STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675127**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUMBLE HEALTHCARE CENTER	**93 ISAACKS RD HUMBLE, TX 77338**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 interview and record review, the facility failed to consult the physician for changes in condition for 1 of 17 residents (Resident # 32) reviewed for changes in condition as evidenced by: Resident #32 had elevated blood pressures recorded on her August 2012 MAR indicated [REDACTED]. This deficient practice affected 1 resident and had the potential to place an additional 84 residents at risk for not having their physician consulted when having a change of condition which could result in a delay of medical treatment. Finding Include: Resident # 32 Record review of Resident # 32's face sheet revealed he was admitted to facility on 7/3/2013 with the following Diagnoses: [REDACTED]. He was [AGE] years old. Record review of Resident # 32's MAR indicated [REDACTED] -2/1/2014 at 6:00 AM B/P 191/91 -2/2/2014 at 6:00 AM B/P 166/95 -2/7/2014 at 4:00 PM B/P 190/80 -2/10/2014 at 6:00 AM B/P 199/79 -2/11/2014 at 4:00 PM B/P 180/81 -2/12/2014 at 4:00 PM B/P 193/84 -2/13/2014 at 6:00 AM B/P 197/97 -2/14/2014 at 6:00 AM B/P 191/93 Record review of Resident # 32's February 2014 physician orders [REDACTED]. -[MEDICATION NAME] 1 mg, 1 tablet at bedtime -[MEDICATION NAME] 100 mg, 1 tablet by mouth twice a day -[MEDICATION NAME] 20 mg. 1 tablet by mouth daily -[MEDICATION NAME] 10 mg, 1 tablet by mouth every day In an interview with the DON on 2/14/2014 at 6:00 PM she was shown Resident #32's February MAR indicated [REDACTED]. According to CMS Form 672 the facility census was 85.
F 0164 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep each resident's personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident's right to personal privacy for 5 of 18 residents (Residents # 25, 49, 54, 30, and 75) reviewed for personal privacy. -LVN A did not shut the door or pull the privacy curtain while administering medications through a feeding tube to Resident # 25. -MA D and LVN A left residents' records containing individually identifying health information exposed, where they could be observed by other residents and visitors, while providing care to residents. -CNA G did not knock prior to entering Resident # 75's room. This deficient practice affected 5 residents and the potential to affect the additional 80 residents in the facility. Failure to provide personal privacy related to medical and emotional conditions could decrease resident's feelings and self-esteem Findings include: Resident # 25 Observation on 2/11/14 at 4:50 PM of LVN A administering mediation to Resident # 25 through a feeding tube in the resident's stomach. During the care, LVN A left the resident's door open and the curtain was not pulled, exposing her to anyone walking by. In an interview on 2/13/14 at 2:20 PM, LVN A stated with Resident # 25, she did not pull the curtain because no one else was in the room. She stated she could not remember if she had shut the door, but that normally she would. Resident # 49 Observation on 2/12/14 at 7:55 AM, MA D was observed administering medications to Resident # 49. MA D left the MARS open while she was in the room with Resident #49. In an interview on 2/13/14 at 1:50 PM, MA D stated the MARS should be closed when she steps away from the cart so that no one can see private information on the residents. Observation of the wound treatment cart on 2/12/2014 at 9:30 AM and 10:00 AM revealed the book with individual resident's TARs was left open and with resident information exposed in the hallway while LVN A was in Resident # 54's room providing wound care. Observation of the wound treatment cart on 2/13/2014 at 9:33 AM and 10:00 AM revealed the book with individual resident's TARs was left open and with resident information exposed in the hallway while LVN B was in Resident # 30's room providing wound care. When the care was complete at 9:53 AM the books with the TARs were still open. Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Observation was conducted of CNA G providing catheter and peri-care for Resident # 75 on 2/13/2014 at 11:37 AM. She obtained supplies from the linen cart in the hall and placed a handful of gloves in the pocket of her uniform. When she entered the room she said I forgot to knock on the door. In an interview on 2/14/14 at 4:15 PM, the DON was asked if was okay to leave the MAR open during medication pass or the door open when administering medication through a feeding tube. She stated no, that it would be a HIPAA violation with the resident's information on the MAR and a privacy issue with the door open during care. Record review of the facility's policy Confidentiality of Information, revised December 2006, read, in part, . Our facility shall treat all resident information confidentially. The facility will safeguard all resident records. to protect the confidentiality of the information. Record review of the facility's policy Resident Rights Guidelines for All Nursing Procedures, revised October 2010, read in part, .For any procedure that involves direct resident care, follow these steps:. f. Close the room entrance door and provide for the resident's privacy. Record review of the facility's policy Quality of Life-Dignity revised October 2009, read in part, . 6 . a. Staff will Knock and request permission before entering residents' rooms . According to CMS 672 the census was 85.
F 0246 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were placed within reach for 1 of 17 sampled residents (Resident # 75) -Resident # 75's call light was observed out of reach on 2/12/2014. This affected 1 residents and placed 84 residents at risk of their needs not being met, falls, and injuries. Findings include: Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Observation of Resident # 75 on 2/12/2014 at 7:30 AM revealed she was up in her wheelchair with the over the bed table in front of her. Her wheelchair was positioned at the middle of the bed with the bed to her left side. Her call light was attached to her pillow that was at the head of the bed and behind the resident. The resident had a protective boot to her left lower leg and a dressing on her left foot. In an interview with the DON on 2/14/2014 at 6:00 PM she said call light should be placed within reach. According to CMS Form 672 the facility census was 85.
F 0248 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide activities to meet the interests and needs of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing individualized activity program which identified and met each resident's interest and the physical, mental, and psychosocial well-being for 2 of 17 residents (Resident #1, and #35) reviewed for activities. The facility failed to conduct an initial activity assessment for Resident's #1 and # 35. The facility failed to provided Resident # 35 an ongoing activity program to meet her well-being. This failure placed 2 residents and could affect 83 residents at risk for becoming isolated from others, having a depressed mood, boredom, loneliness, and an over-all decreased quality of life. Finding Include: Resident #1 Record review of

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

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

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NAME OF PROVIDER OF SUPPLIER **HUMBLE HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **93 ISAACKS RD HUMBLE, TX 77338**	

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F 0248

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 1)
Resident #1's current medical record revealed he was admitted to facility on 1/29/14 with a [DIAGNOSES REDACTED]. He was [AGE] years old. Review of Resident #1's chart revealed no activities assessment in his current medical record. Observations on 2/11/14 at 12:30 PM and 3:00 PM and 2/12/14 at 8:30 AM and 12:30 PM and 2/13/14 at 1:15 PM revealed Resident #1 was not engaged in activities. Observations on 2/14/14 at 10:15 AM revealed Resident #1 sitting in the TV area asleep in his wheelchair. In an interview with the Activity Dir #2 on 2/13/14 at 3:21 PM she said I couldn't find the assessment for Resident #1. Usually I do it with the ARD but I didn't do it this time. Resident #35 Record review of Resident # 35's face sheet revealed the [AGE] year old admitted to the facility on [DATE] and readmitted on [DATE]. The following [DIAGNOSES REDACTED]. Record review of Resident # 35's 11/9/13 History and Physical revealed she had the following diagnoses; [MEDICAL CONDITIONS], dementia with depression, failure to thrive and debility. Observations on 2/11/14 at 3:05 PM, 2/12/14 at 7:25 AM, 7:45 AM, 12/13/14 at 2:30 PM, 2/14/14 at 8:30 AM and 11:00 AM revealed Resident # 35 was in bed. There was no television or music on. During the survey Resident # 35 was never observed receiving activities. Record review of Resident # 35's Activity Evaluation dated 10/15/13 revealed only the following information was filled out; last name, birth date, language spoken, former occupation, date of admission, veteran, [DIAGNOSES REDACTED]. # 1 on 10/15/13. The Preference interviews (by resident, family member or staff), Activity Pursuit Pattern, Cognitive/Communication, Attitude and Special Precautions/Limitation/Considerations have no information documented. There was no documentation that any attempt had been made to interview the resident, a family member or staff member regarding her past or current interests. Record review of Resident # 35's Activity Progress Notes revealed the following; 10/15/13 Ad (activity director) welcomed resd (resident) to the facility. AD will give her time to adjust to the facility. It was signed by Activity Dir. #1. Continued review revealed on 1/18/14 Resd (resident) stays in her room. She gets visits from AD 3X (three times) a week, her family visits weekly. AD will monitor and chart x (times) 90 days. It was signed by Activity Dir. #1. Record review of Resident # 35's Individual Participation Record revealed the following; -December 2013 she was active in Music 11 times and Relaxation 11 times. There were 13 days that no activity was listed. -January 2014 she was active in Music 11 times. There were 13 days that no activity was listed (additionally, she was hospitalized from [DATE] until 1/17/14). -February 2014 (as of 2/14/14) she was active in Music 4 times and Relaxation 7 times. There were 4 days that no activity was listed. In an interview on 2/14/14 at 8:03 AM, Activity Dir. # 1 stated Resident # 35 could not answer the questions, so she did not fill out the Activity Evaluation. When asked if she had contacted Resident # 35's family to help answer the questions, she stated I guess I can. Activity Dir. # 1 stated she spends one on one time with Resident # 35 three times a week. In an interview on 2/14/14 at 10:50 AM, CNA D stated Resident # 35 gets out of bed for lunch and dinner. She stated Resident # 35 never goes to activities and barely gets out of bed. In an interview on 2/14/14 at 11:05 AM, the DON stated the activity department should have called the family regarding Resident # 35's history and interests. She stated there should have been more thorough assessment. In an interview on 2/14/14 at 11:10 AM, Activity Dir. # 1 stated she would bring the radio into Resident # 35's room Mondays, Wednesdays and Fridays. She stated Resident # 35 would sometimes attend church. She stated she should have further assessed the resident. She stated she did not care plan activities for Resident #35, but she should have a care plan. Record review of the facility's policy titled Activity Assessment, 2001 MDS-PASS, Inc (Revised October 2009), read in part,Policy Statement: In order to promote the physical, mental and psychosocial well-being of residents, an activity assessment is conducted and maintained for each resident.1 Within 14 days of a resident's admission to the facility, an activity assessment will be conducted to help develop an activities plan that reflects the choices and interests of the resident.4. The activity assessment is used to develop an individual activities care plan that will allow the resident to participate in activities of his/her choice and interest. 5. Each resident's activities care plan shall relate to his/her comprehensive assessment and should reflect his/her individual needs. 6. The activity assessment and activities care plan will identify if a resident is capable of pursuing activities without intervention from the facility. 7. The completed activity assessment will be part of the resident's medical record and shall be updated as necessary, but at least annually. According to CMS 672 the census was 85.

F 0252

Level of harm - Potential for minimal harm

Residents Affected - Many

Provide a safe, clean, comfortable and homelike environment.

Based on observation, interview and record review, the facility failed to provide a safe, clean, comfortable and homelike environment for residents as evidenced by: - Room 200, the bathroom sink was observed to be turned around backwards and not operational. - Room 206, the hard plastic door guard glued to the door was observed to be half off the door. - Room 212, 4 screws and 1 nail were observed in the wall of the room. The resident's air conditioning unit was observed to be non-functioning. - Room 214, the room's air conditioning unit was observed to have no knob. The dresser in the room was observed to have broken drawers and 5 screws were observed in the bathroom door. - Room 213, a hole in the dry wall was observed between resident bed A and the room's door. - Room 211, screws were observed in the room's door. There was a missing piece of floor board next to the bathroom and the wall exposed was observed to be crumbling. - Room 209, the hard plastic door guard glued to the door was observed to be coming off the door. A hole was observed in the wall by the closet. - Room 400, the dresser in the room was observed to have broken drawers. - Room 404: 2 unwrapped, unlabeled gray basin on the bathroom floor. - Room 401: denture cup with liquid soap inside and an unlabeled toothbrush on the back of the toilet cover. - Room 407: a bottle of nail polish remover, an unwrapped, unlabeled gray basin in a wire rack on the bathroom wall, an unopened bottle of over the counter joint supplement. - Room 410: a pair of ladies panties on the bathroom floor and a broken dresser. - Broken A/C unit on the wall of the 400 hall. - Room 502, there was a liquid on the bathroom floor and a jagged mirror propped behind the sink faucet in the bathroom. - Observations on 2/13/2014 of the facility's exterior physical environment revealed resident safety hazards in different areas surrounding the building. - The shower room on Hall 2 (secure unit) was observed to be unlocked with an open bottle of shampoo/body wash sitting on a shower chair. - Exposed wires were observed hanging from the wall in the facility's restorative dining room. - In the facility's laundry room, a 4 inch by 4 inch hole in the ceiling and a hole in the wall was observed. This deficient practice could affect all 85 residents by placing them at risk for illness, unclean/unsanitary environment and/or diminished quality of life. Findings include: Observations during initial tour on 2/11/2014 of Hall 2 (secure unit) revealed the following: - 8:40 AM: Room 200, the bathroom sink was observed to be turned around backwards and not operational. - 9:10 AM: Room 206, the hard plastic door guard glued to the door was observed to be half off the door. - 9:30 AM: Room 212, 4 screws and 1 nail were observed in the wall of the room. The resident ' s air conditioning unit was observed to be non-functioning. - 9:42 AM: Room 214, the room's air conditioning unit was observed to have no knob. The dresser in the room was observed to have broken drawers and 5 screws were observed in the bathroom door. - 9:52 AM: Room 213, a hole in the dry wall was observed between resident bed A and the room's door. - 10:02 AM: Room 211, screws were observed in the room's door. There was a missing piece of floor board next to the bathroom and the wall exposed was observed to be crumbling. - 10:06 AM: Room 209, the hard plastic door guard glued to the door was observed to be coming off the door. A hole was observed in the wall by the closet. Observations during initial tour on 2/11/2014 of Hall 4 revealed the following: - 10:30 AM: Room 400, the dresser in the room was observed to have broken drawers. - Room 404: 2 unwrapped, unlabeled gray basin on the bathroom floor. - Room 401: denture cup with liquid soap inside and an unlabeled toothbrush on the back of the toilet cover. - Room 407: a bottle of nail polish remover, an unwrapped, unlabeled gray basin in a wire rack on the bathroom wall, an unopened bottle of over the counter joint supplement. - Room 410: a pair of ladies panties on the bathroom floor. - Broken A/C unit on the wall of the 400 hall. Observation of Room 410 on 2/11/2014 at 12:16 PM revealed the drawers on dresser were broken. Observations during initial tour on 2/11/2014 of Hall 5 revealed the following: - 10:30 AM: Room 502, in the bathroom there was a liquid on the floor and a mirror was propped up behind the sink faucet, leaning against the wall. The mirror had a rough edge to one corner. Observation of the facility's laundry room on 2/14/2014 at 9:40 PM revealed a 4 inch by 4 inch hole in the ceiling and a hole in the wall. Observations on 2/13/2014 of the facility's exterior physical environment revealed the following: - 2:06 PM: A metal shed was observed on the outside of the building which had a mud floor. There was also standing water in the shed floor. A light bulb was observed on the ground in the mud in the shed. There was also a water pump with cords plugged into it laying in the mud as well. - 2:08 PM: An exterior hot water heater was observed in a room on the side of the building. The door to the hot water heater was observed to rotten and only partially intact. Water was observed dripping under the hot water heater and a pool of water was observed standing on the concrete floor under the water heater. - 2:16 PM: A black cable was observed laying on the soggy ground between a power pole approximately 50 feet away from the facility, leading to a Telecom box next to the facility wall. - 2:32 PM: A wooden and metal park bench was

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F 0252

Level of harm - Potential for minimal harm

Residents Affected - Many

(continued... from page 2)
observed inside the resident's fenced smoking area. The bench was observed to have rotten and broken wood slats which exposed pieces of rusted metal on the bench. - 2:32 PM: A large pile of tangled water hoses were observed against a wall inside the resident's fenced smoking area. - 2:34 PM: Cigarettes which were not properly extinguished or disposed of were observed sitting on the window sills and on the ground in the resident smoking area. - 2:34 PM: One chair in the resident smoking area was observed to be constructed of wood and cloth. The cloth was observed to be dirty with bird excrement on the seat. - 2:36 PM: Large amount of bird excrement was observed covering the resident use table and chairs in the resident smoking area. Bird excrement has the potential to carry an illness called histoplasmosis. - 2:38 PM: A concrete pig was observed in the resident smoking area which had two protruding rusty metal wires coming from the top of the head where there pig ' s ears used to be. - 2:44 PM: An unsecured storage shed at the back of the facility was observed which contained tools, wood, paint and containers marked Corrosive. Outside of the storage shed was observed a broken night stand, pile of boards with rusty nails sticking out of them, toilet and a large bin containing empty soda cans was observed with bees swarming around the cans. Also outside of the storage shed were 2 active fire ant beds and standing water on either side of the drive in front of the shed which was approximately 3 feet wide by 15 feet long. - 2:54 PM: An unsecured large shipping container at the back of the facility was observed which contained assorted facility equipment such as wheelchairs and furniture. Observation on 2/11/2014 at 10:20 AM of the secure unit's (Hall 2) shower room revealed the door to the shower room to be unlocked and a gallon jug of Shampoo and Body Wash was observed sitting on a shower chair with no lid on the bottle. Observation on 2/12/2014 at 12:38 PM of the facility's restorative dining room relvealed on either side of the dining room, 2 wires were coming out of the wall and hanging approximately 4 feet off the floor. The ends of the wires were observed to be exposed. In an interview with the DON on 2/14/14 at 4:15 PM she was asked about the resident smoking area, she stated the area should be cleaned. She stated the bird dropping could be a way to contract a disease and was nasty. In an interview with the ADM on 2/14/2014 at 5:58 PM, when asked who was responsible for ensuring equipment in the facility was in good repair, he said the maintenance department. Record review of the CDC website definition of Histoplasmosis read in part; Histoplasmosis is a disease caused by the fungus Histoplasma capsulatum. The fungus lives in the environment, usually in association with large amounts of bird or bat droppings. Lung infection can occur after a person inhales airborne, microscopic fungal spores from the environment. .The symptoms of histoplasmosis are similar to pneumonia, and the infection can sometimes become serious if it is not treated. http://www.cdc.gov/fungal/diseases/histoplasmosis/index.html Record review of the facility's Cleaning Schedules policy and procedure read in part; Policy Statement: Cleaning schedules shall be developed and implemented to ensure that our facility is maintained in a clean and comfortable manner. Policy Interpretation and Implementation: 1. Cleaning schedules are developed and implemented to assure that each area of our facility is maintained in a safe, clean and comfortable manner. This document was not dated. Record review of the facility's Facility Smoking Policy policy and procedure read in part; Safe Smoking Environment: It is the responsibility of the facility to provide a safe and hazard free environment for those residents having been assessed as being safe for facility smoking privileges. This document was dated 2/21/2013. Record review of the facility's Cleaning and Disinfection of Environmental Surfaces policy and procedure read in part; Policy Statement: Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard. .Non Resident Care Areas: 7. Detergent and water will be used for cleaning surfaces in non resident care areas. .Housekeeping Surfaces: 9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. This document was dated 8/2009. Record review of the facility's Quality of Life - Homelike Environment policy and procedure read in part; Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. .Characteristics of a Personalized, Homelike Setting: 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order; .c. Inviting colors and decor; d. Personalized furniture and room arrangements. This document was dated 10/2009. A request was made during the survey for a policy and procedure related to cleaning/removing garbage and/or trash from the facility's property. This document was not provided prior to exit. According to CMS 672 the census as 85.

F 0253

Level of harm - Potential for minimal harm

Residents Affected - Many

Provide housekeeping and maintenance services.

Based on observation, interview and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior as evidenced by: - Room 200, the bathroom sink was observed to be turned around backwards and not operational. - Room 206, the hard plastic door guard glued to the door was observed to be half off the door. - Room 212, 4 screws and 1 nail were observed in the wall of the room. The resident's air conditioning unit was observed to be non-functioning. - Room 214, the room's air conditioning unit was observed to have no knob. The dresser in the room was observed to have broken drawers and 5 screws were observed in the bathroom door. - Room 213, a hole in the dry wall was observed between resident bed A and the room's door. - Room 211, screws were observed in the room's door. There was a missing piece of floor board next to the bathroom and the wall exposed was observed to be crumbling. - Room 209, the hard plastic door guard glued to the door was observed to be coming off the door. A hole was observed in the wall by the closet. - Room 400, the dresser in the room was observed to have broken drawers. - Room 404: 2 unwrapped, unlabeled gray basin on the bathroom floor. - Room 401: denture cup with liquid soap inside and an unlabeled toothbrush on the back of the toilet cover. - Room 407: a bottle of nail polish remover, an unwrapped, unlabeled gray basin in a wire rack on the bathroom wall, an unopened bottle of over the counter joint supplement. - Room 410: a pair of ladies panties on the bathroom floor and a broken dresser. - Broken A/C unit on the wall of the 400 hall. - Room 502, there was a liquid on the bathroom floor and a jagged mirror propped behind the sink faucet in the bathroom. - In the facility's laundry room, a 4 inch by 4 inch hole in the ceiling and a hole in the wall was observed. This deficient practice could affect the quality of life by having a less than homelike environment for all 85 residents in the facility. Findings include: Observations during initial tour on 2/11/2014 of Hall 2 (secure unit) revealed the following: - 8:40 AM: Room 200, the bathroom sink was observed to be turned around backwards and not operational. - 9:10 AM: Room 206, the hard plastic door guard glued to the door was observed to be half off the door. - 9:30 AM: Room 212, 4 screws and 1 nail were observed in the wall of the room. The resident ' s air conditioning unit was observed to be non-functioning. - 9:42 AM: Room 214, the room's air conditioning unit was observed to have no knob. The dresser in the room was observed to have broken drawers and 5 screws were observed in the bathroom door. - 9:52 AM: Room 213, a hole in the dry wall was observed between resident bed A and the room's door. - 10:02 AM: Room 211, screws were observed in the room's door. There was a missing piece of floor board next to the bathroom and the wall exposed was observed to be crumbling. - 10:06 AM: Room 209, the hard plastic door guard glued to the door was observed to be coming off the door. A hole was observed in the wall by the closet. Observations during initial tour on 2/11/2014 of Hall 4 revealed the following: - 10:30 AM: Room 400, the dresser in the room was observed to have broken drawers. - Room 404: 2 unwrapped, unlabeled gray basin on the bathroom floor. - Room 401: denture cup with liquid soap inside and an unlabeled toothbrush on the back of the toilet cover. - Room 407: a bottle of nail polish remover, an unwrapped, unlabeled gray basin in a wire rack on the bathroom wall, an unopened bottle of over the counter joint supplement. - Room 410: a pair of ladies panties on the bathroom floor. - Broken A/C unit on the wall of the 400 hall. Observation of Room 410 on 2/11/2014 at 12:16 PM revealed the drawers on dresser were broken. Observations during initial tour on 2/11/2014 of Hall 5 revealed the following: - 10:30 AM: Room 502, in the bathroom there was a liquid on the floor and a mirror was propped up behind the sink faucet, leaning against the wall. The mirror had a rough edge to one corner. Observation of the facility's laundry room on 2/14/2014 at 9:40 PM revealed a 4 inch by 4 inch hole in the ceiling and a hole in the wall. In an interview with the ADM on 2/14/2014 at 5:58 PM, when asked who was responsible for ensuring equipment in the facility was in good repair, he said the maintenance department. Record review of the facility's Quality of Life - Homelike Environment policy and procedure read in part; Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. .Characteristics of a Personalized, Homelike Setting: 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order; .c. Inviting colors and decor; d. Personalized furniture and room arrangements. This document was dated 10/2009. According to CMS 672 the census as 85.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0253 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	(continued... from page 3)
F 0273 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assess the resident when the resident enters the nursing home, in a timely manner.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct and complete a comprehensive assessment within 14 days after admission for 1 of 17 residents (Resident # 75) reviewed for comprehensive assessments. Resident # 75 was admitted to the facility on [DATE] and her admission MDS was not signed in all areas as completed until 8/6/2013. This failure affected 1 resident and placed 84 other residents at risk for not having their needs assessed timely. Finding Include: Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Record review of Resident # 75's Admission MDS assessment with 7/24/2013 ARD date revealed she was admitted to the facility on [DATE]. This assessment was signed as completed on 8/1/2013 by the RN assessment coordinator (DON). The date was entered electronically. All sections except the RN signature that the assessment was complete were signed as completed on 8/6/2013 for all disciplines completing sections of the assessment. In an interview with LVN E and the ADON on 2/14/2014 at 1:05 PM they were asked if Resident # 75's admission MDS was completed in a timely manner. LVN E said the ARD date was 7/24/2013 as a result the assessment was completed timely. The ADON said the assessment was considered completed when it was signed. They both said the assessment was not completed with 14 days of admission, in a timely manner. Record review of CMS's RAI Version 3.0 Manual CH 2: Assessments for the RAI dated April 2012, page 2-18, read in part, .The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: . the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. According to CMS Form 672 the facility census was 85.
F 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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, record review and interview the facility failed to ensure the accuracy of the assessments of 1 of 17 residents (Resident # 83) reviewed for accurate assessments. -Resident # 83 had contractures of her bilateral feet and her 12/12/13 quarterly MDS was coded that she had no impairments of her lower extremities that interfered with daily functions or placed her at risk of injury. This failure affected 1 resident and placed 28 residents with contractures at risk of not having their care needs met by staff due to the inaccurate assessment. Finding Include: Record review of Resident # 83's face sheet revealed [AGE] year old admitted to the facility on [DATE] and had the following diagnoses; late effect [MEDICAL CONDITION] disease, [MEDICAL CONDITION] reflux, [MEDICAL CONDITION], affective personality, depression, hypertension and constipation. Observation on 2/13/14 at 4:20 PM revealed Resident # 83's bilateral feet were contracted. Record review of Resident # 83's admission history and physical dated 11/27/12 revealed she had bilateral foot drop. Record review of Resident # 83's physician progress notes [REDACTED]. Record review of Resident # 83's quarterly MDS dated [DATE] revealed there was no limitation of range of motion to her lower extremities (hip, knee, ankle and foot). In an interview on 2/14/14 at 4:05 PM, LVN E stated Resident # 83's MDS should have been coded with decreased ROM to her lower extremities. She stated it was not accurate and was wrong. Record review of CMS MDS RAI Manual Version 3.0, Chapter 3, section G read, in part, .The intent of G0400 is to determine whether functional limitation in range of motion (ROM) interferes with the resident ' s activities of daily living or places him or her at risk of injury .Code 2, impairment on both sides: if resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury . According to CMS 672 there were 29 residents with contractures.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop comprehensive care plans that included measurable objectives and timetables to meet the resident ' s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 7 of 17 residents reviewed for care plans (Resident # 29, 30, 32, 35, 56, 71 and 75) -Resident # 29's care plans for falls, cognitive function, bowel incontinence, pressure ulcers and ADL function were not individualized to reflect the resident was severely cognitively impaired, bedbound and did not speak. She rarely or never understood others. There was no care plan related to visual function and communication. -Resident #30's current care plan did not address communication impairment. Her Quarterly MDS dated [DATE] revealed she should have been care planned for communication. -Resident # 32 did not have a care plan related to visual function or nutritional status. -Resident # 35's current care plan did not address activities. There was no initial comprehensive care plan completed within 21 days of her admission, including addressing the triggered items from her admission MDS (cognitive loss/dementia, communication, ADL function, psychosocial well-being, activities, falls, nutritional status and [MEDICAL CONDITION] drug use). -Resident #56's current care plan did not address ADL's or vision. Her Quarterly MDS dated [DATE] revealed she should have been care planned for ADL's and vision. -Resident #71's current care plan did not address cognition or range of motion. His Significant Change MDS dated [DATE] revealed he should have been care planned for cognition and range of motion. -Resident # 75's 12/18/2013 updated care plan for ADLs was not individualized to reflect the resident required extensive assistance of one person for ADLs. The care plan for bowel incontinence did not have approaches that included incontinent care. There was no care plan for pressure sores. Resident # 75 had pressure ulcer that was identified on 1/29/2014 but the care plan for unstageable pressure ulcer did not have an onset date or a goal target date. These failures affected 7 residents and placed an additional 78 residents at risk for not having their needs identified and addressed. Findings include: Resident # 29 Record review of Resident # 29's face she revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. She was [AGE] years old. Record review of Resident # 29's significant change MDS assessment with 1/11/2014 ARD date revealed she no speech, sometimes she made herself understood but rarely/never understood others. She said moderately impaired vision. She had short and long term memory problem and her cognitive skills for daily decision making were severely impaired. The functional status section of the assessment revealed she needed extensive assistance of one person for bed mobility, transfers, locomotion on and off the unit, dressing, and toilet use. She did not ambulate during the assessment period. It further revealed she had total dependence of one person for eating, personal hygiene, and bathing. She was always incontinent of bowel and bladder. The active [DIAGNOSES REDACTED]. ADL function was not checked for triggered or care planning decision. Record review of Resident # 29's 1/11/2014 updated care plans revealed the following care plans: -I have difficulty recalling recent events related to dementia. The approaches included: Please keep a calendar in my room. Post my name on the door to mu room so I can find it easily. Validate my thoughts/feeling when I get confused or anxious. Give me verbal cues/reminders when I cannot remember. -I required staff assistance for all ADLs related to weakness. The approaches included: I prefer evening showers. Give me verbal cues to help prompt me. Break my task up into smaller steps. Allow me rest breaks between tasks. One person to assist me with bathing. -I am always incontinent of bowel related to inability to feel the urge. The approaches included: Provide me verbal cueing. Teach me about factors affecting bowel control. There was not an approach regarding providing incontinence care. -I am a risk for pressure ulcers related to incontinence and bed/chair bound. The approaches include: encourage me to weigh shift while sitting up in the chair. Develop my turning/repositioning plan with my input. Teach me risk factors for development of pressure ulcers. -I am at risk for falls related to weakness, transferred by staff. The approaches included: I need a night light on to help me see at night. I use a wheelchair for long distance mobility. Remind me to call for assistance. There was no care plan related to visual function and communication. Resident #30 Record review of Resident #30's face sheet revealed she was admitted to the facility on [DATE]. The following [DIAGNOSES REDACTED]. This resident was [AGE] years of age. Record review of Resident #30's Quarterly MDS dated [DATE] revealed under Section B: Hearing, Speech and Vision, she was coded; B5: Makes Self Understood, 3-Rarely/Never understood and B6: Ability to Understand Others, 3-Rarely/Never understands. Record review of Resident #30's care plan revealed no care plans related to Resident #30's communication impairment. Resident # 32 Record review of Resident # 32's face sheet revealed he was admitted to facility on 7/3/2013 with the following Diagnoses: [REDACTED]. Record review of Resident # 32's significant change MDS assessment with 12/30/2013 ARD revealed his vision was impaired and he used corrective lenses. It

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675127**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUMBLE HEALTHCARE CENTER	**93 ISAACKS RD HUMBLE, TX 77338**

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 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) further revealed he needed supervision and set up with eating. The assessment also revealed he was on a therapeutic diet. Section V Care Area Assessment (CAA) Summary revealed the following areas were checked for care area trigger and care planning decision: visual function and nutritional status. Record review of Resident # 32's 12/17/2013 - 3/17/2014 care plan revealed no care plans related to visual function or nutritional status. In an interview with the ADON on 2/14/2014 at 4:15 PM she was asked if she could locate a care plan on visual function and nutrition for Resident # 32. She said the resident did not have a care plan on visual function and nutrition. Resident #35 Record review of Resident # 35's face sheet revealed the [AGE] year old admitted to the facility on [DATE] and readmitted on [DATE]. The following [DIAGNOSES REDACTED]. Record review of Resident # 35's Admission MDS dated [DATE] revealed the following care area triggered and were checked that they had been care planned; cognitive loss/dementia, communication, ADL function, psychosocial well-being, activities, falls, nutritional status and [MEDICAL CONDITION] drug use. Record review of Resident # 35's significant change MDS dated [DATE] revealed Activities triggered and was checked it would be care planned. Record review of Resident # 35's clinical record revealed there was a care plan dated 10/21/13 for Full Code, and the rest of the residents care plans had an onset date of 1/17/14 or 1/28/14. There were no care plans that addressed the triggered items dated for the 10/28/13 MDS. There was no care plan that addressed Activities for the 1/22/14 MDS. In an interview on 2/13/14 at 1:10 PM, LVN E stated she could not find Resident # 35's care plan that addressed the 10/28/14 MDS. She stated it was not in the computer system, the medical record or to be filed. In an interview on 2/14/14 at 8:03 AM, Activity Dir. # 1 stated she could not find Resident # 35's care plan for activities. Resident #56 Record review of Resident #56's face sheet revealed she was readmitted to the facility on [DATE]. The following [DIAGNOSES REDACTED]. This resident was [AGE] years of age. Record review of Resident #56's Quarterly MDS dated [DATE] revealed under Section G: Functional Status, she was coded; Hygiene: 2-Limited assistance, 2-One person physical assist. This document also revealed under Section B: Hearing, Speech and Vision, she was coded; B7: Vision, 1-Impaired and B8: Corrective Lenses, 1-Yes, has corrective lenses. Record review of Resident #56's care plan revealed no care plans related to ADL's or vision. In an interview with the DON on 2/14/2014 at 6:48 PM when asked about the missing care plans for Resident #56, she said when she looked through his clinical record she was not able to find his missing care plans. Resident #71 Record review of Resident #71's face sheet revealed he was readmitted to the facility on [DATE]. The following [DIAGNOSES REDACTED]. This resident was [AGE] years of age. Record review of Resident #71's Significant Change MDS dated [DATE] revealed under Section C: Cognitive Patterns, he was coded; Cognitive Skills for Daily Decision Making: 3-Severely impaired. This document also revealed under Section G: Functional Status, he was coded; Functional Limitation in Range of Motion: 2-Upper extremity, impaired on both sides and 2-Lower extremity, impaired on both sides. Record review of Resident #71's care plan revealed no care plans related to cognition or range of motion. In an interview with the DON on 2/14/2014 at 6:12 PM when asked about the missing care plans for Resident #71, she said when she looked through his clinical record she was not able to find his missing care plans. Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Record review of Resident # 75's significant change MDS assessment with ARD date of 12/18/2013 revealed the resident had a short term and long term memory problem with modified independence with cognitive skill for daily decision making. The functional status section of the assessment revealed she needed extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. Ambulation did not occur during the assessment period. She had total dependence with locomotion on and off the unit of one person and with bathing. She had a range of motion limitation on one side of the lower extremity. The bladder and bowel section of the form revealed she had an indwelling urinary catheter and was always incontinent of bowel. She had history of fall. The skin section revealed the resident was at risk of developing a pressure ulcer but currently did not have pressure ulcer. She had a pressure reducing device or bed. The Care Area Assessment (CAA) Summary revealed the following areas for care area triggered and care plan decision: ADL function, urinary incontinence/indwelling catheter, falls, and pressure ulcer. Record review of Resident # 75's Functional Status - Activities of Daily living (ADL) Assistance for revealed the she was cared for by CNA F and CNA d between 1/23/2014 and 1/29/2014. It further revealed she had total dependence to the need for extensive assistance of one person for bed mobility, transfers, dressing, eating, toilet use and personal hygiene according to the documentation of the care provided. There was not an area regarding skin problems on the document. Record review of Resident # 75's 12/18/2014 updated care plan revealed the following care plan: -I am risk for falls. There were 2 reported falls by the resident and one where the resident was found on the floor. The approaches included: Assist me with stand-by assist for all ambulation. Remind me to ask for assist for all ambulation. Monitor changes in my condition that may warrant increased supervision/assistance and notify the physician. The approached did not reflect that the resident needed extensive assistance of one person for ADLs and she was not ambulating. It did not reflect that she had a memory problem and cognitive deficit. -I require extensive assist for all ADLs related to stroke with generalized weakness. The approaches included: I prefer evening showers. Occupational therapist to work with me on transfers and ambulation. Occupational therapist to work with me on all ADL re-training. Give me verbal cues to help prompt me. Break my tasks up into smaller steps. Allow me rest breaks between tasks. The approaches did not address that the resident needed extensive assistance of one person with ADLs. -I am always incontinent of bowel. The approaches did not address the need for incontinent care. The approaches included: Observe my skin daily for irritation and redness. There were no approaches related to incontinent care. There was not a care plan related to pressure sores and prevention prior to the undated care plan for the unstageable pressure ulcer. Record review of Resident # 75's Wound Skin Healing Record revealed the date of onset for the wound was 1/29/2014 and it was an unstageable to her left heel. -1/29/2014 it measured 3.0 by 5.0 with an unknown depth. There was granulation tissue and dark eschar. It further revealed the surrounding skin was normal for skin. The resident had no pain. Further review of Resident # 75's care plan revealed an undated care plan with the following problem: -An undated care plan with the problem/need I have an unstageable pressure ulcer. Hand written in was Unstageable left heel. There was no onset date on the care plan or goal target date. In an interview with the DON on 2/13/2014 at 2:10 PM she was asked if she saw any interventions for pressure ulcer prevention in Resident # 75 ' s 12/18/2014 care plans. She looked through the care plans and said no. In an interview with the DON on 2/13/2014 at 3:00 PM she said Resident # 75 was not a t risk for pressure ulcers. She was shown how her ADL had changed on her significant change MDS from her previous MDS and she said she was at risk. She was asked what interventions were place to prevent pressure sores for Resident # 75 she said there were no interventions in the care plan for prevention. In an interview with LVN E and the ADON on 2/14/2014 at 1:05 PM LVN E said the facility switched to the I care plan last year. She said new care plans should have an onset date and a goal and target date. When asked if Resident # 75 had a care plan for prevention she said she did not see one. She further stated Resident # 75's should have had a care plan for prevention. She said a care plan for falls should have new approaches after a fall. LVN E said Resident # 75 did not have care plan for visual function or communication. In an interview with LVN E, ADON and DON on 2/14/2014 at 2:40 PM they were asked about some of the approaches on the care plans not matching resident condition. She said ADL care should have approaches for actual care. She said she will add staff approaches to the care plans. Record review of CMS RAI Version 3.0 Manual chapter 3, pages V-5 through V-6, dated April 2012 reads, in part .For each triggered care area, Column B Care Planning Decision is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The Care Planning Decision column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed. The date on which a staff member completes the Care Planning Decision column (V0200A, Column B), which is done after the care plan is completed. The care plan must be completed within 7 days of the completion of the comprehensive assessment (MDS and CAAs), as indicated by the date in V0200B2. Review of the facility's policy titled Care Plans - Comprehensive, 2001 MDS-PASS, Inc (Revised October 2010) read in part, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. 2. The comprehensive care plan is based on an thorough assessment that includes, but is not limited to, the MDS. 4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan. 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers is isolation may have little, if any, benefit for the resident.8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. According to CMS 672 the census as 85.

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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 0279

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 5)

F 0282

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care by qualified persons according to each resident's written plan of care.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview, and record review, the facility failed to provide services in accordance with the written Plan of Care for 1 of 17 residents (Resident # 29 and # 75) reviewed for compliance with physician's orders [REDACTED]. -Resident # 29 did not receive her as needed blood pressure medication as ordered on [DATE]. -Resident # 75's [MEDICATION NAME] was held on 40 occasions in January 2014 and there was no blood pressure documented on 3 occasions. The [MEDICATION NAME] was held on 5 occasions in February 2014 and there was no blood pressure documented on 2 occasions. There were no parameters to hold this medication. -Resident # 75 received two different dose of potassium for 2 days in February 2014. This failure affected 2 residents and placed an additional 83 residents at risk for not receiving the care and services ordered by the physician and a decline in health status. Findings Include: Resident # 29 Record review of Resident # 29's face she revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. She was [AGE] years old. Record review of Resident # 29's February 2014 physician orders [REDACTED]. -Blood pressure check every 12 hours. -[MEDICATION NAME] 0.1 mg, one tablet per [DEVICE] every 8 hours as needed for blood pressure greater than 150/90. Record review if Resident # 29's February 2014 MAR revealed the following: -Blood pressure check every 12 hours. On 2/11/2014 the blood pressure documented at 8:00 AM was 171/91. -[MEDICATION NAME] 0.1 mg, one tablet per [DEVICE] every 8 hours as needed for blood pressure greater than 150/90. There was no documentation that this medication had been administered on 2/11/2014. In an interview with the DON on 2/14/2014 at 6:00 PM she said when the as needed blood pressure medication was not administered the staff was not following doctors orders. Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Record review of Resident # 75's 12/24/2013 admission orders [REDACTED] -Klor-con (KCL) 20 meq by mouth every day. -[MEDICATION NAME] HCL 25 mg, 1 tablet by mouth every 6 hours. Record review of Resident #
75's 1/9/2014 physician telephone order revealed the following orders: -Discontinue KCL 20 meq every day -KCL 40 meq, 1 tablet by mouth every day. Record review of Resident #75's January 2014 MAR revealed the following: -[MEDICATION NAME] HCL
25 mg every 6 hours. The blood pressures and the holding of the medication were also obtained from the front and back of the MAR and the MAR with blood pressure checks at 6 AM, noon, 6 PM and midnight with [MEDICATION NAME]. There were initials
circled to indicate this medication had held or not administered on the following dates and times for the following blood pressures. -1/1/2014 at 6:00 PM B/P 93/46, the blood pressure recorded on under the blood pressure entry was different B/P 102/54. -1/2/2014 at 6:00 PM for B/P 101/62 -1/4/2014 at 6:00 PM for B/P 108/56 -1/5/2014 at 6:00 AM there were no initials documented that the mediation had been administered and there was not a blood pressure documented. -1/5/2014 at 6:00 PM for B/P 108/58 -1/6/2014 at 6:00 AM for B/P 98/40 -1/6/2014 at 6:00 PM for B/P 116/57 -1/6/2014 at midnight for B/P 103/42 -1/7/2014 at 6:00 AM for B/P 92/40 -1/7/2014 at 6:00 PM for B/P 118/69. There was documentation on the back of the MAR that read: 4 PM [MEDICATION NAME] 25 mg held low B/P. -1/7/2014 at midnight for B/P 97/41 -1/8/2014 at 6:00 AM for B/P 100/48 -1/8/2014 at 6:00 PM there were no initials to indicate the medication had been administered. -1/8/2014 at midnight for B/P 92/40 -1/9/2014 at 6:00 AM for B/P 100/54 -1/9/2014 at 6:00 PM for B/P 103/54 -1/9/2014 at midnight for B/P 108/46 -1/12/2014 at 6:00 AM for B/P 98/45 -1/12/2014 at midnight for B/P 114/40 -1/13/2014 at 6:00 AM for B/P 110/41 -1/13/2014 at 6:00 PM for B/P 117/50 -1/13/2014 at midnight for B/P 96/40 -1/14/2014 at 6:00 AM for B/P 112/48, the B/P documented on the back of the was 110/41 -1/14/2014 at midnight for B/P 100/46 -1/15/2014 at 6:00 AM for B/P 108/72 -1/18/2014 at 6:00 AM for B/P 110/40 -1/18/2014 at midnight for B/P 90/40 -1/19/2014 at 6:00 AM for B/P 120/46 -1/19/2014 at 6:00 PM for B/P 129/77. There was documentation on the back of the MAR that read: 4 PM [MEDICATION NAME] 25 mg B/P low. -1/19/2014 at midnight for B/P 100/44 -1/20/2014 at 6:00 AM for B/P 126/50 -1/20/2014 at midnight for B/P 102/54 -1/24/2014 at 6:00 AM for B/P 116/40 -1/24/2014 at midnight for B/P 108/42 -1/25/2014 at 6:00 AM for B/P 116/42 -1/25/2014 at 6:00 PM for B/P 98/57 -1/25/2014 at midnight for B/P 94/40 -1/26/2014 at noon no blood pressure documented -1/26/2014 at 6:00 PM for B/P 113/57 -1/30/2014 at 6:00 AM for B/P 112/45 -1/30/2014 at midnight for B/P 102/40 -1/31/2014 at 6:00 AM for B/P 95/72 -1/31/2014 at midnight for B/P 104/41 Record review of Resident # 75's February 2014 Physician order [REDACTED]. -[MEDICATION NAME] HCL 25 mg, 1 tablet by mouth every 6 hours. -KCL 20 meq, 2 tablets = 40 meq every day. Record review of
Resident # 75's 2/9/2014 physician telephone orders revealed the following order: -KCL 20 meq, 1 tablet by mouth every evening. Record review of Resident # 75's February 2014 MAR revealed the following: -KCL 20 meq, 1 tablet by mouth every evening. This medication had initials documented to indicate that it had been administered on 2/9/2014 and 2/10/2014. -KCL 20 meq, give 2 tablets = 40 meq every day. There was documentation that this had been administered from 2/1/2014 through 2/12/2014 -[MEDICATION NAME] HCL 25 mg, 1 tablet by mouth every 6 hours. There were no parameters. Next to the order on the
MAR had written in was discontinue on 2/3/2014. There were initials circled on the following dates and times to indicate this medication had been held or not administered: -2/1/2014 at noon B/P 138/74 -2/1/2014 at 6:00 PM B/P 101/67 -2/2/2014 at noon B/P 121/86 -2/2/2014 at 6:00 PM B/P 98/57 -2/3/2014 at 6:00 PM B/P 100/55, there were no initials documented that this medication had been administered. On the back of the MAR the following was documented -2/1/2014 [MEDICATION NAME] 3:00
PM held due to low B/P. No blood pressure was documented. -2/2/2014 [MEDICATION NAME] 3:00 PM held due to low B/P. No blood
pressure was documented. -[MEDICATION NAME] 50 mg, 1 tablet by mouth three times a day. There were no parameters to hold this medication. This order had a 2/4/2014 start date. There were initials circled to indicate this medication had been held on the following dates and times. -2/5/2014 for the 5:00 PM dose B/P 101/67 -2/12/2014 for the 1:00 PM dose B/P 97/57 -2/12/2014 for the 5:00 PM dose there were no initials or blood pressure documented. In an interview with the DON on 2/13/2014 at 2:10 PM she was asked if a medication could be held without parameters to hold the medication the DON said the MA should report to the nurse and if the nurse felt it was something to be held she needed to call the doctor. When asked if following doctor's orders if the medication was held without parameters she said it was not following doctor's orders. She was asked about Resident # 75's [MEDICATION NAME]. When asked what was the process for physician orders [REDACTED]. The
DON further stated the monthly orders were reviewed by LVN D. She said the LVN D checked the order from the previous month against the new orders. She said she would need to do an order clarification if need be. Record review of Resident # 75's 2/13/2014 physician telephone orders revealed the following orders: -Discontinue [MEDICATION NAME] 50 mg three times a day. -[MEDICATION NAME] 25 mg by mouth twice a day. Hold for systolic blood pressure less than 120 or diastolic blood pressure less than 80. -Order clarification: KCL 20 meq by mouth, one every morning and evening. In an interview with the LVN D on 2/14/2014 at 12:34 PM she was asked what the process she used for verifying the monthly orders. She said she obtained the new monthly orders and compared them to the previous monthly orders and any new orders written. She said she looked at the previous monthly MAR and the new MAR with any changes. she further stated she documented changes on the new monthly orders. Record review of the facility's revised of April 2010 Administering Medications read in part: . Medications shall be administered in a safe and timely manner, and as prescribed . The individual administering the medications must check the label THREE (3) times to verify the right medication, right dosage . of administration before giving the medications . If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the mediation shall initial and circle the MAR space provided for the drug and dose. Record review of the facility's revised 10/1/2012 Procedure for Medication Administration policy and procedure read in part: . To administer medications in a safe and effective manner . Compare medication label to direction for use on the MAR for accuracy .Obtain and record any vital signs as necessary prior to medication administration . Record review of the facility's revised April 2007 Documentation of Medication Administration policy and procedure read in part: . The facility shall maintain a medications administration record to document all medications administered . Reason (s) why the medication was withheld, not administered . According to CMS Form 672 the facility census was 85.

F 0309 **Level of harm -** Actual harm **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 interview and record review the facility failed to ensure 1 of 17 residents (Resident # 75) reviewed for quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675127**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/14/2014**

NAME OF PROVIDER OF SUPPLIER **HUMBLE HEALTHCARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP **93 ISAACKS RD HUMBLE, TX 77338**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 6) of care received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care in that: --Resident # 75's pain was not effectively controlled. Despite complaints by the Resident of pain due to a pressure sore, the facility failed to accurately complete (2) pain assessments in December 2013, and failed to administer pain medications to the Resident after (3) remarkable complaints of pain in February 2014. This failure affected 1 resident whose pain was uncontrolled and placed 42 residents on pain management at risk of not receiving adequate assessments, medical care and services which could have a negative impact on their health and well-being. Findings Include: Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Record review of Resident # 75's Admission MDS assessment with 7/24/2013 ARD date revealed she was admitted to the facility on [DATE]. Her BIMS score was 9 out of 15 which means the resident was moderately cognitively impaired. The assessment was checked no for the presence of pain. The skin condition section of the assessment revealed she was not a risk for developing a pressure ulcer and did not have a pressure ulcer. Record review of Resident # 75's quarterly MDS assessment with 10/21/2013 ARD date revealed she usually understands others. Her BIMS score was 6 out of 15 which means the resident had a severe cognitively impairment. The assessment was checked no for the presence of pain. The skin condition section of the assessment revealed she was not a risk for developing a pressure ulcer and did not have a pressure ulcer. Observation/Interview of Resident # 75 on 2/11/2014 at 3:00 PM revealed the resident was sitting in a wheelchair in her room. She had a protective boot to her left lower leg and a dressing to her left foot. At that time the resident said her left heel was hurting and felt like it was raw and scraping. She said she had not told the staff she was in pain. She further stated she did not know how to get in touch with them. At that time the call light was pushed. LVN G came into the room to answer the call light and assessed the resident's pain. She said she would look and see if the resident had anything ordered for pain. In an interview with LVN G on 2/11/2014 at 3:15 PM she said she was going to medicate Resident # 75 with 2 Tylenol. Observation was conducted of PTA B and PTA C providing wound care for Resident # 75 on 2/12/2014 at 11:00 AM. Before the care began the resident said her foot was hurting. PTA B asked the resident if her pain was less than 5 the resident said yes but did not give a specific number of her pain on a scale of 1 to 10. The pressure ulcer was on the back of left heel in an area that rested on the bed when she was lying on her back. The pressure ulcer had black eschar covering on the back of the heel and covering most of the pressure ulcer. The surrounding area was red in color with peeling thick areas of skin. When the dressing change was completed the resident told the PTAs that her foot felt like it was scraped. PTA B started the e-stim therapy (electrical stimulation therapy to promote wound healing). At that time the resident again said her heel was hurting a little bit right now. PTA B rolled a towel under the lower part of the back of the resident lower leg/ankle area. She then asked the resident if the foot was hurting more or less. At that time the resident told her she did not know. PTA C said she would ask nursing to give the resident something for pain. She did not leave the room at that time. PTA B washed her hands and when she came out of the bathroom the resident reported it is really aching. PTA B told PTA C to ask if the resident could have something for pain. In an interview with PTA C on 2/12/2014 at 4:30 PM, she said Resident # 75 did not usually complain of pain when she had been in her room. She said she provided Resident # 75's wound care occasionally when PTA B was not working. PTA C said Resident # 75 did not complain of pain when she was ambulating or standing, and the Resident was able to walk in the hallway. PTA C stated that another staff member told her Resident #75 had a wound. She said the resident could move by herself in the bed, roll but when she came back from the hospital she needed some assistance. Observation was conducted of CNA G providing catheter and peri-care for Resident # 75 on 2/13/2014 at 11:37 AM. The resident was in bed with protective boot to her left lower leg. At that time the resident said her heel felt like it was rotting. In an interview with PTA B on 2/13/2014 at 1:12 PM she was asked about the resident pain level 5 before treatment. She said she should notified nursing and repositioned the resident to try and make her more comfortable. When asked Resident # 75's wound care plan she said the care plan read to pre-medication for pain prior to the treatment. She further stated she did not ask anyone if the resident had been pre-medicated for pain prior to the treatment. PTA B said she assessed resident pain before treatment and if it was 5 or more she would notify nursing to make sure they pre-medicate. Record review of resident # 75's skilled daily nurse's notes and nurse notes revealed the following: -12/6/2013 note read at 3:45 PM: Resident complained to CNA that she had fell and put herself back in chair. Resident shaky with complaints of pain shooting down her leg to her ankle form left hip. (Dr. # 1) notified. Son notified requesting she be sent to hospital . PRN Tylenol 325 mg, (two) admin for pain per PRN order . Record review of Resident # 75's 12/6/2013 SBAR revealed the situation was pain and the background was leg pain. The appearance section of the form revealed no documentation of pain level. It further revealed the pain was constant and the intervention was Tylenol 325 mg, 2 by mouth. Under the reported to section it read in part: . Send to ER per family request, x-ray new order. Record review of Resident # 75's medical record revealed she was hospitalized from [DATE] to 12/11/2013. Record review of Resident # 75's 12/11/2014 Resident Summary revealed the resident was being readmitted . It further revealed (no) pain voiced upon entry. Record review of Resident # 75's 12/11/2013 Pain Evaluation revealed that yes was checked for did the resident have any [DIAGNOSES REDACTED]. The form revealed that Debility was documented for the area that read: If yes, describe cause, origin of pain, [MEDICAL CONDITION] of pain, and prior treatment. There was no documentation to the question Have you had pain or hurting in the last 5 days? Under the Wong - Baker pain rating scale the picture of the smiling face with no hurt was circled. The only other documentation on the evaluation was under the section does the resident receive a as needed medication. [MEDICATION NAME] 325 mg two tablet by mouth every four hours as needed was documented. Record review of resident # 75's skilled daily nurse's notes and nurse notes revealed the following: -12/12/2013 note revealed the resident complained of pain in her inner thigh and she was medicated with Tylenol. It further revealed the resident said her pain was better. There was no pain scale documented or which leg the pain was located in. -12/14/2013 note revealed the resident complained of pain to bilateral lower extremities. -12/15/2013 note revealed the resident complained of pain all over and was medicated with Tylenol. Record review of Resident # 75's 12/15/2013 Psychiatric Review/Mental Status Exam revealed the resident had pain in legs and said she did not know if she could walk or not. Record review of resident # 75's skilled daily nurse's notes and nurse notes revealed the following: --12/16/2013 note revealed the resident received a scheduled pain medication for thigh pain. There was no documentation of the pain level. -12/17/2013 note revealed the resident companioned of thigh pain and was medicated with Tylenol for complaints. There was no pain level documented. Record review of Resident # 75's significant change MDS assessment with ARD date of 12/18/2013 revealed the resident had a short term and long term memory problem with modified independence with cognitive skill for daily decision making. The assessment revealed the resident was not able to answer the question of the presence of pain. It further revealed the staff assessment did not reveal the presence of pain. The skin section revealed the resident was at risk of developing a pressure ulcer but currently did not have pressure ulcer. Record review of Resident # 75's 12/18/13 updated care plan revealed the following: -I have potential for episodes of mild pain related to past stroke, Tylenol as needed. The Goal was I verbalize full relief of pain with 3/18/2014 target date. The approaches included: Evaluate my pain daily using 1 - 10 scale. My pain goal is 2. Administer my pain medication as ordered. Monitor for worsening of my pain symptoms and report to physician. Record review of the Resident # 75's Controlled Drug Record for [MEDICATION NAME] APAP 5 - 325 ([MEDICATION NAME]) revealed the resident received the medication of the following dates and times. -12/20/2013 at 1:00 AM -12/20/2013 at 8:00 AM Record review of Resident # 75's medical record revealed she was hospitalized from [DATE] to 12/24/2013 Record review of Resident # 75's 12/24/2013 Resident Summary revealed she was readmitted . It further revealed she was alert, confused and understood information but had difficulty. She had no pain and her skin was clear. It further revealed the resident could ambulate alone, transfer herself, and position herself. It further revealed she had a fall on 12/17/2013. It also revealed the resident had a urinary tract infection and was on an antibiotic. Record review of Resident # 75's 12/24/2013 Pain Evaluation revealed that yes was checked for did the resident have any [DIAGNOSES REDACTED]. The form revealed that Debility was documented for the area that read: If yes, describe cause, origin of pain, [MEDICAL CONDITION] of pain, and prior treatment. There was no documentation to the question Have you had pain or hurting in the last 5 days? Under the Wong - Baker pain rating scale the picture of the smiling face with no hurt was circled. The only other documentation on the evaluation was under the section does the resident receive a as needed medication. [MEDICATION NAME] 325 mg two tablet by mouth every four hours as needed was documented. Record review of resident # 75's skilled daily nurse's notes and nurse notes revealed the following: -12/25/2014 note revealed that the resident complained of her body hurting all over no specific area. Record review of the Resident # 75's Controlled Drug Record for [MEDICATION NAME] APAP 5 - 325 ([MEDICATION NAME]) revealed the resident received the medication of the following dates and times. -12/26/2014 at 5:00 PM Record review of resident # 75's skilled daily nurse's notes and nurse notes revealed the following: -1/29/2014

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F 0309 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 7)

note revealed there was not a time for the following entry New order P/T to eval and treat as needed Lt heel. Boots to bilat feet in and out of bed. Doppler to lower ext. DX Pain/Lt heel ulcer unstageable . It further revealed wound care order by Dr. # 1. Record review of Resident # 75's January 2014 Pain Flowsheet revealed initials or 0 on each day of the month to indicate no pain except for 1/31/2014 for the 6 to 2 PM shift and the 2:00 PM to 10:00 PM shift there was no documentation. There was documentation on 1/3/2014 that the resident was medicated for left leg pain at 3:00 PM but the level of pain was unreadable. She received repositioning and then had no pain. Record review of the Resident # 75's Controlled Drug Record for [MEDICATION NAME] APAP 5 - 325 ([MEDICATION NAME]) revealed the resident received the medication
of the following dates and times. -1/3/2014 at 4:00 PM -1/28/2014 at 9:00 PM Record review of Resident # 75's January2014 MAR indicated [REDACTED] -[MEDICATION NAME] 325 mg. 2 tablets by mouth every 4 hours as needed for pain or temperature.
There was no documentation that -[MEDICATION NAME] 5/325 mg, one tablet every 6 hours as needed for pain. There was documentation that the resident received this medication 1/3/2014 and 1/28/2014. Record review of Resident # 75's 1/24/2014 - 1/29/2014 Physical Therapy Progress Report revealed a wound care evaluation was completed of left heel wound size 3.0 time 5.0 cm, unable to determine depth, wound was covered by 100 percent eschar. Record review of Resident # 75's Wound Skin Healing Record revealed the date of onset for the wound was 1/29/2014 and it was an unstageable to her left heel. -1/29/2014 it measured 3.0 by 5.0 with an unknown depth. There was granulation tissue and dark eschar. It further revealed the surrounding skin was normal for skin. The resident had no pain. Record review of the Resident # 75's Controlled Drug Record for [MEDICATION NAME] APAP 5 - 325 ([MEDICATION NAME]) revealed the resident received the medication of the following dates and times. -2/3/2014 at 5:00 AM -2/8/2014 at 1:00 AM -2/12/2014 at 11:30 AM Record review of Resident # 75's February 2014 Pain Flowsheet revealed there 0's marked in all the spaces except on 2/2/2014 and on 2/8/2014 for the 10 to 6 AM shift that was nothing documented. On 2/2/2014 it revealed the resident had been medicated at 5:00 AM for generalized pain, there was no level of pain documented. Below that at 10:00 it revealed the resident was medicated for pain a 10:00 AM for generalized pain a 6, she received repositioning and her pain level was then a 2. Record review of Resident # 75's February 2014 Physician order [REDACTED]. -[MEDICATION NAME] 5/325 mg one tablet every 6 hours as needed
for pain. This medication had a order date of 12/24/2013. -[MEDICATION NAME] 325 mg, 2 tablets = 650 mg by mouth every 4 hours as needed pain/temperature greater than 101. Record review of Resident # 75's February 2014 MAR indicated [REDACTED] -[MEDICATION NAME] 325 mg. 2 tablets by mouth every 4 hours as needed for pain or temperature. She received it on 2/11/2014. There was no time documented. On the back of the MAR indicated [REDACTED]. There was no level of pain documented. -[MEDICATION NAME] 5/325 mg, one tablet every 6 hours as needed for pain. There were initials to indicate it was administered on 2/3/2014 and 2/8/2014 Record review of Resident # 75's Wound Skin Healing Record revealed the date of onset for the wound was 1/29/2014 and it was an unstageable to her left heel. --2/5/2014 the wound measured 3.8 by 7.4 with an unknown depth. It further revealed the wound had no odor had granulation tissue with black/brown eschar. The surrounding skin color was pink and white and there was maceration on the surrounding tissue/wound edges. The resident had no pain. -2/13/2014 note revealed the wound was unstageable and measured 3.7 cm in length and 7.0 cm in width with an unknown depth. Under the pain section was the resident experiencing pain yes was checked. The hand written note read unable to say pain going back and forth (with) her answers. Record review of Resident # 75's 2/7/2014 - 2/13/2014 Physical Therapy Progress Report revealed a post a note on top of the notes with the resident's name and the following measurements 3.7 by 7.0 by undetermined. Under the continued skill section it revealed the following notations: decrease complaints of pain, facilitate wound healing, decrease risk of infection, and relieve pressure for decreased risk of skin breakdown, Record review of Resident # 75's Daily PT Wound CPT and Progress Documentation revealed the following. 1/30/2014 note revealed the pressure ulcer had eschar. It further revealed the resident had discomfort. There was no further identification of pain level. There was a note that read no complains pt responded well. 1/31/2014 note revealed the resident had discomfort which was not further clarified. Under response to treatment and skilled need statement it read patient education on elevating both lower extremity feet. -2/3/2014 note revealed the pain level was 7 on a scale of 1 to 10 to left heel. There was no other documentation of the note regarding pain. -2/4/2014 note revealed the pain level to left heel was 8 on a scale of 1 to 10. There was no other documentation on the note regarding pain. Under response to treatment and skilled need statement: continue to education for pressure relief was documented. -2/5/2014 note revealed the pain level to left heel was 8 on a scale of 1 to 10. There was no other documentation on the note regarding pain. Under response to treatment and skilled need statement: continue caregiver education to decrease pressure in bed. -2/12/2014 note revealed the pain level was less than 5 on scale of 1 to 10 before dressing change. There was no other documentation on the note regarding pain. Under response to treatment and skilled need statement: continue caregiver training for positioning. In an interview with PTA B on 2/13/2014 at 1:12 PM she said the pain documented on Daily PT Wound CPT and Progress Documentation was documented after the resident had received her treatment. She said she notified nursing of Resident # 75's pain. She said she did not document the pain level before the treatment. She clarified that the pain level documented was after the treatment. There was no documentation regarding the pain level prior to the treatment. When asked about the resident pain level of 5 before treatment she said she should notified nursing and repositioned the resident to try and make her more comfortable. When asked Resident # 75's wound care plan she said the care plan read to pre-medication for pain prior to the treatment. She further stated she did not ask anyone if the resident had been pre-medicated for pain prior to the treatment. PTA B said she assessed resident pain before treatment and if it was 5 or more she would notify nursing to make sure they pre-medicate. In an interview with the DON on 2/13/2014 at 6:00 PM she asked about what were the concerns with Resident # 75's pain. She was informed the resident had pain 7 and 8 on scale of 1 to 10 and did not receive pain medication every time. In an interview with the DON and RCS on 2/14/2014 at 7:05 AM they were asked what staff should do before wound care. The DON said they staff should assess for pain and if the resident report pain it should be addressed with pain medication. At that time they were shown Resident # 75's Daily PT Wound CPT and Progress Documentation where her pain had been 7 to 8 out 10. They asked where that had been found and were informed it was not in the medical record but provided by therapy staff. When shown Resident # 75's pain assessment and asked if complete RCS said it was not filled out and incomplete. When asked what should be done if a resident cannot answer what their pain level was on scale of 1 to 10 the DON said the other pain assessment should be completed. In an interview with LVN B on 2/14/2014 at 7:35 AM she said the staff should ask the resident what their pain level was on scale of 1 to 10 before wound care. She further stated if their pain level was a 5 they should administer an as needed pain medication and not touch them until after the mediation. She said you needed to address pain and if the resident cannot report the level of pain on scale of 1 to 10, the staff should assess for moaning, groaning, grimacing and their breathing. In an interview with Dr. # 1 on 2/14/2014 at 8:55 AM he said he tried to see resident once per month. He said he had another doctor in his office that generally came to the facility every six months. He said would see a resident right away when admitted to the facility within 48 hours. He stated when he came to the facility he did one row of Resident records and if a resident had a problem he would address it. He said currently all of the progress notes were on the medical records, he had checked the office notes. When asked about a resident with a new wound he said usually the wound care doctor for the facility would see the wound. When he was informed the facility had not had a wound physician since May 2013 he said he was unaware. He further stated if (LVN B) brought him down to a resident he would assess the wound. Regarding Resident # 75 Dr. # 1 said the resident was living in the secured unit the last time he saw her and then she went to the hospital. He further stated he did not see her after she was readmitted and he generally saw residents when they were readmitted . Dr. # 1 said there were 3 residents in the facility with the same last name as Resident # 75 and he saw one of the other residents with that last name. Record review if the facility's revised December 2010 Pain Clinical - Protocol read in part: Assessment and Recognition 1. The physician and staff will identify individuals who have pain or who are at risk for having pain . It also includes a revise for any treatments that the resident currently is receiving for pain, including complementary)non-pharmacological) treatments. 2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. 3. The staff and physician will identify the nature (characteristics such as location, intensity, frequency, pattern, etc.) and severity of pain. a. Staff will assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident ' s cognitive level. b. the staff will observe the resident (during rest and movement) for evidence of pain, for example grimacing while being positioned or having a wound dressing changed. 4. The nursing staff will identify any situations or intervention where an increase in the resident's pain may be anticipated; for example wound care, ambulation, or repositioning . As part of the medical assessment, the physician will help identify the extent to which underlying causes of pain can be addressed or reversed . With input from the resident and/or advocate, the physician and staff will establish goals of pain treatment:

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F 0309 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 8) for example, freedom form pain with minimal medication side effects . improved functioning, mood, and sleep . The staff will reassess the individuals pain and related consequences at regular intervals, at least each shift for acute pain or significant change in levels of chronic pain . The staff will discuss significant changes in levels of comfort with the Attending Physician who will consider adjusting intervention accordingly . Record review of the facility's revised October 2010 Pain Assessment and Management policy and procedure read in part: . The pain management program is based on a facility-wide commitment to resident comfort. 2. ' Pain Management is defined as the process of alleviating the resident ' s pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Effectively recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain. g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary . According to CMS For 672 there were 42 residents on a pain management program.
F 0314 **Level of harm -** Actual harm **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 provide the necessary care and services to prevent the development or worsening of pressure ulcers and to promote the healing of pressure ulcers for 3 of 4 Residents (Resident # 75, # 30, and # 35) who were reviewed for pressure ulcer care and management as evidenced by; -Resident # 75 developed an unstageable pressure ulcer to her left heel on 1/29/2014 and was not assessed by a physician until 16 days later. The facility failed to develop a care plan or implement interventions to address risk for pressure ulcers following a significant change in her ADL functions in December 2013. -Resident #30 had a facility acquired stage 4 pressure ulcer which developed on 9/26/12 was last assessed by a wound care physician on 5/1/2013. The wound depth has increased since that date with no documentation of additional assessments for the pressure ulcer. -Resident # 35 readmitted to the facility on [DATE] subsequent to a fall and fractured humerous. Despite being assessed as a moderate risk for skin breakdown on 1/20/14, the Resident developed new pressure areas to her sacral area (1/27/14) and her left hip (2/13/14). There was no documentation by Resident #35 ' s attending physician or the facility ' s dietician of any implemented interventions to prevent pressure sores. These failures affected 3 residents and placed 54 additional residents that were bedfast or in the chair most of the time at risk for development of pressure sores, decline in health, pain and need for additional treatment. Findings included: Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Record review of Resident # 75's Admission MDS assessment with 7/24/2013 ARD date revealed she was admitted to the facility on [DATE]. Her BIMS score was 9 out of 15 which means the resident was moderately cognitively impaired. It further revealed she was independent with bed mobility, transfers, ambulation in her room, and toilet use. She required supervision with set up only with personal hygiene, and bathing. She had no limitations in range of motion. She was always continent of bowel and bladder and did not have an indwelling urinary catheter. She was checked no for the presence of pain. The skin condition section of the assessment revealed she was not a risk for developing a pressure ulcer and did not have a pressure ulcer. Record review of Resident # 75's quarterly MDS assessment with 10/21/2013 ARD date revealed she usually understands others. Her BIMS score was 6 out of 15 which means the resident had a severe cognitively impairment. It functional status section of the assessment revealed she needed supervision- oversight, encouragement or cueing for with bed mobility, dressing, eating, and toilet use. She was independent with transfers and ambulation in her room. She required supervision with set up only with personal hygiene. She required extensive assistance of one person for bathing. She had no limitations in range of motion. She was always continent of bowel and bladder and did not have a indwelling urinary catheter. She was checked no for the presence of pain. The skin condition section of the assessment revealed she was not a risk for developing a pressure ulcer and did not have a pressure ulcer. Record review of Resident # 75's Braden Scale - Predicting Pressure Score Risk revealed the following: -A resident was at severe risk with a score of less than 9. -A resident was at high risk with a score of 10 -12. -A resident was at moderate risk with a score of 13-14. -A resident was at mild risk with a score of 15 - 18. -The 7/19/2013 assessment revealed the Resident's score was 22. - The 10/18/2013 assessment revealed the Resident's score was 22. Observation was conducted of PTA B and PTA C providing wound care for Resident # 75 on 2/12/2014 at 11:00 AM. Before the care began the resident said her foot was hurting. PTA B asked the resident if her pain was less than 5 the resident told her yes. Resident # 75 did not give a specific number on a scale of 1 to 10. The pressure ulcer was on the back of the left heel. The pressure ulcer had black eschar covering most of the pressure ulcer. The surrounding area especially on the inner heel was red in color with peeling thick areas of skin. When the dressing change was completed the resident told the PTAs that her foot felt like it was scraped. PTA B started the e-stim therapy. At that time the resident again said her heel was hurting a little bit right now. PTA B rolled a towel under the lower part of the back of the resident lower leg/ankle area. She then asked the resident if the foot was hurting more or less. At that time the resident told her she did not know. PTA C said she would ask nursing to give the resident something for pain. PTA C did not leave the room at that time. PTA B washed her hands and when she came out of the bathroom the resident reported it is really aching. PTA B told PTA C to ask if the resident could have something for pain. In an interview with LVN B on 2/12/2014 at 7:40 AM she said she did the weekly skin assessments for the whole facility. She stated when Resident # 75's pressure ulcer was found (1/29/2014) it was an unstageable pressure sore. In an interview with CNA E on 2/14/2014 at 11:52 AM she said she was working on the floor when she discovered Resident # 75's wound. She said she was getting the resident ready to get the resident out of bed, had socks on and told CNA E her foot was hurting. CNA E said she took her socks off and she had a discolored wound on her heel. She said she got LVN B and she got the DON and took her right then and there to see the wound. CNA E said the resident had been sick and been in bed. She further stated the resident had been going back and forth to the doctor. She said the resident had not been feeling well and had not been getting out of bed. She further stated the resident ' s appetite had been good. In an interview with PTA C on 2/12/2014 she said Resident # 75 did not usually complain of pain when she had been in her room. She said she provided Resident # 75's wound care occasionally when PTA B was not working. PTA C said Resident # 75 did not complain of pain when she was ambulating or standing. She further stated the resident was walking in the hall with therapy and then all of the sudden she was told she had a wound (after 1/29/2014). She said the resident could move by herself in the bed and roll, but when she came back from the hospital she needed some assistance. In an interview with PTA B on 2/13/2014 at 1:12 PM she said she notified nursing of Resident # 75's pain. When asked about the resident ' s pain level of 5 before treatment she said she should notify nursing and reposition the resident to try and make her more comfortable. When asked about Resident # 75's wound care plan she said the care plan read to pre-medicate for pain prior to the treatment. She further stated she did not ask anyone if the resident had been pre-medicated for pain prior to the treatment. She said LVN B told her the resident had necrotic tissue and it was not healing. When asked about cleaning the wound in a back and forth motion she said it can disturb the granulation tissue and you could have contamination from one part of the wound to another part of the wound. When asked what training she had received in wound care she said she had on the job training in another building. She further stated she had been watched providing wound care by the LVN B and PTA C and maybe the DON, Record review of resident # 75's 12/6/2013 skilled daily nurse's notes at 3:45 PM :Resident complained to CNA that she had fell and put herself back in chair. Resident shaky with complaints of pain shooting down her leg to her ankle form left hip. (Dr. # 1) notified. Son notified requesting she be sent to hospital . PRN Tylenol 325 mg, (two) admin for pain per PRN order . Record review of Resident # 75 ' s medical record revealed she had been hospitalized from12/6/2014 to 12/11/2013. Record review of Resident # 75's 12/11/2013 Resident Summary revealed the resident was being readmitted . The resident summary under pain section read: (no) pain voiced upon entry. The summary revealed she had no [MEDICAL CONDITION], her appetite was good and she had no skin breakdown. It also revealed she could ambulate alone, transfer herself, and position herself independently. Record review of Resident # 75's Braden Scale - Predicting Pressure Score Risk revealed the following: -The 12/11/2013 assessment revealed the Resident's score was 22. Record review of Resident # 75's significant change MDS assessment with ARD date of 12/18/2013 revealed the resident had a short term and long term memory problem with modified independence with cognitive skill for daily decision making. The functional status section of the assessment revealed she needed extensive assistance of one person for bed

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUMBLE HEALTHCARE CENTER	**93 ISAACKS RD HUMBLE, TX 77338**

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 9) mobility, transfers, dressing, toilet use, and personal hygiene. Ambulation did not occur during the assessment period. She had total dependence with locomotion on and off the unit of one person and with bathing. She had a range of motion limitation on one side of the lower extremity. The bladder and bowel section of the form revealed she had an indwelling urinary catheter and was always incontinent of bowel. She was not able to answer the question of the presence of pain. It further revealed the staff assessment did not reveal the presence of pain. The skin section revealed the resident was at risk of developing a pressure ulcer but currently did not have pressure ulcer. She had a pressure reducing device on the bed. The Care Area Assessment (CAA) Summary revealed the following areas for care area triggered and a care plan decision: ADL function, urinary incontinence/indwelling catheter, nutritional status, and pressure ulcer. Record review of Resident # 75's care plan revealed the following care plans were updated on 12/18/2013: -I require extensive assist for all ADLs related to stroke with generalized weakness. There were no interventions related to skin. -I am always incontinent of bowel. The approaches include: Observe my skin daily for irritation and redness. There was no care plan related to pressure sores and prevention prior to the undated care plan for the unstageable pressure ulcer. -I have potential for episodes of mild pain related to past stroke, Tylenol as needed. The Goal was I verbalize full relief of pain with 3/18/2014 target date. the approaches included: Evaluate my pain daily using 1 - 10 scale. My pain goal is 2. Administer my pain medication as ordered. Monitor for worsening of my pain symptoms and report to physician. In an interview with the DON on 2/13/2014 at 2:10 PM she was asked if she saw any interventions for pressure ulcer prevention in Resident # 75's 12/18/2013 care plans. She looked through the care plans and said no. She said Dr. # 1 comes to the facility every two weeks. She further stated the physician was supposed to see the resident every month for the first 90 days and then every 60 days. Record review of Resident # 75's 12/18/2013 [MEDICATION NAME] lab result revealed the level was 13.1 with a reference range of 18.0 - 45.0. This test indicates recent protein loss. Protien is needed for wound healing. Record review of Resident # 75 ' s medical record revealed she was hospitalized from [DATE] to 12/24/2014. Record review of Resident # 75's 12/24/2013 Resident Summary revealed she was readmitted . It further revealed she was alert, confused and understood information but had difficulty. She had no pain and her skin was clear. It further revealed the resident could ambulate alone, transfer herself, and position herself. It further revealed she had a fall on 12/17/2013. It also revealed the resident had a urinary tract infection and was on an antibiotic. Record review of Resident # 75's 12/24/2013 admission orders [REDACTED] -Head to toe skin assessment every week. Record review of Resident # 75's Braden Scale - Predicting Pressure Score Risk revealed the following: -The 12/24/2013 assessment revealed the Resident's score was 22. Record review of Resident # 75's January 2014 Treatment sheet revealed she had a weekly head to toe skin assessment on 1/23/2014 revealed the skin was clear. It further revealed the skin was abnormal on 1/29/2014 and 1/30/2014. In an interview with the DON on 2/12/2014 at 11:35 AM she said the CNA's document any skin checks they do in the computer. She further stated LVN B did the weekly skin assessments for each resident for the whole building. She said she would mark the skin assessment with C for clear or an A for abnormal. Record review of Resident # 75's Functional Status - Activities of Daily living (ADL) Assistance revealed she was cared for by CNA F and CNA E between 1/23/2014 and 1/29/2014. It further revealed she had total dependence to the need for extensive assistance of one person for bed mobility, transfers, dressing, eating, toilet use and personal hygiene according to the documentation of the care provided. There was no area regarding skin problems on the document. In an interview with CNA F on 2/12/2014 at 1:05 PM she said she normally worked on the floor and provided showers. When asked when she documented in the computer she said she normally documented two times per day in the morning and after lunch. She said when she provided a shower she checked the resident's skin to see if it was clear or had any open areas. She further stated when she was working on the floor she checked the skin on the bottom and private areas when she got the resident out of bed or sat them up. When asked if she looked at resident's feet she said she did. When asked about Resident # 75 she said she did not see any wounds on the resident a couple of weeks ago. She further stated the resident did not complain about hurting in her feet. CNA F said she did notice the resident started wearing boots on her feet (protective boots). She further stated if she saw a new wound she would tell (LVN B) and the nurses if it was on the weekends. She said Resident # 75 received her showers on the evening shift. CNA C said again she had never seen any wound on Resident # 75 and she had not seen her wound at all. Record review of resident # 75's 1/29/2014 skilled daily nurse's notes and nurse revealed there was not a time for the following entry New order P/T to eval and treat as needed Lt heel. Boots to bilat feet in and out of bed. Doppler to lower ext. DX Pain/Lt heel ulcer unstageable . It further revealed wound care order by Dr. # 1. This was the first documentation of the pressure sore. Record review of Resident # 75's 1/24/2014 - 1/29/2014 Physical Therapy Progress Report revealed a wound care evaluation was completed of left heel wound size 3.0 time 5.0 cm, unable to determine depth, wound was covered by 100 percent eschar. Record review of Resident # 75's Wound Skin Healing Record revealed the date of onset for the wound was 1/29/2014 and it was an unstageable to her left heel. -1/29/2014 it measured 3.0 by 5.0 with an unknown depth. There was granulation tissue and dark eschar. It further revealed the surrounding skin was normal for skin. The resident had no pain. Record review of Resident # 75's 1/29/2014 physician telephone order revealed the following orders: -Unstageable left heel, cleanse with wound cleanser pat dry. Apply Santyl to the wound cover with 4 by 4's and wrap with soft - foam. Change every day. This was a verbal order that revealed it was written by LVN B and received from Dr. # 1. There was no time on this order. -Physical therapy to evaluate and treat as needed left heel. This was a verbal order that revealed it was written by LVN B and received from Dr. # 1. There was no time on this order. -Physical Therapy clarification order: skilled Physical therapy (Monday - Friday) times 30 days for wound care to left heel. Cleanse with normal saline. Selectively debride (cut away or remove tissue). Apply E-stim and wound dressing with Santyl, [MEDICATION NAME] (non-adherent dressing)/kerlix (rolled gauze). Nursing to change dressing every Saturday, Sunday and holidays. Record review of Resident # 75 ' s undated care plan revealed the following: -A care plan with the problem/need I have an unstageable pressure ulcer. Hand written in was Unstageable left heel. There was no target date for the goal. The approaches included: reposition me every 2 hours, place a gel cushion on my chair. Encourage me to weight shifts while up in a chair. Teach me the risk factors for development of pressure ulcers. Administer my pain medications at least 1 hour prior to initiating treatment. I need a referral to a dietician to evaluate nutritional status. I need daily observation of skin with routine care. I need a full skin evaluation weekly with bath/shower. Adjust my treatment plan if no healing within 2 - 4 weeks. I need float heels on my pillow. Boots to bilateral feet in and out of bed. Monitor for changes in my skin status that may indicate worsening of my pressure ulcer and notify the physician. Record review of Resident # 75's Braden Scale - Predicting Pressure Score Risk revealed the following: -The 1/29/2014 assessment revealed the score was 18. This assessment revealed the resident had no impairment in sensory perception, was occasionally moist and was chairfast. It further revealed she had very limited mobility and excellent nutrition. She had a potential problem for friction and shear. In an interview with LVN B on 2/12/2014 at 11:45 AM she was asked what the process was for her skin assessments. She said she did the skin assessment for a hall on a specific day for the hall. She further stated she looked at the resident from head to toe. She said sometimes she looked at the resident's skin in the shower. LVN B said the CNAs were supposed to report new wounds and should be reporting new wounds. She stated the last time she did a skin check on Resident # 75 prior to the wound being discovered was on 1/23/2014. When asked if she thought the resident could have clear skin and then have an unstageable wound in 6 days she said if the resident were just lying in the bed. She said Resident # 75 was receiving therapy and getting out of bed. LVN B said the facility did not have a physician that specializes in wound care come to the facility weekly but they could have one come to the facility. When asked if the resident's primary care physician had seen the wound she said she was not sure. She further stated he was notified of the new pressure ulcer. When asked what the pressure sore looked like when she saw it for the first time she said the heel was discolored, one side had a leather like black eschar and the other side was vicious red in color. One side of the heel was very tender. LVN B said she also spoke to the corporate nurse responsible for wound care. She said that nurse whose name she could not remember was available via e-mail. LVN B said the corporate wound care nurse did not come to the facility to look at Resident # 75's wound. When asked about the date on the care plan she said she would have to look at the medical record to see when the wound was identified for the date when the care plan was initiated. In an interview with LVN B on 2/14/2014 at 7:35 AM she was asked how she was informed of Resident # 75's unstageable pressure sore. She said one of the CNAs informed her and he went and assessed the wound. She further stated she discussed the wound with therapy, with PTA C. LVN B said she told her it was discovered that day (1/29/2014) and she wrote an order for [REDACTED]. When asked if the primary care physician looked at wounds she said he did look at wounds. When asked when Resident # 75's care plan was initiated she said she was going to have to look at the order (for the wound care). She said the care plan did not have a target date on the goal. When asked what was being done to prevent pressure ulcers for Resident # 75 she said she had a gel cushion on her wheelchair, repositioning every two hours, weight shifts, and teaching how to report to nurse (intervention done after 1/29/2014 pressure sore developed). She

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 10) looked at the care plan and said it said to administer pain medication before wound care. She said nursing was doing Resident # 75's wound care on the weekends and holidays. LVN B said the staff should ask the resident what her pain level was on scale of 1 to 10 before wound care. She further stated if their pain level was a 5 they should administer as needed pain medication and not touch them under after the medication. She said you needed to address pain and if the resident cannot say the level of pain the staff should assess for moaning, groaning, grimacing and their breathing. When asked when wound treatments should be changed she said if it was the same for a while. She further stated wounds were evaluated every 2 weeks by the doctor. She said she did not know if the doctor had looked at Resident # 75's wound. She said she had received an update and training on wound care. LVN B said the DON was with her weekly when she performed wound care. In an interview with the DON on 2/12/2014 at 12:30 PM she said (RN A) was the regional wound clinical specialist. She further stated RN A did their training on wounds and watched wound care with the wound care nurse. Record review of Resident # 75's Physical Therapy Evaluation and Plan of Treatment revealed the Certification Period was 1/29/2014 - 3/29/2014. The wound analysis revealed the first wound was 3.0 cm length by 5.0 cm width, Edge was indistinct and it had adherent soft black eschar, The necrotic tissue amount was 75 to 100 percent. Under the intervention section it read: Was conventional wound care provided prior to (start of care)? = Yes, patient received 30 days of conventional care to address wounds, (without) measurable signs of healing. The assessment summary impressions revealed the resident presented with left heel ulcer that had not responded to conventional treatment. This was signed by Dr. # 1 and the signature date was 2/5/2014. In an interview with PTA B on 2/13/2014 at 1:12 PM she said was asked if the Plan of Care was accurate she said as far as I know the plan of care was accurate. When asked if she had done any research or review prior to starting Resident # 75's wound care she said she did not. When asked about the plan of care reporting that the resident wound care had been done by nursing for 30 days prior to the initiation of therapy she said the companies said the wound must be under nursing for 30 days. She said LVN B told her the resident had necrotic tissue and it was not healing. When asked if the plan of care was accurate if the wound was identified on 1/29/2014 she said it was not accurate. Record review of Resident # 75's Wound Skin Healing Record revealed the date of onset for the wound was 1/29/2014 and it was an unstageable to her left heel. -2/5/2014 the wound measured 3.8 by 7.4 with an unknown depth. It further revealed the wound had no odor had granulation tissue with black/brown eschar. The surrounding skin color was pink and white and there was maceration on the surrounding tissue/wound edges. The resident had no pain. Record review of the facility's week of 2/5/2014 Weekly Pressure Wound QI Log revealed Resident # 75 had an unstageable left heel pressure sore that measured 3.8 by 7.4 with unknown depth. In an interview with CNA E on 2/12/2014 at 3:15 PM she said when giving a Resident a bath or a shower you were to check the whole body for any sores or wounds. She further stated she documented anything observed in the computer. She stated there was a question that asked if the resident had any new skin abrasion and you would have to check yes or no. She said there was not a place for an explanation. CNA E further stated the nurse would then look on the computer and call you to the desk to ask what was going on. She said she would also tell the wound care nurse about any new skin issues. When asked about the documentation for the care provided, she said turning, repositioning was all on the computer and you were supposed to document every two hours. She further stated you were no supposed to wait until the end of the day to document. She said she documented every two to two and a half hours. She further stated the nurse reviewed their notes. In an interview with LVN C on 2/12/2014 at 3:20 PM she was asked about the CNA documentation. She stated they document in the computer and she did not review their documentation. She further stated if there was anything different with the resident they come and tell her. She said she did check to make sure they had done their work and there was nothing in red in the computer. She said if she thought a resident was at risk for skin breakdown she would leave a note for LVN B. LVN C said that LVN B did the wound care but if a CNA got a dressing wet LVN C or the nurse caring for the resident would have to change the dressing herself. When asked about Resident # 75 she said she knew the resident wore a boot on her left leg and she had the wound for several weeks. She said the nurses only provided wound care for Resident # 75 on the weekends. She further stated that sometimes Resident # 75 refused her wound treatment. Record review of Resident # 75's 2/7/2014 - 2/13/2014 Physical Therapy Progress Report revealed a post a note on top of the notes with the resident ' s name and the following measurements 3.7 by 7.0 by undetermined. Under the continued skill section it revealed the following notations: decrease complaints of pain, facilitate wound healing, decrease risk of infection, and relieve pressure for decreased risk of skin breakdown. Record review of Resident # 75's Wound Skin Healing Record revealed the date of onset for the wound was 1/29/2014 and it was an unstageable to her left heel. -2/13/2014 note revealed the wound was unstageable and measured 3.7 com in length and 7.0 cm in width with an unknown depth. Under the pain section was the resident experiencing pain yes was checked. The hand written note read unable to say pain going back and forth (with) her answers. Record review of Resident # 75's Daily PT Wound CPT and Progress Documentation revealed the following. 1/30/2014 note revealed the pressure ulcer had eschar. It further revealed the resident had discomfort. There was no further identification of pain level. There was a note that read no complains pt responded well. 1/31/2014 note revealed the resident had discomfort which was not further clarified. Under response to treatment and skilled need statement it read patient education on elevating both lower extremity feet. -2/3/2014 note revealed the pain level was 7 on a scale of 1 to 10 to left heel. There was no other documentation of the note regarding pain. -2/4/2014 note revealed the pain level to left heel was 8 on a scale of 1 to 10. There was no other documentation on the note regarding pain. Under response to treatment and skilled need statement: continue to education for pressure relief was documented. -2/5/2014 note revealed the pain level to left heel was 8 on a scale of 1 to 10. There was no other documentation on the note regarding pain. Under response to treatment and skilled need statement: continue caregiver education to decrease pressure in bed. -2/12/2014 note revealed the pain level was less than 5 on scale of 1 to 10 before dressing change. There was no other documentation on the note regarding pain. Under response to treatment and skilled need statement: continue caregiver training for positioning. In an interview with PTA B on 2/13/2014 at 1:12 PM she said the pain documented on Daily PT Wound CPT and Progress Documentation was documented after the resident had received her treatment. She said she notified nursing of Resident # 75's pain. She said she did not document the pain level before the treatment. She clarified that the pain level documented was after the treatment. There was no documentation regarding the pain level prior to the treatment. When asked about the resident pain level 5 before treatment she said she should notify nursing and reposition the resident to try and make her more comfortable. When asked Resident # 75's about wound care plan she said the care plan read to pre-medicate for pain prior to the treatment. She further stated she did not ask anyone if the resident had been pre-medicated for pain prior to the treatment. PTA B said she assessed resident pain before treatment and if it was 5 or more she would notify nursing to make sure they pre-medicate. In an interview with the DON on 2/13/2014 at 3:00 PM she said Resident # 75 was not at risk for pressure ulcers. She was shown how her ADL had changed on her significant change MDS from her previous MDS and she said she was at risk. She was asked what interventions were place to prevent pressure sores for Resident # 75 she said there were no interventions in the care plan for prevention. The DON said Resident # 75 had [MEDICAL CONDITION]. At that time she was asked to see documentation of [MEDICAL CONDITION]. She looked through the record and did not find documentation of [MEDICAL CONDITION]. In an interview with the DON on 2/13/2014 at 6:00 PM she asked about what were the concerns with Resident # 75's pain. She was informed the resident had pain 7 and 8 on scale of 1 to 10 and did not receive pain medication every time. When asked if the facility had a wound care physician that came to facility, she said not under contract. When asked who could assess a wound she did not respond. In an interview with the DON and RCS on 2/14/2014 at 7:05 AM they were asked what staff should do before wound care. The DON said they staff should assess for pain and if the resident report pain it should be addressed with pain medication. At that time they were shown Resident # 75's Daily PT Wound CPT and Progress Documentation where her pain had been 7 to 8 out 10. They asked where that had been found and were informed it was not in the medical record but provided by therapy staff. When shown Resident # 75's pain assessment and asked if complete RCS said it was not filled out and incomplete. When asked what should be done if a resident cannot answer what their pain level was on scale of 1 to 10 the DON said the other pain assessment should be completed. When asked if Resident # 75's therapy Plan of Care was accurate with the notation resident had received wound care from nursing 30 days prior to therapy they said it was not accurate. In an interview with Dr. # 1 on 2/14/2014 at 8:55 AM he said he tried to see resident once per month. He said he had another doctor in his office that generally came to the facility every six months. He said would see a resident right away when admitted to the facility within 48 hours. He stated when he came to the facility he did one row of Resident records and if a resident had a problem he would address it. He said currently all of the progress notes were on the medical records, he had checked the office notes. When asked about a resident with a new wound he said usually the wound care doctor for the facility would see the wound. When he was informed the facility had not had a wound physician since May 2013 he said he was unaware. He further stated if (LVN B) brought him down to a resident he would assess the wound. Regarding Resident # 75 Dr. # 1 said the

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 11) resident was living in the secured unit the last time he saw her and then she went to the hospital. He further stated he did not see her after she was readmitted and he generally saw resident when they were readmitted . Dr. # 1 said there were 3 residents in the facility with the same last name as Resident # 75 and he saw one of the other residents with that last name. He further stated personally he did not use Santyl on eschar. He said if the resident did not have a wound but just escha
F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 provide appropriate treatment and services to prevent urinary tract infections for 1 of 1 residents (Resident # 75) reviewed for indwelling urinary catheter. -Resident # 75 did not have leg strap to secure her catheter. CNA G pulled on her indwelling urinary catheter when she turned the resident during catheter care. She did not hold the catheter tubing when she cleaned the tubing and she did not fully clean the resident. with a leg strap during incontinent care. This failure affected 1 resident and placed an addition resident with indwelling urinary catheter at risk for obstruction of urinary flow, infection, pain, urethral trauma and erosion. Findings include: Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Observation was conducted of CNA G providing catheter and peri-care for Resident # 75 on 2/13/2014 at 11:37 AM. She opened the resident ' s brief and rolled in up between her legs next to her peri-area, The indwelling urinary catheter tubing was lying on top of the brief. She rolled the resident to her left side, the indwelling urinary catheter drainage bag was attached to the bed the catheter tubing was being pulled on when the resident was on her left side. There was not a catheter strap to secure the catheter. CNA G did not open the labia when she wiped down. She did not secure the catheter tubing when she cleansed it. She wiped back and forth with the catheter tubing lying on the brief. CNA G emptied the catheter drainage bag. While she was doing so the catheter drainage bag was on the floor. In an interview with CNA G on 2/13/2014 at 2:00 PM she was asked how the catheter should be cleaned during catheter care. She said it should be wiped in a circular motion from the urethra out away from the body. She said failing to do so could cause the catheter to still be dirty. She further stated you were supposed to hold the catheter in place when cleaning it. When asked about the indwelling catheter laying top of the soiled brief she said she tried to tuck the catheter on the outside. She said no one had watched her perform incontinent care. In an interview with the CNA G on 2/14/2014 at 11:15 AM she said she was supposed to open the labia and go down completely when cleansing the resident during care. She said when she did not she could miss spots that could have urine or bowel movement on them and the resident could get an infection. In an interview with the DON on 2/14/14 at 4:15 PM she stated She stated during catheter care, the tubing should be cleaned in a circular motion away from the resident. She stated the tubing should be taped to the leg or a catheter strap used to prevent the catheter from coming out. She stated during care, the catheter bag should be moved from side to side to prevent pulling. She stated the bag should not be placed on the floor due to infection control issues. Record review of the facility's revised October 2010 Catheter Care, Urinary policy and procedure read in part: . Use standard precautions when handling or manipulating the drainage system. 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag . Be sure the catheter tubing and drainage bag are kept off the floor . Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.) . Wash and dry your hands . Wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry . Remove gloves and discard into designated container. Wash and dry your hands thoroughly . With nondominant hand separate the labia of the female resident . Maintain the position of the hand throughout the procedure . For the female: Use a washcloth with warm water to cleanse the labia. Use one area of the washcloth for each downward, cleansing stroke. Change the position of the washcloth and cleanse around the meatus. Do not allow the washcloth to drag on the resident ' s skin or bed linen. With a clean washcloth, rinse with warm water using the above technique . Use a clean washcloth with warm water and soap to cleanse and rinse the catheter form insertion site to approximately four inches outward. 17. Secure catheter utilizing a leg band . According to CMS Form 672 there were two residents with indwelling or external urinary catheters.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible. - The exterior air conditioning vent on the building was observed to have dryer lint built up around the air vent inside the lint trap. Cigarette butts were observed around the lint trap and one lit cigarette was observed one foot from the lint trap in an urn type ashtray. Lint was also observed on the fascia board, wall and door surrounding the lint trap. An Immediate Jeopardy (IJ) situation was identified on 02/13/14 at 4:45 p.m. While the IJ was lowered to a non-immediate Jeopardy on 02/14/14 at 3:00 p.m. The facility remained out of compliance at widespread with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. The facility's Plan of Removal of Immediate Jeopardy was accepted at 1:00 pm on 02/14/14 by notification of the Administrator. This failure placed all 85 residents in the facility at risk for fire injuries, smoke inhalation, burns, hospitalization , and/or death. Non-Immediate Jeopardy -There were 2 bottles of peri-wash on the dresser in Resident # 23's room (who was a confused resident). -There were 2 bottles of peri-wash in the bathroom of Resident #26's room (who was a confused resident). -There was a liquid on the bathroom floor and a jagged mirror propped behind the sink faucet in Resident # 60's bathroom (who would self toilet). -CNA H transferred Resident # 83 on 12/25/13 without using the lift and by herself, causing Resident # 83 pain in her knee. - Observations on 2/13/2014 of the facility's exterior physical environment revealed resident safety hazards in different areas surrounding the building. - The shower room on Hall 2 (secure unit) was observed to be unlocked with an open bottle of shampoo/body wash sitting on a shower chair. - Exposed wires were observed hanging from the wall in the facility's restorative dining room. Findings include: An observation on 2/13/2014 at 3:02 PM of the facility's exterior dryer vent and lint trap revealed the lint trap to be a large metal container approximately 4 feet tall and 3 feet wide with a perforated front to allow for air flow sitting in front of the dryer vent coming out of the facility wall. The dryer was operating at the time of the observation and the metal lint trap was observed to be very hot to the touch. The lint trap was observed sitting on a rotten wood pallet. There was a large amount of lint surrounding the dryer vent inside the lint trap and lint was observed caked against the inside surface of the lint trap. Lint was also observed on the surrounding wall, the fascia board above the lint trap and on the door next to the dryer vent. The door was observed to be in a state of rot and disrepair. Numerous cigarette butts were observed on the ground surrounding lint trap and one cigarette butt laying on the lint in between the lint trap and wall of the facility. A concrete urn style container was observed approximately one foot from the lint trap and contained cigarette butts and one lit cigarette with smoke coming from the cigarette. The lint trap was also observed to be under a pole with power lines coming from the pole and leading to the building. The facility's main power box was observed on the same wall as the lint trap a few feet away and the main generator was observed approximately 10 feet from the lint trap. In an interview with the Housekeeping/Laundry Supervisor on 2/13/2014 at 3:14 PM when asked about the dryer vent and lint trap, he said they cleaned the lint trap on the outside of the building once a month. When asked if he documented when he cleaned the lint trap each month, he said no. He also said the area surrounding the dryer vent was a non-smoking area and staff should not be smoking there. He said there was not a no smoking sign in the area. He said he last cleaned the lint trap about one month ago. He also said he had not cleaned behind the lint trap. When asked what could happen with the cigarettes and the dryer lint and the heat from the dryer vent, and he said fire. He also said he did not remember how long the lint trap was sitting on the rotten pallet. He said the chairs and ashtray had been there since December 2013. Record review of the facility's Fire Hazards in the Laundry policy and procedure read in part; Purpose: Laundry personnel are trained to clean lint screens in dryers. Potential Hazard: Increased fire hazard because of lint build-up on ceilings and other surfaces such as heat

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUMBLE HEALTHCARE CENTER	**93 ISAACKS RD** **HUMBLE, TX 77338**

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 12) producing equipment. Lint build-up in lint traps can also be a hazard. As dryers run, lint will accumulate inside the dryers. To keep the lint from traveling up to the top of the dryers, near the flame, the dryers are equipped with a screen to catch lint and hold it away from the flame. These screens will eventually be covered with lint and must be cleaned. If not cleaned, the screens will prevent air from circulating through the dryers and is a definite fire hazard. Possible Solutions: Routine cleaning surfaces of lint, and emptying of lint traps. This document was not dated. There was no specific documentation related to cleaning the dryer vent and lint trap on the outside of the building. Record review of the facility's plan of removal for the immediate jeopardy read as follows: Plan of Removal of Immediate Jeopardy relating to Accidents/Hazards-Fire Safety ISSUE- Removal of lint from dryer vent by the laundry area on 2/13/14 as identified by Fed/ State Surveyor. Immediate action: Maintenance Director was notified by State that dryer vent is packed with lint and staff is smoking in the areas at 3:30 pm. Maintenance director notified Administrator immediately. An action plan of resolving the identified issue was put in place. - Removed lint trap and old wooden pallet from the identified area at 3:45 pm 2/13/14. - Cleaned lint trap and lint from area around dryer exhaust. Installed non -flammable cement blocks as the base at 4:30 pm 2/13/14. - Cleaned lint trap was reinstalled on base to complete the project of cleaning the dryer vent and area at 4:45PM 2/13/14. - Chairs were removed form area and a non-smoking sign was placed in the identified location at 4:55 pm 2/13/14. - Completed removal of lint hazard was at 5 pm 2/13/14 by administrator and maintenance staff. Available staff inservice was initiated at 4:30 pm 2/13/14 on service area by laundry designated non-smoking area and staff new smoking area will be located on back patio same as resident smoking area. Staff not present will be inserviced prior to starting assigned shifts. Maintenance supervisor was inserivced 1:1 by Administrator on procedure and frequency of cleaning lint trap at 5 pm on 2/13/14. Documentation of daily checks of lint trap and area will be documented in TELS monitoring systems program which records dates and information pertaining to action taken by maintenance supervisor. While the IJ was lowered to a non-immediate Jeopardy on 02/14/14 at 3:00 p.m. The facility remained out of compliance at widespread with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. The facility's Plan of Removal of Immediate Jeopardy was accepted at 1:00 pm on 02/14/14, after verification of the plan of implementation had occurred. Non-Immediate Jeopardy Resident # 23 Observation on 2/11/14 at 8:40 AM revealed in Resident # 23's room there were 2 bottles of peri-wash on the dresser. Record review of Resident # 23's quarterly MDS dated [DATE] revealed his BIMS was 8 (moderately intact cognition), wandered and had a [DIAGNOSES REDACTED]. In an interview on 2/11/14 at 8:40 AM, CNA C stated the peri-wash sprays are not supposed to be left out as a resident could open it and drink it. She stated Resident # 23 was confused. Resident # 26 Observation on 2/11/14 at 8:50 AM revealed in Resident # 26's room there were 2 bottles of peri-wash sitting on the toilet tank. Record review of Resident # 26's quarterly MDS dated [DATE] revealed he had short and long term memory deficits, moderately impaired decision making, required limited assistance with walking and had a [DIAGNOSES REDACTED]. In an interview on 2/11/14 at 8:50 AM, CNA C stated the peri-wash should not be left out as Resident # 26 was confused. She stated the peri-wash should be in a bag and kept at the bottom of the linen cart. Resident # 60 Observation on 2/11/14 at 10:30 AM revealed in Resident # 60's bathroom there was a liquid on the floor and a mirror was propped up behind the sink faucet, leaning against the wall. The mirror had a rough edge to one corner. Record review of Resident # 60's quarterly MDS dated [DATE] revealed her BIMS was 7 (severely impaired cognition), required supervision for walking and toileting and was always continent. In an interview on 2/11/14 at 10:30 AM, CNA D stated both residents in room were fall risks, including Resident # 60 who used the bathroom on her own. When asked about the liquid on the floor, she stated I see it now and that it would put the resident at risk for a fall. When asked about the mirror, CNA D stated I guess they need to stick it on the wall. She stated she did not know how long the mirror had been like that and that it was not okay for it to just propped up like that because it could cut someone. In an interview on 2/11/14 at 10:46 AM, CNA D stated she had removed the mirror from Resident # 60's bathroom and let the nurse and maintenance know about the concerns in the bathroom. Resident # 83 Record review of Resident # 83's face sheet revealed [AGE] year old admitted to the facility on [DATE] and had the following diagnoses; late effect cerebrovascular disease, esophageal reflux, osteoporosis, affective personality, depression, hypertension and constipation. In an interview with Resident # 83 on 2/13/14 at 4:20 PM, she stated she was transferred from a shower chair to bed by 1 CNA since the other CNA did not want to help several weeks ago. She stated when this happened, her knee got hurt. Observation on 2/13/14 at 4:20 PM revealed Resident # 83's bilateral feet were contracted and she used an electric wheel chair for mobility. Record review of Resident # 83's admission history and physical dated 11/27/12 revealed she had bilateral foot drop. Record review of Resident # 83's physician progress notes [REDACTED]. Record review of Resident # 83's quarterly MDS dated [DATE] revealed there was no limitation of range of motion to her lower extremities (hip, knee, ankle and foot). Record review of Resident # 83's nurse note dated 12/25/13 at 4:15 PM read, in part, Resident was being transferred from shower chair to wheelchair. Resident slipped out of shower chair during transfer. Resident left leg went backwards and the knee area assessment done per nurse. No swelling at this time. Resident complained of pain upon palpitation to area above knee. Schedule Norco given as directed. MD notified. New order x-ray of left knee and femur. Record review of Resident # 83's 12/25/13 x-ray report of her left knee revealed no acute fracture. It revealed there were degenerative changes, possible prior fracture and displaced or subluxed patella. This x-ray was review by Resident # 83's physician on 12/26/13 who wrote exam of the knee reveals no pain, no swelling. She had permanent contractures to that knee. In an interview on 2/13/14 at 5:55 PM, CNA H stated she had been working with Resident # 83 on 12/25/13. She stated she could not find anyone to help transfer the resident out of the shower chair and admitted she transferred the resident by herself into bed. She stated she did not have the lift pad under her in the shower chair, so when she tried to transfer her, she said my feet hit her feet and caught and bent her knee. She stated neither of them actually fell . CNA H stated Resident # 83 was usually transferred with a lift or with 2 people. In an interview on 2/14/14 at 7:15 AM, the DON stated on 12/25/13 CNA H did transfer Resident # 83 by herself because another CNA would not help her. The DON stated she had counseled the CNAs and the one CNA who would not assist with the transfer no longer worked at the facility. Observations on 2/13/2014 of the facility's exterior physical environment revealed the following: - 2:06 PM: A metal shed was observed on the outside of the building which had a mud floor. There was also standing water in the shed floor. A light bulb was observed on the ground in the mud in the shed. There was also a water pump with cords plugged into it laying in the mud. - 2:08 PM: An exterior hot water heater was observed in a room on the side of the building. The door to the hot water heater was observed to be rotted and only partially intact. Water was observed dripping under the hot water heater and a pool of water was observed standing on the concrete floor under the water heater. - 2:16 PM: A black cable was observed laying on the soggy ground between a power pole approximately 50 feet away from the facility, leading to a Telecom box next to the facility wall. - 2:32 PM: A wooden and metal park bench was observed inside the resident's fenced smoking area. The bench was observed to have rotten and broken wood slats which exposed pieces of rusted metal on the bench. - 2:32 PM: A large pile of tangled water hoses were observed against a wall inside the resident's fenced smoking area. - 2:34 PM: Cigarettes which were not properly extinguished or disposed of were observed sitting on the window sills and on the ground in the resident smoking area. - 2:34 PM: One chair in the resident smoking area was observed to be constructed of wood and cloth. The cloth was observed to be dirty with bird excrement on the seat. - 2:36 PM: Large amount of bird excrement was observed covering the resident use table and chairs in the resident smoking area. Bird excrement has the potential to carry an illness called histoplasmosis. - 2:38 PM: A concrete pig was observed in the resident smoking area which had two protruding rusty metal wires coming from the top of the head where there pig ' s ears used to be. - 2:44 PM: An unsecured storage shed at the back of the facility was observed which contained tools, wood, paint and containers marked Corrosive. Outside of the storage shed was observed a broken night stand, pile of boards with rusty nails sticking out of them, toilet and a large bin containing empty soda cans was observed with bees swarming around the cans. Also outside of the storage shed were 2 active fire ant beds and standing water on either side of the drive in front of the shed which was approximately 3 feet wide by 15 feet long. - 2:54 PM: An unsecured large shipping container at the back of the facility was observed which contained assorted facility equipment such as wheelchairs and furniture. Observation on 2/11/2014 at 10:20 AM of the secure unit's (Hall 2) shower room revealed the door to the shower room to be unlocked and a gallon jug of Shampoo and Body Wash was observed sitting on a shower chair with no lid on the bottle. Observation on 2/12/2014 at 12:38 PM of the facility's restorative dining room revealed on either side of the dining room, 2 wires were coming out of the wall and hanging approximately 4 feet off the floor. The ends of the wires were observed to be exposed. In an interview with the DON on 2/14/14 at 4:15 PM she was asked about the resident smoking area, she stated the area should be cleaned. She stated the bird dropping could be a way to contract a disease and was nasty. Record review of the CDC website definition of Histoplasmosis read in part; Histoplasmosis is a disease caused by the fungus Histoplasma capsulatum. The fungus lives in the environment, usually in association with large amounts of bird or bat droppings. Lung

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 13) infection can occur after a person inhales airborne, microscopic fungal spores from the environment. .The symptoms of histoplasmosis are similar to pneumonia, and the infection can sometimes become serious if it is not treated. http://www.cdc.gov/fungal/diseases/histoplasmosis/index.html Record review of the facility's Cleaning Schedules policy and procedure read in part; Policy Statement: Cleaning schedules shall be developed and implemented to ensure that our facility is maintained in a clean and comfortable manner. Policy Interpretation and Implementation: 1. Cleaning schedules are developed and implemented to assure that each area of our facility is maintained in a safe, clean and comfortable manner. This document was not dated. Record review of the facility's Facility Smoking Policy policy and procedure read in part; Safe Smoking Environment: It is the responsibility of the facility to provide a safe and hazard free environment for those residents having been assessed as being safe for facility smoking privileges. This document was dated 2/21/2013. Record review of the facility's Cleaning and Disinfection of Environmental Surfaces policy and procedure read in part; Policy Statement: Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard. .Non Resident Care Areas: 7. Detergent and water will be used for cleaning surfaces in non resident care areas. .Housekeeping Surfaces: 9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. This document was dated 8/2009. Record review of the facility's policy Safe Lifting and Movement of Residents, revised October 2009, read in part, .In order to protect the safety and well-being of staff and residents and to promote quality care, this facility uses appropriate techniques and devices to left and move residents .12. Safe lifting and movement of residents is part of an overall facility employee health and safety program, which: a. Involves employees in identifying problem areas and implementing workplace safety and injury-prevention strategies. A request was made during the survey for a policy and procedure related to cleaning/removing garbage and/or trash from the facility's property. This document was not provided prior to exit. According to CMS 672 the census as 85.
F 0367 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that special or therapeutic diets are ordered by the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review the facility failed to follow physician's diet orders for 2 of 44 residents who were prescribed a therapeutic diet. Resident #61 was prescribed a no added salt diet and was observed putting salt on her lunch meal. Resident #81 was prescribed nectar thickened liquids and was observed drinking regular consistency milk, juice and water. Failure to provide a no added salt diet could lead to increased blood pressure and heart complications. Failure to provide thickened liquids could lead to choking, aspiration pneumonia and hospitalization . This failure affected 2 residents and placed 42 residents at risk for not receiving the therapeutic diet prescribed by their physician. Finding Include: Resident #61 Record review of Resident #61's current medical chart revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. Her [DIAGNOSES REDACTED]. She was [AGE] years old. Review of the monthly physician's orders [REDACTED]. Review of Resident #61's plan of care dated 8/13/2010 under the section titled Problem/Need read I have potential for experiencing fluctuating/unstable blood pressures due to HTN (hypertension). Review of the nutritional evaluation dated 1/13/14 read Reg. CC/RCS, NAS diet. Observations of Resident #61 on 2/11/14 at 12:25 PM revealed her putting salt onto her lunch meal. A salt shaker was observed in her hand and numerous salt granules were observed on top of her lunch meal. In an interview with Resident #61 on 2/11/14 at 12:25 PM when asked if she put salt on her food she said yes, it's much better that way. I used the salt when it needs it. In an interview with the DON on 2/11/14 at 5:30 PM she was asked if Resident #61 was allowed to use salt on her food she said no, she noncompliant with her diet. She was asked if Resident #61 had a waiver for noncompliance with her diet, she said no. Resident #81 Record review of Resident #81's current medical chart revealed he was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. He was [AGE] years old. Review of Resident #81's monthly physician's orders [REDACTED]. Review of the Speech Therapy Evaluation and Plan of Treatment dated 8/28/2013 under the section titled Recommendations read Intake, Diet Recs(recommendations) - Liquids = Nectar thick liquids. Review of the Nutritional Progress Notes dated 12/11/13 read Resident refuses to drink thickened liquids, becomes upset when I encourage him to drink thickened liquids. Observations of Resident #81 on 2/12/14 at 12:30 PM, 2/13/14 at 8:45 AM and 2/13/14 at 12:40 PM revealed him in the dining room eating his meals and drinking regular consistency ice tea, milk and juices. In an interview with the DON on 2/14/14 at 3:50 PM she was asked if Resident #81 was on thickened liquids she said yes. When asked if there was a wavier for his noncompliance she said No, he doesn't have a wavier for the thickened liquids. Record review of the facility's policy titled Therapeutic Diets, 2001 MED-PASS, Inc (Revised December 2008) read in part, Therapeutic diets shall be prescribed by the Attending Physician. The facility will strive for the fewest possible dietary restrictions. Based on the FSM there were 44 residents in the facility that receive a therapeutic diet.
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Store, cook, and serve food in a safe and clean way** Based on observation, interview, and record review the facility failed to store, prepare and distribute food under sanitary conditions. Equipment was not clean Dust was in the ice machine filter Staff hair was protruding out of their hair restraints. There failures affected 79 residents who ate foods prepared in the kitchen by placing them at risk for food borne illness or disease. Finding Include: Observations of the kitchen on 2/11/14 between 8:45 AM and 9:10 AM revealed the following: The oven had black burnt food spillage on the bottom shelf. The range hood had old grease and dust on it. The ice machine outer filter had dust and dirt in between the grills. Observations on 12/12/14 at 10:05 AM revealed the oven had black burnt food spillage on the bottom shelf and the range hood had old grease and dust on it. Kitchen aide #1 and cook #1 has hair protruding from underneath their hair restraints. Kitchen aide #2 hair restraint did not cover the front part of her hair. In an interview with the FSM on 2/11/14 at 9:00 AM she said the ovens were cleaned daily. The oven was scheduled to be cleaned today. When asked about the filter on the ice machine she said the staff is responsible for cleaning the ice machine including the filter. I will get them to clean it today. In an interview with the FSM on 12/12/14 at 10:15 AM she said the staff cleaned the wrong oven yesterday. We will clean it today. At 1:15 PM the FSM was informed of staff's hair protruding out of the hair restraints at which time she stated, the hair restraints should cover the entire head. She said I will talk to them. Review of the facility's undated policy titled Cleaning Ice-Making Machine, read in part, Monthly:.3. Wash outside using cloth or nylon brush. Undated policy titled Cleaning Stove read in part, Daily:.3. Clean up spills.8. Wash outside of oven anytime ovens are cool. 9. Wash off outside of oven after each meal. Based on the facility's CMS 671 there were 6 residents who receive their nourishment by gastric tube therefore 79 residents receive they meal from the facility kitchen.
F 0387 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that doctors visit residents regularly, as required.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that 2 of 17 residents (Resident #'s 30 and 75) reviewed for physician visit was seen at least once every 30 days for the first 90 days of admission and then every 60 days. -Resident #30 had not been seen by her primary care physician since 10/7/2013. -Resident # 75 had not been seen by her primary care physician since 11/27/2013. This failure affected 2 residents and placed an additional 84 residents at risk of not receiving appropriate and adequate medical care. Findings Include: Resident #30 Record review of Resident #30's face sheet revealed she was admitted to the facility on [DATE]. The following [DIAGNOSES REDACTED]. This resident is [AGE] years of age. Record review of Resident #30's clinical record revealed the last time the resident's stage 4 pressure ulcer was assessed by a physician was on 5/1/2013 by Advantage Wound Care. No documentation was found showing Resident #30's stage 4 pressure ulcer was ever assessed by a physician from 5/1/2013 through 2/13/2014. Further review of the clinical record revealed the last documentation of a physician's visit for Resident #30 was on 10/7/2013. Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Record review of Resident # 75's medical record revealed 11/27/2013 was the last physician progress notes [REDACTED]. In an interview with the DON on 2/13/2014 at 2:10 PM she said Dr. # 1 comes to the facility every two weeks. She further stated the physician was supposed to see the resident every month for the first 90 days and then every 60 days. In an interview with Dr. # 1 on 2/14/2014 at 8:55 AM he said he tried to see resident once per month. He said he had another doctor in his office that generally came to the facility every six months. He said would see a

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F 0387 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 14) resident right away when admitted to the facility within 48 hours. He stated when he came to the facility he did one row of Resident records and if a resident had a problem he would address it. He said currently all of the progress notes were on the medical records, he had checked the office notes. Regarding Resident # 75 Dr. # 1 said the resident was living in the secured unit the last time he saw her and then she went to the hospital. He further stated he did not see her after she was readmitted and he generally saw resident when they were readmitted . Dr. # 1 said there were 3 residents in the facility with the same last name as Resident # 75 and he saw one of the other residents with that last name. Record review of the facility's revised August 2008 Physician Services policy and procedure read in part: . Physician visit, frequency of visits, emergency care if residents, etc. are provided in accordance with current OBRA regulations and facility policy. According to CMS Form 672 the facility census was 85.
F 0425 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 observation, interview, and record review the facility failed to provide pharmaceutical services that included a procedure for the accurate administration of all drugs and biologicals to meet the needs of 1 of 9 residents (Resident # 49) reviewed for medication administration. -Resident #49 received received 2 drops of Tobramycin into her left eye when 1 drop was the ordered dose. This deficient practice affected 1 resident and placed an additional 84 residents at risk for not receiving their medications as ordered which could result in physical complications and a decline in health status. Findings Include: Record review of Resident # 49's face sheet revealed the [AGE] year old admitted to the facility on [DATE] and had the following [DIAGNOSES REDACTED]. Observation on 2/12/14 at 7:55 AM revealed MA D administering medications to Resident # 49. MA D was observed instilling 2 drops of Tobramycin (Tobradex) in the resident's left eye. A third drop fell on the resident's cheek. Record review of Resident # 49's February 2014 physician orders [REDACTED]. Record review of Resident # 49's February 2014 MAR indicated [REDACTED]. It was signed as given at 9:00 AM on 2/12/14 by MA D. In an interview on 2/13/14 at 7:40 AM, MA D stated she administered 2 drops of the medication into Resident # 49's left eye. When asked to look at the Resident's MAR, MA D stated now it says one. I thought it said 2. When asked if she administered the correct dose, she stated I guess not. In an interview on 12/13/14 at 1:15 PM, the DON stated MA D had told her she had messed up the eye drops for Resident # 49. The DON stated it was not following physician orders [REDACTED]. Record review of the facility's policy revised April 2010 Physician Medication Orders, read in part, .Medications shall be administered only upon the written order. Record review of the facility's policy Procedure for Medication Administration, revised 10/1/12 read in part, . To administer medications in a safe and effective manner. c) Compare medication label to directions for use on the MAR for accuracy. According to CMS 672 the census was 85.
F 0431 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmacy services to meet the needs of each resident in all aspects of the provision of pharmacy services in 1 of 1 medication room, 2 of 2 storage room (closets), 4 of 5 medication/treatment carts, and 1 of 84 residents (Resident #54) rooms. -The storage closet on Hall 5 that contained the over the counter medications was unlocked on 2/11/14 at 10:50 AM with no staff in or near the room. -Hall 1, 2, and 3 Nurse Medication Cart was locked but the bottom drawer was not closed on 2/11/2014 at 12:25 PM. The medication cart contained the following: -Medication Patches, eye drops, and oral medication were stored in the same section of the medication cart. -A Novolog Flexpen not labeled with the date it was opened. -Hall 1, 2, and 3 Medication Aide Medication Cart revealed the following: -eye drops were stored next to by mouth medication. -Six tablets of Clonidine HCL 0.1 mg with an expiration date of 6/18/2014. -A can of Protein Supplement Powder with an expiration date of 12/8/2014. It was labeled with two open dates, 1/14/2014 and 2/2/2014. -Stored in the same compartment without dividers was nasal spray, patches and by mouth medications. -One of the locked compartments for the narcotics was not affixed to the medication cart. It could be lifted off of the medication cart partially -Treatment Medication Cart was unlocked and unattended on 2/12/2014 at 10:05 AM. -Medication Room contained the following: -A bottle of Gas Ban with an expiration date of November 2014. -One Acetaminophen Suppository 650 mg with an expiration date of 9/7/2013. -11 Acetaminophen Suppositories 650 mg with an expiration date of 6/11/2013. -Formula Storage Room contained a 1500 cc bottle of Jevity 1.5 with an expiration date of 12/31/2013. -The Medication Cart for Hall 2, 5 and 6 contained a bottle of Atropine Solution 1% that expired 8/13, a blister pack of Hydrocodone 10/325 mg that had a ripped foil and tape securing one tablet, a locked narcotic compartment (middle drawer) could be removed from the medication cart and 7 blister packs of narcotics with the count sheet around them for discharged residents. -A unopened bottle of Alleviate Joint Supplement was observed in resident # 54's room. These failures had the potential to affect the security, potency and efficacy of medications which could cause a risk for drug diversion, a decline in the health status and a delay in treatment for [REDACTED]. Findings include: Storage Closet for over the counter medications Observation on 2/11/14 at 10:50 AM revealed the storage closet door, which contained the facility's over the counter medication supply, was closed, but unlocked. Inside the closet were bottles of over the counter medications, such a Tylenol, vitamins and stool softeners on shelves from the floor level and higher. The closet was on a resident hallway (Hall 5) and there were no staff members nearby. In an interview on 2/11/14 at 10:50 AM, the DON stated the closet should not be unlocked and it was the responsibility of the nurses and medication aides make sure it was locked. She stated it should be locked so no one could just access it who was not supposed to. Hall 1, 2, and 3 Nurse Medication Cart Observation of the Hall 1, 2, and 3 Nurse Medication Cart on 2/11/2014 at 12:25 PM revealed the medication cart was unlocked but the bottom drawer was not closed. There was no staff near the medication cart. In an interview with the MA B on 2/11/2014 at 12:27 PM she said the drawer on the medication cart was not closed and it was the nurse medication cart. She said a resident could get into the cart and take things, medications. Observation of the Hall 1, 2, and 3 Nurse Medication Cart revealed the following: -Medication Patches, eye drops, and oral medication were stored in the same section of the medication cart. -A Novolog Flexpen not labeled with the date it was opened. In an interview with LVN A on 2/11/2014 at 3:47 PM she said the Novolog insulin should have been labeled with the date it was opened. When asked about the internal medication being stored with the external medication she said that was how the facility kept stock. Hall 1, 2, and 3 Medication Aide Medication Cart Observation of the Hall 1, 2, and 3 Medication Aide Medication Cart on 2/11/2014 at 3:17 PM revealed the following: -eye drops were stored next to by mouth medication. -Six tablets of Clonidine HCL 0.1 mg with an expiration date of 6/18/2014. -A can of Protein Supplement Powder with an expiration date of 12/8/2014. It was labeled with two open dates, 1/14/2014 and 2/2/2014. -Stored in the same compartment without dividers was nasal spray, patches and by mouth medications. -One of the locked compartments for the narcotics was not affixed to the medication cart. It could be lifted off of the medication cart partially In an interview with MA C on 2/11/2014 at 3:17 PM she was asked how the medication should be stored on the medication cart. She said you were supposed to have all the eye drops together and then all the pills. She further stated there was no space on the medication cart. She said she checked her medication cart every day for expired medications, especially the over the counter medications. She acknowledged the expiration date of the Clonidine and the Protein supplement. Medication Cart for Halls 2, 5 and 6 Observation on 2/11/14 at 3:25 PM of the medication cart for Hall 2, 5 and 6 contained the following; -a bottle of Atropine Solution 1% that expired 8/13 -a blister pack of Hydrocodone 10/325 mg that had a ripped foil and tape securing one tablet. -the locked narcotic compartment (middle drawer) could be removed from the medication cart. -3 blister packs of Lorazepam for a discharged resident, 1 with 6 tablets, 1 with 30 tablets, and 1 with 60 tablets, with their count sheets secured to them with an elastic band. -4 blister packs for a discharged resident, 1 with 25 tablets of Xanax 0.5 mg, 1 with 29 tablets of Xanax 1 mg, 1 with 60 tablet of Hydrocodone and 1 with 30 tablets of Hydrocodone. Their count sheets were secured with an elastic band around them. In an interview on 2/11/14, MA F stated you were not supposed to tape narcotics because you could not be sure it belonged to the resident, and the tablet should been destroyed. She stated she did not always check to see if they had been taped. She stated that was the practice to put the count sheet around the narcotic with an elastic band when a

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NAME OF PROVIDER OF SUPPLIER **HUMBLE HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **93 ISAACKS RD HUMBLE, TX 77338**	

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F 0431 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 15) resident discharged . In an interview on 2/11/14 at 2:35 PM, the DON stated narcotics that were discontinued or for discharged residents should not be kept in the drawer with the count sheet, and should be brought to her. Treatment Medication Cart Observation of the treatment medication cart on 2/12/2014 at 10:05 AM revealed it was unlocked and unattended when LVN B was in Resident # 54's room. The cart was in the hall next to Resident # 54's room with the drawer section of the cart facing out to the hallway. It was locked by LVN B when she exited the room. Medication Room Observation of the Medication Room on 2/11/2014 at 4:04 PM revealed the following: -A bottle of Gas Ban with an expiration date of November 2014. -One Acetaminophen Suppository 650 mg with an expiration date of 9/7/2013. -11 Acetaminophen Suppositories 650 mg with an expiration date of 6/11/2013. These medications were placed in a large open box with discontinued medications by the DON. In an interview with the DON on 2/11/2014 at 4:08 PM she was asked how often the medication carts and the medication room were checked for expired mediations she said the staff was supposed to do it every week. She said the medication room was checked not too long ago. She acknowledged the expiration dates on the bottle of gas ban and the suppositories. Formula Storage Room Observation of the Formula Storage Room on 2/11/2014 at 4:20 PM revealed a 1500 cc bottle of Jevity 1.5 with an expiration date of 12/31/2013. It was removed from the storage room by the DON. In an interview with the DON on 2/11/2014 at 4:20 PM she acknowledged the expiration date on the Jevity. Resident #54 Review of Resident #54's current medical records revealed she was admitted to facility on 8/9/13. Her [DIAGNOSES REDACTED]. She was [AGE] years old. Review of the Resident #54's monthly physician's orders [REDACTED]. Review of her most recent quarterly MDS dated [DATE] revealed she scored a 15 out of 15 for her cognitive/decision making skills. Review of the care plans updated 1/22/14 revealed no plan of care for self-administration of medications. Observation of Resident #54's on 2/11/14 at 9:10 AM revealed a unopened bottle of Alleviate joint supplement 120 tablets on her window sill. In an interview with Resident #54 on 2/11/14 at 9:10 AM she was asked if the joint supplements were her's, she said Yes, they are mine. My friend gave them to me. I haven't opened them and I don't plan on taking them. When asked if the nurse could remove the supplements from her room, she said No, I want them there. In an interview with the DON on 2/12/2014 at 8:10 PM she was asked about over the counter supplements being left in a resident room she said they try to catch when a resident had them but sometimes the family will bring them in. She said they then try to get an order for [REDACTED]. When asked about the compartment on the medication carts that had the narcotics she said the pharmacy came out to the facility and picked them up and would bring them back tonight. She further stated prior to yesterday no one had come to her about the drawers. When asked how the medications should be stored in the medication cart she said the oral medication should be stored separate from the external medication. She said the pharmacy checked the medication carts once a month and she spot checked once a month. When asked about the discontinued narcotic left on the medication cart she said they should be turned into to her or the ADON. She said they were to be counted if on the cart. She further stated someone misappropriate the drugs. When asked about tape over the foil backing of the blister pack the DON said if the mediation falls out it should be wasted. She further stated the tape compromises the integrity of the package and someone could put in a medication that looks like the narcotic. When asked what should be done when insulin was opened she said it should be labeled with the date when it was opened. The DON said the Novolog flexpen was good for 28 days once opened. In an interview with the DON on 2/14/14 at 4:15 PM she stated the medication carts need to be locked at all times if unattended as a resident could get into the cart. Record review of the facility's policy titled Medication Storage in the Facility, 4. Bedside Storage of medications, Revised 10/1/12, read in part, Policy: Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. Record review of the facility's policy Controlled Substances, revised December 2011 read in part, . The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances .8. Unless otherwise instructed by the Director of Nursing Services, when a resident refuses a non-unit dose medication or it is not given, or receives partial tablets or single dose ampules, or it is not given, the medication shall be destroyed, and may not be returned to the container . Record review of the facility's policy Disposal of Medications and Related Supplies, revised 10/1/12, read in part, . Discontinued Medications . When medications are discontinued by physician order, a resident is transferred or discharged and does not take medications with him/her, or in the event of resident ' s death, the medications become the property of the facility and are marked on the prescription label as discontinued and destroyed, or may be returned to the issuing pharmacy as permitted . B. Expired Medications. When medications are expired, the medication become the property of the facility and will be removed from the medication storage area and stored in a designated area for expired medications until destroyed . Record review of the facility's policy Storage of Medications revised April 2007 read in part, . The facility shall store all drugs and biological in a safe, secure, and orderly manner . 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biological. All such drugs shall be returned to the dispensing pharmacy or destroyed. 5. Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications .7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, cart, and boxes.) containing drugs and biological shall be locked when not in use, and trays or cart used to transport such items shall not be left unattended if open or otherwise potentially available to others . Record review of the facility's policy Security of Medication Cart revised April 2007 read in part, . The medication cart shall be secured during medication passes . The nurse must secure the medication cart during the medication pass to prevent unauthorized entry . 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being use, it must be locked and parked at the nurse's station or inside the medication room . Record review of the facility's policy Medication Storage in the Facility, revised 10/1/12, read in part, . Medications and biological are stored safely, securely, and properly, following manufacturer ' s recommendations or those of the supplier . b . Medication rooms, carts, and medication supplies are locked or attended by person with authorized access. C. Orally administered medications are kept separate from externally use medications, such as suppositories, ointments and lotions .h. Potentially harmful substances (such as . household poisons, cleaning supplies, disinfectants) are clearly identified and stored in a locked area separately from medications .o . Dated insulin vials when first opened .r. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures form medication disposal . According to CMS 672 the census was 85.
F 0441 **Level of harm -** Minimal harm or potential for actual harm **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 the facility failed to ensure that the resident smoking area was clean and free from bird excretement, 5 of 7 CNAs (CNA I, C, B, A and G), 2 of 3 MAs (MA A and MA D), 3 of 4 LVNs (LVN B, LVN E, LVN A), and 1 of 2 PTAs (PTA B) were able to demonstrate competency in infection control for 11 of 16 residents (Residents # 1, 29, 30, 54, 71, 72, 75, 65, 39, 25 and 49) observed receiving incontinent care, catheter care, wound care and medication administration as evidenced by: -CNA I did not wash or sanitize her hands during incontinent care to Resident # 1. She placed a bottle of peri-wash spray that had been used during the care back into the supply cabinet without cleaning it. -CNA C did not fully clean all areas of the resident skin that had come in contact with urine when she provided incontinent care for Resident # 29. She placed the clean bed pad under the soiled wet pad. She carried the bottle of peri-wash out into the hall that had not been sanitized and then returned it to the room. CNA D left the room after the care was complete without washing her hands. -LVN B did not wash her hands before she left the room after she provided wound care for Resident # 30. She used the same area of the gauze when she patted the wound dry. -LVN B did not cleanse or sanitize her scissors or pen before she placed them on the clean barrier when she was providing wound care for Resident # 54. She placed a medication cup on top of the TAR book that she later placed on the clean barrier and then on the clean gauze that when then placed on Resident # 54's wound. She left the room without washing her hands. -CNA B placed clean gloves on top of the refrigerator in the resident's room with cleaning or sanitizing it first when providing peri-care for Resident # 54. She placed the clean bed pad under the soiled bed pad. She did not wash or sanitize her hands after cleaning the resident before touching the clean bed pad. She placed the pillow case with the soiled linen next to the resident's head. She left the room without washing her hands. -CNA A did not clean all the areas of the Resident # 71's skin that had been in contact with urine. CNA A did wash or sanitize her hands each time she changed her gloves during the care. CNA A

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F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 16) and CNA B did not change their gloves nor wash their hands after handling the wet bed pad before touching the bed pad and bed linen. They did not cleanse the mattress when it was wet from urine. They left the soiled linen in the room when they left the room. -MA A did not wear gloves when she handled a tissue that Resident # 72 spit food that was in his mouth into. -CNA G did not wash her hands before she provided indwelling urinary catheter care for Resident # 75. She did not thoroughly clean the resident when providing the care. The catheter rested on the soiled brief when it was being cleansed. She placed the catheter drainage bag on the floor when she emptied it. She left the room without washing her hands. -There was an unlabeled urinal and urine specimen container (that is placed on the toilet between the seat and the bowl) that were laying on the back of the toilet in Resident # 65's bathroom. -LVN A did not wash or sanitize her hands after removing her gloves after administering medications to Resident # 39 and # 25. -MA D did not wash or sanitizer her hands after she removed her gloves after administering medications to Resident # 49. These failures affected 11 residents and placed an additional 74 residents at risk for cross contamination and the development of infection. Findings include: Resident Smoking Area Observation of the resident use smoking area on 2/13/2014 2:36 PM revealed a large amount of bird excrement covering the resident use table and chairs. Bird excrement has the potential to carry an illness known as histoplasmosis. Record review of the CDC website definition of Histoplasmosis read in part; Histoplasmosis is a disease caused by the fungus Histoplasma capsulatum. The fungus lives in the environment, usually in association with large amounts of bird or bat droppings. Lung infection can occur after a person inhales airborne, microscopic fungal spores from the environment. .The symptoms of histoplasmosis are similar to pneumonia, and the infection can sometimes become serious if it is not treated. In an interview on 2/14/14 at 4:15 PM, the DON stated the area should be cleaned. She stated the bird dropping could be a way to contract a disease and was nasty. Resident # 1 Record review of Resident # 1's face sheet revealed the [AGE] year old admitted to the facility on [DATE] and had the following diagnoses; mental disorder, altered mental status, fractured radius, [DIAGNOSES REDACTED], Alzheimer ' s disease and dementia with behavior disturbance. Record review of Resident # 1's admission MDS assessment dated [DATE] revealed he was always incontinent of bowel and bladder and required limited assistance of 1 person for toileting needs. Record review of Resident # 1's admission care plan revealed a care plan for bowel and bladder incontinence and for staff to check for incontinence every 2 hours. Observation on 2/12/14 at 9:16 AM of CNA I providing incontinent care of urine and bowel movement to Resident # 1 on his bed. CNA I washed her hands, put on gloves and removed the resident's pants. She undid the brief, and cleaned the Resident's front peri-area using a spray bottle of peri-wash and a towel. Without changing gloves, she picked up bottle of peri-wash with her dirty hand and sprayed and cleaned his front area again. CNA I removed her gloves, and without cleaning her hands, put on new gloves and rolled the resident on his right side. She tucked the dirty brief (stool and urine) under him and then rolled the resident onto his left side and removed the dirty brief. She tucked a clean towel under the resident, picked up the peri-wash, placed it on the towel next to the resident and put the dirty brief in a bag. She then removed her gloves, during which time the resident rolled onto his back and onto the spray bottle of peri-wash. CNA I, without cleaning her hands, put on new gloves and rolled the resident on his side. She picked up the bottle of peri-wash and a towel, and cleaned the resident's bottom of stool, placing the bottle on the resident's wheel chair. CNA I then removed her gloves, and without cleaning her hands, opened the dresser and got out a clean brief (pull-up). She put on new gloves and put the pull-up on the resident, removed the dirty sheet from the bed and removed her gloves. CNA I then went to the closet, got a clean pair of pants, put on new gloves and put them on Resident # 1. CNA I then removed her gloves and washed her hands. The spray bottle of peri-wash, along with a box of gloves and towel was in the resident's wheel chair. CNA I made the resident ' s bed with clean sheets, picked up the dirty bottle of peri-wash and without cleaning it, placed it into a cupboard in the shower room. In a telephone interview on 2/13/14 at 1:37 PM, CNA I stated when she was cleaning Resident # 1 of stool, she thought she had washed her hands during the care and that she would normally wash her hands and I think I did wash my hands between. She stated we always wash before and after care. When asked about the bottle of peri-wash, she stated she had placed it in the chair and put it back into the supply cabinet in the shower room. She stated she cleaned it off when she put it in the cabinet. When asked if the bottle was clean, she said no but that she thought she had changed her gloves. When asked if she washed her hands after cleaning the resident of stool, she said no. Resident # 29 Record review of Resident # 29's face sheet revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. She was [AGE] years old. Record review of Resident # 29's significant change MDS assessment with 1/11/2014 ARD date revealed she had long term and short term memory problems. Her cognitive skills for daily decision making were severely impaired. She needed extensive assistance of one person with bed mobility, dressing and toilet use. She had total dependence of one person for personal hygiene. She was always incontinent of urine and bowel. Record review of Resident # 29's 1/11/2014 updated care plans revealed the following care plans: -I am always incontinent of urine related to my inability to feel the urge. The approaches included: Assist me with perineal cleansing as needed. -I am always incontinent of bowel related to my inability to feel the urge. Observation was conducted of CNA C and CNA D providing incontinent care for Resident # 29 on 2/12/2014 at 10:15 AM. The clean pad, two wash clothes, and a bottle of peri-wash were sitting on the bed near the foot of the bed when the room was entered. CNA D changed her gloves after moving the bed without washing or sanitizing her hands. When the covers were pulled down the resident urinated and the urine got on her thighs almost to the knee area. CNA C sprayed peri-wash on a dry wash cloth that she then used to clean the resident. When she finished cleansing the peri-area in the front she placed the soiled wash cloth on the bed pad where it rested against the resident's right outer thigh. She did not clean the resident's thighs where they had become wet from the resident urinating. CNA C used a clean wash cloth to pat the resident dry in the front. She then sprayed peri-wash on this same wash cloth to cleanse the resident rectal and buttock area. After cleaning this area she turned the wash cloth and used the same wash cloth to pat the resident dry. CNA C placed the clean pad under the soiled pad that was rolled under the resident. The resident was not wearing a brief and when she urinated the urine wet the pad. When the resident was turned to her other side the plastic bag used for the soiled linen fell on the floor. CNA C picked it up and handed it to CNA D when then placed it on the bed. CNA D touched the soiled pad and then the clean bed pad. CNA D left the room without washing or sanitizing her hands. CNA C left the room holding the bottle of peri-wash and went into the hall. She then returned to the room and placed the bottle of peri-wash in the resident's dresser drawer. In an interview with CNA C on 2/12/2014 at 12:43 she said she documented the care she provided in the computer. She further stated she tried to document twice during her shift in the computer. CNA C said most of the time she document only once during the shift. She said if there was new wound on a resident she would tell the nurse immediately. She further stated she had discovered previous wounds and the nurse had come to look at them immediately. When asked about the incontinent care with Resident # 29 she said she did not wash the resident's thighs when she provided the care. When asked what could happen if urine was left on the skin she said the resident could get a rash or sores. She said she usually use wet wash cloths when she provided incontinent care. When asked about the soiled washcloth resting against the resident leg she said they were supposed to put soiled linen in the bag. She further stated the dirty linen could make her side dirty. When asked about using the same wash cloth that she dried the resident with to clean her she said they were short on towels and she kept turning the washcloth when she used it. She said using the washcloth could cause cross contamination and the resident would not really be clean. When asked about tucking the clean pad under the soiled bed pad she said it could cause cross contamination and touching the dirty pad and then the clean pad could cause cross contamination. When CNA C was asked about leaving the room with the peri-wash she said normally does not leave in the room. She stated they wipe it off and sit it on the clean linen cart. When asked if they use the bottle of peri-wash for more than one resident she said yes, they just use it on the towel to clean the resident. Observation of Resident # 29's room on 2/14/2014 at 8:35 AM revealed the syringe used during the care for [DEVICE] was resting on a paper towel open to air. In an interview with CNA D on 2/14/2014 at 12:12 PM she said no one in the facility had watched her perform incontinent care. She then said she had training and did a return demonstration for LVN D. She said when the resident urinated on her legs and they were not cleaned it could cause cross contamination, get an infection or irritation to the skin. She said when you use peri-wash you were supposed to use a wet washcloth. CNA D stated when gloves were removed your hands were not clean and you were supposed to wash your hands before you put on a new pair. When asked about reaching into a box of gloves with hand that had not been washed you could contaminate the box. She said your hands should be washed after closing the door to the room, when you finish cleaning the resident from the front, anytime get anything on your gloves, and when leave the room. She said if you do not wash hand before leave the room you could contaminate what you touch. When asked about the bag for the soiled linen dropping on the floor and then being placed on the bed she said it could contaminate the bed. She said the clean bed pad under the soiled bed bad would make the clean bed pad dirty and contaminated. Resident # 30 Record review of Resident # 30's face sheet revealed she was admitted to the

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F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 17) facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. She was [AGE] years old. Observation was conducted of LVN B providing wound care for Resident # 30 on 2/13/2014 at 9:33 AM. After she applied saline to the wound when she was patting it dry she did use the same area of the gauze on some the areas. She left the room without washing or sanitizing her hands after the care. She went to the treatment cart and used hand sanitizer. She returned to the room, put on gloves and cleaned her marker with alcohol wipe and then placed it in her pocket. She then gathered the trash bag and left the room without was washing or sanitizing her hands. Resident # 54 Record review of Resident # 54's face sheet revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. She was [AGE] years old. Record review of Resident # 54's quarterly MDS assessment with a 1/22/2014 ARD date revealed her BIMS score was 15 out of 15 which means the resident was cognitively intact. The functional status section of the assessment revealed she needed extensive assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene. The assessment further revealed the resident was always incontinent of bowel and urine. Record review of Resident # 54's care plans revealed the following care plans: -I am always incontinent of urine. The problem onset date was 8/9/2012. The approaches included: Provide incontinence pads. Assess for environmental factors that may contribute to my incontinence. Assist me with perineal cleansing as needed. -I am always incontinent of bowel. The problem onset date was 8/9/2012. The approaches included: Assess for environmental factors that may contribute to my incontinence. Teach me about factors affecting bowel control. Provide me verbal cueing. Observe mu skin daily for irritation and redness. Observation was conducted of LVN B providing wound care for Resident # 54. She placed a wax paper barrier on top of the cleaned over the bed table. She then placed scissors and a permanent marker on top of the barrier without cleansing or sanitizing them first. She placed a plastic medication cup on top of the TAR binder and put the ointment she used during the treatment in the plastic cup. She then placed the plastic cup on top of the wax paper barrier. LVN B cleansed the scissors with an alcohol wipe and then used them to cut the dressing off Resident # 54's right foot. When she removed the outer dressing she laid it on the resident ' s bed. She placed the scissors back on the wax paper barrier. She placed the plastic sup on top of the clean gauze and used a tongue depressor to remove the ointment form the medication cup which she then used to apply the ointment to the gauze when the mediation cup had been resting. LVN B then placed that gauze directly on the resident ' s right heel pressure sore. When she finished the care she used an alcohol wipe to cleanse the scissors. She did not open the scissors and clean the cutting portion of the scissors. She left the room with scissors and placed them on top of the medication cart and then inside the treatment cart. She then went to the linen cart and obtained a towel. She used the towel to wipe/dry the top of the over the bed table. She did not used cleanser to wipe the table. After wiping the table she removed her gloves and without washing her hands left the room. In an interview with LVN B on 2/14/2014 at 7:35 AM she said her scissors and pen should be cleaned before they were set down on the barrier and failing to do so could contaminate the barrier. When asked how the scissors should be cleaned she said they should be opened to clean and not opening them could spread infection. When asked about placing the medication cup that she put medication in on top of the book of TARs and then placing it on the barrier she said it was not clean and could transfer germs to the barrier and possibly contaminate it. When asked about the same medication cup resting on top of the gauze she said the gauze could be contaminated. She said the soiled dressing should be placed in a biohazard bag when they were removed. When asked about Resident # 46 ' s dressing being on her bed she said it could contaminate the bed. When asked how long hands should be washed she said 5 seconds. She said hands should be washed before leaving the room and dialing to do so could cause cross contamination. When asked about using just a towel on the table she said it was to absorb the saline she spilled. She further stated it should be cleaned with bleach wipes. Observation was conducted of CNA B and CNA E providing peri-care for Resident # 54 on 2/12/2014 at 10:40 AM. CNA B placed a handful of gloves on top of the refrigerator next to the resident ' s bed. She did not clean the top of the refrigerator and there was not a barrier on top of the refrigerator. CNA B wet the wash clothes in the bathroom sink and then placed those washcloths and a bottle of peri-wash on top of a dry washcloth on top of the refrigerator. CNA B cleansed the resident folds of her thighs before she cleansed the labia. She left the wash cloth she cleansed the labia resting between the resident ' s legs. CNA B rolled the soiled bed pad under the resident and then placed the clean bed pad under the soiled pad. She did change gloves or wash or sanitize her hands after cleansing the resident prior to touching the clean bed pad. The soiled linen was placed in a pillow case that then rested first by the right side of the resident ' s head and then the left side of her head. CNA B left the room without washing or sanitizing her hands. In an interview with CNA B on 2/13/2014 at 1:45 PM she was asked about placing the gloves used during care on top of the refrigerator she said she should have had a base before she placed the items on the table. She further stated those items became dirty and placing them on refrigerator could cause cross contamination. When asked about the peri-wash being left out she said it should be put in a bag where it belongs. She further stated it was left out someone could mistake it for something else and possibly be poisoned. When asked how a female resident should be cleansed in the front she said she cleaned the sides and then the middle area (labia) first. She said failure to do so could cause cross contamination. She said placing the clean pad under the dirty pad could cause cross contamination. She said the dirty line was placed too close to the resident ' s face and the resident could inhale it. CNA B said your hands should be washed agree done with care and opening the door and leaving the room without washing your hands could cause cross contamination. When asked if she had been watching performing peri-care she said she had been watched by the nurse on the floor but not the DON or ADON. In an interview with CNA E on 2/14/2014 at 11:52 AM she said the dirty lien beside the resident ' s head could cause contamination and the resident could get sick, germs. She said placing the clean bed pad under the soiled bed pad could cause cross contamination. She said touching soiled bed pad before the clean pad could cause cross contamination. Resident # 71 Record review of Resident # 71's face sheet revealed he was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. He was [AGE] years old. Record review of Resident # 71's significant change MDS assessment with 12/12/2013 ARD date revealed his hearing and vision was highly impaired. It further revealed he sometimes made himself understood. He rarely/never understands others. It also revealed his cognitive skill for daily decision making was severely impaired. The functional status section of the assessment revealed total dependence of one person with bed mobility, dressing, eating, toilet use and personal hygiene. It further revealed he was always incontinent of bowel and urine. Record review of Resident # 71's care plans revealed the following care plans goal target date of 3/14/2014: -I am always incontinent of urine as I cannot recognize the urge related to effects of aging. The approaches included: Provide incontinence pads. Assist me with perineal cleansing as needed. -I am always incontinent of bowel as I cannot recognize the urge related to effects of aging. The approaches included: Observe my skin daily for irritation and redness. Assess me for constipation/impaction. Assess for environmental factors that may contribute to my incontinence. Observation of CNA A and CNA B providing incontinent care for Resident # 71 on 2/11/2014 at 2/12/2014 at 9:00 AM revealed the resident's gown was soaking wet from upper abdomen to thigh area. The resident was not wearing a brief. CNA A wet wash cloths in the bathroom sink and then set them aside until she was ready to cleanse the resident. CNA A retracted the resident foreskin but did pull in forward after she cleansed his penis. She removed her gloves and without washing or sanitizing her hands she donned clean gloves. When the resident was turned on his side it was noted that the bed pad the resident was laying on was saturated. The plastic covering the bed was wet as well. After CNA A finished cleansing the resident rectal and buttock area she removed her gloves and without washing or sanitizing her hands she obtained clean gloves from the boxes of gloves in the bathroom. CNA A then rolled the wet pad under Resident # 71 and used a dry towel to wipe the mattress. She did not use cleanser on the mattress. She rolled a clean bed pad under the wet pad. They turned the resident and then CNA B used the same towel to wipe the wet mattress. She pulled out the soiled/wet bed pad and without washing or sanitizing her hands she pulled the clean bed pad under the resident. Both CNAs removed the wet hospital gown from the resident. They did not cleanse the resident ' s thighs or abdominal area. They pulled up the residents covers while both wearing the same gloves that had wiped the wet bed and touched the wet bed pad. CNA A gathered the soiled linen and put it in a pillow case that was then placed on top of two pillows without pillow case that were sitting on top of the bedside table. One of the pillows was sitting on top of the syringe that was used for administering medications and water through the resident's [DEVICE]. The container that the syringe was supposed to be stored was open and sitting on a paper towel not in a plastic bag. The container that goes with the syringe was sitting on the table not in a plastic bag. When the CNAs left the room they left the pillow case with the soiled linen in the room. In an interview with CNA A on 2/12/2014 at 9:04 AM she was asked about the resident being extremely wet and when he was last changed. She said she changed the resident at about 6:30 AM. In an interview with CNA A on 2/13/2014 at 1:35 PM she was asked about wetting the wash cloth before care and if they were still warm. She said sometimes they were supposed to have a basin with warm water. When asked what area she should clean when the resident's gown and bed pad was very wet she said where the gown and the wet bed pad

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUMBLE HEALTHCARE CENTER	**93 ISAACKS RD HUMBLE, TX 77338**

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F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 18) touched the resident. She further stated you were supposed to wipe that part or the resident could get irritated or skin breakdown. When asked about providing care to a resident that was not circumcised she said you were supposed to pull back the foreskin and them pull it forward when done. CNA A said hands were not clean when gloves were removed. She further stated hands were dirty and you were supposed to wash your hands. When asked about the wet bed she said she should have had a wet washcloth and a dry one. She further stated that would have cleaned the bed. She said she just dried the bed. When asked if she had been watched performing incontinent care she said she had been watched by the ADON. When asked about rolling the clean bed pad under the soiled bed pad with soiled pad resting on top of the clean bed pad she said the clean bed pad just becomes soiled. She further stated she should have changed her gloves, washed her hands and put on gloves after touching the soiled pad. When asked what could happen when she did not do so she said, I don ' t know. When asked about the soiled linen being left in the room she said she was supposed to take it out and she had went to get a barrel to take it out of the room. When asked what could happen with the tube feeding syringe being open on the table under the pillows and the soiled linen she said, I don ' t know nurses deal with that. When asked about the peri-wash being left out she said a resident can get the peri-wash. In an interview with CNA B on 2/13/2014 at 1:45 PM she was asked when she should change gloves during incontinent care she said after cleaning the resident from the front, the back, and after touching the dirty brief. When asked about touching the clean areas after touching the dirty brief she said it could cause cross contamination. When asked about the wet bed she said it should have been disinfected and she should have made sure it was dry prior to putting on the clean linen. She said failing to do so could lead to bacterial or cross contamination to the clean sheets. When asked about the syringe on the bedside table she said it could cause cross contamination with those items. When asked about the linen being left in the room she said you should have a bag for the linen and one for the trash. Resident # 72 Record review of Resident # 72's face sheet revealed he was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Observation of Resident # 72 on 2/11/2014 at 10:00 AM revealed he was in bed and MA A was administering water. She told the resident to spit what was in his mouth in the tissue. She handed the tissue to the resident and took the tissue back from the resident after he had spilt into it. She was not wearing gloves. In an interview with MA A on 2/14/2014 at 12:09 PM she was asked about handling the tissue without gloves. She said it could cause cross contamination and you could catch germs. Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Record review of Resident # 75's significant change MDS assessment with ARD date of 12/18/2013 revealed the resident had a short term and long term memory problem with modified independence with cognitive skill for daily decision making. The functional status section of the assessment revealed she needed extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. Ambulation did not occur during the assessment period. She had total dependence with locomotion on and off the unit of one person and with bathing. She had a range of motion limitation on one side of the lower extremity. The bladder and bowel section of the form revealed she had an indwelling urinary catheter and was always incontinent of bowel. She was not able to answer the question of the presence of pain. It further revealed the staff assessment did not reveal the prescience of pain. She had history of fall. The skin section revealed the resident was at risk of developing a pressure ulcer but currently did not have pressure ulcer. She had a pressure reducing device or bed. The Care Area Assessment (CAA) Summary revealed the following areas for care area triggered and care plan decision: ADL function, urinary incontinence/indwelling catheter, falls, nutritional status, pressure ulcer and psychotropic drug use. Record review of Resident # 75's 12/18/2013 updated care plan revealed the following care plan: -I am always incontinent of bowel. The approaches included observe my skin daily for irritation and redness. There were no approaches related to incontinent care. -I use an indwelling catheter. The approaches included catheter care for me every shift. Observation was conducted of PTA B and PTA C providing wound care for Resident # 75 on 2/12/2014 at 11:00 AM. The supplies had been set up prior to the observation. PTA B picked up a piece of gauze that she said was wet with normal saline, with tweezers and then wrapped a portion of the gauze around cotton tipped applicator. She cleansed the wound while continuing to wrap the gauze around the cotton tipped applicator. At time the same section of the gauze was used to cleanse a different area of the wound and there was some back and forth motion with the cleansing. She did not wash her hands for 15 seconds after she removed her gloves when she finished cleansing the wound. PTA B then placed a piece of gauze that had a line of ointment on it that she said was Santyl over the wound, wrapped the heel with rolled gauze and secured with tape. In an interview with PTA B on 2/13/2014 at 1:12 PM she was asked about cleaning the wound in back and forth motion. She said it can disturb the granulation tissue and you could have contamination from one part of the wound to another part of the wounds. When asked how long hands should be washed she said 20 seconds. She said hands were not clean when gloves were removed and should be washed. Observation was conducted of CNA G providing catheter and peri-care for Resident # 75 on 2/13/2014 at 11:37 AM. She obtained supplies from the linen cart in the hall and placed a handful of gloves in the pocket of her uniform. When she entered the room she said I forgot to knock on the door. She placed the supplies on the resident's over the bed table next to her box of tissue, denture cup. She did not clean the table prior to setting the supplies on it. She donned gloves from her pocket without washing or sanitizing her hands. CNA G then went into the bathroom and filled a basin with water and obtained a urinal. She placed the basin on top of the resident ' s wheel chair cushi
F 0465 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interview and record review, the facility failed to provide a safe, clean, comfortable and homelike environment for residents, as evidenced by: - Room 200, the bathroom sink was observed to be turned around backwards and not operational. - Room 206, the hard plastic door guard glued to the door was observed to be half off the door. - Room 212, 4 screws and 1 nail were observed in the wall of the room. The resident's air conditioning unit was observed to be non-functioning. - Room 214, the room's air conditioning unit was observed to have no knob. The dresser in the room was observed to have broken drawers and 5 screws were observed in the bathroom door. - Room 213, a hole in the dry wall was observed between resident bed A and the room's door. - Room 211, screws were observed in the room's door. There was a missing piece of floor board next to the bathroom and the wall exposed was observed to be crumbling. - Room 209, the hard plastic door guard glued to the door was observed to be coming off the door. A hole was observed in the wall by the closet. - Room 400, the dresser in the room was observed to have broken drawers. - Room 404: 2 unwrapped, unlabeled gray basin on the bathroom floor. - Room 401: denture cup with liquid soap inside and an unlabeled toothbrush on the back of the toilet cover. - Room 407: a bottle of nail polish remover, an unwrapped, unlabeled gray basin in a wire rack on the bathroom wall, an unopened bottle of over the counter joint supplement. - Room 410: a pair of ladies panties on the bathroom floor and a broken dresser. - Broken A/C unit on the wall of the 400 hall. - Room 502, there was a liquid on the bathroom floor and a jagged mirror propped behind the sink faucet in the bathroom. - Observations on 2/13/2014 of the facility's exterior physical environment revealed resident safety hazards in different areas surrounding the building. - The shower room on Hall 2 (secure unit) was observed to be unlocked with an open bottle of shampoo/body wash sitting on a shower chair. - Exposed wires were observed hanging from the wall in the facility's restorative dining room. - In the facility's laundry room, a 4 inch by 4 inch hole in the ceiling and a hole in the wall was observed. This failure placed all 85 residents in the facility at risk for decreased quality of life, fire injuries, smoke inhalation, burns, hospitalization , and/or death. Findings include: Observations during initial tour on 2/11/2014 of Hall 2 (secure unit) revealed the following: - 8:40 AM: Room 200, the bathroom sink was observed to be turned around backwards and not operational. - 9:10 AM: Room 206, the hard plastic door guard glued to the door was observed to be half off the door. - 9:30 AM: Room 212, 4 screws and 1 nail were observed in the wall of the room. The resident ' s air conditioning unit was observed to be non-functioning. - 9:42 AM: Room 214, the room's air conditioning unit was observed to have no knob. The dresser in the room was observed to have broken drawers and 5 screws were observed in the bathroom door. - 9:52 AM: Room 213, a hole in the dry wall was observed between resident bed A and the room's door. - 10:02 AM: Room 211, screws were observed in the room's door. There was a missing piece of floor board next to the bathroom and the wall exposed was observed to be crumbling. - 10:06 AM: Room 209, the hard plastic door guard glued to the door was observed to be coming off the door. A hole was observed in the wall by the closet. Observations during initial tour on 2/11/2014 of Hall 4 revealed the following: - 10:30 AM: Room 400, the dresser in the room was observed to have broken drawers. - Room 404: 2 unwrapped, unlabeled gray basin on the bathroom floor. - Room 401: denture cup with liquid soap inside and an unlabeled toothbrush on the back of the toilet cover. - Room

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NAME OF PROVIDER OF SUPPLIER **HUMBLE HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **93 ISAACKS RD** **HUMBLE, TX 77338**	

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F 0465 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 19) 407: a bottle of nail polish remover, an unwrapped, unlabeled gray basin in a wire rack on the bathroom wall, an unopened bottle of over the counter joint supplement. - Room 410: a pair of ladies panties on the bathroom floor. - Broken A/C unit on the wall of the 400 hall. Observation of Room 410 on 2/11/2014 at 12:16 PM revealed the drawers on dresser were broken. Observations during initial tour on 2/11/2014 of Hall 5 revealed the following: - 10:30 AM: Room 502, in the bathroom there was a liquid on the floor and a mirror was propped up behind the sink faucet, leaning against the wall. The mirror had a rough edge to one corner. Observations on 2/13/2014 of the facility's exterior physical environment revealed the following: - 2:06 PM: A metal shed was observed on the outside of the building which had a mud floor. There was also standing water in the shed floor. A light bulb was observed on the ground in the mud in the shed. There was also a water pump with cords plugged into it laying in the mud as well. - 2:08 PM: An exterior hot water heater was observed in a room on the side of the building. The door to the hot water heater was observed to rotten and only partially intact. Water was observed dripping under the hot water heater and a pool of water was observed standing on the concrete floor under the water heater. - 2:16 PM: A black cable was observed laying on the soggy ground between a power pole approximately 50 feet away from the facility, leading to a Telecom box next to the facility wall. - 2:32 PM: A wooden and metal park bench was observed inside the resident's fenced smoking area. The bench was observed to have rotten and broken wood slats which exposed pieces of rusted metal on the bench. - 2:32 PM: A large pile of tangled water hoses were observed against a wall inside the resident's fenced smoking area. - 2:34 PM: Cigarettes which were not properly extinguished or disposed of were observed sitting on the window sills and on the ground in the resident smoking area. - 2:34 PM: One chair in the resident smoking area was observed to be constructed of wood and cloth. The cloth was observed to be dirty with bird excrement on the seat. - 2:36 PM: Large amount of bird excrement was observed covering the resident use table and chairs in the resident smoking area. Bird excrement has the potential to carry an illness called histoplasmosis. - 2:38 PM: A concrete pig was observed in the resident smoking area which had two protruding rusty metal wires coming from the top of the head where there pig ' s ears used to be. - 2:44 PM: An unsecured storage shed at the back of the facility was observed which contained tools, wood, paint and containers marked Corrosive. Outside of the storage shed was observed a broken night stand, pile of boards with rusty nails sticking out of them, toilet and a large bin containing empty soda cans was observed with bees swarming around the cans. Also outside of the storage shed were 2 active fire ant beds and standing water on either side of the drive in front of the shed which was approximately 3 feet wide by 15 feet long. - 2:54 PM: An unsecured large shipping container at the back of the facility was observed which contained assorted facility equipment such as wheelchairs and furniture. Observation on 2/11/2014 at 10:20 AM of the secure unit's (Hall 2) shower room revealed the door to the shower room to be unlocked and a gallon jug of Shampoo and Body Wash was observed sitting on a shower chair with no lid on the bottle. Observation on 2/12/2014 at 12:38 PM of the facility's restorative dining room revealed on either side of the dining room, 2 wires were coming out of the wall and hanging approximately 4 feet off the floor. The ends of the wires were observed to be exposed. Observation of the facility's laundry room on 2/14/2014 at 9:40 PM revealed a 4 inch by 4 inch hole in the ceiling and a hole in the wall. In an interview with the DON on 2/14/14 at 4:15 PM she was asked about the resident smoking area, she stated the area should be cleaned. She stated the bird dropping could be a way to contract a disease and was nasty. In an interview with the ADM on 2/14/2014 at 5:58 PM, when asked who was responsible for ensuring equipment in the facility was in good repair, he said the maintenance department. Record review of the facility's Quality of Life - Homelike Environment policy and procedure read in part; Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. .Characteristics of a Personalized, Homelike Setting: 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order; .c. Inviting colors and decor; d. Personalized furniture and room arrangements. This document was dated 10/2009. Record review of the CDC website definition of Histoplasmosis read in part; Histoplasmosis is a disease caused by the fungus Histoplasma capsulatum. The fungus lives in the environment, usually in association with large amounts of bird or bat droppings. Lung infection can occur after a person inhales airborne, microscopic fungal spores from the environment. .The symptoms of histoplasmosis are similar to pneumonia, and the infection can sometimes become serious if it is not treated. Record review of the facility's Cleaning Schedules policy and procedure read in part; Policy Statement: Cleaning schedules shall be developed and implemented to ensure that our facility is maintained in a clean and comfortable manner. Policy Interpretation and Implementation: 1. Cleaning schedules are developed and implemented to assure that each area of our facility is maintained in a safe, clean and comfortable manner. This document was not dated. Record review of the facility's Facility Smoking Policy policy and procedure read in part; Safe Smoking Environment: It is the responsibility of the facility to provide a safe and hazard free environment for those residents having been assessed as being safe for facility smoking privileges. This document was dated 2/21/2013. Record review of the facility's Cleaning and Disinfection of Environmental Surfaces policy and procedure read in part; Policy Statement: Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard. .Non Resident Care Areas: 7. Detergent and water will be used for cleaning surfaces in non resident care areas. .Housekeeping Surfaces: 9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. This document was dated 8/2009. A request was made during the survey for a policy and procedure related to cleaning/removing garbage and/or trash from the facility's property. This document was not provided prior to exit. According to CMS 672 the census as 85.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Be administered in an acceptable way that maintains the well-being of each resident .** Based on observation, interview and record review the facility administration failed to develop and implement a plan for identifying and eliminating potential fire hazards in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one of one facilities when: - The Administrator failed to communicate all safety recommendations adopted by the Safety Committee to the appropriate department within the facility. - The exterior air conditioning vent on the building was observed to have dryer lint built up around the air vent inside the lint trap. Cigarette butts were observed around the lint trap and one lit cigarette was observed one foot from the lint trap in an urn type ashtray. Lint was also observed on the overhang, wall and door surrounding the lint trap. An Immediate Jeopardy (IJ) situation was identified on 02/13/14 at 4:45 p.m. While the IJ was lowered to a non-immediate Jeopardy on 02/14/14 at 3:00 p.m. The facility remained out of compliance at widespread with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. The facility's Plan of Removal of Immediate Jeopardy was accepted at 1:00 pm on 02/14/14 by notification of the Administrator. This failure placed all 85 residents in the facility at risk for fire injuries, smoke inhalation, burns, hospitalization , and/or death. Finding Include: An observation on 2/13/2014 at 3:02 PM of the facility's exterior dryer vent and lint trap revealed the lint trap to be a large metal container approximately 4 feet tall and 3 feet wide with a perforated front to allow for air flow sitting in front of the dryer vent coming out of the facility wall. The dryer was operating at the time of the observation and the metal lint trap was observed to be very hot to the touch. The lint trap was observed sitting on a rotten wood pallet. There was a large amount of lint surrounding the dryer vent inside the lint trap and lint was observed caked against the inside surface of the lint trap. Lint was also observed on the surrounding wall, the fascia board above the lint trap and on the door next to the dryer vent. The door was observed to be in a state of rot and disrepair. Numerous cigarette butts were observed on the ground surrounding lint trap and one cigarette butt laying on the lint in between the lint trap and wall of the facility. A concrete urn style container was observed approximately one foot from the lint trap and contained numerous cigarette butts and one lit cigarette with smoke coming from the cigarette. The lint trap was also observed to be under a pole with power lines coming from the pole and leading to the building. The facility's main power box was observed on the same wall as the lint trap a few feet away and the main generator was observed approximately 10 feet from the lint trap. In an interview with the Housekeeping/Laundry Supervisor on 2/13/2014 at 3:14 PM when asked about the dryer vent and lint trap, he said they cleaned the lint trap on the outside of the building once a month. He also said the area surrounding the dryer vent was a non-smoking area and staff should not be smoking there. He said there was not a no smoking sign in the area. He said he last cleaned the lint trap about one month ago. He also said he had not cleaned behind the lint trap. When asked what could happen with the cigarettes and the dryer lint and the heat from the dryer vent, and he said fire. He also said he did not remember how long the lint trap was sitting on the rotten pallet. He said the chairs and ashtray had been there since December 2013. In an interview

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 20) with the Administrator on 2/14/14 at 5:00 PM he stated he did not know staff was smoking by the outside dryer lint trap. He stated he did not know there was a big build up of lint outside the laundry room. He stated he conducted staff interviews and was than made aware that staff was smoking outside by the dryer lint trap. The staff began smoking there sometime in December when the weather became very cold. The lint trap blew out hot air and the staff was using it as a heater while on their breaks. He said no one thought about it as a fire trap. Continued interview with the Administrator on 2/14/14 at 5:00 PM he stated all staff members were in-serviced before the start of their shift. The wooden pallet was removed and cement blocks were placed underneath the lint trap. The lint trap and the surrounding areas was cleaned of all lint and cigarette butts. The chairs and ash trays were removed from the area. The area was designated a non-smoking area and a no smoking signs were posted outside on the door and next to the dryer lint trap. He stated if anyone is catch smoking in that area they will be discipline immediately. He stated to accommodate the staff and to ensure their compliance they designated a staff smoking area next to the resident smoking area. They began daily checks of the outside lint trap and the surrounding area. The checks will be documented in their TELS monitoring systems program which records dates and information pertaining to action taken by maintenance supervisor. Record review of the facility's Hazardous Areas in the Facility, 2001 MED-PASS, inc. (Revised December 2007) read in part, All hazardous areas in the facility shall be identified with appropriate precautionary signs. 1. All hazardous areas are so designated and can be identified on floor plans posted throughout the facility. 2. Hazardous areas, such as power rooms, boiler rooms, oxygen or other flammable liquids storage rooms, etc., are posted with No Smoking signs. 3. Smoking is prohibited in all hazardous area. 4. The facility's Safety Committee shall recommends measures to ensure that residents cannot access hazards areas in the facility. 5. The Administrator is responsible for communicating all safety recommendations adopted by the Safety Committee to the appropriate department within the facility. Record review of the facility's Facility Smoking Policy policy and procedure read in part; Safe Smoking Environment: It is the responsibility of the facility to provide a safe and hazard free environment for those residents having been assessed as being safe for facility smoking privileges. This document was dated 2/21/2013. The Administrator was notified on 2/13/14 at 4:45 PM that an Immediate Jeopardy situation was identified due to the above failures. The facility submitted their first plan of removal on 2/14/14 at 10:00 AM. The facility's final Plan of Removal was accepted on 2/14/14 at 1:00 PM and included: Immediate action: Removed lint trap and old wooden pallet from the identified area at 3:45 PM 2/13/14. Cleaned lint trap and lint from area around dryer exhaust. Installed non-flammable cement blocks as the base at 4:30 PM 2/13/14. Cleaned lint trap was reinstalled on base to complete the project of cleaning the dryer vent and area at 4:45 PM 2/13/14. Chairs were removed from area and a non-smoking sign was placed in the identified location at 4:55 PM 2/13/14. Completed removal of lint hazard was at 5 PM 2/13/14 by Administrator and maintenance staff. Available staff in-service was initiated at 4:30 PM 2/13/14 on service area by laundry designated non-smoking area and staff new smoking area will be located on back patio same as resident smoking area. Staff not present will be in-serviced prior to starting assigned shifts. Maintenance supervisor was in-serviced 1:1 by Administrator on procedure and frequency of cleaning lint trap at 5 PM on 2/13/14. Documentation of daily checks of lint trap and area will be documented in TELS monitoring systems program which records dates and information pertaining to action taken by maintenance supervisor. Review of the facility's Inservice Training Report dated 2/13/14 read effective immediately the only smoking area is the back patio by the dining room. Smoking is no longer allowed outside the laundry. Failure to comply may result in termination of employment. Signatures from employee CNA's, Nursing staff, Dietary staff, Maintenance staff, and Housekeeping staff on the 6 AM - 2 PM, 2 PM - 10 PM and 10 PM to 6 AM shifts were noted on the inservice. Review of the facility's Inservice Training Report dated 2/13/14 at 5:00 PM read Make daily routine rounds of service area. Checking the dryer lint trap and area around for any hazard of lint accumulation. Take immediate action to remove lint if hazard is found. Document observation and/or any action taken in your TELS monitoring system program the maintenance manager signature was noted on the inservice. The surveyors confirmed the Plan of Removal (POR) had been implemented sufficiently to remove the IJ by: Lint was removed from the external lint trap cage, the surrounding walls, the fascia board, the door, the door cracks and vents and the surrounding grounds. A no smoking sign was posted on the door next to the external dryer lint trap. The ash trays, chairs and cigarette butts were removed from the area. The lint trap was placed on a cement blocks. The IJ was lowered to a non-immediate Jeopardy on 02/14/14 at 3:00 p.m. The facility remained out of compliance at widespread with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. According to the facility's 672 the census was 85.
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 the facility failed to ensure that 6 of 7 CNAs (CNA I, C, B, A, G and H), and 2 of 3 MAs (MA A and MA D) were able to demonstrate competency in providing incontinent care, catheter care, transfers and infection control for 7 of 8 residents ((Residents # 1, 29, 54, 71, 72,75, and 49) observed receiving incontinent care, catheter care, and medication administration as evidenced by: -CNA I did not wash or sanitize her hands during incontinent care to Resident # 1. She placed a bottle of peri-wash spray that had been used during the care back into the supply cabinet without cleaning it. -CNA C did not fully clean all areas of the resident skin that had come in contact with urine when she provided incontinent care for Resident # 29. She placed the clean bed pad under the soiled wet pad. She carried the bottle of peri-wash out into the hall that had not been sanitized and then returned it to the room. CNA D left the room after the care was complete without washing her hands. -CNA B placed clean gloves on top of the refrigerator in the resident's room with cleaning or sanitizing it first when providing peri-care for Resident # 54. She placed the clean bed pad under the soiled bed pad. She did not wash or sanitize her hands after cleaning the resident before touching the clean bed pad. She placed the pillow case with the soiled linen next to the resident's head. She left the room without washing her hands. -CNA A did not clean all the areas of the Resident # 71's skin that had been in contact with urine. CNA A did wash or sanitize her hands each time she changed her gloves during the care. CNA A and CNA B did not change their gloves nor wash their hands after handling the wet bed pad before touching the bed pad and bed linen. They did not cleanse the mattress when it was wet from urine. They left the soiled linen in the room when they left the room. -MA A did not wear gloves when she handled a tissue that Resident # 72 spit food that was in his mouth into. -CNA G did not wash her hands before she provided indwelling urinary catheter care for Resident # 75. She did not thoroughly clean the resident when providing the care. The catheter rested on the soiled brief when it was being cleansed. She placed the catheter drainage bag on the floor when she emptied it. She left the room without washing her hands. -MA D did not wash or sanitizer her hands after she removed her gloves after administering medications to Resident # 49. -CNA H transferred Resident # 83 on 12/25/13 without using the lift and by herself, causing Resident # 83 pain in her knee on 12/25/13. These failures affected 7 residents and placed an additional 35 residents at risk for cross contamination and the development of infection. Findings include: Resident # 1 Record review of Resident # 1's face sheet revealed the [AGE] year old admitted to the facility on [DATE] and had the following diagnoses; mental disorder, altered mental status, fractured radius, [MEDICAL CONDITION], Alzheimer ' s disease and dementia with behavior disturbance. Record review of Resident # 1's admission MDS assessment dated [DATE] revealed he was always incontinent of bowel and bladder and required limited assistance of 1 person for toileting needs. Record review of Resident # 1's admission care plan revealed a care plan for bowel and bladder incontinence and for staff to check for incontinence every 2 hours. Observation on 2/12/14 at 9:16 AM of CNA I providing incontinent care of urine and bowel movement to Resident # 1 on his bed. CNA I washed her hands, put on gloves and removed the resident's pants. She undid the brief, and cleaned the Resident's front peri-area using a spray bottle of peri-wash and a towel. Without changing gloves, she picked up bottle of peri-wash with her dirty hand and sprayed and cleaned his front area again. CNA I removed her gloves, and without cleaning her hands, put on new gloves and rolled the resident on his right side. She tucked the dirty brief (stool and urine) under him and then rolled the resident onto his left side and removed the dirty brief. She tucked a clean towel under the resident, picked up the peri-wash, placed it on the towel next to the resident and put the dirty brief in a bag. She then removed her gloves, during which time the resident rolled onto his back and onto the spray bottle of peri-wash. CNA I, without cleaning her hands, put on new gloves and rolled the resident on his side. She picked up the bottle of peri-wash and a towel, and cleaned the resident's bottom of stool, placing the bottle on the resident's wheel chair. CNA I then removed her gloves, and without cleaning her hands, opened the dresser and got out a clean brief (pull-up). She put on new gloves and put the pull-up on the resident, removed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675127**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/14/2014**

NAME OF PROVIDER OF SUPPLIER **HUMBLE HEALTHCARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP **93 ISAACKS RD HUMBLE, TX 77338**

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

F 0498

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 21)
the dirty sheet from the bed and removed her gloves. CNA I then went to the closet, got a clean pair of pants, put on new gloves and put them on Resident # 1. CNA I then removed her gloves and washed her hands. The spray bottle of peri-wash, along with a box of gloves and towel was in the resident's wheel chair. CNA I made the resident ' s bed with clean sheets, picked up the dirty bottle of peri-wash and without cleaning it, placed it into a cupboard in the shower room. In a telephone interview on 2/13/14 at 1:37 PM, CNA I stated when she was cleaning Resident # 1 of stool, she thought she had washed her hands during the care and that she would normally wash her hands and I think I did wash my hands between. She stated we always wash before and after care. When asked about the bottle of peri-wash, she stated she had placed it in the chair and put it back into the supply cabinet in the shower room. She stated she cleaned it off when she put it in the cabinet. When asked if the bottle was clean, she said no but that she thought she had changed her gloves. When asked if she washed her hands after cleaning the resident of stool, she said no. Resident # 29 Record review of Resident # 29's face sheet revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. She was [AGE] years old. Record review of Resident # 29's significant change MDS assessment with 1/11/2014 ARD
date revealed she had long term and short term memory problems. Her cognitive skills for daily decision making were severely impaired. She needed extensive assistance of one person with bed mobility, dressing and toilet use. She had total dependence of one person for personal hygiene. She was always incontinent of urine and bowel. Record review of Resident # 29's 1/11/2014 updated care plans revealed the following care plans: -I am always incontinent of urine related to my inability to feel the urge. The approaches included: Assist me with perineal cleansing as needed. -I am always incontinent of bowel related to my inability to feel the urge. Observation was conducted of CNA C and CNA D providing incontinent care for Resident # 29 on 2/12/2014 at 10:15 AM. The clean pad, two wash clothes, and a bottle of peri-wash were sitting on the bed near the foot of the bed when the room was entered. CNA D changed her gloves after moving the bed without washing or sanitizing her hands. When the covers were pulled down the resident urinated and the urine got on her thighs almost to the knee area. CNA C sprayed peri-wash on a dry wash cloth that she then used to clean the resident. When she finished cleansing the peri-area in the front she placed the soiled wash cloth on the bed pad where it rested against the resident's right outer thigh. She did not clean the resident's thighs where they had become wet from the resident urinating. CNA C used a clean wash cloth to pat the resident dry in the front. She then sprayed peri-wash on this same wash cloth to cleanse the resident rectal and buttock area. After cleaning this area she turned the wash cloth and used the same wash cloth to pat the resident dry. CNA C placed the clean pad under the soiled pad that was rolled under the resident. The resident was not wearing a brief and when she urinated the urine wet the pad. When the resident was turned to her other side the plastic bag used for the soiled linen fell on the floor. CNA C picked it up and handed it to CNA D when then placed it on the bed. CNA D touched the soiled pad and then the clean bed pad. CNA D left the room without washing or sanitizing her hands. CNA C left the room holding the bottle of peri-wash and went into the hall. She then returned to the room and placed the bottle of peri-wash in the resident's dresser drawer. In an interview with CNA C on 2/12/2014 at 12:43 she said she documented the care she provided in the computer. She further stated she tried to document twice during her shift in the computer. CNA C said most of the time she document only once during the shift. She said if there was new wound on a resident she would tell the nurse immediately. She further stated she had discovered previous wounds and the nurse had come to look at them immediately. When asked about the incontinent care with Resident # 29 she said she did not wash the resident's thighs when she provided the care. When asked what could happen if urine was left on the skin she said the resident could get a rash or sores. She said she usually use wet wash cloths when she provided incontinent care. When asked about the soiled washcloth resting against the resident leg she said they were supposed to put soiled linen in the bag. She further stated the dirty linen could make her side dirty. When asked about using the same wash cloth that she dried the resident with to clean her she said they were short on towels and she kept turning the washcloth when she used it. She said using the washcloth could cause cross contamination and the resident would not really be clean. When asked about tucking the clean pad under the soiled bed pad she said it could cause cross contamination and touching the dirty pad and then the clean pad could cause cross contamination. When CNA C was asked about leaving the room with the peri-wash she said normally does not leave in the room. She stated they wipe it off and sit it on the clean linen cart. When asked if they use the bottle of peri-wash for more than one resident she said yes, they just use it on the towel to clean the resident. Observation of Resident # 29's room on 2/14/2014 at 8:35 AM revealed the syringe used during the care for [DEVICE] was resting on a paper towel open to air. In an interview with CNA D on 2/14/2014 at 12:12 PM she said no one in the facility had watched her perform incontinent care. She then said she had training and did a return demonstration for LVN D. She said when the resident urinated on her legs and they were not cleaned it could cause cross contamination, get an infection or irritation to the skin. She said when you use peri-wash you were supposed to use a wet washcloth. CNA D stated when gloves were removed your hands were not clean and you were supposed to wash your hands before you put on a new pair. When asked about reaching into a box of gloves with hand that had not been washed you could contaminate the box. She said your hands should be washed after closing the door to the room, when you finish cleaning the resident from the front, anytime get anything on your gloves, and when leave the room. She said if you do not wash hand before leave the room you could contaminate what you touch. When asked about the bag for the soiled linen dropping on the floor and then being placed on the bed she said it could contaminate the bed. She said the clean bed pad under the soiled bed bad would make the clean bed pad dirty and contaminated. Resident # 54 Record review of Resident # 54's face sheet revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. She was [AGE] years old. Record review of Resident # 54's quarterly MDS assessment with a 1/22/2014 ARD date revealed her BIMS score was 15 out of 15 which means the resident was cognitively intact. The functional status section of the assessment revealed she needed extensive assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene. The assessment further revealed the resident was always incontinent of bowel and urine. Record review of Resident # 54's care plans revealed the following care plans: -I am always incontinent of urine. The problem onset date was 8/9/2012. The approaches included: Provide incontinence pads. Assess for environmental factors that may contribute to my incontinence. Assist me with perineal cleansing as needed. -I am always incontinent of bowel. The problem onset date was 8/9/2012. The approaches included: Assess for environmental factors that may contribute to my incontinence. Teach me about factors affecting bowel control. Provide me verbal cueing. Observe mu skin daily for irritation and redness. Observation was conducted of CNA B and CNA E providing peri-care for Resident # 54 on 2/12/2014 at 10:40 AM. CNA B placed a handful of gloves on top of the refrigerator next to the resident ' s bed. She did not clean the top of the refrigerator and there was not a barrier on top of the refrigerator. CNA B wet the wash clothes in the bathroom sink and then placed those washcloths and a bottle of peri-wash on top of a dry washcloth on top of the refrigerator. CNA B cleansed the resident folds of her thighs before she cleansed the labia. She left the wash cloth she cleansed the labia resting between the resident ' s legs. CNA B rolled the soiled bed pad under the resident and then placed the clean bed pad under the soiled pad. She did change gloves or wash or sanitize her hands after cleansing the resident prior to touching the clean bed pad. The soiled linen was placed in a pillow case that then rested first by the right side of the resident ' s head and then the left side of her head. CNA B left the room without washing or sanitizing her hands. In an interview with CNA B on 2/13/2014 at 1:45 PM she was asked about placing the gloves used during care on top of the refrigerator she said she should have had a base before she placed the items on the table. She further stated those items became dirty and placing them on refrigerator could cause cross contamination. When asked about the peri-wash being left out she said it should be put in a bag where it belongs. She further stated it was left out someone could mistake it for something else and possibly be poisoned. When asked how a female resident should be cleansed in the front she said she cleaned the sides and then the middle area (labia) first. She said failure to do so could cause cross contamination. She said placing the clean pad under the dirty pad could cause cross contamination. She said the dirty line was placed too close to the resident ' s face and the resident could inhale it. CNA B said your hands should be washed agree done with care and opening the door and leaving the room without washing your hands could cause cross contamination. When asked if she had been watching performing peri-care she said she had been watched by the nurse on the floor but not the DON or ADON. In an interview with CNA E on 2/14/2014 at 11:52 AM she said the dirty lien beside the resident ' s head could cause contamination and the resident could get sick, germs. She said placing the clean bed pad under the soiled bed pad could cause cross contamination. She said touching soiled bed pad before the clean pad could cause cross contamination. Resident # 71 Record review of Resident # 71's face sheet revealed he was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. He was [AGE] years old. Record review of Resident
71's significant change MDS assessment with 12/12/2013 ARD date revealed his hearing and vision was highly impaired. It further revealed he sometimes made himself understood. He rarely/never understands others. It also revealed his cognitive

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUMBLE HEALTHCARE CENTER	**93 ISAACKS RD HUMBLE, TX 77338**

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F 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 22) skill for daily decision making was severely impaired. The functional status section of the assessment revealed total dependence of one person with bed mobility, dressing, eating, toilet use and personal hygiene. It further revealed he was always incontinent of bowel and urine. Record review of Resident # 71's care plans revealed the following care plans goal target date of 3/14/2014: -I am always incontinent of urine as I cannot recognize the urge related to effects of aging. The approaches included: Provide incontinence pads. Assist me with perineal cleansing as needed. -I am always incontinent of bowel as I cannot recognize the urge related to effects of aging. The approaches included: Observe my skin daily for irritation and redness. Assess me for constipation/impaction. Assess for environmental factors that may contribute to my incontinence. Observation of CNA A and CNA B providing incontinent care for Resident # 71 on 2/11/2014 at 2/12/2014 at 9:00 AM revealed the resident ' s gown was soaking wet from upper abdomen to thigh area. The resident was not wearing a brief. CNA A wet wash cloths in the bathroom sink and then set them aside until she was ready to cleanse the resident. CNA A retracted the resident foreskin but did pull in forward after she cleansed his penis. She removed her gloves and without washing or sanitizing her hands she donned clean gloves. When the resident was turned on his side it was noted that the bed pad the resident was laying on was saturated. The plastic covering the bed was wet as well. After CNA A finished cleansing the resident rectal and buttock area she removed her gloves and without washing or sanitizing her hands she obtained clean gloves from the boxes of gloves in the bathroom. CNA A then rolled the wet pad under Resident # 71 and used a dry towel to wipe the mattress. She did not use cleanser on the mattress. She rolled a clean bed pad under the wet pad. They turned the resident and then CNA B used the same towel to wipe the wet mattress. She pulled out the soiled/wet bed pad and without washing or sanitizing her hands she pulled the clean bed pad under the resident. Both CNAs removed the wet hospital gown from the resident. They did not cleanse the resident ' s thighs or abdominal area. They pulled up the residents covers while both wearing the same gloves that had wiped the wet bed and touched the wet bed pad. CNA A gathered the soiled linen and put it in a pillow case that was then placed on top of two pillows without pillow case that were sitting on top of the bedside table. One of the pillows was sitting on top of the syringe that was used for administering medications and water through the resident's [DEVICE]. The container that the syringe was supposed to be stored was open and sitting on a paper towel not in a plastic bag. The container that goes with the syringe was sitting on the table not in a plastic bag. When the CNAs left the room they left the pillow case with the soiled linen in the room. In an interview with CNA A on 2/12/2014 at 9:04 AM she was asked about the resident being extremely wet and when he was last changed. She said she changed the resident at about 6:30 AM. In an interview with CNA A on 2/13/2014 at 1:35 PM she was asked about wetting the wash cloth before care and if they were still warm. She said sometimes they were supposed to have a basin with warm water. When asked what area she should clean when the resident's gown and bed pad was very wet she said where the gown and the wet bed pad touched the resident. She further stated you were supposed to wipe that part or the resident could get irritated or skin breakdown. When asked about providing care to a resident that was not circumcised she said you were supposed to pull back the foreskin and them pull it forward when done. CNA A said hands were not clean when gloves were removed. She further stated hands were dirty and you were supposed to wash your hands. When asked about the wet bed she said she should have had a wet washcloth and a dry one. She further stated that would have cleaned the bed. She said she just dried the bed. When asked if she had been watched performing incontinent care she said she had been watched by the ADON. When asked about rolling the clean bed pad under the soiled bed pad with soiled pad resting on top of the clean bed pad she said the clean bed pad just becomes soiled. She further stated she should have changed her gloves, washed her hands and put on gloves after touching the soiled pad. When asked what could happen when she did not do so she said, I don ' t know. When asked about the soiled linen being left in the room she said she was supposed to take it out and she had went to get a barrel to take it out of the room. When asked what could happen with the tube feeding syringe being open on the table under the pillows and the soiled linen she said, I don ' t know nurses deal with that. When asked about the peri-wash being left out she said a resident can get the peri-wash. In an interview with CNA B on 2/13/2014 at 1:45 PM she was asked when she should change gloves during incontinent care she said after cleaning the resident from the front, the back, and after touching the dirty brief. When asked about touching the clean areas after touching the dirty brief she said it could cause cross contamination. When asked about the wet bed she said it should have been disinfected and she should have made sure it was dry prior to putting on the clean linen. She said failing to do so could lead to bacterial or cross contamination to the clean sheets. When asked about the syringe on the bedside table she said it could cause cross contamination with those items. When asked about the linen being left in the room she said you should have a bag for the linen and one for the trash. Resident # 72 Record review of Resident # 72's face sheet revealed he was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Observation of Resident # 72 on 2/11/2014 at 10:00 AM revealed he was in bed and MA A was administering water. She told the resident to spit what was in his mouth in the tissue. She handed the tissue to the resident and took the tissue back from the resident after he had spilt into it. She was not wearing gloves. In an interview with MA A on 2/14/2014 at 12:09 PM she was asked about handling the tissue without gloves. She said it could cause cross contamination and you could catch germs. Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Record review of Resident # 75's significant change MDS assessment with ARD date of 12/18/2013 revealed the resident had a short term and long term memory problem with modified independence with cognitive skill for daily decision making. The functional status section of the assessment revealed she needed extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. Ambulation did not occur during the assessment period. She had total dependence with locomotion on and off the unit of one person and with bathing. She had a range of motion limitation on one side of the lower extremity. The bladder and bowel section of the form revealed she had an indwelling urinary catheter and was always incontinent of bowel. She was not able to answer the question of the presence of pain. It further revealed the staff assessment did not reveal the prescience of pain. She had history of fall. The skin section revealed the resident was at risk of developing a pressure ulcer but currently did not have pressure ulcer. She had a pressure reducing device or bed. The Care Area Assessment (CAA) Summary revealed the following areas for care area triggered and care plan decision: ADL function, urinary incontinence/indwelling catheter, falls, nutritional status, pressure ulcer and [MEDICAL CONDITION] drug use. Record review of Resident # 75's 12/18/2013 updated care plan revealed the following care plan: -I am always incontinent of bowel. The approaches included observe my skin daily for irritation and redness. There were no approaches related to incontinent care. -I use an indwelling catheter. The approaches included catheter care for me every shift. Observation was conducted of CNA G providing catheter and peri-care for Resident # 75 on 2/13/2014 at 11:37 AM. She obtained supplies from the linen cart in the hall and placed a handful of gloves in the pocket of her uniform. When she entered the room she said I forgot to knock on the door. She placed the supplies on the resident ' s over the bed table next to her box of tissue, denture cup. She did not clean the table prior to setting the supplies on it. She donned gloves from her pocket without washing or sanitizing her hands. CNA G then went into the bathroom and filled a basin with water and obtained a urinal. She placed the basin on top of the resident ' s wheel chair cushion and the urinal on the floor. She opened the resident ' s brief and rolled in up between her legs next to her peri-area. The indwelling urinary catheter tubing was lying on top of the brief. At that time the resident told her she was hurting. She rolled the resident to her left side; the indwelling urinary catheter drainage bag was attached to the bed the catheter tubing was being pulled on when the resident was on her left side. There was not a catheter strap to secure the catheter. CNA G then picked up the trash can with her gloved hands and moved it closer to the bed. She used these same gloves to clean the resident. She did not open the labia when she wiped down. She did not secure the catheter tubing when she cleansed it. She wiped back and forth with the catheter tubing lying on the brief. After cleansing the rectal area, with the resident having been incontinent of small amount of stool, she pulled out the soiled brief. She said not wash or sanitizing her hands or change gloves before she applied the clean brief. CNA G pulled up the resident ' s pants with those same gloves. At that time the resident said her heel felt like it was rotting. CNA G emptied the catheter drainage bag. While she was doing so the catheter drainage bag was on the floor. She gathered the trash and soiled linen bags. She then took the basin to the bathroom sink and rinsed it and dried it with a paper towel. She then placed it in a plastic bag and then placed the bag on the floor in the bathroom. CNA G left the room without washing her hands. She took the trash and linen to the utility room and then used hand sanitizer. In an interview with CNA G on 2/13/2014 at 2:00 PM she was asked how the catheter should be cleaned during catheter care. She said it should be wiped in a circular motion from the urethra out away from the body. She said failing to do so could cause the catheter to still be dirty. She further stated you were supposed to hold the catheter in place when cleaning it. When asked about the indwelling catheter laying top of the soiled brief she said she tried to tuck the catheter on the outside. When asked when you were to wash your hands when providing care she said before and after

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NAME OF PROVIDER OF SUPPLIER **HUMBLE HEALTHCARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP **93 ISAACKS RD HUMBLE, TX 77338**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 23) care and when moving to the back. She said she did not wash her hands before she provided the care to Resident # 75 and failure to do so could cause contamination. She said gloves should be changed before the clean brief was applied. When asked about touching the trash can she said her gloves were no longer clean and it could cause contamination. She said she did not wash her hands when she left the room and failing to do so could cause contamination. She said no one had watched her perform incontinent care. In an interview with the CNA G on 2/14/2014 at 11:15 AM she said her pockets were clean when asked about gloves in her pocket. She said they were not allowed to keep gloves in their pocket and they were contaminated. She said you were supposed to knock before go inside the room or you invade their privacy. When asked about the supplies on the table she said it should be disinfected and the supplies could be contaminated. She further stated you were supposed to remove her personal care items from the table such as tissues and put them on the night stand. When asked about cleaning the resident she said she was supposed to open the labia and go down completely. She said when she did not do so she could miss spots that could have urine or bowel movement on them and the resident could get an infection. When asked about the catheter drainage bag on the floor she said it could become contaminated and the resident could get an infection. Resident # 49 Observation on 2/12/14 at 7:55 AM, MA D was observed administering medications to Resident # 49. MA D did not wash or sanitize her hands after administering the resident her medications and touched her pen, the MAR and the medication cart. In an interview on 2/13/14 at 1:50 PM, MA D stated she should use hand sanitizer or wash her hands after removing her gloves. Resident # 83 Record review of Resident # 83's face sheet revealed [AGE] year old admitted to the facility on [DATE] and had the following diagnoses; late effect [MEDICAL CONDITION] disease, [MEDICAL CONDITION] reflux, [MEDICAL CONDITION], affective personality, depression, hypertension and constipation. In an interview with Resident # 83 on 2/13/14 at 4:20 PM, she stated she was transferred from a shower chair to bed by 1 CNA since the other CNA did not want to help several weeks ago. She stated when this happened, her knee got hurt. Observation on 2/13/14 at 4:20 PM revealed Resident # 83's bilateral feet were contracted and she used an electic wheel chair for mobility. Record review of Resident # 83's admission history and physical dated 11/27/12 revealed she had bilateral foot drop. Record review of Resident # 83's physician progress notes [REDACTED]. Record review of Resident # 83's quarterly MDS dated [DATE] revealed there was no limitation of range of motion to her lower extremities (hip, knee, ankle and foot). Record review of Resident # 83's nurse note dated 12/25/13 at 4:15 PM read, in part, Resident was being transferred from shower chair to wheelchair. Resident slipped out of shower chair during transfer. Resident left leg went backwards and the knee area assessment done per nurse. No swelling at this time. Resident complained of pain upon palpitation to area above knee. Schedule [MEDICATION NAME] given as directed. MD notified. New order x-ray of left knee and femur. Record review of Resident # 83's 12/25/13 x-ray report of her left knee revealed no acute fracture. It revealed there were [MEDICAL CONDITION] changes, possible prior fracture and displaced or subluxed patella. This x-ray was review by Resident # 83's physician on 12/26/13 who wrote exam of the knee reveals no pain, no swelling. She had permanent contractures to that knee. In an interview on 2/13/14 at 5:55 PM, CNA H stated she had been working with Resident # 83 on 12/25/13. She stated she could not find anyone to help transfer the resident out of the shower chair and admitted she transferred the resident by herself into bed. She stated she did not have the lift pad under her in the shower chair, so when she tried to transfer her, she said my feet hit her feet and caught and bent her knee. She stated neither of them actually fell . CNA H stated Resident # 83 was usually transferred with a lift or with 2 people. In an interview on 2/14/14 at 7:15 AM, the DON stated on 12/25/13 CNA H did
F 0502 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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** Based on record review and interview, the facility failed to ensure laboratory services were obtained for 1 of 18 residents (Resident #1) reviewed for laboratory services. Resident #1 had an physician order [REDACTED]. This failure affected 1 resident and placed 84 residents at risk of not getting the care and services to promote their health and quality of life. Findings Include: Record review of Resident #1's current medical record revealed he was admitted to facility on 1/29/14 with a [DIAGNOSES REDACTED]. He was [AGE] years old. Review of the physician's telephone orders dated 2/7/14 revealed he was ordered an [MEDICATION NAME] on 2/10/14. Record review of Resident #1's clinical record revealed no laboratory results for the [MEDICATION NAME] were in the clinical record. In an interview with the DON on 2/13/14 at 6:00 PM she stated she could not locate the results of the [MEDICATION NAME] level. She said we didn't do the lab. We will do it now. Record review of the facility's policy titled Lab and Diagnostic Test Results- Clinical Protocol 2005 MED-PASS, Inc (Revised October 2010), read in part, Assessment and Recognition: 1. The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. According to CMS 672 the census was 85.
F 0513 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep signed and dated reports of x-rays and other diagnostic services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure radiology results were maintained in the medical record for 1 of 17 residents (Resident 75) reviewed for radiology tests. Resident 75's Bilateral Lower extremity venous and arterial Doppler were not filed in the clinical record. This failure could affect 37 resident who had diagnostic testing completed in the past 30 days and could lead to at risk of a delay in coordination of care. The findings were: Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Record review of Resident # 75's 1/29/2014 physician telephone order revealed the following orders: -Doppler to lower extremities. Diagnoses: [REDACTED]. This was a verbal order that revealed it was written by LVN B and received from Dr. # 1. There was no time on this order. Record review of Resident # 75's medical record revealed the results were not in record as of 12/12/2014. They were provided by the DON. In an interview with the DON on 2/13/2014 at 2:10 PM she was asked about lab test, x-ray she said the lab results were held for the doctor ' s review in folder if they were no abnormal. She said Dr. # 1 like the folder when he comes to the facility. She said Dr. # 1 comes to the facility every two weeks. Record review of the facility's policy titled Lab and Diagnostic Test Results- Clinical Protocol 2005 MED-PASS, Inc (Revised October 2010), read in part, Assessment and Recognition: 1. The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. Review of Nursing Staff: 1. A nurse will review all results According to CMS Form 672 the facility census was 85. .
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain a complete clinical record for 3 of 17 residents (Resident # 29, 32, and 75) reviewed for clinical records. -Resident # 29's January and February 2014 physician orders did not contain the current dose of [MEDICATION NAME] she was receiving. There were no initials to indicate her [MEDICATION NAME] had been administered on two occasions in February 2014. -Resident # 32's February 2014 physician orders had two different orders for blood sugar checks. One of the orders had been discontinued on 10/9/2014 but it was still on the February 2014 monthly orders. -Resident # 75 was receiving the correct dose of [MEDICATION NAME] in February 2014 but the staff was documenting they had administered a different dose. Resident # 75's pain assessment was not completely filled out. It did not address that the resident had pain in the five day prior to the assessment. Her Plan of Care for Physical Therapy did not accurately reflect the care she had received for her unstageable pressure ulcer. Her pain level prior to wound care treatment was not documented consistently. This failure affected 3 resident and placed 82 residents at risk of not having their records communicate their care needs to providers and not having the care they received documented. Findings Include: Resident # 29 Record review of Resident # 29's face she revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. She was [AGE] years old. Record review of Resident # 29's 12/13/2014 physician telephone orders revealed the following order: -Increase [MEDICATION NAME] to 125 mg/5 ml, give 10 ml twice a day. Record review of Resident # 29's January 2014 physician orders revealed the following orders:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675127**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUMBLE HEALTHCARE CENTER	**93 ISAACKS RD HUMBLE, TX 77338**

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| F 0514

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some | (continued... from page 24)
-[MEDICATION NAME] 125 mg/5 ml 12 ml per [DEVICE] every bedtime. This order had a 11/8/2013 order date. -There was no order for the [MEDICATION NAME] 125 mg/5 ml, give 10 mg (250 mg) per [DEVICE] twice daily. Record review if Resident # 29's January 2014 MAR revealed the following: -[MEDICATION NAME] 125 mg/5 ml 12 ml per [DEVICE] every bedtime. Next to this medication the abbreviation for discontinued had been hand written on the MAR. -[MEDICATION NAME] 125 mg/5 ml, give 10 mg (250 mg) per [DEVICE] twice daily. The initials documented from 1/1/2014 through 1/31/2014 that this medication had been administered. Record review of Resident # 29's February 2014 physician orders revealed the following orders: -[MEDICATION NAME] 5 mg, 1 tablet per [DEVICE] every bedtime. -[MEDICATION NAME] 125 mg/5 ml 12 ml per [DEVICE] every bedtime. This order had an 11/8/2013 order date. -There was no order for the [MEDICATION NAME] 125 mg/5 ml, give 10 mg (250 mg) per [DEVICE] twice daily. Record review if Resident # 29's February 2014 MAR revealed the following: -[MEDICATION NAME] 5 mg, 1 tablet per [DEVICE] every bedtime. There were no initials to signify that this medication had been administered on 2/5/2014 and 2/8/2014. -[MEDICATION NAME] 125 mg/5 ml 12 ml per [DEVICE] every bedtime. Next to this medication the abbreviation for discontinued had been hand written on the MAR. -[MEDICATION NAME] 125 mg/5 ml, give 10 mg (250 mg) per [DEVICE] twice daily. The initials documented from 2/1/2014 through 2/11/2014 that this medication had been administered. In an interview with the LVN D on 2/14/2014 at 12:34 PM she was asked what the process she used for verifying the monthly orders. She said she obtained the new monthly orders and compared them to the previous monthly orders and any new orders written. She said she looked at the previous monthly MAR and the new MAR with any changes. she further stated she documented changes on the new monthly orders. When asked about the [MEDICATION NAME] order for Resident # 29 she said the order should be 125 mg per [DEVICE] twice a day. She said normally she would write the changes on the monthly orders and she did not know why she did not. She said she did make sure the changes were put on the MAR. LVN D said she would sent an order to the doctor with a clarification. Resident # 32 Record review of Resident # 32's 10/9/2013 physician telephone order revealed the following orders: -Discontinue blood sugar checks before meals and at bedtime with sliding scale. -Blood sugar checks every week at 6:00 AM (Monday) with an order date of 10/9/2013. Record review of Resident # 32\'s February 2014 physician orders revealed the following orders: -Blood sugar checks three times a day with an order date of 7/23/2013. -Blood sugar checks every week at 6:00 AM (Monday) with an order date of 109/2013. Record review of Resident # 32's MAR revealed the following: -Blood sugar checks three times a day. The abbreviation for discontinued was hand written in next to this order. -Blood sugar checks every week at 6:00 AM (Monday). This was what the staff was currently following. Resident # 75 Record review of Resident # 75's face sheet revealed she was admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. She was [AGE] years old. Record review of Resident # 72's 12/24/2013 admission orders [REDACTED] -[MEDICATION NAME] 10 mg every day by mouth. -[MEDICATION NAME] 5/325 mg one tablet every 6 hours as needed for pain. Record review of Resident # 75's 1/20/2013 physician telephone order revealed the following order: -Discontinue [MEDICATION NAME] 10 mg when finish supply and give 15 mg, ? tablet every day by mouth Record review of Resident #75's January 2014 MAR revealed the following: -Abilifty (sic)10 mg every day by mouth. There were initials to indicate this medication had been administered from 1/1/2014 through 1/22/2014. -Ability 15 mg. give ? tablet (=7.5 mg) by mouth every day. There was documentation that this medication had been administered from 1/21/2014 through 1/31/2014. Record review of Resident # 75's February 2014 Physician Orders revealed the following orders: -[MEDICATION NAME] 5/325 mg one tablet every 6 hours as needed for pain. -Abilifty (sic) 10 mg every day by mouth. Record review of Resident # 75's February 2014 MAR revealed the following: -Abilifty (sic) 10 mg every day by mouth. There was documentation that this medications had been administered from 2/1/2014 through 2/12/2014. Record review of Resident # 75's 2/13/2014 Medication Error Report revealed the medication order was [MEDICATION NAME] 15 mg, ? tablet by mouth every day. The description of the error revealed the order was not transcribed correctly on the February 2014 MAR and the medication was being documented as 10 mg every day. It further revealed the resident was receiving the correct dose. The report revealed it was a transcription error. Record review of Resident # 75's 12/6/2013 SBAR revealed the situation was pain and the background was leg pain. The appearance section of the form revealed no documentation of pain level. It further revealed the pain was constant and the intervention was Tylenol 325 mg, 2 by mouth. Under the reported to section it read in part: . Send to ER per family request, x-ray new order Record review of resident # 75's skilled daily nurse's notes and nurse notes from 12/13/2014 to 2/11/2014 revealed documentation of pain on the following dates: -12/6/2014 note read at 3:45 PM: Resident complained to CNA that she had fell and put herself back in chair. Resident shaky with complaints of pain shooting down her leg to her ankle form left hip. (Dr. # 1) notified. Son notified requesting she be sent to hospital . PRN Tylenol 325 mg, (two) admin for pain per PRN order . Record review of Resident # 75's 12/11/2013 Pain Evaluation revealed that yes was checked and debility was documented under the area did the resident have a [DIAGNOSES REDACTED]. There was no documentation to the question Have you had pain or hurting in the last 5 days? Under the Wong - Baker pain rating scale the picture of the smiling face with no hurt was circled. The only other documentation on the evaluation was under the section does the resident receive an as needed medication. [MEDICATION NAME] 325 mg two tablet by mouth every four hours as needed was documented. Record review of Resident # 75's 12/24/2013 Resident Summary revealed she was readmitted . It further revealed she was alert, confused and understood information but had difficulty. She had no pain and her skin was clear. It further revealed the resident could ambulate alone, transfer herself, and position herself. It further revealed she had a fall on 12/17/2014. It also revealed the resident had a urinary tract infection and was on an antibiotic. Record review of Resident # 75's 12/24/2014 Pain Evaluation revealed that yes was checked and debility was documented under the area did the resident have a [DIAGNOSES REDACTED]. There was no documentation to the question Have you had pain or hurting in the last 5 days? Under the Wong - Baker pain rating scale the picture of the smiling face with no hurt was circled. The only other documentation on the evaluation was under the section does the resident receive an as needed medication. [MEDICATION NAME] 325 mg two tablet by mouth every four hours as needed was documented. Record review of the Resident # 75's Controlled Drug Record for [MEDICATION NAME] APAP 5 - 325 ([MEDICATION NAME]) revealed the resident received the medication of the following dates and times. -12/20/2013 at 1:00 AM -12/20/2014 at 8:00 AM Record review of Resident # 75 ' s January 2014 MAR revealed she had the following pain medications ordered and received them on the following dates and times: -[MEDICATION NAME] 325 mg. 2 tablets by mouth every 4 hours as needed for pain or temperature. She received it on 2/11/2014. There was no time documented. On the back of the MAR was a hand written notation that it was administered at 3:30 PM for complaints of pain in the heel. There was no level of pain documented. -[MEDICATION NAME] 5/325 mg, one tablet every 6 hours as needed for pain. There was no documentation that the resident received this medication in January 2014. Record review of Resident # 75's February 2014 MAR revealed she had the following pain medications ordered and received them on the following dates and times: -[MEDICATION NAME] 325 mg. 2 tablets by mouth every 4 hours as needed for pain or temperature. She received it on 2/11/2014. There was no time documented. On the back of the MAR was a hand written notation that it was administered at 3:30 PM for complaints of pain in the heel. There was no level of pain documented. -[MEDICATION NAME] 5/325 mg, one tablet every 6 hours as needed for pain. There were initials to indicate it was administered on 2/3/2014 and 2/8/2014 Record review of Resident # 75's Wound Skin Healing Record revealed the date of onset for the wound was 1/29/2014 and it was an unstageable to her left heel. Record review of Resident # 75's 1/29/2014 physician telephone order revealed the following orders: -Unstageable left heel, cleanse with wound cleanser pat dry. Apply Santyl to the wound cover with 4 by 4 ' s and wrap with soft - foam. Change every day. This was a verbal order that revealed it was written by LVN B and received from Dr. # 1. There was no time on this order. -Physical therapy to evaluate and treat as needed left heel. This was a verbal order that revealed it was written by LVN B and received from Dr. # 1. There was no time on this order. Record review of Resident # 75's Physical Therapy Evaluation and Plan of Treatment revealed the Certification Period was 1/29/2014 - 3/29/2014. The wound analysis revealed the first wound was 3.0 cm length by 5.0 cm width, Edge was indistinct and it had Adherent soft black eschar, The necrotic tissue amount was 75 to 100 percent. Under the intervention section it read: Was conventional wound care provided prior to (start of care)? = Yes, patient received 30 days of conventional care to address wounds, (without) measurable signs of healing. The assessment summary impressions revealed the resident presented with left heel ulcer that had not responded to conventional treatment. This was signed by Dr. # 1 and the signature date was 2/5/2014. Record review of Resident # 75's Daily PT Wound CPT and Progress Documentation revealed the following. 1/30/2014 note revealed the pressure ulcer had eschar. It further revealed the resident had discomfort. There was no further identification of pain level. There was a note that read no complains pt responded well. 1/31/2014 note revealed the resident had discomfort which was not further clarified. Under response to treatment and skilled need statement it read patient education on elevating both lower extremity feet. -2/3/2014 note revealed the pain level was 7 on a scale of 1 to 10 to left heel. There was no other documentation of the note regarding pain. -2/4/2014 note revealed the pain level to left heel was 8 on a scale of 1 to 10. There was no other documentation on the note regarding pain. Under response to treatment and skilled need statement: continue to education for pressure relief |

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F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 25) was documented. -2/5/2014 note revealed the pain level to left heel was 8 on a scale of 1 to 10. There was no other documentation on the note regarding pain. Under response to treatment and skilled need statement: continue caregiver education to decrease pressure in bed. -2/12/2014 note revealed the pain level was less than 5 on scale of 1 to 10 before dressing change. There was no other documentation on the note regarding pain. Under response to treatment and skilled need statement: continue caregiver training for positioning. In an interview with PTA B on 2/13/2014 at 1:12 PM she said the pain documented on Daily PT Wound CPT and Progress Documentation was documented after the resident had received her treatment. She said she notified nursing of Resident # 75 pain. She said she did not document the pain level before the treatment. She clarified that the pain level documented was after the treatment. There was no documentation regarding the pain level prior to the treatment. She said the plan of care was filled out by the physical therapist that was only in the facility 1 to 2 days per week. When asked if the Plan of Care was accurate she said as far as I know the plan of care was accurate. When asked if she had done any research or review prior to starting Resident # 75's wound care she said she did not. When asked about the plan of care reporting that the resident wound care had been done by nursing for 30 days prior to the initiation of therapy she said the companies said the wound must be under nursing for 30 days. She said LVN B told her the resident had necrotic tissue and it was not healing. When asked if the plan of care was accurate if the wound was identified on 1/29/2014 she said it was not accurate. In an interview with the DON on 2/13/2014 at 2:10 PM she was asked what Resident # 75 ' s dose of [MEDICATION NAME] was supposed to be. The DON looked at the medical record and said the monthly orders said the dose was 10 mg. She was shown the 1/20/2014 order and then said ? tablet. She said she would need to research what dose of [MEDICATION NAME] the resident was receiving. When asked what was the process for physician orders she said the medical records staff person put the order in the computer and then it was faxed to pharmacy. The DON further stated the monthly orders were reviewed by LVN D. She said the LVN D checked the order from the previous month against the new orders. She said she would need to do an order clarification if need be. In an interview with the DON on 2/13/2014 at 3:00 PM she said the order for Ability got missed. She said she would call the doctor and get the order corrected. In an interview/observation with the RCS on 2/13/2014 at 3:15 PM she said the order for the [MEDICATION NAME] did not get changed on Resident # 75 ' s MAR. She said she wanted to see the blister pack to see what dose the resident had been receiving. At that time the blister pack was observed and the dose was [MEDICATION NAME] 15 mg I/2 tablet. In an interview with the DON and RCS on 2/14/2014 at 7:05 AM they were shown Resident # 75's pain assessment and asked if complete RCS said it was not filled out and incomplete. When asked what should be done if a resident cannot answer what their pain level was on scale of 1 to 10 the DON said the other pain assessment should be completed. When asked if Resident # 75's therapy Plan of Care was accurate with the notation resident had received wound care from nursing 30 days prior to therapy they said it was not accurate. In an interview with the LVN D on 2/14/2014 at 12:34 PM she was asked about the [MEDICATION NAME] for Resident # 75 she said she did not see it before she was informed about it. In an interview with the DON on 2/13/2014 at 2:10 PM she was asked if she saw any interventions for pressure ulcer prevention in Resident # 75 ' s 12/18/2014 care plans. She looked through the care plans and said no. When asked about lab test, x-ray she said the lab results were held for the doctor ' s review in folder if they were no abnormal. She said Dr. # 1 like the folder when he comes to the facility. She said Dr, # 1 comes to the facility every two weeks. She further stated the physician was supposed to see the resident every month for the first 90 days and then every 60 days. When asked if a medication could be held without parameters to hold the medication the DON said the MA should report to the nurse and if the nurse felt it was something to be held she needed to call the doctor. When asked if following doctor ' s orders if the medication was held without parameters she said it was not following doctor ' s orders. She was asked about Resident # 75 ' s [MEDICATION NAME]. She was asked what Resident # 75 ' s dose of [MEDICATION NAME] was supposed to be. The DON looked at the medical record and said the monthly orders said the dose was 10 mg. She was shown the ////////////// order and then said ? tablet. She said she would need to research what dose of [MEDICATION NAME] the resident was receiving. When asked what was the process for physician orders she said the medical records staff person put the order in the computer and then it was faxed to pharmacy. The DON further stated the monthly orders were reviewed by LVN D. She said the LVN D checked the order from the previous month against the new orders. She said she would need to do an order clarification if need be. In an interview with the DON on 2/13/2014 at 3:00 PM she said Resident # 75 was not a t risk for pressure ulcers. She was shown how her ADL had changed on her significant change MDS from her previous MDS and she said she was at risk. She was asked what interventions were place to prevent pressure sores for Resident # 75 she said there were no interventions in the care plan for prevention. The DON said Resident # 75 had [MEDICAL CONDITION]. At that time she was asked to see documentation of [MEDICAL CONDITION]. She looked through the record and did not find documentation of [MEDICAL CONDITION]. The DON said the order for Ability got missed. She said she would call the doctor and get the order corrected. She further stated she was going to call for parameter for the [MEDICATION NAME]. In an interview/observation with the RCS on 2/14/2014 at 3:15 PM she said the order for the [MEDICATION NAME] did not get changed on Resident # 75 ' s MAR. She said she wanted to see the blister pack to see what dose the resident had been receiving. At that time the blister pack was observed and the dose was [MEDICATION NAME] 15 mg I/2 tablet. Record review if the facility's revised December 2010 Pain Clinical - Protocol read in part: Assessment and Recognition 1. The physician and staff will identify individuals who have pain or who are at risk for having pain . It also includes a revise for any treatments that the resident currently is receiving for pain, including complementary)non-pharmacological) treatments. 2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. 3. The staff and physician will identify the nature (characteristics such as location, intensity, frequency, pattern, etc.) and severity of pain. a. Staff will assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident ' s cognitive level. b. the staff will observe the resident (during rest and movement) for evidence of pain, for example grimacing while being positioned or having a wound dressing changed. Record review of the facility's revised October 2010 Pain Assessment and Management policy and procedure read in part: . The pain management program is based on a facility-wide commitment to resident comfort. 2. ' Pain Management is defined as the process of alleviating the resident ' s pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Effectively recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain. g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary . Record review of the facility's revised April 2008 Charting and Documentation policy and procedure read in part: . All services provided to the resident , or any changed in the resident ' s medical or mental condition, shall be documented in the resident ' s medical record .All observations, medications administered, services performed, etc., must be documented in the resident's clinical record . Record review of the facility ' s revised of April 2010 Administering Medications read in part: . Medications shall be administered in a safe and timely manner, and as prescribed . The individual administering the medications must check the label THREE (3) times to verify the right medication, right dosage . of administration before giving the medications . Record review of the facility ' s policy Physician Medication Orders, revised April 2010 read in part, .4. Verbal orders must be recorded immediately in the resident ' s chart by the person receiving the order and just include the date and time of the order . 6. Order for medications must include: . b. Quantity or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration if other than oral; and 3. Reason or problem for which given . 8. Drug and biological orders must be recorded on the Physician ' s Order Sheet in the resident ' s chart. Such orders are reviewed by the Pharmacist on a monthly basis .10. Physician ' s order not specifying the number of doses, or duration of medication, shall be subject to automatic stop orders. a. To prevent continued administration of potentially hazardous medications without appropriate review and authorization, drugs not specifically limited to duration of use and number of doses when ordered will be controlled by automatic stop orders . Record review of the facility ' s policy Medication Orders, revised October 2010 read in part, . 2. A current list of orders must be maintained in the clinical record of each resident. 3. Orders must be written and maintained in chronological order . According to CMS Form 672 the facility census was 85.