stop & Watch and Interact 4.0 programs. ach situation based on individual resident condition qualified staff evaluate the resident; initiate the appr continues to provide care and monitor the resident u thad been implemented sufficiently to remove the L sign-in sheet revealed that staff from the nursing de 16 until 01/10/16. The topics included in part: Abus 08/06 until 01/10/16 to that staff -resident interaction	with examples provided of how the s with affected residents. Staff were and ended January 10, 2016 for RN's, LVN upational Therapy and Speech Therapy thru January 10, 2016 will not be of Discomfort in Dementia Protocol ation of the Stop & Watch tool as sed nurses on whether specific or reporting purposes to the primary y of reporting for vital signs, on January 9, 2016 by the District N's, LVN's, Unit Managers, ADON's, al Therapy, Occupational Therapy, Speech 4.0 programs. Staff that were not able to to work with residents until they have at the time of the event. Once a ropriate emergency personnel arrive. J by: partment representing all three shifts ie and Neglect, Dementia Resident.
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	Level of harm - Immediate jeopardy	time to monitor the plan of remove Facility 672 dated 1/06/2016 reve Write and use policies that forb of residents' property. **NOTE- TERMS IN BRACKET Based on observations, interviews prohibit mistreatment, neglect an Resident #4 suffered a fall with la condition. He became non-respor called for a non-emergency ambu Resident #1 had an un-witnessed 1 Nurse assessed the resident and to have a fracture to his cervical spi An IJ was identified on 01/08/201 scope of pattern and a severity le for effectiveness. These failures affected two reside Intake #: 8, 0, 8, 2, Findings Include: Resident #4 Record review of Resident #4 's f required one person assist with b Record review of Resident #4 's f Record review of Resident #4 's f Record review of Resident #4 's f Resident #4 was at risk for falls d CONDITION]. Approach: Fallin, therapy, provide assistive devices to identify possible causes, and p Resident #4 was a fall risk. Record review of Interdisciplinary 1/6/2016. Record further revealed room where she found resident Jav wheelchair and then to bed. Reco	val for effectiveness. aled a census of 110. iid mistreatment, neglect and abuse of residents a TS HAVE BEEN EDITED TO PROTECT CONFID s and record review the facility failed to implement t d abuse for two (Resident #1,and #4) of eight reside cerations to the head on 1/6/2016 and was not assess isive on 01/08/16 around 11:00am, the facility did n lance versus calling 911. The resident remained in t fall while out on pass. He was not assessed upon ret old the facility he had the fall and injuries he was see ne. 6. While the JJ was removed on 01/13/2016, the fac vel of actual harm due to the facility needing more t nts and placed 108 residents at risk for mistreatment 'ace sheet revealed a [AGE] year old male with an au MDS dated [DATE] revealed a BIMS score of 12 wl ed mobility, dressing, and toilet use. Care Plan dated 12/14/2015 with a reviewed date of it; Resident had moderate independence with decisions. Approach: Provide clear choices and adequate in s of bad decisions, involve family members in decis ue to: history of previous falls, non-ambulation, bloo g star program, encourage resident to ask for assista et c, all bell within reach, notify MD as indicated. IDIAGNOSES REDACTED]. Approach: Administ etd, call bell within reach, notify MD as indicated. IDIAGNOSES REDACTED]. Approach: Administ etd, call bell within reach, notify MD as indicated. IDIAGNOSES REDACTED]. Approach: Administ etd, call bell within reach, notify MD as indicated. IDIAGNOSES REDACTED]. Approach: Administ etd, call bell within reach, notify MD as indicated. IDIAGNOSES REDACTED]. Approach: Administ etd, call bell within reach, notify MD as indicated. IDIAGNOSES REDACTED]. Approach: Administ etd, call bell within reach, notify MD as indicated. IDIAGNOSES REDACTED]. Approach: Administ etd, call bell within reach, notify MD as indicated. IDIAGNOSES REDACTED]. Approach: Administ etd, call bell within reach, notify MD as indicated. IDIAGNOSES REDACTED]. Approach: Administ etd, call bell within reach, notify MD as indicated. IDIAGNOSES REDACTE	nd theft DENTIALITY** their policy and procedures that nts reviewed for neglect and abuse. sed appropriately after change in out assess the resident appropriately and the facility until 4:11 pm. urn to the facility. After the Hospital nt to the hospital. He was found to compliance at a ime to monitor the plan of removal t, abuse and neglect. thich indicated moderate cognitive impairment, 12/23/15 revealed: on making. Resident had difficulty with formation for resident to make ions regarding important matters. od pressure changes, and [MEDICAL nee, physical therapy, occupational we for potential patterns of falls ter medication as ordered, fall risk assessment, r therapy and was feeling alright tive and alert, lying in bed with head of d or doorway entrance to signify that #4 suffered a fall at 11:00am on n and LVN A was called to the dining seed by LVN A and assisted to rea to the back of the head and right esident #4 fell in dining room and LVN A
		no history of falls. Recommendat Record review of Resident #4 's I Diseases: Dementia. In an interview on 1/6/16 at 2:20p side on the floor. LVN A said she	ions: encourage resident to ask for assistance avoid nterdisciplinary Post Fall Review completed by LV on with LVN A she said she was called to dining rot e assessed Resident #4 and found 2 lacerations to the	attempting to get up on his own. N A and dated 1/6/16 read: Predisposing om and found Resident #4 lying on his e back of his head and he had a skin

DEPARTMENT OF HEALTI CENTERS FOR MEDICARE	H AND HUMAN SERVICES E & MEDICAID SERVICES		PRINTED:7/19/2016 FORM APPROVED			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 01/13/2016			
AME OF PROVIDER OF SI	675231 UPPLIER	STREET AD	DRESS, CITY, STATE, ZIP			
ACINTO CITY HEALTHC		1405 HOLLA HOUSTON,	AND			
For information on the nursing	g home's plan to correct this deficien	cy, please contact the nursing home or the state				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST MATION)	BE PRECEDED BY FULL REGULATORY			
F 0224	(continued from page 4)	sician of the fall. She further said that orders wer	re received for Tylonal 650mg for			
Level of harm - Immediate jeopardy	discomfort, wound care orders fo (cat scan).	or skin tear of right arm and both wounds to head				
Residents Affected - Many	for four hours and then every fou Record review of Resident #4's N for four hours, every four hours f vital signs were done starting on Record review of Resident #4's N instructions on the Neurological 1	r hours for 24 hours and every eight hours for 7; eurological Record read in part: frequency every or 24 hours, every eight hours for remaining 72 01/6/16 at 11:15am and ended on 01/07/16 at 10 eurological record dated 01/6/16-01/7/16 reveal Record in regards to frequency was followed.	2 hours. y 30 minutes for four hours, every one hour hours or as ordered by physician .neuro ):30am. ed neither the physican's order nor the			
	In an interview with Resident #1 ( head Resident #4 was not the san Interview on 01/7/16 at 9:40am L assess him. Interview on 01/7/16 at 10:00am l	am with Resident #4, he said he was not feeling (Resident #4 's roommate) on 01/7/16 at 9:30an ne. He said Resident #4 did not act the same and VN A when it was reported to her that Resident LVN A said Resident #4 was fine he was just tir	h he said that immediately after hitting his he stayed in bed and did not eat. #4 was hurting all over she said she would red.			
	turning all night and was in pain a Observation on 01/7/16 12:00pm Observation and interview on 01/7 like getting out of bed.	revealed Resident was resting with his eyes clos 7/16 at 4:00pm revealed Resident #4 was in bed	ed. and not feeling well. He said he did not feel			
	untouched. Record review of nurse 's notes d Report given. Went to Resident #	n revealed Resident #4 was in bed with his eyes of lated 1/8/2016 at 12:15pm read: placed call to ho 44 's room, made resident aware he would be tra 08/16 at 1:00pm revealed Resident #4 was in be	ospital, spoke to emergency room nurse. Insferred to hospital.			
	stimuli. His RP was at his bedside lunch tray was at his bedside unto facility that Resident #4 needed to	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]. Resident #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					
	<ul> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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 tha 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.</li> <li>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.</li> <li>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 pla</li></ul>					
	Record review of nurse 's note da transportation. Son at bedside. Vi Record review of nurse 's note da	tted 1/8/16 at 1:00pm read: BS=100. Resident re ital signs: Blood pressure-138/76, respirations-20 tted 1/8/16 at 2:00pm read: Responds to painful	sponds to painful stimuli. Awaiting on 0, pulse- 78.			
	even and unlabored. Vital signs:	rt. tted 1/8/16 at 2:30pm read: Awaiting on transpoi blood pressure-140/78, 80, 20, 97%. tted 1/8/16 at 3:00pm read: Resident responding	• •			
	Record review of nurse 's note da pressure 140/79, pulse 79, respira In an interview with DON on 1/8/	at bedside and aware of change of condition. ted 1/8/16 at 4:50pm read: EMS personnel arriv ations 20, and temperature 97.8. '16 at 5:10pm she said that ADON and LVN H b tions. She stated They both failed to assess with	both will be counseled on assessment, the depth of			
	Record review of emergency room department post fall 3 days ago. If fall. Primary Impression: Urinary In an interview with Resident #4 '	n visit dated 1/08/2016 revealed resident was [A Patient is non-responsive. Per EMS, family says 7 Tract Infection. Secondary Impressions: Altere s RP on 1/9/16 at 2:00pm he revealed that Resi	GE] years old and presented to emergency patient was not his normal self after d mental status, [DIAGNOSES REDACTED].			
		rt. pm with Resident #4 at hospital, resident respor felt well since the fall. He said he is hoping to ge				
	[REDACTED].	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)				
	Record review of Resident #1 's C Program, encourage resident to as	Care Plan dated 12/15/2015 revealed that he was sk for assistance, place call light in reach, observ sist to toilet frequently and as accepted, place fre	ve for potential patterns of falls to			
	In an interview on 1/06/2016 at 1 hit his head when he fell down 4- day, he did not tell any staff and 1 one noticed the bump on his head Resident #1 said the hospital nurr further revealed that CT (cat scan	1:00am with Resident #1 he revealed that he had 5 steps. Resident #1 said he fell on [DATE] and the staff didn 't ask about the bump and scratche and scratches until the hospital nurse came to v se noticed immediately and she told the facility or p) revealed a fracture to his neck and he needed to ng neck brace per physician order.	l when he returned to the facility that same es to his forehead. Resident #1 said no visit him at the facility on 12/23/2015. of the fall and his injuries. Resident			
	In a telephone interview on 1/06/2	2016 at 10:00am with the VA Nurse she said tha f the nurses at the facility. The VA Nurse said sl				

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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 SU			ESS, CITY, STATE, ZIP
JACINTO CITY HEALTHC	ARE CENTER	1405 HOLLANI HOUSTON, TX	
		cy, please contact the nursing home or the state sur	
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE MATION)	PRECEDED BY FULL REGULATORY
F 0224 Level of harm - Immediate jeopardy	said he fell down some stairs whi fall until she notified them on 12/ Record review of nursing notes da	ated 12/23/2015 at 1:00pm revealed Resident #1 sai	facility was not aware of Resident #1's d he fell at home on 12/22/2015. Head to
Residents Affected - Many	<ul> <li>to eassessment performed. Resid.</li> <li>of nose. No bruising noted. Call j pain, bruising, redness or neurolo Record review of Neurological re 12/23/2015 and continued to 5:30 Record review of nurses note date fall. Hospital nurse voiced concerfollowed for falls with suspected Record review of the Situation, B 6:05pm revealed that Resident #1 received from physician to send 1 Record review of the Situation to send 1 Record review of the Situation to send 1 Record review with DON on 1/1 they return. She further said that the Out of Facility Release of Rereturned. She further revealed the Record review of Out of Facility indicating that Resident #1 return. She further said that the Out of Facility Release of Rereturned. She further revealed the Record review of Out of Facility 1 out on pass on 12/18/15, 12/24/1; indicating that Resident #1 return Record review of in-service dated report.</li> <li>Record review of in-service dated residents.</li> <li>Record review of Dementia, resid facility read:</li> <li>-Visual strategies; Approach the r focus attention on the communic enlargement, pictures, drawings, -Auditory strategies; use touch to re objects as reminders.</li> <li>In an interview with Housekeeper had not been trained on abuse or trained on residents with dementia.</li> <li>In an interview with Housekeeper had not been trained on abuse or trained on residents with dementia.</li> <li>In an interview of IREDACTED].</li> <li>-The facility must develop and im residents and misappropriation of -The facility must develop and imistreatment of [REDACTED].</li> <li>-The facility must develop and imistreatment of [REDACTED].</li> <li>-The facility administrator and the accepted on 01/12/16 at 4:13pm.</li> <li>The facility administrator and the sidents have the right to be free seclusion.</li> <li>-The facility must develop and imistreatment of [REDACTED].</li> <li>-The facility must develop and imistreatment of [REDACTED].</li> <li>-The facility m</li></ul>	ent #1 was alert and oriented. Small laceration on the placed to physician. No new orders received. Contingical change. cord dated 12/23/2015 revealed that Neurological common 12/23/2015. dt 21/23/2015 at 4:30pm revealed facility called VA mregarding documentation of facility nurse and recommendation (SB / 's physician was notified of fall while Resident #1 to emergency room for evaluation and to 12/24/2015 read: Diagnostic Impression; C3 cervic (REDACTED). of Nursing (DON) on 1/8/2016 at 5:00pm she was to how residents were monitored when they returned. 1/2016 at 3:30pm she said that residents should be a when residents go out on pass that the residents musponsibility form and they sign in when they return to the nurse on duty signs the form as well. Release of Responsibility form in Resident #1 's ch 5, 12/22/15, 1/03/16, 1/04/16, and 1/07/16. There we de to facility on those days. 12/22/2015 revealed staff was in-service on reportion topic, provide contextual and environmental cand symbols. Sittive, unhurried speech, state the person 's name at inents befitting an adult. aassure, use touch to guide, lead, redirect, and prom 13/0 am with RCS N revealed that she was not sure it. F on 01/09/16 at 8:50am revealed that he had been neglect. He was not sure who the abuse prohibition a. With Licensed Vocational Nurse (LVN) D revealed rin-serviced on abuse and neglect or working with resident property. With the policies and procedures that prohibition in a. Sursing assistant registry or licensing authorit an employee that would indicate unfitness for servi alleged violations have been thoroughly involities resident from the frond the state nursing assistant registry or licensing authorit an employee that would indicate unfitness for servi alleged violations have been thoroughly involition at an externet. Note that a buse prohibition a. The service on abuse and neglect or working with resident specent, service on 37 non-interv sites sessment. In the state nursing assistant registry or licensing authorit an employee th	he forehead observed, scratch to the tip hue with Neuro vital signs, monitor for hecks were started at 12:45am on A Nurse regarding Resident #1 and his juested that hospital protocol be AR) Communication Form dated 12/23/2015 at was out on pass 12/22/2015. Orders treatment for [REDACTED]. cal [MEDICATION NAME] process fracture: Insure of policy regarding assessments of The DON said she would find out. Issessed before going out on pass and when st inform the nurse and sign out on so that they know the resident has art revealed Resident #1 signed himself ere no signatures by nurse or resident ing abuse and able to assess the need to standing abuse. Intia care and communicating with dementia ised date of October 02, 2015 provided by esent objects or written cues to ues; use colors, highlighting, ind yours to increase a sense of pt desired behavior, use familiar f she had been trained on working with working at the facility for three residents with dementia. (22, 2015 provided by facility read: corporal punishment, and involuntary of mistreatment, neglect, and abuse of v of abusing, neglecting, or mistreating oncerning abuse, neglect, or ites any knowledge it has of cc as a nursing assistant or other or abuse, including injuries of an iately, through established procedures, estigated and must take precautions to ator was informed at that time. "several revisions were made it was "of Resident 's Rights to voice concerns the thacility for DADS Hotline and viewable residents and found no concerns and the company 's Compliance Hotline phone are to alert the charge nurse of any R if they have a concern and notify the or Until Complete Assessment Is Done and bservation of any limb shortening or internal aluation for injuries and \or med. a, (decrease LOC, unresponsiveness, eration required sutures/staples if yes notify

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AME OF PROVIDER OF SUI ACINTO CITY HEALTHCA		STREET ADD 1405 HOLLA HOUSTON, T	
	SUMMARY STATEMENT OF D	cy, please contact the nursing home or the state superior of the s	survey agency.
(X4) ID PREFIX TAG F 0224 Level of harm - Immediate jeopardy Residents Affected - Many F 0226 Level of harm - Immediate jeopardy Residents Affected - Many	OR LSC IDENTIFYING INFOR!         (continued from page 6)         assessment at the scene of fall If a         report and notify MD via telephon         will be notified         Training:         The DON and the District Director         Housekeeping, Laundry and Deph         Abuse and Neglect Prohibition         Assessment of discomfort in Den         Change in Condition         Emergency Transports via 911 ve         Abuse and Neglect Prohibition tra         January 10, 2016 including RN 's         Nurse Managers, Rehab Staff, Di         attend any of the training offered         they have been re-educated on th         Te Assessment of Discomfort protoc         The Assessment of Discomfort protoc         trained on the steps they should f         Conducting a physical evaluation         Review residents history for pote         Evaluate for pharmacologic inter         The Assessment of discomfort and in         Evaluate for pharmacologic inter         The Assessment of discomfort in January         's, Certified Nursing Assistants, G         staff. Staff that were not able to a         allowed to work with residents ur         program.         The facility 's policy for identific:	MATION) any abnormalities call EMS and send resident out ne. If no answer within one hour,, the Medical Di- rol Clinical Services conducted re-education trai artment Manager personnel January 8, 9 and 10, 2 nentia Protocol rsus Non-emergency transfers. ining included a review of the facility 's policy of ctor of Nursing Services and the District Directo examples provided of how abuse and neglect are cition and reporting responsibilities. ining began January 8, 2016 and ended for all sta s, LVN 's, Certified Nursing Assistants, Certified between January 8 thru January 10, 2016 will no f acility 's Abuse and Neglect Prohibition policy Dementia Protocol training included a review of 1 ntia can be managed. The training was provided ces. The training was presented in an oral fashior ol should be applied when staff encounter situation both include: ntially painful conditions tiating non-pharmacologic comfort interventions rentions that are not [MEDICAL CONDITION] Dementia Protocol training began January 8, 201- Certified Medication Aides, Physical Therapy, Ottend any of the training offered between January til they have been re-educated on The Assessment ation of change of condition requires the implemm on support tools provide reporting guidance to lic rer immediate versus non-immediate, or next day 4.0 tool the licensed nurse can determine immedif procedures. was re-educated on Stop & Watch and Interact 4. and the Director of Nursing Services re-educated sing Assistants, Certified Medication Aides, Phy (9 and 10, 2016 on the Stop & Watch and Interact between January 8 and 9, 2016 will not be allows s Stop & Watch and Interact 4.0 programs. ach situation based on individual resident conditi qualified staff revaluate the resident; initiate the agiontinues to provide care and monitor the resident hab been implemented sufficiently to remove the 16-011/01/16 on the stop & Watch and Interact between January 8 and 9, 2016 will not be allows s for a event (Resident staff from the n	t. Do not move resident. A complete irector will be contacted. The RP\facility ining for all Nursing, Dietary, 2016. Training topics included were : on abuse and neglect prohibition. The or of Clinical Services. The training was defined, prevention techniques, aff that were scheduled to work thru d Medication Aides, Staff Development, artment Managers. Staff that were not able to to tbe allowed to work with residents until y. how physical pain and affective discomfort by the Director of Nursing Services and then n with examples provided of how the ons with affected residents. Staff were 6 and ended January 10, 2016 for RN's, LVN ccupational Therapy and Speech Therapy (8 thru January 10, 2016 will not be nt of Discomfort in Dementia Protocol entation of the Stop & Watch tool as ensed nurses on whether specific , for reporting purposes to the primary iacy of reporting for vital signs, .0 on January 9, 2016 by the District IRN's, LVN's, Unit Managers, ADON's, sical Therapy, Occupational Therapy, Speech ct 4.0 programs. Staff that were not able to ed to work with residents until they have ion at the time of the event. Once a ppropriate emergency procedure(s), it until the emergency procedure(s), it until the emergency procedure(s), it until the emergency procedure(s), it until the inter of the event. Once a ppropriate, for any residents ith RCSs and Nurses on various shifts revealed abuse and Neglect. Dementia Resident. ction was appropriate, for any residents ith RCSs and Nurses on various shifts revealed abuse and neglect and care of a resident lowered; however the facility remained out of opardy due to facility needing more heft of "IDENTIALITY** n their policy and procedures that 3 an #7) of eight residents reviewed for and Resident Care Specialist (RCS) K to prevent sessed appropriately after change in d not assess the resident appropriately and in the facility until 4:1 Ipm. one leg to reposition him in bed, it would not help her get water. Resident
	scope of pattern and a severity lev for effectiveness. These failures affected seven resid Intake #: 8, 0, 8, 2, Findings Include: Record review of Suspected reside	6. While the IJ was removed on 01/13/2016, the vel of actual harm due to the facility needing mor lents and placed 103 residents at risk for mistreat ent abuse assessment, long-term care dated Octob e from verbal, sexual, physical, and mental abuse	re time to monitor the plan of removal tment, abuse and neglect. ber 02, 2015 provided by facility read:
	seclusion.	plement written policies and procedures that prob	
FORM CMS-2567(02-99) Previous Versions Obsolete	Event ID: YL1011	Facility ID: 675231	If continuation sheet Page 7 of 17

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:7/19/2016 FORM APPROVED OME NO 0028 0201
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 675231	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 01/13/2016
NAME OF PROVIDER OF SU JACINTO CITY HEALTHC	PPLIER	STREET AD 1405 HOLL HOUSTON,	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY
F 0226	(continued from page 7)		
Level of harm - Immediate jeopardy Residents Affected - Many	residents or who have had a findi mistreatment of [REDACTED]. -The facility must report to the sta actions by a court of law against facility staff member. -The facility must ensure that all a unknown source and misappropri	ividuals who have been found guilty by court of ng entered into the state nursing assistant regist ate 's nursing assistant registry or licensing auth an employee that would indicate unfitness for so alleged violations involving mistreatment, negle iation of a resident 's property, are reported imm	ry concerning abuse, neglect, or norities any knowledge it has of ervice as a nursing assistant or other ect, or abuse, including injuries of an
	<ul> <li>The facility must ensure that all a unknown source and misapproprit to the facility administrator and the actility administrator and the prevent further potential abuse works and the facility administrator and the prevent further potential abuse works and the prevent of the prevent of the prevent further potential abuse works and the prevent further potential abuse works and the prevent of the prevent further potential abuse works and the prevent further prevent for the prevent of th</li></ul>	iation of a resident 's property, are reported immosting of the officials in accordance with state law. In that all alleged violations have been thoroughly hile the investigation is in process. Face sheet revealed resident is a [AGE] year old Care Plan dated 7/02/2014 with a review date on the impairment due to short-term and long-term g care for resident to choose, Provide time to thi falls. Approach: Falling Star Program, Encoura m, chair alarm, place call light in reach, observe sist to toilet frequently and as accepted, place fir related causes. REDACTED]. Approach: Administer medicati thin reach, notify MD as indicated. pm revealed that there was no Falling Star abov pm revealed Resident #6 sitting in wheelchair a g the entrance to her room. Surveyor interveneed d not due to the medication cart blocking entran ph had the cart there to block the entrance to k and did not want her in the room. pm revealed resident #6 in her wheelchair #6 was rer to Resident #6 and moved the cart and told Fs aid and tried to wheel herself into her room. As B grabbed began prying Resident #6 's fingers from the hi a wheel herself into her room. As B grabbed began prying Resident #6 's fingers from the hi a whit the DON revealed that she was a fall risk. h. the John said they should not have grabbed Re gelect. The DON revealed that she was a fall risk. having the just wanted to look in the box in his more vealed redness to Resident #6 's right wri n statement dated 1/06/2016 revealed at about 3 VA not to move it because the resident was a fall hrusses with surgit the revealed that she was surgit side, the CNA grabbed her hand, telling her not more. en statement dated 1/06/2016 revealed that Resi to because she was a fall risk. 1/07/2016 at 9:45am she revealed that Resi to broin Rejort dates 1/07/2016 completed by Do more sident #6 was grabbing onto the door beca on 1/07/2016 at 9:45am she revealed she was awar lenol per orders for pain to resident 's right wri statement dated 1/06/2016	nediately, through established procedures, investigated and must take precautions to female with an admission date of [DATE]. of 10/15/2015 revealed: memory loss. Approach: Staff will offer nk/react. ge resident to ask for assist, orient e for potential patterns of falls to requently used items within reach, and on as ordered, fall risk assessment, fall prevention re residents door or above her bed to identify ttempting to enter her room but was not able d and informed MA B that Resident #6 was ce to room. MA B said he was aware she prevent her from going in the room. He ged between medication cart and door to her swedged between medication cart and door to her Resident #6 she could not go to her room at this ident #6 she could not go to her room at this ident #6 she could not go to her room this time. Resident #6 would not release Resident #6 's wrist/arm and tried to pull andrail. The DON walked by and quickly that they did not want Resident #6 in her room DON informed MA B and RCS K that Resident assessment on Resident #6 and found no hould have allowed her to enter her room or esident #6's hand or arm. The DON said staff ff had training on Dementia but was not sure to re-direct Resident #6 because she did not her wrist. Resident #6 bacid noone had ever er closet. ist. imm, he was by the Med Aid Cart, and was about Il risk. Resident #6 tried to wheel herself to go in her room for her safety. He only dent #6 was trying to enter her room and RCS tatement further revealed that shespoke to anse she was a fall risk. d pain to her right wrist. Observation at the not aware of bruising. The DON said she would ist. 3 small bruises to Resident #6 's right he wander guard. ON read: Description of Allegation- The DON was ame trying to pull herself into the room, RCS tatement further revealed that shespoke to asse she was a fall risk. d pain to her right wrist. Observation at the bON could not see what RCS K did gr my view. However, MA B then reached over he other door frame, causing resident to s rights and allowed resi
	familiarity, use praise and compli- Tactile Strategies; use touch to re- objects as reminders. Resident #4 Record review of Resident #4 's f [REDACTED]. Record review of Resident #4 's f required one person assist with b Record review of Resident #4 's 0	eassure, use touch to guide, lead, redirect, and prace sheet revealed a [AGE] year old male with	rompt desired behavior, use familiar an admission date of [DATE]. Diagnoses: 12 which indicated moderate cognitive impairment, te of 12/23/15 revealed:

CENTERS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:7/19/2016 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER (7572)1	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 01/13/2016
NAME OF PROVIDER OF SU	675231 JPPLIER	STREET ADDR	RESS, CITY, STATE, ZIP
ACINTO CITY HEALTHC	ARE CENTER	1405 HOLLAN HOUSTON, TX	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state sur	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST BE MATION)	PRECEDED BY FULL REGULATORY
F 0226 Level of harm - Immediate jeopardy Residents Affected - Many	decisions, Point out consequence: Resident #4 was at risk for falls du CONDITION]. Approach: Falling therapy, provide assistive devices	ns. Approach: Provide clear choices and adequate i s of bad decisions, involve family members in deci ue to: history of previous falls, non-ambulation, blo g star program, encourage resident to ask for assist s such as wheelchair, place call light in reach, obser lace frequently used items within reach.	isions regarding important matters. ood pressure changes, and [MEDICAL ance, physical therapy, occupational
	Resident #4 was care planned for, fall prevention protocol as indicat In an interview with Resident #4 c today. Observation at the same tin bed elevated. His call light was w Resident #4 was a fall risk. Record review of Interdisciplinary 1/6/2016. Record further revealed room where she found resident ly wheelchair and then to bed. Reco	[DIAGNOSES REDACTED]. Approach: Admini ted, call bell within reach, notify MD as indicated. on 1/6/16 at 9:40am he said he was at the facility fc me revealed resident was well groomed, very talka vithin reach. There were no falling star above the be v Post Fall Report dated 1/6/2016 revealed Residen 1 that Resident #4 's fall occurred in the dining roo ring on floor on his right side. Resident #4 was asser rd further revealed Resident #4 sustained an open a	or therapy and was feeling alright tive and alert, lying in bed with head of ed or doorway entrance to signify that at #4 suffered a fall at 11:00am on m and LVN A was called to the dining essed by LVN A and assisted to
	was called to dining room by staf read: Resident stated he leaned fc no history of falls. Recommendat Record review of Resident #4 's I Diseases: Dementia. In an interview on 1/6/16 at 2:20p side on the floor. LVN A said she tear to his right arm. Resident #4 neuro vitals and notified the phys	nt Investigation Follow-up dated 1/6/16 revealed F f where LVN A found Resident #4 on the floor on rward to get up and fell to the floor. Past Intervent ions: encourage resident to ask for assistance avoid nterdisciplinary Post Fall Review completed by LV m with LVN A she said she was called to dining ro assessed Resident #4 and found 2 lacerations to th was assisted to the wheelchair and then assisted to ician of the fall. She further said that orders were r skin tear of right arm and both wounds to head. L	his right side. Summary of investigation ions read: New resident to facility, d attempting to get up on his own. VN A and dated 1/6/16 read: Predisposing oom and found Resident #4 lying on his he back of his head and he had a skin his bed. LVN A said she started received for Tylenol 650mg for
	(cat scan). Record review of Resident #4's ph for four hours and then every fou Record review of Resident #4's Ne for four hours, every four hours for vital signs were done starting on Record review of Resident #4's Ne instructions on the Neurological I In an interview on 01/7/16 at 9:30 In an interview with Resident #1 ( head Resident #4 was not the sam	visician's orders [REDACTED].monitor neuro che r hours for 24 hours and every eight hours for 72 h eurological Record read in part: frequency every 33 or 24 hours, every eight hours for remaining 72 ho 01/6/16 at 11:15am and ended on 01/07/16 at 10:33 eurological record dated 01/6/16-01/7/16 revealed Record in regards to frequency was followed. am with Resident #4, he said he was not feeling wa Resident #4 's roommate) on 01/7/16 at 9:30am h e. He said Resident #4 did not act the same and he VN A when it was reported to her that Resident #4	cks every 15 minutes for one hour, every hour ours. 0 minutes for four hours, every one hour urs or as ordered by physician .neuro 0am. neither the physican's order nor the ell and that he was hurting all over. e said that immediately after hitting his s stayed in bed and did not eat.
	Interview on 01/7/16 at 10:15 an turning all night and was in pain a Observation on 01/7/16 12:00pm ; Observation and interview on 01/7 like getting out of bed. Observation on 01/8/16 at 8:00 am untouched. Record review of nurse 's notes d Report given. Went to Resident # Observation and interview on 01/6 stimuli. His RP was at his bedside unto	LVN A said Resident #4 was fine he was just tired. with Resident #1 he said Resident #4 was not fine. and did not sleep. revealed Resident was resting with his eyes closed 7/16 at 4:00pm revealed Resident #4 was in bed an a revealed Resident #4 was in bed with his eyes clo ated 1/8/2016 at 12:15pm read: placed call to hosp 4 's room, made resident aware he would be trans 8/16 at 1:00pm revealed Resident #4 was in bed w e and said he would not wake up and shook his sho puched. The RP said the Hospital Nurse told him tt o be sent back to the hospital for evaluation.	He said Resident #4 had been tossing and d not feeling well. He said he did not feel sed. His breakfast tray was beside his bed ital, spoke to emergency room nurse. ferred to hospital. with eyes closed and did respond to verbal juider, Resident #4 did not respond. His
	In an interview on 1/8/16 at 3:14p [DIAGNOSES REDACTED]. Re at facility on 1/06/2016 after lunc chart. The RP said that Resident 4 that he arrived at facility at 11:00 said he informed the nurse of Res said LVN H told him that Resider Resident #4 still had not woken u Observation on 1/8/ at 3:14pm of dry and cracked and lunch was at shook Resident #4 by the shoulde In an interview with LVN H on 1/ Resident #4 was to be transferred chose the one with the least estim non-responsiveness, she said no. In an interview with the DON on of change in condition on 1/7/16	m with Resident #4 's Responsible Party (RP) reversatident #4's RP further revealed that he was not m h time. He said LVN H told him they did not have #4 was not acting like his self and had been acting am today and Resident #4 would not wake up and gident #4 's condition and she assessed him and sain t #4 would be transferred to hospital for evaluation	otified of Resident #4 's fall until he arrived his phone number in Resident #4 's different since the fall. The RP said his breakfast had not been eaten. He id she would call the physician. The RP n but that was over 3 hours ago and d of bed elevated. Resident 's lips were to trespond to verbal stimuli. The RP ician of change in mental status and d several ambulance companies and for Resident #4 due to at LVN H had not called 911. She was aware ty of skull on 1/7/16. She further
	immediately for transfer. Record review of nurse 's notes d Hospital nurse requested that nur- remained at bedside. Call was pla of recent fall from wheelchair. Record review of nurse 's note da dispatcher. Stated will send ambu Record review of nurse 's note da placed to MD. New order to give Record review of nurse 's note da transportation. Son at bedside. Vi Record review of nurse 's note da or symptoms of pain or discomfo Record review of nurse 's note da even and unlabored. Vital signs: I Record review of nurse 's note da Respirations 20 per minute. Son a Record review of nurse 's note da pressure 140/79, pulse 79, respira	ated 1/8/16 at 12:00pm said hospital nurse was vis se on duty to assess Resident #4. Resident #4 said 1 (ced to physician regarding assessment and Resider ted 1/8/16 at 12:25pm read: placed call to ambulan lance right away. Made charge nurse aware. ted 1/8/16 at 12:30pm read: Resident in room. Son glucacon 1mg IM (intra-muscular)if resident not a ted 1/8/16 at 1:00pm read: Resident respect tal signs: Blood pressure-138/76, respirations-20, p ted 1/8/16 at 2:30pm read: Responds to painful stin rt. ted 1/8/16 at 2:30pm read: Awaiting on transportat blood pressure-140/78, 80, 20, 97%. ted 1/8/16 at 3:00pm read: Resident responding to at bedside and aware of change of condition. ted 1/8/16 at 4:50pm read: EMS personnel arrived.	iting with Resident #4 and family. he was not feeling well. VA Nurse nt #4 not feeling well and also made aware accesservice. The above report given to a at bedside. Blood sugar (BS)=69. Call wake. onds to painful stimuli. Awaiting on pulse-78. muli and moves all extremities. No sign tion. Resident denies pain. Respirations painful stimuli. No signs of distress. . Blood sugar at this time is 71. Blood

DEPARTMENT OF HEALTH			PRINTED:7/19/2016 FORM APPROVED
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ND PLAN OF ORRECTION	IDENNTIFICATION NUMBER	B. WING	01/13/2016
ME OF PROVIDER OF SU	675231	CTDEET	ADDRESS, CITY, STATE, ZIP
CINTO CITY HEALTHC		1405 HO	DLLAND
r information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the s	ON, TX 77029 state survey agency.
X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		JST BE PRECEDED BY FULL REGULATORY
F 0226	(continued from page 9)	· · · · · ·	
Level of harm - Immediate jeopardy	Record review of emergency room department post fall 3 days ago. I	Patient is non-responsive. Per EMS, family	as [AGE] years old and presented to emergency
Residents Affected - Many	In an interview with Resident #4 ' said Resident #4 was still not aler	s RP on 1/9/16 at 2:00pm he revealed that t.	Resident #4 was diagnosed with [REDACTED]. RP
		Felt well since the fall. He said he is hoping	
	Face sheet further revealed Resid Record review of care plan dated Depression/Anxiety. Approach: F	ent #3 was her own legal guardian. 7/15/15 with a review date of 10/15/15 reve rovide calm, reassuring environment, enco	with an admitted [DATE]. Diagnoses: [REDACTED] ealed resident was care planned for urage resident and staff to be alert to events or ure as needed, modify environment to promote
	In an interview with Resident #3 of that she doesn't put up with it an like it when RCS M was assigned roommate (Resident #5) and take scared of RCS M. Resident #3 sa	d takes care of it herself by telling him off. I to her hall and she was scared of him. Res her call light away so she would not be abl	ident #3 had witnessed RCS M speak rudely to her e to use it and stated her roommate was also strator and RCS M was moved to a different hall
	In an interview with the DON on		e of the incident involving Resident #3 and RCS M.
	Record review of Resident #7 ' s c [REDACTED].		ale with an admission date of [DATE]. Diagnoses: of 13 which indicated no cognitive impairment. The
	MDS assessment further revealed Resident #7 was total dependence	I that Resident #7 required extensive assista	nce for bed mobility and personal hygiene.
	Approach: Falling Star Program, items within reach, offer/assist to	encourage resident to ask for assistance, pla toilet frequently and as accepted.	ace call light in reach, place frequently used CS G was rude and speaks aggressively towards
	call light for pain medication RC she never returns to let him know	S G just enters the room, turns off the call live if she told the nurse he needed something it	for pain.
	being investigated. The DON fur also said staff would be receiving In a telephone interview with RCS	ther said that she double checked the Medic sensitivity training now and quarterly. S G on 1/13/2016 at 1:00pm she said that sh	of the incident involving RCS G and incident was ation Administration Record [REDACTED]. The DO the took care of Resident #7 on Friday. She asked wid that Resident #7 reported that the dees not
	let him know when she tells the n	she was the only RCS of his fail. RCS G s iurse he needs medicine for pain. She said s ometimes, maybe I come off rude .	id that Resident #7 reported that she does not he was not aware that she had to report back to
	[REDACTED].	-	ale with an admission date of [DATE]. Diagnoses:
	score of 15 which indicated no co	gnitive impairment.	revealed a Brief Interview for Mental Status (BIMS)
	Program, encourage resident to as	sk for assistance, place call light in reach, o sist to toilet frequently and as accepted, place	
	In an interview on 1/06/2016 at 1 hit his head when he fell down 4 day, he did not tell any staff and 1 one noticed the bump on his head Resident #1 said the hospital nurr further revealed that CT (cat scan	1:00am with Resident #1 he revealed that he 5 steps. Resident #1 said he fell on [DATE the staff didn 't ask about the bump and scr l and scratches until the hospital nurse came se noticed immediately and she told the faci t) revealed a fracture to his neck and he nee	e to visit him at the facility on 12/23/2015.
	In a telephone interview on 1/06/2 s care and the assessment skills o had a large bump to his forehead	f the nurses at the facility. The VA Nurse sa along with scratches. She said she asked Ro le he was out on pass. The Hospital nurse s	d that she was very concerned about Resident #1 ' aid she noticed immediately that Resident #1 esident #1 about the bump and scratches and he aid the facility was not aware of Resident #1's
	Record review of nursing notes da toe assessment performed. Reside of nose. No bruising noted. Call p	nted 12/23/2015 at 1:00pm revealed Resider ent #1 was alert and oriented. Small lacerati placed to physician. No new orders received	nt #1 said he fell at home on 12/22/2015. Head to on on the forehead observed, scratch to the tip I. Continue with Neuro vital signs, monitor for
	pain, bruising, redness or neurolo Record review of Neurological red 12/23/2015 and continued to 5:30	cord dated 12/23/2015 revealed that Neurol	ogical checks were started at 12:45am on
	Record review of nurses note date	d 12/23/2015 at 4:30pm revealed facility ca rn regarding documentation of facility nurse	alled VA Nurse regarding Resident #1 and his and requested that hospital protocol be
	Record review of the Situation, B 6:05pm revealed that Resident #1 received from physician to send H	ackground, Assessment and Recommendati 's physician was notified of fall while Resid Resident #1 to emergency room for evaluati	on (SBAR) Communication Form dated 12/23/2015 a dent #1 was out on pass 12/22/2015. Orders on and treatment for [REDACTED]. 23 cervical [MEDICATION NAME] process fracture:
	Record review of physician order In an interview with the Director or residents who go out on pass and In an interview with DON on 1/1 they return. She further said that the Out of Facility Release of Re:	of Nursing (DON) on 1/8/2016 at 5:00pm sl how residents were monitored when they r l/2016 at 3:30pm she said that residents sho when residents go out on pass that the resid sponsibility form and they sign in when the	
	Record review of Out of Facility I	5, 12/28/15, 1/03/16, 1/04/16, and 1/07/16.	#1 's chart revealed Resident #1 signed himself There were no signatures by nurse or resident
	Record review of in-service dated report.		n reporting abuse and able to assess the need to nuderstanding abuse.
			n Dementia care and communicating with dementia
	1		

STATEMENT OF DEFICIENCES       (CL) FROVIDER (SUPPLIER (CLAC) DESCREPTION       (CL) FROVIDER (SUPPLIER (CLAC) (STAL)       STREET ADDRESS, CTIY, ST Late HOLLAND (STAL)         VAME OF PROVIDER OF SUPPLIER       STREET ADDRESS, CTIY, ST Late HOLLAND (STAL)       STREET ADDRESS, CTIY, ST Late HOLLAND (STAL)         For information on the antering bown's plan to correct thic deficiency, plane contex the muning home in the state states of galaxy.       StREET ADDRESS, CTIY, ST Late HOLLAND (STAL)         FO20       SUMMAND STATEMENT OF DEFICIENCES (CACH DEFICIENCY MUST EF RERECIDED BODDRESS)       StREET ADDRESS, CTIY, ST Late of home - inmediate popenty         F023       StREET ADDRESS, CTIY, ST Late of home - inmediate popenty       StREET ADDRESS, CTIY, ST Late of home - inmediate popenty         Residents Affected - Mary Image: use calculate, from page 100 Resident address and popenty, and symphols.       StREET ADDRESS, CTIY, ST Late of home - inmediate popenty         Residents Affected - Mary Image: use calculate, darwings, and symphols.       The calculate of construct, darwings, and symphols.         F0251       Her a qualified full-time scelar worker in a facility with more than 120 bods.         Residents Affected - Mary Image in the inclusion of the instrem in the coll worker in a facility with more than 120 bods.         The calculate interpole in 100 Coll at 10.30 AM with Resident 11 was incleaned social Worker resident popenty         F0201       Her address and the coll worker in a facility with more than 120 bods.         The coll in 100 Coll in 100 Coll in 100		AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:7/1 FORM APPR OMB NO. 09	OVED
NAME OF PROVIDER OF SUPPLICE         INSERT ADDRESS, CITY, ST.           MCINTO CITY HEALTHCARE CENTER         INSERT ADDRESS, CITY, ST.           MCINTO CITY HEALTHCARE CENTER         INSERT ADDRESS, CITY, ST.           MCAID OF PROVIDER OF SUPPLICE         STATUTES INSERT ADDRESS, CITY, ST.           CAID DREFIX TAG         OR LECEDENTFIVIO ADDRESMATION).           F0226         Continued	ICIENCIES 9 PLAN OF	) CLIA IDENNTIFICATION NUMBER	A. BUILDING	(X3) DATE SI COMPLETED <b>01/13/2016</b>	
HOUNTON, TX 7029           For information on the function phone of the state survey gasery.           (X4) ID PREFIX TAG         SUMMARY STATEMENT OF DETICIENCIES (GACI DEFICIENCY MUST BE PRECEDED D OR LSC DESTIFYING INFORMATION)           F0226         Continued from page 10           Level of hum- humediate         Continued from page 10           Residents Affected - Mary         Encode of the indicator from the front, in his vision field, unlike, present objects or dispondy strategies: use colling, encode the indicator from the front, in his vision field, unlike, present objects or endorgement, pictures, dravings, and symbols.           F0251         III et a qualified full-time scala worker in a facility with more than 120 bods.           Residents Affected - Mary         Hink deficient practice paged a full time Social Worker rais for not having needs net including an The facility fuel to enployed paged a full time Social Worker rais for not having needs net including an The facility fuel to enployed in the social worker in a facility with more than 120 bods.           Residents Affected - Mary         Time deficient practice paged a census of 110 residents at risk for not having needs net including an The facility field to enploy and that the body and travel differ was as the facility only and then to reurn home, but was unsure on how the process worked.           Interview on 10/2016 to 11/2016 to 10/2016 to 10/2016 to 10/2016 to 11/2016 to 11/2016 to 10		PPLIER		ET ADDRESS, CITY, STATE, ZIP	
<ul> <li>(AA 1D PREFIX TAG</li> <li>SLIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED B (SUBMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED B (SUBMARY STATEMENT (NORMATION))</li> <li>F0226</li> <li>(continuedfrom page 10) Record review of Demutin, resident from the front, in his vision field, smile, present objects of facility read:</li> <li>(continuedfrom page 10) Record review of Demutin, resident from the front, in his vision field, smile, present objects of facility read:</li> <li>(continuedfrom page 10) Record review of Demutin, resident from the front, in his vision field, smile, present objects facility read:</li> <li>(continuedfrom page 10) Record review of Demutin (Submary Statement 10)</li> <li>(F) 2531</li> <li>Level of harm - Minimal harm operating for a statement of the statement of the statement of the statement of the statement of the facility failed to employ a full time Social Worker is a facility of the statement of the statement of the facility failed to employ a full time Social Worker revises the last learned Social Worker we during the survey conducted by DADS.</li> <li>(Conservations conducted during the survey from 16/2016 to 11/32/2016 revealed no Social Worker we during the survey conducted by DADS.</li> <li>(Dimersion of the facility failed to report a state the base bera waiting to do so. Resident 74 M was at the facility only and then to return home, but was unster on how the process worked.</li> <li>(Diever on 17/2016 at 9/38 AM with LVNL that reddents whore of a social Worker we during the survey conducted by DADS.</li> <li>(Diever on 11/2016 at 9/38 AM with LVNL that reddents whore of a social Worker we during the survey conducted by DADS.</li> <li>(Diever on 11/2016 at 9/38 AM with LVNL that reddents whore of a social Worker we and thick.</li> <li>(Diever on 11/2016 at 9/38 AM with LVNL that reddents whore of a social Worker we anot thick we and the facility hase been without a Social Worker</li></ul>			HOUS	TON, TX 77029	
<ul> <li>F 0226 continued from page 10)</li> <li>Record of harm - Immediating the state of the sta</li></ul>		· ·			JLATORY
Level of harm - Immediating and the second of Demential, resident from the front, in his vision field, smile, present objects of -Visual stranges: Approach the resident from the front, in his vision field, smile, present objects of -Visual stranges: Approach the resident from the front, in his vision field, smile, present objects of -Visual stranges: approach the resident symphols.           F 0251         Level of harm - Minimal harm or potential for actual to full time basis for a facility with more than 120 heds.           The second symmetry of the time Social Worker is an early source to income the facility failed to ensure a qualified Moreir approximation. Interview and record review the facility with more than 120 heds.           This deficient provide a full time Social Worker and the second social Worker exists and the second appointenses. The second worker and that here has the second worker and the second worker and that here has been waiting to do so. Resident 111 was at the facility of all time social worker and that here has been waiting to do so. Resident 111 was at the facility of all time social Worker and that here has been waiting to do so. Resident 111 was at the facility only and then to return home, but was unsare on how the process worked.           Findings included:         Comerciance conductating the same of time discharge the social Worker yet. The social worker yet to 16/2016 at 10:43. AM with A level and they facility that and the book of many to a social Worker yet. Observation on 16/2016 to 10:53. AM with M harvesident 49 harves a concil. Worker yet. Observation on 16/2016 to 10:53. AM with M harvesident 40 harves a Social Worker yet. Observation on 16/2016 to 10:53. AM with M harvesident 40 harves a Social Worker yet. Observation on 16/2016 to 10:53. AM with M harvesident 40 harves an social Worker yet. Observation on 16/2016 to 10:53.	226		MATION)		
<ul> <li>Residents Affected - Mary</li> <li>enlargement, pictures, drawings, and symbols.</li> <li>F 0251</li> <li>Level of harn - Minimal filter a qualified full-time social worker in a facility with more than 120 beds.</li> <li>Based on observation, interview and record review the facility failed to ensure a qualified Social Worker means that the post of the omploy a full time Social Worker are signed 12/52015.</li> <li>Residents Affected - Mary</li> <li>Kingins Included: during the survey from 1/6/2016 to 1/13/2016 revealed no Social Worker, Resident speak with the social worker and that she has been waiting to do so. Resident #11 was at the facility only and then is creating the 1/13/2016 revealed no Social Worker were speak with the social worker and that she has been waiting to do so. Resident #11 was at worker and the social worker and that she has been waiting to do so. Resident #11 was at worker at the facility only and then to return to more, but was usuare on how the process worked.</li> <li>Interview on 1//2016 at 10.53 AM with MAI revealed there was currently no social worker at the facility only and then to return to more, but was usuare on how the wave a Social Worker set. Observation on 1//2016 at 10.54 AM with MAI therewheld there was a worken at the facility only and then to return the polarity work the in. but were as a boat the work as a dot of the social worker at the the facility on the social worker at the inclusion on 1//2016 at 1.54 AM with I/VNI. In there induces the word and thick.</li> <li>Interview on 1//2016 at 9.36 AM with AVNI. I was been to worked the word and thick.</li> <li>Interview on 1//2016 at 9.36 AM with AVNI. I was been to worked the word at how an to may for here and for his house and that be word at house any whore the and the social trans work how the polarity to work how the word and how and the social trans work how the polarity work how the social Worker set and a binding.</li> <li>F 0309</li> <li>F 0309</li> <li< td=""><td>vel of harm - Immediate</td><td>Record review of Dementia, reside facility read: -Visual strategies; Approach the re</td><td>esident from the front, in his vision field</td><td>smile, present objects or written cues to</td><td>rovided by</td></li<></ul>	vel of harm - Immediate	Record review of Dementia, reside facility read: -Visual strategies; Approach the re	esident from the front, in his vision field	smile, present objects or written cues to	rovided by
F 0251       Hire a qualified full-time social worker in a facility with more than 120 beds.         Level of harm - Minimal mark of the social work in a 120 bed.       Based on observation, interview and record review the facility failed to ensure a qualified Social Work farm or potential for attain the facility with more of 10 residents at risk for on thaving meeds me in tubing an indical approximate, physical decision and the social Worker withings Included.         Residents Affected - Mary       Find find full-time basis for a facility with more than 120 beds.         Description of the social worker and there were from 16/2016 to 1132016 revealed no Social Worker, Residem lapseak with the social worker and that she has been waiting to do so. Resident 911 was at the facility in part the facility has been without a Social Worker weight on 16/2016 at 10:33 AM with MA 1 revealed there was currently no social worker at the 1 was mare how king the facility has been without a Social Worker or where at the 10 been without a Social Worker or where at the 10 been without a Social Worker or where at the 10 been without a Social Worker or where at the 10 been without a Social Worker or where at the 10 been without a Social Worker or where were dry and hard the facility has been station when has been without a Social Worker were were was no Socia to 0 been without a Social Worker were were was no Socia to 0 been without a Social Worker were were was no Socia to 0 been worker.         F 0309       Level of harm - Immordial       Level of harm - Immordial         F worker Affected - Jamie Worker of the facility has been worker.       Level of harm - Immordial         Level of harm - Immordiat       Level of harm - Immordian an emore worker at the facin thy facility of the fa	sidents Affected - Many	enlargement, pictures, drawings, a	and symbols.		fami
<ul> <li>harm or potential for actual full-time basis for a facility with more than 120 beds.</li> <li>Residents Affected - Marn</li> <li>Residents Affected - Marn</li> <li>The facility failed to employ a full time Social Worker since the last licensed Social Worker resigned 12/5/2015.</li> <li>This deficient practice placed a census of 110 residents at risk for not having needs met including an medical appointments. psychosocial needs or timely discharge planning.</li> <li>The operations conducted during the survey from 1/6/2016 to 1/13/2016 revealed no Social Worker we during the survey conducted by DADS.</li> <li>Interview on 1/6/2016 at 10.30 AM with Resident #1 lasked about the new Social Worker, Resident speak with the social worker and that she has been waiting to do so. Resident #1 was at the facility and then to return home, but wais unnear on how the process worked.</li> <li>Interview on 1/7/2016 at 0.36 AM with LVN L that residents who need a podiatrist rounki.</li> <li>Interview on 1/7/2016 at 0.36 AM of Resident #8 lying in bod. Resident #8 social Worker per on a list checks the list on each station when she comes to the facility. LVN L stated since there was an Social Worker extends and hick.</li> <li>Interview on 1/7/2016 at 1.36 DW mith Resident #7 segnaring his discharge. Resident #9 askel if c go home. Resident #9 stated he did not want to pay for here and for his house and the would rat know who ta list a boate gring provide.</li> <li>F 0309</li> <li>Level of harm - Immediati jeopardy</li> <li>F rouse on 1/3/2015 with LYN A revealed that since there has been no Social Worker, each statis there in a lass interview on 1/3/2015 at 1.45 PM with the Administrator revealed the facility had how has a state of discharges, pay letter or no scient Worker, each statis there in a lass or that facility field of was not assessed appropriat provide that scients #1 states for discharges, but the scients physicians to ensure that every the CNS form 672 refle</li></ul>	251			-	
<ul> <li>1252015.</li> <li>1252015.</li> <li>1252016.</li> <li>1252016.&lt;</li></ul>	m or potential for actual	full-time basis for a facility with r	more than 120 beds.		•
<ul> <li>same day. After the Veterans Admistration (VA) Nurse assessed the resident on 12/23/15 and told ti 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 scope of pattern and a severity level of actual harm due to the facility needing more time to monitor for effectiveness.</li> <li>These failures affected two residents and placed 102 residents as needing assistance or dependent on risk for not having their needs met, injury and a decline in health status. Intake #: 8, 0, 8, 2, Findings Include:</li> <li>Resident #4</li> <li>Record review of Resident #4 's face sheet revealed a [AGE] year old male with an admission date of [REDACTED].</li> <li>Record review of Resident #4 's MDS dated [DATE] revealed a BIMS score of 12 which indicated 1 required one person assist with bed mobility, dressing, and toilet use.</li> <li>Record review of Resident #4 's Care Plan dated 12/14/2015 with a reviewed date of 12/23/15 reveal Resident #4 had Cognitive Deficit; Resident had moderate independence with decision making. Resident #4 had Cognitive Deficit; Resident had moderate independence with decision regarding Resident #4 was at risk for falls due to: history of previous falls, non-ambulation, blood pressure cha CONDITION]. Approach: Falling star program, encourage resident to ask for assistance, physical therapy, provide assistive devices such as wheelchair, place call light in reach, observe for potential to identify possible causes, and place frequently used items within reach.</li> <li>Resident #4 was care planned for, (DIAGNOSES REDACTED]. Approach: Administer medication fall prevention protocol as indicated, call bell within reach. There were no falling star above the bed or doorway e Resident #4 was a fall risk.</li> <li>Record review of Interdisciplinary Post Fall Report dated 1/6/2016 revealed Resident #4 suffered a 1/6/2016. Record further revealed that Resident #4</li></ul>	m sidents Affected - Many 309 vel of harm - Immediate pardy	The facility failed to employ a full 12/5/2015. This deficient practice placed a cemedical appointments, psychosoc Findings Included: Observations conducted during the during the survey conducted by D Interview on 1/6/2016 at 10:30 AM speak with the social worker and only and then to return home, but Interview on 1/6/2016 at 10:36 AM was unsure how long the facility I Interview on 1/6/2016 at 10:40 AM Observation on 1/7/2016 at 9:36 A and thick. Interview on 1/7/2016 at 9:38 AM checks the list on each station wh unsure as to when the next time th 5 AM. LVN L stated Resident #8 Interview on 1/7/2016 at 1:40 PM go home. Resident #9 stated he di know who to talk to about going I Interview on 1/7/2016 at 1:45 PM In an interview on 1/13/2015 with LVN their own residents discharges and as to what all it takes for discharge The CMS form 672 reflected 110 i <b>Provide necessary care and serv</b> **NOTE- TERMS IN BRACKET Based on observation, interview an of 4 resident #4 and <b>R</b> well-being when the facility failed.	time Social Worker since the last licens nsus of 110 residents at risk for not havi ial needs or timely discharge planning. e survey from 1/6/2016 to 1/13/2016 rev PADS. M with Resident #11asked about the new that she has been waiting to do so. Resic was unsure on how the process worked. M with MA J revealed there was current has been without a Social Worker or wh M, the Administrator stated they did not LM of Resident #8 lying in bed. Residen with LVN L that residents who need a 1 en she comes to the facility. LVN L stat he podiatrist would be in; but she knows was added to the podiatry list in Decem with Resident # 9 regarding his dischar did not want to pay for here and for his he come. with the ADON revealed that Resident the facility; which has been two weeks A revealed that since there has been no d getting residents seen for ancillary ser residents resided at the facility. <b>ices to maintain the highest well being</b> S HAVE BEEN EDITED TO PROTEC on record review the facility failed to pr esident #1) reviewed attained the highes d to properly assess residents after a fall. ucerations to the head on 1/6/2016 and w sive on 01/08/16 around 11:00am, the fa lance versus calling 911. The resident re spital via ambulance.	ag needs met including ancillary services, ealed no Social Worker was present in the Social Worker. Resident #11 stated she v ent #11 was at the facility for rehabilitation y no social worker at the facility. MA J st n there would be a Social Worker, have a Social Worker yet. #8's feet were dry and his toe nails were odiatrist were put on a list and the podiati d since there was no Social Worker, she v that the podiatrist rounds early mornings a er. e. Resident #9 asked if could get help for use and that he would rather go home but 9 was here for long-term care. the facility had not had a full time social Social Worker, each station has been in cl ices. LVN A also stated that she was not a ians to ensure that everything is set up. of each resident r CONFIDENTIALITY** vide the necessary care and services to er practicable, physical, mental and psycho- as not assessed appropriately after change cility did not assess the resident appropria mained in the facility from 11:00am until	e facility wanted to on ated she e long rist was around him to did not worker harge of sure sure 2 social e in ately and 4:11pm
<ul> <li>witceltain and the local keepend the revealed kesterin #4 sustained an open area to the back wrist.</li> <li>Record review of Incident/Accident Investigation Follow-up dated 1/6/16 revealed Resident #4 fell i was called to dining room by staff where LVN A found Resident #4 on the floor on his right side. S read: Resident stated he leaned forward to get up and fell to the floor. Past Interventions read: New no history of falls. Recommendations: encourage resident to ask for assistance avoid attempting to g Record review of Resident #4 's Interdisciplinary Post Fall Review completed by LVN A and dated Diseases: Dementia.</li> <li>In an interview on 1/6/16 at 2:20pm with LVN A she said she was called to dining room and found I side on the floor. LVN A said she assessed Resident #4 and found 2 lacerations to the back of his he tear to his right arm. Resident #4 was assisted to the wheelchair and then assisted to his bed. LVN A neuro vitals and notified the physician of the fall. She further said that orders were received for Tyle</li> </ul>		same day. After the Veterans Adr and had injuries he was sent to th An IJ was identified on 01/08/201 scope of pattern and a severity lev for effectiveness. These failures affected two residen risk for not having their needs me Intake #: 8, 0, 8, 2, Findings Include: Resident #4 Record review of Resident #4 ' s fa [REDACTED]. Record review of Resident #4 ' s fa [REDACTED]. Record review of Resident #4 ' s fa (Record review of Resident #4 ' s fa (REDACTED]. Record review of Resident #4 ' s fa (Resident #4 had Cognitive Defici making decisions in new situation decisions, Point out consequences Resident #4 was care planned for, fall prevention protocol as indicat In an interview with Resident #4 was (rall sch CONDITION]. Approach: Falling therapy, provide assistive devices to identify possible causes, and pl Resident #4 was care planned for, fall prevention protocol as indicat In an interview with Resident #4 coday. Observation at the same tir bed elevated. His call light was w Resident #4 was a fall risk. Record review of Incident/Accidel room where she found resident ly wheelchair and then to bed. Record wist. Record review of Incident/Accidel read: Resident stated he leaned for no history of falls. Recommendat Record review of Resident #4 's II Diseases: Dementia. In an interview on 1/6/16 at 2:20p side on the floor. LVN A said she tear to his right arm. Resident #4 's II	nistration (VA) Nurse assessed the resid e hospital. He was found to have a fractu- kel of actual harm due to the facility nee- nts and placed 102 residents as needing a t, injury and a decline in health status. Acce sheet revealed a [AGE] year old mal ADS dated [DATE] revealed a BIMS sc ed mobility, dressing, and toilet use. Care Plan dated 12/14/2015 with a review t; Resident had moderate independence us. Approach: Provide clear choices and of bad decisions, involve family memb et to: history of previous falls, non-ambig such as wheelchair, place call light in reach. [DIAGNOSES REDACTED]. Approac ed, call bell within reach, notify MD as on 1/6/16 at 9:40am he said he was at the ne revealed resident was well groomed, ithin reach. There were no falling star al 'Post Fall Report dated 1/6/2016 revealed that Resident #4 's fall occurred in the ing on floor on his right side. Resident #4 rost fall Report dated 1/6/2016 revealed that Resident #4 's fall occurred in the ing on floor on his right side. Resident #4 roward to get up and fell to the floor. Pas ions: encourage resident to ask for assis interdisciplinary Post Fall Review compl m with LVN A she said she was called t 'assessed Resident #4 and found 2 lacer was assisted to the wheelchair and then	nt on 12/23/15 and told the facility he have re to his cervical spine. 106, the facility remained out of complian ing more time to monitor the plan of rem- ssistance or dependent on staff for mobili e with an admission date of [DATE]. Diag re of 12 which indicated moderate cognit ed date of 12/23/15 revealed: vith decision making. Resident had diffict dequate information for resident to make rs in decisions regarding important matte lation, blood pressure changes, and [MEE] for assistance, physical therapy, occupati ach, observe for potential patterns of falls the decision altern, lying in bed with ove the bed or doorway entrance to signif d Resident #4 suffered a fall at 11:00am of lining room and LVN A was called to the 4 was assessed by LVN A and assisted to an open area to the back of the head and evealed Resident #4 fell in dining room an eloor on his right side. Summary of inve Interventions read: New resident to facili ince avoid attempting to get up on his ow ted by LVN A and dated 1/6/16 read: Pre o dining room and found Resident #4 lyin, tions to the back of his head and he had a systed to his bed. LVN A said she startec	d fallen ce at a oval ty at gnoses: ive impairment, ulty with ers. DICAL ional s risk assessment, ht head of fy that on right nd LVN A stigation ity, n. disposing g on his s skin

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:7/19/2016 FORM APPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 675231	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 01/13/2016		
AME OF PROVIDER OF SU	JPPLIER		SS, CITY, STATE, ZIP		
ACINTO CITY HEALTHC	ARE CENTER	1405 HOLLAND HOUSTON, TX 7			
or information on the nursing (X4) ID PREFIX TAG		cy, please contact the nursing home or the state surve DEFICIENCIES (EACH DEFICIENCY MUST BE P			
	OR LSC IDENTIFYING INFORM		RECEDED BT FULL REGULATORT		
F 0309		r skin tear of right arm and both wounds to head. LV	N A said no orders were received for CT		
Level of harm - Immediate jeopardy		ysician's orders [REDACTED].monitor neuro check r hours for 24 hours and every eight hours for 72 hou			
Residents Affected - Many	Record review of Resident #4's N for four hours, every four hours f vital signs were done starting on Record review of Resident #4's N instructions on the Neurological I In an interview on 01/7/16 at 9:30	aurological Record read in part: frequency every 30 r or 24 hours, every eight hours for remaining 72 hours 01/6/16 at 11:15am and ended on 01/07/16 at 10:30ar eurological record dated 01/6/16-01/7/16 revealed ne Record in regards to frequency was followed. am with Resident #4, he said he was not feeling well Resident #4 's roommate) on 01/7/16 at 9:30am he s	minutes for four hours, every one hour s or as ordered by physician .neuro m. either the physican's order nor the and that he was hurting all over.		
	Interview on 01/7/16 at 9:40am L assess him. Interview on 01/7/16 at 10:00am I	e. He said Resident #4 did not act the same and he st VN A when it was reported to her that Resident #4 w .VN A said Resident #4 was fine he was just tired. with Resident #1 he said Resident #4 was not fine. He and did not sleep.	as hurting all over she said she would		
	Observation and interview on 01/2 like getting out of bed.	revealed Resident was resting with his eyes closed. //16 at 4:00pm revealed Resident #4 was in bed and n revealed Resident #4 was in bed with his eyes close	Ū.		
	untouched.	ated 1/8/2016 at 12:15pm read: placed call to hospita			
	Report given. Went to Resident # Observation and interview on 01/ stimuli. His RP was at his bedside lunch tray was at his bedside unto facility that Resident #4 needed to	4 's room, made resident aware he would be transfer 18/16 at 1:00pm revealed Resident #4 was in bed wit 2 and said he would not wake up and shook his shoul buched. The RP said the Hospital Nurse told him that 0 be sent back to the hospital for evaluation. m with Resident #4 's Responsible Party (RP) reveal	rred to hospital. h eyes closed and did respond to verbal lder, Resident #4 did not respond. His t she would inform the Nurse at the		
	[DIAGNOSES REDACTED]. Re at facility on 1/06/2016 after lunc chart. The RP said that Resident that he arrived at facility at 11:00 said he informed the nurse of Res	sdident #4's RP further revealed that he was not noti h time. He said LVN H told him they did not have hi #4 was not acting like his self and had been acting dii am today and Resident #4 would not wake up and his ident #4 's condition and she assessed him and said ht #4 would be transferred to hospital for evaluation	fied of Resident #4 ' s fall until he arrived is phone number in Resident #4 ' s fferent since the fall. The RP said s breakfast had not been eaten. He she would call the physician. The RP		
	Observation on 1/8/ at 3:14pm of dry and cracked and lunch was at shook Resident #4 by the shoulde	P. Resident #4 revealed he was lying in bed with head of bedside and had not been eaten. Resident #4 did not r and Resident #4 did not respond. 8/16 at 3:30pm she said that she had notified physici	respond to verbal stimuli. The RP		
	Resident #4 was to be transferred chose the one with the least estim non-responsiveness, she said no.	to hospital. She further revealed that she contacted s ated time of arrival. When asked if she called 911 fo She said this was not an emergency situation.	several ambulance companies and or Resident #4 due to		
	of change in condition on 1/7/16 revealed that Resident #4 did not immediately for transfer.	1/8/16 at 3:35pm she revealed she was unaware that l and had requested an order from physician for x-ray become unresponsive until 1:00pm on 1/8/16. DON	of skull on 1/7/16. She further said she would have ADON call 911		
	Hospital nurse requested that nurse remained at bedside. Call was pla of recent fall from wheelchair.	ated 1/8/16 at 12:00pm said hospital nurse was visitin se on duty to assess Resident #4. Resident #4 said he ced to physician regarding assessment and Resident	was not feeling well. VA Nurse #4 not feeling well and also made aware		
	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.				
	placed to MD. New order to give	ted 1/8/16 at 12:30pm read: Resident in room. Son at glucacon 1mg IM (intra-muscular)if resident not awa	ake.		
	transportation. Son at bedside. Vi	ted 1/8/16 at 1:00pm read: BS=100. Resident respon- tal signs: Blood pressure-138/76, respirations-20, put ted 1/8/16 at 2:00pm read: Responds to painful stimu	lse- 78.		
	or symptoms of pain or discomfo		5		
	even and unlabored. Vital signs: I	ted 1/8/16 at 3:00pm read: Resident responding to pa	1 1		
	Record review of nurse 's note da	at bedside and aware of change of condition. ted 1/8/16 at 4:50pm read: EMS personnel arrived. B	Blood sugar at this time is 71. Blood		
		16 at 5:10pm she said that ADON and LVN H both v			
	Record review of emergency room department post fall 3 days ago. If fall. Primary Impression: Urinary In an interview with Resident #4 '	ions. She stated They both failed to assess with urgen n visit dated 1/08/2016 revealed resident was [AGE] vatient is non-responsive. Per EMS, family says patie Tract Infection. Secondary Impressions: Altered me s RP on 1/9/16 at 2:00pm he revealed that Resident at	years old and presented to emergency ent was not his normal self after ntal status, [DIAGNOSES REDACTED].		
	was not feeling well and hasn 't f Resident#1	pm with Resident #4 at hospital, resident responded elt well since the fall. He said he is hoping to get bet	ter so he can return to his home.		
	[REDACTED]. Record review of Resident #1 ' s M	linical record revealed a [AGE] year old male with a Animum Data Set ((MDS) dated [DATE] revealed a	-		
	Program, encourage resident to as identify possible causes, offer/ass	Tare Plan dated 12/15/2015 revealed that he was at risk for assistance, place call light in reach, observe for ist to toilet frequently and as accepted, place frequent	r potential patterns of falls to		
	hit his head when he fell down 4- day, he did not tell any staff and t one noticed the bump on his head Resident #1 said the hospital nurs further revealed that CT (cat scan time revealed resident was wearin	:00am with Resident #1 he revealed that he had a fall 5 steps. Resident #1 said he fell on [DATE] and whe he staff diah 't ask about the bump and scratches to 0 and scratches until the hospital nurse came to visit h e noticed immediately and she told the facility of the ) revealed a fracture to his neck and he needed to we ug neck brace per physician order.	In he returned to the facility that same his forehead. Resident #1 said no nim at the facility on 12/23/2015 . e fall and his injuries. Resident ar a neck brace. Observation at same		
	s care and the assessment skills of	016 at 10:00am with the VA Nurse she said that she f the nurses at the facility. The VA Nurse said she no along with scratches. She said she asked Resident #1	oticed immediately that Resident #1		

CENTERS FOR MEDICARE	& MEDICAID SERVICES		PRINTED:7/19/2016 FORM APPROVED OMB NO. 0938-0391	
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 SU			SS, CITY, STATE, ZIP	
JACINTO CITY HEALTHC	ARE CENTER	1405 HOLLAND HOUSTON, TX 7	7029	
For information on the nursing (X4) ID PREFIX TAG	· ·	cy, please contact the nursing home or the state surve DEFICIENCIES (EACH DEFICIENCY MUST BE PL		
	OR LSC IDENTIFYING INFORM			
F 0309 Level of harm - Immediate	(continued from page 12) said he fell down some stairs whi fall until she notified them on 12/	le he was out on pass. The Hospital nurse said the fac	ility was not aware of Resident #1's	
jeopardy Residents Affected - Many	Record review of nursing notes dated 12/23/2015 at 1:00pm revealed Resident #1 said he fell at home on 12/22/2015. He toe assessment performed. Resident #1 was alert and oriented. Small laceration on the forehead observed, scratch to the toe assessment performed.			
	Record review of Neurological rec	cord dated 12/23/2015 revealed that Neurological che	cks were started at 12:45am on	
	fall. Hospital nurse voiced concer followed for falls with suspected Record review of the Situation, Br 6:05pm revealed that Resident #1 received from physician to send F Record review of CT report dated acute	d 12/23/2015 at 4:30pm revealed facility called VA N n regarding documentation of facility nurse and requi- head injuries. ackground, Assessment and Recommendation (SBAR 's physician was notified of fall while Resident #1 wa tesident #1 to emergency room for evaluation and tre 12/24/2015 read: Diagnostic Impression; C3 cervical	ested that hospital protocol be R) Communication Form dated 12/23/2015 at as out on pass 12/22/2015. Orders atment for [REDACTED].	
	residents who go out on pass and In an interview with DON on 1/11 they return. She further said that v the Out of Facility Release of Res returned. She further revealed tha Record review of Out of Facility F out on pass on 12/18/15, 12/24/15 indicating that Resident #1 return An immediate jeopardy (IJ) was id	of Nursing (DON) on 1/8/2016 at 5:00pm she was un- how residents were monitored when they returned. T /2016 at 3:30pm she said that residents should be ass when residents go out on pass that the residents must ponsibility form and they sign in when they return so t the nurse on duty signs the form as well. Release of Responsibility form in Resident #1 's chart 5, 12/28/15, 1/03/16, 1/04/16, and 1/07/16. There were	he DOÑ said she would find out. essed before going out on pass and when inform the nurse and sign out on o that they know the resident has t revealed Resident #1 signed himself e no signatures by nurse or resident or was informed at that time.	
	and to be free of retaliation. copy concerns. They were re-educated Compliance Hotines. 2. The DON and Charge Nurses of following the completion of the a 3. The facility mailed copies of th numbers to the resident 's respon 4. To protect non-interviewable re Certified Nursing Assistants will changes they observe. • Charge nurses will conduct week Charge nurses will conduct week bear of the training of the training to the training of the training of the training and the training of the training training: The DON and the District Directo Housekeeping, Laundry and Dep Abuse and Neglect Prohibition Assessment of discomfort in Der Change in Condition Emergency Transports via 911 v Abuse and Neglect Prohibition training was provided by the Dire presented in an oral fashion with identification, investigation, prote Abuse and Neglect Prohibition training was provided by the Dire presented in an oral fashion with identification, investigation, prote Abuse and Neglect Prohibition training was provided by the Dire presented in an oral fashion with identification, investigation, prote Abuse and Neglect Prohibition training was provided by the Dire presented in an oral fashion with identification, investigation, prote Abuse and Neglect Prohibition training was provided by the Dire presented in an oral fashion with identification, investigation, prote Abuse and Neglect Prohibition traina anuary 10, 2016 including RN 's Nurse Managers, Rehab Staff, Di attend any of the training offered they have been re-educated on the The Assessment of discomfort in January 10, 2016 including RN 's	e Resident Rights, DADS Hotline phone number and sible party / family member. sidents from abuse included the following actions: utilize the Stop & Watch tool following all ADL car- ly head to toes skin checks ents for changes in behavior and complete the SBAR beess on Fall Do Not Move Resident From The Floor sessments include AROM and PROM and visual obso s sign of fracture. The staff will do the following: BP, pulse, per (care path) then proceed with initial nursing eval- re off the floor until complete exam has been perform or new bone deformity, head trauma, altered manta, ( TION] new or worsen cognitive impairment), lacera a. nplaints of [MEDICAL CONDITION] or spinal injur my abnormalities call EMS and send resident out. Do ne. If no answer within one hour,, the Medical Director or net Manager personnel January 8, 9 and 10, 2016 mentia Protocol	<ul> <li>e Hotline phone numbers to report any he facility for DADS Hotline and</li> <li>wable residents and found no concerns</li> <li>the company 's Compliance Hotline phone</li> <li>e to alert the charge nurse of any</li> <li>if they have a concern and notify the</li> <li>Until Complete Assessment Is Done and ervation of any limb shortening or internal</li> <li>uation for injuries and \ or</li> <li>ted.</li> <li>(decrease LOC, unresponsiveness, titon required sutures/staples if yes notify</li> <li>y, head trauma, perform Neurological on or wile contacted. The RP\facility</li> <li>g for all Nursing, Dietary,</li> <li>5. Training topics included were :</li> </ul>	
	District Director of Clinical Servi Assessment of Discomfort protoc trained on the steps they should fo Conducting a physical evaluatior Review residents history for pote Evaluating the discomfort and in Evaluate for pharmacologic inter The Assessment of discomfort in 1 's, Certified Nursing Assistants, 6 staff. Staff that were not able to a allowed to work with residents ur program. The facility 's policy for identific: well as Interact 4.0. These decisio symptoms, signs, and lab results a	ces. The training was presented in an oral fashion with ol should be applied when staff encounter situations v blow which include: ntially painful conditions training non-pharmacologic comfort interventions ventions that are not [MEDICAL CONDITION] Dementia Protocol training began January 8, 2016 an Certified Medication Aides, Physical Therapy, Occup ttend any of the training offered between January 8 t til they have been re-educated on The Assessment of ation of change of condition requires the implementat on support tools provide reporting guidance to license are immediate versus non-immediate, or next day, for 4.0 tool the licensed nurse can determine immediacy of	th examples provided of how the with affected residents. Staff were d ended January 10, 2016 for RN 's, LVN ational Therapy and Speech Therapy rru January 10, 2016 will not be 'Discomfort in Dementia Protocol ion of the Stop & Watch tool as d nurses on whether specific reporting purposes to the primary	

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:7/19/2016 FORM APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 675231	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 01/13/2016	
NAME OF PROVIDER OF SU		STREET ADDRE	SS, CITY, STATE, ZIP	
JACINTO CITY HEALTHC	ARE CENTER	1405 HOLLAND HOUSTON, TX 2		
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state surve		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE P MATION)	RECEDED BY FULL REGULATORY	
F 0309 Level of harm - Immediate jeopardy	(continued from page 13) The Director of Nursing Services Director of Clinical Services.	was re-educated on Stop & Watch and Interact 4.0 o and the Director of Nursing Services re-educated RN		
Residents Affected - Many	Staff Development, Certified Nu Therapy and MDS nurses January attend any of the training offered been re-educated on the facility ' The licensed nurse will evaluate e medical emergency is identified, and calls 911. The licensed staff f The surveyors confirmed the POR Record Review of the In-Service : had been in-serviced from 01/08/ in Condition and assessments and Observations were made from 01/08/ staff were able to verbalize the in The Administrator and DON were compliance at a pattern level and time to monitor the plan of remov	sing Assistants, Certified Medication Aides, Physica (9 and 10, 2016 on the Stop & Watch and Interact 4 between January 8 and 9, 2016 will not be allowed t s Stop & Watch and Interact 4.0 programs. ach situation based on individual resident condition a qualified staff evaluate the resident; initiate the appre- continues to provide care and monitor the resident un had been implemented sufficiently to remove the IJ sign-in sheet revealed that staff from the nursing dep 16 until 01/10/16. The topics included in part: Abuse I Emergency transport versus non-emergency transport 08/06 until 01/10/16 , for any residents that have a cl 16-01/10/16 between 4:30am to 4:00 pm daily with 6 formation from the recent in-services. • informed on 01/13/16 at 1:35pm that the IJ was low a severity of actual harm that is not immediate jeopa	al Therapy, Occupational Therapy, Speech O programs. Staff that were not able to o work with residents until they have at the time of the event. Once a opriate emergency procedure(s), till the emergency personnel arrive. by: artment representing all three shifts e and Neglect, Dementia Resident Change ort hange in condition/falls and care of CNAs and Nurses on various shifts revealed vered; however the facility remained out of rdy due to facility needing more	
F 0490 <b>Level of harm -</b> Immediate jeopardy	Be administered in an acceptabl **NOTE- TERMS IN BRACKET Based on observation, interview a	e way that maintains the well-being of each reside S HAVE BEEN EDITED TO PROTECT CONFID nd record review the Administrator and DON failed effectively and efficiently to attain or maintain the F	ent . ENTIALITY** to administer the facility in a manner	
Residents Affected - Many	mental and psychosocial well-bei #4, #8, #5, #3, #7and #1). The Administrator failed to: implement the facility Abuse, N	ng for 7 of 8 residents reviewed for abuse and neglec leglect, and Exploitation (ANE) Policy to prevent ab rsing staff conducted accurate assessmnets of resider	ct and quality of care. (Residents #6, use and neglect.	
	The DON failed to: -Train and monitor the staff on ma- -Train and monitor the nursing star These failures affected 7 residents Intake #: 8, 0, 8, 2, An IJ was identified on 01/08/201	anagement of Residents with Dementia. ff on assessing Residents when they had a change in and placed 103 residents at risk for inadequate care 6. While the IJ was removed on 01/13/2016, the faci vel of actual harm due to the facility needing more ti	and diminishing health conditions. lity remained out of compliance at a	
	for effectiveness. Findings Include: In an interview on 01/08/16 at 2:1 her. She also said she was not aw In an interview at 01/08/16 at 2:30 and procedure, in-services and sk In an interview on 1/09/2016 at 8: with Dementia. She said she know ago as she is new to the facility a	3pm the Administrator said she monitored the DON are of the situation regarding the abuse, neglect and pm the DON said she ensured the nurses were comp ill check-off sheets. 30am, Administrator said staff were going to be in-s ws that the staff was in-serviced on Dementia care by nd she would have to find out about the in-services.	by in-service of staff and monitoring quality of care. betent in their skills by having a policy erviced on how to handle residents ( the state but was not sure how long	
	in-serviced monthly. DON said st DON said staff will all be educated dementia, and abuse and neglect	9/2016 at 2:30pm she said that the facility has policie he had not held an in-service prior to the IJ as today ed on Stop and Watch. DON also said that all emplo before the start of their shift.	was her third day at the facility. byees will be in-serviced on falls,	
	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 In an interview on 01/09/2016 at 8 she was in-serviced this morning training but knows that the facilit	was asked about abuse and neglect training, she said 3:53am with RCS Q, she was able to name the Admin on abuse and neglect as well as falls. RCS Q was no	II'm not sure . nistrator as abuse coordinator. RCS Q said t sure of when she had dementia	
	employed for 2 weeks. Housekee sure who the abuse coordinator w In an interview with LVN S on 1/ she was in-serviced on falls, abuse the abuse coordinator. LVN S sai In an interview on 1/12/2016 with	ping F said he has not had abuse or neglect training, ras. 09/2016 at 8:55am she said that this was her second e and neglect this morning before her shift. LVN S w d she had not been in-serviced on residents with dem LVN C, she said she had recently been in-serviced of	falls or dementia training and was not day working at the facility. She said was able to name the Administrator as aentia or how to care for them. on abuse and neglect. She named facility	
	when. In an interview on 1/12/2016 with training on dementia and redirect	inator. LVN C said she had training on dementia and ADON, she said that she was in-serviced on falls an ing residents but was not sure how long ago.		
	Resident #6 had moderate cogniti options in simple terms regarding Resident #6 was care planned for resident to environment, bed alar identify possible causes, Offer/as observe for potential medication i Observation on 1/06/2016 at 3:15 to as medication cart was blockin trying to enter her room but could wanted in the room and that is w further revealed she was a fall ris Observation on 1/06/2016 at 3:19	pm revealed Resident #6 sitting in wheelchair attempt g the entrance to her room. Surveyor intervened and I not due to the medication cart blocking entrance to ny he had the cart there to block the entrance to preve k and did not want her in the room. pm revealed Resident #6 in her wheelchair wedged b	nory loss. Approach: Staff will offer act. sident to ask for assist, orient potential patterns of falls to ntly used items within reach, and oting to enter her room but was not able informed MA B that Resident #6 was room. MA B said he was aware she ent her from going in the room. He we tween medication cart and door to her	
	room. Surveyor intervened and ir room. MA B and RCS K went ov time. Resident #6 grabbed the har box in her closet. MA B and RCS	formed MA B and RCS K that Resident #6 was wed er to Resident #6 and moved the cart and told Reside adrail and tried to wheel herself into her room. Resid K told her she was not able to go into her room at the nd wheel herself into her room. MA B grabbed Resid	lged between medication cart and door to her ent #6 she could not go to her room at this lent #6 said she wanted to look at the his time. Resident #6 would not release	

CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED:7/19/2016 FORM APPROVED OMB NO. 0938-0391
TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 675231	(X2) MULTIPLE CONSTRUC A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 01/13/2016
AME OF PROVIDER OF SU ACINTO CITY HEALTHC			STREET ADDRESS, CITY, ST 1405 HOLLAND HOUSTON TX 77029	ATE, ZIP
or information on the nursing	home's plan to correct this deficien	cy, please contact the nursing he		
(X4) ID PREFIX TAG			IENCY MUST BE PRECEDED B	Y FULL REGULATORY
ACINTO CITY HEALTHC. For information on the nursing	home's plan to correct this deficien SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFORI (continued from page 14) her hand off the railing. RCS K th removed MA B and RCS K from because she would make a mess and take #6 had the right to enter her room Interview on 1/06/2016 at 3:30pm injuries. She further revealed that they could have tried redirecting is staff would be in-serviced in Abu sure of the date. In an interview with RCS K on 1/4 want her in the room because Res In an interview with Resident #6 at grabbed her arm like that before. Observation on 1/06/2016 at 3:45 Record review of MA B 's written to move it. He was told by the RC in her room. As she tried to go in only touched the resident and not In an interview with DON on 1/07 wrist. The DON said she had not Resident #4 Record review of Resident #4 's C Resident #4 Record review of Resident #4 's C Resident #4 was care planned for, fall prevention protocol as indicas In an interview with Resident #4 's C Resident #4 was care planned for, fall prevention protocol as indicas In an interview with Resident #4 's I to day. Observation at the same ti light was within reach. There wer risk. In an interview on 1/06/2016 at 2: side on the floor. LVN A said she tear to right arm. Resident #4 was and notified physician of fall. She	DEFICIENCIES (EACH DEFIC MATION) The DEFICIENCIES (EACH DEFIC MATION) The DEFICIENCIES (EACH DEFIC MATION) The DON revealed that she with the DON revealed that she MA B and RCS K acted inappr her. The DON said they should se/Neglect. The DON revealed D6/2016 at 3:35pm she said that ident #6 was a fall risk. tt 3:45pm she said that MA B ar She said she just wanted to look pm revealed redness to Residen that the RCS K grabbed her har hing more. ith Resident #6 on 1/07/2016 at the shape of finger prints. Resid 1/07/2016 at 9:45am she revealed (Tylenol per orders for her pain 7/216 at 10:00am she verified t noticed them before because the Care Plan dated 12/14/2015 with t; Resident had moderate indeps s. Approach: Provide clear cho s of bad decisions, involve famil ace frequently used items within [DIAGNOSES REDACTED]. ed, call bell within reach, notify n 1/06/2016 at 9:40am he said the sasest Resident #4 and foum assisted to wheelchair and ther further said that orders were re- s. Approach: Provide clear cho s of bad decisions, involve famile to to: history of previous falls, re- g star program, encourage resides such as wheelchair, place call 1 ace frequently used items within [DIAGNOSES REDACTED]. ed, call bell within reach, notify n 1/06/2016 at 9:40am he said 1 the revealed resident was well g e no falling star above the bed of 20pm with LVN A she said she assisted to wheelchair and ther further said that orders were re- further said that orders were	<b>HOUSTON, TX 77029</b> me or the state survey agency. IENCY MUST BE PRECEDED B fingers from the handrail. The DC told the DON that they did not wa was a fall risk. DON informed MA e performed an assessment on Resi opriately and should have allowed not have grabbed Resident #6's har that she was sure staff had training she was trying to re-direct Resider a RCS K hurt her wrist. Resident # in the box in her closet. t #6' s right wrist. aled at about 3pm, he was by the l ident #6 was a fall risk. Resident # d, telling her not to go in her roon 9:40am she revealed she had three ent #6 said she had pain to her righ d she was aware not aware of brui to her right wrist. hat there were 3 small bruises to R by were under the wander guard. a reviewed date of 12/23/15 revea endence with decisions making. Res ces and adequate information for r y members in decisions regarding on-ambulation, blood pressure cha in to ask for assistance, physical tf ight in reach, observe for potential n reach. Approach: Administer medication 'MD as indicated. ne was at the facility for therapy an 'oomed, lying in bed with head of 1 r doorway entrance to signify that was called to dining room and fou 12 lacerations to the back of his he assisted to his bed. LVN A said s1	N walked by and quickly nt Resident #6 in her room B and RCS K that Resident dent #6 and found no her to enter her room or id or arm. The DON said on Dementia but was not it #6 because she did not #6 said no one had ever Med Aid Cart, and was about 6 tried to wheel herself 1 for her safety. He small bruises on her t wrist. sing. The DON said she would esident #6 's right led: ident had difficulty with esident to make important matters. nges, and [MEDICAL terapy, occupational patterns of falls as ordered, fall risk assessment, d was feeling alright bed elevated. His call Resident #4 was a fall nd Resident #4 lying on his ad and he had a skin te started neuro vitals omfort, wound care
	Record review of Interdisciplinary 1/6/2016. Resident #4 was assess sustained an open area to the bacl Record review of Resident #4 's I Diseases: Dementia. In an interview on 1/08/16 at 3:14 REDACTED].#4 's fall until he a his phone number in Resident #4 different since the fall. The RP sa his breakfast had not been eaten. she would call the physician. The but that was over 3 hours ago and Observation on 1/08/ at 3:14pm of dry and cracked and lunch was at shook Resident #4 by the shoulde In an interview with LVN H on 1/ Resident #4 was to be transferred chose the one with the least estim non-responsiveness, she said no. In an interview with LVN H on 1/ Resident #4 was to be transferred chose the one with the least estim non-responsiveness, she said no. In an interview with the DON on aware of change in condition on further revealed that Resident #4 911 immediately for transfer. Record review of nurse 's notes d Hospital nurse requested that nur- remained at bedside. Call was pla of recent fall from wheelchair. Record review of nurse 's notes da dispatcher. Stated will send ambu Record review of nurse 's note da placed to MD. New order to give Record review of nurse 's note da transportation. Record review of nurse 's note da transportation. Record review of nurse 's note da pressure 140/79, pulse 79, respirat In an interview with DON on 1/08 of assessment, and starting interview Record review of nurse 's note da pressure 140/79, pulse 79, respiration not his normal self after fall.	Post Fall Report dated 1/6/201 ed by LVN A and assisted to wl c of the head and right wrist. Interdisciplinary Post Fall Revie prived at facility on 1/06/2016 at 's chart. The RP said that Residi id that he arrived at facility at 1 He said he informed the nurse o RP said LVN H told him that F Resident #4 still had not woke 'Resident #4 still had not woke 'Resident #4 still had not woke 'Resident #4 still had not prespo 08/2016 at 3:30pm she said that to hospital. She further revealed ated time of arrival. When aske 1/08/2016 at 3:35pm she reveale /07/2016 and had requested and idid not become unresponsive ur ated 1/8/2016 at 12:15pm read: 4 's room, made resident aware ted 1/08/2016 at 12:25pm read: lance right away. Made charge ted 1/08/2016 at 12:30pm read: E ted 1/08/2016 at 2:30pm read: E ted 1/08/2016 at 2:30pm read: E ted 1/08/2016 at 3:00pm read: E ted 1/08/2016 at 3:00pm read: E ted 1/08/2016 at 3:00pm read: F imfort. ted 1/08/2016 at 3:00pm read: F tions 20, and temperature 97.8. /2016 at 5:10pm she said that A entions. She stated They both fa n visit dated 1/08/2016 revealed	ing in bed with head of bed elevate Resident #4 did not respond to ve ad. she had notified physician of char I that she contacted several ambula d if she called 911 for Resident #4 d she was unaware that LVN H ha order from physician for x-ray of s til 1:00pm on 1/08/2016. DON sai ospital nurse was visiting with Res. Resident #4 said he was not feelin sment and Resident #4 not feeling placed call to hospital, spoke to en he would be transferred to hospita placed call to ambulance service. The nurse aware. Resident in room. Son at bedside. ar)if resident not awake. S=100. Resident responds to paint desponds to painful stimuli and mo awaiting on transportation. Resider (78, 80, 20, 97%. tesident responding to painful stim change of condition. MS personnel arrived. Blood suga DON and LVN H both will be cou	all at 11:00am on In ther revealed Resident #4 1/06/16 read: Predisposing a [DIAGNOSES Id him they did not have 1 had been acting Id not wake up and assessed him and said hospital for evaluation ed. Resident 's lips were rbal stimuli. The RP ge in mental status and nce companies and due to d not called 911. She was kull on 1/07/2016. She d she would have ADON call ident #4 and family. ge well. Hospital nurse well and also made aware ergency room nurse. L The above report given to Blood sugar (BS)=69. Call iul stimuli. Awaiting on ves all extremities. No tt denies pain. uli. No signs of r at this time is 71. Blood nseled on assessment, the depth S, family says patient was

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:7/19/2016 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2016		
JAME OF PROVIDER OF SU	675231 IPPLIER	STREET	ADDRESS, CITY, STATE, ZIP		
ACINTO CITY HEALTHC	ARE CENTER	1405 HG	OLLAND ON, TX 77029		
For information on the nursing	home's plan to correct this deficient	cy, please contact the nursing home or the			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				
F 0490	(continued from page 15)	,			
Level of harm - Immediate jeopardy	home. Resident #8	t felt well since the fall. He said he is hop	ng to get better so he can return to his		
Residents Affected - Many	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 a brief. Resident #8 said RCS grabl further revealed that same RCS h not seen her in about 4 days.	bed him by one leg and spun him around in ad pushed him into the bed before. Resider	as rough with him while trying to change his bed so she could change his brief. Resident #8 t #8 was not sure of RCS 's name. He said he had		
	about, but she would find out. In an interview with the DON on room when incident occurred and	1/11/2016 at 11:40am she revealed that RC RSC H had provided a written statement.	are who the RCS was that Resident #8 was talking S G, RSC I and RCS H were all in Resident #8's		
	noise. RCS H said she opened the She said she told RCS I to move I was asked if she did anything reg	door and the curtain was drawn. She said Resident #8 slowly. RCS H said RCS I res arding the treatment of [REDACTED].	vas passing by Resident #8 's room and heard RCS I was turning Resident #8 and moved his leg. sonded with That 's not how I do it . When RCS H		
	to assist. RCS G said Resident #8 screamed . RCS G further revealed was going to report them for bein	hollers every time he was changed. RCS of that the Resident #8 's roommate heard g mean to Resident #8.	was changing Resident #8 and she was in the room 5 said that when RCS I turned Resident #8 he Resident #8 screaming and roommate told them he		
	#8 a bed bath. RCS I said RCS H the roommate said in Spanish tha Resident #3	was also in the room to translate for Resid the was going to report them for being me			
	Depression/Anxiety. Approach: F		aled resident was care planned for urage resident and staff to be alert to events or ure as needed, modify environment to promote		
	that she doesn 't put up with it an like it when RCS M was assigned roommate (Resident #5) and take scared of RCS M. Resident #3 sa but now he was working on her h In an interview with the DON on	d takes care of it herself by telling him off to her hall and she was scared of him. Re her call light away so she would not be ab id she had mentioned it to previous admini all again andshe was worried he might cor	ident #3 had witnessed RCS M speak rudely to her te to use it and stated her roommate was also strator and RCS M was moved to a different hall te into her room. e of the incident involving Resident #3 and RCS M.		
	Resident #5 Record review of Resident #5 ' s c		e of 12/17/15 revealed Resident #5 was care		
	planned for falls. Approach: Falli	ng Star Program, place call light in reach,	e of 12/17/15 revealed Resident #5 was care 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: She said that whenever she used I This call light won 't get you wat she told the previous administrator	45pm Resident #5 said she didn ' t like it v er call light he would come in the room an er and then took the call light away and pl or and RCS M was moved to another hall b	hen that mean man would come into her room. d take it away. She said that RCS M told her		
	In an interview on 1/06/2015 at 1: true. Resident #3 said she had wit In an interview with DON on 1/08 said RCS M has been removed fr	the search is speaking rudely to Resident #3/2016 at 1:50pm she said she was aware o om the floor and suspended pending investores.	#3) said that everything Resident #5 said was and had witnessed him take her call light away. the incident involving Resident #5 and RCS M. She igation. DON said all employees will be in-serviced not be able to care for residents until they		
	Approach: Falling Star Program, items within reach, offer/assist to In an interview with Resident #7 c also said that when RCS G enters	toilet frequently and as accepted. on $1/11/$ at 11:25am he revealed that RCS ( the room she refuses to give her name. Re	ace call light in reach, place frequently used i was rude and speaks aggressively towards him. He sident #7 also said that when he used the call		
	never returns to let him know if s In an interview with DON on 1/11	he told the nurse he needed something for /2016 at 11:35am she said she was aware	and leaves the room. Resident #7 said she pain. of the incident involving RCS G and incident was ration Administration Record [REDACTED]. The DON		
	also said staff would be receiving In a telephone interview with RCS the nurse to tell Resident #7 that s let him know when she tells the n	sensitivity training now and quarterly. $\delta$ G on 1/13/2016 at 1:00pm she said that s she was the only RCS on his hall. RCS G s urse he needs medicine for pain. She said	he took care of Resident #7 on Friday. She asked aid that Resident #7 reported that she does not he was not aware that she had to report back to		
	Resident#1 Record review of Resident #1 's O Program, encourage resident to as	ometimes, maybe I come off rude . Care Plan dated 12/15/2015 revealed that h sk for assistance, place call light in reach, ist to toilet frequently and as accepted, pla			
	observe for potential medication I In an interview on 1/06/2016 at 11 hit his head when he fell down 4- day, he did not tell any staff and t one noticed the bump on his head Resident #1 said the hospital nurs	related causes. :00am with Resident #1 he revealed that h 5 steps. Resident #1 said he fell on [DATE he staff didn ' t ask about the bump and sc and scratches until the hospital nurse cam he noticed immediately and she told the fac	e had a fall while he was out on pass. He said he and when he returned to the facility that same atches to his forehead. Resident #1 said no to visit him at the facility on 12/23/2015.		
	time revealed resident was wearin In a telephone interview on 1/06/2	ng neck brace per physician order.	d that she was very concerned about Resident #1		

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE a			PRINTED:7/19/2016 FORM APPROVED
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF CORRECTION	/ CLIA IDENNTIFICATION NUMBER	A. BUILDING B. WING	01/13/2016
	675231		
AME OF PROVIDER OF SU			DDRESS, CITY, STATE, ZIP
ACINTO CITY HEALTHCA	ARE CENTER	1405 HOLI HOUSTON	
Ũ	1	ncy, please contact the nursing home or the state	, , ,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST MATION)	Γ BE PRECEDED BY FULL REGULATORY
F 0490	(continued from page 16) Resident #1 had a large hump to	his forehead along with scratches. She said she	asked Resident #1 about the hump and
Level of harm - Immediate jeopardy	scratches and he said he fell dow of Resident #1's fall until she not	n some stairs while he was out on pass. The Ho	ospital nurse said the facility was not aware
Residents Affected - Many	toe assessment performed. Resid	lent #1 was alert and oriented. Small laceration placed to physician. No new orders received. C	on the forehead observed, scratch to the tip
	Record review of Neurological re 12/23/2015 and continued to 5:3	ecord dated 12/23/2015 revealed that Neurologi 0pm on 12/23/2015.	cal checks were started at 12:45am on
	Record review of nurses note date	ed 12/23/2015 at 4:30pm revealed facility calle oncern regarding documentation of facility nurse	
	followed for falls with suspected	head injuries.	ealed that Resident #1's physician was notified of
	fall while Resident #1 was out on evaluation and treatment for [RE Record review of CT report dated	n pass 12/22/2015. Orders received from physic EDACTED].	cian to send Resident #1 to emergency room for ervical [MEDICATION NAME] process fracture:
	acute Record review of physician order		
	residents who go out on pass and In an interview with DON on 1/1 they return. She further said that	when residents go out on pass that the resident	rned. The DON said she would find out. I be assessed before going out on pass and when s must inform the nurse and sign out on
	returned. She further revealed th Record review of Out of Facility	esponsibility form and they sign in when they re at the nurse on duty signs the form as well. Release of Responsibility form in Resident #1 ' 5, 12/28/15, 1/03/16, 1/04/16, and 1/07/16. The	s chart revealed Resident #1 signed himself
	indicating that Resident #1 return Record review of Suspected resid -Residents have the right to be from		tober 02, 2015 provided by facility read:
		plement written policies and procedures that p	rohibit mistreatment, neglect, and abuse of
		lividuals who have been found guilty by court of	
	mistreatment of [REDACTED].	ing entered into the state nursing assistant regis ate 's nursing assistant registry or licensing aut	
	actions by a court of law against facility staff member.	an employee that would indicate unfitness for s	service as a nursing assistant or other
	unknown source and misappropr to the facility administrator and t	alleged violations involving mistreatment, negl iation of a resident 's property, are reported im to other officials in accordance with state law. that all alleged violations have been thoroughly	mediately, through established procedures,
	prevent further potential abuse w An immediate jeopardy (IJ) was A Plan of Removal (POR) for the	hile the investigation is in process. identified on 01/08/16 at 2:13 pm and the Admi I was submitted on 01/09/16 at 12:40pm and	inistrator was informed at that time.
	The POR included in part: Immediate Action:		
	1. The Interdiscplinary Team inter and to be free of retaliation. copy concerns. They were re-educated	rviewed 69 interviewable residents, provided a y of the DADS Hotline phone number and Com I regarding where the phone numbers were post	pliance Hotline phone numbers to report any
	Compliance Hotlines. 2. The DON and Charge Nurses of following the completion of the a	conducted Head to Toe skin checks on 37 non-i	nterviewable residents and found no concerns
	<ol> <li>The facility mailed copies of the numbers to the resident 's respondent to protect non-interviewable results.</li> </ol>	ne Resident Rights, DADS Hotline phone numb nsible party / family member. esidents from abuse included the following acti	
	<ul> <li>Certified Nursing Assistants will changes they observe.</li> <li>Charge nurses will conduct wee</li> </ul>	Il utilize the Stop & Watch tool following all Al	DL care to alert the charge nurse of any
	<ul> <li>Charge nurses will monitor resid family and physician.</li> </ul>	dents for changes in behavior and complete the	
		rocess on Fall Do Not Move Resident From The ssessments include AROM and PROM and	e Floor Until Complete Assessment Is Done and
ORM CMS-2567(02-99)	Event ID: YL1011	Facility ID: 675231	If continuation sheet