STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675081	A. BUILDING _____ B. WING _____	10/21/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN ACRES LIVING AND REHABILITATION CENTER	2525 CENTERVILLE RD DALLAS, TX 75228

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 0157	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to immediately consult with the resident's physician and interested family member when the resident had a significant change in physical status for one (Resident #1) of 27 residents reviewed for skin/wound care and/or pacemakers. 1. LVN B failed to immediately consult with Resident #1's physician when he saw the resident's surgical wound had opened and the pacemaker was clearly visible. Resident #1 was admitted to the hospital and received an intravenous antibiotic. An Immediate Jeopardy (IJ) was identified on 10/16/13. While the IJ was removed on 10/21/13, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could also affect the 27 residents, who were cared for by LVN B, by placing them at risk for delayed medical care and treatment, increased infection, wound deterioration and/or death. Findings included: Resident #1's Admission Record, dated 08/22/13, reflected he was originally admitted to the facility on [DATE]. Resident #1's MDS assessment, dated 08/29/13, reflected the resident was a [AGE] year-old male with [DIAGNOSES REDACTED]. The functional status indicated resident required set up assistance only for all activities of daily living. Resident was continent of bowel and bladder. The section on the MDS assessment regarding cognition was blank. Resident #1's Care Plan, dated 07/31/13, reflected only problems of falls and fall potential. Resident #1's Nursing Progress Note, dated 08/16/13 reflected the resident's pacemaker was being removed and a new one was to be implanted. Resident #1 was sent to the hospital via non- emergency transport for the procedure. Resident #1's Nursing Progress Note, dated 08/16/13 at 11:27 AM reflected he was not able to shower for one week, lift his left arm above his shoulder, or lift more than 10 pounds with his left arm. The Note also reflected not to remove the steri-strips on the wound for one week, and the physician would continue to monitor. Resident #1's Physician's Note from the Cardiologist, dated 09/26/13, reflected the resident saw the Cardiologist that day. Interview with Resident #1's family member on 10/16/13 at 11:30 AM revealed he/she took the resident to the doctor on 09/26/13 for a check-up following the visit of 08/16/13. The family member stated the doctor pulled the dressing back and told the him/her the pacemaker site looked good and to keep it covered. Interview with LVN B on 10/15/13 at 3:05 PM revealed he changed Resident #1's dressing on 10/11/13 because it was soiled. LVN B stated the wound was opened and he could see the pacemaker. He revealed he thought the treatment nurse was taking care of the wound. LVN B stated there was no drainage. Interview with LVN A, the treatment nurse for the entire facility, on 10/15/13 at 2:00 PM revealed she had no information regarding a wound or wound care for Resident #1. Another interview with LVN B, on 10/16/13 at 12:15 PM with the DON present, revealed Resident #1's surgical site was never red or swollen and 10/11/13 was the first time he saw a dressing on the wound. LVN B stated again he thought the treatment nurse was taking care of it because there were no orders on Resident #1's Treatment Administration Record. He revealed he did not contact Resident #1's physician when he saw the opened wound on the resident's chest with his pacemaker exposed. When asked if he told the treatment nurse about the resident's opened wound, LVN B replied, No. Interview with the DON and Administrator on 10/15/13 at 3:30 PM revealed they did not have any knowledge that LVN B was aware Resident #1's wound had opened and his pacemaker was exposed, and LVN B covered the area with a dressing. The DON stated she was contacted by the ER regarding the information they received from LVN C on 10/13/13. She also stated the weekend supervisor told her about the wound after the arrival of the surveyors. The DON and Administrator revealed they had started an investigation. The DON stated, on 10/16/13 at approximately 2:00 PM, LVN B was suspended pending investigation. Interview with CNA M, who worked the first shift on Resident #1's unit, on 10/16/13 at 8:10 AM revealed she frequently cared for him. She stated on 10/13/13 she notified LVN C there was drainage on Resident #1's dressing. CNA M revealed Resident #1 usually would not take off his tee shirt except in the shower. CNA M stated there had not been a dressing on the site until Resident #1 fell on [DATE]. Resident #1's Nurse's Note, dated 10/13/13 at 10:52 AM, reflected incision site is open with purulent drainage. The physician and family were notified and the resident was sent to the ER. Interview with LVN C on 10/19/13 at 11:00 AM revealed on 10/13/13 when he saw the wound, he called the supervisor and treatment nurse to check the wound as well as notifying the physician and family. LVN C did not recall Resident #1 having a dressing previously, nor did LVN C identify anytime he had an occasion to check Resident #1's chest. A telephone interview with Resident #1's physician on 10/16/13 at 3:10 PM revealed he was not aware of the wound until 10/13/13. Resident #1's emergency room Physician's entry, dated 10/13/13 at 2:40 PM, reflected he came to the ER with a wound infection, and there was a left chest wound dehiscence (opening at a surgical site) of a pacemaker device. The opening measured two inches by one inch with purulent (containing pus) drainage. Resident #1 was admitted to the hospital and treated with intravenous antibiotics. Resident #1's Hospital physician progress notes [REDACTED]. Resident #1's physician's orders [REDACTED]. The Order also reflected to monitor for a change in condition. Observation of Resident #1 on 10/15/13 at 10:00 AM revealed he was alert and oriented to time, place and person. He had difficulty answering questions due to his severe hearing loss. An observation on 10/15/13 at 3:15 PM of Resident #1's wound care revealed an opened area approximately two inches by one inch in his left chest with his pacemaker clearly visible. The chest wall behind the pacemaker was also visible. The wound was clean and free of drainage. The facility's current policy, Change in Condition Reporting, dated May 2007, reflected any sudden or serious change would be communicated to the resident's physician with a request for a physician visit promptly and/or an acute care evaluation. The licensed nurse in charge would notify the physician. The facility's policy, Change in Condition Reporting, dated May 2007, did not reflect when the resident's physician would be notified of a change in condition. An Immediate Jeopardy was identified on 10/16/13. The Administrator and DON were notified on 10/16/13 at 1:56 PM of the IJ and a Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 10/18/13 at 1:45 PM and reflected the following: 1. LVN B was terminated and his license was referred to the Texas State Board of Nursing. 2. Nursing administrative staff in-serviced all clinical staff including six RNs, 50 LVNs, five Restorative Aides, 20 MAs, and 108 CNAs. In-service began on 10/18/13 and was scheduled to be completed by 10/23/13. Staff were not scheduled to work until the in-service was completed. Training included hand-outs and a post competency test. In-service for RNs, LVNs and MAs included: Physician and family communication for new and clarifying orders Changes in condition with proper notification Ethics for unit staff where Resident #1 resided. Inservice for CNAs included: Change in condition report to the charge nurse of any skin condition 7. Management and monitoring of the wound care program along with other major changes would be accomplished by nursing administration by the following: Interviews conducted beginning on 10/18/13 at 3:30 PM through 10/21/13 at 6:00 AM, with LVN MM, LVN H, LVN E, ADON LVN E, LVN U, LVN A, RN W, LVN D, RN AA, LVN C, RN V, LVN OO, LVN F, LVN PP, LVN I, RN W, LVN QQ, LVN RR, LVN HHH, LVN III, LVN SS, LVN TT, LVN VV, LVN WW, RN UU, CNA R, CNA Q, CNA YY, CNA FF, CNA ZZ, CNA N, CNA O, CNA M, CNA P, CNA AAA, CNA BBB, MA CCC, CNA DDD, CNA EEE, CNA FFF, CNA GGG, CNA L, CNA JJJ, CNA KKK, MA S, CNA LLL, CNA

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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GOLDEN ACRES LIVING AND REHABILITATION CENTER	2525 CENTERVILLE RD DALLAS, TX 75228

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F 0157	(continued... from page 1) KK, CNA MM, CNA MMM, revealed they attended the in-service, except for one CNA who was scheduled to go the day of interview. All of those who attended were able to identify the content of the in-service and understood the significance of the content. On 10/21/13 the IJ was removed. On 10/21/13 at 2:45 PM , the Administrator and DON were notified the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was still in-servicing staff and monitoring the effectiveness of the Plan of Removal. The facility's roster provided on 10/14/13 reflected 27 residents resided on the unit where Resident #1 resided and where LVN B worked.
F 0224	**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, it was determined the facility failed to implement written policies and procedures that prohibit neglect of residents for one (Resident #1) of 27 residents reviewed for skin/wound care and/or pacemakers. 1. LVN B failed to notify Resident #1's physician when he saw the resident's surgical wound had opened and the pacemaker was clearly visible. 2. Staff failed to develop and implement a Care Plan, including interventions, for Resident #1's new pacemaker and care of the pacemaker surgical wound site. 3. LVN WW failed to clarify and write physician's orders [REDACTED]. 4. LVN B placed a dressing on Resident #1's opened surgical wound without a physician's orders [REDACTED]. 5. Staff failed to accurately assess Resident #1's skin related to his surgical wound pacemaker site. Resident #1 was admitted to the hospital and received an intravenous antibiotic. An Immediate Jeopardy (IJ) was identified on 10/16/13. While the IJ was removed on 10/21/13, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could also affect the 27 residents, who were cared for by LVN B, by placing them at risk for delayed medical care and treatment, increased infection, wound deterioration and/or death. Findings included: Resident #1's Admission Record, dated 08/22/13, reflected he was originally admitted to the facility on [DATE]. Resident #1's MDS assessment, dated 08/29/13, reflected the resident was a [AGE] year-old male with [DIAGNOSES REDACTED]. The functional status indicated resident required set up assistance only for all activities of daily living. Resident was continent of bowel and bladder. The section on the MDS assessment regarding cognition was blank. Resident #1's Care Plan, dated 07/31/13, reflected only problems of falls and fall potential. On 10/16/13 at 3:30 PM, an interview with the DON revealed the MDS Coordinator responsible for care plans was on medical leave. Resident #1's Nursing Progress Note, dated 08/16/13 reflected the resident's pacemaker was being removed and a new one was to be implanted. Resident #1 was sent to the hospital via non- emergency transport for the procedure. Resident #1's Nursing Progress Note, dated 08/16/13 at 11:27 AM reflected he was not able to shower for one week, lift his left arm above his shoulder, or lift more than 10 pounds with his left arm. The Note also reflected not to remove the steri-strips on the wound for one week, and the physician would continue to monitor. An interview with LVN WW on 10/16/13 at 5:20 PM revealed she received Resident #1 back from getting the new pacemaker. She did not remember what documentation was sent back with the resident. LVN WW stated she did not transcribe the above information onto a Physician's Telephone Order because she did not think they were actually physician's orders [REDACTED]. Resident #1's Care Plan, dated 07/31/13, did not reflect an update and/or review regarding his new pacemaker, surgical wound site, or surgical wound site care. All of Resident #1's physician's orders [REDACTED]. Resident #1's Nursing Progress Notes from 08/18/13 through 10/13/13 did not reflect assessment of his surgical site. Resident #1's Skin Assessment, dated 08/19/13, did not reflect his new surgical site wound. Resident #1's Physician's Note from the Cardiologist, dated 09/26/13, reflected the resident saw the Cardiologist that day. Interview with Resident #1's family member on 10/16/13 at 11:30 AM revealed he/she took the resident to the doctor on 09/26/13 for a check-up following the visit of 08/16/13. The family member stated the doctor pulled the dressing back and told the him/her the pacemaker site looked good and to keep it covered. Resident #1's Hospice Visit Note Report, dated 09/30/13, reflected the facility was providing wound care. The Note reflected he had an abrasion to his forehead and a skin tear to his right arm following a fall, but there was no mention of a dressing to his chest. There were no other hospice notes regarding skin assessment, wounds or wound care. Interview on 10/15/13 at 2:35 PM with the Hospice DON, Hospice RN and Hospice CNA revealed the Hospice RN did not check the resident's wounds, but there was a dressing. The Hospice CNA stated there was a dressing, which he covered with a towel when showered Resident #1. They stated Resident #1 enrolled in hospice on 09/06/13. Interview on 10/14/13 at 3:40 PM with LVN MM, who worked the second shift on Resident #1's unit, revealed she had not seen a dressing on Resident #1. She stated there was no evidence of swelling or infection at the site. Interview on 10/14/13 at 3:50 PM with LVN E, who worked the second shift on Resident #1's unit, revealed she had not seen a wound, dressing or drainage on Resident #1's chest. Interview with CNA NNN, who worked the second shift on Resident #1's unit, on 10/14/13 at 3:55 PM revealed she had not seen a dressing on Resident #1's chest. Interview on 10/18/13 at 5:30 AM with LVN I, who worked the third shift on Resident #1's unit, revealed she had not seen a dressing on Resident #1's chest. Interview with CNA Q, who worked the third shift on Resident #1's unit, on 10/18/13 at 5:40 AM revealed she changed Resident #1's tee shirt one day last week (week of 10/06/13 through 10/12/13) and there was not a dressing or anything unusual about his chest. Interview with LVN B on 10/15/13 at 3:05 PM revealed he changed Resident #1's dressing on 10/11/13 because it was soiled. LVN B stated the wound was opened and he could see the pacemaker. He revealed he thought the treatment nurse was taking care of the wound. LVN B stated there was no drainage. Interview with LVN A, the treatment nurse for the entire facility, on 10/15/13 at 2:00 PM revealed she had no information regarding a wound or wound care for Resident #1. Another interview with LVN B, on 10/16/13 at 12:15 PM with the DON present, revealed Resident #1's surgical site was never red or swollen and 10/11/13 was the first time he saw a dressing on the wound. LVN B stated again he thought the treatment nurse was taking care of it because there were no orders on Resident #1's Treatment Administration Record. He revealed he did not contact Resident #1's physician when he saw the opened wound on the resident's chest with his pacemaker exposed. When asked if he told the treatment nurse about the resident's opened wound, LVN B replied, No. Interview with the DON and Administrator on 10/15/13 at 3:30 PM revealed they did not have any knowledge that LVN B was aware the resident's wound had opened and his pacemaker was exposed and LVN B placed a dressing over the site. The DON stated she was contacted by the ER regarding the information they received from LVN C on 10/13/13. She also stated the weekend supervisor told her about the wound after the arrival of the surveyors. The DON and Administrator revealed they had started an investigation. The DON stated, on 10/16/13 at approximately 2:00 PM, LVN B was suspended pending investigation. Interview with CNA M, who worked the first shift on Resident #1's unit, on 10/16/13 at 8:10 AM revealed she frequently cared for him. She stated on 10/13/13 she notified LVN C there was drainage on Resident #1's dressing. CNA M revealed Resident #1 usually would not take off his tee shirt except in the shower. CNA M stated there had not been a dressing on the site until Resident #1 fell on [DATE]. Interview with LVN E, who worked the second shift on Resident #1's unit, on 10/16/13 at 5:10 PM revealed she had not seen a wound, dressing or drainage on Resident #1's chest. She stated there was not a dressing on the resident after his fall on 10/07/13. Resident #1's Nurse's Note, dated 10/13/13 at 10:52 AM, reflected incision site is open with purulent drainage. The physician and family were notified and the resident was sent to the ER. Interview with LVN C on 10/19/13 at 11:00 AM revealed on 10/13/13 when he saw the wound, he called the supervisor and treatment nurse to check the wound as well as notifying the physician and family. LVN C did not recall Resident #1 having a dressing previously, nor did LVN C identify anytime he had an occasion to check Resident #1's chest. A telephone interview with Resident #1's physician on 10/16/13 at 3:10 PM revealed he was not aware of the wound until 10/13/13. Resident #1's emergency room Physician's entry, dated 10/13/13 at 2:40 PM, reflected he came to the ER with a wound infection, and there was a left chest wound dehiscence (opening at a surgical site) of a pacemaker device. The opening measured two inches by one inch with purulent (containing pus) drainage. Resident #1 was admitted to the hospital and treated with intravenous antibiotics. Resident #1's Hospital physician progress notes [REDACTED]. Resident #1's physician's orders [REDACTED]. The Order also reflected to monitor for a change in condition. Observation of Resident #1 on 10/15/13 at 10:00 AM revealed he was alert and oriented to time, place and person. He had difficulty answering questions due to his severe hearing loss. An observation on 10/15/13 at 3:15 PM of Resident #1's wound care revealed an opened area approximately two inches by one inch in his left chest with his pacemaker clearly visible. The chest wall behind the pacemaker was also visible. The wound was clean and free of drainage. The facility's current policy, Abuse Prevention, dated February 2010 reflected staff of the facility would take action to protect and prevent neglect from occurring within the facility. The policy also reflected neglect was defined as the failure to provide goods and services

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F 0224	(continued... from page 2) necessary to avoid physical harm. The facility's current policy, Change in Condition Reporting, dated May 2007, reflected any sudden or serious change would be communicated to the resident's physician with a request for a physician visit promptly and/or an acute care evaluation. The licensed nurse in charge would notify the physician. The facility's policy, Change in Condition Reporting, dated May 2007, did not reflect when the resident's physician would be notified of a change in condition. The facility's current policy regarding skin assessments, dated May 2007 reflected all residents would be assessed on admission, when a comprehensive assessment was required, and quarterly thereafter to identify the risk of skin breakdown. The facility's current policy regarding wound care, dated May 2007, reflected weekly assessments of skin would be completed on all residents with wounds requiring treatment and documented. An Immediate Jeopardy was identified on 10/16/13. The Administrator and DON were notified on 10/16/13 at 1:56 PM of the IJ and a Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 10/18/13 at 1:45 PM and reflected the following: 1. LVN B was terminated and his license was referred to the Texas State Board of Nursing. 2. Other staff members were interviewed by DON, ADON LVN Y, ADON LVN Z, ADON RN and ADON RN AA to determine if others had knowledge of Resident #1's wound. 3. The hospice provider for Resident #1 was changed following collaboration with the family. 4. Skin Assessments were conducted on all residents by the nursing administrative staff, which included the DON, ADON LVN Y, ADON LVN Z, ADON RN and ADON RN AA. These assessments were completed on 10/15/13. No new sites of altered skin integrity were found. 5. Specific schedules were established for weekly skin assessments on all facility units. 6. Nursing administrative staff in-serviced all clinical staff including six RNs, 50 LVNs, five Restorative Aides, 20 MAs, and 108 CNAs. In-service began on 10/18/13 and was scheduled to be completed by 10/23/13. Staff were not scheduled to work until the in-service was completed. Training included hand-outs and a post competency test. In-service for RNs, LVNs and MAs included: a. Wound care process and documentation of that process b. Physician and family communication for new and clarifying orders c. Changes in condition with proper notification d. Head to toe assessments e. Detailed care plan f. Notification process for skin integrity changes g. Weekly nurse manager skin assessments h. Ethics for unit staff where Resident #1 resided. Inservice for CNAs included: a. Change in condition report to the charge nurse of any skin condition In-service for Hospice providers included: a. Assessment documentation b. Reporting all changes to facility staff 7. Management and monitoring of the wound care program along with other major changes would be accomplished by nursing administration by the following: a. Reviewing all 24 hour reports, new physician's orders [REDACTED]. b. Wound care nurses providing care to all pressure wounds, non-pressure areas and surgical wounds. The charge nurse being responsible for notification of the wound care nurse. The wound care nurse attending the daily clinical meeting for issues and concerns. Wound care nurse coverage being seven days a week. c. Charge nurse skin assessments being followed up by skin assessments completed by the clinical manager to evaluate findings. Hospice patients would also have weekly skin assessments by the hospice nurse and communicated to facility staff. Interviews conducted beginning on 10/18/13 at 3:30 PM through 10/21/13 at 6:00 AM, with LVN MM, LVN H, LVN E, ADON LVN E, LVN U, LVN A, RN W, LVN D, RN AA, LVN C, RN V, LVN OO, LVN F, LVN PP, LVN I, RN W, LVN QQ, LVN RR, LVN HHH, LVN III, LVN SS, LVN TT, LVN VV, LVN WW, RN UU, CNA R, CNA Q, CNA YY, CNA FF, CNA ZZ, CNA N, CNA O, CNA M, CNA P, CNA AAA, CNA BBB, MA CCC, CNA DDD, CNA EEE, CNA FFF, CNA GGG, CNA L, CNA JJJ, CNA KKK, MA S, CNA LLL, CNA KK, CNA MM, CNA MMM, revealed they attended the in-service, except for one CNA who was scheduled to go the day of interview. All of those who attended were able to identify the content of the in-service and understood the significance of the content. On 10/21/13 the IJ was removed. On 10/21/13 at 2:45 PM , the Administrator and DON were notified the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was still in-servicing staff and monitoring the effectiveness of the Plan of Removal. The facility's roster provided on 10/14/13 reflected 27 residents resided on the unit where Resident #1 resided and where LVN B worked.
F 0226	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to follow its policies and procedures that prohibit neglect of residents for one (Resident #1) of 27 residents reviewed for skin/wound care and/or pacemakers. 1. LVN B failed to notify Resident #1's physician when he saw the resident's surgical wound had opened and the pacemaker was clearly visible. 2. Staff failed to develop and implement a Care Plan, including interventions, for Resident #1's new pacemaker and care of the pacemaker surgical wound site. 3. LVN WW failed to clarify and write physician's orders [REDACTED]. 4. LVN B placed a dressing on Resident #1's opened surgical wound without a physician's orders [REDACTED]. 5. Staff failed to accurately assess Resident #1's skin related to his surgical wound pacemaker site. Resident #1 was admitted to the hospital and received an intravenous antibiotic. An Immediate Jeopardy (IJ) was identified on 10/16/13. While the IJ was removed on 10/21/13, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could also affect the 27 residents, who were cared for by LVN B, by placing them at risk for delayed medical care and treatment, increased infection, wound deterioration and/or death. Findings included: The facility's current policy, Abuse Prevention, dated February 2010 reflected staff of the facility would take action to protect and prevent neglect from occurring within the facility. The policy also reflected neglect was defined as the failure to provide goods and services necessary to avoid physical harm. Resident #1's Admission Record, dated 08/22/13, reflected he was originally admitted to the facility on [DATE]. Resident #1's MDS assessment, dated 08/29/13, reflected the resident was a [AGE] year-old male with [DIAGNOSES REDACTED]. The functional status indicated resident required set up assistance only for all activities of daily living. Resident was continent of bowel and bladder. The section on the MDS assessment regarding cognition was blank. Resident #1's Care Plan, dated 07/31/13, reflected only problems of falls and fall potential. On 10/16/13 at 3:30 PM, an interview with the DON revealed the MDS Coordinator responsible for care plans was on medical leave. Resident #1's Nursing Progress Note, dated 08/16/13 reflected the resident's pacemaker was being removed and a new one was to be implanted. Resident #1 was sent to the hospital via non-emergency transport for the procedure. Resident #1's Nursing Progress Note, dated 08/16/13 at 11:27 AM reflected he was not able to shower for one week, lift his left arm above his shoulder, or lift more than 10 pounds with his left arm. The Note also reflected not to remove the steri-strips on the wound for one week, and the physician would continue to monitor. An interview with LVN WW on 10/16/13 at 5:20 PM revealed she received Resident #1 back from getting the new pacemaker. She did not remember what documentation was sent back with the resident. LVN WW stated she did not transcribe the above information onto a Physician's Telephone Order because she did not think they were actually physician's orders [REDACTED]. Resident #1's Care Plan, dated 07/31/13, did not reflect an update and/or review regarding his new pacemaker, surgical wound site, or surgical wound site care. All of Resident #1's physician's orders [REDACTED]. Resident #1's Nursing Progress Notes from 08/18/13 through 10/13/13 did not reflect assessment of his surgical site. Resident #1's Skin Assessment, dated 08/19/13, did not reflect his new surgical site wound. Resident #1's Physician's Note from the Cardiologist, dated 09/26/13, reflected the resident saw the Cardiologist that day. Interview with Resident #1's family member on 10/16/13 at 11:30 AM revealed he/she took the resident to the doctor on 09/26/13 for a check-up following the visit of 08/16/13. The family member stated the doctor pulled the dressing back and told the him/her the pacemaker site looked good and to keep it covered. Resident #1's Hospice Visit Note Report, dated 09/30/13, reflected the facility was providing wound care. The Note reflected he had an abrasion to his forehead and a skin tear to his right arm following a fall, but there was no mention of a dressing to his chest. There were no other hospice notes regarding skin assessment, wounds or wound care. Interview on 10/15/13 at 2:35 PM with the Hospice DON, Hospice RN and Hospice CNA revealed the Hospice RN did not check the resident's wounds, but there was a dressing. The Hospice CNA stated there was a dressing, which he covered with a towel when showered Resident #1. They stated Resident #1 enrolled in hospice on 09/06/13. Interview on 10/14/13 at 3:40 PM with LVN MM, who worked the second shift on Resident #1's unit, revealed she had not seen a dressing on Resident #1. She stated there was no evidence of swelling or infection at the site. Interview on 10/14/13 at 3:50 PM with LVN E, who worked the second shift on Resident #1's unit, revealed she had not seen a wound, dressing or drainage on Resident #1's chest. Interview with CNA NNN, who worked the second shift on Resident #1's unit, on 10/14/13 at 3:55 PM revealed she had not seen a dressing on Resident #1's chest. Interview on 10/18/13 at 5:30 AM with LVN I, who worked the third shift on Resident #1's unit, revealed she had not seen a dressing on Resident #1's chest. Interview with CNA Q, who worked the third shift on Resident #1's unit, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675081	A. BUILDING _____ B. WING _____	10/21/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN ACRES LIVING AND REHABILITATION CENTER	2525 CENTERVILLE RD DALLAS, TX 75228

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F 0226	(continued... from page 3) 10/18/13 at 5:40 AM revealed she changed Resident #1's tee shirt one day last week (week of 10/06/13 through 10/12/13) and there was not a dressing or anything unusual about his chest. Interview with LVN B on 10/15/13 at 3:05 PM revealed he changed Resident #1's dressing on 10/11/13 because it was soiled. LVN B stated the wound was opened and he could see the pacemaker. He revealed he thought the treatment nurse was taking care of the wound. LVN B stated there was no drainage. Interview with LVN A, the treatment nurse for the entire facility, on 10/15/13 at 2:00 PM revealed she had no information regarding a wound or wound care for Resident #1. Another interview with LVN B, on 10/16/13 at 12:15 PM with the DON present, revealed Resident #1's surgical site was never red or swollen and 10/11/13 was the first time he saw a dressing on the wound. LVN B stated again he thought the treatment nurse was taking care of it because there were no orders on Resident #1's Treatment Administration Record. He revealed he did not contact Resident #1's physician when he saw the opened wound on the resident's chest with his pacemaker exposed. When asked if he told the treatment nurse about the resident's opened wound, LVN B replied, No. Interview with the DON and Administrator on 10/15/13 at 3:30 PM revealed they did not have any knowledge that LVN B was aware the resident's wound had opened and his pacemaker was exposed and LVN B placed a dressing over the site. The DON stated she was contacted by the ER regarding the information they received from LVN C on 10/13/13. She also stated the weekend supervisor told her about the wound after the arrival of the surveyors. The DON and Administrator revealed they had started an investigation. The DON stated, on 10/16/13 at approximately 2:00 PM, LVN B was suspended pending investigation. Interview with CNA M, who worked the first shift on Resident #1's unit, on 10/16/13 at 8:10 AM revealed she frequently cared for him. She stated on 10/13/13 she notified LVN C there was drainage on Resident #1's dressing. CNA M revealed Resident #1 usually would not take off his tee shirt except in the shower. CNA M stated there had not been a dressing on the site until Resident #1 fell on [DATE]. Interview with LVN E, who worked the second shift on Resident #1's unit, on 10/16/13 at 5:10 PM revealed she had not seen a wound, dressing or drainage on Resident #1's chest. She stated there was not a dressing on the resident after his fall on 10/07/13. Resident #1's Nurse's Note, dated 10/13/13 at 10:52 AM, reflected incision site is open with purulent drainage. The physician and family were notified and the resident was sent to the ER. Interview with LVN C on 10/19/13 at 11:00 AM revealed on 10/13/13 when he saw the wound, he called the supervisor and treatment nurse to check the wound as well as notifying the physician and family. LVN C did not recall Resident #1 having a dressing previously, nor did LVN C identify anytime he had an occasion to check Resident #1's chest. A telephone interview with Resident #1's physician on 10/16/13 at 3:10 PM revealed he was not aware of the wound until 10/13/13. Resident #1's emergency room Physician's entry, dated 10/13/13 at 2:40 PM, reflected he came to the ER with a wound infection, and there was a left chest wound dehiscence (opening at a surgical site) of a pacemaker device. The opening measured two inches by one inch with purulent (containing pus) drainage. Resident #1 was admitted to the hospital and treated with intravenous antibiotics. Resident #1's Hospital physician progress notes [REDACTED]. Resident #1's physician's orders [REDACTED]. The Order also reflected to monitor for a change in condition. Observation of Resident #1 on 10/15/13 at 10:00 AM revealed he was alert and oriented to time, place and person. He had difficulty answering questions due to his severe hearing loss. An observation on 10/15/13 at 3:15 PM of Resident #1's wound care revealed an opened area approximately two inches by one inch in his left chest with his pacemaker clearly visible. The chest wall behind the pacemaker was also visible. The wound was clean and free of drainage. The facility's current policy, Change in Condition Reporting, dated May 2007, reflected any sudden or serious change would be communicated to the resident's physician with a request for a physician visit promptly and/or an acute care evaluation. The licensed nurse in charge would notify the physician. The facility's policy, Change in Condition Reporting, dated May 2007, did not reflect when the resident's physician would be notified of a change in condition. The facility's current policy regarding skin assessments, dated May 2007 reflected all residents would be assessed on admission, when a comprehensive assessment was required, and quarterly thereafter to identify the risk of skin breakdown. The facility's current policy regarding wound care, dated May 2007, reflected weekly assessments of skin would be completed on all residents with wounds requiring treatment and documented. An Immediate Jeopardy was identified on 10/16/13. The Administrator and DON were notified on 10/16/13 at 1:56 PM of the IJ and a Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 10/18/13 at 1:45 PM and reflected the following: 1. LVN B was terminated and his license was referred to the Texas State Board of Nursing. 2. Other staff members were interviewed by DON, ADON LVN Y, ADON LVN Z, ADON RN and ADON RN AA to determine if others had knowledge of Resident #1's wound. 3. The hospice provider for Resident #1 was changed following collaboration with the family. 4. Skin Assessments were conducted on all residents by the nursing administrative staff, which included the DON, ADON LVN Y, ADON LVN Z, ADON RN and ADON RN AA. These assessments were completed on 10/15/13. No new sites of altered skin integrity were found. 5. Specific schedules were established for weekly skin assessments on all facility units. 6. Nursing administrative staff in-serviced all clinical staff including six RNs, 50 LVNs, five Restorative Aides, 20 MAs, and 108 CNAs. In-service began on 10/18/13 and was scheduled to be completed by 10/23/13. Staff were not scheduled to work until the in-service was completed. Training included hand-outs and a post competency test. In-service for RNs, LVNs and MAs included: a. Wound care process and documentation of that process b. Physician and family communication for new and clarifying orders c. Changes in condition with proper notification d. Head to toe assessments e. Detailed care plan f. Notification process for skin integrity changes g. Weekly nurse manager skin assessments h. Ethics for unit staff where Resident #1 resided. Inservice for CNAs included: a. Change in condition report to the charge nurse of any skin condition In-service for Hospice providers included: a. Assessment documentation b. Reporting all changes to facility staff 7. Management and monitoring of the wound care program along with other major changes would be accomplished by nursing administration by the following: a. Reviewing all 24 hour reports, new physician's orders [REDACTED]. b. Wound care nurses providing care to all pressure wounds, non-pressure areas and surgical wounds. The charge nurse being responsible for notification of the wound care nurse. The wound care nurse attending the daily clinical meeting for issues and concerns. Wound care nurse coverage being seven days a week. c. Charge nurse skin assessments being followed up by skin assessments completed by the clinical manager to evaluate findings. Hospice patients would also have weekly skin assessments by the hospice nurse and communicated to facility staff. Interviews conducted beginning on 10/18/13 at 3:30 PM through 10/21/13 at 6:00 AM, with LVN MM, LVN H, LVN E, ADON LVN E, LVN U, LVN A, RN W, LVN D, RN AA, LVN C, RN V, LVN OO, LVN F, LVN PP, LVN I, RN W, LVN QQ, LVN RR, LVN HHH, LVN III, LVN SS, LVN TT, LVN VV, LVN WW, RN UU, CNA R, CNA Q, CNA YY, CNA FF, CNA ZZ, CNA N, CNA O, CNA M, CNA P, CNA AAA, CNA BBB, MA CCC, CNA DDD, CNA EEE, CNA FFF, CNA GGG, CNA L, CNA JJJ, CNA KKK, MA S, CNA LLL, CNA KK, CNA MM, CNA MMM, revealed they attended the in-service, except for one CNA who was scheduled to go the day of interview. All of those who attended were able to identify the content of the in-service and understood the significance of the content. On 10/21/13 the IJ was removed. On 10/21/13 at 2:45 PM , the Administrator and DON were notified the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was still in-servicing staff and monitoring the effectiveness of the Plan of Removal. The facility's roster provided on 10/14/13 reflected 27 residents resided on the unit where Resident #1 resided and where LVN B worked.
F 0279	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet a resident's medical and nursing need and described the services that were to be furnished to attain or maintain the resident's highest practicable physical well-being for one (Resident #1) of 24 residents reviewed for skin/wound care and/or pacemakers. Staff failed to develop and implement a Care Plan, including interventions, for Resident #1's new pacemaker and care of the pacemaker surgical wound site. Resident #1 was admitted to the hospital and received an intravenous antibiotic. An Immediate Jeopardy (IJ) was identified on 10/16/13. While the IJ was removed on 10/21/13, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could also affect the 27 residents, who were cared for by LVN B, by placing them at risk for delayed medical care and treatment, increased infection, wound deterioration and/or death. Findings included: Resident #1's Admission Record, dated 08/22/13, reflected he was originally admitted to the facility on [DATE]. Resident #1's MDS assessment, dated 08/29/13, reflected the resident was a [AGE] year-old male with [DIAGNOSES REDACTED]. The functional status indicated resident required set up assistance only for all activities of daily living.

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F 0279	(continued... from page 4) Resident was continent of bowel and bladder. The section on the MDS assessment regarding cognition was blank. Resident #1's Care Plan, dated 07/31/13, reflected only problems of falls and fall potential. On 10/16/13 at 3:30 PM, an interview with the DON revealed the MDS Coordinator responsible for care plans was on medical leave. Resident #1's Nursing Progress Note, dated 08/16/13 reflected the resident's pacemaker was being removed and a new one was to be implanted. Resident #1 was sent to the hospital via non- emergency transport for the procedure. Resident #1's Nursing Progress Note, dated 08/16/13 at 11:27 AM reflected he was not able to shower for one week, lift his left arm above his shoulder, or lift more than 10 pounds with his left arm. The Note also reflected not to remove the steri-strips on the wound for one week, and the physician would continue to monitor. An interview with LVN WW on 10/16/13 at 5:20 PM revealed she received Resident #1 back from getting the new pacemaker. She did not remember what documentation was sent back with the resident. LVN WW stated she did not transcribe the above information onto a Physician's Telephone Order because she did not think they were actually physician's orders [REDACTED]. Resident #1's Care Plan, dated 07/31/13, did not reflect an update and/or review regarding his new pacemaker, surgical wound site, or surgical wound site care. All of Resident #1's physician's orders [REDACTED]. Resident #1's Physician's Note from the Cardiologist, dated 09/26/13, reflected the resident saw the Cardiologist that day. Interview with Resident #1's family member on 10/16/13 at 11:30 AM revealed he/she took the resident to the doctor on 09/26/13 for a check-up following the visit of 08/16/13. The family member stated the doctor pulled the dressing back and told the him/her the pacemaker site looked good and to keep it covered. Interview on 10/14/13 at 3:40 PM with LVN MM, who worked the second shift on Resident #1's unit, revealed she had not seen a dressing on Resident #1. She stated there was no evidence of swelling or infection at the site. Interview on 10/14/13 at 3:50 PM with LVN E, who worked the second shift on Resident #1's unit, revealed she had not seen a wound, dressing or drainage on Resident #1's chest. Interview with CNA NNN, who worked the second shift on Resident #1's unit, on 10/14/13 at 3:55 PM revealed she had not seen a dressing on Resident #1's chest. Interview on 10/18/13 at 5:30 AM with LVN I, who worked the third shift on Resident #1's unit, revealed she had not seen a dressing on Resident #1's chest. Interview with CNA Q, who worked the third shift on Resident #1's unit, on 10/18/13 at 5:40 AM revealed she changed Resident #1's tee shirt one day last week (week of 10/06/13 through 10/12/13) and there was not a dressing or anything unusual about his chest. Interview with LVN B on 10/15/13 at 3:05 PM revealed he changed Resident #1's dressing on 10/11/13 because it was soiled. LVN B stated the wound was opened and he could see the pacemaker. He revealed he thought the treatment nurse was taking care of the wound. LVN B stated there was no drainage. Interview with LVN A, the treatment nurse for the entire facility, on 10/15/13 at 2:00 PM revealed she had no information regarding a wound or wound care for Resident #1. Another interview with LVN B, on 10/16/13 at 12:15 PM with the DON present, revealed Resident #1's surgical site was never red or swollen and 10/11/13 was the first time he saw a dressing on the wound. LVN B stated again he thought the treatment nurse was taking care of it because there were no orders on Resident #1's Treatment Administration Record. He revealed he did not contact Resident #1's physician when he saw the opened wound on the resident's chest with his pacemaker exposed. When asked if he told the treatment nurse about the resident's opened wound, LVN B replied, No. Interview with the DON and Administrator on 10/15/13 at 3:30 PM revealed they did not have any knowledge that LVN B was aware the resident's wound had opened and his pacemaker was exposed, and LVN B covered the site with a dressing. The DON stated she was contacted by the ER regarding the information they received from LVN C on 10/13/13. She also stated the weekend supervisor told her about the wound after the arrival of the surveyors. The DON and Administrator revealed they had started an investigation. The DON stated, on 10/16/13 at approximately 2:00 PM, LVN B was suspended pending investigation. Interview with CNA M, who worked the first shift on Resident #1's unit, on 10/16/13 at 8:10 AM revealed she frequently cared for him. She stated on 10/13/13 she notified LVN C there was drainage on Resident #1's dressing. CNA M revealed Resident #1 usually would not take off his tee shirt except in the shower. CNA M stated there had not been a dressing on the site until Resident #1 fell on [DATE]. Interview with LVN E, who worked the second shift on Resident #1's unit, on 10/16/13 at 5:10 PM revealed she had not seen a wound, dressing or drainage on Resident #1's chest. She stated there was not a dressing on the resident after his fall on 10/07/13. Resident #1's Nurse's Note, dated 10/13/13 at 10:52 AM, reflected incision site is open with purulent drainage. The physician and family were notified and the resident was sent to the ER. Interview with LVN C on 10/19/13 at 11:00 AM revealed on 10/13/13 when he saw the wound, he called the supervisor and treatment nurse to check the wound as well as notifying the physician and family. LVN C did not recall Resident #1 having a dressing previously, nor did LVN C identify anytime he had an occasion to check Resident #1's chest. A telephone interview with Resident #1's physician on 10/16/13 at 3:10 PM revealed he was not aware of the wound until 10/13/13. Resident #1's emergency room Physician's entry, dated 10/13/13 at 2:40 PM, reflected he came to the ER with a wound infection, and there was a left chest wound dehiscence (opening at a surgical site) of a pacemaker device. The opening measured two inches by one inch with purulent (containing pus) drainage. Resident #1 was admitted to the hospital and treated with intravenous antibiotics. Resident #1's Hospital physician progress notes [REDACTED]. Resident #1's physician's orders [REDACTED]. The Order also reflected to monitor for a change in condition. Observation of Resident #1 on 10/15/13 at 10:00 AM revealed he was alert and oriented to time, place and person. He had difficulty answering questions due to his severe hearing loss. An observation on 10/15/13 at 3:15 PM of Resident #1's wound care revealed an opened area approximately two inches by one inch in his left chest with his pacemaker clearly visible. The chest wall behind the pacemaker was also visible. The wound was clean and free of drainage. An Immediate Jeopardy was identified on 10/16/13. The Administrator and DON were notified on 10/16/13 at 1:56 PM of the IJ and a Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 10/18/13 at 1:45 PM and reflected the following: LVN B was terminated and his license was referred to the Texas State Board of Nursing. Nursing administrative staff in-serviced all clinical staff including six RNs, 50 LVNs, five Restorative Aides, 20 MAs, and 108 CNAs. In-service began on 10/18/13 and was scheduled to be completed by 10/23/13. Staff were not scheduled to work until the in-service was completed. Training included hand-outs and a post competency test. In-service for RNs, LVNs and MAs included: Detailed care plan Management and monitoring of the wound care program along with other major changes would be accomplished by nursing administration. Interviews conducted beginning on 10/18/13 at 3:30 PM through 10/21/13 at 6:00 AM, with LVN MM, LVN H, LVN E, ADON LVN E, LVN U, LVN A, RN W, LVN D, RN AA, LVN C, RN V, LVN OO, LVN F, LVN PP, LVN I, RN W, LVN QQ, LVN RR, LVN HHH, LVN III, LVN SS, LVN TT, LVN VV, LVN WW, RN UU, CNA R, CNA Q, CNA YY, CNA FF, CNA ZZ, CNA N, CNA O, CNA M, CNA P, CNA AAA, CNA BBB, MA CCC, CNA DDD, CNA EEE, CNA FFF, CNA GGG, CNA L, CNA JJJ, CNA KKK, MA S, CNA LLL, CNA KK, CNA MM, CNA MMM, revealed they attended the in-service, except for one CNA who was scheduled to go the day of interview. All of those who attended were able to identify the content of the in-service and understood the significance of the content. On 10/21/13 the IJ was removed. On 10/21/13 at 2:45 PM , the Administrator and DON were notified the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was still in-servicing staff and monitoring the effectiveness of the Plan of Removal. The facility's roster provided on 10/14/13 reflected 27 residents resided on the unit where Resident #1 resided and where LVN B worked.
F 0281	**Make sure services provided by the nursing facility meet professional standards of quality** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to provide services that met professional standards of quality for one (Resident #1) of 27 residents reviewed for skin/wound care and/or pacemakers. 1. LVN B failed to notify Resident #1's physician when he saw the resident's surgical wound had opened and the pacemaker was clearly visible. 2. LVN B placed a dressing on Resident #1's opened surgical wound without a physician's orders [REDACTED]. Resident #1 was admitted to the hospital and received an intravenous antibiotic. An Immediate Jeopardy (IJ) was identified on 10/16/13. While the IJ was removed on 10/21/13, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could also affect the 27 residents, who were cared for by LVN B, by placing them at risk for delayed medical care and treatment, increased infection, wound deterioration and/or death. Findings included: ?217.11. Standards of Nursing Practice. The Texas Board of Nursing is responsible for regulating the practice of nursing within the State of Texas for Vocational Nurses, Registered Nurses, and Registered Nurses with advanced practice authorization. The standards of practice establish a minimum acceptable level of nursing practice in any setting for each level of nursing licensure or advanced practice authorization. Failure to meet these standards may result in action against the nurse's license even if no actual patient injury resulted. (1) Standards Applicable to All Nurses.

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F 0281	(continued... from page 5) All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall: (A) Know and conform to the Texas Nursing Practice Act and the board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice; (B) Implement measures to promote a safe environment for clients and others . (D) Accurately and completely report and document: (i) the client's status including signs and symptoms; (ii) nursing care rendered.(vi) contacts with other health care team members concerning significant events regarding client's status.(M)Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.(P) Collaborate with the client, members of the health care team and, when appropriate, the client's significant other(s) in the interest of the client's health care. Resident #1's Admission Record, dated 08/22/13, reflected he was originally admitted to the facility on [DATE]. Resident #1's MDS assessment, dated 08/29/13, reflected the resident was a [AGE] year-old male with [DIAGNOSES REDACTED]. The functional status indicated resident required set up assistance only for all activities of daily living. Resident was continent of bowel and bladder. The section on the MDS assessment regarding cognition was blank. Resident #1's Care Plan, dated 07/31/13, reflected only problems of falls and fall potential. Resident #1's Nursing Progress Note, dated 08/16/13 reflected the resident's pacemaker was being removed and a new one was to be implanted. Resident #1 was sent to the hospital via non- emergency transport for the procedure. Resident #1's Nursing Progress Note, dated 08/16/13 at 11:27 AM reflected he was not able to shower for one week, lift his left arm above his shoulder, or lift more than 10 pounds with his left arm. The Note also reflected not to remove the steri-strips on the wound for one week, and the physician would continue to monitor. Resident #1's Care Plan, dated 07/31/13, did not reflect an update and/or review regarding his new pacemaker, surgical wound site, or surgical wound site care. All of Resident #1's physician's orders [REDACTED]. Resident #1's Nursing Progress Notes from 08/18/13 through 10/13/13 did not reflect assessment of his surgical site. Resident #1's Skin Assessment, dated 08/19/13, did not reflect his new surgical site wound. Resident #1's Physician's Note from the Cardiologist, dated 09/26/13, reflected the resident saw the Cardiologist that day. Interview with Resident #1's family member on 10/16/13 at 11:30 AM revealed he/she took the resident to the doctor on 09/26/13 for a check-up following the visit of 08/16/13. The family member stated the doctor pulled the dressing back and told the him/her the pacemaker site looked good and to keep it covered. Interview with LVN B on 10/15/13 at 3:05 PM revealed he changed Resident #1's dressing on 10/11/13 because it was soiled. LVN B stated the wound was opened and he could see the pacemaker. He revealed he thought the treatment nurse was taking care of the wound. LVN B stated there was no drainage. Interview with LVN A, the treatment nurse for the entire facility, on 10/15/13 at 2:00 PM revealed she had no information regarding a wound or wound care for Resident #1. Another interview with LVN B, on 10/16/13 at 12:15 PM with the DON present, revealed Resident #1's surgical site was never red or swollen and 10/11/13 was the first time he saw a dressing on the wound. LVN B stated again he thought the treatment nurse was taking care of it because there were no orders on Resident #1's Treatment Administration Record. He revealed he did not contact Resident #1's physician when he saw the opened wound on the resident's chest with his pacemaker exposed. When asked if he told the treatment nurse about the resident's opened wound, LVN B replied, No. Interview with the DON and Administrator on 10/15/13 at 3:30 PM revealed they did not have any knowledge that LVN B was aware the resident's wound had opened and his pacemaker was exposed and LVN B placed a dressing over the site. The DON stated she was contacted by the ER regarding the information they received from LVN C on 10/13/13. She also stated the weekend supervisor told her about the wound after the arrival of the surveyors. The DON and Administrator revealed they had started an investigation. The DON stated, on 10/16/13 at approximately 2:00 PM, LVN B was suspended pending investigation. Interview with CNA M, who worked the first shift on Resident #1's unit, on 10/16/13 at 8:10 AM revealed she frequently cared for him. She stated on 10/13/13 she notified LVN C there was drainage on Resident #1's dressing. CNA M revealed Resident #1 usually would not take off his tee shirt except in the shower. CNA M stated there had not been a dressing on the site until Resident #1 fell on [DATE]. Resident #1's Nurse's Note, dated 10/13/13 at 10:52 AM, reflected incision site is open with purulent drainage. The physician and family were notified and the resident was sent to the ER. Interview with LVN C on 10/19/13 at 11:00 AM revealed on 10/13/13 when he saw the wound, he called the supervisor and treatment nurse to check the wound as well as notifying the physician and family. LVN C did not recall Resident #1 having a dressing previously, nor did LVN C identify anytime he had an occasion to check Resident #1's chest. A telephone interview with Resident #1's physician on 10/16/13 at 3:10 PM revealed he was not aware of the wound until 10/13/13. Resident #1's emergency room Physician's entry, dated 10/13/13 at 2:40 PM, reflected he came to the ER with a wound infection, and there was a left chest wound dehiscence (opening at a surgical site) of a pacemaker device. The opening measured two inches by one inch with purulent (containing pus) drainage. Resident #1 was admitted to the hospital and treated with intravenous antibiotics. Resident #1's Hospital physician progress notes [REDACTED]. Resident #1's physician's orders [REDACTED]. The Order also reflected to monitor for a change in condition. Observation of Resident #1 on 10/15/13 at 10:00 AM revealed he was alert and oriented to time, place and person. He had difficulty answering questions due to his severe hearing loss. An observation on 10/15/13 at 3:15 PM of Resident #1's wound care revealed an opened area approximately two inches by one inch in his left chest with his pacemaker clearly visible. The chest wall behind the pacemaker was also visible. The wound was clean and free of drainage. The facility's current policy, Change in Condition Reporting, dated May 2007, reflected any sudden or serious change would be communicated to the resident's physician with a request for a physician visit promptly and/or an acute care evaluation. The licensed nurse in charge would notify the physician. The facility's policy, Change in Condition Reporting, dated May 2007, did not reflect when the resident's physician would be notified of a change in condition. The facility's current policy regarding wound care, dated May 2007, reflected weekly assessments of skin would be completed on all residents with wounds requiring treatment and documented. An Immediate Jeopardy was identified on 10/16/13. The Administrator and DON were notified on 10/16/13 at 1:56 PM of the IJ and a Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 10/18/13 at 1:45 PM and reflected the following: 1. LVN B was terminated and his license was referred to the Texas State Board of Nursing. LVN B's Counseling/Disciplinary Notice, dated 10/24/13, reflected he was terminated on 10/22/13. On 10/21/13 the IJ was removed. On 10/21/13 at 2:45 PM , the Administrator and DON were notified the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was still in-servicing staff and monitoring the effectiveness of the Plan of Removal. The facility's roster provided on 10/14/13 reflected 27 residents resided on the unit where Resident #1 resided and where LVN B worked.
F 0309	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for one (Resident #1) of 27 residents reviewed for skin/wound care and/or pacemakers. 1. LVN B failed to notify Resident #1's physician when he saw the resident's surgical wound had opened and the pacemaker was clearly visible. 2. Staff failed to develop and implement a Care Plan, including interventions, for Resident #1's new pacemaker and care of the pacemaker surgical wound site. 3. LVN WW failed to clarify and write physician's orders [REDACTED]. 4. LVN B placed a dressing on Resident #1's opened surgical wound without a physician's orders [REDACTED]. 5. Staff failed to accurately assess Resident #1's skin related to his surgical wound pacemaker site. Resident #1 was admitted to the hospital and received an intravenous antibiotic. An Immediate Jeopardy (IJ) was identified on 10/16/13. While the IJ was removed on 10/21/13, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could also affect the 27 residents, who were cared for by LVN B, by placing them at risk for delayed medical care and treatment, increased infection, wound deterioration and/or death. Findings included: Resident #1's Admission Record, dated 08/22/13, reflected he was originally admitted to the facility on [DATE]. Resident #1's MDS assessment, dated 08/29/13, reflected the resident was a [AGE] year-old male with [DIAGNOSES REDACTED]. The functional status indicated resident required set up assistance only for all activities of daily living. Resident was continent of bowel and bladder. The section on the MDS assessment regarding cognition was blank. Resident #1's Care Plan, dated 07/31/13, reflected only problems of falls and fall potential. On 10/16/13 at 3:30 PM, an interview with the DON revealed the MDS Coordinator responsible for care plans was on medical leave. Resident #1's Nursing Progress Note, dated 08/16/13 reflected the resident's pacemaker was being removed and a new one was to be implanted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675081	A. BUILDING _____ B. WING _____	10/21/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN ACRES LIVING AND REHABILITATION CENTER	2525 CENTERVILLE RD DALLAS, TX 75228

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309	

(continued... from page 6)

Resident #1 was sent to the hospital via non- emergency transport for the procedure. Resident #1's Nursing Progress Note, dated 08/16/13 at 11:27 AM reflected he was not able to shower for one week, lift his left arm above his shoulder, or lift more than 10 pounds with his left arm. The Note also reflected not to remove the steri-strips on the wound for one week, and the physician would continue to monitor. An interview with LVN WW on 10/16/13 at 5:20 PM revealed she received Resident #1 back from getting the new pacemaker. She did not remember what documentation was sent back with the resident. LVN WW stated she did not transcribe the above information onto a Physician's Telephone Order because she did not think they were actually physician's orders [REDACTED]. Resident #1's Care Plan, dated 07/31/13, did not reflect an update and/or review regarding his new pacemaker, surgical wound site, or surgical wound site care. All of Resident #1's physician's orders [REDACTED]. Resident #1's Nursing Progress Notes from 08/18/13 through 10/13/13 did not reflect assessment of his surgical site. Resident #1's Skin Assessment, dated 08/19/13, did not reflect his new surgical site wound. Resident #1's Physician's Note from the Cardiologist, dated 09/26/13, reflected the resident saw the Cardiologist that day. Interview with Resident #1's family member on 10/16/13 at 11:30 AM revealed he/she took the resident to the doctor on 09/26/13 for a check-up following the visit of 08/16/13. The family member stated the doctor pulled the dressing back and told the him/her the pacemaker site looked good and to keep it covered. Resident #1's Hospice Visit Note Report, dated 09/30/13, reflected the facility was providing wound care. The Note reflected he had an abrasion to his forehead and a skin tear to his right arm following a fall, but there was no mention of a dressing to his chest. There were no other hospice notes regarding skin assessment, wounds or wound care. Interview on 10/15/13 at 2:35 PM with the Hospice DON, Hospice RN and Hospice CNA revealed the Hospice RN did not check the resident's wounds, but there was a dressing. The Hospice CNA stated there was a dressing, which he covered with a towel when showered Resident #1. They stated Resident #1 enrolled in hospice on 09/06/13. Interview on 10/14/13 at 3:40 PM with LVN MM, who worked the second shift on Resident #1's unit, revealed she had not seen a dressing on Resident #1. She stated there was no evidence of swelling or infection at the site. Interview on 10/14/13 at 3:50 PM with LVN E, who worked the second shift on Resident #1's unit, revealed she had not seen a wound, dressing or drainage on Resident #1's chest. Interview with CNA NNN, who worked the second shift on Resident #1's unit, on 10/14/13 at 3:55 PM revealed she had not seen a dressing on Resident #1's chest. Interview on 10/18/13 at 5:30 AM with LVN I, who worked the third shift on Resident #1's unit, revealed she had not seen a dressing on Resident #1's chest. Interview with CNA Q, who worked the third shift on Resident #1's unit, on 10/18/13 at 5:40 AM revealed she changed Resident #1's tee shirt one day last week (week of 10/06/13 through 10/12/13) and there was not a dressing or anything unusual about his chest. Interview with LVN B on 10/15/13 at 3:05 PM revealed he changed Resident #1's dressing on 10/11/13 because it was soiled. LVN B stated the wound was opened and he could see the pacemaker. He revealed he thought the treatment nurse was taking care of the wound. LVN B stated there was no drainage. Interview with LVN A, the treatment nurse for the entire facility, on 10/15/13 at 2:00 PM revealed she had no information regarding a wound or wound care for Resident #1. Another interview with LVN B, on 10/16/13 at 12:15 PM with the DON present, revealed Resident #1's surgical site was never red or swollen and 10/11/13 was the first time he saw a dressing on the wound. LVN B stated again he thought the treatment nurse was taking care of it because there were no orders on Resident #1's Treatment Administration Record. He revealed he did not contact Resident #1's physician when he saw the opened wound on the resident's chest with his pacemaker exposed. When asked if he told the treatment nurse about the resident's opened wound, LVN B replied, No. Interview with the DON and Administrator on 10/15/13 at 3:30 PM revealed they did not have any knowledge that LVN B was aware the resident's wound had opened and his pacemaker was exposed and LVN B placed a dressing over the site. The DON stated she was contacted by the ER regarding the information they received from LVN C on 10/13/13. She also stated the weekend supervisor told her about the wound after the arrival of the surveyors. The DON and Administrator revealed they had started an investigation. The DON stated, on 10/16/13 at approximately 2:00 PM, LVN B was suspended pending investigation. Interview with CNA M, who worked the first shift on Resident #1's unit, on 10/16/13 at 8:10 AM revealed she frequently cared for him. She stated on 10/13/13 she notified LVN C there was drainage on Resident #1's dressing. CNA M revealed Resident #1 usually would not take off his tee shirt except in the shower. CNA M stated there had not been a dressing on the site until Resident #1 fell on [DATE]. Interview with LVN E, who worked the second shift on Resident #1's unit, on 10/16/13 at 5:10 PM revealed she had not seen a wound, dressing or drainage on Resident #1's chest. She stated there was not a dressing on the resident after his fall on 10/07/13. Resident #1's Nurse's Note, dated 10/13/13 at 10:52 AM, reflected incision site is open with purulent drainage. The physician and family were notified and the resident was sent to the ER. Interview with LVN C on 10/19/13 at 11:00 AM revealed on 10/13/13 when he saw the wound, he called the supervisor and treatment nurse to check the wound as well as notifying the physician and family. LVN C did not recall Resident #1 having a dressing previously, nor did LVN C identify anytime he had an occasion to check Resident #1's chest. A telephone interview with Resident #1's physician on 10/16/13 at 3:10 PM revealed he was not aware of the wound until 10/13/13. Resident #1's emergency room Physician's entry, dated 10/13/13 at 2:40 PM, reflected he came to the ER with a wound infection, and there was a left chest wound dehiscence (opening at a surgical site) of a pacemaker device. The opening measured two inches by one inch with purulent (containing pus) drainage. Resident #1 was admitted to the hospital and treated with intravenous antibiotics. Resident #1's Hospital physician progress notes [REDACTED]. Resident #1's physician's orders [REDACTED]. The Order also reflected to monitor for a change in condition. Observation of Resident #1 on 10/15/13 at 10:00 AM revealed he was alert and oriented to time, place and person. He had difficulty answering questions due to his severe hearing loss. An observation on 10/15/13 at 3:15 PM of Resident #1's wound care revealed an opened area approximately two inches by one inch in his left chest with his pacemaker clearly visible. The chest wall behind the pacemaker was also visible. The wound was clean and free of drainage. The facility's current policy, Change in Condition Reporting, dated May 2007, reflected any sudden or serious change would be communicated to the resident's physician with a request for a physician visit promptly and/or an acute care evaluation. The licensed nurse in charge would notify the physician. The facility's policy, Change in Condition Reporting, dated May 2007, did not reflect when the resident's physician would be notified of a change in condition. The facility's current policy regarding skin assessments, dated May 2007 reflected all residents would be assessed on admission, when a comprehensive assessment was required, and quarterly thereafter to identify the risk of skin breakdown. The facility's current policy regarding wound care, dated May 2007, reflected weekly assessments of skin would be completed on all residents with wounds requiring treatment and documented. An Immediate Jeopardy was identified on 10/16/13. The Administrator and DON were notified on 10/16/13 at 1:56 PM of the IJ and a Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 10/18/13 at 1:45 PM and reflected the following: 1. LVN B was terminated and his license was referred to the Texas State Board of Nursing. 2. Other staff members were interviewed by DON, ADON LVN Y, ADON LVN Z, ADON RN and ADON
RN AA to determine if others had knowledge of Resident #1's wound. 3. The hospice provider for Resident #1 was changed following collaboration with the family. 4. Skin Assessments were conducted on all residents by the nursing administrative staff, which included the DON, ADON LVN Y, ADON LVN Z, ADON RN and ADON RN AA. These assessments were completed on
10/15/13. No new sites of altered skin integrity were found. 5. Specific schedules were established for weekly skin assessments on all facility units. 6. Nursing administrative staff in-serviced all clinical staff including six RNs, 50 LVNs, five Restorative Aides, 20 MAs, and 108 CNAs. In-service began on 10/18/13 and was scheduled to be completed by 10/23/13. Staff were not scheduled to work until the in-service was completed. Training included hand-outs and a post competency test. In-service for RNs, LVNs and MAs included: a. Wound care process and documentation of that process b. Physician and family communication for new and clarifying orders c. Changes in condition with proper notification d. Head to toe assessments e. Detailed care plan f. Notification process for skin integrity changes g. Weekly nurse manager skin assessments h. Ethics for unit staff where Resident #1 resided. Inservice for CNAs included: a. Change in condition report to the charge nurse of any skin condition In-service for Hospice providers included: a. Assessment documentation b. Reporting all changes to facility staff 7. Management and monitoring of the wound care program along with other major changes would be accomplished by nursing administration by the following: a. Reviewing all 24 hour reports, new physician's orders [REDACTED]. b. Wound care nurses providing care to all pressure wounds, non-pressure areas and surgical wounds. The charge nurse being responsible for notification of the wound care nurse. The wound care nurse attending the daily clinical meeting for issues and concerns. Wound care nurse coverage being seven days a week. c. Charge nurse skin assessments being followed up by skin assessments completed by the clinical manager to evaluate findings. Hospice patients would also have weekly skin assessments by the hospice nurse and communicated to facility staff. Interviews conducted beginning on 10/18/13 at 3:30 PM through 10/21/13 at 6:00 AM, with LVN MM, LVN H, LVN E, ADON LVN E, LVN U, LVN A, RN W, LVN D, RN AA, LVN C, RN
V, LVN OO, LVN F, LVN PP, LVN I, RN W, LVN QQ, LVN RR, LVN HHH, LVN III, LVN SS, LVN TT, LVN VV, LVN WW, RN UU, CNA R, CNA
Q, CNA YY, CNA FF, CNA ZZ, CNA N, CNA O, CNA M, CNA P, CNA AAA, CNA BBB, MA CCC, CNA DDD, CNA EEE, CNA FFF, CNA GGG, CNA L,

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN ACRES LIVING AND REHABILITATION CENTER	**2525 CENTERVILLE RD DALLAS, TX 75228**

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F 0309	(continued... from page 7) CNA JJJ, CNA KKK, MA S, CNA LLL, CNA KK, CNA MM, CNA MMM, revealed they attended the in-service, except for one CNA who was scheduled to go the day of interview. All of those who attended were able to identify the content of the in-service and understood the significance of the content. On 10/21/13 the IJ was removed. On 10/21/13 at 2:45 PM , the Administrator and DON were notified the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was still in-servicing staff and monitoring the effectiveness of the Plan of Removal. The facility's roster provided on 10/14/13 reflected 27 residents resided on the unit where Resident #1 resided and where LVN B worked.