STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. BUILDING _____ B. WING _____	**01/11/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	**4515 VILLAGE CREEK RD FORT WORTH, TX 76119**

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

Level of harm - Immediate jeopardy

Residents Affected - Many

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, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's physical status or a need to alter treatment significantly for six (Residents #2, #3, #8, #9, #11 and #13) of 21 residents reviewed for changes in condition. 1) Resident #3 experienced a 16.3% (20.8 pounds) severe weight loss from 11/01/13 to 12/17/13. Staff failed to consult with the physician after they became aware of her 10% weight loss in two weeks until after surveyor intervention. 2) Resident #9 was re-admitted to the facility on [DATE] with a pressure ulcer on her right lateral leg according to facility staff. The staff failed to notify the physician promptly for treatment orders. 3) Staff administered [MEDICATION NAME] (for blood pressure) to Resident #13 despite below normal blood pressure readings of 71/26, 109/36 and 108/58 and failed to notify the resident's physician . They further failed to notify her physician when her evening blood pressures were 71/26, 109/36, 97/68, 88/45 and 108/58. 4) Staff identified an open pressure ulcer on Resdient #11's coccyx and failed to consult with the physician for 12 days for treatment orders. On the 12th day, the pressure ulcer was ideentified as a Stage 3 pressure ulcer by the wound physician. 5) Resident #2 was readmitted to the facility with an indwelling urinary Foley catheter. The facility failed to notify the physician for orders for care and treatment of [REDACTED]. 6) Resident #8 was admitted to the facility with an indwelling urinary Foley catheter and failed to notify the physician for orders for care and treatment of [REDACTED]. These failures to consult the physician with a drop in blood pressure, severe weight loss, orders for an indwelling urinary catheter and for pressure ulcer treatment orders could affect any of the facility's 75 residents, including Residents #2, #3, #8, #9, #11 and #13, and placed them at risk not having their needs met, a delay in needed medical care and treatment, the potential for deterioration in their clinical condition, increasing the length of time needed for healing, the need for hospitalization and even death. An Immediate Jeopardy (IJ) was identified on 01/02/14. While the IJ was removed on 01/11/14, the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy, because not all staff had been trained and the facility was still monitoring the Plan of Removal.
Findings included: 1) Resident #3 was a [AGE] year-old female re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS assessment revealed she was severely impaired cognitively, was totally dependent on staff for her ADLs, she weighed 133 lbs, and had no weight loss. Resident #3's Care Plan dated 10/24/13 reflected: (Resident #3) poor appetite eating DT Cognitive Deficit/family declined GT placement. Approaches included: Diet as ordered/preferences per family's request.; Medication as ordered, Assist/Cueing with meal; Document meal % and report % to nurse with meal ticket; Offer fluids frq throughout day.; Dietary consult; Psych consult; Notify Dr./RP of any changes in condition. Resident #3's consolidated physician's orders [REDACTED]. The order was dated 10/24/13. Resident #3's Dietary Progress Notes dated 11/21/13 reflected: Resident has 11% significant wt. loss X's 180 days R/T poor appetite, refuses to eat after return from hospital. Resident Received fortified foods, likes chocolate milk. Resident on weekly weights. DSM will monitor meal intake, nursing to monitor weight and skin closely, will follow. Resident #3's Food Intake Record for November 2013 revealed she consumed less than 50% of her meal 27 times. Additionally, meal percentages were not documented at all and left completely blank 24 times. Review of Resident #3's MARs for November 2013 revealed an entry dated 09/27/13 for Med Pass 60 cc by mouth as needed if the resident eats less than 50%. There were no doses initialed as administered. Resident #3's Nutritional assessment dated [DATE] reflected her weight was 128 lbs. The Summary and Recommendations reflected: 10/25/13: Dietary consult ordered for low pre-alb. Nutr assess reveals pt readmitted post hospitalization at (hospital name) for possible [DEVICE] eval due to failure to thrive, dysphagia, and UTI; pt shows wt loss 5 lbs/30 days-4%, following overall wt loss 15 lbs/180 days-10.49%; Pt remains within desireable wt range, as reflected by BMI factor; Pt continues w/varying intake of regular, therapeutic diet; [MEDICATION NAME] was ordered 10/28/13 for appetite stimulant; Pro powder was dc'd 10/25/13 due to pt refusal; pt receives med pass 60 cc TID if intake < 50% for add'l 360 cal/15 gm pro; lab reveals low pre-alb level; due to continued wt loss and low pre alb, recommend adding Medpass 2.0 120 cc BID for add'l 480 cal/20 gm pro; pt to be carefully monitored. NOTE: The recommendation for Medpass 120 cc BID was never ordered. Resident #3's Food Intake Record for December 2013 revealed she consumed less than 50% of her meal seven times between 12/01/13 and 12/12/13. Additionally, meal percentages were not documented at all and left completely blank eight times from 12/01/13 through 12/12/13. Review of Resident #3's MARs for December 2013 revealed an entry dated 09/27/13 for Med Pass 60 cc by mouth as needed if the resident eats less than 50%. There were no doses initialed as administered. Observation on 12/11/13 at 8:00 AM revealed Resident #3 was fed breakfast in the dining room by facility staff. Resident #3 consumed 30% of her eggs, 90% of her oatmeal and 75% of her meat. Observation on 12/11/13 at 1:05 PM revealed Resident #3 was fed lunch in the dining room by facility staff. She only consumed 25% of her meat and 60% of her dessert. During an interview on 12/12/13 at 7:10 PM, LVN W was asked about Resident #3's Med Pass order. LVN W stated she did give the resident Med Pass on occasion. She stated she had been giving her health shakes because Resident #3 would drink them up. She could not answer why there were no doses documented. LVN W stated Resident #3's (family member) often came in the evening and feeds her too much. When asked what she meant by that, LVN W stated he/she would push her to eat yogurt and healthshakes and she (LVN W) thought he overdoes it. During an interview on 12/13/13 at 8:10 AM, LVN D stated she had not given Resident #3 any Med Pass because she was eating much better and did not need any. When asked about the Food Intake Record and informed there were several times she refused to eat or ate less than 50%, LVN D stated she had her meal tickets somewhere and was not aware of Resident #3 ever eating less than 50%. She stated she knew Resident #3's weight was stable, and she had no weight loss this month. Resident #3's Yearly Weight Record reflected the following weights: 10/24/13 - 128.1 lbs 11/01/13 - 127.6 lbs 12/02/13 - 126.6 lbs 12/09/13 - 126.6 lbs Observation on 12/13/13 at 8:24 AM revealed Resident #3 was weighed by Restorative Aide BB. Resident #3 was weighed in her wheelchair, then assisted to a chair and then the empty wheelchair was weighed. The resident's weight was 109.2 lbs. Restorative Aide BB stated she weighed the resident the same way every time. She stated her weight had dropped, and she would report the findings to LVN D and ensure the resident was weighed daily. She added she would request the scale be calibrated for accuracy. Restorative Aide BB checked her records, which were kept in the therapy department, and discovered she had entered the wrong weights on Resident #3's Yearly Weight Record. She corrected the Yearly Weight Record to reflect the following: 11/1/13 - 127.6 lbs 12/02/13 - 122.6 lbs 12/06/13 - 120.6 lbs 12/13/13 - 109.4 lbs On 12/13/13 at 9:30 AM, LVN D was informed of Resident #3's actual weight of 109 lbs by the surveyor. LVN D stated she had been informed, and they were going to get the scale calibrated. During an interview on 12/14/13 at 10:00 AM, LVN T, Resident #3's weekend Charge Nurse, was shown Resident #3's MAR and asked why no Med Pass had been administered as ordered. LVN T explained since the resident returned from the hospital, she had been doing much better so none was given. LVN T was shown Resident #3's Food Intake Records for November and December 2013 with several weekend entries reflecting she had either refused to eat or consumed less than 50%. LVN T stated, The aides didn't tell me. They gave the ticket to the clerk. I should have checked. In an interview on 12/16/13 at 3:20 PM , Restorative Aide BB stated she had spoken with the Dietary Manager, who agreed she (Restorative Aide BB) would personally feed Resident #3 in the therapy department and complete a more detailed summary of her intake with every meal. On 12/17/13 at 12:20 PM, Restorative Aide BB stated the scale had been calibrated. At that time, Resident #3 was weighed, and her weight was down to 106.8 lbs. On 12/17/13 at 2:30 PM, Restorative Aide BB reviewed Resident #3's meal intake documents completed for 12/16/13. The form reflected she consumed 25% of her breakfast, no lunch and only 10% of her dinner. Restorative Aide BB stated she discussed her plans to personally feed Resident #3 with LVN D and the DON, who agreed it was a good idea. Review of Resident #3's December 2013 MAR revealed there was still no Med Pass administered on 12/16/13. Review of Resident #3's Nurse's Notes revealed no indication her physician had been notified of her weight loss. Resident #3's Dietary Progress Notes dated 12/13/13 reflected the following: Resident last weighed @ 109.4, weighed twice. Scales to be checked stated by Rehab aide. Resident continues to have significant amount of weight loss, resident has 14% significant weight loss x's 30 days R/T refusal to eat. (Director of Dietary Services) called dietitian's asst. Dietitian on vacation @ this X, facility needed immediate intervention due to tremendous amount of weight loss within 30 days. Dietitian faxed recommendations, (Director of Dietary Services) was also asked to tell resident's charge nurse of recommendations of Med Pass (with) medications 3x a day. Nurse stated res. already receives 60 cc if she eats less than 50%. Dietitian stated res is a good candidate for appetite stimulant but may not be able to receive it according to what's going on with her. (Director of Dietary Services) talked (with) charge nurse, stated she receives [MEDICATION NAME] already but res still not eating well as observed by (Director of Dietary Services) & rehab aide. Nurse stated she would call the doctor. Doctor's office called (Director of Dietary Services) about dietitian's recommendations and stated she would talk with doctor and get back (with) me. Will follow. The note was signed by Director of Dietary Services. Resident #3's Nutritional assessment dated [DATE] reflected her weight was 127 lbs. Summary and Recommendations reflected: 12/17/13: Dietary consult requested due to weight loss. Nutr assess reveals wt remains stable/ 30 days, following wt loss 9 lbs/90 days-7%, 13 lbs/180 days-9.29%; Pt remains within desirable wt range, as reflected by BMI factor;.Pt continues to refuse to eat; Pt will accept shakes and chocolate milk; [MEDICATION NAME] continues for appetite stimulant; Med Pass continues 60 cc TID if meal intake is < 50% for add'l 360 cal/15 gm pro, due to continued wt loss and low pre-alb, recommend adding Med Pass 2.0 120 cc BID for add'l 480 cal/20 gm pro; wt loss may be expected; .continue to monitor closely; goal is to provide adequate cal and pro to stabilize wt. The assessment was signed by Dietary Consultant PP. During an interview on 01/02/14 at 4:10 PM, Dietary Consultant PP was queried about her Nutritional Assessment of Resident #3. Dietary Consultant PP stated she was called for a consultation on 12/17/13 and the weight reflected on her assessment was the weight she was given for Resident #3 by the facility. When asked about her recommendation for the Med Pass 2.0 supplement, Dietary Consultant PP explained she was informed by facility staff Resident #3 had been receiving doses of Med Pass as needed but she wanted to add a scheduled dose in addition to the PRN dose already ordered. She could not remember who told her Resident #3 was taking the Med Pass. When the Dietary Consultant PP was told Resident #3's weight was actually 109 lbs on 12/13/13, then dropped to 106 lbs, she stated she was never made aware of the weight drop. When asked who provided her the information for her consultation, Dietary Consultant PP stated the Director of Dietary Services faxed a weight sheet prior to her arrival. She explained they typically faxed the information in advance so she could prepare for her visit. During an interview on 01/02/14 at 4:35 PM, the Director of Dietary Services was asked what type of information she sent to the dietitian when a consultation was ordered. She stated she sent them the resident's weights. When asked about Resident #3, she confirmed she sent the dietitian her weights. The Director of Dietary Services retrieved a list of monthly weights to show the surveyor. Resident #3's weight for December was documented as 126.6 lbs; a line was drawn through the entry. The Director of Dietary Services stated, I lined that out later and wrote 109. The Director of Dietary Services retrieved a Dietitian Consultant Worksheet and stated she typically filled it out and gave it to the Dietitian. When asked whether she provided one for Resident #3's consultation, the Director of Dietary Services replied, I can't remember if I did this last time. They never let me know when they are coming. The Director of Dietary Services also explained she had informed the Dietitian Resident #3 was taking Med Pass supplement. She stated she had been informed by LVN D the resident was getting it. On 12/17/13 at 2:17 PM, an interview with NP P, Resident #3's Nurse Practitioner, revealed she had not been notified of Resident #3's weight loss and was unaware of the recent weight drop. During an interview on 12/17/13 at 3:07 PM, LVN D stated she remembered the surveyor reporting Resident #3's weight loss on 12/13/13. She stated she reported the information to the DON.

When asked why she did not call the physician, LVN D stated she was going to wait until the scale was calibrated. In an interview on 12/17/13 at 4:10 PM, the DON stated Resident #3's physician had been called and lab orders were obtained for a CBC, CMP and Pre-[MEDICATION NAME] level to be done. She added a care plan meeting with the family was being arranged and Physician K, Resident #3's attending physician, would attend. The DON stated Resident #3 was getting health shakes instead of Med Pass but staff had not been documenting it. She stated nursing administration was going to take over monitoring Resident #3's meal intake and every resident in the building would be re-weighed. When asked why the physician was not notified on 12/13/13 when the discrepancy was found, the DON stated, No. It was the intent but it got dropped. An interview on 01/02/14 at 2:21 PM with Restorative Aide BB revealed she had begun re-weighing residents but had not completed the task (16 days since the DON said all residents would be re-weighed.). Restorative Aide BB provided lists dated 12/31/13 through 01/02/14 with the names and weights of residents. When asked when she was asked to initiate re-weighing the residents, she stated she had not been told by anyone to re-weigh the residents. When asked why she was re-weighing the residents, Restorative Aide BB said, I know that's what you do when you have a discrepancy. In an interview on 01/03/13 at 12:12 PM, the DON was asked whether she had implemented the re-weighing of all the residents as she had informed the surveyor she would. The DON stated, We are in the process of doing that now. During an interview on 01/06/13 at 12:00 PM, Physician K stated he had taken part in care plan meetings regarding Resident #3. He stated he had decreased her medications, which were not critical to maintain function. Physician K stated he learned the facility had not been calling the family to assist her when she would not eat as had been agreed upon during a previous meeting. 2) The facility's current policy and procedure, Weight and Height Measurement dated 2006 reflected: Basic Responsibility- Licensed Nurse, Nursing Assistant and Restorative Nursing Assistant . Purpose: -To obtain accurate weight and height of each resident. -To maintain constant control of weight changes. -To assess nutrition and hydration status of resident -To identify significant change in condition Procedure: 1. Calibrate scale according to manufacturer's instructions . 3. Assist resident into wheelchair or scale chair. Place wheelchair on scale platform properly, according to manufacturer's directions. 4. Weigh according to manufacturer's directions and subtract weight of wheelchair from total weight to obtain resident's weight. Documentation Guidelines: Documentation may include: -Date and weight . -Notify the charge nurse or physician of all weight changes of five pounds (or 5%) or more in a 30-day period or ten percent in a 180-day period or per state requirement. 3) Resident #9 was an [AGE] year-old female re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment reflected resident #9 had a BIMS score of 11, indicating she was moderately impaired cognitively, she was totally dependent on staff for bed mobility, transfers and hygiene and required extensive assistance for dressing. The MDS further reflected Resident #9 was at risk of developing pressure sores but had no pressure sores at that time. Resident #9's most recent Braden Scale dated 08/28/13 reflected a score of 12 indicating she was at high risk for developing pressure sores. Resident #9's Care Plan dated 09/19/13 reflected she was Total-Extensive dependence on staff for completion of ADLs related to debility. Approaches included: Monitor skin weekly and document. Notify physician of changes. Resident #9's Care Plan dated 09/24/13 reflected she had a decubitus ulcer on her right mid lower leg measuring 2.1 cm x 1.3 cm x 0.2 cm and was Stage II. Approaches included: Treatment (blank line) as ordered. Notify Dr. of ineffectiveness of treatment.Document wound appearance and notify Dr of S/SX of infection .Pressure relieving pillows to offload. The Care Plan was last updated on 12/05/13 and reflected the wound measured 1.8 cm x 0.5 cm x 0.1 cm and reflected: Cont. tx per order. The Care Plan was signed by the MDS Coordinator. In an interview on 12/11/13 at 4:30 PM, the MD Coordinator was asked why there was no Care Plan for Resident #9's pressure sores prior to 09/24/13. The MDS Coordinator stated she was unaware of the wound prior to 09/24/13. On 12/10/13 at 11:05 AM, during initial tour with LVN A, Resident #9 was observed sleeping in her bed. LVN A stated she was not Resident #9's usual Charge Nurse but was covering the hall that day. She identified the resident as possibly having a pressure sore on her heel. There was a sign above the resident's bed that read: Boots must be worn on this patient at all times, thanks for your cooperation. Resident #9's Physician's Progress Notes reflected she was last seen by NP O on 10/15/13. The Progress Note dated 10/15/13 reflected no indication she had pressure sores. Observation on 12/10/13 at 1:46 PM with LVN A and CNA M revealed Resident #9 was lying in bed awake and alert. Resident #9's right heel dressing was removed and revealed an open area approximately 1.0 cm X 0.8 cm. Wound care was given as ordered. A dressing was observed on Resident #9's lower right lateral leg dated 12/08/13. When LVN A was queried about the dressing she stated she knew nothing about it. LVN A removed the dressing and revealed an open wound with a moderate amount of beige drainage within the wound and on the dressing. The wound edges were completely macerated and the wound bed could not be visualized. LVN A stated she did not know about the wound. She cleaned the wound with saline, measured the wound at 2.5 cm x 2.0 cm x 0.5 cm, and stated she was going to apply a clean, dry dressing and call the physician. During the care, CNA M stated she knew about the wound and explained it began as a blister caused by a brace she used to wear which was similar to the one on Resident #9's left leg. She stated she thought the blister had started two to three months ago, healed, then reopened. She stated whenever she showered Resident #9, she would tell her nurse and the nurse would change both dressings. LVN A stated there was no order for a treatment for [REDACTED]. When Resident #9 was asked whether she saw the wound doctor, she stated she had not. CNA M explained Resident #9 used to go to [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday but that had changed to Monday, Wednesday and Friday and the wound care physician came weekly on Wednesday. She confirmed the wound care physician had not seen Resident #9 since her wound reopened. Resident #9's Nurse's Notes reflected the following entries related to her dressing changes: 09/24/13 at 10:30 AM: CNA notified Charge Nurse that resident has an open area to R calf 2.1 x 1.3 x 0.2 cleaned (with) NS applied Collagen & [MEDICATION NAME] dressing. (responsible party) called (phone number) & notified of (change) in condition. Signed by LVN D. (NOTE: There were no further entries indicating the physician was notified or orders obtained.) 10/28/13 at 10:00 AM: NO (new order) clean R heel NS pat dry apply silver hydrogel, collagen, & dry dressing Q day (responsible party and phone number) informed of new area on foot. Signed by LVN D. 11/02/13 at 2:00 PM: Assisted resident back to bed after lunch. Tx done to wounds in R heel & R leg. Moderate amount of blood noted. Kept dry and comfortable. Signed by LVN T 11/03/13 at 11:00 AM: .Tx to R heel and R leg done. Small amt of drainage & blood noted. Heel protectors on resident. Signed by LVN T. 11/09/13 at 11:00 AM: .Tx done to R leg and heel, heel protectors on bilateral heels. Signed by LVN T. 11/10/13 at 11:00 AM: .Tx to R leg and heel done. Signed by LVN T. 11/11/13 at 8:15 AM: .wound care to R heel given. Signed by LVN D. 11/15/13 at 11:00 AM: Repositioned wound care given ? c/o pain. Podus boots on bil ft. Signed by LVN D. 11/16/13 at 10:00 AM: .L heel and leg dressing. ? odor noted. Small amount of drainage, blood stain observed. Signed by LVN T. 11/22/13 at 7:40 AM: .Dressing (change) to R heel. Signed by LVN D. 11/30/13 at 11:00 AM: Tx to L heel & leg done. Kept dry and comfortable. Signed by LVN T. 12/01/13 at 11:00 AM: Dressing to L heel and leg changed. Small amt of drainage noted. Signed by LVN T. 12/07/13 at 11:00 AM: .L heel and leg tx done. Signed by LVN T. 12/08/13 at 11:00 AM: .Dressing to the wound changed. Yellowish drainage noted. Incontinent care provided. Kept dry and comfortable. Signed by LVN T. 12/10/13 at 1:00 PM: .This nurse observe a wound on the left leg measure 2.5 cm x 2 cm x 0.5 cm. (Physician X) notify and talked to (NP O), an order for [REDACTED]. Signed by LVN A. 12/11/13 at 10:15 AM: Spoke (with) (NP O) for (Physician X). Order clarification to continue previous order for R calf. Cleanse (with) NS, pat dry apply silver hydrogel, collagen, cover (with) dry protective dressing QD. Signed by LVN D. Resident #9's Physician's Telephone Orders dated 08/29/13 reflected: .Continue everything on TARS. Resident #9's Monthly Consolidated Orders for the month of September, 2013 reflected the following handwritten note written across the top: MD Please compare hosp list before signing 8/31/13. Review The orders were signed by the ADON on 08/31/13 and by the attending physician on 09/05/13 and included: Cleanse Rt heel w/ NS, pat dry, apply calcium alginate, silver absorbing agent collagen dressing w/ santyl, cover with dry dressing BID. Cleanse blister on Lt calf w/ NS, pat dry, apply skin prep bid. Resident #9's Treatment Record for September 2013 reflected the following entries: EZ boot to be worn in bed and chair to offload wound, float heels in bed to offload wound. The order was signed as completed every shift. Cleanse Rt heel w/ NS, pat dry, apply calcium alginate, silver absorbing agent collagen dressing w/ santyl, cover with dry dressing BID. Cleanse blister on Lt calf w/ NS, pat dry, apply skin prep bid. The treatments were never signed as completed and both treatments had handwritten noted that reflected: DC 09/13/13. Review of Resident #9's Physician Telephone orders revealed no order to discontinue the treatments. Resident #9's Physician's Telephone Orders dated 10/28/13 reflected an order to clean the right heel with normal saline, pat dry, apply silver hydrogel, collagen dressing and a dry, protective dressing daily. Review of Resident #9's Treatment Orders for the month of November 2013 revealed there were no wound treatment or prevention orders at all. Resident #9's Treatment Orders for the month of December 2013 reflected an order to cleanse her right heel with normal saline, pat dry, apply silver hydrogel, collagen dressing and a dry, protective dressing daily. The order date was 10/28/13. There were no orders related to her right leg. On 12/10/13, the DON was asked to provide her wound tracking and surveillance records to the survey team. Review of the weekly wound records dated 09/02/13 through 11/06/13 revealed there were no entries related to Resident #9. During an interview on 12/10/13 at 2:30 PM, the DON was asked why Resident #9 was not represented in the wound surveillance reports. The DON explained the lists represented only the residents who were seen by the wound care physician. She stated Resident #9 was not seen by the wound care physician because she was out at [MEDICAL TREATMENT] on those days. When asked how residents with wounds were treated if they had [MEDICAL TREATMENT] or any other scheduling conflicts with the wound care physician, the DON stated the primary care physician provided the orders. During another interview on 12/10/13 at 3:30 PM, the DON was asked if she kept her own surveillance records of wounds in the facility to monitor residents who were not seen by the wound care physician. The DON stated she received report daily and the nurses gave her a sheet with the wound measurements. She stated she was still looking for Resident #9 ' s sheet and had been unable to locate it. The DON stated Resident #9 was the only resident with a wound who was not seen by the wound care physician. On 12/10/13 at 4:38 PM, LVN A informed this surveyor she had obtained an order to apply Calcium Alginate, a dry dressing and consult the wound care physician. When asked whether the physician was aware of the wound, LVN A replied, No. When asked how the wound care physician was supposed to see Resident #9 when he only came to the facility on Wednesday, her [MEDICAL TREATMENT] day, LVN A stated she did not know. She stated the Doctors were aware the wound care physician only rounded on Wednesday. When LVN A was then asked whether she reminded the physician of that fact when the order for the wound care consult was obtained, she stated she did not. During an interview on 12/11/13 at 8:15 AM, LVN D, Resident #9's usual 7:00 AM to 3:00 PM Charge Nurse, was asked about Resident #9's right leg wound. LVN D stated the wound started as a blister caused by a hard plastic ski-boot style brace she was wearing at the time. She stated Resident #9 was sent to the hospital related to blood pressure issues and, when she returned, it was an open wound. When asked about documentation, LVN D stated she documented wounds on Wednesdays and kept the information in a separate folder and she would provide the information. LVN D stated she treated the leg wound by cleaning with normal saline, applying silver hydrogel and collagen, and cover with a dry, protective dressing every day. LVN D stated she had corrected the order obtained the day before by LVN A. When asked when she obtained the treatment orders, LVN D stated she would look back and get the exact date. (NOTE: the order was never found.) When LVN D was asked where she documented her treatments, she stated she documented in the Treatment Administration Record. When told there was no entry for Resident #9's leg wound, LVN D stated she saw that, it's on there now. LVN D then stated she documented in the nurse's notes when the treatments were done. When told there were no entries found there either, LVN D stated she would check. When asked whether a physician had observed Resident #9's right leg wound, LVN D stated the wound care physician was treating until her [MEDICAL TREATMENT] days changed. When asked when that happened, LVN D reviewed Resident #9's record and determined the [MEDICAL TREATMENT] schedule changes on or around 09/13/13. The record also reflected Resident #9 returned from the hospital on [DATE], there were no new orders for wound care. During the same conversation, LVN D located a Pressure Ulcer Record for Resident #9. The Record reflected two wounds. A wound to the right, outer lower leg was identified on a body outline as Site A with the date first observed as 09/24/13. The wound was identified as Stage II, 2.1 cm x 1.3 cm x 1.2 cm, no drainage or odor. LVN D stated she measured the wound that morning and documented it on the Record. The entry for the morning of

	12/11/13 reflected it measured 1.3 cm x 0.5 cm x 0.1 cm, Stage II with no drainage. When LVN D was asked why the wound documentation was not started until 09/24/13, she replied, When I got this sheet, that's when I started charting on this sheet, I didn't have this sheet before. When asked where she charted before obtaining the sheet, LVN D replied, I didn't chart anywhere. LVN D stated she was a CNA before Resident #9 went to the hospital, she explained she was transitioning to a nurse position and, when Resident #9 returned from the hospital, she was her nurse. When LVN D was asked, since she knew about the wound, if she ever called to get orders, she looked through the chart and stated she had spoken to NP O. LVN D stated, When she came back, I just continued with her previous orders. When asked if she ever checked to see if the orders were written, LVN D replied, No. During an interview on 12/11/13 at 11:06 AM, NP O stated she was not sure when she became aware of the wound on Resident #9's leg. She confirmed her last note about the resident was dated 10/15/13. She stated she was at the facility on 12/05/13 but she did not see Resident #9. NP O stated she remembers the staff talking to her about a wound that day but she could not say which wound specifically. NP O stated she did not know if she was aware the wound care physician was not treating Resident #9. She could not recall ever looking at Resident #9's wounds. When asked whether LVN D had called her about orders, NP O confirmed she had. NP O stated, I don't know that I was made aware until yesterday that it had progressed, I did talk to them on the 5th. An observation on 12/12/13 at 10:30 AM, Medical Director/Physician K, accompanied LVN D to Resident #9's room to assess her wounds. When Medical Director/Physician K observed the wound he stated it was a
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement its policies and procedures, which prohibit neglect for two (Residents #1 and #2) of 14 residents reviewed for neglect. 1) a.The facility failed to properly transcribe and administer the following medications for Resident #1 in two of two months reviewed: [MEDICATION NAME] 25 mg - missed three of five doses; [MEDICATION NAME] 20 mg - missed three of five doses; [MEDICATION NAME] eye drops- missed three of five doses; [MEDICATION NAME] 40 mg-20 mg was given and only administered three out of five times; [MEDICATION NAME] - was given in the morning instead of at bedtime as ordered; [MEDICATION NAME] 200 mg- 100 mg was given for three days; [MEDICATION NAME] - was given in the morning instead of at bedtime as ordered; Levetiracetam 1000 mg- 500 mg was administered for three days; [MEDICATION NAME] XL - missed three 60 mg doses and missed five 30 mg doses; and [MEDICATION NAME] 0.1 mg - missed five doses. b. LVN D failed to administer the correct dose of pain medications to Resident #1 when she repeatedly complained of leg pain. LVN D administered one [MEDICATION NAME] 5/325 mg tablet when the ordered dose was two 10/325 mg tablets. 2. The facility failed to discontinue Resident #2's [MEDICATION NAME] 25mg (for Hypertension) as ordered. The morning dose of [MEDICATION NAME] was discontinued on 02/03/14 and the evening dose was not discontinued until after the 02/28/14 dose, for a total of 31 doses. These failures could affect any the facility's 75 residents, including Residents #1 and #2, by placing them at risk for ongoing medication errors resulting in depression, eye discomfort, unrelieved pain, stomach upset, [MEDICAL CONDITION], weakness, confusion, dizziness, headache, [MEDICAL CONDITIONS] and death and could affect the 75 residents in the facility. Findings included: 1) Review of Resident #1's Physician's Telephone Orders dated 02/26/14 revealed she was to be readmitted to the facility with [DIAGNOSES REDACTED]. Review of Resident #1's admission Nurse's Note dated 02/26/14 at 2:20 PM revealed she was confused but able to make her needs known at that time. Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: [MEDICATION NAME] Hcl 25 mg tablets by mouth twice daily (used to treat high blood pressure); [MEDICATION NAME] 20 mg tablets by mouth twice daily (used to treat chest pain

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. BUILDING _____ B. WING _____	**01/11/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	**4515 VILLAGE CREEK RD FORT WORTH, TX 76119**

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 - Many

(continued... from page 1)
caused by heart damage); [MEDICATION NAME] Sodium 100 mg caps, two twice daily (used to prevent constipation); [MEDICATION
NAME] 0.05% eye drops, one drop in each eye twice daily (used for increase tear production); [MEDICATION NAME] 20 mg tablets, give 40 mg at bedtime (used to lower cholesterol); [MEDICATION NAME] 20 mg tablets, give 10 mg by mouth at bedtime (used to treat depression); [MEDICATION NAME] 100 mg tablets, give 200 mg at bedtime (used to treat pain caused by [MEDICAL CONDITION]); [MEDICATION NAME] 325 mg, give one at bedtime (iron supplement used to treat [MEDICAL CONDITION]); Levetiracetam 500 mg tablets, give 1000 mg at bedtime (used to treat [MEDICAL CONDITION]); [MEDICATION NAME] XL 30 mg by
mouth every day (used to treat high blood pressure and chest pain); [MEDICATION NAME] XL 60 mg by mouth every evening; and [MEDICATION NAME] HCL 0.1 mg by mouth every day (used to treat high blood pressure). Review of the facility ' s admission orders [REDACTED] [MEDICATION NAME] 30 mg PO QD; and [MEDICATION NAME] HCL 0.1 mg PO QD. Review of Resident #1's February
2014 MARs revealed the following: [MEDICATION NAME] 25 mg tablets twice a day was only transcribed and initialed as administered once on 02/27/14. (Not twice a day as ordered) [MEDICATION NAME] 20 mg tablets was only transcribed and initialed as administered once a day on 02/27/4 and 02/28/14. (Not twice a day as ordered) [MEDICATION NAME] Sodium 100 mg caps was only transcribed and initialed as administered once on 02/27/14 and 02/28/14. (Not twice a day as ordered) [MEDICATION NAME] eye drops were only transcribed and initialed as administered once a day on 02/27/14 and 02/28/14. (Not twice a day as ordered) [MEDICATION NAME] was transcribed as 20 mg at bedtime and only initialed as administered on 02/26/14 and 02/27/14. (Not on 02/28/14 as ordered) [MEDICATION NAME] was transcribed and initialed as administered as 10 mg at 6:30 AM. (Not at bedtime as ordered) [MEDICATION NAME] 100 mg was transcribed and initialed as administered at bedtime. (Not 200mg as ordered) [MEDICATION NAME] 325 mg was transcribed and initialed as administered at 6:30 AM. (Not at bedtime as ordered) Levetiracetam 500 mg was transcribed and initialed as administered daily at bedtime. (Not 1000 mg as ordered) [MEDICATION NAME] XL was transcribed as 30 mg by mouth every evening and was only administered on 02/26/14 and 02/27/14. (Not 60 mg as ordered and none on 02/28/14) [MEDICATION NAME] XL 60 mg was not transcribed to the February MAR
and so no doses were given in February. Review of Resident #1's March 2014 MARs revealed the following: [MEDICATION NAME]
XL 30 mg by mouth every day was not transcribed and so was not administered from 03/01/14 through 03/05/14, when surveyor inquired. [MEDICATION NAME] HCL 0.1 mg by mouth every day was not transcribed and so was not administered from 03/01/14 through 03/05/14, when surveyor inquired. An interview with the Unit Manager on 03/04/14 at 4:32 PM revealed it was typically her duty to check all orders daily for accuracy but she was pulled off the floor or on 02/24/14 to work on the monthly consolidated orders for the remainder of the month. She stated, during that time, the DON was performing the daily checks on both nurses' stations. During an interview on 03/05/15 at 10:25 AM, LVN C stated she had transcribed the admission orders [REDACTED]. When shown the errors found by the surveyors, LVN C stated she was not aware of the errors. She stated RN A had transcribed the orders to the March MARs and she remembered RN A pointing out some discrepancies to her but she thought she had corrected them. During an interview on 03/05/14 at 11:25 AM, RN A stated she had transcribed the March MARs for Resident #1 but had never looked at February's MARs. RN A stated she had caught a few discrepancies after the hospital orders had been transcribed to the facility's admission orders [REDACTED]. She was not aware of any medication errors. An interview with the DON on 03/05/14 at 11:25 AM revealed all orders, including new admission orders [REDACTED]. The DON explained pink copies of all resident's orders were to be placed in a box and both she and the Unit Manager checked those pink copies every day before they left to ensure all orders written over the past 24 hours were transcribed correctly. When asked about Resident #1, the DON confirmed the Unit Manager was not checking orders at that time as she had been pulled to work on the monthly orders. The DON stated she did not know why Resident #1's orders had not been checked; she stated the pink copies must not have made it into the designated box. b) Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: [MEDICATION NAME] 10/325 mg one tablet every six hours as needed for pain. [MEDICATION NAME] 10/325 mg two tablets every six hours as needed for pain. Resident #1's admission orders [REDACTED]. Review of Resident #1's MAR for February 2014 revealed an entry for [MEDICATION NAME]-Apap 10-325 two every six hours as needed for pain. The entry was initialed as administered on 02/26/14 at 3:00 PM and 9:00 PM by LVN D. The back of the MAR reflected the following entries: 2/26/14 at 3:00 PM: Resident c/o pain, pain level 8/10, [MEDICATION NAME] ([MEDICATION NAME]) 5/325 admin, pain level at
3:30 PM 6/10. The entry was signed by LVN D. 2/26/14 at 9:00 PM: Resident c/o pain, telling, 8/10, [MEDICATION NAME] 5/325 mg admin, pain level @ 9:30 (PM), 7/10, ineffective. The entry was signed by LVN D. During an interview on 03/05/14 at 12:45 PM, LVN D explained she was Resident #1's Charge Nurse on 02/26/14 but LVN C was completing the admission orders [REDACTED]. When asked why she only administered 5/325 mg when the order and MAR both indicated the dose was two 10/325 tablets, LVN D stated she had seen the dose on the MAR but when she went to the medication cart, her old card was still on the cart (from prior to her hospitalization) and so she just administered that. When asked why she did not question the dosage on the card as it conflicted with the MAR or check the orders in the chart, LVN D stated, It never occurred to me she was really in pain, I didn't touch the orders, I gave her what she had on the cart. During an interview on 03/05/14 at 2:47 PM, the DON was shown Resident #1's MARs and told about the medication error regarding the [MEDICATION NAME]. The DON
stated she was not aware of the error and that it should not have happened. She confirmed [MEDICATION NAME] 10/325 mg tablets were kept in the E-kit and LVN D could have easily retrieved the proper dose. When asked how Resident #1's pain should have been handled, the DON stated if a resident complains of pain, they should be assessed and a pain level ascertained. She stated the resident should be medicated if indicated and re-assessed in 30-45 minutes for relief. The DON stated, if the medication was not effective and another medication could not be given, the physician should be called and made aware of all the details surrounding the situation. An observation on 03/05/14 at 3:28 PM revealed [MEDICATION NAME] 10/325 tablets were stocked in the medication room E-kit at Resident #1's nurse's station. 2. Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #2 had a BIMS of 4 and was dependent on staff for most of his ADLs. Review of Resident #2's Care Plan dated 02/27/14 revealed: Date & Problem: DX [MEDICAL CONDITION]/HTN/[MEDICAL CONDITION] Goal: (Resident #2) will not suffer any
complications caused by Dx's thru the next eval date. Approaches & Disciplines: Lab as ordered Notify Dr. of results Medications as ordered. Notify Dr of effectiveness Monitor for [MEDICAL CONDITION], SOB, Pain in extremities with discoloration of skin and warm to touch Document and Notify Dr/RP/Hospice Resident #2's Physician's Telephone Orders dated 01/09/13 reflected [MEDICATION NAME] 25 mg twice a day. Resident #2's Physician's Telephone Orders dated 01/30/14 reflected increase [MEDICATION NAME] to 50 mg twice a day for blood pressure. Review of Resident #2's MARs for the month of January 2014 revealed the last dose of [MEDICATION NAME] 25 mg was on 01/30/14 after the 9:00 PMdose. Further review of this MAR revealed [MEDICATION NAME] 50 mg was started on 01/30/14 at 9:00 PM. Review of Resident #2's MARs for the month of February
2014 revealed [MEDICATION NAME] 50 mg twice a day was administered as ordered. Further review of this MAR revealed the morning dose (9 AM) of [MEDICATION NAME] 25 mg was administered on 02/01/14, 02/02/14/ and 02/03/14. DC'D was hand written
after the 9 AM dose was administered on 02/03/14. The evening dose (4:00 PM) of [MEDICATION NAME] 25 mg was administered
each day during the month of February. A total of 31 doses of [MEDICATION NAME] 25 mg were administered that the physician had discontinued on 01/30/14. During an interview on 03/04/14 at 3:55 PM the surveyor reviewed Resident #2's February 2014's MARs with LVN B, Resident #2's evening charge nurse. LVN B stated she did administer [MEDICATION NAME] 25 mg and
[MEDICATION NAME] 50 mg on the days she worked, as were documented on Resident #2's MAR. During an interview on 03/05/14 at
10:05 AM the ADM stated the Unit Manager did the February 2014 monthly recapitulations of physician orders [REDACTED]. During an interview on 03/04/14 at 4:30 PM the Unit Manager stated she checks the pink slips (copy of telephone physician orders) daily to make sure the orders were correct on the MARs. She stated when she did the February 2014 monthly recapitulations of physician orders, she was taken off the floor from 01/25/14 through the end of the month, and the DON took over her tasks, including verifying the pink slips were checked, for the whole building. During an interview on 03/06/14 at 4:30 PM the ADM stated Resident #2 receiving 31 doses of [MEDICATION NAME], which had been discontinued, was a
careless error. The ADM further stated the DON told her she did miss a few a days of checking pink slips. During an interview on 03/06/14 at 8:47 AM the surveyor asked the DON how she thought Resident #2's received 31 doses of [MEDICATION NAME] that had been discontinued. The DON stated when RN A taught the Unit Manager how to do the monthly recapitulations of physician orders, RN A did not instruct the Unit Manager to continue to add additional physician orders [REDACTED]. Nursing 2013 Drug Handbook 33rd Edition, Wolters Kluwer, Copyright 2013, pages 680 - 681 reflected the following nursing considerations for [MEDICATION NAME]: Monitor patient's blood pressure, pulse and body weight frequently.Elderly patients may be more sensitive to drug's hypotensive effects. Overdose signs and symptoms include: [MEDICAL CONDITIONS] headache and
flushing. 3. Review of the facility's current undated policy and procedure Monthly Review of physician's orders [REDACTED]. Purpose: To ensure that physician order's are accurate. Policy: To verify prior to the beginning of each month that all

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	676052	A. BUILDING _____ B. WING _____	**01/11/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	**4515 VILLAGE CREEK RD FORT WORTH, TX 76119**

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 -** Many	(continued... from page 2) physician orders [REDACTED]. (RN A)/(Unit Manager) will be responsible for this monthly review. DON will schedule the delivery of the orders. DON will have (RN A) to be removed from the schedule as a floor nurse for the last 5-6 days of each month. (RN A) will inform DON of all concerns regarding the orders upon the completion of the review. (RN A) will take the prior month MARS and compare them to the clinical record. (RN A) will then take the clinical record and compare it to the new MARS. (RN A) will then handwrite onto the new MAR any new orders that will come after the 25th of the month. Attending nurses will write any new orders on the current MAR until the end of the month. If a new admission comes at the end of the month, (RN A)/Designee reviewing the MAR should make a new set of physician's orders [REDACTED]. (RN A)/Designee should also make a new set of MARS and TARS for the next month. (RN A)/Designee will via fax all updates to the person responsible for preparing the monthly orders: (name of pharmacy tech) at [PHONE NUMBER]. Clarifications orders will be written. 11-7 will compare the old MAR to the New MAR for accuracy. Review of the facility's current policy and procedure Unnecessary Drugs dated 2012 revealed: Purpose: Each resident's drug regimen must be free from unnecessary drugs: Procedure: An unnecessary drug is any drug when used: 1. In excessive dose (including duplicate therapy); or 2. For excessive duration; or 3. Without adequate monitoring; or 4. Without adequate indications for its use; or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 6. An combination of the reasons above. Review of an undated Medication Pass Inservice from an RN/LVN Orientation Book located at the Nurse's Station revealed the following: Steps to take during the med pass:. 16. Before administering the medication, always check 'The 6R 's' 17. Triple check medications vs. MAR before administering the medications. 18. If any of the 6 R's do not match or if you have any questions about the medication itself DO NOT GIVE THE MEDICATION! Check the chart or call the pharmacy with your concern. The pharmacist would rather you ask a question than a mistake be made. DURING THE MEDICATION PASS: 'THE 6 Rs' Before administering any medication, always check the 6 Rs, The right resident. The right drug: verify each drug against the medication administration record (MAR) before administering. The right dose: verify against the MAR. The right time: administer drugs as instructed on the MAR and within the time frame established by your facility. CHECKPOINTS.Related issues.Make sure discontinued medications have been removed from the cart as soon as they have been discontinued. 4. Review of the facility's Form-672, Resident Census and Conditions of Residents, dated 03/03/14 and signed by DON reflected a census of 75.

F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement its policies and procedures, which prohibit neglect for two (Residents #1 and #2) of 14 residents reviewed for neglect. 1) a. The facility failed to properly transcribe and administer the following medications for Resident #1 in two of two months reviewed: [MEDICATION NAME] 25 mg - missed three of five doses; [MEDICATION NAME] 20 mg - missed three of five doses; [MEDICATION NAME] eye drops-missed three of five doses; [MEDICATION NAME] 40 mg-20 mg was given and only administered three out of five times; [MEDICATION NAME] - was given in the morning instead of at bedtime as ordered; [MEDICATION NAME] 200 mg- 100 mg was given for three days; [MEDICATION NAME] - was given in the morning instead of at bedtime as ordered; Levetiracetam 1000 mg- 500 mg was administered for three days; [MEDICATION NAME] XL - missed three 60 mg doses and missed five 30 mg doses; and [MEDICATION NAME] 0.1 mg - missed five doses. b. LVN D failed to administer the correct dose of pain medications to Resident #1 when she repeatedly complained of leg pain. LVN D administered one [MEDICATION NAME] 5/325 mg when the ordered dose was two 10/325 mg tablets. 2. The facility failed to discontinue Resident #2's [MEDICATION NAME] 25mg (for Hypertension) as ordered. The morning dose of [MEDICATION NAME] was discontinued on 02/03/14 and the evening dose was not discontinued until after the 02/28/14 dose, for a total of 31 doses. These failures could affect any the facility's 75 residents, including Residents #1 and #2, by placing them at risk for ongoing medication errors resulting in depression, eye discomfort, unrelieved pain, stomach upset, [MEDICAL CONDITION], weakness, confusion, dizziness, headache, [MEDICAL CONDITIONS] and death and could affect the 75 residents in the facility. Findings include: A. The facility's current, undated Staff Responsible for Coordinating/Implementing Abuse Prevention Program Policies and Procedures reflected, .The administrator assumes the responsibility for the overall coordination and implementation of our facility's abuse prevention program policies and procedures. The facility's Abuse Prevention Policy, revised September 2012, reflected the policy was to protect all residents from all forms of neglect. It further noted staff would be trained on identifying all forms of neglect. The facility's abuse prevention/intervention program included the following in regard to neglect: Assessing, care planning, and monitoring of residents with needs and behaviors that may lead to conflict or neglect; and identifying areas within the facility that may make neglect more likely to occur and conduct frequent monitoring of those areas. 1) Review of Resident #1's Physician's Telephone Orders dated 02/26/14 revealed she was to be readmitted to the facility with [DIAGNOSES REDACTED]. Review of Resident #1's admission Nurse's Note dated 02/26/14 at 2:20 PM revealed she was confused but able to make her needs known at that time. Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: [MEDICATION NAME] Hcl 25 mg tablets by mouth twice daily (used to treat high blood pressure); [MEDICATION NAME] 20 mg tablets by mouth twice daily (used to treat chest pain caused by heart damage); [MEDICATION NAME] Sodium 100 mg caps, two twice daily (used to prevent constipation); [MEDICATION NAME] 0.05% eye drops, one drop in each eye twice daily (used for increase tear production); [MEDICATION NAME] 20 mg tablets, give 40 mg at bedtime (used to lower cholesterol); [MEDICATION NAME] 20 mg tablets, give 10 mg by mouth at bedtime (used to treat depression); [MEDICATION NAME] 100 mg tablets, give 200 mg at bedtime (used to treat pain caused by [MEDICAL CONDITION]); [MEDICATION NAME] 325 mg, give one at bedtime (iron supplement used to treat [MEDICAL CONDITION]); Levetiracetam 500 mg tablets, give 1000 mg at bedtime (used to treat [MEDICAL CONDITION]); [MEDICATION NAME] XL 30 mg by mouth every day (used to treat high blood pressure and chest pain); [MEDICATION NAME] XL 60 mg by mouth every evening; and [MEDICATION NAME] HCL 0.1 mg by mouth every day (used to treat high blood pressure). Review of the facility ' s admission orders [REDACTED] [MEDICATION NAME] 30 mg PO QD; and [MEDICATION NAME] HCL 0.1 mg PO QD. Review of Resident #1's February 2014 MARs revealed the following: [MEDICATION NAME] 25 mg tablets twice a day was only transcribed and initialed as administered once on 02/27/14. (Not twice a day as ordered) [MEDICATION NAME] 20 mg tablets was only transcribed and initialed as administered once a day on 02/27/4 and 02/28/14. (Not twice a day as ordered) [MEDICATION NAME] Sodium 100 mg caps was only transcribed and initialed as administered once on 02/27/14 and 02/28/14. (Not twice a day as ordered) [MEDICATION NAME] eye drops were only transcribed and initialed as administered once a day on 02/27/14 and 02/28/14. (Not twice a day as ordered) [MEDICATION NAME] was transcribed as 20 mg at bedtime and only initialed as administered on 02/26/14 and 02/27/14. (Not on 02/28/14 as ordered) [MEDICATION NAME] was transcribed and initialed as administered as 10 mg at 6:30 AM. (Not at bedtime as ordered) [MEDICATION NAME] 100 mg was transcribed and initialed as administered at bedtime. (Not 200mg as ordered) [MEDICATION NAME] 325 mg was transcribed and initialed as administered at 6:30 AM. (Not at bedtime as ordered) Levetiracetam 500 mg was transcribed and initialed as administered daily at bedtime. (Not 1000 mg as ordered) [MEDICATION NAME] XL was transcribed as 30 mg by mouth every evening and was only administered on 02/26/14 and 02/27/14. (Not 60 mg as ordered and none on 02/28/14) [MEDICATION NAME] XL 60 mg was not transcribed to the February MAR and so no doses were given in February. Review of Resident #1's March 2014 MARs revealed the following: [MEDICATION NAME] XL 30 mg by mouth every day was not transcribed and so was not administered from 03/01/14 through 03/05/14, when surveyor inquired. [MEDICATION NAME] HCL 0.1 mg by mouth every day was not transcribed and so was not administered from 03/01/14 through 03/05/14, when surveyor inquired. An interview with the Unit Manager on 03/04/14 at 4:32 PM revealed it was typically her duty to check all orders daily for accuracy but she was pulled off the floor or on 02/24/14 to work on the monthly consolidated orders for the remainder of the month. She stated, during that time, the DON was performing the daily checks on both nurses' stations. During an interview on 03/05/15 at 10:25 AM, LVN C stated she had transcribed the admission orders [REDACTED]. When shown the errors found by the surveyors, LVN C stated she was not aware of the errors. She stated RN A had transcribed the orders to the March MARs and she remembered RN A pointing out some discrepancies to her but she thought she had corrected them. During an interview on 03/05/14 at 11:25 AM, RN A stated she had transcribed the March MARs for Resident #1 but had never looked at February's MARs. RN A stated she had caught a few discrepancies after the hospital orders had been transcribed to the facility's admission orders [REDACTED]. She was not

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) aware of any medication errors. An interview with the DON on 03/05/14 at 11:25 AM revealed all orders, including new admission orders [REDACTED]. The DON explained pink copies of all resident's orders were to be placed in a box and both she and the Unit Manager checked those pink copies every day before they left to ensure all orders written over the past 24 hours were transcribed correctly. When asked about Resident #1, the DON confirmed the Unit Manager was not checking orders at that time as she had been pulled to work on the monthly orders. The DON stated she did not know why Resident #1's orders had not been checked; she stated the pink copies must not have made it into the designated box. b) Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: [MEDICATION NAME] 10/325 mg one tablet every six hours as needed for pain. [MEDICATION NAME] 10/325 mg two tablets every six hours as needed for pain. Resident #1's admission orders [REDACTED]. Review of Resident #1's MAR for February 2014 revealed an entry for [MEDICATION NAME]-Apap 10-325 two every six hours as needed for pain. The entry was initialed as administered on 02/26/14 at 3:00 PM and 9:00 PM by LVN D. The back of the MAR reflected the following entries: 2/26/14 at 3:00 PM: Resident c/o pain, pain level 8/10, [MEDICATION NAME] ([MEDICATION NAME]) 5/325 admin, pain level at 3:30 PM 6/10. The entry was signed by LVN D. 2/26/14 at 9:00 PM: Resident c/o pain, telling, 8/10, [MEDICATION NAME] 5/325 mg admin, pain level @ 9:30 (PM), 7/10, ineffective. The entry was signed by LVN D. During an interview on 03/05/14 at 12:45 PM, LVN D explained she was Resident #1's Charge Nurse on 02/26/14 but LVN C was completing the admission orders [REDACTED]. When asked why she only administered 5/325 mg when the order and MAR both indicated the dose was two 10/325 tablets, LVN D stated she had seen the dose on the MAR but when she went to the medication cart, her old card was still on the cart (from prior to her hospitalization) and so she just administered that. When asked why she did not question the dosage on the card as it conflicted with the MAR or check the orders in the chart, LVN D stated, It never occurred to me she was really in pain, I didn't touch the orders, I gave her what she had on the cart. During an interview on 03/05/14 at 2:47 PM, the DON was shown Resident #1's MARs and told about the medication error regarding the [MEDICATION NAME]. The DON stated she was not aware of the error and that it should not have happened. She confirmed [MEDICATION NAME] 10/325 mg tablets were kept in the E-kit and LVN D could have easily retrieved the proper dose. When asked how Resident #1's pain should have been handled, the DON stated if a resident complains of pain, they should be assessed and a pain level ascertained. She stated the resident should be medicated if indicated and re-assessed in 30-45 minutes for relief. The DON stated, if the medication was not effective and another medication could not be given, the physician should be called and made aware of all the details surrounding the situation. An observation on 03/05/14 at 3:28 PM revealed [MEDICATION NAME] 10/325 tablets were stocked in the medication room E-kit at Resident #1's nurse's station. 2. Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #2 had a BIMS of 4 and was dependent on staff for most of his ADLs. Review of Resident #2's Care Plan dated 02/27/14 revealed: Date & Problem: DX [MEDICAL CONDITION]/HTN/[MEDICAL CONDITION] Goal: (Resident #2) will not suffer any complications caused by Dx's thru the next eval date. Approaches & Disciplines: Lab as ordered Notify Dr. of results Medications as ordered. Notify Dr of effectiveness Monitor for [MEDICAL CONDITION], SOB, Pain in extremities with discoloration of skin and warm to touch Document and Notify Dr/RP/Hospice Resident #2's Physician's Telephone Orders dated 01/09/13 reflected [MEDICATION NAME] 25 mg twice a day. Resident #2's Physician's Telephone Orders dated 01/30/14 reflected increase [MEDICATION NAME] to 50 mg twice a day for blood pressure. Review of Resident #2's MARs for the month of January 2014 revealed the last dose of [MEDICATION NAME] 25 mg was on 01/30/14 after the 9:00 PMdose. Further review of this MAR revealed [MEDICATION NAME] 50 mg was started on 01/30/14 at 9:00 PM. Review of Resident #2's MARs for the month of February 2014 revealed [MEDICATION NAME] 50 mg twice a day was administered as ordered. Further review of this MAR revealed the morning dose (9 AM) of [MEDICATION NAME] 25 mg was administered on 02/01/14, 02/02/14/ and 02/03/14. DC'D was hand written after the 9 AM dose was administered on 02/03/14. The evening dose (4:00 PM) of [MEDICATION NAME] 25 mg was administered each day during the month of February. A total of 31 doses of [MEDICATION NAME] 25 mg were administered that the physician had discontinued on 01/30/14. During an interview on 03/04/14 at 3:55 PM the surveyor reviewed Resident #2's February 2014's MARs with LVN B, Resident #2's evening charge nurse. LVN B stated she did administer [MEDICATION NAME] 25 mg and [MEDICATION NAME] 50 mg on the days she worked, as were documented on Resident #2's MAR. During an interview on 03/05/14 at 10:05 AM the ADM stated the Unit Manager did the February 2014 monthly recapitulations of physician orders [REDACTED]. During an interview on 03/04/14 at 4:30 PM the Unit Manager stated she checks the pink slips (copy of telephone physician orders) daily to make sure the orders were correct on the MARs. She stated when she did the February 2014 monthly recapitulations of physician orders, she was taken off the floor from 01/25/14 through the end of the month, and the DON took over her tasks, including verifying the pink slips were checked, for the whole building. During an interview on 03/06/14 at 4:30 PM the ADM stated Resident #2 receiving 31 doses of [MEDICATION NAME], which had been discontinued, was a careless error. The ADM further stated the DON told her she did miss a few a days of checking pink slips. During an interview on 03/06/14 at 8:47 AM the surveyor asked the DON how she thought Resident #2's received 31 doses of [MEDICATION NAME] that had been discontinued. The DON stated when RN A taught the Unit Manager how to do the monthly recapitulations of physician orders, RN A did not instruct the Unit Manager to continue to add additional physician orders [REDACTED]. Nursing 2013 Drug Handbook 33rd Edition, Wolters Kluwer, Copyright 2013, pages 680 - 681 reflected the following nursing considerations for [MEDICATION NAME]: Monitor patient's blood pressure, pulse and body weight frequently.Elderly patients may be more sensitive to drug's hypotensive effects. Overdose signs and symptoms include: [MEDICAL CONDITIONS] headache and flushing. 3. Review of the facility's current undated policy and procedure Monthly Review of physician's orders [REDACTED]. Purpose: To ensure that physician order's are accurate. Policy: To verify prior to the beginning of each month that all physician orders [REDACTED]. (RN A)/(Unit Manager) will be responsible for this monthly review. DON will schedule the delivery of the orders. DON will have (RN A) to be removed from the schedule as a floor nurse for the last 5-6 days of each month. (RN A) will inform DON of all concerns regarding the orders upon the completion of the review. (RN A) will take the prior month MARS and compare them to the clinical record. (RN A) will then take the clinical record and compare it to the new MARS. (RN A) will then handwrite onto the new MAR any new orders that will come after the 25th of the month. Attending nurses will write any new orders on the current MAR until the end of the month. If a new admission comes at the end of the month, (RN A)/Designee reviewing the MAR should make a new set of physician's orders [REDACTED]. (RN A)/Designee should also make a new set of MARS and TARS for the next month. (RN A)/Designee will via fax all updates to the person responsible for preparing the monthly orders: (name of pharmacy tech) at [PHONE NUMBER]. Clarifications orders will be written. 11-7 will compare the old MAR to the New MAR for accuracy. Review of the facility's current policy and procedure Unnecessary Drugs dated 2012 revealed: Purpose: Each resident's drug regimen must be free from unnecessary drugs: Procedure: An unnecessary drug is any drug when used: 1. In excessive dose (including duplicate therapy); or 2. For excessive duration; or 3. Without adequate monitoring; or 4. Without adequate indications for its use; or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 6. An combination of the reasons above. Review of an undated Medication Pass Inservice from an RN/LVN Orientation Book located at the Nurse's Station revealed the following: Steps to take during the med pass:. 16. Before administering the medication, always check 'The 6R 's' 17. Triple check medications vs. MAR before administering the medications. 18. If any of the 6 R's do not match or if you have any questions about the medication itself DO NOT GIVE THE MEDICATION! Check the chart or call the pharmacy with your concern. The pharmacist would rather you ask a question than a mistake be made. DURING THE MEDICATION PASS: 'THE 6 Rs' Before administering any medication, always check the 6 Rs, The right resident. The right drug: verify each drug against the medication administration record (MAR) before administering. The right dose: verify against the MAR. The right time: administer drugs as instructed on the MAR and within the time frame established by your facility. CHECKPOINTS.Related issues.Make sure discontinued medications have been removed from the cart as soon as they have been discontinued. 4. Review of the facility's Form-672, Resident Census and Conditions of Residents, dated 03/03/14 and signed by DON reflected a census of 75.

F 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Make sure each resident receives an accurate assessment by a qualified health professional** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the MDS assessments accurately reflected

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

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F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) the current condition/status for four (Residents #3, #9, #41 and #40) of 41 residents reviewed for MDS accuracy. 1) Resident #9's MDS assessment reflected she had no pressure sores when she was receiving treatment for two. 2) Resident #3's weight was inaccurately recorded on her MDS when she was readmitted from the hospital. 3) Resident #41's quarterly MDS assessment failed to reflect her accurate weight and her recent unplanned weight loss. 4) Resident #40's admission MDS inaccurately recorded the resident was on a physician-prescribed weight-loss regime. These failures could affect the 75 residents at the facility, including Resident #3, #9, #41 and #40, placing them at risk for not having care and services identified, which the residents required, resulting in the potential for poor quality of care and life. Findings included: 1) Resident #9 was an [AGE] year-old female re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment reflected resident #9 had a BIMS score of 11, indicating she was moderately impaired cognitively. The MDS further reflected Resident #9 was at risk of developing pressure sores but had no pressure sores at that time. Observation of wound care on 12/10/13 at 1:46 PM with LVN A and CNA M revealed Resident #9 was lying in bed awake and alert. Resident #9's right heel dressing was removed and revealed an open area approximately 1.0 cm X 0.8 cm. Wound care was given as ordered. A dressing was observed on Resident #9's right outer, lower leg, which was dated 12/08/13. When queried about the dressing, LVN A stated she knew nothing about it. LVN A removed the dressing and revealed an open wound with a moderate amount of beige drainage both within the wound and on the dressing. The wound edges were completely macerated and the wound bed could not be visualized. LVN A stated she did not know about the wound. She cleaned the wound with saline, measured the wound at 2.5 cm x 2.0 cm x 0.5 cm, and stated she was going to apply a clean, dry dressing and call the physician. During an interview on 12/11/13 at 8:15 AM, LVN D, Resident #9's usual 7:00 AM to 3:00 PM Charge Nurse, was asked about Resident #9's right leg wound. LVN D stated the wound started as a blister caused by a hard plastic ski-boot style brace she was wearing at the time. She stated Resident #9 was sent to the hospital related to blood pressure issues and, when she returned (on 08/28/13), it was an open wound. When asked about documentation, LVN D stated she documented wounds on Wednesdays and kept the information in a separate folder and she would provide the information. Resident #9's Admission Nursing assessment dated [DATE] reflected a diagram of a human body. There were circles drawn on the back of both heels and in the adjacent area under Comments was written.(L) heel soft eschar .(illegible) heel soft intact. Resident #9's Care Plan dated 09/24/13 reflected she had a decubitus ulcer on her right mid lower leg measuring 2.1 cm x 1.3 cm x 0.2 cm and was Stage II. Approaches included: Treatment (blank line) as ordered. Notify Dr. of ineffectiveness of treatment.Document wound appearance and notify Dr of S/SX of infection.Pressure relieving pillows to offload. The Care Plan was last updated on 12/05/13 and reflected the wound measured 1.8 cm x 0.5 cm x 0.1 cm and reflected Cont. tx per order. The MDS Coordinator signed the Care Plan. Another Care Plan dated 11/07/13 reflected she had a decubitus ulcer on her heel measuring 1.1 cm x 1.0 cm x 2 cm and was Stage II. Approaches included: Treatment (blank line) as ordered . The care plan was last updated on 12/11/13 and reflected: R heel 0.9 x 0.5 x 0.1 - slough, ? odor. In an interview on 12/11/13 at 4:30 PM, the MDS Coordinator stated she had initiated the Care Plans for Resident #9 ' s decubitus ulcers. When shown Resident #9's MDS assessment dated [DATE] and asked why it reflected no pressure sores, the MDS Coordinator replied, That's on me, I missed it. Interview with the DON on 12/12/13 at 10:02 AM revealed she checked the MDS assessments for accuracy and completion. The DON was shown Resident #9's MDS assessment dated [DATE] (she signed on 12/06/13) and asked why it did not reflect her wounds, she replied, I don't know. 2) Resident #3 was a [AGE] year-old female re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS assessment revealed she was severely impaired cognitively, was totally dependent on staff for her ADLs, she weighed 133 lbs, and had no weight loss. Resident #3's Yearly Weight Record for 2013 reflected the following: 10/01/13 - 133 lbs 10/06/13 - Hosp 10/21/13 - Hosp 10/22/13 - Hosp Return 128.2 lbs During an interview on 01/09/14 at 11:30 AM, when the Director of Dietary Services was shown Resident #3's admission MDS assessment dated [DATE] and her weight records. When asked why she documented Resident #3's weight on her MDS as 133 lbs when she weighed 128.2 upon her re-admission she stated she had 133 on her documentation for October. She had not seen the re-admission weight. 3) Resident #41 was a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS reflected she had severe cognitive impairment, was independent with eating, weighed 130 lbs and had no weight loss. A Communication Page regarding Resident #41, dated 11/26/13 and signed by Restorative BB, reflected it was addressed to the DON, ADON, Dietary, and Charge Nurse. The Note reflected: Wt-Loss Alert; 11/6-130.0 wt; 11/26-122.4-(down) 7.6 in 20 days. Not feeling very well after flu shot; refusing to eat. Resident #41's Dietary Progress Notes an entry dated 12/12/13 that reflected: Resident continues to receive NAS diet tol. well with no difficulty @ this X .wt @ 130 fairly stable x's 30 days .(Director of Dietary Services) will continue to monitor meal intake, nursing to monitor wt. & skin, will follow. The Director of Dietary Services signed the note. In an interview on 01/07/14 at 2:15 PM, the Director of Dietary Services confirmed she had received the communication form reflecting Resident #41's weight loss. The Director of Dietary Services also confirmed she completed the section of the MDS assessment that reflected her weight. When asked why she documented the resident weighed 130 lbs and had no weight loss, when she actually weighed 122 lbs the Director of Dietary Services replied, I must have looked at an old sheet. 4) Resident #40 was an [AGE] year-old female, was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed the resident's cognitive skills for daily decision-making were moderately impaired and she had a Physician-prescribed weight loss program. Review of Resident #40's admission physician orders [REDACTED]. Review of Resident #40's INITIAL CARE PLAN dated 11/05/13 revealed: PROBLEM: Nutritional Risk related to: Mech soft INITIAL CARE PLAN OUTCOME: Will maintain weight within two pounds of each month. NURSING INTERVENTION: Weigh wkly x 4 then per protocol. Diet as ordered: Report food intake of less than 75% of five meals in two days to R.D. for assessment. Offer fluids throughout shifts. On 01/07/14 at 2:30 PM the surveyor reviewed with the MDS Coordinator Resident #40's admission MDS assessment dated [DATE], which revealed, Physician-prescribed weight loss program. The MDS Coordinator stated, I don't know anything about her (Resident #40 being on a weight loss program. The MDS Coordinator further stated that was the Director of Dietary Services section (on the MDS) to complete. On 01/07/14 at 3:40 PM the surveyor reviewed with the Director of Dietary Services Resident #40's admission MDS assessment dated [DATE], which revealed, Physician-prescribed weight loss program. The Director of Dietary Services stated, That doesn't look like stuff I would put it, _____ (Name of MDS Coordinator) was putting in some stuff for me. 5) During another interview on 01/09/14 at 12:04 PM, the DON was shown the inaccuracies on the MDS assessment entries for Residents #3, #9, #40 and #41 and asked if she was reviewing them for accuracy before she signed them. The DON replied, Yes. She added she was going line by line now and so it was taking longer to complete them. 6) In another interview with the MDS Coordinator on 01/09/14 at 10:48 AM, revealed she had no policies related to MDS assessments and she referred to the MDS RAI Manual. 7) In another interview on 07/09/14, the MDS Coordinator provided the survey team with a policy titled, MDS Policy and Procedure dated 01/08/14 and stated it had been implemented. The policy reflected: Purpose: To maintain an accurate record of all residents that are occupants of this facility. To accurately reflect all aspects of care, problems and concerns for each resident. Policy: The assessment process will be monitored by an RN and MDS Coordinator assuring that all parts of the MDS is accurately completed, data input and transmittted to the state in the time allotted by state regulations. 8) The Form CMS-672, Resident Census and Conditions of Residents, dated 12/11/13 and signed by the MDS Coordinator, reflected the census was 75 residents.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 interview and record review, the facility failed to develop a comprehensive care plan, which included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being for 11 (Residents #2, #4, #9, #13, #16, #29, #35, #36, #37, #38 and #40) of 40 residents reviewed for care plans. 1) Resident #2 was admitted to the facility on [DATE] and there were no Care Plans initiated for this resident. 2) Resident #9 was re-admitted to the facility on [DATE] with existing pressure sores. a. She had no Care Plans initiated for the prevention of skin breakdown; b. The care plan for her existing wounds were not initiated until 09/09/13. c. Her Care Plans for Hypertension and Diabetes were initiated by the Director of Dietary Services and did not reflect the monitoring of her blood pressure or blood sugar levels. 3) Resident #13 had no

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) Care Plans to address her risk for developing pressure sores. She developed a Stage III pressure sore to her right thigh. 4) Resident #16 had no Care Plans to address her risk for developing pressure sores. She developed two large Stage II pressure sores on her buttocks. 5) Resident #4 was readmitted to the facilty on 09/02/13. a. She had no Care Plans to address her [DEVICE]. b. She had no Care Plans her incontinence of bladder and bowel. 6) Resident #40 had no Care Plans to address her pocketing foods. 7) The facility had an outbreak of diarrhea: a. The facility failed to initiate an acute Care Plan for Resident #29, who had new symptoms of diarrhea. b. The facility failed to initiate an acute Care Plan for Resdient #35, who had new symptoms of diarreha. c. The facility failed to initiate an acute Care Plan for Resident #36, who had new symptoms of diarrhea. d. The facility failed to initiate an acute Care Plan for Resident #37, who had new symptoms of diarrhea. e. The facility failed to initiate an acute Care Plan for Resident #38, who had new symptoms of diarrhea. These failures could affect the facility's 75 residents, including Residents #2, #4, #9, #13, #16, #29. #35, #36, #37, #38, #40 and placed them at risk for the potential of not being care planned according to the results of their comprehensive assessments and not receiving the necessary medical care and services needed. Findings included: 1) Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #2's cognitive skills for daily decision-making were moderately impaired. Resident #2 had an indwelling catheter and was always incontinent of bowel. Resident #2 required extensive assistance of one person for bed mobility, transfers, locomotion and was totally dependent of one person for dressing, eating, and toileting. During an interview on 01/07/14 at 4:00 PM, the MDS Coordinator stated she was unable to find any care plans for Resident #2. 2. Resident #9 was an [AGE] year-old female re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment reflected resident #9 had a BIMS score of 11, indicating she was moderately impaired cognitively. The MDS further reflected Resident #9 was at risk of developing pressure sores but had no pressure sores at that time and was not receiving pressure ulcer care. Resident #9's most recent Braden Scale dated 08/28/13 reflected a score of 12 indicating she was at high risk for developing pressure sores. Resident #9's Care Plan dated 09/19/13 reflected she was Total-Extensive dependence on staff for completion of ADLs related to debility. Approaches included: Monitor skin weekly and document. Notify physician of changes. Resident #9's Care Plan dated 09/24/13 reflected she had a decubitus ulcer on her right mid lower leg measuring 2.1 cm x 1.3 cm x 0.2 cm and was Stage II. Approaches included: Treatment (blank line) as ordered. Notify Dr. of ineffectiveness of treatment.Document wound appearance and notify Dr of S/SX of infection.Pressure relieving pillows to offload. The Care Plan was last updated on 12/05/13 and reflected the wound measured 1.8 cm x 0.5 cm x 0.1 cm and reflected Cont. tx per order. The Care Plan was signed by the MDS Coordinator. Another Care Plan dated 11/07/13 reflected she had a decubitus ulcer on her heel measuring 1.1 cm x 1.0 cm x 2 cm and was Stage II. Approaches included Treatment (blank line) as ordered . The care plan was last updated on 12/11/13 and reflected: R heel 0.9 x 0.5 x 0.1 - slough, ? odor. Resident #9's Admission Nursing assessment dated [DATE] reflected a diagram of a human body. There were circles drawn on the back of both heels and in the adjacent area under Comments was written .(L) heel soft eschar .(illegible) heel soft intact. In an interview on 12/11/13 at 4:30 PM, the MDS Coordinator was asked why there was no Care Plan for Resident #9's pressure sores prior to 09/24/13. The MDS Coordinator stated she was unaware of the wound prior to 09/24/13. When shown Resident #9's Admission Nursing Assessment and the skin assessment, the MDS Coordinator replied, That's on me, I missed it. Resident #9's care plan for Hypertension reflected: Problem Onset 07/05/13, (Resident #9) has potential for retaining abnormal body fluids R/T Hx. [MEDICAL CONDITION]& [MEDICAL CONDITION]. Approaches included: Diet as ordered by physician; Obtain monthly weights; Diet consult as needed. A handwritten entry next to the approaches reflected 09/20/13 Explained that [MEDICAL TREATMENT] her life line. Unable to drink fluids after [MEDICAL TREATMENT] as she would like. Resident #9 care plan for Diabetes reflected: (Resident #9 has potential for abnormal blood sugar levels R/T Hx. of Diabetes. Approaches included: Diet as ordered by physician; Monitor meal intake; Offer appropriate snacks according to physician orders; diet consult as needed. A handwritten entry next to the approaches reflected: 09/20/13-RP state hospital phys. Informed family to give her whatever she desires w/in reasons to eat. D/T end of life issues. During an interview on 12/12/13 at 9:50 AM, the MDS Coordinator was shown Resident #9's MDS assessment dated [DATE] and was asked why there were no pressure ulcers or care indicated on the assessment. The MDS Coordinator stated she did not know about them until 09/24/13. When reminded the date of the assessment was 11/29/13 and she just signed the assessment on 12/06/13, the MDS Coordinator replied, I missed that. The DON was shown Resident #9's MDS assessment dated [DATE] (she signed on 12/06/13) and asked why it did not reflect her wounds, she replied, I don't know. 3. Resident #13 was a [AGE] year-old female readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS assessment revealed she had severely impaired cognition and was totally dependent on staff for assistance with ADLs. The MDS reflected she was at risk for developing pressure sores but had none at the time of the assessment. Resident #13 ' s most recent Braden Scale dated 09/26/13 reflected a score of 14 indicating she was at moderate risk for developing pressure sores. Review of all available Care Plans for Resident #13 revealed she had no Care Plan related to the prevention of pressure sores. Resident #13's Care Plan dated 11/27/13 reflected she had a decubitus ulcer in her right thigh (ischium) measuring 1.2 cm x 0.7 cm x 0.1 cm and was a Stage III. 4) Resident #16 was a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment further reflected she was totally dependent on staff for all her activities of daily living, she could not communicate her needs, had severely impaired cognition, she was at risk for developing pressure sores but had none at the time of the assessment. Resident #16's last Braden Scale dated 02/09/13 reflected a score of 11 indicating she was High Risk for developing pressure sores. Review of all available Care Plans for Resident #16 revealed she had no Care Plan related to the prevention of pressure sores. Resident #16's Care Plan dated 11/27/13 reflected she had a Stage II Decubitus Ulcer on her left buttocks that measured 5.0 cm x 3.5 cm x 0.1 cm and one on her right buttock that measured 6.3 cm x 3.3 cm x 0.1 cm. Approaches included: Treatment: Collagen/duoderm as ordered. Notify Dr. of ineffectiveness of treatment. 5) Resident #4 was a [AGE] year-old male, readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #4 was severely impaired for cognitive skills for daily decision-making, had a feeding tube and was always incontinent of bowel and bladder. a. Review of Resident #4's readmission physician orders [REDACTED]. Review of all available care plans for Resident #4 revealed no Care Plan related to her [DEVICE]. During an interview on 01/07/14 at 2:30 PM the surveyor asked the MDS Coordinator stated Resident #4 should have had Care Plans related to her [DEVICE]. b. Review of all available care plans for Resdient #4 revealed no Care Plans related to the resident's incontinence. 6) Resident #40 was an [AGE] year-old female, was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed the resident's cognitive skills for daily decision-making were moderately impaired. This MDS assessment revealed Resident #40 required set up help only for meals. Resident #40 had no swallowing disorders and required a mechanically altered diet. Review of Resident #40's Nurse's Notes dated 11/09/13 on the day shift revealed the resident was pocketing her food and the nurse received an order for [REDACTED]. Resident #40, cont to pocket everything you put into her (Resident #40's) mouth. Don/ADON informed. Review of the Speech Therapist note dated 11/10/13 revealed, Reason For Referral: This [AGE] year old female presents to speech therapy with a recent decline in swallowing and cognitive abilities .Swallowing Lingual Function - moderate impairment (50-75% impairment; combination of oral and non-oral nutrition; requires thickened liquids, difficulty masticated foods) .Impact on Burden of Care/Daily Life - The patient requires mod to max cues of PO intake and ADL participation due to safety reasons . Review of Resident #40's Nurse's Noted dated 12/21/13 (day shift) revealed, .can't swallow medicine . Review of Resident #40's COMMUNICATION PAGE dated 12/23/13 revealed, _____ (name of Resident #40) - Refusing to eat - holding food + liquids in mouth! When swallowing liquids - she coughs and refuses to open mouth. (sign for no) signs of tearing or running nose this AM. Will not swallow medicine. Points to throat. Asked if she was having a hard time swallowing. She nods head yes and hold mouth shut. Tongue thick in mouth, sticks at roof of mouth. Also experiencing cognitive change. Coaching x 4 to swallow or participate (sign for with) therapy. Tongue coated (sign for with) food + meds. To: DON: MDS: ADON: Dietary: C Nurse. Restorative Aide BB signed this note. During an interview on 01/06/14 at 2:25 PM Restorative Aide BB stated she became aware Resident #40 was pocketing food on 12/23/13 and wrote a communication page, regarding the pocketing. Restorative Aide BB further stated she gave a copy of the communication page to the DON, ADON, Charge Nurse LVN F and to the Director of Dietary Services. Review of Resident #40's DIETARY PROGRESS NOTES dated 12/23/13 revealed, Resident (Resident #40) refusing to eat, pocketing food + liquids in mouth when swallowing resident coughs + refuses to open her mouth. No tearing or runny nose @ this x. Resident would not swallow medicine that AM. Resident will point @ throat. Resident was asked if se was having a hard time swallowing + she nodded her head yes + held her mouth shut. Resident also experiencing some cognitive change. Resident coached x's 4 to swallow or participate (sign for with) therapy. Tongue coated (sign for with) food. + meds. To continue to monitor closely, will follow resident to be placed on weekly weights. The Director of Dietary Services signed this note. Review of Resident #40's Nurse's Notes

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	676052	A. BUILDING _____ B. WING _____	01/11/2014

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IMMANUELS HEALTHCARE	4515 VILLAGE CREEK RD FORT WORTH, TX 76119

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 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) dated 12/23/13 (day shift) revealed Alert, pleasant assist to DR, unable to swallow pureed food well, does pocket food. Has to be spoon fed meal unable to complete task . During an interview on 01/06/14 at 10:50 AM the DON stated she was aware Resident #40 was pocketing food. The DON further stated the Speech Therapist told her Resident #40's pocketing was due to cognitive. I have been watching her (Resident #40) over the last week, not consistent (pocketing), mainly breakfast. The surveyor asked the DON if the physician had been notified of the resident pocketing and the DON stated, Yes, that's how speech therapy got notified. The surveyor asked the DON if pocketing triggered calling the Dietary Consultant and the DON stated, If the resident at less than 50%. During an interview on 01/07/14 at 2:30 PM, the MDS Coordinator stated she was feeding Resident #40, around Christmas time, and noticed the resident was pocketing her food (in her mouth). The MDS Coordinator stated she notified the Restorative Aide, who swept out the resident's mouth. The MDS Coordinator stated she did tell the resident's charge nurse, but did not remember who, and the charge nurse already knew about Resident #40s pocketing of food. She further stated this was the first time she (the MDS Coordinator) knew about the resident pocketing her food. When asked if she ever checked Resident #40's Care Plan to see if it had been updated, the MDS Coordinator replied, No, I did not. When asked why Resident #40's MDS assessment showed her to be on a physician prescribed weight loss program, the MDS Coordinator stated she did not know and added the Director of Dietary Serviced filled out that section of the assessment. When asked when she should have started a Care Plan related to the resident pocketing food, the MDS Coordinator said it should have been as soon as her diet changed. She stated that was a failure to communicate and she would have started one had she known. When asked how she typically found out information about the residents, she stated the staff should write her a communication sheet but that did not always happen. When shown Resident #40's communication page related to her pocketing food and asked if she ever received copies of them, the MDS Coordinator replied, Every now and then, sometimes, not always. When the MDS Coordinator was shown Resident #4's Care Plan related to Hypertension and asked why the emphasis was on [MEDICAL CONDITION], she explained the Director of Dietary services had initiated that care plan and initiated any care plan that was appropriate for her department and the MDS Coordinator initiated those related to nursing. When asked whether Hypertension was a nursing issue, the MDS Coordinator replied, Yes. When asked how she determined which Care Plans to initiate, she stated whatever was triggered on the MDS assessment. During an interview on 01/07/14 at 3:40 PM, the Director of Dietary Services stated she had been writing Care Plans for the past six or seven months. She stated she had a list of Care Plans on her computer and tried to individualize them to the residents. She looked at the resident's [DIAGNOSES REDACTED]. When the Director of Dietary Services was asked what training she had received relating to the initiation of Care Plans, she stated she had worked for (another company) and at the last nursing home, The DON trained me to write nursing care plans. When asked about acute Care Plans and given the example of Resident #40's pocketing of food, the DIrector of Dietary Services stated the nursing department should do one but she would do one as well. She stated she had generated Care Plans for Resident #40, which were still on her computer. She further stated these care plans remained on her computer until the next quarterly Care Plan meeting. Then she would print them and add them to any other care plans written by nursing. The following Care Plans were on the Director of Dietary Services computer, (not available to staff) requested by the surveyor. Related Diagnosis: [REDACTED]. Problem Onset: 11/12/2013 _____ (Resident #40) has potential for choking and aspiration R/T Hx. Of Swallowing Difficulty _____ (Resident #40) is at risk for aspiration/Weight loss D/T AMS/Occasional Pocketing of food w/o staff's ability to redirect On 1/03/2014 _____ (Resident #40) has Weight loss per weight committee (Weight: 163.6) Goal & Target Date _____ (Resident #40) will experience no S/S of choking or aspiration until next review date _____ (Resident #40) will be assisted with consumption therapeutic diet for needed caloric intake thru the next eval date Approaches Diet as ordered by physician Monitor for s/s of choking or aspiration Diet Consult as needed ST to screen, eval tx as indicated Spoonfed while queing (sic) to chew and swallow Remove any food she pockets before leaving Dining Rm. Report to Charge Nurses and Document % (meal eaten) Keep her in upright position during meals and at least 30 min post meals Document Meal % Notify Dr./RP of any changes in resident Notify Dr/RP of change in weight Document weigth (sic) Weight per facility's protocol Contact Family/RP for family conference Appt: [DATE] @1:30 pm. When shown examples of Care Plans for Resident #9, #40 and #4, the Director of Dietary Services confirmed she had initiated some of the Care Plans. She stated for Hypertension, she wrote about fluid issues and for Diabetes, I put the potential for abnormal blood sugar. When asked about Dementia concerns, the Director of Dietary Services said, I put weight loss. In another interview with the MDS Coordinator on 01/09/13 at 10:48 AM, when asked why there were no care plans for Residents #9, #13 and #16, she stated she was not sure. 7) a. Resident #29 was a [AGE] year-old female, readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #29 was always continent of her bowels. Review of Resident #29's physician orders [REDACTED]. ADON MM wrote this verbal telephone orderReview of all available Care Plans for Resident #29 revealed she had no Care Plan related to the new onset of diarrhea. b. Resident #35 was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #35 had a BIMS of three (severely impaired), was independent with toileting and was always continent of bowel and bladder. Review of Resident #35's physician orders [REDACTED]. ADON MM wrote this verbal telephone order. c. Resident #36 was a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #36 had a BIMS of 3 (severely impaired), required supervision for toileting and was occasionally incontinent of bowel. Review of Resident #36's physician orders [REDACTED]. ADON MM wrote this verbal telephone order.Review of all available Care Plans for Resident #35 revealed she had no Care Plan related to the new onset of diarrhea. Review of all available Care Plans for Resident #36 revealed she had no Care Plan related to the new onset of diarrhea. d. Resident #37 was a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS revealed Resident #37 was cognitively intact, was incontinent of bowel and bladder and required extensive assistance with toileting. Review of Resident #37's physician order [REDACTED]. Review of all available Care Plans for Resident #37 revealed she had no Care Plan related to the new onset of diarrhea. e. Resident #38 was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS revealed Resident #38 had severe cognitive impairment, was incontinent of bowel and was totally dependent on staff for assistance with toileting. Review of Resident #38's physician order [REDACTED]. Review of Resident #38's physician orders [REDACTED]. ADON MM wrote this verbal telephone order.Review of all available Care Plans for Resident #38 revealed she had no Care Plan related to the new onset of diarrhea. Interview with the DON on 12/12/13 at 10:02 AM revealed she checked the MDS assessments for accuracy and completion. When asked if she ever reviewed the resident's Care Plans, the DON replied, No. When asked who did, the DON stated the MDS Coordinator and the Administrator reviewed them. She identified the MDS Coordinator as solely responsible for generating and writing the Care Plans and identified her as the only nursing representative to attend the resident's Care Plan meetings. In an interview on 01/06/14 at 8:45 AM, when the MDS Coordinator was asked if any care plans had been initiated related to the outbreak of diarrhea and vomiting, she stated there were none. When asked who initiated acute care plans, the MDS Coordinator replied, If they give me paperwork, I will. 8) When The MDS Coordinator was asked for any policies related to Care Planning, she stated she was unable to find any. 9) The Form CMS-672, Resident Census and Conditions of Residents, dated 12/11/13 and signed by the MDS Coordinator, reflected the census was 75 residents.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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, it was determined the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being for two (Residents #1, #3, #5 and #6) of 19 residents reviewed for quality of care. 1) The facility failed to medicate Resident #3 when he was observed in pain. The resident continued to complain of pain every two hours for two shifts. 2) LVN D twice failed to administer the correct dose of pain medication to Resident #1 when she repeatedly complained of leg pain. LVN D administered one [MEDICATION NAME] 5/325 mg tablet when the ordered dose was two 10/325 mg tablets. 3) Resident #5 received nine doses of [MEDICATION NAME] between 10:00 pm and 11:30 PM (from 03/04/14 to 03/21/14), despite her physician's specific orders that she was not to have the medication at bedtime. No pain assessments were documented and the physician was not notified. 4) Resident #6 received 22 doses of pain medication between 02/04/14 and 03/03/14 with no pre and/or post pain assessments documented. An Immediate

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F 0309

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 7)

Jeopardy (IJ) was initially identified on 03/20/14. While the IJ was removed on03/24/14, the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy, because not all staff had been trained and the facility was still monitoring the Plan of Removal. Failure to intervene appropriately when a resident complains of pain, administer pain medications as ordered by the physician and assess the effects of those medications could affect any of the 50 residents who were assigned to LVNs D, F, O, P, and T and placed them at risk for unrelieved pain, over sedation and poor quality of life. Findings included: 1) Resident #3 was a [AGE] year-old male who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #3's cognitive skills for daily decision-making were moderately impaired, decisions poor and required total dependence of staff for his ADLs. This MDS assessment revealed Resident #3 was on scheduled pain medications and required PRN pain medication. Resident #3 had indicators of pain or possible pain observed in one or two days. Review of Resident #3's Care Plan dated 03/20/14 revealed: PROBLEM - (Resident #3) expresses pain of joints on movement/personal care RESIDENT GOAL - (Resident #3)
will be assessed for pain w/routine med pass this eval period APPROACH PLAN 1. Pain meds per physician orders [REDACTED]. 2. Monitor for adverse reaction and effectiveness. 3. Therapy to eval and tx as indicated. 4. Encourage resident to make frequent changes in position. 5. Notify physician/Family of any/all changes. 6. Monitor for causes of increased pain (ie: activity, temperature). -Ask/assess for pain or discomfort w/routine med pass. Review of Resident #3's physician progress notes [REDACTED].Pt indicating having increased back pain . Review of Resident #3's consolidated physician orders [REDACTED]. - [MEDICATION NAME] ([MEDICATION NAME]) Patch 50 mcg topically every 72 hours - [MEDICATION NAME] 10 ml every
eight hours per [DEVICE] - [MEDICATION NAME] ml every four hours as needed per [DEVICE] for pain. Review of Resident #3's MARs dated March 2014 revealed the [MEDICATION NAME] Patch 50 mcg was initialed as administered on 03/15/14. Further review
of this MAR revealed the [MEDICATION NAME] Patch 50 mcg patch was not initialed as administered on 03/18/14. During an observation on 03/20/14 at 4:55 PM, Resident #3 was observed in bed and CNA G was at his bedside. This surveyor was accompanied by the Unit Manager and MDS nurse. When Resident #3 was asked for permission to perform a skin check to ensure he was wearing only one [MEDICATION NAME], he nodded indicating it was. As the skin check proceeded, Resident #3 was observed to be grimacing and wincing with movement. When asked by CNA G if he was in pain, Resident #3 blinked his eyes rapidly and nodded his head. When CNA G told him she would tell his charge nurse, he nodded in agreement. Only one, undated [MEDICATION NAME] was observed on Resident #3's left chest. Review of Resident #3's Nurse's Notes dated 03/20/14 at 5:00 PM revealed, [DEVICE] infusing well (with) no difficulty patent, (and) intact. Routine meds administered. HOB (up). Abdomen soft non-distended. LVN J signed this note. Review of Resident #3's [MEDICATION NAME] Patch Usage & Disposal Record revealed a [MEDICATION NAME] Patch 50 mcg Patch was applied to Resident #3 on 03/20/14 at 6:00 PM. The Unit Manager signed
that she applied the patch. This patch was applied after it was verified by the Unit Manager that the [MEDICATION NAME] scheduled to be applied on 03/18/14 was not applied. She stated the [MEDICATION NAME] last applied was on 03/15/14. Review of Resident #3's [MEDICATION NAME] Narcotic sheet dated 03/20/14 and 03/21/14 revealed the medication was given at the following times: - 03/20/14 at 2:15 AM - PRN dose - 03/20/14 at 6:15 AM - scheduled dose - 03/20/14 at 2:00 PM - scheduled dose - 03/21/14 at 2:00 AM - PRN dose -03/21/14 at 6:00 AM - scheduled dose . Record review of Resident #3's MAR dated 03/20/14 revealed a scheduled dose of [MEDICATION NAME] was signed as administered at 10:00 PM. During an interview on 03/21/14 at 5:05 PM, CNA G was reminded of the observation with Resident #3 and asked if she had reported his pain to anyone. CNA G stated she reported Resident #3's pain to LVN B immediately after leaving his room. A telephone interview on 03/23/14 at 3:25 PM LVN B stated she was Resident #3's charge nurse on 03/20/14 from 3-7:30 PM. She stated LVN J came in at 6:00 PM to replace her. LVN J stated CNA G did tell her Resident #3 was in pain approximately 6:00 PM. She further stated she was passing medications via a [DEVICE] at the time to another resident and she told LVN J Resident #3 was in pain. An interview on 03/22/14 at 4:25 PM CNA G stated she was Resident #3's CNA on 03/20/14 on the3-11 PM and the 11 P-7AM shifts. The surveyor asked CNA G how Resident #3 was on her shift. CNA G stated, He (Resident #3) complained of pain every two hours. He is not typically like that. She stated she told LVN J (6-11 PM nurse) that Resident #3 was in pain and LVN J said, Ok. CNA G stated she told RN M (11 PM -7 AM nurse) that Resident #3 was in pain. The surveyor told CNA G that Resident #3 that Resident #3 did not get any PRN pain medication on 3-11 PM shift and CNA G stated, No wonder he was hollering. He has never asked me for pain medicaiton so many times. I asked him (Resident #3) if he was in pain, he said yes. I told the nurse every time. CNA G further stated she did not tell nursing management. Review of Resident #3's Nurse's Notes dated 03/20/14 at 9:00 PM revealed, Routine PRN med administered via G tube. No s/s of distress. Respirations even (and) unlabored. SR (up) x 2. Call light in reach. Reposition for comfort. Incontinent care provided. [MEDICATION NAME] 1.5 infusing well @ 55 cc/hr. LVN J signed this note. An interview on 03/23/14 at 3:25 PM LVN B stated she was Resident #3's charge nurse on 03/20/14 from 3 - 7:30 PM. She stated LVN J came in at 6:00 PM to replace her. LVN J stated CNA G did tell her Resident #3 was in pain approximately 6:00 PM. She further stated she was passing medications via a [DEVICE] at the time to another resident and she told LVN J Resident #3 was in pain. An interview on 03/21/14 at 3:50 PM LVN J stated she came to work approximately 6:00 PM on 03/20/14 to cover for LVN B, who was leaving her shift early. She stated LVN B was Resident #3's charge nurse. The surveyor showed LVN J her Nurse's Note on 03/20/14 at 5:00 PM for Resident #3 and asked her if she started her shift at 6:00 PM why she had an entry for 5:00 PM. LVN J stated, Don't we have an hour either way? LVN J stated LVN B told her she had passed all of her [DEVICE] medications (Resident #3 had a [DEVICE]) so she LVN J began passing medications to the residents to other residents, when she started at 6 PM. The surveyor asked LVN J if she was notified by CNA G Resident #3 was in pain and she stated she was not. 2) Review of Resident #1's Physician's Telephone Orders dated 02/26/14 revealed she was to be readmitted to the facility with [DIAGNOSES REDACTED]. Review of Resident #1's admission Nurse's Note dated 02/26/14 at 2:20 PM revealed she was confused but able to make her needs known at that time. Review of Resident #1's Comprehensive Plan of Care dated 03/06/14 revealed she complained of increased pain/discomfort due to leg and generalized pain. Approaches included: 1) Monitor for s/s of increased pain/discomfort-assess resident for possible causes give meds, tx.s, physical and relaxation modalities, etc-assess for relief. Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: [MEDICATION NAME] 10/325 mg one tablet every six hours as needed for pain. [MEDICATION NAME]
10/325 mg two tablets every six hours as needed for pain. [MEDICATION NAME] 50 mg every 12 hours as needed for pain. Resident #1's Pain assessment dated [DATE] reflected she had no pain. Review of Resident #1's MAR for February 2014 revealed: An entry for [MEDICATION NAME]-Apap 10-325 two tablets every six hours as needed for pain. The entry was initialed as administered on 02/26/14 at 3:00 PM and 9:00 PM by LVN D. An entry for [MEDICATION NAME] 50 mg every 12 hours
as needed for pain. The entry was initialed as administered on 02/26/14 at 8:00 PM by LVN D. The back of the MAR reflected the following entries: 2/26/14 at 3:00 PM: Resident c/o pain, pain level 8/10, [MEDICATION NAME] ([MEDICATION NAME]) 5/325
admin, pain level at 3:30 PM 6/10. The entry was signed by LVN D. 02/26/14 at 8:00 PM: Resident c/o pain 8/10, [MEDICATION NAME] 50 mg admin, pain level after 30 mins, 7/10. The entry was signed by LVN D. 2/26/14 at 9:00 PM: Resident c/o pain, telling, 8/10, [MEDICATION NAME] 5/325 mg admin, pain level @ 9:30(PM), 7/10, ineffective. The entry was signed by LVN D. Review of Resident #1's nurse's noted for 02/26/14 revealed LVN D made no entries related to Resident #1's pain. During an interview on 03/05/14 at 12:45 PM, LVN D explained she was Resident #1's Charge Nurse on 02/26/14 but LVN C was completing the admission orders Kept complaining of pain, her (Resident #1) legs were hurting and she wanted pain medication. I medicated her with [MEDICATION NAME] 5/325 mg at 4:00 PM. An hour later she was still complaining of pain. Every time I passed her room, she was yelling in pain. She told the CNAs to tell me. The CNAs told me she was hurting. She kept yelling throughout my shift. She (Resident #1) said, Her legs were hurting real bad. When asked why she only administered 5/325 mg when the order and MAR both indicated the dose was two 10/325 tablets, LVN D stated she had seen the dose on the MAR but when she went to the medication cart, her old card was still on the cart (from prior to her hospitalization) and so she just administered that. When asked why she did not question the dosage on the card as it conflicted with the MAR or check the orders in the chart, LVN D stated, I didn't think her (Resident #1) pain was legitimate. She is mean all the time. It never occurred to me she was in so much pain. I didn't touch the orders, I just gave her what she had in the cart. When LVN D was reminded this resident had just returned from spending over a month in the hospital due to a wound on her leg, LVN D hesitated then stated, I didn't think she was in pain. An Interview with Resident #1 on 03/05/14 at 2:30 PM with Resident #1 revealed she could not remember having pain the day she was admitted and her current pain management was effective. During an interview on 03/05/14 at 2:47 PM, the DON was shown Resident #1's MARs and told about the medication error regarding the [MEDICATION NAME]. The DON stated she was not aware of the error and that it should not have happened. She confirmed [MEDICATION NAME] 10/325 mg tablets were kept in the E-kit and LVN D could have easily retrieved the proper dose. When asked how Resident #1's pain should have been handled, the DON stated if a resident complains of pain, they should be

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F 0309

Level of harm - Immediate jeopardy

Residents Affected - Some

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assessed and a pain level ascertained. She stated the resident should be medicated if indicated and re-assessed in 30-45 minutes for relief. The DON stated, if the medication was not effective and another medication could not be given, the physician should be called and made aware of all the details surrounding the situation. An observation on 03/05/14 at 3:28 PM revealed [MEDICATION NAME] 10/325 tablets were stocked in the medication room E-kit at Resident #1's nurse's station. 3) Resident #5 was an [AGE] year-old female re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS assessment revealed she had no cognitive impairment; was receiving scheduled and PRN pain medications, and she reported she had occasional pain rated 4 out of 10 on a 1-10 scale with10 being most severe. Review of Resident #5's Comprehensive Resident Care Plan dated 11/7/13 and reviewed 01/30/14 revealed the following: PROBLEM: Pain management for Spinal Stenosis, Muscle Spasms Arthropathy and Late Effect [MEDICAL CONDITION] GOAL: (Resident #5) will be at her comfort level within 30 mins of discomfort this eval period. APPROACHES: 1. Assess for pain/discomfort and document 2. Medication per order . [MEDICATION NAME] (routine & PRN) 3. Document/Notify physician of effects of meds. 4. Will be assessed/asked if in pain/discomfort @ time of Routine Med Pass Q shift . Review of Resident #5's physician's Progress Note dated 03/05/14 revealed she had a past medical history of [REDACTED]. The assessment/plan portion of the note reflected: .DJD-on [MEDICATION NAME]/[MEDICATION NAME] (pain medication) . Resident #5's Physician's Telephone Orders dated 02/24/14 reflected: N/O's 1) D/C [MEDICATION NAME] (sleeping pill) 1 mg PO PRN 2) Add [MEDICATION NAME] 1 mg tab (1) PO q HS Dx: [MEDICAL CONDITION] 3) [MEDICATION NAME] 7.5/325 Give (1) PO BID @ 9A & 6 PM. 4) [MEDICATION NAME] 7.5/325 Give (1) PRN tab in the daytime not at H.S. Q6(hours) The order was written by LVN F. Resident #5's Physician's Telephone Orders dated 03/05/14 reflected: Order clarification for Med time change for: ([MEDICATION NAME]) pregabalin 75 mg give 1 cap po BID @ 10:00 AM and 10:00 PM . Review of Resident #5's MAR for the month of March 2014 revealed: An entry for [MEDICATION NAME] 7.5/325 mg 1 PO BID at 10 AM and 6 PM An entry for [MEDICATION NAME] 7.5/325 mg 1 PO Q 6 HRS PRN PAIN Give in daytime only NOT HS. The MAR revealed only three PRN doses were signed as administered and those were given in the afternoon hours with pain assessments completed by LVN L. Review of Resident #5's Controlled Substance Record for [MEDICATION NAME] 7.5/325 mg revealed the following doses were signed out in the evening hours: 03/04/14 at 11:30 PM by LVN F 03/11/14 at 11:00 PM by LVN F 03/12/14 at 10:00 PM by LVN F 03/13/14 at 10:00 PM by LVN F 03/14/14 at 10:00 PM by LVN F 03/17/14 at 11:00 PM by LVN F 03/18/14 at 11:00 PM by LVN F 03/19/14 at 11:30 PM by LVN F 03/21/14 at 11:00 PM by LVN F Review of Resident #5 ' s Nurse ' s Notes revealed the following: An undated, untimed entry made by LVN F reflected the following: Physician R called (with) request to (change) resident [MEDICATION NAME] 7.5/325 to TID @ (sic) she takes it PRN like a routine @ HS. Physician R declined & stated to continue [MEDICATION NAME] 7.5/325 BID 9A & 6P & Give [MEDICATION NAME] 7.5/325 PRN in the daytime not @ HS Q6 (hours). 1) D/C [MEDICATION NAME] 1 mg PO PRN 2) Add [MEDICATION NAME] 1 mg tab PO q HS. Dx. [MEDICAL CONDITION]. Notified_____ RP. OK. Further review of the Nurse's Notes for February and March 2014 revealed there were no entries related to Resident #5 complaining of pain or requesting medication. Review of Resident #5's Weekly Summary dated 03/05/14-03/11/14 revealed she had vocal complaints of moderate pain rated 6 out of 10. Primary Diagnosis(es) included: DM II, Debility, [MEDICAL CONDITION], Chronic Back Pain. The Summary was completed by LVN F. Review of Resident #5's Weekly Summary dated 03/12/14-03/(illegible)/14 revealed she had occasional pain rated 6 out of 10. Primary Diagnosis(es) included: DM II, Debility, PKD (sic), Chronic Back Pain. The summary was completed by LVN F. During an interview on 03/23/14 at 10:45 AM, LVN L, (Resident #5's weekend Charge Nurse) was asked about pain management. He stated if a resident complained of pain, he would administer a pain pill then monitor for effectiveness, if not effective, the doctor should be called. LVN L stated the pre and post pain assessments were documented on the MAR. When asked about Resident #5's pain, LVN L explained she used to get a PRN dose at night but the order changed, He explained she would ask for it every night but when he saw the order changed so she could not have it at night anymore, he took the order to her and sowed it to her. He stated he offered to call the physician for her and she told him not to. She told him she wanted to talk to the doctor herself. LVN L stated, since that time, she had not requested pain medication from him at night any longer. During an interview on 03/23/14 at 1:15 PM, LVN F (Resident #5 ' s 3:00 PM - 11:00 PM Charge Nurse) stated all PRN pain assessments should be documented on the back of the MAR and logged on the Narcotic Sheet. When she was asked about Resident #5's pain management, she stated, .(Resident #5) hurts all the time, she begs for pain pills at night. I called (Physician R), she was getting it ([MEDICATION NAME]) at night. She would be asking as soon as I walked in and again at 10:00 (PM). She was still complaining so I said I'll see if I can have an order for [REDACTED]. her to have it TID, she said she could have it PRN in the daytime not at bedtime. LVN F confirmed that was when she had written the order on 02/24/14. LVN F stated she had also spoken with Physician R when she came in and had encouraged Resident #5 to speak with her as well. She stated the physician did not change her mind and still did not want the resident to have [MEDICATION NAME] at night. LVN F stated Resident #5 continued to ask for a dose at bedtime and she gave it to her. When asked if she called the Physician first, LVN F replied, No, I didn't think it was a good order. When shown the routing sleeping pill order and asked if that was maybe why the physician did not want her to have the medication, LVN F replied, She's been taking it for a long time. When LVN F was again asked if it occurred to her to call the physician all those nights the resident was complaining and ask what she should do, she replied, No, because it's (Physician R) and her response is not that good .with call back, it's not that good. A surveyor asked LVN F if she realized she could not give that dose. LVN F replied, Yeah, I realize that. I shouldn't give her a pill that late. When LVN F was asked if she ever signed the medication out on the MAR, documented any pain assessments during these episodes or made any nursing notes on the matter, she reviewed the documentation and replied, I guess not. On 3/23/14 at 3:20 PM, Resident #5 was observed sitting in her room, watching television. At that time, when Resident #5 was asked about her pain management by the facility she stated it was OK. When asked whether she had pain at night, Resident #5 replied, Sometimes it hurts in my back, sometimes not. When asked whether she was getting pain medication at night, Resident #5 stated she did occasionally and it sometimes helped. When asked whether she had spoken with her doctor about the pain, Resident #5 stated she had and was told there was nothing they could do. When asked who gave her pain medication at night, Resident #5 stated, Whatever nurse is on. 4) Resident #6 was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS assessment revealed he had clear speech, no cognitive impairment, was totally dependent on staff for his activities of daily living, was receiving PRN pain medication but denied pain at the time of the assessment. Review of Resident #6's Comprehensive Resident Care Plan dated 08/15/13 and reviewed 01/30/14 revealed the following: PROBLEM: Pain management for Contractures R/T Late [MEDICAL CONDITION]/ [MEDICAL CONDITION] GOAL: (Resident #6) will be free of pain or discomfort/at his comfort level within 30 mins of c/o pain or discomfort thru this eval period. APPROACHES: 1. Medication per order [MEDICATION NAME], Tylenol PRN [MEDICATION NAME] routinely (routine & PRN) 2. Document/Notify Dr. effect of medication. 3. Assess/Document pain level freq and tolerance . Review of Resident #6 's physician ' s Progress Note dated 03/05/14 revealed he .c/o pain back/knee-start scheduled [MEDICATION NAME] & cont. PRN as well . Resident #6's Physician's Telephone Orders dated 03/05/14 reflected: [MEDICATION NAME] 10/325 1 po BID. Review of Resident #6's MAR for the month of February 2014 revealed: An entry for [MEDICATION NAME] 5/325 mg 1 TAB PO Q 6 HRS PRN MODERATE OT SEVERE PAIN An entry for [MEDICATION NAME] 5/325 mg 2 TABS PO Q 6 HRS PRN MODERATE TO SEVERE PAIN Review of Resident #6's active clinical record, controlled drug record (CDR) and MAR (the document identified by the DON as the location of resident PRN pain pre and post- assessments) for 02/04/14 through 03/03/14 revealed [MEDICATION NAME] 5/325 mg tablets were signed out as administered on the CDR and without documented pre and post pain assessments for the following dates and times: 02/04/14 at 04:00 PM by LVN F 02/05/14 at 04:00 PM by LVN F 02/06/14 at 02:30 PM by LVN O 02/06/14 at 04:00 PM by LVN F 02/06/14 at 08:00 PM by LVN F 02/07/14 at 04:00 PM by LVN F 02/10/14 at 09:00 AM by LVN O 02/11/14 at 04:00 PM by LVN F 02/12/14 at 04:00 PM by LVN F 02/13/14 at 04:00 PM by LVN O 02/13/14 at 04:00 PM by LVN F 02/13/14 at 10:00 PM by LVN F 02/17/14 at 09:00 AM by LVN T 02/17/14 at 04:00 PM by LVN F 02/18/14 at 04:00 PM by LVN F 02/18/14 at 10:00 PM by LVN F 02/19/14 at 04:00 PM by LVN F 02/20/14 at 08:00 PM by LVN F 02/24/14 at 06:00 PM by LVN F 02/24/14 at 04:00 PM by LVN F 02/28/14 at 09:00 AM by LVN T 03/03/14 at 10:00 AM by LVN T During an interview on 03/22/14 at 1:50 PM, Resident #6 stated, I have a lot of pain. Resident #6 stated his pain was .sometimes in his knees, sometimes all over. Resident #6 stated his pain comes and goes and medication usually helped, but not always that good. During an interview on 03/23/14 at 1:15 PM, LVN F was asked about Resident #6's pain. LVN F stated Resident #6 had chronic pain and asked for medication around the clock. She stated sometimes he would complain he did not get his pain medication when he did get it. LVN F stated most of the time he complained of pain in his legs and if you move him, he'll start screaming When asked if she had ever contacted the physician about Resident #6's around the clock pain medication, LVN F stated, (Physician U) was aware of it, I suppose I could have called. NOTE: Physician U stopped working for the facility on 12/31/14 and was not Resident #6's physician. When asked if she know why she did not sign the medication out on the MAR, LVN F replied, No. When LVN F was asked how anyone would know whether he was getting any relief,

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 9) LVN F stated she thought he was. She stated sometimes he would ask for two pills but she would not give it to him because she thought it would over-sedate him. She stated she had taken care of him when he had been given two tablets and he did not want to get up for dinner. When asked whether she had documented that or shared that with anyone, she stated she had not. During an interview on 03/24/14 at 9:58 AM, LVN O was shown Resident #3's MARs and CDRs and asked about his pain assessments. LVN O acknowledged she had failed to document them and stated she should have flipped the MAR and documented his pain before and after medicating him. 5) Review of an undated Medication Pass In-service from an RN/LVN Orientation Book located at the Nurse's Station revealed the following: Steps to take during the med pass:. 16. Before administering the medication, always check 'The 6 R's' 17. Triple check medications vs. MAR before administering the medications. 18. If any of the 6 R's do not match or if you have any questions about the medication itself DO NOT GIVE THE MEDICATION! Check the chart or call the pharmacy with your concern. The pharmacist would rather you ask a question than a mistake be made. DURING THE MEDICATION PASS: 'THE 6 Rs' Before administering any medication, always check the 6 Rs, The right resident. The right drug: verify each drug against the medication administration record (MAR) before administering. The right dose: verify against the MAR . The right time: administer drugs as instructed on the MAR and within the time frame established by your facility. CHECKPOINTS.Related issues.Make sure discontinued medications have been removed from the cart as soon as they have been discontinued. Review of the facility's Pain Policy and Procedure dated 09/24/12 revealed the following: Purpose: Resident's pain will be managed at a level that is acceptable to that resident. Policy: 1. A resident will be assessed on admission for pain (location, duration, onset, alleviating/aggravating factors) a. If pain is present it will be assessed for its characteristics.5. Resident will be assessed with [REDACTED]. 6. A pain of any level unacceptable to the resident requires further assessment and follow up. Procedure: 1. Nurses will assess, monitor, anf follow-up on reported verbal, physical, and/or nonverbal signs and symptoms of pain or discomfort . 5. Review pain management care plan and implement. 6. Update care plan as often as necessary to maintain efficiency. 7. Determine the resident ' s preference for managing pain. 8. Nurse will assess and determine medication history and its effectiveness. 9. Nurse will review pain medicine ordered and its effectiveness to reduce pain to an acceptable level for the resident. 10. Nurse will reassess resident's perception of pain within 1 hour of any intervention and document. 11. Follow up with MD if resident receives no noted relief to perceived pain, for further orders . 13. Document findings in resident's chart. 14. Communicate pain status if any and interventions used during shift report and 24 (hour) report. 6) An Immediate Jeopardy situation was identified on 03/20/14. On 03/20/14 at 11:30 AM, the Administrator was notified of the IJ, and a Plan of Removal for the IJ was requested. 7) The facility's Plan of Removal was accepted on 03/23/14 at 9:00 AM and contained the following: On March 20th, the Department of Human Services informed this Administrator that Immanuel's HealthCare had been placed in an Immediate Jeopardy due to the failure to adequately assessing a resident for pain. THE FOLLOWING STEPS HAVE BEEN TAKEN TO REMOVE THE IMMEDIATE JEOPARDY: On March 20th This Administrator contacted the Medical Director and informed him. March 21st: DON or Nurse Manager {Unit Manager) will in-service the licensed staff on the rights of the Medication Administration. This in-service will be completed by the end or business on March 22nd, Prior to March 20th (March 6th) Administrator counseled with DON, Nurse Manager and Weekend Supervisor on promptly and efficiently reviewing all initial nursing assessments. Prior to March 20th The attending nurse for Resident #1 had been suspended in early March and has not worked at the facility since. On March 20th Unit Manager and MDS Coordinator began in-servicing/testing the licensed nursing staff on pain management. This in-service will be completed by the close of business Saturday March 22nd. On March 20th Also, Unit Manager, and MDS Coordinator completed an in-house Wong Baker pain assessment on all residents. This assessment included asking the cognitive residents about their pain regiment's effectiveness. This effort was to re-visit and ensure that all residents experiencing pain had an effective pain regiment in place. Prior to March 20th (March 10th) DON in-serviced/ tested the licensed Nursing staff on the new pain management policy. This policy included assessing daily q shift for pain. On March 21st, DON will repeat the new pain policy in-service/testing. This policy includes assessing daily q shift for pain. This in-service will be completed by the close of business on Saturday March 22nd. (SEE POLICY ATTACHED) On March 21st In addition to the pain assessments included in the initial nursing assessment package, and the MDS's Assessments, the review of pain will be added to the daily clinical review for the next 6 months. On March 21st, Director of Nursing and Nursing Manager will meet at the end of EACH day in the Administrator ' s Office to present PROOF that orders, initial assessments .items from daily nursing round sheet are indeed completed. EACH MONDAY the Weekend Supervisor will meet the Administrator to provide the proof of completed task from the weekend. This meeting will continue through 2014. On the days that I am not in the building the proof will be provided to the CEO. (See copy of the daily nursing round sheet) On March 21st The pain management initiative will be added to the monthly Q. A. agenda with Medical Director for the remainder of 2014. On March 21st all new hires, staff on vacation, out ill .etc. will not be allowed back to work prior to completing all of the above in-services/trainings. On March 22nd, Director of Nursing began in-servicing/testing licensed nursing on the 5 rights of medication administration. This will be completed by March 24th. 8) The following staff were interviewed following their attendance at the facility in-services: LVN J on 03/23/14 at 9:20 AM RN M on 03/23/14 at 10:00 AM LVN L on 03/23/14 at 10:45 AM LVN H on 03/23/14 at 12:05 PM LVN E on 03/23/14 at 12:30 PM LVN I on 03/23/14 at 2:45 PM LVN O on 03/24/14 at 12:30 PM LVN K on 03/24/14 at 12:45 PM LVN Q on 03/24/14 at 3:30 PM When interviewed, staff verbalized learning how often to do pain assessments, what to do when another staff member told them one of their residents was complaining of pain, how to complete pre and post pain assessments and correct documentation after administering a PRN pain medication. The following MA was interviewed following their attendance at the facility in-services: MA N on 03/23/14 at 12:40 PM. When interviewed, MA N verbalized understanding he should always report any resident complaints to the Charge Nurse immediately. He stated the Charge Nurse was responsible for assessing the resident ' s pain before and after medications were given. 9) On 03/24/14 at 10:26 AM, when the DON was asked how she thought the IJ occurred she stated: Regarding Resident #3 missing a [MEDICATION NAME], the nurse was new and she thought she was struggling. The DON stated the next day, the Unit Manager was unable to check MARs because she had to work the floor (take a nurse assignment) and the daily rounds were not done. The DON stated that nurse had since cut her hours and she has had to assist her on her shift. The DON stated she could not explain LVN P other than to say she was a new nurse in the facility and had to work a split hall, which meant working out of different carts, which was difficult. Resident #5 received [MEDICATION NAME] at HS, when it was not ordered she stated, I
F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received the necessary treatment and services to promote healing and prevent new pressure ulcers from developing for six (Residents #8, #9, #11, #12, #13 and #16) of 16 residents reviewed for pressure ulcers. 1) Resident #9 was re-admitted to the facility on [DATE] with a pressure ulcer on her right outer leg. The staff failed to: A) Provide accurate and timely skin assessments; B) Ensure complete and accurate descriptions of pressure ulcers for continued monitoring; C) Ensure there were physician orders [REDACTED]. D) Notify the physician promptly for treatment orders; and E) Ensure care plans were initiated and carried out. 2) Resident #11 was identified with skin breakdown during a weekly head to toe skin assessment on 10/05/13, but there were no treatment orders until 10/16/13. The facility further failed to: A) Ensure the physician was notified promptly for treatment orders; B) Ensure there were physician orders [REDACTED]. C) Ensure complete and accurate descriptions of pressure ulcer for continued monitoring; D) Ensure care plans were developed timely and carried out; E) Ensure skin assessments were conducted regularly and F) Ensure weekly nursing assessments were completed correctly. 3) Resident #16 developed two Stage II pressure ulcers on her buttocks, which deteriorated to Stage III. The Wound Care Physician changed her treatment order, which the facility failed to implement. 4) Resident #13 was identified with a reddened area on her buttock on 11/21/13. The staff failed to: A) Ensure the Dietician's recommendations were implemented; B) Ensure complete and accurate skin assessments and descriptions were obtained; C) Ensure treatments were not conducted without a physician's orders [REDACTED]. D) Notify the physician promptly for treatment orders; and E) Ensure physician-ordered treatments were implemented. 5) Resident #8 was readmitted to the facility with pressure ulcers to both her great toes and the facility failed to: A) Provide accurate and timely skin assessments; B) Ensure complete and accurate descriptions of the pressure

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F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 10) ulcers for continued monitoring; C) Ensure treatments were not conducted without a physician's orders [REDACTED]. D) Notify the physician promptly for treatment orders; and E) Ensure care plans were initiated and carried out. 6) Resident #12 had a pressure area on her right lateral foot and the facility failed to: A) Provide accurate skin assessments; B) Ensure complete and accurate descriptions of the pressure ulcers for continued monitoring; C) Ensure physician-ordered treatments were implemented in a timely manner. D) Ensure LVN G conducted a thorough head to toe assessment. An Immediate Jeopardy (IJ) was identified on 12/12/13. While the IJ was removed on 01/11/14, the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy, because not all staff had been trained and the facility was still monitoring the Plan of Removal. These failures to accurately assess/stage pressure ulcers, consult with the residents' physicians and provide treatments as ordered could affect the facility's 72 residents identified receiving preventive skin care, including Residents #8, #9, #11, #12, #13 and #16, which placed them at risk for further deterioration of existing pressure ulcers and the development of new pressure ulcers, which could result in increased healing time, infection,[MEDICAL CONDITION], discomfort, pain, and the potential need for hospitalization . Findings included: 1) Resident #9's MDS assessment dated [DATE] reflected she was an [AGE] year-old female re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment reflected Resident #9 had a BIMS score of 11, indicating she was moderately impaired cognitively. She was totally dependent on staff for bed mobility, transfers and hygiene and required extensive assistance for dressing. The MDS assessment further reflected Resident #9 was at risk for developing pressure ulcers but had no pressure ulcers at that time. Resident #9's most recent Braden Scale assessment for pressure ulcers was dated 08/28/13 and reflected a score of 12, which indicated she was at high risk for developing pressure ulcers. Resident #9's Admission Nursing assessment dated [DATE] reflected the following skin issues: .Left heel soft eschar intact, R heel soft intact. There was no mark on the body diagram or entry noted on the right leg. Resident #9's Monthly Consolidated Orders for September 2013 reflected the following handwritten note written across the top: MD Please compare hosp list before signing 8/31/13. Review The orders were signed by ADON MM on 08/31/13 and by the attending physician on 09/05/13 and included: Cleanse Rt heel w/ NS, pat dry, apply calcium alginate, silver absorbing agent collagen dressing w/ santyl, cover with dry dressing BID. Cleanse blister on Lt calf w/ NS, pat dry, apply skin prep bid. Resident #9's Physician's Telephone Orders dated 08/29/13 reflected: .Continue everything on TARS. Resident #9's TAR for September 2013 reflected the following entries: EZ boot to be worn in bed and chair to offload wound, float heels in bed to offload wound. The treatment order was signed as completed every shift. Cleanse Rt heel w/ NS, pat dry, apply calcium alginate, silver absorbing agent collagen dressing w/santyl, cover with dry dressing BID. Cleanse blister on Lt calf w/ NS, pat dry, apply skin prep bid. The two previous treatments were never signed as completed and both treatments had handwritten notes, which reflected: DC 09/13/13. Review of Resident #9's Physician Telephone orders revealed no order to discontinue the treatments Resident #9's Care Plan dated 09/19/13 reflected she was totally dependent on staff and required extensive assistance for completion of ADLs related to her debility. Approaches included: Monitor skin weekly and document. Notify physician of changes. Resident #9's Care Plan dated 09/24/13 reflected she had a Stage II decubitus (pressure) ulcer on the middle of her right lower leg, which measured 2.1 cm x 1.3 cm x 0.2 cm. Approaches included: Treatment (blank line) as ordered. Notify Dr. of ineffectiveness of treatment. Document wound appearance and notify Dr of S/SX of infection. Pressure relieving pillows to offload. The Care Plan was last updated on 12/05/13 and reflected the pressure ulcer measured 1.8 cm x 0.5 cm x 0.1 cm and to Cont. tx per order. The Care Plan was signed by the MDS Coordinator. In an interview on 12/11/13 at 4:30 PM, the MDS Coordinator was asked why there was no Care Plan for Resident #9's pressure ulcer prior to 09/24/13. The MDS Coordinator stated she was unaware of the pressure ulcer prior to 09/24/13. Resident #9's Nurse's Notes reflected on the following entries related to her dressing changes: Resident #9's Nurse's Notes reflected on 09/24/13 at 10:30 AM: CNA notified Charge Nurse that resident has an open area to R calf 2.1 x 1.3 x 0.2 cleaned (with) NS applied Collagen & [MEDICATION NAME] dressing. (responsible party) called (phone number) & notified of (change) in condition. Signed by LVN D. NOTE: There were no further entries indicating the physician was notified or orders obtained. Resident #9's Physician's Progress Notes reflected she was last seen by NP O on 10/15/13. The Progress Note dated 10/15/13 reflected no indication she had pressure ulcers. Resident #9's Nurse's Notes reflected on 10/28/13 at 10:00 AM: NO (new order) clean R heel NS pat dry apply silver hydrogel, collagen, & dry dressing Q day (responsible party and phone number) informed of new area on foot. Signed by LVN D. Resident #9's Physician's Telephone Orders dated 10/28/13 reflected an order to clean the right heel with normal saline, pat dry, apply silver hydrogel, collagen dressing and apply a dry, protective dressing daily. Review of Resident #9's Treatment Orders for November 2013 revealed there were no pressure ulcer treatment orders or preventative orders at all. Resident #9's Nurse's Notes reflected on 11/02/13 at 2:00 PM: Assisted resident back to bed after lunch. Tx done to wounds in R heel & R leg. Moderate amount of blood noted. Kept dry and comfortable. Signed by LVN T. Resident #9's Nurse's Notes reflected on 11/03/13 at 11:00 AM: .Tx to R heel and R leg done. Small amt of drainage & blood noted. Heel protectors on resident. Signed by LVN T. Resident #9's Nurse's Notes reflected on 11/09/13 at 11:00 AM: .Tx done to R leg and heel, heel protectors on bilateral heels. Signed by LVN T. Resident #9's Nurse's Notes reflected on 11/10/13 at 11:00 AM: .Tx to R leg and heel done. Signed by LVN T. Resident #9's Nurse's Notes reflected on 11/11/13 at 8:15 AM: .wound care to R heel given. Signed by LVN D. Resident #9's Nurse's Notes reflected on 11/15/13 at 11:00 AM: Repositioned wound care given ? c/o pain. Podus boots on bil ft. Signed by LVN D. Resident #9's Nurse's Notes reflected on 11/16/13 at 10:00 AM: .L heel and leg dressing. ? odor noted. Small amount of drainage, blood stain observed. Signed by LVN T. Resident #9's Nurse's Notes reflected on 11/22/13 at 7:40 AM: .Dressing (change) to R heel. Signed by LVN D. Resident #9's Nurse's Notes reflected on 11/30/13 at 11:00 AM: Tx to L heel & leg done. Kept dry and comfortable. Signed by LVN T. Resident #9's Treatment Orders for December 2013 reflected an order to cleanse her right heel with normal saline, pat dry, apply silver hydrogel, collagen dressing and apply a dry, protective dressing daily. The order date was 10/28/13. There were no orders related to the pressure ulcer on her right calf. Resident #9's Nurse's Notes reflected on 12/01/13 at 11:00 AM: Dressing to L heel and leg changed. Small amt of drainage noted. Signed by LVN T. Resident #9's Nurse's Notes reflected on 12/07/13 at 11:00 AM: .L heel and leg tx done. Signed by LVN T. Resident #9's Nurse's Notes reflected on 12/08/13 at 11:00 AM: .Dressing to the wound changed. Yellowish drainage noted. Incontinent care provided. Kept dry and comfortable. Signed by LVN T. Resident #9's Nurse's Notes reflected on 12/10/13 at 1:00 PM: .This nurse observe a wound on the left leg measure 2.5 cm x 2 cm x 0.5 cm. (Physician X) notify and talked to (NP O), an order for [REDACTED]. Resident #9's Nurse's Notes reflected on 12/11/13 at 10:15 AM: Spoke (with) (NP O) for (Physician X). Order clarification to continue previous order for R calf. Cleanse (with) NS, pat dry apply silver hydrogel, collagen, cover (with) dry protective dressing QD. Signed by LVN D. Resident #9's Weekly Summaries dated 10/24/13, 10/31/13, 11/07/13, 11/21/13, and 11/28/13 all reflected None under the section provided to identify skin conditions. The Summaries were completed by LVN W, Resident #9's 3:00 PM to 11:00 PM Charge Nurse. . During an interview on 12/11/13 at 6:55 PM, LVN W stated she was aware Resident #9 had pressure ulcers but did not perform the dressing changes. She stated she had been told by LVN D that she (LVN D) was in charge of treatments. When LVN W was shown the Weekly Summaries, which she had completed, and was asked why no skin issues were identified, LVN W stated, That's my fault. Resident #9's Weekly Skin Assessments dated 10/09/13 through 12/04/13 reflected the following answers to the entry: Pressure, Diabetic, Venous, Arterial Ulcer, or Incision- __No, __Yes, Describe: 10/09/13: No was checked. 10/16/13: Yes was checked.Coccyx 10/23/13: No was checked. coccyx. 10/30/13: Yes was checked,Coccyx, Bi-heels. 11/06/13: Yes was checked. Coccyx, heels. 11/13/13: Yes was checked. Coccyx, heel. 11/20/13: Yes was checked. Coccyx, heel. 11/27/13: No was checked. R-leg, heel. 12/04/13: Yes was checked Coccyx, R-leg, L heel. The weekly assessments were signed as completed by LVN S, Resident #9's 11:00 PM to 7:00 AM Charge Nurse. During an interview on 12/13/13 at 11:15 AM, LVN S was asked about his weekly skin assessments of Resident #9. LVN S stated when he completed a skin assessment, he did not remove dressings if they were intact. LVN S stated he had changed Resident #9's dressing several times. LVN S was asked how he knew what treatment to apply to the pressure ulcer since there were no treatment orders. LVN S responded when there was no order in the book, he put Calcium Alginate on the wound or triple antibiotic ointment (TAO). When asked why he would use those treatments, LVN S stated, TAO you can use for everything. I see what's on it and use that. When LVN S was asked whether he had reported the issue to anyone, he stated he told the afternoon Charge Nurse there were no orders. When asked why he did not call the physician himself, LVN S stated, No, we have someone who does the skin with the doctor every week. On 12/10/13 at 11:05 AM, during initial tour with LVN A, Resident #9 was observed sleeping in her bed. LVN A stated she was not Resident #9's usual Charge Nurse but was covering the hall that day. She identified the resident as alert and interviewable and possibly having a pressure ulcer on her heel. There was a sign above the resident's bed, which reflected: Boots must be worn on this patient at all times, thanks for your cooperation. Observation on 12/10/13 at 1:46 PM with LVN A and CNA M revealed Resident #9 was lying in bed awake and she was alert. She had a large, soft boot on her right leg and a

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) hard, white plastic brace on her left leg, which was open in the front and extended from her upper calf past her toes. Her left leg was completely turned inward toward her right leg. The brace was removed and was observed to have two inflatable air chambers along the inside walls of the brace. The air chamber along the medial wall of the brace had very little air within it, providing no protection to Resident #9's leg from the hard surface of the brace. The inside of Resident #9's left leg was pink and wrinkled where it lay in the brace. When asked who was responsible for ensuring the brace was properly inflated, CNA M stated she thought the Therapy Department monitored and cared for the boot. LVN A stated she did not know how to care for the brace. At that time, Resident #9's right heel dressing was removed and revealed a pressure ulcer approximately 1.0 cm X 0.8 cm. Wound care was given as ordered. A dressing was also observed on Resident #9's right outer, lower leg, which was dated 12/08/13 (two days earlier). When queried about the dressing, LVN A stated she knew nothing about it. LVN A removed the dressing and revealed a pressure ulcer with a moderate amount of beige-colored drainage both within the wound bed and on the dressing. The edges of the pressure ulcer were completely macerated and the wound bed could not be visualized. LVN A stated she did not know about the pressure ulcer. LVN A cleaned the pressure ulcer with saline, measured the pressure ulcer at 2.5 cm x 2.0 cm x 0.5 cm. LVN A said she was going to apply a clean, dry dressing and call the physician. During this time, CNA M stated she knew about the pressure ulcer and explained it began as a blister caused by a brace Resident #9 used to wear, which was similar to the brace on Resident #9's left leg. She stated she thought the blister started two to three months ago, healed, and then reopened. She stated whenever she showered Resident #9, she would tell her nurse, and the nurse would change both dressings. LVN A then stated there was no treatment ordered for that pressure ulcer. At that same time, when Resident #9 was asked whether she had seen the wound doctor, she stated she had not. CNA M explained Resident #9 used to go to [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday but her schedule changed to Monday, Wednesday and Friday; and the wound care physician only came on Wednesdays. Resident #9 confirmed the wound care physician had not seen her (Resident #9) since her pressure ulcer had reopened. During an interview on 12/10/13 at 4:38 PM, LVN A informed the surveyor she had obtained an order for [REDACTED]. When asked how the wound care physician was supposed to see Resident #9 when he only came to the facility on Wednesday, her [MEDICAL TREATMENT] day, LVN A stated she did not know. She stated the Doctors were aware the wound care physician only saw the residents on Wednesday. When LVN A was then asked whether she reminded the physician of that fact when the order for the wound care consult was obtained, she stated she did not. On 12/10/13, the DON was asked to provide Resident #9's pressure ulcer tracking and surveillance records to the survey team. Review of the weekly skin assessment records dated from 09/02/13 through 11/06/13 revealed there were no entries related to Resident #9. During an interview on 12/10/13 at 2:30 PM, the DON was asked why Resident #9 was not represented in the pressure ulcer surveillance reports. The DON explained the lists represented only the residents who were seen by the wound care physician. She stated Resident #9 was not seen by the wound care physician because she was out at [MEDICAL TREATMENT] on those days. When asked how residents with pressure ulcers were treated if they had [MEDICAL TREATMENT] or any other scheduling conflicts with the wound care physician's visits, the DON stated the primary care physician provided the orders. During another interview on 12/10/13 at 3:30 PM, the DON was asked if she kept her own surveillance records of pressure ulcers in the facility to monitor residents who were not seen by the wound care physician. The DON stated she received report daily and the nurses gave her a sheet with the pressure ulcer measurements. She stated she was still looking for Resident #9's sheet and had been unable to locate it. The DON stated Resident #9 was the only resident with a pressure ulcer, who was not seen by the wound care physician. During an interview on 12/11/13 at 8:15 AM, LVN D, Resident #9's usual 7:00 AM to 3:00 PM Charge Nurse, was asked about Resident #9's right leg pressure ulcer. LVN D stated the pressure ulcer started as a blister caused by a hard plastic ski-boot style brace the resident was wearing at the time. She stated Resident #9 was sent to the hospital due to her blood pressure, and when she returned, it was an open pressure ulcer. When asked about documentation, LVN D stated she documented pressure ulcers on Wednesdays and kept the information in a separate folder. LVN D stated she would provide the information. When asked about the treatment for [REDACTED]. LVN D then stated she had corrected the order obtained the day before by LVN A. When asked when she obtained the treatment orders, LVN D stated she would look back and get the exact date. (NOTE: the order was never found.) When LVN D was asked where she documented her treatments, she stated she documented them in the TAR. When told there was no entry for Resident #9's leg pressure ulcer, LVN D stated she saw that. It's on there now. LVN D then stated she documented in the nurse's notes when the treatments were done. When told there were no entries found there either, LVN D stated she would check. When asked whether a physician had seen Resident #9's right leg pressure ulcer, LVN D stated the wound care physician was treating Resident #9's pressure ulcers until her [MEDICAL TREATMENT] days changed. When asked when that happened, LVN D reviewed Resident #9's clinical record and determined the [MEDICAL TREATMENT] schedule changed on or around 09/13/13. The clinical record also reflected Resident #9 returned from the hospital on [DATE]. Review of the physician's orders [REDACTED]. During the same conversation, LVN D located a Pressure Ulcer Record for Resident #9. The Record reflected two pressure ulcers: a pressure ulcer to the right, outer lower leg was identified on a body outline as Site A with the date first observed as 09/24/13. The pressure ulcer was identified as Stage II, 2.1 cm x 1.3 cm x 1.2 cm, no drainage or odor. LVN D stated she measured the pressure ulcer that morning and documented it on the Record. The entry for the morning of 12/11/13 reflected the pressure ulcer measured 1.3 cm x 0.5 cm x 0.1 cm, Stage II with no drainage. (Note: observation of the pressure ulcer on 12/10/13 revealed the pressure ulcer had beige-colored drainage and the base of the pressure ulcer could not be visualized due to the drainage.) When LVN D was asked why the pressure ulcer documentation was not started until 09/24/13, she replied, When I got this sheet, that's when I started charting on this sheet. I didn't have this sheet before. When asked where she charted before obtaining the sheet, LVN D replied, I didn't chart anywhere. LVN D explained she was a CNA before Resident #9 went to the hospital and was transitioning to a nursing position and when Resident #9 returned from the hospital, she was her nurse. LVN D was then asked, since she knew about Resident #9's pressure ulcer, did she ever call to get orders. LVN D looked through Resident #9's clinical record and stated she had spoken to NP O. LVN D stated, When she (Resident #9) came back, I just continued with her previous orders. When asked if she ever checked to see if the orders were written, LVN D replied, No. During an interview on 12/11/13 at 11:06 AM, NP O stated she was not sure when she became aware of the pressure ulcer on Resident #9's leg. She confirmed her last note about the resident was dated 10/15/13. She stated she was at the facility on 12/05/13 but she did not see Resident #9. NP O stated she remembered the staff talking to her about a pressure ulcer that day, but she could not say which pressure ulcer specifically. NP O stated she did not know if she was aware the wound care physician was not treating Resident #9. She could not recall ever looking at Resident #9's pressure ulcers. When asked whether LVN D had called her about treatment orders, NP O confirmed the LVN had. NP O stated, I don't know that I was made aware until yesterday that it had progressed. I did talk to them (staff) on the fifth (of December). In an interview on 12/11/13 at 3:30 PM, when the DON was asked whether she had seen Resident #9's pressure ulcer, she stated she had seen it the week before. When asked if she had documented anything about the pressure ulcer, she stated she had not. The DON explained she sometimes made rounds with the wound care physician or would watch the nurses perform dressing changes. When queried what she typically monitored when watching her nurses, the DON stated she wanted to see how the pressure ulcer was progressing, how the pressure ulcer was reacting to the treatments and how the nurse performed. When asked how she could have monitored any of those criteria for Resident #9 when there were no orders for treatment and no documentation or measurements readily available, the DON stated she knew it was smaller than when she saw it previously. When asked when she saw it previously, the DON replied, On the calf? I can't say. During a meeting with the Administrator and the DON on 12/11/13 at 5:30 PM the survey team shared their concerns related to the facility's wound/pressure ulcer program and Resident #9's pressure ulcers, particularly the lack of treatment orders; inaccurate, sporadic documentation of the pressure ulcer and the failure to ensure the physician visualized the pressure ulcer. The Administrator stated she met with her nursing staff every day. She explained during the meeting, which was attended by the DON, ADON MM and the MDS Coordinator, each nurse reported about their residents. The Administrator stated she spoke with LVN D specifically about Resident #9 and the only pressure ulcer ever mentioned was the one on her heel. She stated the pressure ulcer on her lower leg was never mentioned and she had no idea Resident #9 had a second pressure ulcer. The DON was asked why, if she knew about the pressure ulcer, she did not correct LVN D during the meetings. The DON stated she only learned about the pressure ulcer two weeks ago. When asked why it was not mentioned last week, the DON did not answer. On 12/12/13 at 10:30 AM, Medical Director/Physician K, accompanied LVN D and the surveyor to Resident #9's room to assess her pressure ulcers. Upon entering the room, Resident #9 was observed with her right foot dangling off the bed wearing only a sock. Her left foot was also only wearing a sock, and her heel was on the bed. A pillow was beneath her knees. When LVN D was asked by the surveyor where the resident's heel protectors were, she did not reply. The surveyor located Resident #9's heel protector boots across the room, on a chair beneath a bedspread. When Physician K

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	676052	A. BUILDING _____ B. WING _____	01/11/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	4515 VILLAGE CREEK RD FORT WORTH, TX 76119

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

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F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 12) observed the pressure ulcer, he stated it was an old pressure ulcer, which had reopened. He added there was slough (soft, dead tissue) within the pressure ulcer causing it to be unstageable. Physician K ordered a treatment of [REDACTED]. LVN D measured the pressure ulcer at that time, only measuring the inner part of pressure ulcer and stated the pressure ulcer measured 1.7 cm x 1.2 cm. The surveyor questioned why the macerated edges were not included in the measurement, and Physician K instructed LVN D to measure the entire pressure ulcer. At that time, the pressure ulcer measured 2.2 cm x 2.5 cm. Resident #9 was observed again on 12/12/13 at 4:55 PM. She was in bed with both legs flat on her mattress with no offloading or heel protection. Resident #9 stated she had not had her boots on at all since the surveyor and LVN D were in earlier with the doctor (six hours earlier). When asked if she ever refused to wear the boots, Resident #9 stated she did not mind wearing the soft one, but the hard plastic one hurt her leg. Resident #9 stated she got to look at the pressure ulcer on her leg, and It looked bad. During an interview on 12/13/13 at 8:10 AM, LVN D was asked whether she ever went back to check on Resident #9 on 12/12/13 to ensure she was wearing her heel protection and was positioned properly. LVN D stated she did go check on her but the resident was in bed, and I didn't pull the cover back to look. I know they are on today (12/13/13). During an interview on 12/12/13 at 2:05 PM, LVN T, Resident #9's weekend Charge Nurse, stated she changed the dressing on Resident #9's pressure ulcers on her right leg and heel. When asked what treatment she provided on the resident's leg, LVN T stated she applied Collagen, Hydrogel and a dressing. She explained she did the treatments as instructed by LVN D. When asked why she did not call the physician herself, LVN T stated she was told by LVN D it was what the doctor wanted. LVN T stated she had told LVN D there were no orders and the TAR needed to be fixed. LVN T stated she later told the DON to remind LVN D to get orders but it had not happened. (Note: On 12/12/13 at 10:30 AM, Physician K ordered a daily treatment of [REDACTED].) A Quick Reference Guide for Pressure Ulcer Treatment developed by the European Pressure Ulcer Advisory Panel (EPUAP) and the National Pressure Ulcer Advisory Panel (NPUAP), copyright 2009, pages 26 reflected the following: Hydrogel Dressings: Use for treatment of [REDACTED]. Alginate Dressings: Use for the treatment of [REDACTED]. Retrieved on 01/16/14 from http://www.santyl.com/ - Santyl (ointment) helps remove nonliving tissue without harming granulation (healing) tissue. In an interview on 12/17/13 at 11:00 AM, LVN Y, Weekend Supervisor, stated one of her duties was no make sure treatments were being done. When asked how she knew who had wounds/pressure ulcers, LVN Y stated the DON called her and gave her a report and left a list in the Weekend Supervisor folder. LVN Y further stated she looked in the treatment book to ensure the correct treatments were being done. When asked what she knew about Resident #9, LVN Y stated she knew the resident had a pressure ulcer on her heel but was unaware of a pressure ulcer on her leg. The DON had not informed her about it. LVN Y stated she had seen the heel pressure ulcer but never noticed the dressing on her lower leg. She stated she had since heard the weekday nurses were changing the dressing. 2) Resident #11 was a [AGE] year-old female, readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed the resident was severely impaired for cognitive skills for daily decision-making, was totally dependent on staff for bed mobility and had two Stage III pressure ulcers. Review of a Detail Admission/Discharge Report dated 12/12/13 for Resident #11 revealed the resident was: -- admitted to the facility on [DATE], -- Transferred to the hospital on [DATE], -- Readmitted to the facility on [DATE], -- Transferred to the hospital on [DATE] and -- Readmitted to the facility on [DATE]. Resident #11's care plan dated 09/15/13 reflected: PROBLEM: (Resident #11) is at risk for developing Wounds D/T debilitated state/DX AEB Diabetes Mellitus, Contractures and immobility deficit. GOAL: (Resident #11) will not develop wounds this eval period. APPROACHES: 1. Assess skin and document findings q week per wound protocol 2. Reposition with pillows as positioning devices q2h and as needed 3. Shower per shower protocol. Dry well and apply lotion 4. Feedings as ordered 5. Pressure relieving devices as needed: Mattress, W/C Cushions 6. Gentle Passive ROM with personal care daily 7. Medications as ordered 8. Dietary Consult as indicated 9. Not (notify) Dr./RP of change in condition. Review of Resident #11's Weekly Skin Assessment dated 10/05/13 revealed: Skin: Warm and Dry were both checked Skin Tears: No was checked Bruises: No was checked Abrasions: No was checked Incisions: Yes was checked - If Yes, describe all areas and location: GT site was hand written in. Rash: No was checked Pressure, Diabetic, Venous, Arterial Ulcer, or Incision: Yes was checked. Describe Coccyx was hand written in. LVN S signed this assessment. Review of Resident #11's Nurse's Notes dated 10/05/13 revealed no mention of an open area/pressure ulcer on the resident's coccyx. In an interview on 12/13/13 at 11:25 AM, the surveyor reviewed Resident #11's Weekly Skin Assessment dated 10/05/13 with LVN S, which he completed. LVN S stated, I think she (Resident #11) came back from the hospital with it (Pressure ulcer). LVN S documented Resident #11 had a pressure ulcer on her coccyx, and he stated he did not describe the pressure ulcer on any of the facility documents. I just change the dressing. I clean the wound with normal saline; sometimes I put a little TAO and a dressing on it (pressure ulcer), to cover it so it doesn't get infected. I do that when the dressing is dirty and when I do my weekly skin assessments. I look for physician (treatment) orders and if there is not an order, I do the TAO. The surveyor asked LVN S if he considered calling the physician if there were no treatment orders, and LVN S stated, No, we have a wound nurse in the house (facility). I call her sometimes. The surveyor asked who
F 0315 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure based on the resident's comprehensive assessment two (Residents #2 and #8) of three residents reviewed with indwelling urinary catheters had a clinical condition demonstrating that catheterization was necessary and one (Resident #22) of four residents reviewed for UTIs who were incontinent received appropriate treatment and services for urinary tract infections. 1. Resident #2: a) Had no orders for changing her indwelling Foley catheter, the size of catheter to use, and I & O from her admission on 07/29/13 to December 2013 until surveyor inquiry in December 2013; b) Did not have her indwelling Foley catheter changed from August through December 2013 (for four months) until surveyor inquiry in December 2013; c) Had staff using the same leg urinary drainage bag (for day) and large urinary drainage bag (for night), cleaning and rinsing them daily in the resident-shared bathroom even when the resident had a urine infection [MEDICAL CONDITION] until surveyor inquiry in December 2013; d) Had three UTIs within two months of admission; e) Had a fourth UTI in October 2013, which was diagnosed per a UA, but there was no follow-up C&S done and/or antibiotic ordered for the UTI until surveyor inquiry in December 2013; f) Had a urinary consult ordered on [DATE], which was not done until surveyor inquiry in December 2013. These failures caused Resident #2 pain and discomfort, continued urinary catheterization, and repeated UTIs, decreased socialization, embarassment at urinary odor and loss of quality of life; and placed Resident #2 at risk [MEDICAL CONDITION], dehydration, injury to the urinary tract, and loss of bladder function, resulting in the need for permanent urinary catheterization, repeated use of antibiotics, the need for stronger (and more expensive) antibiotics and the need for hospitalization . These failures could have affected all 42 residents residing on station two. 2. The facility failed to obtain orders for Resident #8's indwelling urinary catheter when she was readmitted to the facility: for changing the catheter, the size of catheter to use, catheter care and for monitoring I&O and for Resident #8 who was admitted to the facility with an indwelling catheter. After surveyor inquiry, the indwelling urinary catheter was discontinued. These failures affected Resident #8 by failing to ensure the resident needed a catheter and received the care she needed because she had an indwelling urinary catheter, but no orders for it and placed her at risk for infection [MEDICAL CONDITION], pain and discomfort, the need for lab tests and medication and possible hospitalization , resulting in loss of quality of life and decreased health and wellness, and or causing death. This failure could have affected the three residents in the facility, who had indwelling urinary catheters. 5. The facility failed to administer [MEDICATION NAME] to Resident #22, which was needed to treat the infection of E. coli in her urine in September 2013. This failure could have caused Resident #22 to become septic, increasing her discomfort, the need for medication, the need for possible hospitalization , and or causing death. This failure could have affected the 33 residents on station two who were administered medications by MA EE. An Immediate Jeopardy (IJ) was identified on 12/13/13. While the IJ was removed on 01/11/14, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm, that is not immediate jeopardy, because not all staff had been trained and the facility was still monitoring the Plan of Removal. Findings included: 1) The Face Sheet dated 08/01/13 reflected Resident #2 was admitted to the facility on [DATE] with diagnoses, which included but were not limited to Bacterial Pneumonia, Difficulty in Walking, and a History of Respiratory Disease. Resident #2 was a [AGE] year-old-female

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F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) admitted to the facility on [DATE] with diagnosed including: [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #2's cognitive skills for daily decision making were moderately impaired. Resident #2 had an indwelling catheter and was always incontinent of bowel. Resident #2 required extensive assistace of one person for bed mobility, transfers, locomotion and was totally dependent of one person for dressing, eating, and toileting. During an interview on 01/07/14 at 4:00 PM, the MDS Coordinator stated she was unable to find any care plans for Resident #2. Review of Resident #2's Admission Nursing assessment dated [DATE] revealed the resident had a Foley in place. (The nurse's signature was not legible.) It further reflected she had an 18 French 30 cc balloon catheter, and her urine was yellow and cloudy. Review of Resident #2's admission orders [REDACTED]. Review of Resident #2's consolidated physician's orders [REDACTED]. Note: There was no order for the use of [REDACTED]. During an interview with the DON on 12/13/13 at 11:10 AM, she was asked what her expectations were when a resident had a Foley catheter. The DON informed the surveyor when a resident had a Foley catheter, she would expect them to document the resident's I & O, catheter care, and color and consistency of the urine. When asked what she meant about catheter care, the DON said to clean the Foley catheter tubing and make sure it was not gunky. When asked about physician's orders [REDACTED]. physician's orders [REDACTED]. During an interview with LVN H on 12/13/13 at 3:50 PM she informed the surveyor she worked with Resident #2 every day Monday through Friday from 3:00 PM - 11:00 PM. When asked if she had ever changed Resident #2's Foley catheter, LVN H said,No. I haven't put in a new Foley but I changed the (urinary drainage) bag. When asked what a nurse was supposed to do when a resident had a catheter, LVN H replied they would get an order from the doctor to change the catheter every month on this date at this time. LVN H told the surveyor the facility policy was usually for the night shift to change the catheters. LVN H said if she had received the order, but I didn't, she would include it on the TAR, and if she admitted a resident with a Foley catheter, she would get the order to change it and write it on the TAR. LVN H said when they first got an order, it would depend upon the doctor and when he wanted the catheter changed the first time. LVN H said, it might depend on where she came from and the hospital orders. LVN H informed the surveyor if she or another nurse had realized Resident #2's catheter had not been changed, We should have checked to see (if it had been changed). LVN H said she had never called to get an order to change Resident #2's Foley catheter, but any shift could call the doctor and get orders for the Foley catheter. LVN H said she never realized Resident #2's catheter had not been changed or noticed there was nothing on the TAR to change the Foley catheter. During an interview with LVN G on 12/12/13 at 10:15 AM, when asked if she had ever changed Resident #2's Foley catheter, LVN G said,No, she had not. LVN G said there was a nurse on the night shift, who changed the residents' catheters, but she no longer worked for the facility. LVN G said she did not know if Resident #2's catheter had ever been changed and identified RN I as the previous night shift nurse, who may have changed Resident #2's catheter. During an interview with RN U on 12/13/13 at 10:42 AM, she informed the surveyor she worked with Resident #2 on the night shift on Saturday nights only and reconciled the comprehensive orders every month for station two, which included Resident #2. When asked if she had ever changed the Foley catheter, RN U said she did not remember if she had changed it or not. When asked how often a Foley catheter should be changed, RN U replied,It's usually on the orders to change every 30 days or one time a month. When asked if Resident #2 had any orders for her Foley catheter on her consolidated orders, RN U said she was not sure if she has an order or not. During the initial tour with LVN G on 12/10/13 at 11:17 AM, Resident #2 was not in her room. LVN G described Resident #2 as alert and oriented with confusion at times. LVN G said Resident #2 was incontinent of bowel but had an indwelling catheter for [MEDICAL CONDITION]. The resident was ambulatory with a rolling walker and was stand by assist with most of her ADLs. On 12/10/13 at 1:15 PM, Resident #2 was observed in her room sitting in a chair. She was well-groomed and dressed appropriately. Resident #2 informed the surveyor she had not been in the facility for very long and had come from another facility. When asked about her Foley catheter, Resident #2 informed the surveyor her catheter leakd sometimes and showed the surveyor her urinary drainage leg bag, which was on her right leg above her knee and had light tea-colored urine in it. When asked, Resident #2 said some of the new girls (CNAs) pulled too hard on the catheter and it leaked (Resident #2 pointed at her Peri area). Resident #2 also informed the surveyor when she had a urinary drainage leg bag for a long time, it would leak sometimes as well. In the Confidential Resident Group Interview on 12/11/13 at 1:30 PM, the attending residents, identified by the facility as alert and oriented, were asked this question: How do staff members treat the residents here, not just yourselves, but others who can't speak for themselves? One of the residents reported he/she knew of a resident, who complained out loud about wanting to have her (indwelling urinary) catheter changed, which annoyed the CNAs. The CNAs would then respond to the resident, telling him/her the nurses were supposed to change the catheter, not them (the CNAs). The CNAs would then tell the nurses, who would ignore both the CNAs and the resident. Two other residents agreed with the first resident. They described the resident, who had the catheter as a resident who used a walker and talked loudly. The resident with the catheter was confirmed as being Resident #2. During an interview with LVN G on 12/12/13 at 10:15 AM, she stated Resident #2 had asked to have her catheter bag changed, but since the facility did not have an extra catheter drainage bag, she did not change it. When asked if she had ever changed the catheter, LVN G said,No, she had not. LVN G said there had been a nurse on the night shift, who changed the residents' catheters, but she no longer worked for the facility. LVN G said she did not know if Resident #2's catheter had ever been changed or not and identified RN I as the previous night shift nurse, who may have changed Resident #2's catheter. LVN G said, to her knowledge, Resident #2 had never complained about her catheter hurting. LVN G said Resident #2's urine used to be amber in color until her physician wrote an order for [REDACTED].#2 ambulated, which was why it was amber-colored. LVN G said at night, the night nurse changed the leg bag to a bedside urinary drainage bag, and in the morning, the night nurse changed it back to the leg bag. When asked about securing Resident #2's catheter, LVN G said she did not know if there was a leg strap on the catheter. Review of Resident #2's Daily Skilled Nurse's Note dated 08/04/13 at 7:00 PM (nurse's signature illegible) revealed the resident's Foley catheter was intact and in place. The note further reflected the resident complained of pain at the catheter site, so the nurse gave Resident #2 [MEDICATION NAME] 2.5/500 mg 1 tab PO, which she tolerated well. Review of Resident #2's Daily Skilled Nurse's Note dated 08/07/13 at 5:00 PM (nurse's signature illegible) revealed the nurse had assessed Resident #2's catheter and noticed blood in the catheter bag. The nurse called Physician K, Resident #2's attending physician, and spoke with NP P, who ordered [MEDICATION NAME] (anti-fungal) 100 mg 1 tab PO X 3 days. Review of Resident #2's Daily Skilled Nurse's Note dated signed by RN I on 08/10/13 at 2:00 AM revealed Resident #2 had a Foley catheter, which was draining pinkish-colored urine and no blood clots were observed. Review of Resident #2's Daily Skilled Nurse's Note dated 08/10/13 at 9:00 AM (nurse's signature illegible) revealed the resident's Foley catheter was intact, and her urine was getting clear of blood. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by LVN E on 08/12/13 (no time) revealed Resident #2's Foley catheter was intact and draining light pink urine. The Note further reflected Physician K was notified, and he had instructed the nurse to drain Resident #2's catheter bag and to continue to monitor the resident's urine. Review of Resident #2's Daily Skilled Nurse's Note dated 08/13/13 at 12:00 AM (nurse's signature illegible) revealed Resident #2's Foley catheter was in place to gravity drainage. It further reflected her urine was amber colored, clear and without any odor noted. Review of Resident #2's Daily Skilled Nurse's Note dated 08/13/13 at 12:00 AM (nurse's signature illegible) revealed Resident #2's urine was amber-colored and clear. It also reflected the nurse notified Physician K, and he said to put tape on Resident #2's catheter to prevent it from pulling. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/14/13 at 12:00 AM revealed Resident #2's Foley catheter was to gravity drainage, and the urine was pinkish colored withred clumps (clots) visible. Review of Resident #2's Daily Skilled Nurse's Note dated 08/14/13 untimed (nurse's signature illegible) revealed Resident #2's urine color was amber and clear. It further reflected the nurse called Physician K, and he gave a new order for a UA with C&S. Review of Resident #2's Daily Skilled Nurse's Note dated 08/14/13 at 5:00 PM (nurse's signature illegible) revealed Resident #2's Foley catheter was in place with drainage to gravity. It further reflected her urine was amber-colored and clear. Review of Resident #2's Daily Skilled Nurse's Note dated 08/15/13 at 2:00 AM and signed by RN I revealed the RN collected a sample of urine from Resident #2's catheter tubing for the UA C&S using sterile technique. Review of Resident #2's Daily Skilled Nurse's Note dated 08/15/13 at 5:00 PM (nurse's signature illegible) revealed her Foley catheter was in place to gravity drainage. It further reflected Resident #2's urine was amber-colored, clear and without an odor. Review of Resident #2's physician's telephone orders revealed an order dated and signed by the physician on 08/15/13, which ordered to continue the Foley catheter and to attach it to a urinary drainage leg bag at 6:00 AM every morning and then to a gravity urinary drainage bag every night at 9:00 PM for one month and then re-evaluate. Further review of Resident #2's physician's telephone orders for August, September, October, November and December 2013 failed to reveal any orders resulting from a re-evaluation of the resident's catheter, orders for the Foley catheter and leg drainage bag, any order for the Foley catheter size, a frequency to change the Foley catheter, whether to document I&O, or to irrigate the Foley catheter. Review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. BUILDING _____ B. WING _____	01/11/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	4515 VILLAGE CREEK RD FORT WORTH, TX 76119

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 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/16/13 at 2:00 AM revealed Resident #2 was awake, and when the CNA had assessed her, Resident #2's diaper is wet. The nurses' note further reflected the CNA reported this to RN I as well as the statement, Her cath hurts. RN I's nurses' note further reflected she went and assessed Resident #2and noted that Res crys (sic) out with pain when Foley tubing is moved only slightly - Foley bulb deflated and (catheter) removed. Res c/o much discomfort. Obtained a #18 with 10 cc bulb (Foley catheter) and inserted it with minimal discomfort noted.Res passing pink color urine. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/16/13 at 6:00 AM revealed Resident #2's urine waspinkish in bag and tubing. It further reflected RN I removed the large bag and placed a leg bag as ordered for day time activity. RN I then wroteLg bag Rinsed and hung up in BR. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/17/13 at 12:00 AM revealed Resident #2's leg bag was changed to a regular urnary drainage bag and theLeg Bag rinsed and hung to dry. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/19/13 at 12:00 AM revealed RN I assessed Resident #2 and she still had her leg bag on. RN I Removed (leg bag) and Lg drain bag attached to catheter. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/19/13 at 6:30 AM revealed Resident #2'sBig drain bag Removed and leg bag attached. Big bag rinsed __ (with) Cla (?) H2O X 3 and placed in drawer on clean towel. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/21/13 at 12:00 AM revealed Resident #2's leg bag had beenrinsed and dried, rest in folded towel. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/19/13 at 6:30 AM revealedBig bag exchanged for small leg bag. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/22/13 at 5:00 AM revealed RN I gave Resident #2 some medicine in yogurt and Resident #2 asked why she was being given medicine. RN I told Resident #1 it was antibiotics for her UTI. The Note further reflectedBig bag (changed) for leg bag. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/24/13 at 12:00 AM revealed:this nurse changed leg bag to foley _ (with) Lg drainage bag. Review of Resident #2's Daily Skilled Nurse's Note for the evening shift on 08/24/13 untimed (nurse's signature illegible) revealed her urine was yellow and cloudy. The Note further reflected,Changed from leg bag to reg. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/26/13 at 7:00 AM revealed,Foley (changed) to leg bag at this time. Review of Resident #2's Daily Skilled Nurse's Note dated 08/27/13 at 6:00 AM (nurse's signature illegible) revealed Drainage bag changed to leg bag as ordered. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/30/13 at 12:00 AM revealed Note still has leg bag to (R) leg for urine drainage. Leg bag off cathe and BS drainage bag to cath. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/30/13 at 12:00 AM revealed, Has Lg bag in place urine is pinkish in tubing. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/30/13 at 7:00 AM revealedBig bag changed to leg bag. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/02/13 at 12:00 AM revealed Has lg drainage bag in place c/o her belly hurts. Repositioned tubing. Review of Resident #2's Daily Skilled Nurse's Note dated 09/04/13 at 9:00 PM (nurse's signature illegible) revealed the nurse notified Physician K (Resident #2's PCP and the facility's Medical Director) there was blood in Resident #2's urine. It further reflected Physician K ordered a UA C&S for in the morning. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/02/13 at 12:00 AM revealed Resident #2 was awake and restless. It further reflected her incontinent brief was wet. RN I assessed Resident #2's Foley catheter anddetermine fluid in bulb low, slowly added more fluid. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/06/13 at 6:00 AM revealedDrainage Bag (changed) to leg bag. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/07/13 at 2:00 AM revealed Resident #2 was awake and restless and complainedFeels full. Observed Foley tubing (with) scant urine in it, none in bag. Realigned tubing under Res (R) leg (with) down grade to Bag had to pump tubing to encourage urine to flow. Review of Resident #2's Daily Skilled Nurse's Note dated 09/10/13 at 9:30 PM (nurse's signature illegible) revealed Resident #2 was on an antibiotic due to UTI, and her urine wasstill cloudy in color. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/11/13 at 12:00 AM revealed Resident #2has lg drainage bag in place. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/11/13 at 6:00 AM revealed,Foley cath changed from Lg bag to leg Bag. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/12/13 at 6:00 AM revealed, Foley bag changed to leg bag and elastic adjusted to her liking. Review of Resident #2's Daily Skilled Nurse's Note dated 09/12/13 at 9:30 PM (nurse's signature illegible) revealed Resident #2'surine still cloudy. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/13/13 at 6:00 AM revealedBig bag removed and Leg Bag applied. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/14/13 at 6:30 AM revealedBig urine bag (changed) back to leg Bag. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/16/13 at 5:00 AM revealedLg drain Bag (changed) to Leg Bag to (R) leg. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/18/13 at 6:30 AM revealedfoley (changed) to leg Bag. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/19/13 at 12:00 AM revealedhas Lg urine drainage Bag at Bedside. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/19/13 at 4:00 AM revealed Resident #2 was awake and wanted to get up.Foley Bag Removed (and) leg bag applied. Review of Resident #2's Daily Skilled Nurse's Note dated 09/19/13 at 10:30 AM (nurse's signature illegible) revealed the nursenoted amber-colored urine in residents urine bag, urine was drained, resident assisted to sit in her bed and relax because she had been walking around. It also reflected NP P was called and an order was received for a UA C&S for the next day. Review of Resident #2's Daily Skilled Nurse's Note dated 09/19/13 at 4:30 PM (nurse's signature illegible) revealed a CNA informed the nurse they thought Resident #2'sFoley bag was leaking, nurse went to check on it, Foley bag was intact was not leaking. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/20/13 at 12:00 AM revealed, Note urine in foley tubing is pink will monitor for Redness. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/20/13 at 7:00 AM revealed RN I informed Resident #2 of the need to collect urine for a UA. The Note reflected open cath tubing and only 2-3 cc urine.bladder empty at this time. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/21/13 at 12:00 AM revealed Resident #2 verbalizes her foley is leaking.note tubing is easily moveable in urethra - 6 cc air was added to tubing bulb. Note: The Foley catheter was not changed. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/23/13 at 12:00 AM revealed Resident #2 was in her bed. RN I observed that Res still has Leg Bag to (R) leg. Was Removed and Lg Bag applied (with) drainage to down drain. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/23/13 at 4:00 AM revealedLg bag (changed) to small leg Bag. Attempts to contact RN I for an interview were unsuccessful. Review of Resident #2's Daily Skilled Nurse's Note dated 09/23/13 at 4:30 PM (nurse's signature illegible) revealed the nurse received the laboratory results of the UA C&S and Physician K was notified. New orders were received: [MEDICATION NAME] (anti-[MEDICAL CONDITION] and for acute UTIs) 150 mg one by mouth two times a day for seven days; [MEDICATION NAME] (for UTIs) 50 mg by mouth two times a day for 10 days; and to repeat the UA C&S three days after the antibiotic was completed two times. Resident #2's Daily Skilled Nurse's Note further reflected Physician K called back and changed the [MEDICATION NAME] to 100 mg by mouth two times a day for 10 days. Review of Resident #2's Nurse's Note dated 09/28/13 at 12:30 PM (nurse's signature illegible) revealed Resident #2Cont on ABT [MEDICAL CONDITION] in urine. During an interview with ADON MM on 12/15/13 at 12:26 PM, when asked, ADON MM said Resident #2 was not on isolation when she [MEDICAL CONDITION] in her urine because she had a Foley catheter so it was contained. Review of Resident #2's Nurse's Note dated 09/28/13 at 2:30 PM (nurse's signature illegible) revealed Resident #2 Cont on ABT [MEDICAL CONDITION] in urine. Review of Resident #2's Nurse's Note dated 09/28/13 at 11:30 PM (nurse's signature illegible) revealed Resident #2ABT cont [MEDICAL CONDITION]. Review of Resident #2's Nurse's Note dated 09/29/13 at 11:30 AM (nurse's signature illegible) revealed Resident #2Cont on ABT [MEDICAL CONDITION] in urine. Review of Resident #2's Nurse's Note dated 09/29/13 at 4:45 PM (nurse's signature illegible) revealed Resident #2Cont on ABT [MEDICAL CONDITION] in urine. Review of Resident #2's Nurse's Note dated 10/05/13 at 2:00 PM (nurse's signature illegible) revealed Resident #2 was status [REDACTED]. Review of Resident #2's Nurse's Note dated 10/13/13 at 12:00 AM (nurse's signature illegible) revealed Resident #2 C/O bladder pain. It further reflected the catheter was draining urine and the nurse informed the resident it may have been pulled when she was out on pass with her family. The nurses' note also reflected Resident #2 received [MEDICATION NAME] 2.5/500 mg for the pain. Resident #2's physician's telephone order dated 10/18/13 reflected an order for [REDACTED]. Review of Resident #2's Nurse's Note dated 11/08/13 at 2:00 AM (nurse's signature illegible) revealed Resident #2 C/O abd pain. The Nurses' Note further reflected Resident #2 was medicated with [MEDICATION NAME] 2.5/500 mg for the pain and her Foley catheter was patent and irrigated. On 12/12/13 at 4:00 PM, the surveyor observed Resident #2 ambulating in the hallway. She was well-groomed and dressed appropriately. When asked if her catheter had been changed, Resident #2 said,No, they had changed the urinary drainage bag but not the catheter itself. During an interview with RN L on 12/13/13 at 9:55 AM, when asked if she had ever worked with Resident #2, she said at least one night

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	4515 VILLAGE CREEK RD FORT WORTH, TX 76119

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F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 15) a week. When asked if she had ever changed Resident #2's Foley catheter, RN L said, No, she had not. RN L said she did not change the catheter bags either asthe CNAs change from the bedside drainage bag to the leg bag. RN L said sometimes Resident #2 calls her to fix it. The leg bag strap would be too tight, so RN L would loosen it for Resident #2. During a telephone interview with Resident #2's family member on 12/13/13/at 10:09 AM, he/she informed the surveyor Resident #2 had gone to two physician appointments. The family member said another family member had taken Resident #2 to her General Practitioner on 10/07/13 and then to her Oncologist on 11/27/13. The family member said there had been no Urology appointment, but they had been waiting for one, so the Urologist could fix the problem Resident #2 was having with her catheter. He/She said Resident #2 was a very clean lady, and she had complained to the family member about her Foley catheter leaking. The surveyor asked the family member if Resident #2 complained about the Foley catheter bag leaking or if it was leaking in her private area, and he/she said she had complained about it leaking in her private area. The surveyor asked him/her if the resident complained about pain, and he/she said,No, just that it had been leaking about her private area and the resident did not like to feel wet even though she wore incontinent briefs. The resident was also very afraid about (urine) odor. When asked whether Resident #2's Foley catheter had been changed since her admission to the facility, the family member said he/she did not think the Foley catheter had been changed since being admitted to the facility. The family member asked the surveyor how often the Foley catheter should be changed, and the surveyor told him/her every 30 days, or once a month was the norm. The family member said,Well, she (Resident #2) would have told me if they were changing it (Foley catheter) like that. During an interview with RN U on 12/13/13 at 10:42 AM, she informed the surveyor she worked with Resident #2 on the night shift on Saturday nights only and reconciled the comprehensive orders every month for station two, which included Resident #2. When asked if Resident #2 ever complained about pain or her catheter, RN U said,Yes. Sometimes she (Resident #2) complained about her cath (catheter). RN U said Resident #2 would sometimes say, It's not in the right place, and we (staff) would assure her it's in the right place and draining well. When asked if she had ever changed the Foley catheter, RN U said she did not remember if she had changed it or not. When asked how often a Foley catheter should be changed, RN U replied,It's usually on the orders to change every 30 days or one time a month. When asked if Resident #2 had any orders for her Foley catheter on her consolidated orders, RN U said she was not sure if she has an order or not. During a telephone interview with LVN T on 12/13/13 at 2:07 PM, the LVN reported she had only worked on station two and taken care of Resident #2 one time. LVN T said Resident #2 had not complained to her about her catheter when she had worked with her that one time. LVN T said she did remember when she had worked a long time ago, Resident #2 said she felt like shehad to pee but she had not been her nurse so had done nothing about it. During a telephone interview with LVN V on 12/13/13 at 2:16 PM, she informed the surveyor she worked on station two every now and then. When asked what she would check on Resident #2's Foley catheter, LVN V said she would check the color of her urine. LVN V said Resident #2 had never complained about her catheter. LVN V also said she had never changed Resident #2's catheter. When asked how she would know to change Resident #2's catheter, LVN V said usually, the physician's orders [REDACTED]. LVN V informed the surveyor she had never changed Resident #2's Foley catheter bag as The aide will help her change from the leg bag to the night bag. When asked why it was the CNAs' job, LVN V said, Nobody put that on the aides. That's something they've always done. I've never told them to do it. On 12/13/13 at 2:42 PM, the surveyor observed Resident #2 lying flat in her bed on top of her personal blanket with her legs straight, her pants down about her ankles and her incontinent brief pulled down to just above her knees. The surveyor
F 0322 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give proper treatment to residents with feeding tubes to prevent problems (such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers) and help restore eating skills, if possible.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, and metabolic abnormality for three (Residents #4, #10 and #16) of six reviewed for gastrostomy tubes ([DEVICE]s). 1.Resident #4 was laid flat during incontinent care with her [DEVICE] attached to the feeding pump and infusing at 65 cc/hr. 2.Resident #10 was laid flat during incontinent care with his [DEVICE] attached to the feeding pump and infusing at 70 cc/hr. 3.Resident #16 was resting almost flat in bed with her [DEVICE] attached to the feeding pump and infusing at 70cc/hr. These failures could affect the 18 residents including Residents #4, #10 and #16, who received [DEVICE] feedings, by placing them at risk for aspiration pneumonia, vomiting and dehydration. Findings included: 1.Resident #4 was a [AGE] year-old male, readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #4 was severely impaired for cognitive skills for daily decision-making and had a feeding tube. Review of Resident #4's consolidated November 2013 physician orders [REDACTED]. An observation on 12/10/13 at 2:15 PM revealed CNA R provided incontinent care to Resident #4. The surveyor entered Resident #4's room as CNA R was lowering the head of the resident's bed and she had already donned gloves. CNA R continued to lower the head of the bed until it was flat, while the resident was receiving [MEDICATION NAME] AC tube feeding via a pump at 65 cc/hr. The surveyor asked CNA R if the tube-feeding pump was off and CNA R stated, No it is on. CNA R provided incontinent care to Resident #4, including repositioning Resident #4 back and forth with cleaning and putting on a clean brief. At 2:32 PM, CNA R had completed the incontinent care and raised Resident #4's HOB to 45 degrees. Note the bed was flat for 17 minutes, with the [DEVICE] feedings infusing. In an interview on 12/10/13at 2:32 PM the surveyor asked CNA R if she always laid the HOB flat with the tube feeding pump running when providing care and CNA R stated, Oh yes, we (CNAs) aren't allowed to touch the pumps (tube feeding pumps). In an interview on 12/11/13 at 2:40 PM ADON MM stated when the CNAs provided care they needed to tell the charge nurse and the charge nurse would turn off the tube-feeding pump. ADON MM further stated when the CNA, who completed the resident's care, she then notified the charge nurse and the charge nurse would turn the tube-feeding pump back on. In an interview on 12/11/13 at 3:30 PM the DON stated when the CNAs provided care they could put the tube feeding pump on pause, provide the necessary care and then the CNA could take the feeding tube pump off of pause and let the pump restart. 2) Resident #10 was [AGE] year-old male re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]., [MEDICAL CONDITION] Disorder, Depression, Gastrointestinal Hemorrhage, [MEDICAL CONDITIONS], and Urinary Tract Infection per his readmission MDS assessment dated [DATE]. Further review of the MDS revealed he had severely impaired cognition, he had unclear speech, he was totally dependent on staff all ADLs and was always incontinent of bowel and bladder. The assessment reflected he was fed by a feeding tube. Review of Resident #10's consolidated December 2013 physician's orders [REDACTED]. An observation on 12/11/13 at 9:18 AM revealed Resident #10 was in the process of receiving incontinent care by CNA GG. Resident #10 was observed to be lying almost completely flat and was turned from side to side. He was receiving [MEDICATION NAME] HN via [DEVICE] through a pump running at 70 cc per hour. As she concluded her care, LVN D entered the room with the Wound Physician as he was making his rounds. CNA GG washed her hands and left. LVN D assisted the Wound Physician by lifting the resident's leg so the wound on his heel could be observed and his wound measured. After the Wound Physician had finished, LVN D repositioned Resident #10 and raised the head of his bed. In an interview on 12/11/13 at 9:28 AM, CNA GG was asked whether she always left a tube feeding running during care. CNA GG stated the nurse usually paused the feeding. When asked if she had called for the nurse, CNA GG replied, No, it was running, that was my mistake. Resident #10's Care Plan dated 10/31/13 reflected: (Resident #10) has potential for choking and aspirating R/T Hx. of Dysphagia. Approached included: Feedings as ordered by Physician; Monitor feeding tolerance; Diet Consult as needed; and Obtain weekly weights. 3. Resident #16 was a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment further reflected she was totally dependent on staff for all her activities of daily living, she could not communicate her needs, had severely impaired cognition, and was fed via [DEVICE]. Review of Resident #16's consolidated December 2013 physician's orders [REDACTED]. Observation on 12/14/13 at 10:00 AM revealed Resident #16 was lying in bed. The head of her bed was only raised approximately 20 degrees and she lying low in the bed so that her body was almost flat. She was receiving Glucerna 1.2 Cal tube feeding infusing via pump at 70 cc/hr. During an interview on 12/14/13 at 10:05 AM, when LVN T was shown Resident #16's position in bed, she stated her head should be up higher and she would fix it. Resident #16's Care Plan dated 10/18/12 and updated 10/17/13 reflected: Potential for aspiration related to [MEDICAL CONDITION] and dysphagia R/T [MEDICAL CONDITION]. Approaches included: .3. Elevate HOB 30-45 degrees at all times. 4. Review of the facility's current undated policy and procedure ENTERAL FEEDING PUMP GENERAL GUIDELINES FOR USE OF revealed, PURPOSE 1. To provide enteral nutritional therapy at a

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F 0322 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 16) continuous rate. 2. To prevent aspiration. 3. To prevent volume overload. 5. Review of the facility's Form-672, Resident Census and Conditions of Residents, dated 12/11/13 and signed by the MDS Coordinator reflected 18 residents had [DEVICE]s.

F 0325 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.**

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview, and record review, it was determined the facility failed to ensure that a resident maintained acceptable parameters of nutritional status, such as body weight for three (Resident #3, #40 and #41) of 12 residents reviewed for nutrition. 1. Resident #3 experienced a 16.3% (20.8 lbs) loss of body weight from 11/01/13 to 12/17/13. Failures included: a) Staff failed to document Resident #3's meal intake and administer Med Pass nutritional supplement as ordered when she consumed less than 50% of her meals. b) Staff failed to accurately document Resident #3's weight, and nursing staff was unaware of the extent of her weight loss. c) Staff failed to implement the recommendations made for Resident #3 by the Dietitian after she was consulted by the physician. d) Staff failed to notify the physician after they became aware of her 10% weight loss in two weeks until surveyor inquiry. 2) Resident #40 experienced a 5.67% (9.8 lbs) loss of body weight from 12/03/13 to 01/03/14. Failures included: a) Staff failed to record and document Resident #40's meal intake accurately. b) Staff failed to ensure the Dietary Consultant saw the resident once she was admitted to the facility. c) Staff failed to notify the physician after they became aware of Resident #40's 5.67% weight loss for three days. d) Staff failed to initiate a Care Plan regarding Resident #40 pocketing her food for two months. 3. Resident #41 was identified on 11/26/13 as having a 6% weight loss in 20 days. Failures included: a) Staff failed to notify the physician of the weight loss and recommendations made by the consulting dietitian. b) Staff failed to implement the recommendations made by the dietitian. An Immediate Jeopardy (IJ) was identified on 01/02/14. While the IJ was removed on 01/11/14, the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy, because not all staff had been trained and the facility was still monitoring the Plan of Removal. These failures resulted in: - Resident #3 losing approximately 21 lbs since 11/01/13, placing her at risk for further debility, pressure sores and deterioration of her physical condition. - Placeing Resident #40 at risk for continued weight loss and complicaitons from pocketing her foods. - Placing Resident #41 at risk for continued weight loss and deterioration of her physicial condition. These failures could affect any of the facility's 75 residents placing them at risk for unplanned weight loss, extended healing time, [MEDICAL CONDITION], dehydration and fatigue. Findings included: 1. Resident #3 was a [AGE] year-old female re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS assessment revealed she was severely impaired cognitively, was totally dependent on staff for her ADLs, she weighed 133 lbs, and had no weight loss. 1) Resident #3's Care Plan dated 10/24/13 reflected: (Resident #3) poor appetite eating DT Cognitive Deficit/family declined GT placement. Approaches included: Diet as ordered/preferences per family's request.; Medication as ordered, Assist/Cueing with meal; Document meal % and report % to nurse with meal ticket; Offer fluids frq throughout day.; Dietary consult; Psych consult; Notify Dr./RP of any changes in condition. Resident #3's consolidated physician's orders [REDACTED]. The order was dated 10/24/13. Resident #3's Dietary Progress Notes dated 11/21/13 reflected: Resident has 11% significant wt. loss X's 180 days R/T poor appetite, refuses to eat after return from hospital. Resident Received fortified foods, likes chocolate milk. Resident on weekly weights. DSM will monitor meal intake, nursing to monitor weight and skin closely, will follow. Resident #3's Food Intake Record for November 2013 revealed she consumed less than 50% of her meal 27 times. Additionally, meal percentages were not documented at all and left completely blank 24 times. Review of Resident #3's MARs for November 2013 revealed an entry dated 09/27/13 for Med Pass 60 cc by mouth as needed if the resident eats less than 50%. There were no doses initialed as administered. Resident #3's Nutritional assessment dated [DATE] reflected her weight was 128 lbs. The Summary and Recommendations reflected: 10/25/13: Dietary consult ordered for low pre-alb. Nutr assess reveals pt readmitted post hospitalization at (hospital name) for possible [DEVICE] eval due to failure to thrive, dysphagia, and UTI; pt shows wt loss 5 lbs/30 days-4%, following overall wt loss 15 lbs/180 days-10.49%; Pt remains within desireable wt range, as reflected by BMI factor; Pt continues w/varying intake of regular, therapeutic diet; [MEDICATION NAME] was ordered 10/28/13 for appetite stimulant; Pro powder was dc'd 10/25/13 due to pt refusal; pt receives med pass 60 cc TID if intake < 50% for add'l 360 cal/15 gm pro; lab reveals low pre-alb level; due to continued wt loss and low pre alb, recommend adding Medpass 2.0 120 cc BID for add'l 480 cal/20 gm pro; pt to be carefully monitored. NOTE: The recommendation for Medpass 120 cc BID was never ordered. Resident #3's Food Intake Record for December 2013 revealed she consumed less than 50% of her meal seven times between 12/01/13 and 12/12/13. Additionally, meal percentages were not documented at all and left completely blank eight times from 12/01/13 through 12/12/13. Review of Resident #3's MARs for December 2013 revealed an entry dated 09/27/13 for Med Pass 60 cc by mouth as needed if the resident eats less than 50%. There were no doses initialed as administered. Observation on 12/11/13 at 8:00 AM revealed Resident #3 was fed breakfast in the dining room by facility staff. Resident #3 consumed 30% of her eggs, 90% of her oatmeal and 75% of her meat. Observation on 12/11/13 at 1:05 PM revealed Resident #3 was fed lunch in the dining room by facility staff. She only consumed 25% of her meat and 60% of her dessert. During an interview on 12/12/13 at 7:10 PM, LVN W was asked about Resident #3's Med Pass order. LVN W stated she did give the resident Med Pass on occasion. She stated she had been giving her health shakes because Resident #3 would drink them up. She could not answer why there were no doses documented. LVN W stated Resident #3's (family member) often came in the evening and feeds her too much. When asked what she meant by that, LVN W stated he/she would push her to eat yogurt and healthshakes and she (LVN W) thought he overdoes it. During an interview on 12/13/13 at 8:10 AM, LVN D stated she had not given Resident #3 any Med Pass because she was eating much better and did not need any. When asked about the Food Intake Record and informed there were several times she refused to eat or ate less than 50%, LVN D stated she had her meal tickets somewhere and was not aware of Resident #3 ever eating less than 50%. She stated she knew Resident #3's weight was stable, and she had no weight loss this month. Resident #3's Yearly Weight Record reflected the following weights: 10/24/13 - 128.1 lbs 11/01/13 - 127.6 lbs 12/02/13 - 126.6 lbs 12/09/13 - 126.6 lbs Observation on 12/13/13 at 8:24 AM revealed Resident #3 was weighed by Restorative Aide BB. Resident #3 was weighed in her wheelchair, then assisted to a chair and then the empty wheelchair was weighed. The resident's weight was 109.2 lbs. Restorative Aide BB stated she weighed the resident the same way every time. She stated her weight had dropped, and she would report the findings to LVN D and ensure the resident was weighed daily. She added she would request the scale be calibrated for accuracy. Restorative Aide BB checked her records, which were kept in the therapy department, and discovered she had entered the wrong weights on Resident #3's Yearly Weight Record. She corrected the Yearly Weight Record to reflect the following: 11/1/13 - 127.6 lbs 12/02/13 - 122.6 lbs 12/06/13 - 120.6 lbs 12/13/13 - 109.4 lbs On 12/13/13 at 9:30 AM, LVN D was informed of Resident #3's actual weight of 109 lbs by the surveyor. LVN D stated she had been informed, and they were going to get the scale calibrated. During an interview on 12/14/13 at 10:00 AM, LVN T, Resident #3's weekend Charge Nurse, was shown Resident #3's MAR and asked why no Med Pass had been administered as ordered. LVN T explained since the resident returned from the hospital, she had been doing much better so none was given. LVN T was shown Resident #3's Food Intake Records for November and December 2013 with several weekend entries reflecting she had either refused to eat or consumed less than 50%. LVN T stated, The aides didn't tell me. They gave the ticket to the clerk. I should have checked. In an interview on 12/16/13 at 3:20 PM , Restorative Aide BB stated she had spoken with the Dietary Manager, who agreed she (Restorative Aide BB) would personally feed Resident #3 in the therapy department and complete a more detailed summary of her intake with every meal. On 12/17/13 at 12:20 PM, Restorative Aide BB stated the scale had been calibrated. At that time, Resident #3 was weighed, and her weight was down to 106.8 lbs. On 12/17/13 at 2:30 PM, Restorative Aide BB reviewed Resident #3's meal intake documents completed for 12/16/13. The form reflected she consumed 25% of her breakfast, no lunch and only 10% of her dinner. Restorative Aide BB stated she discussed her plans to personally feed Resident #3 with LVN D and the DON, who agreed it was a good idea. Review of Resident #3's December 2013 MAR revealed there was still no Med Pass administered on 12/16/13. Review of Resident #3's Nurse's Notes revealed no indication her physician had been notified of her weight loss. Resident #3's Dietary Progress Notes dated 12/13/13 reflected the following: Resident last weighed @ 109.4, weighed twice. Scales to be checked stated by Rehab aide. Resident continues to have significant amount of weight loss, resident has 14% significant weight loss x's 30 days R/T refusal to eat. (Director of Dietary Services) called dietitian's asst. Dietitian on vacation @ this X, facility needed immediate intervention due to tremendous amount of weight loss within 30 days. Dietitian faxed recommendations, (Director of Dietary Services) was also asked to tell resident's charge nurse of recommendations of Med Pass (with) medications 3x a day. Nurse stated res. already receives 60 cc if she eats less than 50%. Dietitian stated res is a good candidate for appetite stimulant but may not be able to receive it according to what's going on with her. (Director of Dietary Services) talked (with) charge nurse, stated she receives [MEDICATION NAME] already but res still not eating well as observed by (Director of Dietary Services) & rehab aide. Nurse stated she would call the doctor. Doctor's office called (Director of Dietary Services) about dietitian's recommendations and stated she would talk with doctor and get back (with) me. Will follow. The note was signed by Director of Dietary Services. Resident #3's Nutritional assessment dated [DATE] reflected her weight was 127 lbs. Summary and Recommendations reflected: 12/17/13: Dietary consult requested due to weight loss. Nutr assess reveals wt remains stable/ 30 days, following wt loss 9 lbs/90 days-7%, 13 lbs/180 days-9.29%; Pt remains within desirable wt range, as reflected by BMI factor;.Pt continues to refuse to eat; Pt will accept shakes and chocolate milk; [MEDICATION NAME] continues for appetite stimulant; Med Pass continues 60 cc TID if meal intake is < 50% for add'l 360 cal/15 gm pro, due to continued wt loss and low pre-alb, recommend adding Med Pass 2.0 120 cc BID for add'l 480 cal/20 gm pro; wt loss may be expected; .continue to monitor closely; goal is to provide adequate cal and pro to stabilize wt. The assessment was signed by Dietary Consultant PP. During an interview on 01/02/14 at 4:10 PM, Dietary Consultant PP was queried about her Nutritional Assessment of Resident #3. Dietary Consultant PP stated she was called for a consultation on 12/17/13 and the weight reflected on her assessment was the weight she was given for Resident #3 by the facility. When asked about her recommendation for the Med Pass 2.0 supplement, Dietary Consultant PP explained she was informed by facility staff Resident #3 had been receiving doses of Med Pass as needed but she wanted to add a scheduled dose in addition to the PRN dose already ordered. She could not remember who told her Resident #3 was taking the Med Pass. When the Dietary Consultant PP was told Resident #3's weight was actually 109 lbs on 12/13/13, then dropped to 106 lbs, she stated she was never made aware of the weight drop. When asked who provided her the information for her consultation, Dietary Consultant PP stated the Director of Dietary Services faxed a weight sheet prior to her arrival. She explained they typically faxed the information in advance so she could prepare for her visit. During an interview on 01/02/14 at 4:35 PM, the Director of Dietary Services was asked what type of information she sent to the dietitian when a consultation was ordered. She stated she sent them the resident's weights. When asked about Resident #3, she confirmed she sent the dietitian her weights. The Director of Dietary Services retrieved a list of monthly weights to show the surveyor. Resident #3's weight for December was documented as 126.6 lbs; a line was drawn through the entry. The Director of Dietary Services stated, I lined that out later and wrote 109. The Director of Dietary Services retrieved a Dietitian Consultant Worksheet and stated she typically filled it out and gave it to the Dietitian. When asked whether she provided one for Resident #3's consultation, the Director of Dietary Services replied, I can't remember if I did this last time. They never let me know when they are coming. The Director of Dietary Services also explained she had informed the Dietitian Resident #3 was taking Med Pass supplement. She stated she had been informed by LVN D the resident was getting it. On 12/17/13 at 2:17 PM, an interview with NP P, Resident #3's Nurse Practitioner, revealed she had not been notified of Resident #3's weight loss and was unaware of the recent weight drop. During an interview on 12/17/13 at 3:07 PM, LVN D stated she remembered the surveyor reporting Resident #3's weight loss on 12/13/13. She stated she reported the information to the DON. When asked why she did not call the physician, LVN D stated she was going to wait until the scale was calibrated. In an interview on 12/17/13 at 4:10 PM, the DON stated Resident #3's physician had been called and lab orders were obtained for a CBC,

CMP and Pre-[MEDICATION NAME] level to be done. She added a care plan meeting with the family was being arranged and Physician K, Resident #3's attending physician, would attend. The DON stated Resident #3 was getting health shakes instead of Med Pass but staff had not been documenting it. She stated nursing administration was going to take over monitoring Resident #3's meal intake and every resident in the building would be re-weighed. When asked why the physician was not notified on 12/13/13 when the discrepancy was found, the DON stated, No. It was the intent but it got dropped. An interview on 01/02/14 at 2:21 PM with Restorative Aide BB revealed she had begun re-weighing residents but had not completed the task (16 days since the DON said all residents would be re-weighed.). Restorative Aide BB provided lists dated 12/31/13 through 01/02/14 with the names and weights of residents. When asked when she was asked to initiate re-weighing the residents, she stated she had not been told by anyone to re-weigh the residents. When asked why she was re-weighing the residents, Restorative Aide BB said, I know that's what you do when you have a discrepancy. In an interview on 01/03/13 at 12:12 PM, the DON was asked whether she had implemented the re-weighing of all the residents as she had informed the surveyor she would. The DON stated, We are in the process of doing that now. During an interview on 01/06/13 at 12:00 PM, Physician K stated he had taken part in care plan meetings regarding Resident #3. He stated he had decreased her medications, which were not critical to maintain function. Physician K stated he learned the facility had not been calling the family to assist her when she would not eat as had been agreed upon during a previous meeting. 2) Resident #40, an [AGE] year-old female, was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed the resident's cognitive skills for daily decision-making were moderately impaired. This assessment reflected Resident #40 required set up help only for meals, had no swallowing disorders and required a mechanically altered diet. Review of Resident #40's admission weight on 11/05/13 was 172.6 lbs. Review of Resident #40's INITIAL CARE PLAN dated 11/05/13 revealed: PROBLEM: Nutritional Risk related to: Mech soft INITIAL CARE PLAN OUTCOME: Will maintain weight within two lbs of each month. NURSING INTERVENTION: Weigh wkly x 4 then per protocol. Diet as ordered: Report food intake of less than 75% of five meals in two days to R.D. for assessment. Offer fluids throughout shifts. Review of Resident #40's Nurse's Notes dated 11/09/13 on the day shift revealed the resident was pocketing her food in her mouth and the nurse received an order for [REDACTED]. The evening shift documented Resident #40 continued to pocket her food and crushed medication. Resident #40, cont to pocket everything you put into her (Resident #40's) mouth. DON/ADON informed. Review of the Speech Therapist note dated 11/10/13 revealed, Reason For Referral: This [AGE] year old female presents to speech therapy with a recent decline in swallowing and cognitive abilities.Swallowing Lingual Function - moderate impairment (50-75% impairment; combination of oral and non-oral nutrition; requires thickened liquids, difficulty masticated foods) .Impact on Burden of Care/Daily Life - The patient requires mod to max cues of PO intake and ADL participation due to safety reasons. Review of Resident #40's DIETARY PROGRESS NOTES dated 11/12/13 revealed, Resident (Resident #40) new admit has hx of Altered Mental Status, DM II, UTI, [MEDICAL CONDITION], HTN, Alzheimer's, Hypercholesteromia, [MEDICAL CONDITION], Dementia. Res. receives Puree diet tol. well (with) no difficulty @ this x. The Director of Dietary Services signed this note. Review of Resident #40's Nurse's Noted dated 12/21/13 (day shift) revealed, .can't swallow medicine. During an interview on 01/06/14 at 3:15 PM, the surveyor asked MA EE, assigned to pass medications to Resident #40, if the resident could swallow her medications. MA EE stated she could swallow her medicaitons. It just took time. Review of Resident #40's COMMUNICATION PAGE dated 12/23/13 revealed: (Resident #40) - Refusing to eat - holding food + liquids in mouth! When swallowing liquids - she coughs and refuses to open mouth. (no) signs of tearing (of eyes) or running nose this AM. Will not swallow medicine. Points to throat. Asked if she was having a hard time swallowing. She nods head yes and holds mouth shut. Tongue thick in mouth, sticks at roof of mouth. Also experiencing cognitive change. Coaching x 4 to swallow or participate (with) therapy. Tongue coated (with) food + meds. To: DON: MDS: ADON: Dietary: C Nurse. Restorative Aide BB signed this note. During an interview on 01/06/14 at 2:25 PM, Restorative Aide BB stated she became aware Resident #40 was pocketing food (in her mouth) on 12/23/13 and wrote a communication page, regarding the pocketing. Restorative Aide BB further stated she gave a copy of the communication page to the DON, ADON, Charge Nurse LVN F and to the Director of Dietary Services. Review of Resident #40's DIETARY PROGRESS NOTES dated 12/23/13 revealed, Resident (Resident #40) refusing to eat, pocketing food + liquids in mouth when swallowing resident coughs + refuses to open her mouth. No tearing (of eyes) or runny nose @ this x. Resident would not swallow medicine that AM. Resident will point @ throat. Resident was asked if she was having a hard time swallowing + she nodded her head yes + held her mouth shut. Resident also experiencing some cognitive change. Resident coached x's 4 to swallow or participate (with) therapy. Tongue coated (with) food + meds. To continue to monitor closely, will follow resident to be placed on weekly weights. The Director of Dietary Services signed this note. Review of Resident #40's Nurse's Notes dated 12/23/13 (day shift) revealed Alert, pleasant assist to DR, unable to swallow pureed food well, does pocket food (in mouth). Has to be spoon fed meal unable to complete task . During an interview on 01/06/14 at 10:50 AM, the DON stated she was aware Resident #40 was pocketing food (in her mouth). The DON further stated the Speech Therapist told her Resident #40's pocketing was due to cognitive (deterioration). I have been watching her (Resident #40) over the last week, not consistent (pocketing), mainly breakfast. The surveyor asked the DON if the physician had been notified of the resident pocketing and the DON stated, Yes, that's how speech therapy got notified. The surveyor asked the DON if pocketing triggered calling the Dietary Consultant and the DON stated, If the resident ate less than 50%. Review of Resident #40's Yearly Weight Record revealed: 11/05/13 (Admission) - 172.6 lbs 12/03/13 - 172.4 lbs Review of Resident #40's Care Plan, completed by the Director of Dietary Services, on 01/03/14 revealed Resident #40's weight was 163.6 lbs. Review of Resident #40's Nurse's Notes dated 01/03/14 revealed no mention of the resident's weight loss. Observation on 01/05/14 at 1:00 PM revealed Resident #40 was in the dining room, feeding herself lunch. Resident #40 had a divided plate (three sections), which contained puree chicken, mashed potatoes, puree peas, a separate bowl of applesauce and two 6-ounce glasses of nectar-thickened fluids. At approximately 1:20 PM, a CNA approached Resident #40 to move her from the dining room. The resident still had a spoon in her hand. The resident put the spoon down and was moved to the television room. One third of the divided plate (mashed potatoes) and one third of one of the fluid-filled glasses was consumed. ADON NN and LVN FF were standing over the table where Resident #40 sat. LVN FF, who had been the assigned nurse for the dining room, picked up Resident #40's meal ticket and wrote 50% on it, indicating the resident's intake. The surveyor looked at the meal ticket and asked LVN FF if he thought Resident #40 ate 50% and he said, Yes. The surveyor then asked ADON NN if she thought Resident #40 at 50% and she said, No. The surveyor asked ADON NN how much the resident ate, and she stated, 25%. Review of Resident #40's FOOD INTAKE RECORD dated 01/05/14 revealed Resident #40 ate 50% of her lunch meal. Note: this documentation occurred after the surveyor verified with LVN FF and ADON NN Resident #40 actually ate 25% of her lunch meal. During an interview on 01/05/14 at 1:45 PM, the surveyor asked LVN FF if the unit clerks (who recorded the resident meal tickets) notified him when the residents ate less than 50%. LVN FF replied, Sometimes, but I know how much the residents eat because I'm always in the dining room during meal times on the weekends. If a resident ate less than 25%, I give them cereal or a shake. The surveyor asked LVN FF if he ever notified the physician when a resident ate less than 25%, and LVN FF stated, No, but the families know if they come in during meal time. Observation on 01/06/14 at 10:30 AM revealed Resident #40 was being weighed. The resident's witnessed weight was 162.8 lbs. Review of Resident #40's Nurse's Notes dated 01/06/14 at 7:50 PM revealed, _____ (Physician K) present in facility at this time, notified of 9 lb weight loss in 30 days. New orders given at this time to start [MEDICATION NAME] ES 625 mg/5 mL give 5 mL PO QD + Med Pass give 60 mL PO TID. Note: This was three days after Resident #40's significant weight was identified by the faciity staff. During an interview on 01/07/14 at 2:30 PM, the MDS Coordinator stated she was feeding Resident #40, around Christmas time, and noticed the resident was pocketing her food (in her mouth). The MDS Coordinator stated she notified the Restorative Aide, who swept out the resident's mouth. The MDS Coordinator stated she did tell the resident's charge nurse, but did not remember who, and the charge nurse already knew about Resident #40s pocketing of food. She further stated this was the first time she (the MDS Coordinator) knew about the resident pocketing her food. During an interview on 01/07/14 at 3:40 PM, the Director of Dietary Services stated she generated Care Plans for Resident #40, which were still on her computer. She further stated these care plans remained on her computer until the next quarterly Care Plan meeting. Then she would print them and add them to any other care plans written by nursing. The following Care Plans were on the Directorof Diretary Services computer, requested by the surveyor. Related Diagnosis: [REDACTED]. Problem Onset: 11/12/2013 _____ (Resident #40) has potential for choking and aspiration R/T Hx. Of Swallowing Difficulty _____ (Resident #40) is at risk for aspiration/Weight loss D/T AMS/Occasional Pocketing of food w/o staff's ability to redirect On 1/03/2014 _____ (Resident #40) has Weight loss per weight committee (Weight: 163.6) Goal & Target Date _____ (Resident #40) will experience no S/S of choking or aspiration until next review date _____ (Resident #40) will be assisted with consumption therapeutic diet for needed caloric intake thru the next eval date Approaches Diet as ordered by physician Monitor for s/s of choking or aspiration Diet Consult as needed ST to screen, eval tx as indicated Spoonfed while queing (sic) to chew and swallow Remove any food she pockets before leaving Dining Rm. Report to Charge Nurses and Document % (meal eaten) Keep her in upright position during meals and at least 30 min post meals Document Meal % Notify Dr./RP of any changes in resident Notify Dr/RP of change in weight Document weigth (sic) Weight per facility's protocol Contact Family/RP for family conference Appt: [DATE] @1:30 pm Problem Onset: 11/12/2013 _____ (Resident #40) has potential for weight loss R/T Hx. Of Altered Mental Status/Alzheimers. Goal & Target Date _____ (Resident #40) will experience no significant weight loss until next review date Approaches Diet as ordered by physician Obtain monthly weights Diet Consult as needed. During an interview on 01/07/14 at 10:10 AM, Dietary Consultant OO stated she usually saw each new admission within 30 days of admission, if the resident was not having any problems. She acknowledged she had not seen Resident #40 yet. Dietary Consultant OO further stated she should have been notified once Resident #40 began pocketing foods (in her mouth). Review of Resident #40's Nutritional assessment dated [DATE] revealed Resident #40 lost nine lbs in 30 days. STAFF REPORTING PT IS HAVING DIFFICULTY W/SWALLOWING AND POCKETING OF FOOD. 12/23/13 PT'S DIET DOWNGRADED TO PUREED REQUIRING NTL DUE TO DYSPHAGIA. PT BEING SEEN BY SPEECH DUE TO WT LOSS RECOMMEND FORTIFIED DIET FOR ADDIT 1358 CAL. 60 GM PROT WHICH INCLUDES SHAKE QD, FORTIFIED SOUP AND CEREAL; PT IS RECEIVING MED PASS 2.0 FOR ADDIT 360 CAL/15 GM PROTEIN; RECOMMEND

>MED PASS TO 120 CC TID FOR ADDIT 720 CAL/30 GM PROT .PT IS BEING WEIGHED WEEKLY. Dietary Consultant OO signed this note.

Note: This was the first time Resident #40 was seen/assessed by a Dietary Consultant since her admission (on 11/05/13, two months previously). 3) Resident #41 was a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment reflected she had severe cognitive impairment, was independent with eating, weighed 130 lbs and had no weight loss. Resident #41's Care Plan (retrieved by the MDS Coordinator from her computer) dated 09/19/13 reflected she had the potential for weight loss related to a history of [MEDICAL CONDITIONS] and Dementia. Resident #41's Care Plan was updated on 01/03/14 to include the resident's weight loss of 7 lbs per the weight committee. Approaches included: Diet as ordered by physician; Monitor meal intake, document percentage and notify the doctor and responsible party for intake of 50% or less; Diet Consult as needed; Offer supplements and snacks when consumes 50% or less of meal. Resident #41's physician's orders [REDACTED]. A Communication Page regarding Resident #41, dated 11/26/13 and signed by Restorative Aide BB, reflected it was addressed to the DON, ADON, Dietary, and Charge Nurse. The Note reflected: Wt-Loss Alert; 11/6-130.0 wt; 11/26-122.4- (down) 7.6 in 20 days. Not feeling very well after flu shot; refusing to eat. Review of Resident #41's Nurse's Notes dated 11/26/13 revealed the resident's family was called about a situation, but there was no indication her physician had been notified of her weight loss. During an interview on 01/07/14 at 9:46 AM, LVN F, Resident #41's Charge Nurse, was asked about the resident's weight loss. LVN F confirmed she had received a communication form from

	Restorative Aide BB. She stated she remembered sharing the information with Resident #41's family but could not recall whether or not she notified the physician. Resident #41's Dietary Progress Notes had an entry dated 12/12/13 that reflected: Resident continues to receive NAS diet tol. well with no difficulty @ this X .wt @ 130 fairly stable x's 30 days.(Director of Dietary Services) will continue to monitor meal intake, nursing to monitor wt. & skin, will follow. The note was signed by the Director of Dietary Services. In an interview on 01/07/14 at 2:15 PM, the Director of Dietary Services confirmed she had received the communication form reflecting Resident #41's weight loss. When asked why she documented the resident weighed 130 lbs, when she weighed 122 lbs, the Director of Dietary Services replied, I must have looked at an old sheet. Resident #41's Nutritional assessment dated [DATE] reflected she weighed 122 lbs. The Summary and Recommendations reflected: Nutr Assess reveals wt loss 8 lbs/30 days-6%, 11 lbs/90 days-8%, 8 lbs/180 days-6.15%. Pt remains within desirable wt range, as reflected by BMI factor.Recommend adding fortified food plan, including shake QD, for add'l 1358 Cal/60 gm PRO; Continue to monitor monthly weights; Goal is to provide adequate Cal and PRO to stabilize wt. An observation on 01/05/14 at 12:58 PM revealed Resident #41 was eating in the dining room. Her tray ticket reflected she received a regular, no added salt diet and shake w/meals. Observation revealed no shake was offered to her during or following the meal service. She consumed approximately 75% of her lunch. Another observation on 01/06/14 at 8:50 AM revealed Resident #41 was eating breakfast in her room. Her breakfast tray ticket reflected she received a regular, no added salt diet and shake w/meals. There was no shake on her tray. During an interview on 01/06/14 at 9:00 AM, The Director of Dietary Services
F 0329 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure two (Residents #2 and #5) of 12 residents reviewed for medication regimen were free from unnecessary medications. 1.The facility failed to discontinue Resident #2's [MEDICATION NAME] 25mg (for Hypertension) as ordered. The morning dose of [MEDICATION NAME] was discontinued after the AM dose on 02/03/14 and the evening dose was discontinued after the PM dose on 02/28/14, for a total of 31 doses. 2. Resident #5 received nine doses of [MEDICATION NAME] between 10:00 pm and 11:30 PM (from 03/04/14 to 03/21/14), despite

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. BUILDING _____ B. WING _____	**01/11/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	**4515 VILLAGE CREEK RD FORT WORTH, TX 76119**

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 0329

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 17)
her physician ' s specific orders that she was not to have the medication at bedtime. No pain assessments were documented and the physician was not notified. An Immediate Jeopardy (IJ) was initially identified on 03/20/14. While the IJ was removed on03/24/14, the facility remained out of compliance at a scope of widespread and a severity level of actual harm that is not immediate jeopardy, because not all staff had been trained and the facility was still monitoring the Plan of Removal. These failures placed Residents #2 and #5 at risk for weakness, confusion, dizziness, headache, [MEDICAL CONDITIONS], over sedation, lethargy, and death and could affect the 75 residents in the facility. Findings included: 1. Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #2 had a BIMS of 4 and was dependent on staff for most of his ADLs. Review of Resident #2's Care Plan dated 02/27/14 revealed: Date & Problem: DX [MEDICAL CONDITION]/HTN/[MEDICAL CONDITION] Goal: (Resident #2) will
not suffer any complications caused by Dx ' s thru the next eval date. Approaches & Disciplines: Lab as ordered Notify Dr. of results Medications as ordered. Notify Dr of effectiveness Monitor for [MEDICAL CONDITION], SOB, Pain in extremities with discoloration of skin and warm to touch Document and Notify Dr/RP/Hospice. Resident #2's Physician's Telephone Orders dated 01/09/13 reflected [MEDICATION NAME] 25 mg twice a day. Resident #2's Physician's Telephone Orders dated 01/30/14 reflected increase [MEDICATION NAME] to 50 mg twice a day for blood pressure. Review of Resident #2's MARs for the month of January 2014 revealed the last dose of [MEDICATION NAME] 25 mg was on 01/30/14 after the 9:00 PM dose. Further review of this MAR revealed [MEDICATION NAME] 50 mg was started on 01/30/14 at 9:00 PM. Review of Resident #2's MARs for the month of
February 2014 revealed [MEDICATION NAME] 50 mg twice a day was administered as ordered. Further review of this MAR revealed
the morning dose (9 AM) of [MEDICATION NAME] 25 mg was administered on 02/01/14, 02/02/14/ and 02/03/14. DC'D was hand written after the 9 AM dose was administered on 02/03/14. The evening dose (4:00 PM) of [MEDICATION NAME] 25 mg was administered each day during the month of February. A total of 31 doses of [MEDICATION NAME] 25 mg were administered that the physician had discontinued on 01/30/14. During an interview on 03/04/14 at 3:55 PM the surveyor reviewed Resident #2's February 2014's MARs with LVN B, Resident #2's evening charge nurse. LVN B stated she did administer [MEDICATION NAME] 25
mg and [MEDICATION NAME] 50 mg on the days she worked, as were documented on Resident #2's MAR. During an interview on 03/05/14 at 10:05 AM the ADM stated the Unit Manager did the February 2014 monthly recapitulations of physician orders [REDACTED]. During an interview on 03/04/14 at 4:30 PM the Unit Manager stated she checks the pink slips (copy of telephone physician orders) daily to make sure the orders were correct on the MARs. She stated when she did the February 2014 monthly recapitulations of physician orders, she was taken off the floor from 01/25/14 through the end of the month, and the DON took over her tasks, including verifying the pink slips were checked, for the whole building. During an interview on 03/06/14 at 4:30 PM the ADM stated Resident #2 receiving 31 doses of [MEDICATION NAME], which had been discontinued, was a
careless error. The ADM further stated the DON told her she did miss a few a days of checking pink slips. During an interview on 03/06/14 at 8:47 AM the surveyor asked the DON how she thought Resident #2's received 31 doses of [MEDICATION NAME] that had been discontinued. The DON stated when RN A taught the Unit Manager how to do the monthly recapitulations of physician orders, RN A did not instruct the Unit Manager to continue to add additional physician orders [REDACTED]. Nursing 2013 Drug Handbook 33rd Edition, Wolters Kluwer, Copyright 2013, pages 680 - 681 reflected the following nursing considerations for [MEDICATION NAME]: Monitor patient's blood pressure, pulse and body weight frequently.Elderly patients may be more sensitive to drug's hypotensive effects. Overdose signs and symptoms include: [MEDICAL CONDITIONS] headache and
flushing. 2. Resident #5 was an [AGE] year-old female re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS assessment revealed she had no cognitive impairment; was receiving scheduled and PRN pain medications, and she reported she had occasional pain rated 4 out of 10 on a 1-10 scale with10 being most severe. Review of Resident #5 ' s Comprehensive Resident Care Plan dated 11/7/13 and reviewed 01/30/14 revealed the following: PROBLEM: Pain management for Spinal Stenosis, Muscle Spasms Arthropathy and Late Effect [MEDICAL CONDITION] GOAL: (Resident #5) will be
at her comfort level within 30 mins of discomfort this eval period. APPROACHES: 1. Assess for pain/discomfort and document 2. Medication per order . [MEDICATION NAME] (routine & PRN) 3. Document/Notify physician of effects of meds. 4. Will be assessed/asked if in pain/discomfort @ time of Routine Med Pass Q shift . Review of Resident #5 ' s physician ' s Progress Note dated 03/05/14 revealed she had a past medical history of [REDACTED]. The assessment/plan portion of the note reflected: .DJD-on [MEDICATION NAME]/[MEDICATION NAME] (pain medication) . Resident #5 ' s Physician ' s Telephone Orders
dated 02/24/14 reflected: N/O ' s 1) D/C [MEDICATION NAME] (sleeping pill) 1 mg PO PRN 2) Add [MEDICATION NAME] 1 mg tab
(1) PO q HS Dx: [MEDICAL CONDITION] 3) [MEDICATION NAME] 7.5/325 Give (1) PO BID @ 9A & 6 PM. 4) [MEDICATION NAME] 7.5/325
Give (1) PRN tab in the daytime not at H.S. Q6(hours) The order was written by LVN F. Resident #5 ' s Physician ' s Telephone Orders dated 03/05/14 reflected: Order clarification for Med time change for: ([MEDICATION NAME]) pregabalin 75 mg give 1 cap po BID @ 10:00 AM and 10:00 PM . Review of Resident #5 ' s MAR for the month of March 2014 revealed: An entry for [MEDICATION NAME] 7.5/325 mg 1 PO BID at 10 AM and 6 PM An entry for [MEDICATION NAME] 7.5/325 mg 1 PO Q 6 HRS PRN PAIN
Give in daytime only NOT HS. The MAR revealed only three PRN doses were signed as administered and those were given in the afternoon hours with pain assessments completed by LVN L. Review of Resident #5 ' s Controlled Substance Record for [MEDICATION NAME] 7.5/325 mg revealed the following doses were signed out in the evening hours: 03/04/14 at 11:30 PM by LVN
F 03/11/14 at 11:00 PM by LVN F 03/12/14 at 10:00 PM by LVN F 03/13/14 at 10:00 PM by LVN F 03/14/14 at 10:00 PM by LVN F
03/17/14 at 11:00 PM by LVN F 03/18/14 at 11:00 PM by LVN F 03/19/14 at 11:30 PM by LVN F 03/21/14 at 11:00 PM by LVN F Review of Resident #5 ' s Nurse ' s Notes revealed the following: An undated, untimed entry made by LVN F reflected the following: Physician R called (with) request to (change) resident [MEDICATION NAME] 7.5/325 to TID @ (sic) she takes it PRN like a routine @ HS. Physician R declined & stated to continue [MEDICATION NAME] 7.5/325 BID 9A & 6P & Give [MEDICATION
NAME] 7.5/325 PRN in the daytime not @ HS Q6 (hours). 1) D/C [MEDICATION NAME] 1 mg PO PRN 2) Add [MEDICATION NAME] 1 mg
tab PO q HS. Dx. [MEDICAL CONDITION]. Notified_____ RP. OK. Further review of the Nurse ' s Notes for February and March 2014 revealed there were no entries related to Resident #5 complaining of pain or requesting medication. Review of Resident #5 ' s Weekly Summary dated 03/05/14-03/11/14 revealed she had vocal complaints of moderate pain rated 6 out of 10. Primary Diagnosis(es) included: DM II, Debility, [MEDICAL CONDITION], Chronic Back Pain. The Summary was completed by LVN F. Review
of Resident #5 ' s Weekly Summary dated 03/12/14-03/(illegible)/14 revealed she had occasional pain rated 6 out of 10. Primary Diagnosis(es) included: DM II, Debility, PKD (sic), Chronic Back Pain. The summary was completed by LVN F. During an interview on 03/23/14 at 10:45 AM, LVN L, (Resident #5 ' s weekend Charge Nurse) was asked about pain management. He stated if a resident complained of pain, he would administer a pain pill then monitor for effectiveness, if not effective, the doctor should be called. LVN L stated the pre and post pain assessments were documented on the MAR. When asked about Resident #5 ' s pain, LVN L explained she used to get a PRN dose at night but the order changed, He explained she would ask for it every night but when he saw the order changed so she could not have it at night anymore, he took the order to her and sowed it to her. He stated he offered to call the physician for her and she told him not to. She told him she wanted to talk to the doctor herself. LVN L stated, since that time, she had not requested pain medication from him at night any longer. During an interview on 03/23/14 at 1:15 PM, LVN F (Resident #5 ' s 3:00 PM ? 11:00 PM Charge Nurse) stated all PRN pain assessments should be documented on the back of the MAR and logged on the Narcotic Sheet. When she was asked about Resident #5 ' s pain management, she stated, .(Resident #5) hurts all the time, she begs for pain pills at night. I called (Physician R), she was getting it ([MEDICATION NAME]) at night. She would be asking as soon as I walked in and again at 10:00 (PM). She was still complaining so I said I ' ll see if I can have an order for [REDACTED]. her to have it TID, she said she could have it PRN in the daytime not at bedtime. LVN F confirmed that was when she had written the order on 02/24/14. LVN F stated she had also spoken with Physician R when she came in and had encouraged Resident #5 to speak with her as well. She stated the physician did not change her mind and still did not want the resident to have [MEDICATION NAME] at night. LVN F stated Resident #5 continued to ask for a dose at bedtime and she gave it to her. When asked if she called the Physician first, LVN F replied, No, I didn ' t think it was a good order. When shown the routing sleeping pill order and asked if that was maybe why the physician did not want her to have the medication, LVN F replied, She ' s been taking it for a long time. When LVN F was again asked if it occurred to her to call the physician all those nights the resident was complaining and ask what she should do, she replied, No, because it ' s (Physician R) and her response is not that good .with call back, it ' s not that good. A surveyor asked LVN F if she realized she could not give that dose. LVN F replied, Yeah, I realize that. I shouldn ' t give her a pill that late. When LVN F was asked if she ever signed the medication out on the MAR, documented any pain assessments during these episodes or made any nursing notes on the matter, she reviewed the documentation and replied, I guess not. On 3/23/14 at 3:20 PM, Resident #5 was observed sitting in her room, watching television. At that time, when Resident #5 was asked about her pain management by the facility she stated it was OK. When asked whether she had pain at night, Resident #5 replied, Sometimes it hurts in my back, sometimes not. When asked whether

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	676052	A. BUILDING _____ B. WING _____	**01/11/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	**4515 VILLAGE CREEK RD FORT WORTH, TX 76119**

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 0329 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 18) she was getting pain medication at night, Resident #5 stated she did occasionally and it sometimes helped. When asked whether she had spoken with her doctor about the pain, Resident #5 stated she had and was told there was nothing they could do. When asked who gave her pain medication at night, Resident #5 stated, Whatever nurse is on. 3. Review of the facility's current undated policy and procedure Monthly Review of physician's orders [REDACTED]. Purpose: To ensure that physician order's are accurate. Policy: To verify prior to the beginning of each month that all physician orders [REDACTED]. (RN A)/ (Unit Manager) will be responsible for this monthly review. DON will schedule the delivery of the orders. DON will have (RN A) to be removed from the schedule as a floor nurse for the last 5-6 days of each month. (RN A) will inform DON of all concerns regarding the orders upon the completion of the review. (RN A) will take the prior month MARS and compare them to the clinical record. (RN A) will then take the clinical record and compare it to the new MARS. (RN A) will then handwrite onto the new MAR any new orders that will come after the 25th of the month. Attending nurses will write any new orders on the current MAR until the end of the month. If a new admission comes at the end of the month, (RN A)/Designee reviewing the MAR should make a new set of physician's orders [REDACTED]. (RN A)/Designee should also make a new set of MARS and TARS for the next month. (RN A)/Designee will via fax all updates to the person responsible for preparing the monthly orders: (name of pharmacy tech) at [PHONE NUMBER]. Clarifications orders will be written. 11-7 will compare the old MAR to the New MAR for accuracy. Review of the facility's current policy and procedure Unnecessary Drugs dated 2012 revealed: Purpose: Each resident's drug regimen must be free from unnecessary drugs: Procedure: An unnecessary drug is any drug when used: 1. In excessive dose (including duplicate therapy); or 2. For excessive duration; or 3. Without adequate monitoring; or 4. Without adequate indications for its use; or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 6. An combination of the reasons above . 4) An Immediate Jeopardy situation was identified on 03/20/14. On 03/20/14 at 11:30 AM, the Administrator was notified of the IJ, and a Plan of Removal for the IJ was requested. 5) On March 20th The Department of Aging and Disabilities informed this Administrator that IHC was being placed back into an Immediate Jeopardy for unnecessary medications. THE FOLLOWING STEPS HAVE BEEN TAKEN TO REMOVE THE IMMEDIATE JEOPARDY: Prior to March 20th (March 4th) This Administrator and the DON realized that there was a flaw in the current Monthly Review of the physician's order [REDACTED]. Therefore DON revised/in-serviced on the revision that includes all nurses to be responsible for adding new orders at the end of the month. (from the 25th of the month forward) to the current MAR and the new MAR (that will be placed in the medication room). Prior to March 20th (March 6th) this Administrator counseled with DON and Unit Manager on the importance of daily checking the orders for accuracy. Prior to March 20th (March 10th) DON in-serviced/tested her licensed nurses on the revised Monthly Review of the Physician order [REDACTED]. On March 20th Unit Manager LVN and MDS Director in-serviced/tested licensed nursing staff on transcribing orders, and the new revision to the monthly recap policy. This in-service/test will be completed by the end of business March 22nd. On March 21st DON and Unit Manager LVN will continue to in-service/test the licensed staff on Monthly Review of Physicians Orders Policy, Receiving and Reordering Medication Order ' s Policy, Admissions Orders ' Policy, the Discontinued Order ' s Policy. Also, Pharmacy Consultant prepared an in-service/test on Medication Ordering, Documenting and Removing Medications from the Medication Cart for Destruction. These in-services/test will be completed by the close of business on March 22nd. On March 21 (DON will continue to review with R.N. A, and Unit Manager at the beginning of each month to ensure that all orders received from the 25th of the month forward all were properly transcribed to the current and the new MAR. (see form) On March 21st the DON and Unit Manager will meet at the end of EACH DAY in the Administrator ' s office to present PROOF that orders, initial assessments, items from the daily nursing round sheet are indeed completed. EACH MONDAY THE Weekend Supervisor R.N. will meet the Administrator to provide the proof of the completed task vie the daily nursing round sheet. This meeting will continue through 2014. On the days that I am not in the building the proof will be provided to the CEO. (see copies of the daily nursing round sheets) On March 21st F-TAG 329 Unnecessary Meds will continue to be a part of the monthly Q.A. with the Medical Director for the remainder of 2014. On March 21st Director of Nursing began in-servicing/testing the licensed staff on the 5 rights of medication administration. This training/testing will be completed by the end of business March 24th. On March 21st all new hires, staff, on vacation, out ill etc . will not be allowed back to work prior to completing all o the above in-services/testing . On March 22nd, Director of Nursing R.N. began in-servicing/testing the licensed staff on the 5 rights of medication administration. This will be completed on March 24th. 6. Review of a current facility policy and procedure Transcribing Physician order [REDACTED]. Purpose: To ensure that the resident medications, labs and treatments are being transcribe (sic) according to the physician orders. To ensure licensed nurses are following correct physician orders. Policy: The Nursing Administration Department will review the MAR to ensure that the attending nurses properly transcribe all physician orders. Procedure: The attending nurse will: 1.Received physician order a. Medication b. Lab c. X-ray/US d. Consults e. Diet changes f. Wound care g. Fole care h. [DEVICE] care i. Oxygen 2. Write in on the MAR or TAR 3. Document on: a. 24 hour report b. Nurse Notes 4. Send order to pharmacy 5. Call X-ray/US, write confirmation number on telephone order. 6. If lab, write requisition and plan in lab book. 7. Notify responsible part. 7. The following staff were interviewed following their attendance at the facility in-services: LVN J on 03/23/14 at 9:20 AM RN M on 03/23/14 at 10:00 AM LVN L on 03/23/14 at 10:45 AM LVN H on 03/23/14 at 12:05 PM LVN E on 03/23/14 at 12:30 PM LVN I on 03/23/14 at 2:45 PM LVN O on 03/24/14 at 12:30 PM LVN K on 03/24/14 at 12:45 PM LVN Q on 03/24/14 at 3:30 PM When interviewed, staff verbalized learning how they knew which medications to administer to their assigned residents, what follow up to do after a PRN pain medication was administered, how to update current and next month ' s MARs after a new physician order [REDACTED]. The following MA was interviewed following their attendance at the facility in-services: MA N on 03/23/14 at 12:40 PM. When interviewed, MA N verbalized understanding he should always report any resident complaints to the Charge Nurse immediately. He stated he should compare the medication cards to the MAR and if there was any question related to his medication administration he should check with his Charge Nurse. 8. On 03/06/14 at 8:47 AM the DON stated when the Unit Manager was pulled off the floor to complete monthly recaps, she (the DON) has to pick up verifying daily physician and admission orders [REDACTED]. On 03/24/14 at 10:26 AM the DON when asked how she thought LVN F administered Resident #5 pain medication without an order and the DON stated, I ' m not sure Resident #5 even go the [MEDICATION NAME]. I ' m not sure what happened. I think some things were going on with LVN F. 9. On 03/06/14 at 4:30 PM when the ADM was asked how she thought Resident #2 ' s errors occurred she stated it was just a careless error. She further stated the Unit Manager was not taught to look for further physician orders [REDACTED]. On 03/24/14 at 12:08 PM when the ADM was asked how she thought Resident #5 ' s medication errors occurred she stated the resident ' s nurse let her emotions get in the way. The nurse did not follow the physician orders [REDACTED].#5 ' s complaint of pain. The ADM further stated the nurse did not follow the facility policy and procedure; she did follow her professional judgment and techniques and let bad habits overrule the protocol. 10. While the IJ was removed on 03/24/14, the facility remained out of compliance at a scope of widespread and a severity level of actual harm that is not immediate jeopardy, because not all staff had been trained and the facility was still monitoring the Plan of Removal. 11. Review of the facility's Form-672, Resident Census and Conditions of Residents, dated 03/04/14 and signed by DON reflected a census of 75.
F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to ensure it was free of a medication error rate of five percent or greater. One (LVN A) of four staff observed made errors during the medication pass for one (Resident #4) of five residents observed. There were nine errors observed out of 34 opportunities, resulting in a 26% medication error rate. LVN A failed to administer Resident #4's [DEVICE] medications correctly. LVN A combined the resident's liquid Multi Vitamin and liquid Iron into one plastic cup. LVN A then crushed [MEDICATION NAME], Aspirin, [MEDICATION NAME], Cranberry tablet, Tylenol and [MEDICATION NAME] together and placed the crushed/powdered contents into the plastic cup. She added the liquid Multi Vitamin and liquid Iron to the crushed medication mixture. LVN A then flushed the [DEVICE] and put the cupful of medications through the syringe and flushed the G -tube and restarted the tube feedings. LVN A, by cocktailing, failed to flush between each medication administration. These failures could affect the 18 residents identified by the facility as having [DEVICE]s, including Resident #4, and placed them at risk for not receiving therapeutic dosages of their medications and clogging of the [DEVICE], which could result in additional medical treatment and hospitalization . Findings included: 1. On 12/11/13 at 7:57 AM, LVN A was observed to take Resident #4's blood pressure. It registered 127/83 with a pulse of 79. LVN A began to prepare to Resident #4's medications and set one six-ounce plastic cup and one paper souffle cup on top of her medication cart. LVN A placed [MEDICATION NAME] (for

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F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 19) Hypertension) 50 mg 1 tablet, Aspirin 81 mg (for [MEDICAL CONDITION]) 1 tablet, [MEDICATION NAME] (for Dementia) 10 mg 1 tablet, Cranberry tablet (supplement) 450 mg, Tylenol 500 mg (for pain) 1 tablet and [MEDICATION NAME] (for Diabetes) 500 mg 1 tablet into the souffle cup. LVN A stated, We do cocktail, and proceeded to crush the six tablets together, placed the crushed/powdered contents into the six ounce plastic cup and then added approximately two ounces of water to this cup. LVN A then poured Multi Vitamin (a supplement) 5 ml and Iron (a supplement) 5 ml into the six-ounce cup, which contained the crushed medications. LVN A added approximately one more ounce of water to the six-ounce cup and stirred it all together. LVN A brought the six-ounce plastic cup with medications into Resident #4's room. She filled two additional six-ounce cups with water and placed the cups on the resident's bedside table. LVN A disconnected the feeding tube from the pump. Using the syringe, she pushed in 20 cc of air and auscultated the abdomen to ensure proper feeding tube placement. LVN D then drew up 60 cc of water into the syringe and attaching the syringe to the [DEVICE], plunged the water through the syringe, which was connected to the [DEVICE]. LVN A removed the plunger from the syringe, stirred the medications, which were in the six-ounce plastic cup and poured the contents into the syringe. LVN A then poured 60 cc of water into the six-ounce medication cup, which contained medication residual, stirred the contents and poured the contents into the syringe. LVN A removed the syringe from the [DEVICE], reconnected the feeding tube to the formula tubing and started the feeding pump. Resident #4's consolidated physician orders [REDACTED]. --[MEDICATION NAME] 50 mg, one tablet per [DEVICE] two times a day; --Rosuvastatin 10 mg, one tablet per [DEVICE] every day at bedtime; --Chewable Aspirin 81 mg, one tablet per [DEVICE] every day; --Multivitamin 5 cc, per [DEVICE] every day; --[MEDICATION NAME] 15 mg, ? tablet per [DEVICE] every day at bedtime; --[MEDICATION NAME] 10 mg, one tablet per [DEVICE] every day; --Cranberry 450, one tablet per [DEVICE] every day; --[MEDICATION NAME] 500 mg, one tablet per [DEVICE] twice a day before breakfast and dinner; --Iron 220 mg/5 cc, per [DEVICE] every day; --Tylenol 500 mg, one tablet per [DEVICE] every day; --[MEDICATION NAME] AC per [DEVICE] at 65 cc/hr for 22 hours per day; --Flush [DEVICE] with 200 cc of water four times a day and --Flush [DEVICE] with 60 cc of water before and after medication administration. Resident #4's consolidated physician orders [REDACTED]. In an interview on 12/11/13 at 8:14 AM, LVN A stated, We cocktail all our [DEVICE]s (residents with [DEVICE]s). We have an order (physician). In an interview on 12/11/13 at 2:40 PM, the facility's only ADON stated if the nurses had a physician's orders [REDACTED]. The ADON further stated, All [DEVICE] residents have an order to cocktail. In an interview on 12/11/13 at 3:30 PM, the DON stated she was not aware medications could not be cocktailed when administered through a resident's [DEVICE]. In an interview on 12/17/13 at 11:15 AM, the Pharmacist was asked about the facility's policies on cocktailing medications and the fact all the residents with [DEVICE]s had orders indicating their medications could be cocktailed. The pharmacist stated those orders originated a long time ago and referred to a couple of residents, who were severely fluid restricted and had certain types of [DEVICE]s. The Pharmacist stated, I specifically went over with them (licensed nurses) before not to cocktail medications. When asked when she had discussed the issue with the facility, the Pharmacist said she thought it was eight or nine months ago. When asked if she could remember if the DON or ADON was present at the discussion, the Pharmacist stated she could not recall whether the ADON was present, but the DON was usually present and started the discussions. The Pharmacist added she performed medication pass observations in the facility, and the staff did not cocktail in her presence. She stated if they had, she would have counted it as medication errors. 2. Review of the facility's current undated policy and procedure, ADMINISTERING MEDICATION THROUGH [DEVICE] revealed; .6. Pour medication into syringe or gravity bag an (sic) allow to flow. Hold up enough so that meds will flow into stomach through gravity. (May have to use 'plunger' part of syringe to get meds started in using syringe by gravity.) (sic) 7. ALWAYS FLUSH TUBING WITH 30-40 CC'S OF WATER AFTER ALL MEDICATION HAS BEEN GIVEN. 3. The CMS survey & Certification S&C: 13-02-NH dated 11/02/12 reflected the following in regard to Administration of Medications via a Feeding Tube: .the facility, in consultation with the pharmacist, must provide procedures for the accurate administration of all medications. The procedures must reflect current standards of practice, including but not limited to types of medications that may be safely administered via a feeding tube; appropriate dosage forms; techniques to monitor and verify that the feeding tube is in the right location (e.g., stomach or small intestine, depending on the tube) before administering medications; preparing drugs for enteral administration; administering drugs separately, diluting drugs as appropriate, and flushing the feeding tube before, between, and after drug administration; and that medications with known incompatibilities must not be given at the same time. .For administering medications via tube feeding, the standard of practice is to administer each medication separately and flush the tubing between each medication. An exception would be if there is a physician's orders [REDACTED]. Failure to flush before and in between each medication administration is considered a single medication error. 4. The facility's Form-672, Resident Census and Conditions of Residents, dated 12/11/13 and signed by the MDS Coordinator reflected 18 residents had feeding tubes.

F 0333 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview any record review, it was determined the facility failed to ensure each resident was free of significant medication errors for two (Resident #1 and #2) of 8 residents reviewed for medications. 1) a.The facility failed to properly transcribe and administer the following medications for Resident #1 in two of two months reviewed: [MEDICATION NAME] 25 mg - missed three of five doses; [MEDICATION NAME] 20 mg - missed three of five doses; [MEDICATION NAME] eye drops- missed three of five doses; [MEDICATION NAME] 40 mg- was only given 20 mg dose and only received it three out of five times; [MEDICATION NAME] - was given in the morning instead of at bedtime as ordered; [MEDICATION NAME] 200 mg- 100 mg was given for three days; [MEDICATION NAME] - was given in the morning instead of at bedtime as ordered; Levetiracetam 1000 mg - 500 mg was given for three days; [MEDICATION NAME] XL - missed three 60 mg doses and missed five 30 mg doses; and [MEDICATION NAME] 0.1mg- missed five doses. b. LVN D failed to administer the correct dose of pain medications to Resident #1 when she repeatedly complained of leg pain. LVN D administered one [MEDICATION NAME] 5/325 mg when the ordered dose was two 10/325 mg tablets. 2) The facility failed to discontinue Resident #2's [MEDICATION NAME] 25mg (for Hypertension) as ordered. The morning dose of [MEDICATION NAME] was discontinued on 02/03/14 and the evening dose was not discontinued until after the 02/28/14 dose, for a total of 31 doses. These failures could affect any the facility's 75 residents, including Residents #1 and #2, by placing them at risk for depression, eye discomfort, unrelieved pain, stomach upset, [MEDICAL CONDITION], weakness, confusion, dizziness, headache, [MEDICAL CONDITIONS] and death and could affect the 75 residents in the facility. Findings included: 1) a) Review of Resident #1's Physician's Telephone Orders dated 02/26/14 revealed she was to be readmitted to the facility with [DIAGNOSES REDACTED]. Review of Resident #1's admission Nurse's Note dated 02/26/14 at 2:20 PM revealed she was confused but able to make her needs known at that time. Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: [MEDICATION NAME] 20 mg tablets by mouth twice daily (used to treat chest pain caused by heart damage); [MEDICATION NAME] 0.05% eye drops, one drop in each eye twice daily (used for increase tear production); [MEDICATION NAME] 20 mg tablets, give 40 mg at bedtime (used to lower cholesterol); [MEDICATION NAME] 20 mg tablets, give 10 mg by mouth at bedtime (used to treat depression); [MEDICATION NAME] 100 mg tablets, give 200 mg at bedtime (used to treat pain caused by [MEDICAL CONDITION]); [MEDICATION NAME] 325 mg, give one at bedtime (iron supplement used to treat [MEDICAL CONDITION]); Levetiracetam 500 mg tablets, give 1000 mg at bedtime (used to treat [MEDICAL CONDITION]); [MEDICATION NAME] XL 30 mg by mouth every day (used to treat high blood pressure and chest pain); [MEDICATION NAME] XL 60 mg by mouth every evening; [MEDICATION NAME] HCL 0.1 mg by mouth every day (used to treat high blood pressure). Review of Resident #1's February 2014 MARs revealed the following: [MEDICATION NAME] 25 mg tablets twice a day was only transcribed and initialed as administered once on 02/27/14. (Not twice a day as ordered) [MEDICATION NAME] 20 mg tablets was only transcribed and initialed as administered once a day on 02/27/14 and 02/28/14. (Not twice a day as ordered and not on 02/26/14 evening) [MEDICATION NAME] eye drops were only transcribed and initialed as administered once a day on 02/27/14 and 02/28/14. (Not twice a day as ordered) [MEDICATION NAME] was transcribed as 20 mg at bedtime and only initialed as administered on 02/26/14 and 02/27/14. (Not on 02/28/14 as ordered) [MEDICATION NAME] was transcribed and initialed as administered as 10 mg at 6:30 AM. (Not at bedtime as ordered) [MEDICATION NAME] 100 mg was transcribed and initialed as administered at bedtime. (Not 200 mg as ordered) [MEDICATION NAME] 325 mg was transcribed and initialed as administered at 6:30 AM. (Not at bedtime as ordered) Levetiracetam 500 mg was transcribed and initialed as administered daily at bedtime.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. BUILDING _____ B. WING _____	**01/11/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	**4515 VILLAGE CREEK RD FORT WORTH, TX 76119**

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 0333

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 20)

(Not 1000 mg as ordered) [MEDICATION NAME] XL was transcribed as 30 mg by mouth every evening and was only administered on 02/26/14 and 02/27/14. (Not 60 mg as ordered and none on 02/28/14) [MEDICATION NAME] XL 60 mg was not transcribed to the February MAR and so no doses were given in February. Review of Resident #1's March 2014 MARs revealed the following: [MEDICATION NAME] XL 30 mg by mouth every day was not transcribed and so was not administered from 03/01/14 through 03/05/14, when surveyor inquired. [MEDICATION NAME] HCL 0.1 mg by mouth every day was not transcribed and so was not administered from 03/01/14 through 03/05/14, when surveyor inquired. An interview with the Unit Manager on 03/04/14 at 4:32 PM revealed it was typically her duty to check all orders daily for accuracy but she was pulled off the floor or on 02/24/14 to work on the monthly consolidated orders for the remainder of the month. She stated, during that time, the DON was performing the daily checks on both nurses' stations. During an interview on 03/05/15 at 10:25 AM, LVN C stated she had transcribed the admission orders [REDACTED]. When shown the errors found by the surveyors, LVN C stated she was not aware of the errors. She stated RN A had transcribed the orders to the March MARs and she remembered RN A pointing out some discrepancies to her but she thought she had corrected them. During an interview on 03/05/14 at 11:25 AM, RN A stated she had transcribed the March MARs for Resident #1 but had never looked at February's MARs. RN A stated she had caught a few discrepancies after the hospital orders had been transcribed to the facility's admission orders [REDACTED]. She was not aware of any medication errors. An interview with the DON on 03/05/14 at 11:25 AM revealed all orders, including new admission orders [REDACTED]. The DON explained pink copies of all resident's orders were to be placed in a box and both she and the Unit Manager checked those pink copies every day before they left to ensure all orders written over the past 24 hours were transcribed correctly. When asked about Resident #1, the DON confirmed the Unit Manager was not checking orders at that time as she had been pulled to work on the monthly orders. The DON stated she did not know why Resident #1's orders had not been checked; she stated the pink copies must not have made it into the designated box. b) Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: [MEDICATION NAME] 10/325 mg one tablet every six hours as needed for pain. [MEDICATION NAME] 10/325 mg two tablets every six hours as needed for pain. Resident #1's admission orders [REDACTED]. Review of Resident #1's MAR for February 2014 revealed an entry for [MEDICATION NAME]-Apap 10-325 two every six hours as needed for pain. The entry was initialed as administered on 02/26/14 at 3:00 PM and 9:00 PM by LVN D. The back of the MAR reflected the following entries: 2/26/14 at 3:00 PM: Resident c/o pain, pain level 8/10, [MEDICATION NAME] ([MEDICATION NAME]) 5/325 admin, pain level at 3:30 PM 6/10. The entry was signed by LVN D. 2/26/14 at 9:00 PM: Resident c/o pain, telling, 8/10, [MEDICATION NAME] 5/325 mg admin, pain level @ 9:30 (PM), 7/10, ineffective. The entry was signed by LVN D. During an interview on 03/05/14 at 12:45 PM, LVN D explained she was Resident #1's Charge Nurse on 02/26/14 but LVN C was completing the admission orders [REDACTED]. When asked why she only administered 5/325 mg when the order and MAR both indicated the dose was two 10/325 tablets, LVN D stated she had seen the dose on the MAR but when she went to the medication cart, her old card was still on the cart (from prior to her hospitalization) and so she just administered that. When asked why she did not question the dosage on the card as it conflicted with the MAR or check the orders in the chart, LVN D stated, It never occurred to me she was really in pain, I didn't touch the orders, I gave her what she had on the cart. During an interview on 03/05/14 at 2:47 PM, the DON was shown Resident #1's MARs and told about the medication error regarding the [MEDICATION NAME]. The DON stated she was not aware of the error and that it should not have happened. She confirmed [MEDICATION NAME] 10/325 mg tablets were kept in the E-kit and LVN D could have easily retrieved the proper dose. When asked how Resident #1's pain should have been handled, the DON stated if a resident complains of pain, they should be assessed and a pain level ascertained. She stated the resident should be medicated if indicated and re-assessed in 30-45 minutes for relief. The DON stated, if the medication was not effective and another medication could not be given, the physician should be called and made aware of all the details surrounding the situation. An observation on 03/05/14 at 3:28 PM revealed [MEDICATION NAME] 10/325 tablets were stocked in the medication room E-kit at Resident #1's nurse's station. 2. Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #2 had a BIMS of 4 and was dependent on staff for most of his ADLs. Review of Resident #2's Care Plan dated 02/27/14 revealed: Date & Problem: DX [MEDICAL CONDITION]/HTN/[MEDICAL CONDITION] Goal: (Resident #2) will not suffer any complications caused by Dx's thru the next eval date. Approaches & Disciplines: Lab as ordered Notify Dr. of results Medications as ordered. Notify Dr of effectiveness Monitor for [MEDICAL CONDITION], SOB, Pain in extremities with discoloration of skin and warm to touch Document and Notify Dr/RP/Hospice Resident #2's Physician's Telephone Orders dated 01/09/13 reflected [MEDICATION NAME] 25 mg twice a day. Resident #2's Physician's Telephone Orders dated 01/30/14 reflected increase [MEDICATION NAME] to 50 mg twice a day for blood pressure. Review of Resident #2's MARs for the month of January 2014 revealed the last dose of [MEDICATION NAME] 25 mg was on 01/30/14 after the 9:00 PM dose. Further review of this MAR revealed [MEDICATION NAME] 50 mg was started on 01/30/14 at 9:00 PM. Review of Resident #2's MARs for the month of February 2014 revealed [MEDICATION NAME] 50 mg twice a day was administered as ordered. Further review of this MAR revealed the morning dose (9 AM) of [MEDICATION NAME] 25 mg was administered on 02/01/14, 02/02/14/ and 02/03/14. DC'D was hand written after the 9 AM dose was administered on 02/03/14. The evening dose (4:00 PM) of [MEDICATION NAME] 25 mg was administered each day during the month of February. A total of 31 doses of [MEDICATION NAME] 25 mg were administered that the physician had discontinued on 01/30/14. During an interview on 03/04/14 at 3:55 PM the surveyor reviewed Resident #2's February 2014's MARs with LVN B, Resident #2's evening charge nurse. LVN B stated she did administer [MEDICATION NAME] 25 mg and [MEDICATION NAME] 50 mg on the days she worked, as were documented on Resident #2's MAR. During an interview on 03/05/14 at 10:05 AM the ADM stated the Unit Manager did the February 2014 monthly recapitulations of physician orders [REDACTED]. During an interview on 03/04/14 at 4:30 PM the Unit Manager stated she checks the pink slips (copy of telephone physician orders) daily to make sure the orders were correct on the MARs. She stated when she did the February 2014 monthly recapitulations of physician orders, she was taken off the floor from 01/25/14 through the end of the month, and the DON took over her tasks, including verifying the pink slips were checked, for the whole building. During an interview on 03/06/14 at 4:30 PM the ADM stated Resident #2 receiving 31 doses of [MEDICATION NAME], which had been discontinued, was a careless error. The ADM further stated the DON told her she did miss a few a days of checking pink slips. During an interview on 03/06/14 at 8:47 AM the surveyor asked the DON how she thought Resident #2's received 31 doses of [MEDICATION NAME] that had been discontinued. The DON stated when RN A taught the Unit Manager how to do the monthly recapitulations of physician orders, RN A did not instruct the Unit Manager to continue to add additional physician orders [REDACTED]. Nursing 2013 Drug Handbook 33rd Edition, Wolters Kluwer, Copyright 2013, pages 680 - 681 reflected the following nursing considerations for [MEDICATION NAME]: Monitor patient's blood pressure, pulse and body weight frequently.Elderly patients may be more sensitive to drug's hypotensive effects. Overdose signs and symptoms include: [MEDICAL CONDITIONS] headache and flushing. 3. Review of the facility's current undated policy and procedure Monthly Review of physician's orders [REDACTED]. Purpose: To ensure that physician order's are accurate. Policy: To verify prior to the beginning of each month that all physician orders [REDACTED]. (RN A)/ (Unit Manager) will be responsible for this monthly review. DON will schedule the delivery of the orders. DON will have (RN A) to be removed from the schedule as a floor nurse for the last 5-6 days of each month. (RN A) will inform DON of all concerns regarding the orders upon the completion of the review. (RN A) will take the prior month MARS and compare them to the clinical record. (RN A) will then take the clinical record and compare it to the new MARS. (RN A) will then handwrite onto the new MAR any new orders that will come after the 25th of the month. Attending nurses will write any new orders on the current MAR until the end of the month. If a new admission comes at the end of the month, (RN A)/Designee reviewing the MAR should make a new set of physician's orders [REDACTED]. (RN A)/Designee should also make a new set of MARS and TARS for the next month. (RN A)/Designee will via fax all updates to the person responsible for preparing the monthly orders: (name of pharmacy tech) at [PHONE NUMBER]. Clarifications orders will be written. 11-7 will compare the old MAR to the New MAR for accuracy. Review of the facility's current policy and procedure Unnecessary Drugs dated 2012 revealed: Purpose: Each resident's drug regimen must be free from unnecessary drugs: Procedure: An unnecessary drug is any drug when used: 1. In excessive dose (including duplicate therapy); or 2. For excessive duration; or 3. Without adequate monitoring; or 4. Without adequate indications for its use; or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 6. An combination of the reasons above. Review of an undated Medication Pass Inservice from an RN/LVN Orientation Book located at the Nurse's Station revealed the following: Steps to take during the med pass: . 16. Before administering the medication, always check 'The 6 R's' 17. Triple check medications vs. MAR before administering the medications. 18. If any of the 6 R's do not match or if you have any questions about the medication itself DO NOT GIVE THE MEDICATION! Check the chart or call the pharmacy with your concern. The pharmacist would rather you ask a question than a mistake be made. DURING THE MEDICATION PASS: 'THE 6 Rs'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. BUILDING _____ B. WING _____	01/11/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	4515 VILLAGE CREEK RD FORT WORTH, TX 76119

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 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 21) Before administering any medication, always check the 6 Rs, The right resident. The right drug: verify each drug against the medication administration record (MAR) before administering. The right dose: verify against the MAR . The right time: administer drugs as instructed on the MAR and within the time frame established by your facility. CHECKPOINTS.Related issues.Make sure discontinued medications have been removed from the cart as soon as they have been discontinued. 4. Review of the facility's Form-672, Resident Census and Conditions of Residents, dated 03/03/14 and signed by DON reflected a census of 75.
F 0425 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident for two (Residents #1 and #2) of eight residents reviewed for pharmacy services. 1) a.The facility failed to properly transcribe and administer the following medications for Resident #1 in two of two months reviewed: Hydralazine 25 mg - missed three of five doses; Isosorbide Dinitrate 20 mg - missed three of five doses; Restasis eye drops- missed three of five doses; Lipitor 40 mg-20 mg was given and only administered three out of five times; Celexa - was given in the morning instead of at bedtime as ordered; Gabapentin 200 mg- 100 mg was given for three days; Ferrous Sulfate - was given in the morning instead of at bedtime as ordered; Levetiracetam 1000 mg- 500 mg was administered for three days; Procardia XL - missed three 60 mg doses and missed five 30 mg doses; and Clonidine 0.1 mg - missed five doses. b. LVN D failed to administer the correct dose of pain medications to Resident #1 when she repeatedly complained of leg pain. LVN D administered one Hydrocodone 5/325 mg when the ordered dose was two 10/325 mg tablets. 2. The facility failed to discontinue Resident #2's Hydralazine 25mg (for Hypertension) as ordered. The morning dose of Hydralazine was discontinued on 02/03/14 and the evening dose was not discontinued until after the 02/28/14 dose, for a total of 31 doses. These failures could affect any the facility's 75 residents, including Residents #1 and #2, by placing them at risk for ongoing medication errors resulting in depression, eye discomfort, unrelieved pain, stomach upset, seizures, weakness, confusion, dizziness, headache, fainting, hypotension and death and could affect the 75 residents in the facility. Findings included: 1) Review of Resident #1's Physician's Telephone Orders dated 02/26/14 revealed she was to be readmitted to the facility with [DIAGNOSES REDACTED]. Review of Resident #1's admission Nurse's Note dated 02/26/14 at 2:20 PM revealed she was confused but able to make her needs known at that time. Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: Hydralazine Hcl 25 mg tablets by mouth twice daily (used to treat high blood pressure); Isosorbide Dinitrate 20 mg tablets by mouth twice daily (used to treat chest pain caused by heart damage); Docusate Sodium 100 mg caps, two twice daily (used to prevent constipation); Restasis 0.05% eye drops, one drop in each eye twice daily (used for increase tear production); Lipitor 20 mg tablets, give 40 mg at bedtime (used to lower cholesterol); Celexa 20 mg tablets, give 10 mg by mouth at bedtime (used to treat depression); Gabapentin 100 mg tablets, give 200 mg at bedtime (used to treat pain caused by neuropathy); Ferrous Sulfate 325 mg, give one at bedtime (iron supplement used to treat anemia); Levetiracetam 500 mg tablets, give 1000 mg at bedtime (used to treat seizures); Procardia XL 30 mg by mouth every day (used to treat high blood pressure and chest pain); Procardia XL 60 mg by mouth every evening; and Clonidine HCL 0.1 mg by mouth every day (used to treat high blood pressure). Review of the facility ' s admission orders [REDACTED] Procardia 30 mg PO QD; and Clonidine HCL 0.1 mg PO QD. Review of Resident #1's February 2014 MARs revealed the following: Hydralazine 25 mg tablets twice a day was only transcribed and initialed as administered once on 02/27/14. (Not twice a day as ordered) Isosorbide Dinitrate 20 mg tablets was only transcribed and initialed as administered once a day on 02/27/4 and 02/28/14. (Not twice a day as ordered) Docusate Sodium 100 mg caps was only transcribed and initialed as administered once on 02/27/14 and 02/28/14. (Not twice a day as ordered) Restasis eye drops were only transcribed and initialed as administered once a day on 02/27/14 and 02/28/14. (Not twice a day as ordered) Lipitor was transcribed as 20 mg at bedtime and only initialed as administered on 02/26/14 and 02/27/14. (Not on 02/28/14 as ordered) Celexa was transcribed and initialed as administered as 10 mg at 6:30 AM. (Not at bedtime as ordered) Gabapentin 100 mg was transcribed and initialed as administered at bedtime. (Not 200mg as ordered) Ferrous Sulfate 325 mg was transcribed and initialed as administered at 6:30 AM. (Not at bedtime as ordered) Levetiracetam 500 mg was transcribed and initialed as administered daily at bedtime. (Not 1000 mg as ordered) Procardia XL was transcribed as 30 mg by mouth every evening and was only administered on 02/26/14 and 02/27/14. (Not 60 mg as ordered and none on 02/28/14) Procardia XL 60 mg was not transcribed to the February MAR and so no doses were given in February. Review of Resident #1's March 2014 MARs revealed the following: Procardia XL 30 mg by mouth every day was not transcribed and so was not administered from 03/01/14 through 03/05/14, when surveyor inquired. Clonidine HCL 0.1 mg by mouth every day was not transcribed and so was not administered from 03/01/14 through 03/05/14, when surveyor inquired. An interview with the Unit Manager on 03/04/14 at 4:32 PM revealed it was typically her duty to check all orders daily for accuracy but she was pulled off the floor or on 02/24/14 to work on the monthly consolidated orders for the remainder of the month. She stated, during that time, the DON was performing the daily checks on both nurses' stations. During an interview on 03/05/15 at 10:25 AM, LVN C stated she had transcribed the admission orders [REDACTED]. When shown the errors found by the surveyors, LVN C stated she was not aware of the errors. She stated RN A had transcribed the orders to the March MARs and she remembered RN A pointing out some discrepancies to her but she thought she had corrected them. During an interview on 03/05/14 at 11:25 AM, RN A stated she had transcribed the March MARs for Resident #1 but had never looked at February's MARs. RN A stated she had caught a few discrepancies after the hospital orders had been transcribed to the facility's admission orders [REDACTED]. She was not aware of any medication errors. An interview with the DON on 03/05/14 at 11:25 AM revealed all orders, including new admission orders [REDACTED]. The DON explained pink copies of all resident's orders were to be placed in a box and both she and the Unit Manager checked those pink copies every day before they left to ensure all orders written over the past 24 hours were transcribed correctly. When asked about Resident #1, the DON confirmed the Unit Manager was not checking orders at that time as she had been pulled to work on the monthly orders. The DON stated she did not know why Resident #1's orders had not been checked; she stated the pink copies must not have made it into the designated box. b) Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: Hydrocodone 10/325 mg one tablet every six hours as needed for pain. Hydrocodone 10/325 mg two tablets every six hours as needed for pain. Resident #1's admission orders [REDACTED]. Review of Resident #1's MAR for February 2014 revealed an entry for Hydrocodone-Apap 10-325 two every six hours as needed for pain. The entry was initialed as administered on 02/26/14 at 3:00 PM and 9:00 PM by LVN D. The back of the MAR reflected the following entries: 2/26/14 at 3:00 PM: Resident c/o pain, pain level 8/10, Norco (hydrocodone) 5/325 admin, pain level at 3:30 PM 6/10. The entry was signed by LVN D. 2/26/14 at 9:00 PM: Resident c/o pain, telling, 8/10, Norco 5/325 mg admin, pain level @ 9:30 (PM), 7/10, ineffective. The entry was signed by LVN D. During an interview on 03/05/14 at 12:45 PM, LVN D explained she was Resident #1's Charge Nurse on 02/26/14 but LVN C was completing the admission orders [REDACTED]. When asked why she only administered 5/325 mg when the order and MAR both indicated the dose was two 10/325 tablets, LVN D stated she had seen the dose on the MAR but when she went to the medication cart, her old card was still on the cart (from prior to her hospitalization) and so she just administered that. When asked why she did not question the dosage on the card as it conflicted with the MAR or check the orders in the chart, LVN D stated, It never occurred to me she was really in pain, I didn't touch the orders, I gave her what she had on the cart. During an interview on 03/05/14 at 2:47 PM, the DON was shown Resident #1's MARs and told about the medication error regarding the hydrocodone. The DON stated she was not aware of the error and that it should not have happened. She confirmed Hydrocodone 10/325 mg tablets were kept in the E-kit and LVN D could have easily retrieved the proper dose. When asked how Resident #1's pain should have been handled, the DON stated if a resident complains of pain, they should be assessed and a pain level ascertained. She stated the resident should be medicated if indicated and re-assessed in 30-45 minutes for relief. The DON stated, if the medication was not effective and another medication could not be given, the physician should be called and made aware of all the details surrounding the situation. An observation on 03/05/14 at 3:28 PM revealed Hydrocodone 10/325 tablets were stocked in the medication room E-kit at Resident #1's nurse's station. 2. Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #2 had a BIMS of 4 and was dependent on staff for most of his ADLs. Review of Resident #2's Care Plan dated 02/27/14 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. BUILDING _____ B. WING _____	01/11/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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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 0425 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 22) Date & Problem: DX CHF/HTN/PVD Goal: (Resident #2) will not suffer any complications caused by Dx's thru the next eval date. Approaches & Disciplines: Lab as ordered Notify Dr. of results Medications as ordered. Notify Dr of effectiveness Monitor for edema, SOB, Pain in extremities with discoloration of skin and warm to touch Document and Notify Dr/RP/Hospice Resident #2's Physician's Telephone Orders dated 01/09/13 reflected Hydralazine 25 mg twice a day. Resident #2's Physician's Telephone Orders dated 01/30/14 reflected increase Hydralazine to 50 mg twice a day for blood pressure. Review of Resident #2's MARs for the month of January 2014 revealed the last dose of Hydralazine 25 mg was on 01/30/14 after the 9:00 PMdose. Further review of this MAR revealed Hydralazine 50 mg was started on 01/30/14 at 9:00 PM. Review of Resident #2's MARs for the month of February 2014 revealed Hydralazine 50 mg twice a day was administered as ordered. Further review of this MAR revealed the morning dose (9 AM) of Hydralazine 25 mg was administered on 02/01/14, 02/02/14/ and 02/03/14. DC'D was hand written after the 9 AM dose was administered on 02/03/14. The evening dose (4:00 PM) of Hydralazine 25 mg was administered each day during the month of February. A total of 31 doses of Hydralazine 25 mg were administered that the physician had discontinued on 01/30/14. During an interview on 03/04/14 at 3:55 PM the surveyor reviewed Resident #2's February 2014's MARs with LVN B, Resident #2's evening charge nurse. LVN B stated she did administer Hydralazine 25 mg and Hydralazine 50 mg on the days she worked, as were documented on Resident #2's MAR. During an interview on 03/05/14 at 10:05 AM the ADM stated the Unit Manager did the February 2014 monthly recapitulations of physician orders [REDACTED]. During an interview on 03/04/14 at 4:30 PM the Unit Manager stated she checks the pink slips (copy of telephone physician orders) daily to make sure the orders were correct on the MARs. She stated when she did the February 2014 monthly recapitulations of physician orders, she was taken off the floor from 01/25/14 through the end of the month, and the DON took over her tasks, including verifying the pink slips were checked, for the whole building. During an interview on 03/06/14 at 4:30 PM the ADM stated Resident #2 receiving 31 doses of Hydralazine, which had been discontinued, was a careless error. The ADM further stated the DON told her she did miss a few a days of checking pink slips. During an interview on 03/06/14 at 8:47 AM the surveyor asked the DON how she thought Resident #2's received 31 doses of Hydralazine that had been discontinued. The DON stated when RN A taught the Unit Manager how to do the monthly recapitulations of physician orders, RN A did not instruct the Unit Manager to continue to add additional physician orders [REDACTED]. Nursing 2013 Drug Handbook 33rd Edition, Wolters Kluwer, Copyright 2013, pages 680 - 681 reflected the following nursing considerations for Hydralazine: Monitor patient's blood pressure, pulse and body weight frequently.Elderly patients may be more sensitive to drug's hypotensive effects. Overdose signs and symptoms include: hypotension, tachycardia, headache and flushing. 3. Review of the facility's current undated policy and procedure Monthly Review of physician's orders [REDACTED]. Purpose: To ensure that physician order's are accurate. Policy: To verify prior to the beginning of each month that all physician orders [REDACTED]. (RN A)/(Unit Manager) will be responsible for this monthly review. DON will schedule the delivery of the orders. DON will have (RN A) to be removed from the schedule as a floor nurse for the last 5-6 days of each month. (RN A) will inform DON of all concerns regarding the orders upon the completion of the review. (RN A) will take the prior month MARS and compare them to the clinical record. (RN A) will then take the clinical record and compare it to the new MARS. (RN A) will then handwrite onto the new MAR any new orders that will come after the 25th of the month. Attending nurses will write any new orders on the current MAR until the end of the month. If a new admission comes at the end of the month, (RN A)/Designee reviewing the MAR should make a new set of physician's orders [REDACTED]. (RN A)/Designee should also make a new set of MARS and TARS for the next month. (RN A)/Designee will via fax all updates to the person responsible for preparing the monthly orders: (name of pharmacy tech) at [PHONE NUMBER]. Clarifications orders will be written. 11-7 will compare the old MAR to the New MAR for accuracy. Review of the facility's current policy and procedure Unnecessary Drugs dated 2012 revealed: Purpose: Each resident's drug regimen must be free from unnecessary drugs: Procedure: An unnecessary drug is any drug when used: 1. In excessive dose (including duplicate therapy); or 2. For excessive duration; or 3. Without adequate monitoring; or 4. Without adequate indications for its use; or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 6. An combination of the reasons above. Review of an undated Medication Pass Inservice from an RN/LVN Orientation Book located at the Nurse's Station revealed the following: Steps to take during the med pass:. 16. Before administering the medication, always check 'The 6R 's' 17. Triple check medications vs. MAR before administering the medications. 18. If any of the 6 R's do not match or if you have any questions about the medication itself DO NOT GIVE THE MEDICATION! Check the chart or call the pharmacy with your concern. The pharmacist would rather you ask a question than a mistake be made. DURING THE MEDICATION PASS: 'THE 6 Rs' Before administering any medication, always check the 6 Rs, The right resident. The right drug: verify each drug against the medication administration record (MAR) before administering. The right dose: verify against the MAR. The right time: administer drugs as instructed on the MAR and within the time frame established by your facility. CHECKPOINTS.Related issues.Make sure discontinued medications have been removed from the cart as soon as they have been discontinued. 4. Review of the facility's Form-672, Resident Census and Conditions of Residents, dated 03/03/14 and signed by DON reflected a census of 75.
F 0441 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for nine (Residents #2, #3, #4, #8, #22, #29, #35, #36, #37, and #38) of 24 residents reviewed for infection control. 1) The facility failed to ensure contact precautions were implemented when Resident #2 had a positive urine culture for MRSA. Staff were using the same leg urinary drainage bag and bedside urinary drainage bag repeatedly for Resident #2, washing them and hanging them to dry in the resident's shared bathroom when changing them every morning and every evening. Resident #2's physician-ordered C&S were not conducted as part of the follow-up for the resident's MRSA UTI. The physician was not notified they were not done until surveyor inquiry. 2) The facility's surveillance program for tracking and trending their infections failed to be effective. Resident infections were missed, entered in the wrong month's tracking logs, organisms were not identified and data regarding the infections was missing. Resident #2, who had MRSA in the urine, was not identified as having MRSA. Resident #22 was not identified with an infection in the correct month and with the correct medications. 3) After a facility outbreak of diarrhea: The facility failed to ensure a physician-ordered stool specimen for Ova and Parasite and for[DIAGNOSES REDACTED] were obtained for Residents #37 and #38. The facility failed to ensure a physician-ordered stool specimen for[DIAGNOSES REDACTED] was obtained for Residents #29, #35 and #36. 4) CNA LL failed to perform hand hygiene before beginning incontinent care. CNA Q failed to perform hand hygiene before, during and after incontinent care for Resident #8; and contaminated wipes, the wipes container, perineal was bottle, the door knobs of the resident's room and the the clean linen cart. CNA Q carried the used container of wipes and perineal wash from Resident #8's room and placed them on the clean linen cart. CNA QQ failed to throughly clean all the BM from the resident. 5) CNA M and CNA N failed to perform hand hygiene during and after performing incontinent care to Resident #3. CNA removed her gloves, picked up the opened package of incontinent wipes, removed them from the room and placed them on the clean linen cart. 6) CNA R failed to perform hand hygiene while providing incontinent care to Resident #4. CNA R failed to clean all the BM from the resident. 7) Facility staff were storing their personal items (coats and tote bags) on the clean linen carts on top of, or alongside the residents' clean linen. An Immediate Jeopardy (IJ) was identified on 01/02/14. While the IJ was removed on 01/11/14, the facility remained out of compliance at a scope of widespread and a severity level of no actual harm with potential for more than minimal harm, that is not immediate jeopardy, because not all staff had been trained and the facility was still monitoring the Plan of Removal. Failure to maintain an infection control program to prevent the transmission of disease and infection could result in the spread of infection and could affect the 75 residents in the facility. Findings included: 1) Resident #2 was a [AGE] year-old-female admitted to the facility on [DATE] per her MDS assessment dated [DATE]. The MDS assessment also reflected Resident #2 had active [DIAGNOSES REDACTED]. Resident #2's MDS further reflected she was incontinent of bowel and had an indwelling catheter. Review of Resident #2's current care plans provided by the facility with a most recent date of June 2013 revealed there was no care plan addressing the resident's indwelling Foley catheter. Review of Resident #2's physician's telephone orders revealed an order dated and signed by the physician on 08/15/13, which ordered to continue the Foley and attach it to a leg bag at 6:00 AM every morning and then to a gravity urinary drainage bag every night at 9:00 PM for one month and to then re-evaluate. Review of Resident #2's physician's telephone orders for the August, September,

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	676052	A. BUILDING _____ B. WING _____	01/11/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	4515 VILLAGE CREEK RD FORT WORTH, TX 76119

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 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 23) October, November and December 2013 revealed no orders for an indwelling Foley catheter and urinary drainage bag resulting from a re-evaluation. There were no orders for the Foley catheter size, to change the Foley catheter, to document I&O, or to irrigate the Foley catheter. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/16/13 at 6:00 AM revealed Resident #2's urine was pinkish in bag and tubing. It further reflected RN I removed the large bag and placed a leg bag as ordered for day time activity. RN I then wrote Lg bag Rinsed and hung up in BR. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/17/13 at 12:00 AM revealed Resident #2's leg bag was changed to a regular bag, and the Leg Bag rinsed and hung to dry. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/19/13 at 12:00 AM revealed RN I assessed Resident #2 and the night shift still had her leg bag on so RN I Removed and Lg drain bag attached to catheter. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/19/13 at 6:30 AM revealed Resident #2's Big drain bag Removed and leg bag attached. Big bag rinsed (with) H2O X 3 and placed in drawer on clean towel. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/21/13 at 12:00 AM revealed Resident #2's leg bag had been rinsed and dried, rest in folded towel. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/19/13 at 6:30 AM revealed Big bag exchanged for small leg bag. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/22/13 at 5:00 AM revealed RN I gave Resident #2 some medicine in yogurt and Resident #2 asked what it was for. RN I told Resident #2 it was antibiotics for her UTI. It further reflected Big bag (changed) for leg bag. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/24/13 at 12:00 AM revealed this nurse changed leg bag to foley _ (with) Lg drainage bag. Review of Resident #2's Daily Skilled Nurse's Note for the evening shift on 08/24/13 untimed and unable to read the nurses signature revealed her urine color was yellow and it's consistency cloudy it further reflected Changed from leg bag to reg. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/26/13 at 7:00 AM revealed Foley (changed) to leg bag at this time. Review of Resident #2's Daily Skilled Nurse's Note dated 08/27/13 at 6:00 AM and unable to read nurses signature revealed Drainage bag changed to leg bag as ordered. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 08/30/13 at 12:00 AM revealed Note still has leg bag to (R) leg for urine drainage. Leg bag off cathe and BS drainage bag to cathe. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/21/13 at 12:00 AM revealed Resident #2 verbalizes her foley is leaking.note tubing is easily moveable in urethra - 6 cc air was added to tubing bulb. Review of Resident #2's UA C&S collected on 09/20/13 with results dated 09/23/13 revealed she was positive for a UTI by the bacteria Escherichia coli (E. coli) 50,000-99,000 cfu/ml, [MEDICATION NAME] species >100,000 cfu/ml and Methicillin Resistant Staphylococcus aureus (MRSA) > 100,000 cfu/ml. Review of Resident #2's Physician's Telephone Order dated 09/23/13 revealed an order for [REDACTED]. This order also ordered a repeat UA C&S three days after the antibiotic completed for two specimens. There was no order for contact isolation or contact precautions related to the resident's MRSA infection. Review of Resident #2's Physician's Telephone Order dated 09/23/13 revealed an order clarification to change the [MEDICATION NAME] from 50 mg to 100 mg by mouth two times a day for 10 days but still no order for contact isolation or contact precautions due to the resident's MRSA infection. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/23/13 at 12:00 AM revealed Resident #2 was in her bed and RN I observed that Res still has Leg Bag to (R) leg. Was Removed and Lg Bag applied (with) drainage to down drain. Review of Resident #2's Daily Skilled Nurse's Note dated and signed by RN I on 09/23/13 at 4:00 AM revealed Lg bag (changed) to small leg Bag. Review of Resident #2's Daily Skilled Nurse's Note dated 09/23/13 at 4:30 PM (unable to read nurses signature) revealed the nurse received the laboratory results of the UA C&S and Physician K was notified. Orders were received for two antibiotics: [MEDICATION NAME] 150 mg one by mouth two times a day for seven days and [MEDICATION NAME] 50 mg by mouth two times a day for 10 days. It further reflected to repeat the UA C&S three days after the antibiotic was completed two times. Resident #2's nurse's note further reflected Physician K called back and changed the [MEDICATION NAME] to 100 mg by mouth two times a day for 10 days.
Review
of Resident #2's Nurse's Note dated 09/28/13 at 12:30 PM (unable to read the nurse's signature) revealed Resident #2 Cont on ABT for MRSA in urine. Review of Resident #2's Nurse's Note dated 09/28/13 at 2:30 PM (unable to read the nurse's signature) revealed Resident #2 Cont on ABT for MRSA in urine. Review of Resident #2's Nurse's Note dated 09/28/13 at 11:30 PM (unable to read the nurse's signature) revealed Resident #2 ABT cont for MRSA. Review of Resident #2's Nurse's Note dated 09/29/13 at 11:30 AM (unable to read the nurse's signature) revealed Resident #2 Cont on ABT for MRSA in urine. Review of Resident #2's Nurse's Note dated 09/29/13 at 4:45 PM (unable to read the nurse's signature) revealed Resident #2 Cont on ABT for MRSA in urine. Review of Resident #2's Nurse's Note dated 10/05/13 at 2:00 PM (unable to read the nurse's signature) revealed Resident #2 was status [REDACTED]. During an interview with LVN G on 12/12/13 at 10:15 AM, she revealed Resident #2 had asked to have her catheter bag changed but since they did not have an extra catheter bag, she did not change it. When asked if she had ever changed the resident's indwelling catheter, LVN G said no she had not. LVN G said there was a nurse on the night shift, who changed residents' catheters but she no longer worked for the facility. LVN G said she did not know if Resident #2's catheter had ever been changed or not and gave the surveyor the name of RN I as having been the night shift nurse who may have changed Resident #2's catheter. LVN G said, to her knowledge, Resident #2 had never complained about her catheter hurting. LVN G said Resident #2's urine used to be amber in color until her physician wrote an order for [REDACTED]. LVN G said her physician felt the catheter was being pulled when Resident #2 ambulated, which was why it was now amber-colored. LVN G said at night the night nurse changed the leg bag to a bedside drainage bag, and in the morning, the night nurse changed it to a leg bag. LVN G said she did not know if there was a leg strap on the catheter except while she wore the leg bag during the day. During a telephone interview with Resident #2's family member on 12/13/13/at 10:09 AM, he/she informed the surveyor he/she had never seen gowns for visitors or staff to put on at any time since Resident #2 had been admitted and never heard or was told she was on any kind of isolation or to wash his/her hands upon entering or leaving Resident #2's room. During a telephone interview with LVN V on 12/13/13 at 2:16 PM, she informed the surveyor she worked on station two every now and then. LVN V informed the surveyor she had never had to change Resident #2's Foley catheter bag as The aide will help her (Resident #2) change from the leg bag to the night bag. When asked why it was the CNA's job, LVN V said, Nobody put that on the aides. That's something they've always done. I've never told them to do it. During an interview with LVN H on 12/13/13 at 3:50 PM, she informed the surveyor she worked with Resident #2 every day Monday through Friday from 3:00 PM - 11:00 PM. LVN H said she had changed Resident #2's leg bag every night and would wash it out in the sink. LVN H said she would use the soap dispenser in Resident #2's bathroom and squirt soap into the end of the leg bag used to drain the urine out. LVN H said she would clean the leg bag inside and out and then hang it on the hand rails in Resident #2's bathroom to dry. When it dried, she would place it in Resident #2's drawer. While telling the surveyor this, LVN H had a very disgusted look on her face and also told the surveyor, they re-used both bags until they started to look bad and can't clean it as well.about once a month. When asked if Resident #2 had ever been on isolation for the MRSA in her urine, at first LVN H said she did not have to be in isolation because it was in her urine and she had a catheter. When asked about staff emptying and washing the leg bag, she said oh, she would wear a gown and gloves. When asked about Resident #2's bathroom and whether it was shared with the residents in the next room, LVN H said Resident #2's roommate and the two residents in the next room did not get up to the bathroom. The surveyor then pointed out the CNAs used the bathroom to wash their hands as well after providing care. During an interview with the DON on 12/14/13 at 12:15 PM, the surveyor asked whether the nurses or the CNAs were supposed to change Resident #2's Foley catheter bags from the leg bag to the large drainage bag for night. The DON said the nurses were to change the urinary drainage bags, not the CNAs. The DON said the CNAS were never instructed to change the urinary drainage bags. When asked about the facility's infection control program, the DON said ADON MM was responsible for the facility's infection control program. When asked if it had always been the facility's policy to re-use the leg and bed side drainage catheter bags, the DON said it had never been our policy to re-use catheter bags. When asked, the DON said she had not been aware of the nurses and CNAs washing and re-using the urinary drainage bags and replied with, No. It's disgusting.just heard about it today. The DON informed the surveyor she would check into that. When asked what special training her nursing staff had in regard to catheter care, the DON said, No specific training. It's so obvious. It's a given. Basic one-o-one (101 Nursing).
The DON said there had been no in-services on catheter care for her nursing staff but the CNAs did check-offs for peri care yearly. The DON said the check-offs were done by her charge nurses and the weekend supervisor on peri care but not necessarily with catheters. When asked how she ensured catheter care was done properly, the DON said she presumed with their (the CNAs') schooling, they would know. When asked what type of plan she had in place for catheter care, the DON said they had a policy for catheter care. The DON said the nurses don't have access to it. The DON said there was a policy book at the nurses' station. The DON said the nurses should monitor if the catheter is functioning, is urine draining, what color is the urine, what consistency is the urine. During an interview with ADON MM on 12/15/13 at 12:26 PM, when asked if

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	676052	A. BUILDING _____ B. WING _____	01/11/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	4515 VILLAGE CREEK RD FORT WORTH, TX 76119

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 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 24) she knew they were re-using the leg and bed-side drainage bags for Resident #2, washing them out in the bathroom sink and hanging them over the hand rails to dry, ADON MM said, I have never heard that. I had no idea. I would have gone to The Director of Medical Records, QA and Ordering of Supplies. During an interview with the ADM on 12/15/13 at 1:45 PM, when asked about the re-using of the urinary drainage bags and washing them out in the sink, she said, Absolutely not, I told (ADON MM) to go talk to the CNAs and nurses to find out where they got that idea, to do in-servicing and fix that right now! The ADM said she did not know why the Director of Medical Records, QA and Ordering of Supplies had not ordered a leg bag for each day. The ADM said the physician's orders [REDACTED]. During an interview with RN L on 12/16/13 at 7:55 AM, she informed the surveyor it was usual for the CNAs to change the catheter urinary drainage bags, and they had to wash them so they were clean. RN L said when she came to work, the leg urinary drainage bags were already clean and hanging. When asked why they re-used the bags, she said, Everybody cuts costs. When the surveyor asked the RN about the potential for cross-contamination, RN L did not express her understanding of the idea of cross contamination and whether the CNAs and/or residents sharing the bathroom with Resident #2 could have been exposed to the MRSA in the resident's urine. RN L verbalized she had no idea Resident #2 had MRSA in her urine at one time. When asked if she had ever cleaned out one of the urinary drainage bags, RN L said, CNAs clean them out. I never touched her bag. During an interview with LVN AA on 12/16/13 at 8:55 AM, she informed the surveyor she worked on station two with Resident #2 on Monday and Tuesday nights on the 11:00 PM to 7:00 AM shift off and on for about a year. When asked who changed the urinary drainage bags for Resident #2, LVN AA said the CNAs did after they emptied the bag of urine, they washed them out in Resident #2's bathroom sink. LVN AA said they measured the amount of urine as well and, Nobody said it. They get her (Resident #2) up and change the (urinary drainage) bag when they get her up. It's just part of getting her up. When asked, LVN AA was not sure if Resident #2 had MRSA in her urine and said Resident #2 wasn't ever on isolation. I'm thinking because it was in her urine in a catheter, so we didn't have to isolate her. LVN AA said one time Resident #2 came to her and complained about her catheter. She (Resident #2) said it felt like it was filling up in her stomach, so I went in and lowered it (the drainage bag) and got all the urine out of her tubing. LVN AA said No when asked if she had ever changed the Foley catheter. LVN AA said a lot of things were just oversight, not intentional and should be brought to the nurses' attention so they would not do it again. LVN AA said she still did not know what the facility wanted her to do. LVN AA said she called the other day and got an order for [REDACTED]. We need to find out what they want us to do. The nurse changes them when she gets a new bag, nightly or weekly or what. They need to clarify if they want me to change them. I will. They just need to decide how they want it done. During a telephone interview with NP P on 12/17/13 at 9:54 AM, she was asked about the order for changing of Resident #2's leg bag to a nighttime bed side drainage bag. NP P said Resident #2 wanted a leg bag during the day and she had an order to switch the bag from one to another. When asked if she was aware they were re-using and washing out the urinary drainage bags, NP P said, The bags are not connected to her. The catheter is connected to her and needs to be sterile, except when she had MRSA. The surveyor said the urinary drainage bag was usually connected to a closed system, which should be sterile, and NP P said, The Foley catheter is connected to the patient. If they didn't understand, they should have called. The surveyor asked if she (NP P) had intended for staff to get new urinary drainage bags each time they changed them, and NP P said, Each time? No, because that part is not connected to the patient. The surveyor stated the bacteria can travel up the drainage tubing, and NP P said, We can't do this. Don't have the supplies to do that. They should have called. NP P added, from the point of the catheter, you also have a balloon up there. The catheter is the sterile part. The (urinary drainage) bag doesn't have to be. It's not connected to the patient. The CDC's (Center for Disease Control and Prevention) Guidelines for Prevention of Catheter-Associated Urinary Tract Infections dated 03/25/03 reflected: With indwelling catheters, infecting microorganisms can migrate to the bladder along the outside of the catheter in the periurethral mucous sheath. During an interview on 12/17/13 at 11:00 AM with LVN Y, the Weekend Supervisor, when asked about the admission process when the resident has a Foley catheter, she said the nurse should call the doctor and see if he wants to keep the catheter, get an order for [REDACTED]. The surveyor had to remind LVN Y/Weekend Supervisor about having an order for [REDACTED]. When asked what a nurse should do if a resident with a catheter complained of pain, LVN Y said to do an abdominal assessment, get an order for [REDACTED]. When asked if this was currently being done at the facility, LVN Y said, No. It has not been happening (getting orders). When asked what a nurse should do if a resident, such as Resident #2, was found to have an infection with MRSA in her urine, LVN Y said, Get an order for [REDACTED].#2 had MRSA in her urine. LVN Y said she did no know staff were re-using the urinary drainage bags and washing and hanging them to dry in Resident #2's bathroom. LVN Y also said the nurses, not the CNAs, were to change the urinary drainage bags. When asked if she had ever changed Resident #2's Foley catheter or her urinary drainage bags, she said she had not. During an interview with LVN H on 12/13/13 at 3:50 PM, LVN H said when she got a new drainage leg bag for Resident #2, she sometimes dated and initialed it and sometimes she did not. LVN H said both the large bedside drainage bag and the leg bag would be cleaned and hung to dry in the bathroom and the caps which came with the bags to keep them sterile would not be used so the bags were left open to the air. Review of Resident #2's Lab Report dated 10/09/13 and found in her clinical record, revealed two UA results for Resident #2. At the top of the Lab Report was written, If a Urine Culture is needed on this specimen, and has not already been ordered, please contact the laboratory within 24 hours to request additional testing. At the bottom of the Lab Report was written, wanted cxs (cultures). There were also two sets of illegible initials as well as what appeared to be two different dates. One was illegible and the other date was 10/18/13. During an interview with Physician K on 12/12/13 at 7:44 PM, the surveyor showed him Resident #2's laboratory results dated [DATE] and asked about the order for the UA C&S to be done twice, and the C&Ss evidently not having been done on Resident #2's two UA results. Physician K said he did not know why they had not been done and was not aware they had not been done. Physician K said it should have been automatic as most labs run a culture as routine. During an interview with the DON on 12/13/13 at 11:10 AM, the surveyor showed the DON the laboratory results of the UAs for Resident #2 dated 10/09/13, and asked who should have followed up on the labs. The DON said ADON MM should have followed up on he labs and caught there were no cultures done on the UAs. ADON MM was responsible for the labs for station two. She did not know why there were no cultures run on the UAs, and said she would check in to it. During an interview with LVN H on 12/13/13 at 3:50 PM, the surveyor showed LVN H Resident #2's laboratory results of the UA, which had no C&S results, dated 10/09/13 and asked her if she noticed anything wrong with it. LVN H could find nothing wrong and said she would call the doctor with the results. The surveyor then pointed out there were no C&S results. LVN H said any of the nurses could have received the results. When asked what she did when she received an order for [REDACTED]. LVN H said she put it in the lab book as a UA with C&S and she did not know why a C&S had not been done for the UA dated 10/09/13. During an interview with the DON on 12/14/13 at 12:15 PM, when asked what the process was when an order for [REDACTED]. The DON said the nurse just had to check the box for UA C&S on the lab slip and it was every nurses' responsibility to call the doctor if they received lab results. During an interview with the DON on 12/15/13 at 8:18 AM the surveyor asked the DON for the results of the most recent UA C&S for Resident #2. During an interview with ADON MM on 12/15/13 at 12:26 PM, the ADON said Resident #2 was not on isolation when she had MRSA in her urine because she had a Foley catheter so the infection was contained. Review of Resident #2's physician's telephone order dated 12/13/13 at 2:00 PM revealed an order for [REDACTED]. During an interview with the DON on 12/16/13 at 10:35 AM she informed the surveyor the urine for Resident #2's UA was just picked up today. The surveyor asked, So the order was written on the 13th.and not actually done until today (12/16/13)? The DON said the doctor specified to pick the urine specimen up on the 16th. Review of Resident #2's nurses' note dated 12/17/13 at 4:10 AM revealed the UA C&S ordered to be done on 12/16/13 was collected and sent to the lab. (This was done one day late according to the order.) Review of Resident #2's UA C&S laboratory results dated [DATE] at 12:43 PM revealed the UA results indicated the resident had a UTI. The results were as follows: Leukocytes esterase result was A-Abnormal and a Small amount were found in the urine; Urinary WBC result was A-Abnormal with 0-5 the amount shown; Urinary RBC result was A-Abnormal with 0-5 the amount shown; Urinary [MEDICATION NAME] cells result was A-Abnormal with Few seen; and Urinary Bacteria result was A-Abnormal with a Moderate amount seen. Review of the web-site: http://www.mayoclinic.com/health/urinalysis/MY /METHOD=print&DSECTION=all; on 12/27/13 at 10:30 revealed the following: Urinalysis is a test that evaluates a sample of your urine. Urinalysis is used to detect and assess a wide range of disorders, including urinary tract infection, kidney disease and diabetes. Evidence of infection. [MEDICATION NAME] and leukocyte esterase are produced as a result of an infection. If either [MEDICATION NAME] or leukocyte esterase - a product of white blood cells - is detected in your urine, it may be a sign of a urinary tract infection. Microscopic exam Several drops of the urine are examined with a microscope. If any of the following are observed in above-average levels, additional testing may be necessary: White blood cells (leukocytes) may be a sign of an infection. Red blood cells (erythrocytes) may be a sign of kidney diseases, blood disorders or another underlying medical condition, such as [DIAGNOSES REDACTED].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. BUILDING _____ B. WING _____	**01/11/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	**4515 VILLAGE CREEK RD FORT WORTH, TX 76119**

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 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 25) [MEDICATION NAME] cells - cells that line your hollow organs and form your skin - in your urine may be a sign of a tumor. But more often, they indicate that the urine sample was contaminated during the test, and a new sample is needed. Bacteria or yeasts may indicate an infection. 3) The facility provided their Infection Control Logs for the months of August, September, October and November 2013 to the surveyors on 12/11/13 for review. The Infection Control Logs contained the following: The facility's Infection Control Log Sheet dated 1992 reflected the following: Date Reported to the Infection Control/Quality Assurance Committee _____/_____/_____ Reporting Period _____ To ____ Total Number of Infections: Skin____, Urinary Tract Infection_____, Upper Respiratory Infection_____, Eye_____, Other_____. The log had vertical columns on the sheet with the following headings: Resident admitted Onset Date Site Infection Related DX Culture (With a column for Yes/Date and a column for No) X-Ray Date Organism Antibiotic Isolated (With a column for Yes/Date and a column for No) Nosocomial (With a with a column for Yes and a column for No) Re-Cultured Date Date Resolved September 2013's Infection Control Log was reported to the Infection Control/Quality Assurance Committee on 09/30/13. There were 11 resident names listed. The log began with the date 09/28/13 and ended with the date 09/03/13. The September 2013 log did not include identification of any of the organisms for the infections, which had cultures checked as having been done, except for one UTI with the organism E. coli. The log reflected there were two skin infections, five UTIs, one URI, no eye infections and two Other infections. There were no entries in the following columns: admitted , Site, X-Ray Date, Isolated, Nosocomial, Re-Cultured Date or the Date Resolved. On the Culture column, there were four infections checked, but no dates and only the one organism, E. coli had been entered. Under the column Infection Related [DIAGNOSES REDACTED]. October 2013's Infection Control Log was reported to the Infection Control/Quality Assurance Committee on 10/31/13. There were 12 resident names listed on this log. The log began with the date 10/04/13 and ended with the date 10/28/13. The October log did not identify any organisms which caused the infections although three residents had a culture done (but no date). All of the infections were identified as not being nosocomial or hospital-acquired infections, and none of the residents were isolated. There were no entries in the following columns: admitted , Site, Culture (the No column), X-Ray Date, Organism, Isolated (the yes column), Nosocomial (the yes column), Re-Cultured Date and Date Resolved. The log reflected there were three skin infections, six UTIs, two URIs, no eye infections, and the Other was left blank. In the Infection Related DX column there were seven UTIs, two URIs, one WBC Increased, one cellulitis and one left blank. (This does not match with the amounts written at the top of the page.) There were three entries with UTIs with no onset dates. November 2013's Infection Control Log was reported to the Infection Control/Quality Assurance Committee on 11/30/13. There were 13 resident names listed on this log. This log began with the date 11/02/13 and ended with the date 11/26/13. The November log did not identify any organisms which caused the infections although nine of the infections had a culture done but not dated. All of the infections were listed as not isolated. Eight infections were listed as nosocomial with four listed as not nosocomial. There were no entries in the admitted , Site, Organism, Isolated Yes/Date column, Re-Cultured date or Date Resolved columns. This log reflected there were two skin infections, six UTIs, one URI, one eye infection and three Other infections. In the Infection Related DX column, there was one Amputee wound, one GT site skin, five UTIs, one respiratory distress, one tooth extraction, one vaginal discharge/UTI and two increased WBCs. (This does not match with the amounts written at the top of the page.) A) Resident #2 was a [AGE] year-old-female admitted to the facility on [DATE] per her admission assessment dated [DATE]. This document also reflected Resident #2 had active [DIAGNOSES REDACTED].

F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the administrator and DON failed to use the facility's resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psycho-social well-being for 2 (Residents #1 and #2) of 14 residents reviewed for neglect and quality of care. 1) The Administrator failed to monitor and supervise the DON to ensure the DON carried out her responsibilities to ensure nursing services were provided in a manner to promote the well-being of the 15 residents reviewed for neglect and quality of care. 2) The DON failed to monitor and supervise the facility nursing staff to: a) ensure pharmacy services were carried out in such a way as to prevent the administration of unnecessary drugs and ensure the residents were free from significant medication errors (Residents #1, and #2); and ensure Resident #1 received the necessary care and services to manage her pain. The facility failed to properly transcribe and administer the following medications for Resident #1 in two of two months reviewed: [MEDICATION NAME] 25 mg - missed three of five doses; [MEDICATION NAME] 20 mg - missed three of five doses; [MEDICATION NAME] eye drops- missed three of five doses; [MEDICATION NAME] 40 mg-20 mg was given and only administered three out of five times; [MEDICATION NAME] - was given in the morning instead of at bedtime as ordered; [MEDICATION NAME] 200 mg-100 mg was given for three days; [MEDICATION NAME] - was given in the morning instead of at bedtime as ordered; Levetiracetam 1000 mg- 500 mg was administered for three days; [MEDICATION NAME] XL - missed three 60 mg doses and missed five 30 mg doses; and [MEDICATION NAME] 0.1 mg - missed five doses. b. LVN D failed to administer the correct dose of pain medications to Resident #1 when she repeatedly complained of leg pain. LVN D administered one [MEDICATION NAME] 5/325 mg when the ordered dose was two 10/325 mg tablets. c. The facility failed to discontinue Resident #2's [MEDICATION NAME] 25mg (for Hypertension) as ordered. The morning dose of [MEDICATION NAME] was discontinued on 02/03/14 and the evening dose was not discontinued until after the 02/28/14 dose, for a total of 31 doses. These failures could affect any the facility's 75 residents, including Residents #1 and #2, by placing them at risk for ongoing medication errors resulting in depression, eye discomfort, unrelieved pain, stomach upset, [MEDICAL CONDITION], weakness, confusion, dizziness, headache, [MEDICAL CONDITIONS] and death and could affect the 75 residents in the facility. Findings included: 1) Review of Resident #1's Physician's Telephone Orders dated 02/26/14 revealed she was to be readmitted to the facility with [DIAGNOSES REDACTED]. Review of Resident #1's admission Nurse's Note dated 02/26/14 at 2:20 PM revealed she was confused but able to make her needs known at that time. Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: [MEDICATION NAME] Hcl 25 mg tablets by mouth twice daily (used to treat high blood pressure); [MEDICATION NAME] 20 mg tablets by mouth twice daily (used to treat chest pain caused by heart damage); [MEDICATION NAME] Sodium 100 mg caps, two twice daily (used to prevent constipation); [MEDICATION NAME] 0.05% eye drops, one drop in each eye twice daily (used for increase tear production); [MEDICATION NAME] 20 mg tablets, give 40 mg at bedtime (used to lower cholesterol); [MEDICATION NAME] 20 mg tablets, give 10 mg by mouth at bedtime (used to treat depression); [MEDICATION NAME] 100 mg tablets, give 200 mg at bedtime (used to treat pain caused by [MEDICAL CONDITION]); [MEDICATION NAME] 325 mg, give one at bedtime (iron supplement used to treat [MEDICAL CONDITION]); Levetiracetam 500 mg tablets, give 1000 mg at bedtime (used to treat [MEDICAL CONDITION]); [MEDICATION NAME] XL 30 mg by mouth every day (used to treat high blood pressure and chest pain); [MEDICATION NAME] XL 60 mg by mouth every evening; and [MEDICATION NAME] HCL 0.1 mg by mouth every day (used to treat high blood pressure). Review of the facility's admission orders [REDACTED] [MEDICATION NAME] 30 mg PO QD; and [MEDICATION NAME] HCL 0.1 mg PO QD. Review of Resident #1's February 2014 MARs revealed the following: [MEDICATION NAME] 25 mg tablets twice a day was only transcribed and initialed as administered once on 02/27/14. (Not twice a day as ordered) [MEDICATION NAME] 20 mg tablets was only transcribed and initialed as administered once a day on 02/27/4 and 02/28/14. (Not twice a day as ordered) [MEDICATION NAME] Sodium 100 mg caps was only transcribed and initialed as administered once on 02/27/14 and 02/28/14. (Not twice a day as ordered) [MEDICATION NAME] eye drops were only transcribed and initialed as administered once a day on 02/27/14 and 02/28/14. (Not twice a day as ordered) [MEDICATION NAME] was transcribed as 20 mg at bedtime and only initialed as administered on 02/26/14 and 02/27/14. (Not on 02/28/14 as ordered) [MEDICATION NAME] was transcribed and initialed as administered as 10 mg at 6:30 AM. (Not at bedtime as ordered) [MEDICATION NAME] 100 mg was transcribed and initialed as administered at bedtime. (Not 200mg as ordered) [MEDICATION NAME] 325 mg was transcribed and initialed as administered at 6:30 AM. (Not at bedtime as ordered) Levetiracetam 500 mg was transcribed and initialed as administered daily at bedtime. (Not 1000 mg as ordered) [MEDICATION NAME] XL was transcribed as 30 mg by mouth every evening and was only administered on 02/26/14 and 02/27/14. (Not 60 mg as ordered and none on 02/28/14) [MEDICATION NAME] XL 60 mg was not transcribed to the February MAR and so no doses were given in February. Review of Resident #1's March 2014 MARs revealed the following: [MEDICATION NAME] XL 30 mg by mouth every day was not transcribed and so was not administered from 03/01/14 through 03/05/14, when surveyor inquired. [MEDICATION NAME] HCL 0.1 mg by mouth every day was not transcribed and so was not administered from 03/01/14 through 03/05/14, when surveyor inquired. An interview with the Unit Manager on 03/04/14 at 4:32 PM revealed it was typically her duty to check all orders daily for accuracy but she was pulled off the floor or on 02/24/14 to work on the

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F 0490

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 26)
monthly consolidated orders for the remainder of the month. She stated, during that time, the DON was performing the daily checks on both nurses' stations. During an interview on 03/05/15 at 10:25 AM, LVN C stated she had transcribed the admission orders [REDACTED]. When shown the errors found by the surveyors, LVN C stated she was not aware of the errors. She stated RN A had transcribed the orders to the March MARs and she remembered RN A pointing out some discrepancies to her but she thought she had corrected them. During an interview on 03/05/14 at 11:25 AM, RN A stated she had transcribed the March MARs for Resident #1 but had never looked at February's MARs. RN A stated she had caught a few discrepancies after the hospital orders had been transcribed to the facility's admission orders [REDACTED]. She was not aware of any medication errors. An interview with the DON on 03/05/14 at 11:25 AM revealed all orders, including new admission orders [REDACTED]. The DON explained pink copies of all resident's orders were to be placed in a box and both she and the Unit Manager checked those pink copies every day before they left to ensure all orders written over the past 24 hours were transcribed correctly. When asked about Resident #1, the DON confirmed the Unit Manager was not checking orders at that time as she had been pulled to work on the monthly orders. The DON stated she did not know why Resident #1's orders had not been checked; she stated the pink copies must not have made it into the designated box. b) Review of Resident #1's hospital Medication Profile Report dated 02/25/14 revealed the following medications were among those to be continued when she returned to the facility: [MEDICATION NAME] 10/325 mg one tablet every six hours as needed for pain. [MEDICATION NAME] 10/325 mg two tablets every six hours as needed for pain. Resident #1's admission orders [REDACTED]. Review of Resident #1's MAR for February 2014 revealed an entry for [MEDICATION NAME]-Apap 10-325 two every six hours as needed for pain. The entry was initialed as administered on 02/26/14 at 3:00 PM and 9:00 PM by LVN D. The back of the MAR reflected the following entries: 2/26/14 at 3:00 PM: Resident c/o pain, pain level 8/10, [MEDICATION NAME] ([MEDICATION NAME]) 5/325 admin, pain level at 3:30 PM 6/10. The entry was signed by LVN D. 2/26/14 at 9:00 PM: Resident c/o pain, telling, 8/10, [MEDICATION NAME] 5/325 mg admin, pain level @ 9:30 (PM), 7/10, ineffective. The entry was signed by LVN D. During an interview on 03/05/14 at 12:45 PM, LVN D explained she was Resident #1's Charge Nurse on 02/26/14 but LVN C was completing the admission orders [REDACTED]. When asked why she only administered 5/325 mg when the order and MAR both indicated the dose was two 10/325 tablets, LVN D stated she had seen the dose on the MAR but when she went to the medication cart, her old card was still on the cart (from prior to her hospitalization) and so she just administered that. When asked why she did not question the dosage on the card as it conflicted with the MAR or check the orders in the chart, LVN D stated, It never occurred to me she was really in pain, I didn't touch the orders, I gave her what she had on the cart. During an interview on 03/05/14 at 2:47 PM, the DON was shown Resident #1's MARs and told about the medication error regarding the [MEDICATION NAME]. The DON stated she was not aware of the error and that it should not have happened. She confirmed [MEDICATION NAME] 10/325 mg tablets were kept in the E-kit and LVN D could have easily retrieved the proper dose. When asked how Resident #1's pain should have been handled, the DON stated if a resident complains of pain, they should be assessed and a pain level ascertained. She stated the resident should be medicated if indicated and re-assessed in 30-45 minutes for relief. The DON stated, if the medication was not effective and another medication could not be given, the physician should be called and made aware of all the details surrounding the situation. An observation on 03/05/14 at 3:28 PM revealed [MEDICATION NAME] 10/325 tablets were stocked in the medication room E-kit at Resident #1's nurse's station. 2. Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #2 had a BIMS of 4 and was dependent on staff for most of his ADLs. Review of Resident #2's Care Plan dated 02/27/14 revealed: Date & Problem: DX [MEDICAL CONDITION]/HTN/[MEDICAL CONDITION] Goal: (Resident #2) will not suffer any complications caused by Dx's thru the next eval date. Approaches & Disciplines: Lab as ordered Notify Dr. of results Medications as ordered. Notify Dr of effectiveness Monitor for [MEDICAL CONDITION], SOB, Pain in extremities with discoloration of skin and warm to touch Document and Notify Dr/RP/Hospice Resident #2's Physician's Telephone Orders dated 01/09/13 reflected [MEDICATION NAME] 25 mg twice a day. Resident #2's Physician's Telephone Orders dated 01/30/14 reflected increase [MEDICATION NAME] to 50 mg twice a day for blood pressure. Review of Resident #2's MARs for the month of January 2014 revealed the last dose of [MEDICATION NAME] 25 mg was on 01/30/14 after the 9:00 PM dose. Further review of this MAR revealed [MEDICATION NAME] 50 mg was started on 01/30/14 at 9:00 PM. Review of Resident #2's MARs for the month of February 2014 revealed [MEDICATION NAME] 50 mg twice a day was administered as ordered. Further review of this MAR revealed the morning dose (9 AM) of [MEDICATION NAME] 25 mg was administered on 02/01/14, 02/02/14/ and 02/03/14. DC'D was hand written after the 9 AM dose was administered on 02/03/14. The evening dose (4:00 PM) of [MEDICATION NAME] 25 mg was administered each day during the month of February. A total of 31 doses of [MEDICATION NAME] 25 mg were administered that the physician had discontinued on 01/30/14. During an interview on 03/04/14 at 3:55 PM the surveyor reviewed Resident #2's February 2014's MARs with LVN B, Resident #2's evening charge nurse. LVN B stated she did administer [MEDICATION NAME] 25 mg and [MEDICATION NAME] 50 mg on the days she worked, as were documented on Resident #2's MAR. During an interview on 03/05/14 at 10:05 AM the ADM stated the Unit Manager did the February 2014 monthly recapitulations of physician orders [REDACTED]. During an interview on 03/04/14 at 4:30 PM the Unit Manager stated she checks the pink slips (copy of telephone physician orders) daily to make sure the orders were correct on the MARs. She stated when she did the February 2014 monthly recapitulations of physician orders, she was taken off the floor from 01/25/14 through the end of the month, and the DON took over her tasks, including verifying the pink slips were checked, for the whole building. During an interview on 03/06/14 at 4:30 PM the ADM stated Resident #2 receiving 31 doses of [MEDICATION NAME], which had been discontinued, was a careless error. The ADM further stated the DON told her she did miss a few a days of checking pink slips. During an interview on 03/06/14 at 8:47 AM the surveyor asked the DON how she thought Resident #2's received 31 doses of [MEDICATION NAME] that had been discontinued. The DON stated when RN A taught the Unit Manager how to do the monthly recapitulations of physician orders, RN A did not instruct the Unit Manager to continue to add additional physician orders [REDACTED]. Nursing 2013 Drug Handbook 33rd Edition, Wolters Kluwer, Copyright 2013, pages 680 - 681 reflected the following nursing considerations for [MEDICATION NAME]: Monitor patient's blood pressure, pulse and body weight frequently.Elderly patients may be more sensitive to drug's hypotensive effects. Overdose signs and symptoms include: [MEDICAL CONDITIONS] headache and flushing. 3. During an interview on 03/06/14 at 8:45 AM, the DON stated she had in-serviced the staff regarding medication transcription and pain assessments. The DON was asked who was responsible for carrying out the Unit Manager's duties when she was pulled off the floor at the end of the month. The DON explained, In February, I was on her side (of the building), I have to do both sides. When asked about her duties as DON, the DON explained she had to check all new orders and admission orders [REDACTED]'s orders, ensure families and physicians are notified as necessary, review resident charts if discharged and check charts for orders. When the DON was asked if she felt all those responsibilities were doable she stated, For me, at the end of the month, sometimes not doable. When asked how Resident #1's admission orders [REDACTED]. When asked if that had prompted her to check for admission orders [REDACTED]. When asked how she felt the error regarding Resident #1's pain medication had occurred, the DON stated she thought LVN D was an incompetent nurse and she had had to write her up in the past about things a prudent nurse should know. The DON further stated it was an error on all the nurses for leaving the [MEDICATION NAME] 5/325 mg on the medication cart when the resident went to the hospital. When asked about Resident #2 and how she felt the medication errors occurred, the DON stated the procedure was to check the medical record against the old MAR as well as the new MARs to ensure any errors on either MAR were found. She stated the procedure was not followed or the errors would have been found. The DON explained the Unit Manager checked new MARs on the 25th of the month and had not been trained to check the new MAR for new orders written after that time. She explained she had retrained the charge nurses to transcribe any new orders written toward the end of the month on the MARs for the following month. During an interview with on 03/06/14 at 4:32 PM, the Administrator was asked how she felt the errors occurred with Resident #2. The Administrator stated it was not like the Unit Manager not to be careful but she was careless. She stated the Unit Manager did not usually make those mistakes but it was an error not to discontinue the 4:00 PM entry for the medication. The Administrator stated she spoke with RN A and learned RN A had forgotten to train the Unit Manager to go and check for any orders written between the 25th and the 30th of the month. When asked about the errors related to Resident #1, the Administrator stated the DON and the Unit Manager had daily round check off sheets, which verified they checked daily physician orders [REDACTED].#2' s) admission orders They (DON/Unit Manager) didn't tell methey were overwhelmed, but they did tell me today (03/06/14) they were overwhelmed, after I asked. She stated missing Resident #1 was a problem as she had discussed the resident quite a bit. The ADM further stated, It wasn't that the system isn't in place, it was missed. 4. Review of the facility's current undated policy and procedure Monthly Review of physician's orders [REDACTED]. Purpose: To ensure that physician orders [REDACTED]. Policy: To verify prior to the beginning of each month that all physician orders [REDACTED]. (RN A)/(Unit Manager) will be responsible for this monthly review. DON will schedule the delivery of the

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 27) orders. DON will have (RN A) to be removed from the schedule as a floor nurse for the last 5-6 days of each month. (RN A) will inform DON of all concerns regarding the orders upon the completion of the review. (RN A) will take the prior month MARS and compare them to the clinical record. (RN A) will then take the clinical record and compare it to the new MARS. (RN A) will then handwrite onto the new MAR any new orders that will come after the 25th of the month. Attending nurses will write any new orders on the current MAR until the end of the month. If a new admission comes at the end of the month, (RN A)/Designee reviewing the MAR should make a new set of physician's orders [REDACTED]. (RN A)/Designee should also make a new set of MARS and TARS for the next month. (RN A)/Designee will via fax all updates to the person responsible for preparing the monthly orders: (name of pharmacy tech) at [PHONE NUMBER]. Clarifications orders will be written. 11-7 will compare the old MAR to the New MAR for accuracy. Review of the facility's current policy and procedure Unnecessary Drugs dated 2012 revealed: Purpose: Each resident's drug regimen must be free from unnecessary drugs: Procedure: An unnecessary drug is any drug when used: 1. In excessive dose (including duplicate therapy); or 2. For excessive duration; or 3. Without adequate monitoring; or 4. Without adequate indications for its use; or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 6. An combination of the reasons above. Review of an undated Medication Pass Inservice from an RN/LVN Orientation Book located at the Nurse's Station revealed the following: Steps to take during the med pass:. 16. Before administering the medication, always check 'The 6R 's' 17. Triple check medications vs. MAR before administering the medications. 18. If any of the 6 R's do not match or if you have any questions about the medication itself DO NOT GIVE THE MEDICATION! Check the chart or call the pharmacy with your concern. The pharmacist would rather you ask a question than a mistake be made. DURING THE MEDICATION PASS: 'THE 6 Rs' Before administering any medication, always check the 6 Rs, The right resident. The right drug: verify each drug against the medication administration record (MAR) before administering. The right dose: verify against the MAR. The right time: administer drugs as instructed on the MAR and within the time frame established by your facility. CHECKPOINTS.Related issues.Make sure discontinued medications have been removed from the cart as soon as they have been discontinued. Review of the facility ' s Pain Policy and Procedure dated 09/24/12 revealed the following: Purpose: Resident ' s pain will be managed at a level that is acceptable to that resident. Policy: 1. A resident will be assessed on admission for pain (location, duration, onset, alleviating/aggravating factors) a. If pain is present it will be assessed for its characteristics .5. Resident will be assessed with [REDACTED]. 6. A pain of any level unacceptable to the resident requires further assessment and follow up. Procedure: 1. Nurses will assess, monitor, anf follow-up on reported verbal, physical, and/or nonverbal signs and symptoms of pain or discomfort . 5. Review pain management care plan and implement. 6. Update care plan as often as necessary to maintain efficiency. 7. Determine the resident ' s preference for managing pain. 8. Nurse will assess and determine medication history and its effectiveness. 9. Nurse will review pain medicine ordered and its effectiveness to reduce pain to an acceptable level for the resident. 10. Nurse will reassess resident ' s perception of pain within 1 hour of any intervention and document. 11. Follow up with MD if resident receives no noted relief to perceived pain, for further orders . 13. Document findings in resident ' s chart. 14. Communicate pain status if any and interventions used during shift report and 24 (hour) report. 4. Review of the facility's Form-672, Resident Census and Conditions of Residents, dated 03/03/14 and signed by DON reflected a census of 75.
F 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure four CNAs (CNAs M, N, Q and R) of nine CNAs observed were able to demonstrate competency in providing proper incontinent care and used standard infection control procedures for three (Residents #3, #4 and #8) of six residents observed during incontinent care. 1. CNA Q failed to change her gloves while providing incontinent care to Resident #8, failed to practice good hand hygiene before and during incontinent care for Resident #8, went out of Resident #8's room with dirty gloves on retrieved the wipes container from the clean linen cart, came back in and placed them on Resident #8's bed. Upon completion of the incontinent care, CNA Q carried the used container of wipes and perineum wash from Resident #8's room and placed them on the clean linen cart. 2. CNA M and CNA N failed to perform hand hygiene during and after performing incontinent care to Resident #3. CNA removed her gloves, picked up the opened package of incontinent wipes, removed them from the room and placed them on the clean linen cart. 3. CNA R failed to change her gloves while providing incontinent care to Resident #4 when she cleaned the resident's buttocks (with stool) to the front peri area and before handling the residents pillows and blankets. These failures could affect the 19 residents, who required assistance with toileting and the 41 residents, who were dependent on staff for toileting, including Residents #3, #4 and #8, and placed them at risk for skin breakdown and the development of Urinary Tract Infections causing undue pain and discomfort for the resident via cross-contamination. Findings included: 1) Resident #8 was a [AGE] year-old female re-admitted to the facility on [DATE] per her significant change MDS assessment dated [DATE]. Her MDS assessment further reflected she had [DIAGNOSES REDACTED]. Further review of Resident #8's MDS assessment revealed she was incontinent of bowel and bladder and did not have an indwelling catheter. During an observation of incontinent care by CNA Q and CNA LL on 12/11/13 at 12:00 PM, neither CNA washed their hands after entering Resident #8's room to begin incontinent care. Both CNAs donned gloves without washing their hands. Observation of Resident #8 at this time revealed she had an indwelling urinary catheter. During the incontinent care, CNA Q did the actual incontinent care and CNA LL assisted with the turning and positioning of Resident #8. When CNA Q had finished cleaning the BM from the resident's left and right groin area, both CNAs began to position the resident to put on an incontinent brief. However, the surveyor had observed CNA Q did not clean between the resident's labia and stopped the CNAs, and asked CNA Q to spread Resident #8's labia and clean that area. CNA Q had run out of wipes, so without changing her gloves or washing her hands, she left the room, touching the door knob to leave and when she came back in. Once out of the room, CNA Q was observed to pull the cover back on the clean linen cart, retrieved a container of wipes, came back into Resident #8's room and placed the container of wipes on the foot of Resident #8's bed. CNA Q then picked up a clean wipe after opening the container with her contaminated gloves, picked up the bottle of perineal wash she had been using with her left hand, sprayed it onto the wipe, set the bottle of perineal down and using her left hand, spread Resident #8's labia and wiped down the left side. As she finished wiping, the wipe had a moderate amount of brown substance on it, and CNA Q said Oh, I see what you're talking about. CNA Q wiped the inside of Resident #8's labia and then dried the area using a towel. Without changing her gloves, CNA LL opened and squeezed cream into CNA Q's contaminated gloved hands. They turned Resident #8 to her left side and CNA Q wiped the cream on Resident #8's bottom. They then placed Resident #8 on her back and the surveyor asked CNA Q when she did catheter care and what it consisted of, and CNA Q said she wipes it if she sees something on it. After disposing of the dirty linen and trash, CNA Q washed her hands, then picked up the bottle of perineal wash and the container of wipes and took them out to the clean linen cart and placed them on the cart. Note: CNA Q had handled both of these items while wearing gloves contaminated with feces. During an interview with CNA Q on 12/11/13 at 12:20 PM, she was asked about carrying the container of wipes into the resident rooms and then bringing it back to the clean linen cart. CNA Q said, We use them off the cart. Take what is needed. I was in a hurry and took them with me.Oh I went out with dirty gloves. CNA Q asked the surveyor how she did with the incontinent care, and the surveyor told her about picking up the perineal wash bottle with her contaminated gloves and when finished, taking the bottle and placing it on the clean linen cart along with the wipes container. When asked, CNA Q said Some CNAs spray the perineal wash on their wipes but I take it in with me. The surveyor spoke to her about carrying it into Resident #8's room, placing it on the resident's bedside chest of drawers, using her contaminated gloved hands to pick it up and spraying it onto a wipe, which she handled with her contaminated gloved hands. The CNA was also informed about her use of her contaminated gloved hands to get wipes from the wipes container and then taking both the bottle and container of wipes and placing them on the clean linen cart. CNA Q said, Cross-contamination! The surveyor informed CNA Q she would not have spread Resident #8's labia and cleaned there if she had not been asked to by the surveyor, and CNA Q said You're right. The surveyor told her she never changed her gloves during the incontinent care and she should have changed them when going from dirty to clean and CNA Q said, I've learned so much. Thank you. You've taught me a lot. 2) Resident #3 was a [AGE] year-old female re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS assessment revealed she was severely impaired cognitively, was totally dependent on staff for hygiene and bathing and was always incontinent of bowel and bladder. Observation on 12/10/13 at 1:25 PM revealed Resident #3 was assisted to bed by CNA M and CNA N. The CNAs donned gloves and performed incontinent care. CNA

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	676052	A. BUILDING _____ B. WING _____	01/11/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	4515 VILLAGE CREEK RD FORT WORTH, TX 76119

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 0498 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 28) M changed her gloves after cleaning the resident, before placing a new brief on her. Following care, CNA N removed her gloves, picked up the opened package of wipes used during care and exited the room without washing her hands. This surveyor followed CNA N outside the room and saw her in the hall. When asked what she did with the wipes, CNA N replied, I put the wipes back on the cart and pointed to a clean linen cart outside Resident #3's room. When CNA N was asked if she always put the packages of wipes back on the clean linen carts like that, she stated, Yes. We have to. The surveyor re-entered Resident #3's room where CNA M was collecting the soiled linen. When CNA M was asked if they always took the wipes out of resident's rooms like that, she explained she tried to grab enough loose wipes to take with her so that bringing the package in the room was unnecessary, but that package of wipes was already sitting in the room. She stated she felt like that was cross-contamination. CNA M removed her gloves, took the bag of soiled linen out of the room, placed the linen in a bin, and then wheeled the bin down the hall without washing her hands. When asked when she should wash her hands, CNA M stated, Oops! When I leave the room. CNA M then proceeded to enter another resident's room, whose call light was on. She walked around the bed, turned off the call light and told the resident she needed to wash her hands before she could assist him. 3) Resident #4 was a [AGE] year-old female, readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #4 was severely impaired for cognitive skills for daily decision-making, was totally dependent on staff for toilet use, personal hygiene and bathing. Resident #4 was always incontinent of bladder and bowel. An observation on 12/10/13 at 2:15 PM revealed CNA R provided incontinent care to Resident #4. This surveyor entered Resident #4's room as CNA R was lowering the head of the resident's bed and had already donned gloves. CNA R unfastened the soiled brief and tucked it between the resident's legs. She then retrieved a wipe and wiped the resident's left groin, which had stool on the wipe and proceeded with a second wipe and wiped the resident's right groin, which also had stool on it. Without changing her contaminated gloves, CNA R turned Resident #4 onto her left side. Using several wipes, CNA R cleaned stool of liquid consistency off the resident's buttocks. Without changing her contaminated gloves, CNA R placed a clean brief under the resident. CNA R then repositioned Resident #4 onto her right side and straightened out the clean brief and then repositioned the resident onto her back. CNA R retrieved another wipe and wiped the resident's vaginal area and stated, I still have BM in front. CNA R then began to fasten the clean brief, and the surveyor asked her to stop, spread the resident's labia and wipe again. CNA R followed the surveyor's instructions, retrieved a clean wipe, spread the resident's labia, wiped from front to back and had stool on the wipe. CNA R stated, Oh yeah, there's more (stool) on up there. After CNA R completed rewiping, she fastened the new brief, placed pillows behind the resident's back and between her legs, put the bed rails up and pulled the resident's blankets up around the resident before removing her contaminated gloves. CNA R washed her hands before leaving the residents room. In an interview on 12/10/13 at 2:32 PM, the surveyor queried CNA R when she changed her gloves and provided hand hygiene while providing incontinent care, and CNA R stated, After I am through with care. In an interview on 12/11/13 at 2:40 PM, ADON MM was queried about when the CNAs performed hand washing and changed gloves during incontinent care. ADON MM stated when the CNAs entered the resident's room, necessary care was provided and then the CNAs wash their hands before they leave the resident's room. ADON MM further stated, No need to change their (CNAs') gloves or wash hands during care. In an interview on 12/11/13 at 3:30 PM, the DON was queried about when the CNAs performed hand washing and changed gloves during incontinent care. The DON stated when the CNAs entered the resident's room, if they touched BM and each time the CNA had BM on their gloves and before the CNA left the resident room. During the interview, when the DON was asked if she was aware the CNAs were carrying wipes and perineal spray bottles in and out of the residents' rooms, she stated she was aware of it. When asked whether she was concerned about potential cross-contamination and spread of infection, the DON replied, Yes, now that you say that and I process it. In an interview on 12/13/13 at 3:30 PM, the Director of Medical Records and QA, Ordering of Supplies was asked about the distribution of the incontinent wipes the CNAs used to clean the residents. The Director of Medical Records and QA, Ordering of Supplies explained she distributed one package of wipes to each CNA at the beginning of every shift. She stated she did not know how the CNAs were utilizing the packages. When asked about the bottles of perineal wash and whether those were assigned to individual residents, the Director of Medical Records and QA, Ordering of Supplies pointed out a box of empty perineal spray bottles adjacent to gallon jugs of liquid and explained she kept the gallon jugs in the storage room, and the CNAs refilled the bottles as needed. 3. Review of the Long Term Care Clinical Procedures, ?Briggs Corporation 2006, Infection Control Guidelines, which the ADM informed the surveyors was there reference for policy and procedures revealed the following: .Wash your hands before and after procedures; Wash your hands before and after resident contact. 3. Review of the facility's current undated facility policy and procedure Incontinence Care revealed: Procedure 1. Lower head and foot of bed 2. Drape resident for privacy 3. Wash all soiled skin areas and dry very well, especially between skin folds. 4. Apply protective skin lubricant and rub well into skin. 5. Change linen and apply clean egg crate mattress if necessary. Use appropriate protective covering for all egg crate mattresses. 4. The facility's Form-672, Resident Census and Conditions of Residents, dated 12/11/13 and signed by the MDS Coordinator reflected 19 residents required assistance with toileting and 41 residents were dependent on staff with toileting.
F 0502 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to provide or obtain laboratory services to meet the needs of its residents for six (Residents #2,#29, #35, #36, #37 and #38) of 16 residents assessed for laboratory services as evidenced by: 1) The facility failed to obtain urine cultures for one of Resident #2's follow up UA C&S after treatment for [REDACTED]. 2) After a facility outbreak of diarrhea: a. The facility failed to ensure a physician ordered stool specimen for Ova and Parasite and for [MEDICAL CONDITION] were obtained for Resident #38. b. The facility failed to ensure a physician ordered stool specimen for stool culture, Ova and Parasite was obtained for Resident #37. c. The facility failed to ensure a physician ordered stool specimen for [MEDICAL CONDITION] was obtained for Resident #29. d. The facility failed to ensure a physician ordered stool specimen for [MEDICAL CONDITION] was obtained for Resident #35. e. The facility failed to ensure a physician ordered stool specimen for [MEDICAL CONDITION] was obtained for Resident #36. These failures could affect the facility's 75 residents, including Residents #2,#29, #35, #36, #37 and #38, and placed them at risk for not having laboratory work done as ordered by the physician and had the potential to cause a delay in the provision of treatment for [REDACTED]. The findings include: 1.Resident #2 was a [AGE] year-old-female admitted to the facility on [DATE] per her admission assessment dated [DATE]. This document also reflected Resident #2 had active [DIAGNOSES REDACTED]. Resident #2's MDS further stated she was incontinent of bowel and had an indwelling catheter. During the initial tour with LVN G on 12/10/13 at 11:17 AM Resident #2 was not in her room. LVN G described Resident #2 as alert and oriented with confusion at times. LVN G said Resident #2 was incontinent of bowel but had an indwelling catheter for [MEDICAL CONDITION], she was ambulatory with a rolling walker and was stand by assist with most of her ADL's. Review of Resident #2's physician's telephone order dated 08/14/13 revealed an order for [REDACTED]. Review of Resident #2's Laboratory result dated 08/17/13 revealed Resident #2 had a UTI and was infected with the bacteria [MEDICATION NAME] species > 100,000 cfu/ml and it was sensitive to the antibiotic [MEDICATION NAME]. Review of Resident #2's physician's telephone order dated 08/17/13 revealed an order for [REDACTED]. Review of Resident #2's MAR for the month of August 2013 revealed she received all her doses of [MEDICATION NAME] as ordered. Review of Resident #2's physician's telephone order dated 09/04/13 revealed an order for [REDACTED]. Review of Resident #2's Laboratory result dated 09/07/13 revealed Resident #2 had a UTI and was infected with the bacteria [DIAGNOSES REDACTED] pneumoniae >100,000 cfu/ml and it was sensitive to the antibiotic Ciproflaxin. Review of Resident #2's physician's telephone order dated 09/09/13 revealed an [MEDICATION NAME] mg one by mouth two times a day times seven days for a UTI. Review of Resident #2's MAR for the month of September 2013 revealed she received all but one dose [MEDICATION NAME] ordered. The MAR indicated [REDACTED]. Review of Resident #2's physician's telephone order dated 09/19/13 revealed an order for [REDACTED]. Review of Resident #2's Laboratory result dated 09/23/13 revealed Resident #2 had a UTI and was infected with the bacteria E-Coli 50,000-99,000, [MEDICATION NAME] species >100,000 and [MEDICAL CONDITION] (MRSA) >100,000. The lab result showed all three bacteria to be sensitive to [MEDICATION NAME]. Review of Resident #2's physician's telephone order dated 09/23/13 revealed an order for [REDACTED]. Review of Resident #2's physician's telephone order dated 09/23/13 revealed an order clarification to change the [MEDICATION NAME] 50 mg by mouth two times a day for ten days to [MEDICATION NAME] 100mg by mouth two times a day for 10 days. Review of Resident #2's MAR for the month of September and October 2013 revealed she received all her doses of [MEDICATION NAME] 150 mg as ordered. The MAR's further reflected Resident #2 received all but one of her doses of [MEDICATION NAME] 100mg as ordered by the physician. She did not receive her tenth

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0502 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 29) dose of [MEDICATION NAME] on 10/03/13 at 8:00 AM. Review of Resident #2's Laboratory Report found in her chart dated 10/09/13 revealed two Urinalysis results for Resident #2. There were three Urinalysis results on the lab sheet. The three separate urinalysis dates on this sheet were 09/20/13, 10/07/13 and 10/09/13. At the top of the sheet was written If a Urine Culture is needed on this specimen, and has not already been ordered, please contact the laboratory within 24 hours to request additional testing. At the bottom of this sheet was written wanted cxs (cultures) there were two sets of initials which was unable to be read as well as what appeared to be two different dates one was unable to be read and the other date was 10/18/13. During an interview with Medical Director/Physician K on 12/12/13 at 7:44 PM when the surveyor showed him Resident #2's laboratory results dated [DATE] and asked about the UA C&S times two cultures not having been run on Resident #2's two UA's Medical Director/Physician K said he did not know why they had not been run. Medical Director/Physician K said it should have been automatic, most labs run a culture as routine. During an interview with the DON on 12/13/13 at 11:10 AM the surveyor showed the DON the laboratory results of the two UA's for Resident #2 dated 10/07/13 and 10/09/13. When asked who should have followed up on the labs. The DON said ADON MM should have caught there were no cultures done on the urine as she was responsible for the labs for station two. The DON did not know why there were no cultures run and said she would check in to it. On 12/13/13 the DON delivered a new laboratory result dated as run on 12/13/13 at 3:16 PM. Review of Resident #2's laboratory result which were the Final results of a UA C&S collected on 10/09/13 revealed a Urine Culture of [DIAGNOSES REDACTED] pneumonia colony count > 100,000. At the bottom of this lab report was REPRINT: Orig. printing on 10/11/2013 Resident #2 was never treated for [REDACTED]. During an interview with LVN H on 12/13/13 at 3:50 PM the surveyor gave LVN H Resident #2's laboratory results of the urinalysis (which had no C&S results) dated 10/09/13 and asked her if she noticed anything wrong with it. LVN H could find nothing wrong and said she would call the doctor with the results. The surveyor asked her about the other C & S results and she said any of the nurses could have received the results. When asked what she did when received the order for the labs to be done LVN H said she wrote the telephone order and transcribed it into the lab book so when the lab came they would know. LVN H said she put it in the lab book as a UA with C & S and she did not know why a C & S had not been done. During an interview with the DON on 12/14/13 at 12:15 PM when asked what the process was for obtaining an order for [REDACTED]. During an interview with the DON on 12/15/13 at 8:18 AM the DON said for the UA sweep they had pulled a list of all Residents who had UA's by using the lab logs. The surveyor asked the DON for the result of the most recent UA on Resident #2. During an interview with ADON MM on 12/15/13 at 12:26 PM she informed the surveyors they had done a sweep of the building and looked at all people with infections. ADON MM said they looked through the records for everyone who had an infection. She said then they had looked through the residents charts that had infections to make sure labs were done as ordered by the physician and to see if the physician was called and the follow up was done. Review of Resident #2's physician's telephone order dated 12/13/13 at 2:00 PM revealed an order for [REDACTED]. During an interview with the DON on 12/16/13 at 10:35 AM she informed the surveyor the urine for Resident #2's UA was just picked up today. The surveyor asked, So the order was written on the 13th per the plan of removal and not actually done until today? The DON said the doctor specified to pick it up on the 16th. (The UA C & S was actually not done until the 17th a day after it was ordered to be done.) Review of Resident #2's nurses' note dated 12/17/13 at 4:10 AM revealed the UA C & S ordered to be done on 12/16/13 was collected and sent to the lab. (This was done one day late according to the order.) Review of Resident #2's UA C & S laboratory results dated [DATE] at 12:43 PM revealed the urinalysis result indicated an infection. The results were as follows: Leukocytes esterase result was A-Abnormal and a Small amount were found in the urine; Urinary WBC result was A-Abnormal with 0-5 the amount shown; Urinary RBC result was A-Abnormal with 0-5 the amount shown; Urinary [MEDICATION NAME] cells result was A-Abnormal with Few seen and Urinary Bacteria result was A-Abnormal with a Moderate amount seen. Review of the web-site: http://www.mayoclinic.com/health/urinalysis/MY /METHOD=print&DSECTION=all; on 12/27/13 at 10:30 revealed the following: Urinalysis is a test that evaluates a sample of your urine. Urinalysis is used to detect and assess a wide range of disorders, including urinary tract infection, kidney disease and diabetes. .Evidence of infection. [MEDICATION NAME] and leukocyte esterase are produced as a result of an infection. If either [MEDICATION NAME] or leukocyte esterase - a product of white blood cells - is detected in your urine, it may be a sign of a urinary tract infection. Microscopic exam Several drops of the urine are examined with a microscope. If any of the following are observed in above-average levels, additional testing may be necessary: White blood cells (leukocytes) may be a sign of an infection. Red blood cells (erythrocytes) may be a sign of kidney diseases, blood disorders or another underlying medical condition, such as [MEDICAL CONDITION]. [MEDICATION NAME] cells - cells that line your hollow organs and form your skin - in your urine may be a sign of a tumor. But more often, they indicate that the urine sample was contaminated during the test, and a new sample is needed. Bacteria or yeasts may indicate an infection. Review of Resident #2's care plans failed to reveal any pertaining to an indwelling Foley catheter. 2. a. Resident #38 was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS revealed Resident #38 had severe cognitive impairment, was incontinent of bowel and was totally dependent on staff for assistance with toileting. Review of Resident #38's physician order [REDACTED]. Review of Resident #38's physician orders [REDACTED]. ADON MM wrote this verbal telephone order. Review of Resident #38's lab report dated 12/22/13 revealed her stool culture was collected on 12/20/13 and completed on 12/22/13 with negative results. Another lab report dated 12/20/13 reflected the test for Ova and Parasites was rejected because of an insufficient sample. During an interview on 01/03/14 at 11:30 AM the DON stated she had checked with their lab and the stool specimen for [MEDICAL CONDITION] and Ova and Parasite was never collected for Resident #38. b. Resident #37 was a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the MDS revealed Resident #37 was cognitively intact, was incontinent of bowel and bladder and required extensive assistance with toileting. Review of Resident #37's physician order [REDACTED]. During an interview on 01/03/14 at 11:30 AM the DON stated she had checked with their lab and the stool culture was never collected for Resident #37. c. Resident #29 was a [AGE] year-old female, readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #29 was always continent of her bowels. Review of Resident #29's physician orders [REDACTED]. ADON MM wrote this verbal telephone order. Review of Resident #29's CNA Tracking Form dated 12/20/13 through 12/28/13 revealed the resident was incontinent of stool every day on the 7-3 PM shift. During an interview on 01/02/14 at 1:22 PM the DON stated she had checked with their lab and the stool culture was never collected for Resident #29. d. Resident #35 was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #35 had a BIMS of three (severely impaired), was independent with toileting and was always continent of bowel and bladder. Review of Resident #35's physician orders [REDACTED]. ADON MM wrote this verbal telephone order. During an interview on 01/03/14 at 11:30 AM the DON stated she had checked with their lab and the stool culture was never collected for Resident #35. e. Resident #36 was a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #36 had a BIMS of 3 (severely impaired), required supervision for toileting and was occasionally incontinent of bowel. Review of Resident #36's physician orders [REDACTED]. ADON MM wrote this verbal telephone order. During an interview on 01/03/14 at 11:30 AM the DON stated she had checked with their lab and the stool culture was never collected for Resident #36. In an interview on 01/02/14 at 2:12 PM, when a surveyor asked ADON MM about Resident #29 order to collect a stool specimen, she replied, We had a couple of incidents of residents having diarrhea stool, called (Physician K), he told me to order these. When asked what other residents were involved, ADON MM stated she did not remember. When told the test was never done, ADON MM stated the resident did not have any more episodes. When asked how she knew that, ADON MM stated, I asked a couple of times, didn't want an outbreak. When asked if she ever called the physician back to let him know, ADON MM replied, That would have been the proper thing to do. I did not. During an interview on 01/02/13 at 3:10 PM LVN C (Residents #29, #35 and #36's charge nurse) stated, About four people (residents) had diarrhea for one or two days. Their (resident's) rooms were close (to each other). It (stool sample needed) was on the 24-hour report. No one (resident's) had a positive [MEDICAL CONDITION]. Resident #29 did not have a positive [MEDICAL CONDITION]. The surveyor asked LVN C how would she know that since Resident #29's stool specimen was never collected and LVN C stated, Oh. During an interview on 01/03/13 at 12:15 PM the DON stated Residents #35 and #36 were both confused and continent. The surveyor asked how they obtained stools specimens if the resident was confused and the DON stated, The CNA should follow/monitor the resident on cued times and go into the bathroom with the resident to collect the stool, and we bring in a hat (plastic stool collector that fits on commode). During an interview on 01/03/14 at 12:49 PM, when Lab Assistant RR was asked whether a stool culture would identify [MEDICAL CONDITION], he stated it would not and that test required a separate order. He stated both tests could be run on the same specimen provided there was enough sent to the lab. When asked about Resident #38, Lab Assistant RR stated they had received an order to do a stool culture and check for ova and

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	676052	A. BUILDING _____ B. WING _____	01/11/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUELS HEALTHCARE	4515 VILLAGE CREEK RD FORT WORTH, TX 76119

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

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F 0502 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 30) parasites. Lab Assistant RR stated the culture was performed but the facility was sent a notification on 12/20/13 that there was not enough of the specimen to check for ova and parasites, and another one would need to be collected. When queried about Residents #35, #36, #37 and #29, Lab Assistant RR confirmed no specimens had been sent from the facility. In an interview on 01/03/14 at 1:13 PM, LVN F was asked about the recent outbreak of nausea, vomiting and diarrhea in the building. LVN F stated she was aware of Residents #35, 36, 37 and 38 having symptoms. When asked when they started thinking it was an infection, she stated when Resident #35 and #36 had diarrhea, she added Resident #36 had vomiting as well. LVN F stated she had informed ADON MM who told them to keep her informed. LVN F stated they used to fill out Infection sheets but ADON MM told them she was doing it. LVN F stated ADON MM was present during an episode with Resident #35 who had diarrhea all over the floor, her hands, everywhere. When asked whether that had been documented in the resident's chart, LVN F checked and determined it had not. When asked if Resident #35 was the first resident with symptoms, LVN F stated she thought it had started with Resident #36 then, the next day, Resident #35. When asked if she was aware if any of the cultures had been completed, LVN F stated she just remembered ADON MM stating it did not smell like [MEDICAL CONDITION]. When asked about the process for specimen collection, LVN F stated she was told the 11-7 shifts needed to collect urine and stool specimens when ordered. She stated if the night shift was unable to collect it, they would pass it on to the day shift. She stated it should be recorded in the 24-hour report. When asked what her responsibility was if a resident needed a specimen collected, LVN F stated she should try to collect it and let the CNAs know to report any incontinent episodes and let the residents know if they were alert. LVN F stated she was unable to collect any of the ordered specimens. During an interview on 01/03/13 at 2:45 PM CNA N stated LVN J told her, weekend of 12/21/13, that Resident #39 needed a stool specimen. I wait until the nurse comes to me and tells me a stool specimen was needed. CNA N stated she was aware other residents (Residents #10 #38 and #56) had a stomach virus with diarrhea. I think it was a big ordeal. During an interview on 01/04/14 at 10:10 AM LVN J (Residents #29, #35 and #36's charge nurse) stated there was an infection that Spread around the whole building. We were collecting [MEDICAL CONDITION] (specimen ' s) on some residents LVN J stated Resident #35 and #36 had a lot of diarrhea from a report he received from the nurse who preceded him, the weekend of 12/21/13. He stated it was difficult to collect stools from Resident #35 and #36 because they were private residents. LVN J stated the weekend of the 12/28/13 he did not get report that stool specimens were still needed. He stated his assigned resident's did not have diarrhea on his shift, he had asked his CNAs. The surveyor asked LVN J what his procedure was if he needed to collect a stool specimen and he stated he would inform his CNA to let him know when the resident had a stool. LVN J stated he did collect one stool specimen, and it was for Resident #39. During an interview on 01/04/14 at 10:40 AM Weekend Supervisor LVN Y stated on 12/21/13 one of the unit clerks was not feeling well, and had what the residents had. The surveyor asked what the residents had and she stated they had nausea and vomiting, on both sides of the building. Weekend Supervisor LVN Y stated she asked her weekend nurses who of their residents had symptoms and LVN J told her that Resident #39 had vomiting and diarrhea and needed a stool specimen. Weekend Supervisor LVN Y stated she received a written report from the DON that revealed several residents had diarrhea and needed stool specimens. In another interview with the DON on 01/04/14 at 11:25 AM, she stated she had contacted Medical Director/Physician K and Physician SS and informed them none of the stool specimens had been collected. The DON added the physicians told her not to continue to try to collect the specimens as long as no one was symptomatic. When asked if she knew when the outbreak began, the DON replied, I want to say the 18th (December). When informed by a surveyor there was documentation of a resident showing symptoms on 12/14/13 and asked if her first knowledge was 12/18/13, the DON replied, That's when the trend started. Now that you say that, I remember (Resident #36), but with (Resident #35), it was bam, bam, bam after that. The DON stated ADON MM followed-up and obtained the orders. She stated that, as she had not written the orders, they would not have been in her basket to follow-up. On 01/04/13 at 12:55 PM, Weekend Supervisor LVN Y provided the surveyors with a list of residents and stated they were going to collect stool specimens for those on the list. When asked why, she explained she was still concerned and spoke with Medical Director/Physician K who told her to go ahead and collect them. In a follow-up interview with Weekend Supervisor/LVN Y on 01/04/13 at 1:20 PM, when asked how she came up with the names on the list, she pointed out a report sheet and stated she added Resident #43 because she heard he had diarrhea. In an interview on 01/06/14 at 8:45 AM, when the MDS Coordinator was asked if any care plans had been initiated related to the outbreak of diarrhea and vomiting, she stated there were none. When asked who initiated acute care plans, the MDS Coordinator replied, If they give me paperwork, I will. 3. Review of the facility's current policy and procedure Immanuel's Healthcare Lab Policy and Procedure dated 08/13 revealed: Purpose: to establish guidelines to ensure that all residents receive proper lab monitoring for [DIAGNOSES REDACTED]. Policy: It is the policy of Immanuel's Healthcare (IHC) that proper lab monitor is obtained for each resident. Procedure: The charge nurse will: 1. Upon admission of IHC review resident's [DIAGNOSES REDACTED]. 2. Upon receiving an order for [REDACTED]. a. Transcribe the order exactly as it was given from the PCP, PA, or NP to a telephone order (including lab type and frequency). b. Transcribe the ordered labs to the lab requisition in the lab book exactly as was given and written. c. Document 3. Upon lab tech's arrival to draw labs a. Consult with lab tech to see who and what they are drawing b. Ensure the order in resident's chart matches lab requisition 4. Upon receiving a lab result a. Review it b. Call doctor for abnormal results (low, high, and/or critical) c. Transcribe any new orders or instructions d. Document 3. Notify resident's family. 4) The Form CMS-672, Resident Census and Conditions of Residents, dated 12/11/13 and signed by the MDS Coordinator, reflected the census was 75 residents.
F 0505 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Quickly tell the resident's doctor the results of lab tests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify the attending physician of the findings of lab results for one (Resident #2) of 16 residents reviewed for laboratory results as evidenced by: The facility failed to notify the physician of Resident #2's urine culture and sensitivity lab results that were completed on 10/11/13. The culture was positive for [DIAGNOSES REDACTED] pneumonia infection. This failure could have resulted in Resident #2 becoming septic, required her to be hospitalized , increased her discomfort, increased her medical bills and possibly resulted in her death. This failure could affect all 42 residents residing on station two. Findings included: 1)Resident #2 was a [AGE] year-old-female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of this assessment revealed Resident #2's cognitive skills for daily decision making were moderately impaired. Resident #2 had an indwelling catheter and was always incontinent of bowel. Resident #2 required extensive assistance of one person for bed mobility, transfers, locomotion and was totally dependent of one person for dressing, eating, and toileting. During the initial tour with LVN G on 12/10/13 at 11:17 AM, Resident #2 was not in her room. LVN G described Resident #2 as alert and oriented with confusion at times. LVN G said Resident #2 was incontinent of bowel but had an indwelling catheter for [MEDICAL CONDITION], she was ambulatory with a rolling walker and was stand by assist with most of her ADLs. Review of Resident #2's physician's telephone order dated 09/19/13 revealed an order for [REDACTED]. Review of the Laboratory result dated 09/23/13 revealed Resident #2 had a UTI and was infected with the bacteria E-Coli 50,000-99,000, [MEDICATION NAME] species >100,000 and [MEDICAL CONDITION] >100,000. The lab results showed all three bacteria to be sensitive to [MEDICATION NAME]. Review of Resident #2's physician's telephone order dated 09/23/13 revealed an order for [REDACTED]. Review of Resident #2's physician's telephone order dated 09/23/13 revealed an order clarification to increase the [MEDICATION NAME] 50 mg by mouth two times a day for ten days to [MEDICATION NAME] 100 mg by mouth two times a day for 10 days. Review of Resident #2's Laboratory Report found in her chart dated 10/09/13 revealed two Urinalysis results for Resident #2. The urinalysis dates on this sheet were 10/07/13 and 10/09/13. No urine culture results were found in the resident's clinical record. On 12/13/13 the DON provided the surveyor a copy of Resident #2's urine culture, which reflected: REPRINT: Orig. printing on 10/11/2013. This urine culture collected on 10/09/13, reflected [DIAGNOSES REDACTED] pneumonia colony count > 100,000. Resident #2 was never treated for [REDACTED]. Review of Resident #2's nurse's notes dated 10/09/13 through 12/13/13 revealed there was no indication the physician had ever been notified of the urine culture results. During an interview with LVN H on 12/13/13 at 3:50 PM the surveyor gave LVN H Resident #2's laboratory results of the urinalysis (which had no C&S results) dated 10/09/13 and asked her if she noticed anything wrong with it. LVN H could find nothing wrong and said she would call the doctor with the results. The surveyor asked her about the other C&S results and she said any of the nurses could have received the results. When asked what she did when received the order for the labs to be done LVN H said

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F 0505 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 31) she wrote the telephone order and transcribed it into the lab book so when the lab came they would know. LVN H said she put it in the lab book as a UA with C &S and she did not know why a C&S had not been done. During an interview with the DON on 12/14/13 at 12:15 PM the DON said it was every nurse's responsibility to call the doctor if they received lab results. 2) Review of the web-site: http://www.mayoclinic.com/health/urinalysis/MY /METHOD=print&DSECTION=all; on 12/27/13 at 10:30 revealed the following: Urinalysis is a test that evaluates a sample of your urine. Urinalysis is used to detect and assess a wide range of disorders, including urinary tract infection, kidney disease and diabetes. .Evidence of infection. [MEDICATION NAME] and leukocyte esterase are produced as a result of an infection. If either [MEDICATION NAME] or leukocyte esterase - a product of white blood cells - is detected in your urine, it may be a sign of a urinary tract infection . Microscopic exam Several drops of the urine are examined with a microscope. If any of the following are observed in above-average levels, additional testing may be necessary: White blood cells (leukocytes) may be a sign of an infection. Red blood cells (erythrocytes) may be a sign of kidney diseases, blood disorders or another underlying medical condition, such as [MEDICAL CONDITION]. [MEDICATION NAME] cells - cells that line your hollow organs and form your skin - in your urine may be a sign of a tumor. But more often, they indicate that the urine sample was contaminated during the test, and a new sample is needed. Bacteria or yeasts may indicate an infection. Review of Resident #2's care plans failed to reveal any pertaining to an indwelling Foley catheter, UTI's or laboratory work. 3) Review of the facility s current policy and procedure for labs dated August 2013 revealed: Purpose: to establish guidelines to ensure that all residents receive proper lab monitoring for [DIAGNOSES REDACTED]. Policy: It is the policy of (the facility) that proper lab monitoring is obtained for each resident. Procedure: The charge nurse will. 4. Upon receiving a lab result a. Review it b. Call doctor for abnormal results (low, high, and/or critical) c. Transcribe any new orders or instructions d. Document. 4) Review of the facility Census List given to the surveyors on 12/10/13 there were 42 residents residing on station two.
F 0508 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Give or get x-rays and other tests in a timely manner to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to obtain radiology services to meet the needs of one (Resident #29) of 11 residents reviewed for physician-ordered x-rays. Resident #29 had a cough on 12/20/13 and the physician ordered a chest x-ray. The facility failed to ensure the x-ray was done. This failure could effect the facility's 75 residents including Resident #29, by placing them at risk for delayed medical treatment and further decline in their condition. Findings included: 1. Resident #29 was a [AGE] year-old female, who was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. and Depression per the quarterly MDS assessment dated [DATE]. Review of Resident #29 physician's orders [REDACTED]. Review of Resident #29 Nurse's Notes dated 12/20/13 revealed no mention of a chest x- ray. Review of the 24-hour reports dated 12/20/13 revealed no mention of a chest x-ray for Resident #29. During an interview on 01/02/14 at 1:22 PM, the DON stated the chest x-ray ordered on [DATE] for Resident #29 was never done. During an interview on 01/02/14 at 3:10 PM, LVN C stated if she received a new order for a chest x-ray, she would notify the x-ray company a chest x-ray was needed, document it in the Nurse's Notes and the 24-hour report. The surveyor showed LVN C Resident #29's physician order, dated 12/20/13, for a chest x-ray, which she had noted. Then the surveyor showed LVN C Resident #29's Nurse's Notes and the 24-hour report for 12/20/13, neither of which mentioned the x-ray. LVN C stated, I thought I did. As LVN C continued to review Resident #29's Nurse's Notes, she stated, I found where I documented it on 12/25/13, Checked on chest x-ray. The surveyor asked LVN C what her note meant and LVN C stated, That I checked on the results. The surveyor asked how could she do that if the chest x-ray was never ordered, and LVN C stated, Well I thought I checked out the results. I usually don't do things like that. There was a lot going on with her (Resident #29) then. Review of Resident #29 facility's chart revealed no acute care plans related to the resident's cough. In an interview on 01/06/14 at 8:45 AM, when the MDS Coordinator was asked if any care plans had been initiated related to signs and symptoms of infection, she stated there were none. When asked who initiated acute care plans, the MDS Coordinator replied, If they (charge nurses) give me paperwork, I will. 2. During an interview on 01/10/14 at 2:05 PM, the DON stated there was not a facility policy regarding obtaining x-rays. 3. Review of the facility's Form-672, Resident Census and Conditions of Residents, dated 12/11/13 and signed by the MDS Coordinator reflected the facility's census was 75.