STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. BUILDING _____ B. WING _____	07/16/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PITTSBURG NURSING CENTER	123 PECAN GROVE PITTSBURG, TX 75686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure implementation of written policies and procedures to ensure 1 of 8 residents reviewed for neglect was free from neglect. (Resident #1) The facility failed to remove a hazardous chemical out of Resident #1's room after she was seen rubbing it into her eyes. The nurse did not report the incident to the oncoming shift, delaying physician notification and treatment for 21 hours. Resident #1 now is only able to see color and shapes. This failure contributed to Resident #1's eye injury and likely permanent [MEDICAL CONDITION]. An Immediate Jeopardy was determined to have existed from 06/11/17 through 06/12/17. This was determined to be past non-compliance due to the facility's implementation of actions that corrected the non-compliance prior to the beginning of the survey. This failure could place 28 residents with dementia or other delusional disorders at risk for severe injury or delays in medical treatment. Findings included: The facility's Abuse/Neglect Policy last updated November 2016 defined neglect as, .the failure to provide goods and services, necessary to avoid physical harm, mental anguish, or mental health illness . Computerized physician orders [REDACTED].#1 was an [AGE] year old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #1 was usually understood but had difficulty and required cueing for recall. Her vision was good and she could read fine print in newspapers and books. A care plan with an initiation date of 10/12/16 indicated Resident #1 had long and short term memory problems. She needed verbal cues for redirection. Resident #1 needed supervision for decision making. Interventions included to record behaviors and notify the physician of unusual behaviors. The care plan indicated the resident used glasses. One of the approaches was report to the physician any signs of acute eye problems. A care plan with an initiation date of 11/10/16 indicated Resident #1 liked to play dominos, participate in creative creations, and go out of the facility on trips. She enjoyed watching various TV programs, religious services, watching movies, and looking at magazines. Late entry nursing notes, written by LVN B, with an entry date of 6/12/17 at 11:15 p.m. to 11:33 p.m. indicated on 6/11/17 at 1:00 a.m. LVN B administered artificial tears to Resident #1's eyes due to the resident's complaints of irritation and itching. On 6/11/17 at 1:32 a.m., Resident #1 initiated her call light. Upon entering the room Resident #1 was wiping [MEDICATION NAME] (a pink colored topical antiseptic) in her eyes with her fingers. The resident did not know where she obtained the [MEDICATION NAME]. LVN B flushed the resident's eyes because the directions on the bottle indicated to flush the resident's eyes with cold water. The resident tolerated well and seemed to be relieved. Attempted to call NP, but was unsuccessful. According to the [MEDICATION NAME] website, www.[MEDICATION NAME].com, accessed 7/25/17, it indicated: Warnings For external use only When using this product *keep out of eyes, ears, and mouth. May cause serious and permanent eye injury if placed or kept in the eye during surgical procedures, or may cause [DIAGNOSES REDACTED] when instilled in the middle ear through perforated eardrums. *if contact occurs in any of these areas, rinse with cold water right away . During an telephone interview on 07/16/17 at 10:38 a.m., LVN B said she was on duty the night of 6/10-6/11/17 when Resident #1 rubbed the [MEDICATION NAME] in her eyes. She said she forgot to remove the bottle of [MEDICATION NAME] from the room after flushing Resident #1's eyes with water. She said she had not informed the oncoming shift nurse, documented, or informed the physician about the incident. During an interview on 7/16/17 at 7:19 a.m. LVN A said she arrived at work at 6 a.m. on 06/11/17 and relieved LVN B. She said LVN B did not tell her Resident #1 rubbed [MEDICATION NAME] in her eyes. LVN A said there was no incident report of the incident and there was no documentation of the incident in the nursing notes. She said on the morning of 06/11/17 between 8-9 a.m., she was called to Resident #1's room because Resident #1 was complaining of eye pain and complained she could not see. She said when she arrived in the room Resident #1 was holding her eyes, saying they hurt and she said she could not see. LVN A said, while she was assessing Resident #1, the housekeeper was sweeping Resident #1's room. She said when the housekeeper swept under the bed she found a bottle of [MEDICATION NAME] and asked if Resident #1 should have this in her room. She said she told the housekeeper no and took the bottle. LVN A said she asked Resident #1 if the bottle was hers and the resident said yes. LVN A said she asked Resident #1 if she put the contents of the bottle in her eyes and Resident #1 said no. LVN A said she called the NP and reported Resident #1's complaints and told her Resident #1 had drainage to her eyelids with crusting. She said it was not until the end of her 16 hour shift, on 06/11/17 at 10:35 p.m. when LVN B came to relieve her, that she learned Resident #1 had rubbed [MEDICATION NAME] in her eyes. She said the physician was not notified of the incident until 10:45 p.m. on the night of 06/11/17, 21 hours later after the incident occurred. Nursing notes written by LVN A dated 6/11/17 at 11:29 a.m. indicated Resident #1 complained of her eyes hurting and burning. She had some drainage to her eyelashes. The physician was called and ordered [MEDICATION NAME] 0.3-0.1 percent solution (treats bacterial infections/steroid) 1 drop to both eyes two times a day for 10 days. At 9:10 p.m., Resident #1 continued to keep her eyes closed and continued to rub her eyes. During an interview on 07/16/17 at 9:33 a.m., the housekeeper said she went into Resident #1's room on the morning of 06/11/17 to clean it and Resident #1 complained her eyes were hurting. She said reported Resident #1's complaints to LVN A. She said LVN A came to the room to check on Resident #1. The housekeeper said as she was sweeping under the bed, she found a bottle and asked LVN A if Resident #1 was supposed to have it in her room and LVN A said no and took the bottle. During an interview on 07/16/17 at 11:28 a.m., the ADON said she was not made aware of the incident until Monday 06/12/17. She said the 6-2 LVN for 06/12/17 told her that LVN B walked into Resident #1's room and found her rubbing [MEDICATION NAME] in her eyes. She said she looked and did not see an incident report. She said she called and spoke with LVN B over the phone. She said LVN B said she walked into Resident #1s room on 06/11/17 at 1:38 a.m. and Resident #1 had pink stuff on her fingers. LVN B said she saw a bottle of [MEDICATION NAME] on the bedside table and asked Resident #1 where she got it.

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

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Resident #1 told LVN B it was hers. She said she asked LVN B if she removed the [MEDICATION NAME] from Resident #1's room and she said she thought she did, but may have left it in the room. She said LVN B said she did not write an incident statement. She said she was told by the 6-2 charge nurse that the nurse practitioner wanted Resident #1 to be seen by an ophthalmologist as soon as possible. She said an appointment had been made for 9:00 a.m. that morning (6/12/17). The ADON said she did not see the bottle of [MEDICATION NAME]. She said the transportation driver called the facility and notified them the ophthalmologist referred Resident #1 to a cornea specialist in Dallas, TX. A nursing note dated 6/12/17 at 8:48 a.m. indicated Resident #1 needed an appointment to be seen by an eye doctor as soon as possible due to her rubbing [MEDICATION NAME] on her hands and rubbing her eyes. The resident's appointment was made for that day 6/12/17. A cornea specialist note dated 6/12/17 indicated Resident #1 presented with chemical burn in the right and left eye. The resident was at the nursing home and they said she got [MEDICATION NAME] in her eyes this morning. The nurse walked in and said the resident had the cleanser all over her hands and face. She had difficulty opening her eyes saying they hurt. The note indicated it was hard to get an accurate history because the patient had dementia. She went to the local eye doctor, they irrigated her eyes, and sent her here. The most recent MDS dated [DATE] indicated Resident #1 was usually understood but had difficulty and required cueing for recall. Her vision was severely impaired and she could see only light color or shapes. During an interview on 07/16/17 at 5:10 a.m., Resident #1 said she did not know what happened to her eyes. She said one of the nurses told her she put something in her eye, but she does not recall putting anything in her eye. Resident #1 said her eyes hurt and she could not see. A physician note dated 7/5/17 indicated the injury to Resident #1's eyes was severe and there was likely severe stem cell damage with a poor prognosis. The resident constantly removed the shields and rubbed her eyes. The patient was forgetful and may need a full time sitter to monitor her 24 hours. A physician note dated 7/14/17 indicated the severity of the injury to Resident #1's eyes was likely [MEDICAL CONDITION]. The resident was constantly rubbing her eyes and possibly causing more damage. The physician documented that the resident would do poorly due to mental status. She was non-compliant. There was worsening of both eyes since the resident washed her eyes out with [MEDICATION NAME] on 6/12/17. (sic) During an interview on 07/16/17 at 6:22 a.m., the administrator said he was the abuse coordinator. He said on the night of 06/10/17 LVN B found Resident #1 rubbing [MEDICATION NAME] in her eyes when she walked into Resident #1's room. He said the facility was unaware of how Resident #1 obtained a bottle of [MEDICATION NAME]. He said [MEDICATION NAME] was kept in the supply room and on the treatment cart. The administrator said he did not see the bottle of [MEDICATION NAME] found in Resident #1's room. He said the bottle was sent out with Resident #1 to her eye doctor appointment. During an interview on 07/16/17 at 6:25 a.m., the DON said Resident #1 was seen by an eye doctor in another town and he referred her to an eye specialist. She said Resident #1 was placed on one-on-one monitoring after the incident. The DON said the facility had not been able to provide one-on-one coverage for all shifts. She said there was no reason [MEDICATION NAME] should have been in Resident #1's room. She said the facility investigated the incident and was unable to determine how Resident #1 obtained the [MEDICATION NAME]. The DON said she did not see the bottle of [MEDICATION NAME] that was removed from Resident #1's room. During an interview on 07/16/17 at 5:07 a.m., CNA D said she was picking up extra shifts sitting with Resident #1 because the facility needed someone to sit with her to keep her from rubbing and scratching her eyes. She said Resident #1 had been on one-on-one monitoring for approximately one month. During an interview on 07/16/17 at 5:29 a.m., LVN C said Resident #1 had surgery on her eyes. She said Resident #1 rubbed [MEDICATION NAME] in her eyes back in June. She said she was not sure of the exact date because the incident occurred before she was hired. LVN C said [MEDICATION NAME] was kept on the treatment cart and in the supply room. She said both were kept locked. She said she had never seen the treatment cart or the supply room unlocked. On 7/16/17 at 2:50 p.m., the administrator, DON, and ADON were informed that an Immediate Jeopardy was determined to have existed from 06/11/17 through 06/12/17. The Immediate Jeopardy was determined to be past non-compliance due to the facility's implementation of actions that corrected the non-compliance prior to the beginning of the survey. The Immediate Jeopardy was removed on 06/12/17 because, prior to surveyor entrance, the facility had removed all medications and hazardous products from all resident rooms, had in-serviced all staff regarding reporting all incidents and keeping harmful products out of resident rooms, and had sent the resident for medical treatment. There were no hazardous products found unsecured or in resident rooms and the staff was aware of reporting and prevention measures. An in-service dated June 12, 2017 indicated all staff were in-serviced to remove from residents' rooms any medication, prescription creams, ointments, soaps, powders, hazardous items, or anything that indicated the item should be kept out of the reach of children. They were informed that all carts and rooms containing chemicals or medications were to be kept locked when a staff member was not directly accessing the area. During an interview on 07/16/17 at 2:43 p.m., the ADON said on 06/12/17 she and the administrator did inspections of all resident rooms and removed any items they felt could be dangerous or hazardous. She said during the in-services, the staff was told to immediately remove any items of this sort they may see in the residents' rooms. She said on 6/12/17 she counseled and in-serviced LVN B regarding reporting significant events to the on-coming shift, removal of hazardous chemical/items from the resident rooms, notifying the physician of significant changes of condition, completing accurate nursing notes and incident reports, and documenting pertinent information on the 24 hour nursing report. During a telephone interview on 07/16/17 at 10:38 a.m., LVN B said she had now been counseled regarding her failures in this matter and was in-serviced regarding proper reporting, documentation, removal of hazards, and physician notification. During an interview on 07/16/17 at 2:49 p.m., the administrator said the staff were in-serviced on removing potential hazardous and dangerous material from the residents' rooms and proper reporting. He also verified that LVN B was counseled multiple times in regards to the incident. During observations on 07/16/17 from 4:47 a.m. until exit, the treatment cart, supply room, housekeeping supply room, biohazard room and the medications carts were all observed to be locked with no hazardous items accessible. During an interview on 07/16/17 at 2:43 p.m., the ADON said the facility had 28 residents with dementia or other delusional disorders.
F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violation of neglect, were reported to the administrator and state agency in accordance with state law and failed to have evidence of all alleged violations was thoroughly investigated for 1 of 8 residents reviewed for neglect. (Resident #1) The facility did not report an incident of neglect immediately to the administrator and state agency when Resident #1 was found rubbing a hazardous chemical in her eyes. The facility did not investigate or provide documentation of the investigation into the incident of neglect for Resident #1. This failure could place the census of 42 residents at risk of neglect. Findings included: A computerized physician order [REDACTED].#1 was an [AGE] year old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #1 was usually understood but had difficulty and required cueing for recall. Her vision was good and she could read fine print in newspapers and books. A care plan with an initiation date of 10/12/16 indicated Resident #1 had long and short term memory problems. She needed verbal cues for redirection. Resident #1 needed supervision for decision making. An intervention was to record behaviors and notify the physician of unusual behaviors. The care plan indicated the resident used glasses. One of the approaches was

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F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) report to the physician any signs of acute eye problems. Late entry nursing notes, written by LVN B, with an entry date of 6/12/17 at 11:15 p.m. to 11:33 p.m. The notes indicated on 6/11/17 at 1:32 a.m., Resident #1 initiated her call light. Upon entering the room Resident #1 was wiping [MEDICATION NAME] (a pink colored topical antiseptic) in her eyes with her fingers. The resident did not know where she obtained the [MEDICATION NAME]. LVN B flushed the resident's eyes because the directions on the bottle indicated to flush the resident's eyes with cold water. The resident tolerated well and seemed to be relieved. Attempted to call NP, but was unsuccessful. According to the [MEDICATION NAME] website, www.[MEDICATION NAME].com, accessed 7/25/17, it indicated: Warnings For external use only When using this product *keep out of eyes, ears, and mouth. May cause serious and permanent eye injury if placed or kept in the eye during surgical procedures, or may cause [DIAGNOSES REDACTED] when instilled in the middle ear through perforated eardrums. *if contact occurs in any of these areas, rinse with cold water right away . During an interview on 07/16/17 at 10:38 a.m., LVN B said she was on duty the night of 6/10-6/11/17 when Resident #1 rubbed the [MEDICATION NAME] in her eyes. She said she forgot to remove the bottle of [MEDICATION NAME] from the room after flushing Resident #1's eyes with water. LVN B said she did not inform the oncoming shift nurse, document, or inform the physician or administrator about the incident. During an interview on 07/16/17 at 5:10 a.m., Resident #1 said she did not know what happened to her eyes. She said one of the nurses told her she put something in her eye, but she does not recall putting anything in her eye. Resident #1 said her eyes hurt and she could not see. During an interview on 7/16/17 at 7:19 a.m. LVN A said she arrived at work at 6 a.m. on 06/11/17 and relieved LVN B. She said LVN B did not tell her Resident #1 rubbed [MEDICATION NAME] in her eyes. LVN A said there was no incident report of the incident and there was no documentation of the incident in the nursing notes. She said on the morning of 06/11/17 between 8-9 a.m., she was called to Resident #1's room because Resident #1 was complaining of eye pain and complained she could not see. She said when she arrived in the room Resident #1 was holding her eyes, saying they hurt and she said she could not see. LVN A said, while she was assessing Resident #1, the housekeeper was sweeping Resident #1's room. She said when the housekeeper swept under the bed she found a bottle of [MEDICATION NAME] and asked if Resident #1 should have this in her room. She said she told the housekeeper no and took the bottle. LVN A said she asked Resident #1 if the bottle was hers and the resident said yes. She said she then asked Resident #1 if she put the contents of the bottle in her eyes and Resident #1 said no. Nursing notes written by LVN A dated 6/11/17 at 11:29 a.m. indicated Resident #1 complained of her eyes hurting and burning. During an interview on 07/16/17 at 11:28 a.m., the ADON said she was not made aware of the incident until Monday 06/12/17. She said the 6-2 LVN for 06/12/17 told her that LVN B walked into Resident #1's room and found her rubbing [MEDICATION NAME] in her eyes. She said she looked and did not see an incident report. She said she called and spoke with LVN B over the phone. She said LVN B said she did not write an incident statement During an interview on 07/16/17 at 6:22 a.m., the administrator said he was the abuse coordinator. He said on the night of 06/10/17 LVN B found Resident #1 rubbing [MEDICATION NAME] in her eyes when she walked into Resident #1's room. He said the facility was unaware of how Resident #1 obtained a bottle of [MEDICATION NAME]. He said he was not notified of the incident until 06/12/17 and he did not call the incident into the state agency because he did not think it met the standards to be called into the state agency. The administrator could not provide documentation of an investigation. During an interview on 07/16/17 at 6:25 a.m., the DON said there was no reason [MEDICATION NAME] should have been in Resident #1's room. She said the facility investigated the incident and was unable to determine how Resident #1 obtained the [MEDICATION NAME]. She said she did not have an investigation report of the incident. The facility's Abuse/Neglect Policy last updated November 2016 defined neglect as, .the failure to provide goods and services, necessary to avoid physical harm, mental anguish, or mental health illness . The CMS 672 dated 7/16/17 indicated the census was 42.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free from accident hazards as possible for 1 of 8 residents reviewed for accident hazards. (Resident #1) The facility failed to remove hazardous chemicals out Resident #1's room after she was seen rubbing it into her eyes. The nurse did not report the incident to the oncoming shift, delaying physician notification and treatment for 21 hours. Resident #1 now only sees colors and shapes. This failure contributed to Resident #1's eye injury and likely permanent blindness. An Immediate Jeopardy was determined to have existed from 06/11/17 through 06/12/17. This was determined to be past non-compliance due to the facility's implementation of actions that corrected the non-compliance prior to the beginning of the survey. This failure could place 28 residents with dementia and other delusional disorders at risk for severe injury or delays in medical treatment. Findings included: Computerized physician orders [REDACTED].#1 was an [AGE] year old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #1 was usually understood but had difficulty and required cueing for recall. Her vision was good and she could read fine print in newspapers and books. A care plan with an initiation date of 10/12/16 indicated Resident #1 had long and short term memory problems. She needed verbal cues for redirection. Resident #1 needed supervision for decision making. An intervention was to record behaviors and notify the physician of unusual behaviors. The care plan indicated the resident used glasses. One of the approaches was report to the physician any signs of acute eye problems. A care plan with an initiation date of 11/10/16 indicated Resident #1 liked to play dominos, participate in creative creations, and go out of the facility on trips. She enjoyed watching various TV programs, religious services, watching movies, and looking at magazines. Late entry nursing notes, written by LVN B, with an entry date of 6/12/17 at 11:15 p.m. to 11:33 p.m. indicated on 6/11/17 at 1:00 a.m. LVN B administered artificial tears to Resident #1's eyes due to the resident's complaints of irritation and itching. On 6/11/17 at 1:32 a.m., Resident #1 initiated her call light. Upon entering the room Resident #1 was wiping Hibiclens (a pink colored topical antiseptic) in her eyes with her fingers. The resident did not know where she obtained the Hibiclens. LVN B flushed the resident's eyes because the directions on the bottle indicated to flush the resident's eyes with cold water. The resident tolerated well and seemed to be relieved. Attempted to call NP, but was unsuccessful. According to the Hibiclens website, www.hibiclens.com, accessed 7/25/17, it indicated: Warnings For external use only When using this product *keep out of eyes, ears, and mouth. May cause serious and permanent eye injury if placed or kept in the eye during surgical procedures, or may cause [DIAGNOSES REDACTED] when instilled in the middle ear through perforated eardrums. *if contact occurs in any of these areas, rinse with cold water right away . During an telephone interview on 07/16/17 at 10:38 a.m., LVN B said she was on duty the night of 6/10-6/11/17 when Resident #1 rubbed the Hibiclens in her eyes. She said she forgot to remove the bottle of Hibiclens from the room after flushing Resident #1's eyes with water. She said she had not informed the oncoming shift nurse, documented, or informed the physician about the incident. During an interview on 7/16/17 at 7:19 a.m. LVN A said she arrived at work at 6 a.m. on 06/11/17 and relieved LVN B. She

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) said LVN B did not tell her Resident #1 rubbed Hibiclens in her eyes. LVN A said there was no incident report of the incident and there was no documentation of the incident in the nursing notes. She said on the morning of 06/11/17 between 8-9 a.m., she was called to Resident #1's room because Resident #1 was complaining of eye pain and complained she could not see. She said when she arrived in the room Resident #1 was holding her eyes, saying they hurt and she said she could not see. LVN A said, while she was assessing Resident #1, the housekeeper was sweeping Resident #1's room. She said when the housekeeper swept under the bed she found a bottle of Hibiclens and asked if Resident #1 should have this in her room. She said she told the housekeeper no and took the bottle. LVN A said she asked Resident #1 if the bottle was hers and the resident said yes. LVN A said she asked Resident #1 if she put the contents of the bottle in her eyes and Resident #1 said no. LVN A said she called the NP and reported Resident #1's complaints and told her Resident #1 had drainage to her eyelids with crusting. She said it was not until the end of her 16 hour shift, on 06/11/17 at 10:35 p.m. when LVN B came to relieve her, that she learned Resident #1 had rubbed Hibiclens in her eyes. She said the physician was not notified of the incident until 10:45 p.m. on the night of 06/11/17, 21 hours later after the incident occurred. Nursing notes written by LVN A dated 6/11/17 at 11:29 a.m. indicated Resident #1 complained of her eyes hurting and burning. She had some drainage to her eyelashes. The physician was called and ordered Tobradex 0.3-0.1 percent solution (treats bacterial infections/steroid) 1 drop to both eyes two times a day for 10 days. At 9:10 p.m., Resident #1 continued to keep her eyes closed and continued to rub her eyes. During an interview on 07/16/17 at 9:33 a.m., the housekeeper said she went into Resident #1's room on the morning of 06/11/17 to clean it and Resident #1 was complaining her eyes were hurting. She said she reported Resident #1's complaint to LVN A. She said LVN A came to the room to check on Resident #1. The housekeeper said as she was sweeping under the bed, she found a bottle and asked LVN A if Resident #1 was supposed to have it in her room and LVN A said no and took the bottle. During an interview on 07/16/17 at 11:28 a.m., the ADON said she was not made aware of the incident until Monday 06/12/17. She said the 6-2 LVN for 06/12/17 told her that LVN B walked into Resident #1's room and found her rubbing Hibiclens in her eyes. She said she looked and did not see an incident report. She said she called and spoke with LVN B over the phone. She said LVN B said she walked into Resident #1s room on 06/11/17 at 1:38 a.m. and Resident #1 had pink stuff on her fingers. LVN B said she saw a bottle of Hibiclens on the bedside table and asked Resident #1 where she got it. Resident #1 told LVN B it was hers. She said she asked LVN B if she removed the Hibiclens from Resident #1's room and she said she thought she did, but may have left it in the room. She said LVN B said she did not write an incident statement. She said she was told by the 6-2 charge nurse that the nurse practitioner wanted Resident #1 to be seen by an ophthalmologist as soon as possible. She said an appointment had been made for 9:00 a.m. that morning (6/12/17). The ADON said she did not see the bottle of Hibiclens. She said the transportation driver called the facility and notified them the ophthalmologist referred Resident #1 to a cornea specialist in Dallas, TX. A nursing note dated 6/12/17 at 8:48 a.m. indicated Resident #1 needed an appointment to be seen by an eye doctor as soon as possible due to her rubbing Hibiclens on her hands and rubbing her eyes. The resident's appointment was made for that day 6/12/17. A cornea specialist note dated 6/12/17 indicated Resident #1 presented with chemical burn in the right and left eye. The resident was at the nursing home and they said she got Hibiclens in her eyes this morning. The nurse walked in and said the resident had the cleanser all over her hands and face. She had difficulty opening her eyes saying they hurt. The note indicated it was hard to get an accurate history because the patient had dementia. She went to the local eye doctor, they irrigated her eyes, and sent her here. The most recent MDS dated [DATE] indicated Resident #1 was usually understood but had difficulty and required cueing for recall. Her vision was severely impaired and she could see only light color or shapes. During an interview on 07/16/17 at 5:10 a.m., Resident #1 said she did not know what happened to her eyes. She said one of the nurses told her she put something in her eye, but she does not recall putting anything in her eye. Resident #1 said her eyes hurt and she could not see. A physician note dated 7/5/17 indicated the injury to Resident #1's eyes was severe and there was likely severe stem cell damage with a poor prognosis. The resident constantly removed the shields and rubbed her eyes. The patient was forgetful and may need a full time sitter to monitor her 24 hours. A physician note dated 7/14/17 indicated the severity of the injury to Resident #1's eyes was likely blindness. The resident was constantly rubbing her eyes and possibly causing more damage. The physician documented that the resident would do poorly due to mental status. She was non-compliant. There was worsening of both eyes since the resident washed her eyes out with Hibiclens on 6/12/17. (sic) During an interview on 07/16/17 at 6:22 a.m., the administrator said he was the abuse coordinator. He said on the night of 06/10/17 LVN B found Resident #1 rubbing Hibiclens in her eyes when she walked into Resident #1's room. He said the facility was unaware of how Resident #1 obtained a bottle of Hibiclens. He said Hibiclens was kept in the supply room and on the treatment cart. The administrator said he did not see the bottle of Hibiclens found in Resident #1's room. He said the bottle was sent out with Resident #1 to her eye doctor appointment. During an interview on 07/16/17 at 6:25 a.m., the DON said Resident #1 was seen by an eye doctor in another town and he referred her to an eye specialist. She said Resident #1 was placed on one-on-one monitoring after the incident. The DON said the facility had not been able to provide one-on-one coverage for all shifts. She said there was no reason Hibiclens should have been in Resident #1's room. She said the facility investigated the incident and was unable to determine how Resident #1 obtained the Hibiclens. The DON said she did not see the bottle of Hibiclens that was removed from Resident #1's room. During an interview on 07/16/17 at 5:07 a.m., CNA D said she was picking up extra shifts sitting with Resident #1 because the facility needed someone to sit with her to keep her from rubbing and scratching her eyes. She said Resident #1 had been on one-on-one monitoring for approximately one month. During an interview on 07/16/17 at 5:29 a.m., LVN C said Resident #1 had surgery on her eyes. She said Resident #1 rubbed Hibiclens in her eyes back in June. She said she was not sure of the exact date because the incident occurred before she was hired. LVN C said Hibiclens was kept on the treatment cart and in the supply room. She said both were kept locked. She said she had never seen the treatment cart or the supply room unlocked. The facility's Abuse/Neglect Policy last updated November 2016 defined neglect as, .the failure to provide goods and services, necessary to avoid physical harm, mental anguish, or mental health illness . On 7/16/17 at 2:50 p.m., the administrator, DON, and ADON were informed that an Immediate Jeopardy was determined to have existed from 06/11/17 through 06/12/17. The Immediate Jeopardy was determined to be past non-compliance due to the facility's implementation of actions that corrected the non-compliance prior to the beginning of the survey. The Immediate Jeopardy was removed on 06/12/17 because, prior to surveyor entrance, the facility had removed all medications and hazardous products from all resident rooms, had in-serviced all staff regarding reporting all incidents and keeping harmful products out of resident rooms, and had sent the resident for medical treatment. There were no hazardous products found unsecured or in resident rooms and the staff was aware of reporting and prevention measures. An in-service dated June 12, 2017 indicated all staff were in-serviced to remove from residents' rooms any medication, prescription creams, ointments, soaps, powders, hazardous items, or anything that indicated the item should be kept out of the reach of children. They were informed that all carts and rooms containing chemicals or medications were to be kept locked when a staff member was not directly accessing the area. During an interview on 07/16/17 at 2:43 p.m., the ADON said on 06/12/17 she and the administrator did inspections of all resident rooms and removed any items they felt could be dangerous or hazardous. She said during the in-services, the staff was told to immediately remove any items of this sort they may see in the residents' rooms. She said on 6/12/17 she counseled and in-serviced LVN B regarding reporting significant events to the on-coming shift, removal of hazardous chemical/items from the resident rooms, notifying the physician of significant changes of condition, completing accurate nursing notes and incident reports, and documenting pertinent information on the 24 hour nursing report. During a telephone interview on 07/16/17 at 10:38 a.m., LVN B said she had now been counseled regarding her failures in this matter and was in-serviced regarding proper reporting, documentation, removal of hazards, and physician notification. During an interview on 07/16/17 at 2:49 p.m., the administrator said the staff were in-serviced on removing potential hazardous and dangerous material from the residents' rooms and proper reporting. He also verified that LVN B was counseled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. BUILDING _____ B. WING _____	**07/16/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PITTSBURG NURSING CENTER	**123 PECAN GROVE PITTSBURG, TX 75686**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) multiple times in regards to the incident. During observations on 07/16/17 from 4:47 a.m. until exit, the treatment cart, supply room, housekeeping supply room, biohazard room and the medications carts were all observed to be locked with no hazardous items accessible. During an interview on 07/16/17 at 2:43 p.m., the ADON said the facility had 28 residents with dementia or other delusional disorders.