STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455416	A. BUILDING _____ B. WING _____	09/30/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE COURTYARDS AT FORT WORTH	8001 WESTERN HILLS BLVD FORT WORTH, TX 76108

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to immediately consult one (Resident #1) of four residents' physician when there is a signifiant change in the resident's physical status. When Resident #1 was found with fire ants everywhere on her body and was being bitten, LVN F failed to: -- conduct a head-to-toe assessment to determine with accuracy the number of fire ant bites she sustained, assessing for an allergic reaction and pain. -- provide Resident #1's physician/NP with an accurate assessment of Resident #1's status and allowing the physician/NP to respond appropriately with orders to send her to the hospital. -- notify the physician/NP Resident #1 was sent to the ER and when the resident returned from the ER with new orders until the resident had been back in the facility for over two hours. On 09/26/13 an Immediate Jeopardy (IJ) was identified in the area of quality of care and accurate assessments. While the IJ was removed on 09/30/13, the facility remained out of compliance at a level of actual harm that is not immediate jeopardy and at a potential for more than minimal harm and scope of pattern. because staff were still being inserviced and the facility was monitoring the effectiveness of their plan of removal. These failures placed the facility's 152 residents, including Residents #1, #2, #3 and #4, at risk for not being adequately assessed with [REDACTED]. in a delay in treatment or [DIAGNOSES REDACTED]. Findings included: On 09/26/13, based on administrative review, the investigation was reopened for further investigation of a current Immediate Jeopardy situation. Resident #1's MDS assessment, dated 08/25/13, reflected a [AGE] year-old female who was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The assessment reflected Resident #1 had severe cognitive impairment, received nourishment via tube feeding, and required total dependence on staff for activities of daily living to include bed mobility and personal hygiene. Resident #1's care plan with a current review date of 08/11/13, reflected the following: a) ADL functions reflected she was totally dependent for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. Approaches included to provide Resident #1 with assistance as needed. b) [DIAGNOSES REDACTED]. Approaches included following safety measures and implementing [MEDICAL CONDITION] precautions. c) Resident had difficulty making self understood related to her [DIAGNOSES REDACTED]. Approaches included to observe for non-verbal signs of distress (guarding, moaning, restlessness, grimacing, withdrawal, etc.). Turn/reposition, communicate, provide pericare, assess for pain, and provide liquids/food as needed. Staff must anticipate needs. Resident unable to communicate. d) Resident is at risk for skin breakdown related to bowel and bladder incontinence. The goal was for the resident's skin to remain intact. Approaches included to assess the resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. On 09/12/13 at 11:00 AM, Resident #1 was observed in her room, lying on her bed. She was in a fetal position and had severe contractures of her arms, legs, and hands. She had swollen, inflamed, red welts on all visible areas of her body. Small clusters of welts and individual welts were around her hairline, upper and lower extremities, neck, and upper shoulder blades, plus on her hands and feet. A cluster of welts was on her inner left thigh in an area approximately 6.0 to 8.0 inches in length and 3.0 to 4.0 inches in width. Observation by the surveyor on 09/12/13 at 11:30 AM revealed Resident #1 was covered with red welts, which appeared to be ant bites, except for her middle back, feeding tube area, vaginal area, and under her breasts. The red welts were too numerous to count. During the assessment, Resident #1 responded to verbal and physical stimulus by opening her eyes and frowning. On 09/12/13 at 11:00 AM, during the initial observation of Resident #1, a family member was present and identified the welts as fire ant bites. The family member stated the incident occurred on 09/01/13. The family member further stated he/she received a telephone call on 09/01/13 around 5:30 AM from a staff member informing him/her ants were found in the resident's room and Resident #1, along with her bed, had been moved to another room. the family member indicated this was a repeat notification of the ants observed on 08/31/13. The family member stated he/she received another telephone call from the facility later that same morning from a different staff member informing him/her of ants in the resident's room. The family member stated he/she became concerned and decided to check on the resident. The family member stated when he/she arrived, Resident #1 was in her room, in bed, and covered in ants. The family member stated he/she began yelling for help and several staff members came to help brush the ants off the resident. The family member revealed he/she had to insist Resident #1 be sent to the hospital, where she was informed by hospital staff the number of ant bites suffered by Resident #1 could have led to her death. Resident #1's nurse's notes dated 09/01/13 and timed both at 5:30 AM and 11:40 PM (start of shift was on 08/31/13), reflected ants were on the resident's dresser and some on her bed. The nurse conducted an assessment of the resident and noted she had no ant bites and had no signs and symptoms of pain. The resident's MD was notified and an order was received to move the resident to another room, and the family was notified of the resident's transfer to a different room due to the presence of ants. An entry at 8:30 AM, reflected the resident was resting comfortably and there were no signs of ants or ant bites in the new room (which shared a wall with Resident #1's old room). The next nurse's notes entry for Resident #1, dated 09/03/13 at 9:30 AM, reflected the nurse heard a nurse aide calling come STAT (immediately) to room (Resident #1's room). The nurse entered the room and observed two nurse aides and the resident's mother striping her bed. Resident #1's mother was yelling that her daughter had ants all on her. The resident had bites on both arms, along her collar bone and the front of her legs, and that the areas were slightly swollen and red. The physician's NP was consulted and gave orders for 50 mg of [MEDICATION NAME] and 7.5 mg of Loratab via her feeding tube, and to apply [MEDICATION NAME] cream to her body. The resident's mother wanted her transferred to a hospital, at 10:00 AM, and at 4:00 PM, Resident #1 returned from the hospital via ambulance. A Patient/Resident Incident/Accident Investigation Worksheet, completed by LVN F on 09/01/13, documented on 09/01/13 at 9:20 AM, Resident #1 was found to have ant bites. At 9:20 AM, the resident's mother came and found ants in the resident's bed and room. Staff then cleaned the ants off the resident and applied cream with medication given per [DEVICE]. On 09/13/13 at 9:15 AM, during an interview with CNA E, she confirmed she worked on 09/01/13, and that she had been assigned the hall where Resident #1 resided. She stated her shift began at 6:00 AM. She stated she was not informed about ants being found in Resident #1's room and bed during the previous shift. She stated she checked on Resident #1 briefly, but did not pull back her sheet to check for ants or perform any incontinence care. She stated around 9:00 AM, she saw Resident #1's family member enter the resident's room and then heard the resident's family member yelling for help. She stated when she arrived at Resident #1's room, hundreds of ants were on Resident #1, as well as on her bed and under the resident. CNA E stated she had previously seen ants on the 200 and 300 halls, but denied seeing them on any resident. CNA E stated staff now report any sightings of ants to the charge nurse and maintenance. On 09/17/13 at 11:04 AM, during an interview with MA G, he confirmed he worked on 09/01/13. He stated he heard Resident #1's family member call for help and went to assist. He stated Resident #1 was covered from head-to-toe in ants. He stated he focused on helping get the ants off her. He added there were too many ants to count. During a confidential staff interview, he/she stated he/she had assisted with removing ants from Resident #1 on 09/01/13, and had provided care

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

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F 0157 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 1) for the resident when the resident returned from the hospital. The confidential interviewee (CI) stated he/she was present when Resident #1's family member arrived at the facility around 9:00 AM on 09/01/13, and called for help. The CI removed Resident #1's brief during the incident and could tell Resident #1 had not been provided incontinent care for a significant amount of time due to the wetness of the brief and pad, and the feeding residue on the pad (however, this was not confirmed). The CI believed the level of wetness and amount of feeding residue indicated Resident #1's sheets had not been changed the night before when the ants where initially found in the resident's bed. The CI stated Resident #1's brief was filled with ants, and there were hundreds of ants on the resident, including when LVN F was in the room. The CI described Resident #1 as being covered in bites. The CI stated when Resident #1 returned from the hospital, she had to sit in her wheelchair for approximately an hour to an hour and a half because her bed, which had a new mattress, was not ready. The CI stated Resident #1 was then moved to another unit. The CI stated he/she went to check on the resident and she was wrapped in a sheet and when he/she removed the sheet from the resident, he/she observed three to four ants. The CI stated he/she knew the sheets and the mattress were clean and free of ants, so he/she checked Resident #1's wheelchair. The CI stated he/she discovered the pad in the seat of the wheelchair had a hole with food in it as well as food under the pad. The CI shook the pad and approximately eight to nine ants came out of the pad. The CI stated this incident was reported to the DON and Administrator. On 09/16/13 at approximately 11:15 AM, during an interview with LVN F, she confirmed she worked on 09/01/13, and her shift was 6:00 AM to 2:00 PM. She stated she had been the charge nurse for the 200 and 300 halls, which included Resident #1. She stated the night nurse told her ants had been found in Resident #1's room and the resident was moved to a new room. She stated she did a quick check of Resident #1 during walking rounds at approximately 6:00 AM, and then did a complete check of Resident #1 at approximately 8:30 AM. She stated the complete check included pulling back Resident #1's covers and checking her body for ant bites and did not find any. During the interview with LVN F, she further stated that at approximately 9:20 AM, she was called by a nurse aide to Resident #1's room. She stated she did not see a great deal of ants; no more than 30 ants. LVN F stated she observed ant bites around Resident #1's collarbone and the front of her chest. She stated she did not observe any ant bites on Resident #1's trunk or vaginal area. She stated the bites did not have blisters and Resident #1 did not have any facial expression indicating she was in pain. (Note: CNA E and the CI both stated they saw hundreds of ants, and MA G stated he saw too many (ants) to count.) LVN F further stated she contacted Resident #1's physician's answering service and then spoke with the physician's NP regarding the incident. She stated the NP who prescribed Resident #1 [MEDICATION NAME] and Loritab, said if Resident #1's family member wanted her sent to the hospital to go ahead and send her. Resident #1's family member requested the resident be sent to the hospital so she contacted a non-emergency transport company and was told that due to Resident #1 being total care, they would be unable to transport the resident. She stated she then contacted an ambulance service for a non-emergency transport. LVN F stated she was not sure if she had notified Resident #1's physician about Resident #1 being sent to the hospital, but did notify the physician upon the resident's return to the facility. (Note: LVN F's nurse's notes for 09/01/13, provided no evidence the physician or his NP were consulted prior to the resident being transferred to a local hospital or upon the resident's return to the facility.) On 09/17/13 at 3:30 PM, during an interview with the DON, she stated that on 09/01/13, between 9:30 AM to 10:00 AM, she was notified of the incident involving Resident #1 and the ants. She recalled that Resident #1 was sent out to the hospital due to the family member's request. The DON stated she arrived at the facility shortly after she was notified of the incident but she did not observe Resident #1 until she had returned from the hospital. The DON stated she conducted the investigation of the incident. she could ot explain why LVN F's nurse's notes did not provide and accurate assessment of the number of Resident #1's number of ant bites. She stated she did not interview LVN F regarding her statement that Resident #1 only received 30 ant bites. She stated she was not aware LVN F had not disclosed the severity of Resident #1's ant bites when she consulted with the physician's NP. She was not aware that neither the physician nor the physician's NP had been consulted regarding Resident #1's transfer to the hospital. She was not aware that neither the physician nor his NP were notified when Resident #1 returned to the facility from the hospital. Nurse's notes, dated 09/01/13 at 4:00 PM, reflected the hospital's physician gave orders for the resident to receive 500 mg of Keflex four times a day for seven days, 4 mg of [MEDICATION NAME][MEDICATION NAME] to take as directed on the package, and [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) 2.5 mg/167 mg per 5 ml solution, take 10 ml (two teasponns) every 6 hours as needed for pain. The nurses' notes provided no documented evidence the resident's physician or the physician's PA were notified of the request to transfer the resident to the hospital or of the resident's return from the hospital with new orders. On 09/13/13 at 10:15 AM, during an interview with the physician's NP, she stated she was first notified around midnight (12:00 AM) on 09/01/13, of the ants in Resident #1's room. She stated she received another telephone call later that morning, but was uncertain of the time, and was told the resident had been moved to another room. She stated a third telephone call was received from the facility on 09/01/13, saying Resident #1's family member was worried about Resident #1 being in pain from some ant bites. She stated she prescribed a topical cream, pain medication, and [MEDICATION NAME]. She stated she was not informed of the number of ant bites or seriousness of the incident. The NP stated she received another telephone call from the facility on 09/02/13 at around midnight to inform her that Resident #1's family member did not want Resident #1 to take the steroids prescribed by the emergency room physician. The NP stated she had been unaware Resident #1 had transferred to a hospital emergency room or of Resident #1's return to the facility. The NP stated she did not see Resident #1 until Tuesday (09/03/13), but could tell that she would have sent Resident #1 to the hospital at the time of the incident if the seriousness of the incident had been conveyed. The NP stated she had recently had problems getting accurate reports from staff at the facility. She stated staff were not reporting the full extent of situations and were not prepared with information. On 09/12/13 at 12:30 PM, during an interview with Resident #1's physician, he stated the red welts observed by the surveyors were ant bites. He stated if he had seen the ant bites immediately after the incident, he would have sent her to the hospital. The physician stated he did not initially handle the incident, but the information his office received about the incident did not relay the seriousness of the incident. The physician stated the worst case scenario would have been Resident #1 experiencing anaphylactic shock. A secondary concern was a massive infection. The physician stated Resident #1 could experience scarring in the areas of the ant bites, and added that it could take up to another month for the bites to heal, and stated, There had to be hundreds of ants to have caused the extent of (Resident #1's) injuries. Resident #1's nurse's notes reflected the following entries regarding her ant bites: Entry dated 09/03/13 on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected Resident #1 was small and frail in stature and unable to make needs known. The resident had contractures to knees, hips, and elbows bilaterally. Ant bites are noted to Resident #1's entire body from dense to sparse concentrations. The densest concentrations of ant bites are in the following areas: the base of the back of the neck, the right posterior flank area, left posterior thigh, and left posterior lateral calf. The ants bites are cluster of fluid filled pustules, too numerous to count. Entry dated 09/06/13 (5 days after the incident) on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected a skin assessment was performed due to the incident of multiple ant bites. The densest concentrations of ant bites are the left posterior thigh and left posterior lateral calf. The ant bites in these areas are very red and irritated with a decrease in the fluid filled pustules. The ant bites to the neck, bilateral arms, and right flack are red and angry, but the concentration of redness has decreased. Observation on 09/13/13 at 12:29 PM, of Resident #1 in her room, revealed she was in bed with socks on her hand. Resident #1's family member was present and stated the socks were used to prevent Resident #1 from scratching herself. Ant bites were observed on all of Resident #1's limbs, neck, shoulders, back, right rib cage, and left inner thigh. Several of the ant bites were observed to have pustules. The family member removed the socks and Resident #1 immediately began scratching her neck and shoulder area. Resident #1 had several dark red scratch marks on both her upper arms and shoulder area. Resident #1's facial expression indicated she was distressed. Resident #1 made slight groaning noises and continued to attempt to scratch at areas with ant bites. Review of the Provider Investigation Report, signed by the DON and dated 09/06/13, identified the category of the incident involving Resident #1 as Other: Ant Bites. It reflected the incident occurred on 09/01/13, and was reported to the State Agency on 09/01/13. The summary of the investigation reflected: A nurse observed ants on the resident's dresser and on her bed on 08/31/13 at approximately 11:40 PM. The resident and her roommate were moved to another room and both residents were assessed and no observations of ants were noted on either resident. Staff continued to monitor throughout the shift. On 09/01/13 at 9:30 AM, the resident's mother observed ants on the resident. A nurse assessed Resident #1 and observed multiple ant bits on Resident #1 and the areas were closed and slightly swollen. The Post-Investigation action section reflected facility staff had been monitoring for ants in the facility since 08/28/13, due to ants found in two rooms. Resident #1 was moved to another room, and her previous room was deep cleaned, and she was provided with a new wheelchair cushion. A head-to-toe assessment was conducted every shift. A pest control

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F 0157

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 2)

provider treated the interior and exterior of the facility. (The copies of billing from the pest control provider were for 08/09/13, 08/13/13, 08/16/13, 08/20/13, 08/21/13, 08/26/13, 08/27/13, and 09/06/13.) Staff, including nursing staff, maintenance, housekeeping and administration, were educated on monitoring rooms for ant activity, implementing safety checks for ants, who to notify in the event of finding ants, and how to respond if ants were observed on residents or beds/linens. Daily monitoring continued for observation of ants. The plan did not address ensuring nurses conduct accurate assessments of residents and ensuring nurses provide complete and accurate information when consulting with a resident's physician. It furthermore did not provide information regarding how they addressed ensuring nurses consult/notify a physician when a resident is being transferred to a hospital and again when they return with an order to review the treatment orders from the hospital to allow the attending physician to determine if he wants to approve the new treatment plan or change it. Review of the facility's Patient/Resident Incident/Accident Investigation Worksheets revealed on 08/31/13 at 11:49 PM, Resident #3 was found in her room with ants on her dresser. The nurse conducted a head-to-toe assessment of the resident and found no ant bites. (Note: This incident occurred the day before Resident #1 was found in the same room covered with ants.) Review of the facility's Service Request Log for the contract exterminator revealed the following: 08/20/13 at 2:30 p.m. - Entire unit needs to be sprayed. Bugs and ants in every room. On 08/21/13 (no time) - Entire room [ROOM NUMBER] and bed B have ants. On 08/21/13 (no time) - Ants in closet in room [ROOM NUMBER] on clothes. On

09/01/13 (no time) - Ants in resident room [ROOM NUMBER] and restroom. On 09/03/13 (no time) - Ants at nurses' station (station not specified). Review of the pest control service provider's receipts for treatment revealed the following: 08/13/13: room [ROOM NUMBER] was treated. The facility's exterior was treated. Ants were the targeted pest. Ants were noted during service. A Fire Ant mound was noted near an exit door. Ants were noted in room [ROOM NUMBER]. 08/16/13: this visit was in regard to cockroaches in the kitchen and the treatment of [REDACTED]. 08/20/13: The facility's exterior area was treated. Ants were noted during service. The courtyard of the secured unit, 200 hall, was treated. rooms [ROOM NUMBERS] were treated for [REDACTED]. 08/21/13: Patient/guest rooms were treated. The targeted pest was ants. rooms [ROOM NUMBERS] were treated. Ants were noted during service under cold base in rooms [ROOM NUMBERS]. 08/25/13: The facility's exterior area and patient/guest rooms were treated. The targeted pest was ants. The areas were inspected and treated and rooms were serviced. room [ROOM NUMBER], baseboards, was treated. Ants were noted during services; baseboards around bed. 08/27/13: The facility's perimeter was treated and ants were the target. Ants were noted during service; several ants near building on exterior of building. Trees/shrubs were contacting the facility creating a path for pests to enter. The service provider suggested the facility trim back vegetation to eliminate contact. 09/06/13: The exterior of the widnoew and ground near room [ROOM NUMBER]. On 09/13/13 at 3:20 PM, interview with the Pest Control Service Provider revealed only one fire ant mound was found after the incident that occurred on 09/01/13. The service provider completed a power spray approximately two weeks ago. It will sometimes drive the insects into the facility where they will ingest the poison and then die. The service provider and the facility are working on controlling the issue. On 09/13/13 at 2:28 PM, interview with the Administrator revealed the facility did not have a specific policy regarding ants, just the statement written for the in-service conducted after the incident on 09/01/13. On 09/13/13 at 2:50 PM, interview with the Maintenance Director revealed prior to the incident on 09/01/13, the facility had been calling the exterminator when ants were found in the facility. The Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The identified repairs were completed following the compilation of the list of repairs needed, however completion dates were not provided at that time. Any ants seen in the facility are logged by staff in a maintenance log book located at each nurses' station. The log books are check twice a day. Insect sightings are also logged in a pest control book located at the nurses' station that is monitored by the pest control service provider on a monthly basis. If only a couple of ants are sighted the maintenance staff will treat the area himself. If it is a resident room he will also treat outside near the exterior wall of the room. Maintenance staff also monitor outside for ant mounds on a daily basis. Review of an undated, untitled document attached to the Facility's Provider Investigation Report involving Resident #1 revealed a list of resident rooms in the facility with environmental issues. On 09/13/13 at 2:50 PM, the Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The list included a total of 82 resident rooms that needed caulk around the windows. The following are the rooms identified: 1, 3, 11, 18, 20-22, 24-25, 28-30, 33-34, 38-39, 41-42, 45, 59-60, 200-213, 215-226, 228, 301-309, 311-313, 315, 401-408, 412-415, 418-420, 422-424, 426-427, and 429. The list also included 20 rooms that needed caulk around the windows and in the bathroom. The identified rooms were: 4, 23, 26, 31-32, 35-36, 40, 44, 48-49, 51-58, and 310. Also identified on the list were the following five rooms that needed caulking in the bathroom only: 9, 10, 12, 19, and 411. The list identified seven rooms where ants were found, the rooms were: 5, 9, 11, 20, 53, 55, and 406. The list also identified other environmental issues in resident rooms. In room [ROOM NUMBER] a hole in the widow screen was identified. In room [ROOM NUMBER] the window doesn't shut all the way, and the frame was rotten. In room [ROOM NUMBER] the window was still broken, and room [ROOM NUMBER] had broken window trim. The window in room [ROOM NUMBER]

was described as being in bad shape. room [ROOM NUMBER] had a hole by the bathroom door, and room [ROOM NUMBER] had a

broken baseboard. A total of 107 resident rooms of the 120 resident rooms in the facility were identified as needing some type of repair. On 09/13/13 at approximately 4:00 PM, the Administrator and Assistant Administrator revealed the plan to address the ants in the facility included the following: One hour checks of total care residents by direct care staff, daily checks on residents' rooms by clinical staff and housekeeping, and daily checks by maintenance outside the facility for ant mounds. Logs of the resident and room checks were kept at each nurses' station, one for direct care staff and one for housekeeping. Staff documents any sightings of ants in the maintenance log as well as the other identified logs. The Assistant Administrator stated he has begun marking rooms where ants were sited on a floor plan so he can monitor which rooms are impacted. The Administrator stated the monitoring began on 08/28/13, but some of the nurses' stations did not begin their logs until 09/02/13. Maintenance staff is monitoring the maintenance logs kept at the nursing stations at least once a day. Maintenance treats any sightings of insects immediately and coordinates further treatments with the pest control service providers. Review of the facility's Daily Ant Inspection logs revealed rooms on the 200 Hall, 300 Hall, 400 Hall, The Terrace, and The Verandah were monitored once a day for ants from 08/28/13 to 09/14/13. Ants were noted on 09/01/13 in Rooms 211, 213, 310, and the 300 Hall Shower Room. Ants were noted on 09/01/13 in room [ROOM NUMBER], and the

300 Hall. Ants were noted on 09/04/13 in rooms [ROOM NUMBERS]. Ants were noted on 09/04/13 in Rooms 310, and 417, and 400

Hall Shower Room. Ants were noted on 09/05/13 in room [ROOM NUMBER]. Ants were noted on 09/06/13 in room [ROOM NUMBER].

Ants were noted on 09/10/13 in room [ROOM NUMBER]. Ants were noted on 09/12/13 in room [ROOM NUMBER]. Ants were noted on

09/14/13 in rooms [ROOM NUMBERS]. Review of the in-service regarding ants/residents, conducted on 09/04/13, revealed the following: If a resident is found to have ants in the room the following should be done; head-to-toe assessment done on the resident, shower the resident, change gown and linens. If the resident is needed to change rooms the bed must be changed as well. One hour ant round logs are to be completed by each shift. The facility's current Nursing Policies and Procedures included: Physician Communication/Change in Condition, revised September 2011 and reflected the following: POLICY: 1. To improve communication between physicians and nursing staff in order to promote optimal patient/resident care. 2. To provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition. PROCEDURES: 1. Complete assessment of the patient/resident which may include but is not limited to: .B. Current physical condition C. Patient's/resident's previous condition (declining, improving, stable) .E. Vital signs, TPR (temperature), BP (blood pressure).Lung Sounds, N/V Abdominal Assessment, Pain. .H. allergies [REDACTED]. .L. Any interventions/first aide (sic) provided to the patient/resident. 2. Notify the physician of the change in medical condition. (The physician notification grid may be used as a reference tool regarding acceptable notification timeframes.) The nurse will document all assessments and changes in the patient's/resident's condition in the medical record. 3. If the physician does not respond within an acceptable time frame, the Medical Director and Director of Nursing will be notified. 4. The patient's/resident's family member/legal representative will be notified of any change in condition requiring an emergent transfer to the hospital. A Physician Communication Grid was provided as guidelines for notifying the physician and reflected: These guidelines are not intended to substitute for good nursing judgment. If the nurse feels uncomfortable with a situation he/she should not delay contacting the physician or call 911 if it appears to be a life-threatening event. An Immediate Jeopardy was identified on 09/26/13 in the area of Quality of Care and accurate assessments. On 09/26/13 at 1:00 PM, the Assistant Administrator and DON were informed an Immediate Jeopardy (IJ) had been identified. A Plan of Removal for the IJ was requested. . The Plan of Removal for the IJ was accepted on 09/27/13 at 7:30

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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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) PM, and reflected the following: Resident #1's bed was found with ants on 08/31/13 at 11:49 PM. Assessment of the resident revealed there were no ant bites. The resident was moved to another room, which shared a wall with her first room. On 09/01/13 at 8:30 AM, ants were found on Resident #1. LVN F was informed, but her documentation in the resident's clinical record was not an accurate description of the number of ants. MA G and CNA E, along with Resident #1's family member were stripping the bed and wiping ants off the resident. LVN F documented ants were under the resident as well as having been bitten on both arms, collar bone and front of the legs. There was no evidence of a comprehensive clinical assessment. Information provided to the NP was unknown. Orders were received to give [MEDICATION NAME] 50 mg and [MEDICATION NAME] 7.5 mg per [DEVICE] and to apply [MEDICATION NAME] cream. Resident #1 was transferred to the ER for treatment at the insistence of the resident's family member. LVN F provided no other reason for Resident #1 being sent to the ER. Resident #1 returned to the facility the same day and was taken to a ro
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement the policies and procedures, which prohibit neglect for one (Resident #1) of four residents reviewed for neglect. When Resident #1 was found with fire ants everywhere on her body and was being bitten, LVN F failed to: -- conduct a head-to-toe assessment to determine with accuracy the number of fire ant bites she sustained, assessing for an allergic reaction and pain. -- provide Resident #1's physician/NP with an accurate assessment of Resident #1's status and allowing the physician/NP to respond appropriately with orders to send her to the hospital. -- notify the physician/NP Resident #1 was sent to the ER and when the resident returned from the ER with new orders until the resident had been back in the facility for over two hours. On 09/26/13 an Immediate Jeopardy (IJ) was identified in the area of quality of care and accurate assessments. While the IJ was removed on 09/30/13, the facility remained out of compliance at a level of actual harm that is not immediate jeopardy and at a potential for more than minimal harm and scope of pattern. because staff were still being inserviced and the facility was monitoring the effectiveness of their plan of removal. These failures placed the facility's 152 residents, including Residents #1, #2, #3 and #4, at risk for not being adequately assessed with [REDACTED]. in a delay in treatment or [DIAGNOSES REDACTED]. Findings included: On 09/26/13, based on administrative review, the investigation was reopened for further investigation of a current Immediate Jeopardy situation. Resident #1's MDS assessment, dated 08/25/13, reflected a [AGE] year-old female who was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The assessment reflected Resident #1 had severe cognitive impairment, received nourishment via tube feeding, and required total dependence on staff for activities of daily living to include bed mobility and personal hygiene. Resident #1's care plan with a current review date of 08/11/13, reflected the following: a) ADL functions reflected she was totally dependent for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. Approaches included to provide Resident #1 with assistance as needed. b) [DIAGNOSES REDACTED]. Approaches included following safety measures and implementing [MEDICAL CONDITION] precautions. c) Resident had difficulty making self understood related to her [DIAGNOSES REDACTED]. Approaches included to observe for non-verbal signs of distress (guarding, moaning, restlessness, grimacing, withdrawal, etc.). Turn/reposition, communicate, provide pericare, assess for pain, and provide liquids/food as needed. Staff must anticipate needs. Resident unable to communicate. d) Resident is at risk for skin breakdown related to bowel and bladder incontinence. The goal was for the resident's skin to remain intact. Approaches included to assess the resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. On 09/12/13 at 11:00 AM, Resident #1 was observed in her room, lying on her bed. She was in a fetal position and had severe contractures of her arms, legs, and hands. She had swollen, inflamed, red welts on all visible areas of her body. Small clusters of welts and individual welts were around her hairline, upper and lower extremities, neck, and upper shoulder blades, plus on her hands and feet. A cluster of welts was on her inner left thigh in an area approximately 6.0 to 8.0 inches in length and 3.0 to 4.0 inches in width. Observation by the surveyor on 09/12/13 at 11:30 AM revealed Resident #1 was covered with red welts, which appeared to be ant bites, except for her middle back, feeding tube area, vaginal area, and under her breasts. The red welts were too numerous to count. During the assessment, Resident #1 responded to verbal and physical stimulus by opening her eyes and frowning. On 09/12/13 at 11:00 AM, during the initial observation of Resident #1, a family member was present and identified the welts as fire ant bites. The family member stated the incident occurred on 09/01/13. The family member further stated he/she received a telephone call on 09/01/13 around 5:30 AM from a staff member informing him/her ants were found in the resident's room and Resident #1, along with her bed, had been moved to another room. the family member indicated this was a repeat notification of the ants observed on 08/31/13. The family member stated he/she received another telephone call from the facility later that same morning from a different staff member informing him/her of ants in the resident's room. The family member stated he/she became concerned and decided to check on the resident. The family member stated when he/she arrived, Resident #1 was in her room, in bed, and covered in ants. The family member stated he/she began yelling for help and several staff members came to help brush the ants off the resident. The family member revealed he/she had to insist Resident #1 be sent to the hospital, where she was informed by hospital staff the number of ant bites suffered by Resident #1 could have led to her death. Resident #1's nurse's notes dated 09/01/13 and timed both at 5:30 AM and 11:40 PM (start of shift was on 08/31/13), reflected ants were on the resident's dresser and some on her bed. The nurse conducted an assessment of the resident and noted she had no ant bites and had no signs and symptoms of pain. The resident's MD was notified and an order was received to move the resident to another room, and the family was notified of the resident's transfer to a different room due to the presence of ants. An entry at 8:30 AM, reflected the resident was resting comfortably and there were no signs of ants or ant bites in the new room (which shared a wall with Resident #1's old room). The next nurse's notes entry for Resident #1, dated 09/03/13 at 9:30 AM, reflected the nurse heard a nurse aide calling come STAT (immediately) to room (Resident #1's room). The nurse entered the room and observed two nurse aides and the resident's mother striping her bed. Resident #1's mother was yelling that her daughter had ants all on her. The resident had bites on both arms, along her collar bone and the front of her legs, and that the areas were slightly swollen and red. The physician's NP was consulted and gave orders for 50 mg of [MEDICATION NAME] and 7.5 mg of Loratab via her feeding tube, and to apply [MEDICATION NAME] cream to her body. The resident's mother wanted her transferred to a hospital, at 10:00 AM, and at 4:00 PM, Resident #1 returned from the hospital via ambulance. A Patient/Resident Incident/Accident Investigation Worksheet, completed by LVN F on 09/01/13, documented on 09/01/13 at 9:20 AM, Resident #1 was found to have ant bites. At 9:20 AM, the resident's mother came and found ants in the resident's bed and room. Staff then cleaned the ants off the resident and applied cream with medication given per [DEVICE]. On 09/13/13 at 9:15 AM, during an interview with CNA E, she confirmed she worked on 09/01/13, and that she had been assigned the hall where Resident #1 resided. She stated her shift began at 6:00 AM. She stated she was not informed about ants being found in Resident #1's room and bed during the previous shift. She stated she checked on Resident #1 briefly, but did not pull back her sheet to check for ants or perform any incontinence care. She stated around 9:00 AM, she saw Resident #1's family member enter the resident's room and then heard the resident's family member yelling for help. She stated when she arrived at Resident #1's room, hundreds of ants were on Resident #1, as well as on her bed and under the resident. CNA E stated she had previously seen ants on the 200 and 300 halls, but denied seeing them on any resident. CNA E stated staff now report any sightings of ants to the charge nurse and maintenance. On 09/17/13 at 11:04 AM, during an interview with MA G, he confirmed he worked on 09/01/13. He stated he heard Resident #1's family member call for help and went to assist. He stated Resident #1 was covered from head-to-toe in ants. He stated he focused on helping get the ants off her. He added there were too many ants to count. During a confidential staff interview, he/she stated he/she had assisted with removing ants from Resident #1 on 09/01/13, and had provided care for the resident when the resident returned from the hospital. The confidential interviewee (CI) stated he/she was present when Resident #1's family member arrived at the facility around 9:00 AM on 09/01/13, and called for help. The CI removed Resident #1's brief during the incident and could tell Resident #1 had not been provided incontinent care for a significant amount of time due to the wetness of the brief and pad, and the feeding residue on the pad (however, this was not confirmed). The CI believed the level of wetness and amount of feeding residue indicated Resident #1's sheets had not been changed the night before when the ants where initially found in the resident's bed. The CI stated Resident #1's brief was filled with ants, and there were hundreds of ants on the resident, including when LVN F was in the room. The CI described Resident #1 as being covered in bites. The CI stated when Resident #1 returned from the hospital, she had to sit in her

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	455416	A. BUILDING _____ B. WING _____	09/30/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE COURTYARDS AT FORT WORTH	8001 WESTERN HILLS BLVD FORT WORTH, TX 76108

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 4) wheelchair for approximately an hour to an hour and a half because her bed, which had a new mattress, was not ready. The CI stated Resident #1 was then moved to another unit. The CI stated he/she went to check on the resident and she was wrapped in a sheet and when he/she removed the sheet from the resident, he/she observed three to four ants. The CI stated he/she knew the sheets and the mattress were clean and free of ants, so he/she checked Resident #1's wheelchair. The CI stated he/she discovered the pad in the seat of the wheelchair had a hole with food in it as well as food under the pad. The CI shook the pad and approximately eight to nine ants came out of the pad. The CI stated this incident was reported to the DON and Administrator. On 09/16/13 at approximately 11:15 AM, during an interview with LVN F, she confirmed she worked on 09/01/13, and her shift was 6:00 AM to 2:00 PM. She stated she had been the charge nurse for the 200 and 300 halls, which included Resident #1. She stated the night nurse told her ants had been found in Resident #1's room and the resident was moved to a new room. She stated she did a quick check of Resident #1 during walking rounds at approximately 6:00 AM, and then did a complete check of Resident #1 at approximately 8:30 AM. She stated the complete check included pulling back Resident #1's covers and checking her body for ant bites and did not find any. During the interview with LVN F, she further stated that at approximately 9:20 AM, she was called by a nurse aide to Resident #1's room. She stated she did not see a great deal of ants; no more than 30 ants. LVN F stated she observed ant bites around Resident #1's collarbone and the front of her chest. She stated she did not observe any ant bites on Resident #1's trunk or vaginal area. She stated the bites did not have blisters and Resident #1 did not have any facial expression indicating she was in pain. (Note: CNA E and the CI both stated they saw hundreds of ants, and MA G stated he saw too many (ants) to count.) LVN F further stated she contacted Resident #1's physician's answering service and then spoke with the physician's NP regarding the incident. She stated the NP who prescribed Resident #1 [MEDICATION NAME] and Loritab, said if Resident #1's family member wanted her sent to the hospital to go ahead and send her. Resident #1's family member requested the resident be sent to the hospital so she contacted a non-emergency transport company and was told that due to Resident #1 being total care, they would be unable to transport the resident. She stated she then contacted an ambulance service for a non-emergency transport. LVN F stated she was not sure if she had notified Resident #1's physician about Resident #1 being sent to the hospital, but did notify the physician upon the resident's return to the facility. (Note: LVN F's nurse's notes for 09/01/13, provided no evidence the physician or his NP were consulted prior to the resident being transferred to a local hospital or upon the resident's return to the facility.) On 09/17/13 at 3:30 PM, during an interview with the DON, she stated that on 09/01/13, between 9:30 AM to 10:00 AM, she was notified of the incident involving Resident #1 and the ants. She recalled that Resident #1 was sent out to the hospital due to the family member's request. The DON stated she arrived at the facility shortly after she was notified of the incident but she did not observe Resident #1 until she had returned from the hospital. The DON stated she conducted the investigation of the incident. she could ot explain why LVN F's nurse's notes did not provide and accurate assessment of the number of Resident #1's number of ant bites. She stated she did not interview LVN F regarding her statement that Resident #1 only received 30 ant bites. She stated she was not aware LVN F had not disclosed the severity of Resident #1's ant bites when she consulted with the physician's NP. She was not aware that neither the physician nor the physician's NP had been consulted regarding Resident #1's transfer to the hospital. She was not aware that neither the physician nor his NP were notified when Resident #1 returned to the facility from the hospital. Nurse's notes, dated 09/01/13 at 4:00 PM, reflected the hospital's physician gave orders for the resident to receive 500 mg of Keflex four times a day for seven days, 4 mg of [MEDICATION NAME][MEDICATION NAME] to take as directed on the package, and [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) 2.5 mg/167 mg per 5 ml solution, take 10 ml (two teasponns) every 6 hours as needed for pain. The nurses' notes provided no documented evidence the resident's physician or the physician's PA were notified of the request to transfer the resident to the hospital or of the resident's return from the hospital with new orders. On 09/13/13 at 10:15 AM, during an interview with the physician's NP, she stated she was first notified around midnight (12:00 AM) on 09/01/13, of the ants in Resident #1's room. She stated she received another telephone call later that morning, but was uncertain of the time, and was told the resident had been moved to another room. She stated a third telephone call was received from the facility on 09/01/13, saying Resident #1's family member was worried about Resident #1 being in pain from some ant bites. She stated she prescribed a topical cream, pain medication, and [MEDICATION NAME]. She stated she was not informed of the number of ant bites or seriousness of the incident. The NP stated she received another telephone call from the facility on 09/02/13 at around midnight to inform her that Resident #1's family member did not want Resident #1 to take the steroids prescribed by the emergency room physician. The NP stated she had been unaware Resident #1 had transferred to a hospital emergency room or of Resident #1's return to the facility. The NP stated she did not see Resident #1 until Tuesday (09/03/13), but could tell that she would have sent Resident #1 to the hospital at the time of the incident if the seriousness of the incident had been conveyed. The NP stated she had recently had problems getting accurate reports from staff at the facility. She stated staff were not reporting the full extent of situations and were not prepared with information. On 09/12/13 at 12:30 PM, during an interview with Resident #1's physician, he stated the red welts observed by the surveyors were ant bites. He stated if he had seen the ant bites immediately after the incident, he would have sent her to the hospital. The physician stated he did not initially handle the incident, but the information his office received about the incident did not relay the seriousness of the incident. The physician stated the worst case scenario would have been Resident #1 experiencing anaphylactic shock. A secondary concern was a massive infection. The physician stated Resident #1 could experience scarring in the areas of the ant bites, and added that it could take up to another month for the bites to heal, and stated, There had to be hundreds of ants to have caused the extent of (Resident #1's) injuries. Resident #1's nurse's notes reflected the following entries regarding her ant bites: Entry dated 09/03/13 on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected Resident #1 was small and frail in stature and unable to make needs known. The resident had contractures to knees, hips, and elbows bilaterally. Ant bites are noted to Resident #1's entire body from dense to sparse concentrations. The densest concentrations of ant bites are in the following areas: the base of the back of the neck, the right posterior flank area, left posterior thigh, and left posterior lateral calf. The ants bites are cluster of fluid filled pustules, too numerous to count. Entry dated 09/06/13 (5 days after the incident) on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected a skin assessment was performed due to the incident of multiple ant bites. The densest concentrations of ant bites are the left posterior thigh and left posterior lateral calf. The ant bites in these areas are very red and irritated with a decrease in the fluid filled pustules. The ant bites to the neck, bilateral arms, and right flack are red and angry, but the concentration of redness has decreased. Observation on 09/13/13 at 12:29 PM, of Resident #1 in her room, revealed she was in bed with socks on her hand. Resident #1's family member was present and stated the socks were used to prevent Resident #1 from scratching herself. Ant bites were observed on all of Resident #1's limbs, neck, shoulders, back, right rib cage, and left inner thigh. Several of the ant bites were observed to have pustules. The family member removed the socks and Resident #1 immediately began scratching her neck and shoulder area. Resident #1 had several dark red scratch marks on both her upper arms and shoulder area. Resident #1's facial expression indicated she was distressed. Resident #1 made slight groaning noises and continued to attempt to scratch at areas with ant bites. Review of the Provider Investigation Report, signed by the DON and dated 09/06/13, identified the category of the incident involving Resident #1 as Other: Ant Bites. It reflected the incident occurred on 09/01/13, and was reported to the State Agency on 09/01/13. The summary of the investigation reflected: A nurse observed ants on the resident's dresser and on her bed on 08/31/13 at approximately 11:40 PM. The resident and her roommate were moved to another room and both residents were assessed and no observations of ants were noted on either resident. Staff continued to monitor throughout the shift. On 09/01/13 at 9:30 AM, the resident's mother observed ants on the resident. A nurse assessed Resident #1 and observed multiple ant bits on Resident #1 and the areas were closed and slightly swollen. The Post-Investigation action section reflected facility staff had been monitoring for ants in the facility since 08/28/13, due to ants found in two rooms. Resident #1 was moved to another room, and her previous room was deep cleaned, and she was provided with a new wheelchair cushion. A head-to-toe assessment was conducted every shift. A pest control provider treated the interior and exterior of the facility. (The copies of billing from the pest control provider were for 08/09/13, 08/13/13, 08/16/13, 08/20/13, 08/21/13, 08/26/13, 08/27/13, and 09/06/13.) Staff, including nursing staff, maintenance, housekeeping and administration, were educated on monitoring rooms for ant activity, implementing safety checks for ants, who to notify in the event of finding ants, and how to respond if ants were observed on residents or beds/linens. Daily monitoring continued for observation of ants. The plan did not address ensuring nurses conduct accurate assessments of residents and ensuring nurses provide complete and accurate information when consulting with a resident's physician. It furthermore did not provide information regarding how they addressed ensuring nurses consult/notify a physician when a resident is being transferred to a hospital and again when they return with an order to review the

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	455416	A. BUILDING _____ B. WING _____	**09/30/2013**

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 5)

treatment orders from the hospital to allow the attending physician to determine if he wants to approve the new treatment plan or change it. Review of the facility's Patient/Resident Incident/Accident Investigation Worksheets revealed on 08/31/13 at 11:49 PM, Resident #3 was found in her room with ants on her dresser. The nurse conducted a head-to-toe assessment of the resident and found no ant bites. (Note: This incident occurred the day before Resident #1 was found in the same room covered with ants.) Review of the facility's Service Request Log for the contract exterminator revealed the following: 08/20/13 at 2:30 p.m. - Entire unit needs to be sprayed. Bugs and ants in every room. On 08/21/13 (no time) - Entire room [ROOM NUMBER] and bed B have ants. On 08/21/13 (no time) - Ants in closet in room [ROOM NUMBER] on clothes. On

09/01/13 (no time) - Ants in resident room [ROOM NUMBER] and restroom. On 09/03/13 (no time) - Ants at nurses' station (station not specified). Review of the pest control service provider's receipts for treatment revealed the following: 08/13/13: room [ROOM NUMBER] was treated. The facility's exterior was treated. Ants were the targeted pest. Ants were noted during service. A Fire Ant mound was noted near an exit door. Ants were noted in room [ROOM NUMBER]. 08/16/13: this visit was in regard to cockroaches in the kitchen and the treatment of [REDACTED]. 08/20/13: The facility's exterior area was treated. Ants were noted during service. The courtyard of the secured unit, 200 hall, was treated. rooms [ROOM NUMBERS] were treated for [REDACTED]. 08/21/13: Patient/guest rooms were treated. The targeted pest was ants. rooms [ROOM NUMBERS] were treated. Ants were noted during service under cold base in rooms [ROOM NUMBERS]. 08/25/13: The facility's exterior area and patient/guest rooms were treated. The targeted pest was ants. The areas were inspected and treated and rooms were serviced. room [ROOM NUMBER], baseboards, was treated. Ants were noted during services; baseboards around bed. 08/27/13: The facility's perimeter was treated and ants were the target. Ants were noted during service; several ants near building on exterior of building. Trees/shrubs were contacting the facility creating a path for pests to enter. The service provider suggested the facility trim back vegetation to eliminate contact. 09/06/13: The exterior of the widnoew and ground near room [ROOM NUMBER]. On 09/13/13 at 3:20 PM, interview with the Pest Control Service Provider revealed only one fire ant mound was found after the incident that occurred on 09/01/13. The service provider completed a power spray approximately two weeks ago. It will sometimes drive the insects into the facility where they will ingest the poison and then die. The service provider and the facility are working on controlling the issue. On 09/13/13 at 2:28 PM, interview with the Administrator revealed the facility did not have a specific policy regarding ants, just the statement written for the in-service conducted after the incident on 09/01/13. On 09/13/13 at 2:50 PM, interview with the Maintenance Director revealed prior to the incident on 09/01/13, the facility had been calling the exterminator when ants were found in the facility. The Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The identified repairs were completed following the compilation of the list of repairs needed, however completion dates were not provided at that time. Any ants seen in the facility are logged by staff in a maintenance log book located at each nurses' station. The log books are check twice a day. Insect sightings are also logged in a pest control book located at the nurses' station that is monitored by the pest control service provider on a monthly basis. If only a couple of ants are sighted the maintenance staff will treat the area himself. If it is a resident room he will also treat outside near the exterior wall of the room. Maintenance staff also monitor outside for ant mounds on a daily basis. Review of an undated, untitled document attached to the Facility's Provider Investigation Report involving Resident #1 revealed a list of resident rooms in the facility with environmental issues. On 09/13/13 at 2:50 PM, the Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The list included a total of 82 resident rooms that needed caulk around the windows. The following are the rooms identified: 1, 3, 11, 18, 20-22, 24-25, 28-30, 33-34, 38-39, 41-42, 45, 59-60, 200-213, 215-226, 228, 301-309, 311-313, 315, 401-408, 412-415, 418-420, 422-424, 426-427, and 429. The list also included 20 rooms that needed caulk around the windows and in the bathroom. The identified rooms were: 4, 23, 26, 31-32, 35-36, 40, 44, 48-49, 51-58, and 310. Also identified on the list were the following five rooms that needed caulking in the bathroom only: 9, 10, 12, 19, and 411. The list identified seven rooms where ants were found, the rooms were: 5, 9, 11, 20, 53, 55, and 406. The list also identified other environmental issues in resident rooms. In room [ROOM NUMBER] a hole in the widow screen was identified. In room [ROOM NUMBER] the window doesn't shut all the way, and the frame was rotten. In room [ROOM NUMBER] the window was still broken, and room [ROOM NUMBER] had broken window trim. The window in room [ROOM NUMBER]

was described as being in bad shape. room [ROOM NUMBER] had a hole by the bathroom door, and room [ROOM NUMBER] had a

broken baseboard. A total of 107 resident rooms of the 120 resident rooms in the facility were identified as needing some type of repair. On 09/13/13 at approximately 4:00 PM, the Administrator and Assistant Administrator revealed the plan to address the ants in the facility included the following: One hour checks of total care residents by direct care staff, daily checks on residents' rooms by clinical staff and housekeeping, and daily checks by maintenance outside the facility for ant mounds. Logs of the resident and room checks were kept at each nurses' station, one for direct care staff and one for housekeeping. Staff documents any sightings of ants in the maintenance log as well as the other identified logs. The Assistant Administrator stated he has begun marking rooms where ants were sited on a floor plan so he can monitor which rooms are impacted. The Administrator stated the monitoring began on 08/28/13, but some of the nurses' stations did not begin their logs until 09/02/13. Maintenance staff is monitoring the maintenance logs kept at the nursing stations at least once a day. Maintenance treats any sightings of insects immediately and coordinates further treatments with the pest control service providers. Review of the facility's Daily Ant Inspection logs revealed rooms on the 200 Hall, 300 Hall, 400 Hall, The Terrace, and The Verandah were monitored once a day for ants from 08/28/13 to 09/14/13. Ants were noted on 09/01/13 in Rooms 211, 213, 310, and the 300 Hall Shower Room. Ants were noted on 09/01/13 in room [ROOM NUMBER], and the

300 Hall. Ants were noted on 09/04/13 in rooms [ROOM NUMBERS]. Ants were noted on 09/04/13 in Rooms 310, and 417, and 400

Hall Shower Room. Ants were noted on 09/05/13 in room [ROOM NUMBER]. Ants were noted on 09/06/13 in room [ROOM NUMBER].

Ants were noted on 09/10/13 in room [ROOM NUMBER]. Ants were noted on 09/12/13 in room [ROOM NUMBER]. Ants were noted on

09/14/13 in rooms [ROOM NUMBERS]. Review of the in-service regarding ants/residents, conducted on 09/04/13, revealed the following: If a resident is found to have ants in the room the following should be done; head-to-toe assessment done on the resident, shower the resident, change gown and linens. If the resident is needed to change rooms the bed must be changed as well. One hour ant round logs are to be completed by each shift. The facility's current Nursing Policies and Procedures included: Physician Communication/Change in Condition, revised September 2011 and reflected the following: POLICY: 1. To improve communication between physicians and nursing staff in order to promote optimal patient/resident care. 2. To provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition. PROCEDURES: 1. Complete assessment of the patient/resident which may include but is not limited to: .B. Current physical condition C. Patient's/resident's previous condition (declining, improving, stable) .E. Vital signs, TPR (temperature), BP (blood pressure).Lung Sounds, N/V Abdominal Assessment, Pain. .H. allergies [REDACTED]. .L. Any interventions/first aide (sic) provided to the patient/resident. 2. Notify the physician of the change in medical condition. (The physician notification grid may be used as a reference tool regarding acceptable notification timeframes.) The nurse will document all assessments and changes in the patient's/resident's condition in the medical record. 3. If the physician does not respond within an acceptable time frame, the Medical Director and Director of Nursing will be notified. 4. The patient's/resident's family member/legal representative will be notified of any change in condition requiring an emergent transfer to the hospital. A Physician Communication Grid was provided as guidelines for notifying the physician and reflected: These guidelines are not intended to substitute for good nursing judgment. If the nurse feels uncomfortable with a situation he/she should not delay contacting the physician or call 911 if it appears to be a life-threatening event. Review of the facility's current Abuse, Neglect and Misappropriation of Property policy, revised on February 2008, revealed the following: 1. The facility's Leadership prohibits neglect, mental or physical abuse, including involuntary seclusion and misappropriation of a patient's/resident's property and/or funds. 2. The facility's Leadership will conduct a prompt investigation of any allegation received of suspected abuse, neglect or misappropriation of property and/or funds. 3. The facility's Leadership will provide notification to the proper authorities, and, when required, the release of information to those agencies, pursuant to applicable federal and/or state law (F223, F224, F225, and F226). 4. The facility's Leadership will designate a staff member to oversee the abuse prohibition policy (Facility Abuse Coordinator). 5. The facility's Leadership will implement appropriate and necessary guidelines, which prohibit the mistreatment, neglect, and abuse of the patient/resident including misappropriation of property and/or funds. Guidelines for investigation reflected the following: A. Immediately assess resident/patient at the time if discovery of alleged abuse. B. Document assessment in the medical record. C. Maintain resident's/patient's protection during the investigation.

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	455416	A. BUILDING _____ B. WING _____	09/30/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE COURTYARDS AT FORT WORTH	8001 WESTERN HILLS BLVD FORT WORTH, TX 76108

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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 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 6) D. Notify the attending physician and resident's/patient's legally responsible party. E. Notify the Administrator, Director of Nursing, and Social Worker regardless of the times of da
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its written policies and procedures, which prohibit neglect, for one (Resident #1) of four residents reviewed for neglect. When Resident #1 was found with fire ants everywhere on her body and was being bitten, LVN F failed to: -- conduct a head-to-toe assessment to determine with accuracy the number of fire ant bites she sustained, assessing for an allergic reaction and pain. -- provide Resident #1's physician/NP with an accurate assessment of Resident #1's status and allowing the physician/NP to respond appropriately with orders to send her to the hospital. -- notify the physician/NP Resident #1 was sent to the ER and when the resident returned from the ER with new orders until the resident had been back in the facility for over two hours. On 09/26/13 an Immediate Jeopardy (IJ) was identified in the area of quality of care and accurate assessments. While the IJ was removed on 09/30/13, the facility remained out of compliance at a level of actual harm that is not immediate jeopardy and at a potential for more than minimal harm and scope of pattern. because staff were still being inserviced and the facility was monitoring the effectiveness of their plan of removal. These failures placed the facility's 152 residents, including Residents #1, #2, #3 and #4, at risk for not being adequately assessed with [REDACTED]. in a delay in treatment or [DIAGNOSES REDACTED]. Findings included: On 09/26/13, based on administrative review, the investigation was reopened for further investigation of a current Immediate Jeopardy situation. Review of the facility's current Abuse, Neglect and Misappropriation of Property policy, revised on February 2008, revealed the following: 1. The facility's Leadership prohibits neglect, mental or physical abuse, including involuntary seclusion and misappropriation of a patient's/resident's property and/or funds. 2. The facility's Leadership will conduct a prompt investigation of any allegation received of suspected abuse, neglect or misappropriation of property and/or funds. 3. The facility's Leadership will provide notification to the proper authorities, and, when required, the release of information to those agencies, pursuant to applicable federal and/or state law (F223, F224, F225, and F226). 4. The facility's Leadership will designate a staff member to oversee the abuse prohibition policy (Facility Abuse Coordinator). 5. The facility's Leadership will implement appropriate and necessary guidelines, which prohibit the mistreatment, neglect, and abuse of the patient/resident including misappropriation of property and/or funds. Guidelines for investigation reflected the following: A. Immediately assess resident/patient at the time if discovery of alleged abuse. B. Document assessment in the medical record. C. Maintain resident's/patient's protection during the investigation. D. Notify the attending physician and resident's/patient's legally responsible party. E. Notify the Administrator, Director of Nursing, and Social Worker regardless of the times of day. F. Conduct/make arrangements for physical/mental examination. DO NOT CLEAN, SHOWER OR BATHE Resident in allegations of physical/sexual assault, rape, molestation or coercion prior to any such examination. G. Complete the Suspected Abuse Reporting Tool and begin the Investigation Reporting Tool. H. Notify per Component VII. I. Written summaries of interviews with individuals having first-hand knowledge of the incident. NOTE: Employees/witnesses are not to write out statements. Employees/witnesses will be interviewed by designated Facility staff and the interviewer will record all witness accounts in a document, written, dated and signed by the interviewer. J. Social Service to provide support services to resident/patient and implement an interdisciplinary care plan. K. Depending on the incident, other residents in the facility may be interviewed. DON or designee will review the resident's medical record. L. Unless otherwise directed by the Legal Department, all investigations are to be in writing and kept on file in the administrator's office. M. Complete the Abuse Investigation Checklist. Resident #1's MDS assessment, dated 08/25/13, reflected a [AGE] year-old female who was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The assessment reflected Resident #1 had severe cognitive impairment, received nourishment via tube feeding, and required total dependence on staff for activities of daily living to include bed mobility and personal hygiene. Resident #1's care plan with a current review date of 08/11/13, reflected the following: a) ADL functions reflected she was totally dependent for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. Approaches included to provide Resident #1 with assistance as needed. b) [DIAGNOSES REDACTED]. Approaches included following safety measures and implementing [MEDICAL CONDITION] precautions. c) Resident had difficulty making self understood related to her [DIAGNOSES REDACTED]. Approaches included to observe for non-verbal signs of distress (guarding, moaning, restlessness, grimacing, withdrawal, etc.). Turn/reposition, communicate, provide pericare, assess for pain, and provide liquids/food as needed. Staff must anticipate needs. Resident unable to communicate. d) Resident is at risk for skin breakdown related to bowel and bladder incontinence. The goal was for the resident's skin to remain intact. Approaches included to assess the resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. On 09/12/13 at 11:00 AM, Resident #1 was observed in her room, lying on her bed. She was in a fetal position and had severe contractures of her arms, legs, and hands. She had swollen, inflamed, red welts on all visible areas of her body. Small clusters of welts and individual welts were around her hairline, upper and lower extremities, neck, and upper shoulder blades, plus on her hands and feet. A cluster of welts was on her inner left thigh in an area approximately 6.0 to 8.0 inches in length and 3.0 to 4.0 inches in width. Observation by the surveyor on 09/12/13 at 11:30 AM revealed Resident #1 was covered with red welts, which appeared to be ant bites, except for her middle back, feeding tube area, vaginal area, and under her breasts. The red welts were too numerous to count. During the assessment, Resident #1 responded to verbal and physical stimulus by opening her eyes and frowning. On 09/12/13 at 11:00 AM, during the initial observation of Resident #1, a family member was present and identified the welts as fire ant bites. The family member stated the incident occurred on 09/01/13. The family member further stated he/she received a telephone call on 09/01/13 around 5:30 AM from a staff member informing him/her ants were found in the resident's room and Resident #1, along with her bed, had been moved to another room. the family member indicated this was a repeat notification of the ants observed on 08/31/13. The family member stated he/she received another telephone call from the facility later that same morning from a different staff member informing him/her of ants in the resident's room. The family member stated he/she became concerned and decided to check on the resident. The family member stated when he/she arrived, Resident #1 was in her room, in bed, and covered in ants. The family member stated he/she began yelling for help and several staff members came to help brush the ants off the resident. The family member revealed he/she had to insist Resident #1 be sent to the hospital, where she was informed by hospital staff the number of ant bites suffered by Resident #1 could have led to her death. Resident #1's nurse's notes dated 09/01/13 and timed both at 5:30 AM and 11:40 PM (start of shift was on 08/31/13), reflected ants were on the resident's dresser and some on her bed. The nurse conducted an assessment of the resident and noted she had no ant bites and had no signs and symptoms of pain. The resident's MD was notified and an order was received to move the resident to another room, and the family was notified of the resident's transfer to a different room due to the presence of ants. An entry at 8:30 AM, reflected the resident was resting comfortably and there were no signs of ants or ant bites in the new room (which shared a wall with Resident #1's old room). The next nurse's notes entry for Resident #1, dated 09/03/13 at 9:30 AM, reflected the nurse heard a nurse aide calling come STAT (immediately) to room (Resident #1's room). The nurse entered the room and observed two nurse aides and the resident's mother striping her bed. Resident #1's mother was yelling that her daughter had ants all on her. The resident had bites on both arms, along her collar bone and the front of her legs, and that the areas were slightly swollen and red. The physician's NP was consulted and gave orders for 50 mg of [MEDICATION NAME] and 7.5 mg of Loratab via her feeding tube, and to apply [MEDICATION NAME] cream to her body. The resident's mother wanted her transferred to a hospital, at 10:00 AM, and at 4:00 PM, Resident #1 returned from the hospital via ambulance. A Patient/Resident Incident/Accident Investigation Worksheet, completed by LVN F on 09/01/13, documented on 09/01/13 at 9:20 AM, Resident #1 was found to have ant bites. At 9:20 AM, the resident's mother came and found ants in the resident's bed and room. Staff then cleaned the ants off the resident and applied cream with medication given per [DEVICE]. On 09/13/13 at 9:15 AM, during an interview with CNA E, she confirmed she worked on 09/01/13, and that she had been assigned the hall where Resident #1 resided. She stated her shift began at 6:00 AM. She stated she was not informed about ants being found in Resident #1's room and bed during the previous shift. She stated she checked on Resident #1 briefly, but did not pull back her sheet to check for ants or perform any incontinence care. She stated around 9:00 AM, she saw Resident #1's family member enter the resident's room and then heard the resident's family member yelling for help. She stated when she arrived at Resident #1's room, hundreds of ants were on Resident #1, as well as on her bed and under the resident. CNA E stated she

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 7) had previously seen ants on the 200 and 300 halls, but denied seeing them on any resident. CNA E stated staff now report any sightings of ants to the charge nurse and maintenance. On 09/17/13 at 11:04 AM, during an interview with MA G, he confirmed he worked on 09/01/13. He stated he heard Resident #1's family member call for help and went to assist. He stated Resident #1 was covered from head-to-toe in ants. He stated he focused on helping get the ants off her. He added there were too many ants to count. During a confidential staff interview, he/she stated he/she had assisted with removing ants from Resident #1 on 09/01/13, and had provided care for the resident when the resident returned from the hospital. The confidential interviewee (CI) stated he/she was present when Resident #1's family member arrived at the facility around 9:00 AM on 09/01/13, and called for help. The CI removed Resident #1's brief during the incident and could tell Resident #1 had not been provided incontinent care for a significant amount of time due to the wetness of the brief and pad, and the feeding residue on the pad (however, this was not confirmed). The CI believed the level of wetness and amount of feeding residue indicated Resident #1's sheets had not been changed the night before when the ants where initially found in the resident's bed. The CI stated Resident #1's brief was filled with ants, and there were hundreds of ants on the resident, including when LVN F was in the room. The CI described Resident #1 as being covered in bites. The CI stated when Resident #1 returned from the hospital, she had to sit in her wheelchair for approximately an hour to an hour and a half because her bed, which had a new mattress, was not ready. The CI stated Resident #1 was then moved to another unit. The CI stated he/she went to check on the resident and she was wrapped in a sheet and when he/she removed the sheet from the resident, he/she observed three to four ants. The CI stated he/she knew the sheets and the mattress were clean and free of ants, so he/she checked Resident #1's wheelchair. The CI stated he/she discovered the pad in the seat of the wheelchair had a hole with food in it as well as food under the pad. The CI shook the pad and approximately eight to nine ants came out of the pad. The CI stated this incident was reported to the DON and Administrator. On 09/16/13 at approximately 11:15 AM, during an interview with LVN F, she confirmed she worked on 09/01/13, and her shift was 6:00 AM to 2:00 PM. She stated she had been the charge nurse for the 200 and 300 halls, which included Resident #1. She stated the night nurse told her ants had been found in Resident #1's room and the resident was moved to a new room. She stated she did a quick check of Resident #1 during walking rounds at approximately 6:00 AM, and then did a complete check of Resident #1 at approximately 8:30 AM. She stated the complete check included pulling back Resident #1's covers and checking her body for ant bites and did not find any. During the interview with LVN F, she further stated that at approximately 9:20 AM, she was called by a nurse aide to Resident #1's room. She stated she did not see a great deal of ants; no more than 30 ants. LVN F stated she observed ant bites around Resident #1's collarbone and the front of her chest. She stated she did not observe any ant bites on Resident #1's trunk or vaginal area. She stated the bites did not have blisters and Resident #1 did not have any facial expression indicating she was in pain. (Note: CNA E and the CI both stated they saw hundreds of ants, and MA G stated he saw too many (ants) to count.) LVN F further stated she contacted Resident #1's physician's answering service and then spoke with the physician's NP regarding the incident. She stated the NP who prescribed Resident #1 [MEDICATION NAME] and Loritab, said if Resident #1's family member wanted her sent to the hospital to go ahead and send her. Resident #1's family member requested the resident be sent to the hospital so she contacted a non-emergency transport company and was told that due to Resident #1 being total care, they would be unable to transport the resident. She stated she then contacted an ambulance service for a non-emergency transport. LVN F stated she was not sure if she had notified Resident #1's physician about Resident #1 being sent to the hospital, but did notify the physician upon the resident's return to the facility. (Note: LVN F's nurse's notes for 09/01/13, provided no evidence the physician or his NP were consulted prior to the resident being transferred to a local hospital or upon the resident's return to the facility.) On 09/17/13 at 3:30 PM, during an interview with the DON, she stated that on 09/01/13, between 9:30 AM to 10:00 AM, she was notified of the incident involving Resident #1 and the ants. She recalled that Resident #1 was sent out to the hospital due to the family member's request. The DON stated she arrived at the facility shortly after she was notified of the incident but she did not observe Resident #1 until she had returned from the hospital. The DON stated she conducted the investigation of the incident. she could ot explain why LVN F's nurse's notes did not provide and accurate assessment of the number of Resident #1's number of ant bites. She stated she did not interview LVN F regarding her statement that Resident #1 only received 30 ant bites. She stated she was not aware LVN F had not disclosed the severity of Resident #1's ant bites when she consulted with the physician's NP. She was not aware that neither the physician nor the physician's NP had been consulted regarding Resident #1's transfer to the hospital. She was not aware that neither the physician nor his NP were notified when Resident #1 returned to the facility from the hospital. Nurse's notes, dated 09/01/13 at 4:00 PM, reflected the hospital's physician gave orders for the resident to receive 500 mg of Keflex four times a day for seven days, 4 mg of [MEDICATION NAME][MEDICATION NAME] to take as directed on the package, and [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) 2.5 mg/167 mg per 5 ml solution, take 10 ml (two teasponns) every 6 hours as needed for pain. The nurses' notes provided no documented evidence the resident's physician or the physician's PA were notified of the request to transfer the resident to the hospital or of the resident's return from the hospital with new orders. On 09/13/13 at 10:15 AM, during an interview with the physician's NP, she stated she was first notified around midnight (12:00 AM) on 09/01/13, of the ants in Resident #1's room. She stated she received another telephone call later that morning, but was uncertain of the time, and was told the resident had been moved to another room. She stated a third telephone call was received from the facility on 09/01/13, saying Resident #1's family member was worried about Resident #1 being in pain from some ant bites. She stated she prescribed a topical cream, pain medication, and [MEDICATION NAME]. She stated she was not informed of the number of ant bites or seriousness of the incident. The NP stated she received another telephone call from the facility on 09/02/13 at around midnight to inform her that Resident #1's family member did not want Resident #1 to take the steroids prescribed by the emergency room physician. The NP stated she had been unaware Resident #1 had transferred to a hospital emergency room or of Resident #1's return to the facility. The NP stated she did not see Resident #1 until Tuesday (09/03/13), but could tell that she would have sent Resident #1 to the hospital at the time of the incident if the seriousness of the incident had been conveyed. The NP stated she had recently had problems getting accurate reports from staff at the facility. She stated staff were not reporting the full extent of situations and were not prepared with information. On 09/12/13 at 12:30 PM, during an interview with Resident #1's physician, he stated the red welts observed by the surveyors were ant bites. He stated if he had seen the ant bites immediately after the incident, he would have sent her to the hospital. The physician stated he did not initially handle the incident, but the information his office received about the incident did not relay the seriousness of the incident. The physician stated the worst case scenario would have been Resident #1 experiencing anaphylactic shock. A secondary concern was a massive infection. The physician stated Resident #1 could experience scarring in the areas of the ant bites, and added that it could take up to another month for the bites to heal, and stated, There had to be hundreds of ants to have caused the extent of (Resident #1's) injuries. Resident #1's nurse's notes reflected the following entries regarding her ant bites: Entry dated 09/03/13 on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected Resident #1 was small and frail in stature and unable to make needs known. The resident had contractures to knees, hips, and elbows bilaterally. Ant bites are noted to Resident #1's entire body from dense to sparse concentrations. The densest concentrations of ant bites are in the following areas: the base of the back of the neck, the right posterior flank area, left posterior thigh, and left posterior lateral calf. The ants bites are cluster of fluid filled pustules, too numerous to count. Entry dated 09/06/13 (5 days after the incident) on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected a skin assessment was performed due to the incident of multiple ant bites. The densest concentrations of ant bites are the left posterior thigh and left posterior lateral calf. The ant bites in these areas are very red and irritated with a decrease in the fluid filled pustules. The ant bites to the neck, bilateral arms, and right flack are red and angry, but the concentration of redness has decreased. Observation on 09/13/13 at 12:29 PM, of Resident #1 in her room, revealed she was in bed with socks on her hand. Resident #1's family member was present and stated the socks were used to prevent Resident #1 from scratching herself. Ant bites were observed on all of Resident #1's limbs, neck, shoulders, back, right rib cage, and left inner thigh. Several of the ant bites were observed to have pustules. The family member removed the socks and Resident #1 immediately began scratching her neck and shoulder area. Resident #1 had several dark red scratch marks on both her upper arms and shoulder area. Resident #1's facial expression indicated she was distressed. Resident #1 made slight groaning noises and continued to attempt to scratch at areas with ant bites. Review of the Provider Investigation Report, signed by the DON and dated 09/06/13, identified the category of the incident involving Resident #1 as Other: Ant Bites. It reflected the incident occurred on 09/01/13, and was reported to the State Agency on 09/01/13. The summary of the investigation reflected: A nurse observed ants on the resident's dresser and on her bed on 08/31/13 at approximately 11:40 PM. The resident and her roommate were moved to another room and both residents were assessed and no

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 8) observations of ants were noted on either resident. Staff continued to monitor throughout the shift. On 09/01/13 at 9:30 AM, the resident's mother observed ants on the resident. A nurse assessed Resident #1 and observed multiple ant bits on Resident #1 and the areas were closed and slightly swollen. The Post-Investigation action section reflected facility staff had been monitoring for ants in the facility since 08/28/13, due to ants found in two rooms. Resident #1 was moved to another room, and her previous room was deep cleaned, and she was provided with a new wheelchair cushion. A head-to-toe assessment was conducted every shift. A pest control provider treated the interior and exterior of the facility. (The copies of billing from the pest control provider were for 08/09/13, 08/13/13, 08/16/13, 08/20/13, 08/21/13, 08/26/13, 08/27/13, and 09/06/13.) Staff, including nursing staff, maintenance, housekeeping and administration, were educated on monitoring rooms for ant activity, implementing safety checks for ants, who to notify in the event of finding ants, and how to respond if ants were observed on residents or beds/linens. Daily monitoring continued for observation of ants. The plan did not address ensuring nurses conduct accurate assessments of residents and ensuring nurses provide complete and accurate information when consulting with a resident's physician. It furthermore did not provide information regarding how they addressed ensuring nurses consult/notify a physician when a resident is being transferred to a hospital and again when they return with an order to review the treatment orders from the hospital to allow the attending physician to determine if he wants to approve the new treatment plan or change it. Review of the facility's Patient/Resident Incident/Accident Investigation Worksheets revealed on 08/31/13 at 11:49 PM, Resident #3 was found in her room with ants on her dresser. The nurse conducted a head-to-toe assessment of the resident and found no ant bites. (Note: This incident occurred the day before Resident #1 was found in the same room covered with ants.) Review of the facility's Service Request Log for the contract exterminator revealed the following: 08/20/13 at 2:30 p.m. - Entire unit needs to be sprayed. Bugs and ants in every room. On 08/21/13 (no time) - Entire room [ROOM NUMBER] and bed B have ants. On 08/21/13 (no time) - Ants in closet in room [ROOM NUMBER] on clothes. On 09/01/13 (no time) - Ants in resident room [ROOM NUMBER] and restroom. On 09/03/13 (no time) - Ants at nurses' station (station not specified). Review of the pest control service provider's receipts for treatment revealed the following: 08/13/13: room [ROOM NUMBER] was treated. The facility's exterior was treated. Ants were the targeted pest. Ants were noted during service. A Fire Ant mound was noted near an exit door. Ants were noted in room [ROOM NUMBER]. 08/16/13: this visit was in regard to cockroaches in the kitchen and the treatment of [REDACTED]. 08/20/13: The facility's exterior area was treated. Ants were noted during service. The courtyard of the secured unit, 200 hall, was treated. rooms [ROOM NUMBERS] were treated for [REDACTED]. 08/21/13: Patient/guest rooms were treated. The targeted pest was ants. rooms [ROOM NUMBERS] were treated. Ants were noted during service under cold base in rooms [ROOM NUMBERS]. 08/25/13: The facility's exterior area and patient/guest rooms were treated. The targeted pest was ants. The areas were inspected and treated and rooms were serviced. room [ROOM NUMBER], baseboards, was treated. Ants were noted during services; baseboards around bed. 08/27/13: The facility's perimeter was treated and ants were the target. Ants were noted during service; several ants near building on exterior of building. Trees/shrubs were contacting the facility creating a path for pests to enter. The service provider suggested the facility trim back vegetation to eliminate contact. 09/06/13: The exterior of the widnoew and ground near room [ROOM NUMBER]. On 09/13/13 at 3:20 PM, interview with the Pest Control Service Provider revealed only one fire ant mound was found after the incident that occurred on 09/01/13. The service provider completed a power spray approximately two weeks ago. It will sometimes drive the insects into the facility where they will ingest the poison and then die. The service provider and the facility are working on controlling the issue. On 09/13/13 at 2:28 PM, interview with the Administrator revealed the facility did not have a specific policy regarding ants, just the statement written for the in-service conducted after the incident on 09/01/13. On 09/13/13 at 2:50 PM, interview with the Maintenance Director revealed prior to the incident on 09/01/13, the facility had been calling the exterminator when ants were found in the facility. The Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The identified repairs were completed following the compilation of the list of repairs needed, however completion dates were not provided at that time. Any ants seen in the facility are logged by staff in a maintenance log book located at each nurses' station. The log books are check twice a day. Insect sightings are also logged in a pest control book located at the nurses' station that is monitored by the pest control service provider on a monthly basis. If only a couple of ants are sighted the maintenance staff will treat the area himself. If it is a resident room he will also treat outside near the exterior wall of the room. Maintenance staff also monitor outside for ant mounds on a daily basis. Review of an undated, untitled document attached to the Facility's Provider Investigation Report involving Resident #1 revealed a list of resident rooms in the facility with environmental issues. On 09/13/13 at 2:50 PM, the Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The list included a total of 82 resident rooms that needed caulk around the windows. The following are the rooms identified: 1, 3, 11, 18, 20-22, 24-25, 28-30, 33-34, 38-39, 41-42, 45, 59-60, 200-213, 215-226, 228, 301-309, 311-313, 315, 401-408, 412-415, 418-420, 422-424, 426-427, and 429. The list also included 20 rooms that needed caulk around the windows and in the bathroom. The identified rooms were: 4, 23, 26, 31-32, 35-36, 40, 44, 48-49, 51-58, and 310. Also identified on the list were the following five rooms that needed caulking in the bathroom only: 9, 10, 12, 19, and 411. The list identified seven rooms where ants were found, the rooms were: 5, 9, 11, 20, 53, 55, and 406. The list also identified other environmental issues in resident rooms. In room [ROOM NUMBER] a hole in the widow screen was identified. In room [ROOM NUMBER] the window doesn't shut all the way, and the frame was rotten. In room [ROOM NUMBER] the window was still broken, and room [ROOM NUMBER] had broken window trim. The window in room [ROOM NUMBER] was described as being in bad shape. room [ROOM NUMBER] had a hole by the bathroom door, and room [ROOM NUMBER] had a broken baseboard. A total of 107 resident rooms of the 120 resident rooms in the facility were identified as needing some type of repair. On 09/13/13 at approximately 4:00 PM, the Administrator and Assistant Administrator revealed the plan to address the ants in the facility included the following: One hour checks of total care residents by direct care staff, daily checks on residents' rooms by clinical staff and housekeeping, and daily checks by maintenance outside the facility for ant mounds. Logs of the resident and room checks were kept at each nurses' station, one for direct care staff and one for housekeeping. Staff documents any sightings of ants in the maintenance log as well as the other identified logs. The Assistant Administrator stated he has begun marking rooms where ants were sited on a floor plan so he can monitor which rooms are impacted. The Administrator stated the monitoring began on 08/28/13, but some of the nurses' stations did not begin their logs until 09/02/13. Maintenance staff is monitoring the maintenance logs kept at the nursing stations at least once a day. Maintenance treats any sightings of insects immediately and coordinates further treatments with the pest control service providers. Review of the facility's Daily Ant Inspection logs revealed rooms on the 200 Hall, 300 Hall, 400 Hall, The Terrace, and The Verandah were monitored once a day for ants from 08/28/13 to 09/14/13. Ants were noted on 09/01/13 in Rooms 211, 213, 310, and the 300 Hall Shower Room. Ants were noted on 09/01/13 in room [ROOM NUMBER], and the 300 Hall. Ants were noted on 09/04/13 in rooms [ROOM NUMBERS]. Ants were noted on 09/04/13 in Rooms 310, and 417, and 400 Hall Shower Room. Ants were noted on 09/05/13 in room [ROOM NUMBER]. Ants were noted on 09/06/13 in room [ROOM NUMBER]. Ants were noted on 09/10/13 in room [ROOM NUMBER]. Ants were noted on 09/12/13 in room [ROOM NUMBER]. Ants were noted on 09/14/13 in rooms [ROOM NUMBERS]. Review of the in-service regarding ants/residents, conducted on 09/04/13, revealed the following: If a resident is found to have ants in the room the following should be done; head-to-toe assessment done on the resident, shower the resident, change gown and linens. If the resident is needed to change rooms the bed must be changed as well. One hour ant round logs are to be completed by each shift. The facility's current Nursing Policies and Procedures included: Physician Communication/Change in Condition, revised September 2011 and reflected the following: POLICY: 1. To improve communication between physicians and nursing staff in order to promote optimal patient/resident care. 2. To provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition. PROCEDURES: 1. Complete assessment of the patient/resident which may include but is not limited to: .B. Current physical condition C. Patient's/resident's previous condition (declining, improving, stable) .E. Vital signs, TPR (temperature), BP (blood pressure)ZXXXZ
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 9) Based on observation, interview and record review, the facility failed to ensure one (Resident #1) of four (Residents #1, #2, #3, and #4) residents reviewed for quality of care was provided the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the comprehensive assessment and plan of care. When Resident #1 was found with fire ants everywhere on her body and was being bitten, LVN F failed to: -- conduct a head-to-toe assessment to determine with accuracy the number of fire ant bites she sustained, assessing for an allergic reaction and pain. -- provide Resident #1's physician/NP with an accurate assessment of Resident #1's status and allowing the physician/NP to respond appropriately with orders to send her to the hospital. -- notify the physician/NP Resident #1 was sent to the ER and when the resident returned from the ER with new orders until the resident had been back in the facility for over two hours. On 09/26/13 an Immediate Jeopardy (IJ) was identified in the area of quality of care and accurate assessments. While the IJ was removed on 09/30/13, the facility remained out of compliance at a level of actual harm that is not immediate jeopardy and at a potential for more than minimal harm and scope of pattern. because staff were still being inserviced and the facility was monitoring the effectiveness of their plan of removal. These failures placed the facility's 152 residents, including Residents #1, #2, #3 and #4, at risk for not being adequately assessed with [REDACTED]. in a delay in treatment or [DIAGNOSES REDACTED]. Findings included: On 09/26/13, based on administrative review, the investigation was reopened for further investigation of a current Immediate Jeopardy situation. Resident #1's MDS assessment, dated 08/25/13, reflected a [AGE] year-old female who was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The assessment reflected Resident #1 had severe cognitive impairment, received nourishment via tube feeding, and required total dependence on staff for activities of daily living to include bed mobility and personal hygiene. Resident #1's care plan with a current review date of 08/11/13, reflected the following: a) ADL functions reflected she was totally dependent for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. Approaches included to provide Resident #1 with assistance as needed. b) [DIAGNOSES REDACTED]. Approaches included following safety measures and implementing [MEDICAL CONDITION] precautions. c) Resident had difficulty making self understood related to her [DIAGNOSES REDACTED]. Approaches included to observe for non-verbal signs of distress (guarding, moaning, restlessness, grimacing, withdrawal, etc.). Turn/reposition, communicate, provide pericare, assess for pain, and provide liquids/food as needed. Staff must anticipate needs. Resident unable to communicate. d) Resident is at risk for skin breakdown related to bowel and bladder incontinence. The goal was for the resident's skin to remain intact. Approaches included to assess the resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. On 09/12/13 at 11:00 AM, Resident #1 was observed in her room, lying on her bed. She was in a fetal position and had severe contractures of her arms, legs, and hands. She had swollen, inflamed, red welts on all visible areas of her body. Small clusters of welts and individual welts were around her hairline, upper and lower extremities, neck, and upper shoulder blades, plus on her hands and feet. A cluster of welts was on her inner left thigh in an area approximately 6.0 to 8.0 inches in length and 3.0 to 4.0 inches in width. Observation by the surveyor on 09/12/13 at 11:30 AM revealed Resident #1 was covered with red welts, which appeared to be ant bites, except for her middle back, feeding tube area, vaginal area, and under her breasts. The red welts were too numerous to count. During the assessment, Resident #1 responded to verbal and physical stimulus by opening her eyes and frowning. On 09/12/13 at 11:00 AM, during the initial observation of Resident #1, a family member was present and identified the welts as fire ant bites. The family member stated the incident occurred on 09/01/13. The family member further stated he/she received a telephone call on 09/01/13 around 5:30 AM from a staff member informing him/her ants were found in the resident's room and Resident #1, along with her bed, had been moved to another room. the family member indicated this was a repeat notification of the ants observed on 08/31/13. The family member stated he/she received another telephone call from the facility later that same morning from a different staff member informing him/her of ants in the resident's room. The family member stated he/she became concerned and decided to check on the resident. The family member stated when he/she arrived, Resident #1 was in her room, in bed, and covered in ants. The family member stated he/she began yelling for help and several staff members came to help brush the ants off the resident. The family member revealed he/she had to insist Resident #1 be sent to the hospital, where she was informed by hospital staff the number of ant bites suffered by Resident #1 could have led to her death. Resident #1's nurse's notes dated 09/01/13 and timed both at 5:30 AM and 11:40 PM (start of shift was on 08/31/13), reflected ants were on the resident's dresser and some on her bed. The nurse conducted an assessment of the resident and noted she had no ant bites and had no signs and symptoms of pain. The resident's MD was notified and an order was received to move the resident to another room, and the family was notified of the resident's transfer to a different room due to the presence of ants. An entry at 8:30 AM, reflected the resident was resting comfortably and there were no signs of ants or ant bites in the new room (which shared a wall with Resident #1's old room). The next nurse's notes entry for Resident #1, dated 09/03/13 at 9:30 AM, reflected the nurse heard a nurse aide calling come STAT (immediately) to room (Resident #1's room). The nurse entered the room and observed two nurse aides and the resident's mother striping her bed. Resident #1's mother was yelling that her daughter had ants all on her. The resident had bites on both arms, along her collar bone and the front of her legs, and that the areas were slightly swollen and red. The physician's NP was consulted and gave orders for 50 mg of [MEDICATION NAME] and 7.5 mg of Loratab via her feeding tube, and to apply [MEDICATION NAME] cream to her body. The resident's mother wanted her transferred to a hospital, at 10:00 AM, and at 4:00 PM, Resident #1 returned from the hospital via ambulance. A Patient/Resident Incident/Accident Investigation Worksheet, completed by LVN F on 09/01/13, documented on 09/01/13 at 9:20 AM, Resident #1 was found to have ant bites. At 9:20 AM, the resident's mother came and found ants in the resident's bed and room. Staff then cleaned the ants off the resident and applied cream with medication given per [DEVICE]. On 09/13/13 at 9:15 AM, during an interview with CNA E, she confirmed she worked on 09/01/13, and that she had been assigned the hall where Resident #1 resided. She stated her shift began at 6:00 AM. She stated she was not informed about ants being found in Resident #1's room and bed during the previous shift. She stated she checked on Resident #1 briefly, but did not pull back her sheet to check for ants or perform any incontinence care. She stated around 9:00 AM, she saw Resident #1's family member enter the resident's room and then heard the resident's family member yelling for help. She stated when she arrived at Resident #1's room, hundreds of ants were on Resident #1, as well as on her bed and under the resident. CNA E stated she had previously seen ants on the 200 and 300 halls, but denied seeing them on any resident. CNA E stated staff now report any sightings of ants to the charge nurse and maintenance. On 09/17/13 at 11:04 AM, during an interview with MA G, he confirmed he worked on 09/01/13. He stated he heard Resident #1's family member call for help and went to assist. He stated Resident #1 was covered from head-to-toe in ants. He stated he focused on helping get the ants off her. He added there were too many ants to count. During a confidential staff interview, he/she stated he/she had assisted with removing ants from Resident #1 on 09/01/13, and had provided care for the resident when the resident returned from the hospital. The confidential interviewee (CI) stated he/she was present when Resident #1's family member arrived at the facility around 9:00 AM on 09/01/13, and called for help. The CI removed Resident #1's brief during the incident and could tell Resident #1 had not been provided incontinent care for a significant amount of time due to the wetness of the brief and pad, and the feeding residue on the pad (however, this was not confirmed). The CI believed the level of wetness and amount of feeding residue indicated Resident #1's sheets had not been changed the night before when the ants where initially found in the resident's bed. The CI stated Resident #1's brief was filled with ants, and there were hundreds of ants on the resident, including when LVN F was in the room. The CI described Resident #1 as being covered in bites. The CI stated when Resident #1 returned from the hospital, she had to sit in her wheelchair for approximately an hour to an hour and a half because her bed, which had a new mattress, was not ready. The CI stated Resident #1 was then moved to another unit. The CI stated he/she went to check on the resident and she was wrapped in a sheet and when he/she removed the sheet from the resident, he/she observed three to four ants. The CI stated he/she knew the sheets and the mattress were clean and free of ants, so he/she checked Resident #1's wheelchair. The CI stated he/she discovered the pad in the seat of the wheelchair had a hole with food in it as well as food under the pad. The CI shook the pad and approximately eight to nine ants came out of the pad. The CI stated this incident was reported to the DON and Administrator. On 09/16/13 at approximately 11:15 AM, during an interview with LVN F, she confirmed she worked on 09/01/13, and her shift was 6:00 AM to 2:00 PM. She stated she had been the charge nurse for the 200 and 300 halls, which included Resident #1. She stated the night nurse told her ants had been found in Resident #1's room and the resident was moved to a new room. She stated she did a quick check of Resident #1 during walking rounds at approximately 6:00 AM, and then did a complete check of Resident #1 at approximately 8:30 AM. She stated the complete check included pulling back Resident #1's covers and checking her body for ant bites and did not find any. During the interview with LVN F, she further stated that at approximately 9:20 AM, she was called by a nurse aide to Resident #1's room. She stated she did not see a great deal of ants; no more than 30 ants. LVN F stated she observed ant bites around Resident #1's

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 10) collarbone and the front of her chest. She stated she did not observe any ant bites on Resident #1's trunk or vaginal area. She stated the bites did not have blisters and Resident #1 did not have any facial expression indicating she was in pain. (Note: CNA E and the CI both stated they saw hundreds of ants, and MA G stated he saw too many (ants) to count.) LVN F further stated she contacted Resident #1's physician's answering service and then spoke with the physician's NP regarding the incident. She stated the NP who prescribed Resident #1 [MEDICATION NAME] and Loritab, said if Resident #1's family member wanted her sent to the hospital to go ahead and send her. Resident #1's family member requested the resident be sent to the hospital so she contacted a non-emergency transport company and was told that due to Resident #1 being total care, they would be unable to transport the resident. She stated she then contacted an ambulance service for a non-emergency transport. LVN F stated she was not sure if she had notified Resident #1's physician about Resident #1 being sent to the hospital, but did notify the physician upon the resident's return to the facility. (Note: LVN F's nurse's notes for 09/01/13, provided no evidence the physician or his NP were consulted prior to the resident being transferred to a local hospital or upon the resident's return to the facility.) On 09/17/13 at 3:30 PM, during an interview with the DON, she stated that on 09/01/13, between 9:30 AM to 10:00 AM, she was notified of the incident involving Resident #1 and the ants. She recalled that Resident #1 was sent out to the hospital due to the family member's request. The DON stated she arrived at the facility shortly after she was notified of the incident but she did not observe Resident #1 until she had returned from the hospital. The DON stated she conducted the investigation of the incident. she could ot explain why LVN F's nurse's notes did not provide and accurate assessment of the number of Resident #1's number of ant bites. She stated she did not interview LVN F regarding her statement that Resident #1 only received 30 ant bites. She stated she was not aware LVN F had not disclosed the severity of Resident #1's ant bites when she consulted with the physician's NP. She was not aware that neither the physician nor the physician's NP had been consulted regarding Resident #1's transfer to the hospital. She was not aware that neither the physician nor his NP were notified when Resident #1 returned to the facility from the hospital. Nurse's notes, dated 09/01/13 at 4:00 PM, reflected the hospital's physician gave orders for the resident to receive 500 mg of Keflex four times a day for seven days, 4 mg of [MEDICATION NAME][MEDICATION NAME] to take as directed on the package, and [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) 2.5 mg/167 mg per 5 ml solution, take 10 ml (two teasponns) every 6 hours as needed for pain. The nurses' notes provided no documented evidence the resident's physician or the physician's PA were notified of the request to transfer the resident to the hospital or of the resident's return from the hospital with new orders. On 09/13/13 at 10:15 AM, during an interview with the physician's NP, she stated she was first notified around midnight (12:00 AM) on 09/01/13, of the ants in Resident #1's room. She stated she received another telephone call later that morning, but was uncertain of the time, and was told the resident had been moved to another room. She stated a third telephone call was received from the facility on 09/01/13, saying Resident #1's family member was worried about Resident #1 being in pain from some ant bites. She stated she prescribed a topical cream, pain medication, and [MEDICATION NAME]. She stated she was not informed of the number of ant bites or seriousness of the incident. The NP stated she received another telephone call from the facility on 09/02/13 at around midnight to inform her that Resident #1's family member did not want Resident #1 to take the steroids prescribed by the emergency room physician. The NP stated she had been unaware Resident #1 had transferred to a hospital emergency room or of Resident #1's return to the facility. The NP stated she did not see Resident #1 until Tuesday (09/03/13), but could tell that she would have sent Resident #1 to the hospital at the time of the incident if the seriousness of the incident had been conveyed. The NP stated she had recently had problems getting accurate reports from staff at the facility. She stated staff were not reporting the full extent of situations and were not prepared with information. On 09/12/13 at 12:30 PM, during an interview with Resident #1's physician, he stated the red welts observed by the surveyors were ant bites. He stated if he had seen the ant bites immediately after the incident, he would have sent her to the hospital. The physician stated he did not initially handle the incident, but the information his office received about the incident did not relay the seriousness of the incident. The physician stated the worst case scenario would have been Resident #1 experiencing anaphylactic shock. A secondary concern was a massive infection. The physician stated Resident #1 could experience scarring in the areas of the ant bites, and added that it could take up to another month for the bites to heal, and stated, There had to be hundreds of ants to have caused the extent of (Resident #1's) injuries. Resident #1's nurse's notes reflected the following entries regarding her ant bites: Entry dated 09/03/13 on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected Resident #1 was small and frail in stature and unable to make needs known. The resident had contractures to knees, hips, and elbows bilaterally. Ant bites are noted to Resident #1's entire body from dense to sparse concentrations. The densest concentrations of ant bites are in the following areas: the base of the back of the neck, the right posterior flank area, left posterior thigh, and left posterior lateral calf. The ants bites are cluster of fluid filled pustules, too numerous to count. Entry dated 09/06/13 (5 days after the incident) on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected a skin assessment was performed due to the incident of multiple ant bites. The densest concentrations of ant bites are the left posterior thigh and left posterior lateral calf. The ant bites in these areas are very red and irritated with a decrease in the fluid filled pustules. The ant bites to the neck, bilateral arms, and right flack are red and angry, but the concentration of redness has decreased. Observation on 09/13/13 at 12:29 PM, of Resident #1 in her room, revealed she was in bed with socks on her hand. Resident #1's family member was present and stated the socks were used to prevent Resident #1 from scratching herself. Ant bites were observed on all of Resident #1's limbs, neck, shoulders, back, right rib cage, and left inner thigh. Several of the ant bites were observed to have pustules. The family member removed the socks and Resident #1 immediately began scratching her neck and shoulder area. Resident #1 had several dark red scratch marks on both her upper arms and shoulder area. Resident #1's facial expression indicated she was distressed. Resident #1 made slight groaning noises and continued to attempt to scratch at areas with ant bites. Review of the Provider Investigation Report, signed by the DON and dated 09/06/13, identified the category of the incident involving Resident #1 as Other: Ant Bites. It reflected the incident occurred on 09/01/13, and was reported to the State Agency on 09/01/13. The summary of the investigation reflected: A nurse observed ants on the resident's dresser and on her bed on 08/31/13 at approximately 11:40 PM. The resident and her roommate were moved to another room and both residents were assessed and no observations of ants were noted on either resident. Staff continued to monitor throughout the shift. On 09/01/13 at 9:30 AM, the resident's mother observed ants on the resident. A nurse assessed Resident #1 and observed multiple ant bits on Resident #1 and the areas were closed and slightly swollen. The Post-Investigation action section reflected facility staff had been monitoring for ants in the facility since 08/28/13, due to ants found in two rooms. Resident #1 was moved to another room, and her previous room was deep cleaned, and she was provided with a new wheelchair cushion. A head-to-toe assessment was conducted every shift. A pest control provider treated the interior and exterior of the facility. (The copies of billing from the pest control provider were for 08/09/13, 08/13/13, 08/16/13, 08/20/13, 08/21/13, 08/26/13, 08/27/13, and 09/06/13.) Staff, including nursing staff, maintenance, housekeeping and administration, were educated on monitoring rooms for ant activity, implementing safety checks for ants, who to notify in the event of finding ants, and how to respond if ants were observed on residents or beds/linens. Daily monitoring continued for observation of ants. The plan did not address ensuring nurses conduct accurate assessments of residents and ensuring nurses provide complete and accurate information when consulting with a resident's physician. It furthermore did not provide information regarding how they addressed ensuring nurses consult/notify a physician when a resident is being transferred to a hospital and again when they return with an order to review the treatment orders from the hospital to allow the attending physician to determine if he wants to approve the new treatment plan or change it. Review of the facility's Patient/Resident Incident/Accident Investigation Worksheets revealed on 08/31/13 at 11:49 PM, Resident #3 was found in her room with ants on her dresser. The nurse conducted a head-to-toe assessment of the resident and found no ant bites. (Note: This incident occurred the day before Resident #1 was found in the same room covered with ants.) Review of the facility's Service Request Log for the contract exterminator revealed the following: 08/20/13 at 2:30 p.m. - Entire unit needs to be sprayed. Bugs and ants in every room. On 08/21/13 (no time) - Entire room [ROOM NUMBER] and bed B have ants. On 08/21/13 (no time) - Ants in closet in room [ROOM NUMBER] on clothes. On 09/01/13 (no time) - Ants in resident room [ROOM NUMBER] and restroom. On 09/03/13 (no time) - Ants at nurses' station (station not specified). Review of the pest control service provider's receipts for treatment revealed the following: 08/13/13: room [ROOM NUMBER] was treated. The facility's exterior was treated. Ants were the targeted pest. Ants were noted during service. A Fire Ant mound was noted near an exit door. Ants were noted in room [ROOM NUMBER]. 08/16/13: this visit was in regard to cockroaches in the kitchen and the treatment of [REDACTED]. 08/20/13: The facility's exterior area was treated. Ants were noted during service. The courtyard of the secured unit, 200 hall, was treated. rooms [ROOM NUMBERS] were treated for [REDACTED]. 08/21/13: Patient/guest rooms were treated. The targeted pest

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 11) was ants. rooms [ROOM NUMBERS] were treated. Ants were noted during service under cold base in rooms [ROOM NUMBERS]. 08/25/13: The facility's exterior area and patient/guest rooms were treated. The targeted pest was ants. The areas were inspected and treated and rooms were serviced. room [ROOM NUMBER], baseboards, was treated. Ants were noted during services; baseboards around bed. 08/27/13: The facility's perimeter was treated and ants were the target. Ants were noted during service; several ants near building on exterior of building. Trees/shrubs were contacting the facility creating a path for pests to enter. The service provider suggested the facility trim back vegetation to eliminate contact. 09/06/13: The exterior of the widnoew and ground near room [ROOM NUMBER]. On 09/13/13 at 3:20 PM, interview with the Pest Control Service Provider revealed only one fire ant mound was found after the incident that occurred on 09/01/13. The service provider completed a power spray approximately two weeks ago. It will sometimes drive the insects into the facility where they will ingest the poison and then die. The service provider and the facility are working on controlling the issue. On 09/13/13 at 2:28 PM, interview with the Administrator revealed the facility did not have a specific policy regarding ants, just the statement written for the in-service conducted after the incident on 09/01/13. On 09/13/13 at 2:50 PM, interview with the Maintenance Director revealed prior to the incident on 09/01/13, the facility had been calling the exterminator when ants were found in the facility. The Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The identified repairs were completed following the compilation of the list of repairs needed, however completion dates were not provided at that time. Any ants seen in the facility are logged by staff in a maintenance log book located at each nurses' station. The log books are check twice a day. Insect sightings are also logged in a pest control book located at the nurses' station that is monitored by the pest control service provider on a monthly basis. If only a couple of ants are sighted the maintenance staff will treat the area himself. If it is a resident room he will also treat outside near the exterior wall of the room. Maintenance staff also monitor outside for ant mounds on a daily basis. Review of an undated, untitled document attached to the Facility's Provider Investigation Report involving Resident #1 revealed a list of resident rooms in the facility with environmental issues. On 09/13/13 at 2:50 PM, the Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The list included a total of 82 resident rooms that needed caulk around the windows. The following are the rooms identified: 1, 3, 11, 18, 20-22, 24-25, 28-30, 33-34, 38-39, 41-42, 45, 59-60, 200-213, 215-226, 228, 301-309, 311-313, 315, 401-408, 412-415, 418-420, 422-424, 426-427, and 429. The list also included 20 rooms that needed caulk around the windows and in the bathroom. The identified rooms were: 4, 23, 26, 31-32, 35-36, 40, 44, 48-49, 51-58, and 310. Also identified on the list were the following five rooms that needed caulking in the bathroom only: 9, 10, 12, 19, and 411. The list identified seven rooms where ants were found, the rooms were: 5, 9, 11, 20, 53, 55, and 406. The list also identified other environmental issues in resident rooms. In room [ROOM NUMBER] a hole in the widow screen was identified. In room [ROOM NUMBER] the window doesn't shut all the way, and the frame was rotten. In room [ROOM NUMBER] the window was still broken, and room [ROOM NUMBER] had broken window trim. The window in room [ROOM NUMBER] was described as being in bad shape. room [ROOM NUMBER] had a hole by the bathroom door, and room [ROOM NUMBER] had a broken baseboard. A total of 107 resident rooms of the 120 resident rooms in the facility were identified as needing some type of repair. On 09/13/13 at approximately 4:00 PM, the Administrator and Assistant Administrator revealed the plan to address the ants in the facility included the following: One hour checks of total care residents by direct care staff, daily checks on residents' rooms by clinical staff and housekeeping, and daily checks by maintenance outside the facility for ant mounds. Logs of the resident and room checks were kept at each nurses' station, one for direct care staff and one for housekeeping. Staff documents any sightings of ants in the maintenance log as well as the other identified logs. The Assistant Administrator stated he has begun marking rooms where ants were sited on a floor plan so he can monitor which rooms are impacted. The Administrator stated the monitoring began on 08/28/13, but some of the nurses' stations did not begin their logs until 09/02/13. Maintenance staff is monitoring the maintenance logs kept at the nursing stations at least once a day. Maintenance treats any sightings of insects immediately and coordinates further treatments with the pest control service providers. Review of the facility's Daily Ant Inspection logs revealed rooms on the 200 Hall, 300 Hall, 400 Hall, The Terrace, and The Verandah were monitored once a day for ants from 08/28/13 to 09/14/13. Ants were noted on 09/01/13 in Rooms 211, 213, 310, and the 300 Hall Shower Room. Ants were noted on 09/01/13 in room [ROOM NUMBER], and the 300 Hall. Ants were noted on 09/04/13 in rooms [ROOM NUMBERS]. Ants were noted on 09/04/13 in Rooms 310, and 417, and 400 Hall Shower Room. Ants were noted on 09/05/13 in room [ROOM NUMBER]. Ants were noted on 09/06/13 in room [ROOM NUMBER]. Ants were noted on 09/10/13 in room [ROOM NUMBER]. Ants were noted on 09/12/13 in room [ROOM NUMBER]. Ants were noted on 09/14/13 in rooms [ROOM NUMBERS]. Review of the in-service regarding ants/residents, conducted on 09/04/13, revealed the following: If a resident is found to have ants in the room the following should be done; head-to-toe assessment done on the resident, shower the resident, change gown and linens. If the resident is needed to change rooms the bed must be changed as well. One hour ant round logs are to be completed by each shift. The facility's current Nursing Policies and Procedures included: Physician Communication/Change in Condition, revised September 2011 and reflected the following: POLICY: 1. To improve communication between physicians and nursing staff in order to promote optimal patient/resident care. 2. To provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition. PROCEDURES: 1. Complete assessment of the patient/resident which may include but is not limited to: .B. Current physical condition C. Patient's/resident's previous condition (declining, improving, stable) .E. Vital signs, TPR (temperature), BP (blood pressure).Lung Sounds, N/V Abdominal Assessment, Pain. .H. allergies [REDACTED]. .L. Any interventions/first aide (sic) provided to the patient/resident. 2. Notify the physician of the change in medical condition. (The physician notification grid may be used as a reference tool regarding acceptable notification timeframes.) The nurse will document all assessments and changes in the patient's/resident's condition in the medical record. 3. If the physician does not respond within an acceptable time frame, the Medical Director and Director of Nursing will be notified. 4. The patient's/resident's family member/legal representative will be notified of any change in condition requiring an emergent transfer to the hospital. A Physician Communication Grid was provided as guidelines for notifying the physician and reflected: These guidelines are not intended to substitute for good nursing judgment. If the nurse feels uncomfortable with a situation he/she should not delay contacting the physician or call 911 if it appears to be a life-threatening event. An Immediate Jeopardy was identified on 09/26/13 in the area of Quality of Care and accurate assessments. On 09/26/13 at 1:00 PM, the Assistant Administrator and DON were informed an Immediate Jeopardy (IJ) had been identified. A Plan of Removal for the IJ was requested. . The Plan of Removal for the IJ was accepted on 09/27/13 at 7:30 PM, and reflected the following: Resident #1's bed was found with ants on 08/31/13 at 11:49 PM. Assessment of the resident revealed there were no ant bites. The resident was moved to another room, which shared a wall with her first room. On 09/01/13 at 8:30 AM, ants were found on Resident #1. LVN F was informed, but her documentation in the resident's clinical record was not an accurate description of the number of ants. MA G and CNA E, along with Resident #1's family member were stripping the bed and wiping ants off the resident. LVN F documented ants were under the resident as well as having been bitten on both arms, collar bone and front of the legs. There was no evidence of a comprehensive clinical assessment. Information provided to the NP was unknown. Orders were received to give [MEDICATION NAME] 50 mg and [MEDICATION NAME] 7.5 mg per [DEVICE] and to apply [MEDICATION NAME] cream. Resident #1 was transferred to the ER for treatment at the insistence of the resident's family member.
F 0469 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective pest control program as evidenced by an infestation of fire ants. When Resident #1 was found with fire ants everywhere on her body and was being bitten, LVN F failed to: -- conduct a head-to-toe assessment to determine with accuracy the number of fire ant bites she sustained, assessing for an allergic reaction and pain. -- provide Resident #1's physician/NP with an accurate assessment of Resident #1's status and allowing the physician/NP to respond appropriately with orders to send her to the hospital. -- notify the physician/NP Resident #1 was sent to the ER and when the resident returned from the ER with new orders until the resident had been back in the facility for over two hours. On 09/26/13 an Immediate Jeopardy (IJ) was identified in the area of quality of care and accurate assessments. While the IJ was removed on 09/30/13, the facility remained out of

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F 0469 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 12) compliance at a level of actual harm that is not immediate jeopardy and at a potential for more than minimal harm and scope of pattern. because staff were still being inserviced and the facility was monitoring the effectiveness of their plan of removal. These failures placed the facility's 152 residents, including Residents #1, #2, #3 and #4, at risk for not being adequately assessed with [REDACTED]. in a delay in treatment or [DIAGNOSES REDACTED]. Findings included: On 09/26/13, based on administrative review, the investigation was reopened for further investigation of a current Immediate Jeopardy situation. Resident #1's MDS assessment, dated 08/25/13, reflected a [AGE] year-old female who was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The assessment reflected Resident #1 had severe cognitive impairment, received nourishment via tube feeding, and required total dependence on staff for activities of daily living to include bed mobility and personal hygiene. Resident #1's care plan with a current review date of 08/11/13, reflected the following: a) ADL functions reflected she was totally dependent for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. Approaches included to provide Resident #1 with assistance as needed. b) [DIAGNOSES REDACTED]. Approaches included following safety measures and implementing [MEDICAL CONDITION] precautions. c) Resident had difficulty making self understood related to her [DIAGNOSES REDACTED]. Approaches included to observe for non-verbal signs of distress (guarding, moaning, restlessness, grimacing, withdrawal, etc.). Turn/reposition, communicate, provide pericare, assess for pain, and provide liquids/food as needed. Staff must anticipate needs. Resident unable to communicate. d) Resident is at risk for skin breakdown related to bowel and bladder incontinence. The goal was for the resident's skin to remain intact. Approaches included to assess the resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. On 09/12/13 at 11:00 AM, Resident #1 was observed in her room, lying on her bed. She was in a fetal position and had severe contractures of her arms, legs, and hands. She had swollen, inflamed, red welts on all visible areas of her body. Small clusters of welts and individual welts were around her hairline, upper and lower extremities, neck, and upper shoulder blades, plus on her hands and feet. A cluster of welts was on her inner left thigh in an area approximately 6.0 to 8.0 inches in length and 3.0 to 4.0 inches in width. Observation by the surveyor on 09/12/13 at 11:30 AM revealed Resident #1 was covered with red welts, which appeared to be ant bites, except for her middle back, feeding tube area, vaginal area, and under her breasts. The red welts were too numerous to count. During the assessment, Resident #1 responded to verbal and physical stimulus by opening her eyes and frowning. On 09/12/13 at 11:00 AM, during the initial observation of Resident #1, a family member was present and identified the welts as fire ant bites. The family member stated the incident occurred on 09/01/13. The family member further stated he/she received a telephone call on 09/01/13 around 5:30 AM from a staff member informing him/her ants were found in the resident's room and Resident #1, along with her bed, had been moved to another room. the family member indicated this was a repeat notification of the ants observed on 08/31/13. The family member stated he/she received another telephone call from the facility later that same morning from a different staff member informing him/her of ants in the resident's room. The family member stated he/she became concerned and decided to check on the resident. The family member stated when he/she arrived, Resident #1 was in her room, in bed, and covered in ants. The family member stated he/she began yelling for help and several staff members came to help brush the ants off the resident. The family member revealed he/she had to insist Resident #1 be sent to the hospital, where she was informed by hospital staff the number of ant bites suffered by Resident #1 could have led to her death. Resident #1's nurse's notes dated 09/01/13 and timed both at 5:30 AM and 11:40 PM (start of shift was on 08/31/13), reflected ants were on the resident's dresser and some on her bed. The nurse conducted an assessment of the resident and noted she had no ant bites and had no signs and symptoms of pain. The resident's MD was notified and an order was received to move the resident to another room, and the family was notified of the resident's transfer to a different room due to the presence of ants. An entry at 8:30 AM, reflected the resident was resting comfortably and there were no signs of ants or ant bites in the new room (which shared a wall with Resident #1's old room). The next nurse's notes entry for Resident #1, dated 09/03/13 at 9:30 AM, reflected the nurse heard a nurse aide calling come STAT (immediately) to room (Resident #1's room). The nurse entered the room and observed two nurse aides and the resident's mother striping her bed. Resident #1's mother was yelling that her daughter had ants all on her. The resident had bites on both arms, along her collar bone and the front of her legs, and that the areas were slightly swollen and red. The physician's NP was consulted and gave orders for 50 mg of [MEDICATION NAME] and 7.5 mg of Loratab via her feeding tube, and to apply [MEDICATION NAME] cream to her body. The resident's mother wanted her transferred to a hospital, at 10:00 AM, and at 4:00 PM, Resident #1 returned from the hospital via ambulance. A Patient/Resident Incident/Accident Investigation Worksheet, completed by LVN F on 09/01/13, documented on 09/01/13 at 9:20 AM, Resident #1 was found to have ant bites. At 9:20 AM, the resident's mother came and found ants in the resident's bed and room. Staff then cleaned the ants off the resident and applied cream with medication given per [DEVICE]. On 09/13/13 at 9:15 AM, during an interview with CNA E, she confirmed she worked on 09/01/13, and that she had been assigned the hall where Resident #1 resided. She stated her shift began at 6:00 AM. She stated she was not informed about ants being found in Resident #1's room and bed during the previous shift. She stated she checked on Resident #1 briefly, but did not pull back her sheet to check for ants or perform any incontinence care. She stated around 9:00 AM, she saw Resident #1's family member enter the resident's room and then heard the resident's family member yelling for help. She stated when she arrived at Resident #1's room, hundreds of ants were on Resident #1, as well as on her bed and under the resident. CNA E stated she had previously seen ants on the 200 and 300 halls, but denied seeing them on any resident. CNA E stated staff now report any sightings of ants to the charge nurse and maintenance. On 09/17/13 at 11:04 AM, during an interview with MA G, he confirmed he worked on 09/01/13. He stated he heard Resident #1's family member call for help and went to assist. He stated Resident #1 was covered from head-to-toe in ants. He stated he focused on helping get the ants off her. He added there were too many ants to count. During a confidential staff interview, he/she stated he/she had assisted with removing ants from Resident #1 on 09/01/13, and had provided care for the resident when the resident returned from the hospital. The confidential interviewee (CI) stated he/she was present when Resident #1's family member arrived at the facility around 9:00 AM on 09/01/13, and called for help. The CI removed Resident #1's brief during the incident and could tell Resident #1 had not been provided incontinent care for a significant amount of time due to the wetness of the brief and pad, and the feeding residue on the pad (however, this was not confirmed). The CI believed the level of wetness and amount of feeding residue indicated Resident #1's sheets had not been changed the night before when the ants where initially found in the resident's bed. The CI stated Resident #1's brief was filled with ants, and there were hundreds of ants on the resident, including when LVN F was in the room. The CI described Resident #1 as being covered in bites. The CI stated when Resident #1 returned from the hospital, she had to sit in her wheelchair for approximately an hour to an hour and a half because her bed, which had a new mattress, was not ready. The CI stated Resident #1 was then moved to another unit. The CI stated he/she went to check on the resident and she was wrapped in a sheet and when he/she removed the sheet from the resident, he/she observed three to four ants. The CI stated he/she knew the sheets and the mattress were clean and free of ants, so he/she checked Resident #1's wheelchair. The CI stated he/she discovered the pad in the seat of the wheelchair had a hole with food in it as well as food under the pad. The CI shook the pad and approximately eight to nine ants came out of the pad. The CI stated this incident was reported to the DON and Administrator. On 09/16/13 at approximately 11:15 AM, during an interview with LVN F, she confirmed she worked on 09/01/13, and her shift was 6:00 AM to 2:00 PM. She stated she had been the charge nurse for the 200 and 300 halls, which included Resident #1. She stated the night nurse told her ants had been found in Resident #1's room and the resident was moved to a new room. She stated she did a quick check of Resident #1 during walking rounds at approximately 6:00 AM, and then did a complete check of Resident #1 at approximately 8:30 AM. She stated the complete check included pulling back Resident #1's covers and checking her body for ant bites and did not find any. During the interview with LVN F, she further stated that at approximately 9:20 AM, she was called by a nurse aide to Resident #1's room. She stated she did not see a great deal of ants; no more than 30 ants. LVN F stated she observed ant bites around Resident #1's collarbone and the front of her chest. She stated she did not observe any ant bites on Resident #1's trunk or vaginal area. She stated the bites did not have blisters and Resident #1 did not have any facial expression indicating she was in pain. (Note: CNA E and the CI both stated they saw hundreds of ants, and MA G stated he saw too many (ants) to count.) LVN F further stated she contacted Resident #1's physician's answering service and then spoke with the physician's NP regarding the incident. She stated the NP who prescribed Resident #1 [MEDICATION NAME] and Loritab, said if Resident #1's family member wanted her sent to the hospital to go ahead and send her. Resident #1's family member requested the resident be sent to the hospital so she contacted a non-emergency transport company and was told that due to Resident #1 being total care, they would be unable to transport the resident. She stated she then contacted an ambulance service for a non-emergency transport. LVN F stated she was not sure if she had notified Resident #1's physician about Resident #1 being sent to the hospital, but did notify the physician upon the resident's return to the facility. (Note: LVN F's nurse's

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F 0469 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 13) notes for 09/01/13, provided no evidence the physician or his NP were consulted prior to the resident being transferred to a local hospital or upon the resident's return to the facility.) On 09/17/13 at 3:30 PM, during an interview with the DON, she stated that on 09/01/13, between 9:30 AM to 10:00 AM, she was notified of the incident involving Resident #1 and the ants. She recalled that Resident #1 was sent out to the hospital due to the family member's request. The DON stated she arrived at the facility shortly after she was notified of the incident but she did not observe Resident #1 until she had returned from the hospital. The DON stated she conducted the investigation of the incident. she could ot explain why LVN F's nurse's notes did not provide and accurate assessment of the number of Resident #1's number of ant bites. She stated she did not interview LVN F regarding her statement that Resident #1 only received 30 ant bites. She stated she was not aware LVN F had not disclosed the severity of Resident #1's ant bites when she consulted with the physician's NP. She was not aware that neither the physician nor the physician's NP had been consulted regarding Resident #1's transfer to the hospital. She was not aware that neither the physician nor his NP were notified when Resident #1 returned to the facility from the hospital. Nurse's notes, dated 09/01/13 at 4:00 PM, reflected the hospital's physician gave orders for the resident to receive 500 mg of Keflex four times a day for seven days, 4 mg of [MEDICATION NAME][MEDICATION NAME] to take as directed on the package, and [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) 2.5 mg/167 mg per 5 ml solution, take 10 ml (two teasponns) every 6 hours as needed for pain. The nurses' notes provided no documented evidence the resident's physician or the physician's PA were notified of the request to transfer the resident to the hospital or of the resident's return from the hospital with new orders. On 09/13/13 at 10:15 AM, during an interview with the physician's NP, she stated she was first notified around midnight (12:00 AM) on 09/01/13, of the ants in Resident #1's room. She stated she received another telephone call later that morning, but was uncertain of the time, and was told the resident had been moved to another room. She stated a third telephone call was received from the facility on 09/01/13, saying Resident #1's family member was worried about Resident #1 being in pain from some ant bites. She stated she prescribed a topical cream, pain medication, and [MEDICATION NAME]. She stated she was not informed of the number of ant bites or seriousness of the incident. The NP stated she received another telephone call from the facility on 09/02/13 at around midnight to inform her that Resident #1's family member did not want Resident #1 to take the steroids prescribed by the emergency room physician. The NP stated she had been unaware Resident #1 had transferred to a hospital emergency room or of Resident #1's return to the facility. The NP stated she did not see Resident #1 until Tuesday (09/03/13), but could tell that she would have sent Resident #1 to the hospital at the time of the incident if the seriousness of the incident had been conveyed. The NP stated she had recently had problems getting accurate reports from staff at the facility. She stated staff were not reporting the full extent of situations and were not prepared with information. On 09/12/13 at 12:30 PM, during an interview with Resident #1's physician, he stated the red welts observed by the surveyors were ant bites. He stated if he had seen the ant bites immediately after the incident, he would have sent her to the hospital. The physician stated he did not initially handle the incident, but the information his office received about the incident did not relay the seriousness of the incident. The physician stated the worst case scenario would have been Resident #1 experiencing anaphylactic shock. A secondary concern was a massive infection. The physician stated Resident #1 could experience scarring in the areas of the ant bites, and added that it could take up to another month for the bites to heal, and stated, There had to be hundreds of ants to have caused the extent of (Resident #1's) injuries. Resident #1's nurse's notes reflected the following entries regarding her ant bites: Entry dated 09/03/13 on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected Resident #1 was small and frail in stature and unable to make needs known. The resident had contractures to knees, hips, and elbows bilaterally. Ant bites are noted to Resident #1's entire body from dense to sparse concentrations. The densest concentrations of ant bites are in the following areas: the base of the back of the neck, the right posterior flank area, left posterior thigh, and left posterior lateral calf. The ants bites are cluster of fluid filled pustules, too numerous to count. Entry dated 09/06/13 (5 days after the incident) on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected a skin assessment was performed due to the incident of multiple ant bites. The densest concentrations of ant bites are the left posterior thigh and left posterior lateral calf. The ant bites in these areas are very red and irritated with a decrease in the fluid filled pustules. The ant bites to the neck, bilateral arms, and right flack are red and angry, but the concentration of redness has decreased. Observation on 09/13/13 at 12:29 PM, of Resident #1 in her room, revealed she was in bed with socks on her hand. Resident #1's family member was present and stated the socks were used to prevent Resident #1 from scratching herself. Ant bites were observed on all of Resident #1's limbs, neck, shoulders, back, right rib cage, and left inner thigh. Several of the ant bites were observed to have pustules. The family member removed the socks and Resident #1 immediately began scratching her neck and shoulder area. Resident #1 had several dark red scratch marks on both her upper arms and shoulder area. Resident #1's facial expression indicated she was distressed. Resident #1 made slight groaning noises and continued to attempt to scratch at areas with ant bites. Review of the Provider Investigation Report, signed by the DON and dated 09/06/13, identified the category of the incident involving Resident #1 as Other: Ant Bites. It reflected the incident occurred on 09/01/13, and was reported to the State Agency on 09/01/13. The summary of the investigation reflected: A nurse observed ants on the resident's dresser and on her bed on 08/31/13 at approximately 11:40 PM. The resident and her roommate were moved to another room and both residents were assessed and no observations of ants were noted on either resident. Staff continued to monitor throughout the shift. On 09/01/13 at 9:30 AM, the resident's mother observed ants on the resident. A nurse assessed Resident #1 and observed multiple ant bits on Resident #1 and the areas were closed and slightly swollen. The Post-Investigation action section reflected facility staff had been monitoring for ants in the facility since 08/28/13, due to ants found in two rooms. Resident #1 was moved to another room, and her previous room was deep cleaned, and she was provided with a new wheelchair cushion. A head-to-toe assessment was conducted every shift. A pest control provider treated the interior and exterior of the facility. (The copies of billing from the pest control provider were for 08/09/13, 08/13/13, 08/16/13, 08/20/13, 08/21/13, 08/26/13, 08/27/13, and 09/06/13.) Staff, including nursing staff, maintenance, housekeeping and administration, were educated on monitoring rooms for ant activity, implementing safety checks for ants, who to notify in the event of finding ants, and how to respond if ants were observed on residents or beds/linens. Daily monitoring continued for observation of ants. The plan did not address ensuring nurses conduct accurate assessments of residents and ensuring nurses provide complete and accurate information when consulting with a resident's physician. It furthermore did not provide information regarding how they addressed ensuring nurses consult/notify a physician when a resident is being transferred to a hospital and again when they return with an order to review the treatment orders from the hospital to allow the attending physician to determine if he wants to approve the new treatment plan or change it. Review of the facility's Patient/Resident Incident/Accident Investigation Worksheets revealed on 08/31/13 at 11:49 PM, Resident #3 was found in her room with ants on her dresser. The nurse conducted a head-to-toe assessment of the resident and found no ant bites. (Note: This incident occurred the day before Resident #1 was found in the same room covered with ants.) Review of the facility's Service Request Log for the contract exterminator revealed the following: 08/20/13 at 2:30 p.m. - Entire unit needs to be sprayed. Bugs and ants in every room. On 08/21/13 (no time) - Entire Room 424 and bed B have ants. On 08/21/13 (no time) - Ants in closet in Room 426 on clothes. On 09/01/13 (no time) - Ants in resident Room 427 and restroom. On 09/03/13 (no time) - Ants at nurses' station (station not specified). Review of the pest control service provider's receipts for treatment revealed the following: 08/13/13: Room 426 was treated. The facility's exterior was treated. Ants were the targeted pest. Ants were noted during service. A Fire Ant mound was noted near an exit door. Ants were noted in Room 426. 08/16/13: this visit was in regard to cockroaches in the kitchen and the treatment of [REDACTED]. 08/20/13: The facility's exterior area was treated. Ants were noted during service. The courtyard of the secured unit, 200 hall, was treated. Rooms 223 and 225 were treated for [REDACTED]. 08/21/13: Patient/guest rooms were treated. The targeted pest was ants. Rooms 424 and 426 were treated. Ants were noted during service under cold base in Rooms 424 and 426. 08/25/13: The facility's exterior area and patient/guest rooms were treated. The targeted pest was ants. The areas were inspected and treated and rooms were serviced. Room 40, baseboards, was treated. Ants were noted during services; baseboards around bed. 08/27/13: The facility's perimeter was treated and ants were the target. Ants were noted during service; several ants near building on exterior of building. Trees/shrubs were contacting the facility creating a path for pests to enter. The service provider suggested the facility trim back vegetation to eliminate contact. 09/06/13: The exterior of the widnoew and ground near Room 417. On 09/13/13 at 3:20 PM, interview with the Pest Control Service Provider revealed only one fire ant mound was found after the incident that occurred on 09/01/13. The service provider completed a power spray approximately two weeks ago. It will sometimes drive the insects into the facility where they will ingest the poison and then die. The service provider and the facility are working on controlling the issue. On 09/13/13 at 2:28 PM, interview with the Administrator revealed the facility did

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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 0469 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 14) not have a specific policy regarding ants, just the statement written for the in-service conducted after the incident on 09/01/13. On 09/13/13 at 2:50 PM, interview with the Maintenance Director revealed prior to the incident on 09/01/13, the facility had been calling the exterminator when ants were found in the facility. The Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The identified repairs were completed following the compilation of the list of repairs needed, however completion dates were not provided at that time. Any ants seen in the facility are logged by staff in a maintenance log book located at each nurses' station. The log books are check twice a day. Insect sightings are also logged in a pest control book located at the nurses' station that is monitored by the pest control service provider on a monthly basis. If only a couple of ants are sighted the maintenance staff will treat the area himself. If it is a resident room he will also treat outside near the exterior wall of the room. Maintenance staff also monitor outside for ant mounds on a daily basis. Review of an undated, untitled document attached to the Facility's Provider Investigation Report involving Resident #1 revealed a list of resident rooms in the facility with environmental issues. On 09/13/13 at 2:50 PM, the Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The list included a total of 82 resident rooms that needed caulk around the windows. The following are the rooms identified: 1, 3, 11, 18, 20-22, 24-25, 28-30, 33-34, 38-39, 41-42, 45, 59-60, 200-213, 215-226, 228, 301-309, 311-313, 315, 401-408, 412-415, 418-420, 422-424, 426-427, and 429. The list also included 20 rooms that needed caulk around the windows and in the bathroom. The identified rooms were: 4, 23, 26, 31-32, 35-36, 40, 44, 48-49, 51-58, and 310. Also identified on the list were the following five rooms that needed caulking in the bathroom only: 9, 10, 12, 19, and 411. The list identified seven rooms where ants were found, the rooms were: 5, 9, 11, 20, 53, 55, and 406. The list also identified other environmental issues in resident rooms. In Room 3 a hole in the widow screen was identified. In Room 13 the window doesn't shut all the way, and the frame was rotten. In Room 301 the window was still broken, and Room 307 had broken window trim. The window in Room 311 was described as being in bad shape. Room 409 had a hole by the bathroom door, and Room 413 had a broken baseboard. A total of 107 resident rooms of the 120 resident rooms in the facility were identified as needing some type of repair. On 09/13/13 at approximately 4:00 PM, the Administrator and Assistant Administrator revealed the plan to address the ants in the facility included the following: One hour checks of total care residents by direct care staff, daily checks on residents' rooms by clinical staff and housekeeping, and daily checks by maintenance outside the facility for ant mounds. Logs of the resident and room checks were kept at each nurses' station, one for direct care staff and one for housekeeping. Staff documents any sightings of ants in the maintenance log as well as the other identified logs. The Assistant Administrator stated he has begun marking rooms where ants were sited on a floor plan so he can monitor which rooms are impacted. The Administrator stated the monitoring began on 08/28/13, but some of the nurses' stations did not begin their logs until 09/02/13. Maintenance staff is monitoring the maintenance logs kept at the nursing stations at least once a day. Maintenance treats any sightings of insects immediately and coordinates further treatments with the pest control service providers. Review of the facility's Daily Ant Inspection logs revealed rooms on the 200 Hall, 300 Hall, 400 Hall, The Terrace, and The Verandah were monitored once a day for ants from 08/28/13 to 09/14/13. Ants were noted on 09/01/13 in Rooms 211, 213, 310, and the 300 Hall Shower Room. Ants were noted on 09/01/13 in Room 310, and the 300 Hall. Ants were noted on 09/04/13 in Rooms 414 and 417. Ants were noted on 09/04/13 in Rooms 310, and 417, and 400 Hall Shower Room. Ants were noted on 09/05/13 in Room 417. Ants were noted on 09/06/13 in Room 417. Ants were noted on 09/10/13 in Room 301. Ants were noted on 09/12/13 in Room 403. Ants were noted on 09/14/13 in Rooms 301 and 310. Review of the in-service regarding ants/residents, conducted on 09/04/13, revealed the following: If a resident is found to have ants in the room the following should be done; head-to-toe assessment done on the resident, shower the resident, change gown and linens. If the resident is needed to change rooms the bed must be changed as well. One hour ant round logs are to be completed by each shift. An Immediate Jeopardy was identified on 09/26/13 in the area of Quality of Care and accurate assessments. On 09/26/13 at 1:00 PM, the Assistant Administrator and DON were informed an Immediate Jeopardy (IJ) had been identified. A Plan of Removal for the IJ was requested. . The Plan of Removal for the IJ was accepted on 09/27/13 at 7:30 PM, and reflected the following: Resident #1's bed was found with ants on 08/31/13 at 11:49 PM. Assessment of the resident revealed there were no ant bites. The resident was moved to another room, which shared a wall with her first room. On 09/01/13 at 8:30 AM, ants were found on Resident #1. LVN F was informed, but her documentation in the resident's clinical record was not an accurate description of the number of ants. MA G and CNA E, along with Resident #1's family member were stripping the bed and wiping ants off the resident. LVN F documented ants were under the resident as well as having been bitten on both arms, collar bone and front of the legs. There was no evidence of a comprehensive clinical assessment. Information provided to the NP was unknown. Orders were received to give [MEDICATION NAME] 50 mg and [MEDICATION NAME] 7.5 mg per [DEVICE] and to apply [MEDICATION NAME] cream. Resident #1 was transferred to the ER for treatment at the insistence of the resident's family member. LVN F provided no other reason for Resident #1 being sent to the ER. Resident #1 returned to the facility the same day and was taken to a room on the Suites station. There was no evidence to indicate Resident #1's physician or NP was notified of the resident going to the ER or what treatment and medication was ordered for the resident for two and one-half hours following her return to the facility. On 09/01/13, nursing staff, Weekend Supervisor, LVN N and the SW began making rounds of every occupied room in the facility looking for ants. Residents unable to make their needs known were given head-to-toe assessments. There were no additional ant bites identified. The Assistant Administrator, the Maintenance Supervisor and Maintenance Man O walked the entire inside of the facility and the exterior assessing for evidence of ants on 09/01/13 and 09/02/13. Housekeeping deep cleaned the two rooms Resident #1 was in. No other residents were found to be affected. The Maintenance Director contacted the facility's contracted pest control company on 09/01/13, to treat and exterminate the outside of the facility. On 09/01/13, the pest control company treated/exterminated the outside and the inside affected areas. Previous treatment had been done on 08/27/13. Maintenance staff made daily rounds outside the facility at the start of shift, treating identified areas. If an increase in ant activity did not respond to treatment, the Maintenance Supervisor will call the pest control company, who will respond within a four hour time frame to treat the affected area. Nursing staff started making hourly checks of resident rooms on 09/01/13. Housekeeping completed daily rounds and documented ant sightings in their log beginning 08/28/13. Facility protocol, effective 09/01/13, was in place for CNAs to visually monitor the resident rooms hourly and notify findings to the charge nurses. Charge nurses are to document on every room. If a resident has ants in the room, the following should be done: -- Remove any ants off the resident wiping them o
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility's Administrator, the DON and LVN F failed to use the facility's resources effectively and efficiently to maintain the highes practicable physical well-being for one (Resident #1) of four residents reviewed for quality of care, assessment, neglect, consulting with the physician and the facility's physical environment. 1) The Administrator failed to implement the facility's Abuse (and Neglect) Policy when the Administrator failed to provide oversight of an investigation conducted by the DON. This resulted in a failure to identify the DON's inadequate investigation of an incident of neglect. 2) The Administrator failed to ensure the nursing facility was physically maintained in a manner to protect the health and safety of residents and ensured the facility had an effective pest control program. 3) The DON failed to complete a thorough investigation and thus failed to identify training needs of LVN F. The DON conducted the investigation regarding Resident #1 sustaining multiple ant bites, but failed to identify the following: When Resident #1 was found with fire ants everywhere on her body and was being bitten, LVN F failed to: -- conduct a head-to-toe assessment to determine with accuracy the number of fire ant bites she sustained, assessing for an allergic reaction and pain. -- provide Resident #1's physician/NP with an accurate assessment of Resident #1's status and allowing the physician/NP to respond appropriately with orders to send her to the hospital. -- notify the physician/NP Resident #1 was sent to the ER and when the resident returned from the ER with new orders until the resident had been back in the facility for over two hours. On 09/26/13 an Immediate Jeopardy (IJ) was identified in the area of quality of care and accurate assessments. While the IJ was removed on 09/30/13, the facility remained out of compliance at a level of actual harm that is not immediate jeopardy and at a potential for more than minimal harm and scope of pattern. because staff were still being inserviced and the facility was monitoring the effectiveness of their plan of removal. These failures placed the facility's 152 residents, including Residents #1, #2, #3 and #4, at risk for not being adequately assessed with [REDACTED]. in a delay in treatment or [DIAGNOSES REDACTED]. Findings included: On 09/26/13, based on

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	455416	A. BUILDING _____ B. WING _____	09/30/2013

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 15) administrative review, the investigation was reopened for further investigation of a current Immediate Jeopardy situation. Resident #1's MDS assessment, dated 08/25/13, reflected a [AGE] year-old female who was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The assessment reflected Resident #1 had severe cognitive impairment, received nourishment via tube feeding, and required total dependence on staff for activities of daily living to include bed mobility and personal hygiene. Resident #1's care plan with a current review date of 08/11/13, reflected the following: a) ADL functions reflected she was totally dependent for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. Approaches included to provide Resident #1 with assistance as needed. b) [DIAGNOSES REDACTED]. Approaches included following safety measures and implementing [MEDICAL CONDITION] precautions. c) Resident had difficulty making self understood related to her [DIAGNOSES REDACTED]. Approaches included to observe for non-verbal signs of distress (guarding, moaning, restlessness, grimacing, withdrawal, etc.). Turn/reposition, communicate, provide pericare, assess for pain, and provide liquids/food as needed. Staff must anticipate needs. Resident unable to communicate. d) Resident is at risk for skin breakdown related to bowel and bladder incontinence. The goal was for the resident's skin to remain intact. Approaches included to assess the resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. On 09/12/13 at 11:00 AM, Resident #1 was observed in her room, lying on her bed. She was in a fetal position and had severe contractures of her arms, legs, and hands. She had swollen, inflamed, red welts on all visible areas of her body. Small clusters of welts and individual welts were around her hairline, upper and lower extremities, neck, and upper shoulder blades, plus on her hands and feet. A cluster of welts was on her inner left thigh in an area approximately 6.0 to 8.0 inches in length and 3.0 to 4.0 inches in width. Observation by the surveyor on 09/12/13 at 11:30 AM revealed Resident #1 was covered with red welts, which appeared to be ant bites, except for her middle back, feeding tube area, vaginal area, and under her breasts. The red welts were too numerous to count. During the assessment, Resident #1 responded to verbal and physical stimulus by opening her eyes and frowning. On 09/12/13 at 11:00 AM, during the initial observation of Resident #1, a family member was present and identified the welts as fire ant bites. The family member stated the incident occurred on 09/01/13. The family member further stated he/she received a telephone call on 09/01/13 around 5:30 AM from a staff member informing him/her ants were found in the resident's room and Resident #1, along with her bed, had been moved to another room. the family member indicated this was a repeat notification of the ants observed on 08/31/13. The family member stated he/she received another telephone call from the facility later that same morning from a different staff member informing him/her of ants in the resident's room. The family member stated he/she became concerned and decided to check on the resident. The family member stated when he/she arrived, Resident #1 was in her room, in bed, and covered in ants. The family member stated he/she began yelling for help and several staff members came to help brush the ants off the resident. The family member revealed he/she had to insist Resident #1 be sent to the hospital, where she was informed by hospital staff the number of ant bites suffered by Resident #1 could have led to her death. Resident #1's nurse's notes dated 09/01/13 and timed both at 5:30 AM and 11:40 PM (start of shift was on 08/31/13), reflected ants were on the resident's dresser and some on her bed. The nurse conducted an assessment of the resident and noted she had no ant bites and had no signs and symptoms of pain. The resident's MD was notified and an order was received to move the resident to another room, and the family was notified of the resident's transfer to a different room due to the presence of ants. An entry at 8:30 AM, reflected the resident was resting comfortably and there were no signs of ants or ant bites in the new room (which shared a wall with Resident #1's old room). The next nurse's notes entry for Resident #1, dated 09/03/13 at 9:30 AM, reflected the nurse heard a nurse aide calling come STAT (immediately) to room (Resident #1's room). The nurse entered the room and observed two nurse aides and the resident's mother striping her bed. Resident #1's mother was yelling that her daughter had ants all on her. The resident had bites on both arms, along her collar bone and the front of her legs, and that the areas were slightly swollen and red. The physician's NP was consulted and gave orders for 50 mg of [MEDICATION NAME] and 7.5 mg of Loratab via her feeding tube, and to apply [MEDICATION NAME] cream to her body. The resident's mother wanted her transferred to a hospital, at 10:00 AM, and at 4:00 PM, Resident #1 returned from the hospital via ambulance. A Patient/Resident Incident/Accident Investigation Worksheet, completed by LVN F on 09/01/13, documented on 09/01/13 at 9:20 AM, Resident #1 was found to have ant bites. At 9:20 AM, the resident's mother came and found ants in the resident's bed and room. Staff then cleaned the ants off the resident and applied cream with medication given per [DEVICE]. On 09/13/13 at 9:15 AM, during an interview with CNA E, she confirmed she worked on 09/01/13, and that she had been assigned the hall where Resident #1 resided. She stated her shift began at 6:00 AM. She stated she was not informed about ants being found in Resident #1's room and bed during the previous shift. She stated she checked on Resident #1 briefly, but did not pull back her sheet to check for ants or perform any incontinence care. She stated around 9:00 AM, she saw Resident #1's family member enter the resident's room and then heard the resident's family member yelling for help. She stated when she arrived at Resident #1's room, hundreds of ants were on Resident #1, as well as on her bed and under the resident. CNA E stated she had previously seen ants on the 200 and 300 halls, but denied seeing them on any resident. CNA E stated staff now report any sightings of ants to the charge nurse and maintenance. On 09/17/13 at 11:04 AM, during an interview with MA G, he confirmed he worked on 09/01/13. He stated he heard Resident #1's family member call for help and went to assist. He stated Resident #1 was covered from head-to-toe in ants. He stated he focused on helping get the ants off her. He added there were too many ants to count. During a confidential staff interview, he/she stated he/she had assisted with removing ants from Resident #1 on 09/01/13, and had provided care for the resident when the resident returned from the hospital. The confidential interviewee (CI) stated he/she was present when Resident #1's family member arrived at the facility around 9:00 AM on 09/01/13, and called for help. The CI removed Resident #1's brief during the incident and could tell Resident #1 had not been provided incontinent care for a significant amount of time due to the wetness of the brief and pad, and the feeding residue on the pad (however, this was not confirmed). The CI believed the level of wetness and amount of feeding residue indicated Resident #1's sheets had not been changed the night before when the ants where initially found in the resident's bed. The CI stated Resident #1's brief was filled with ants, and there were hundreds of ants on the resident, including when LVN F was in the room. The CI described Resident #1 as being covered in bites. The CI stated when Resident #1 returned from the hospital, she had to sit in her wheelchair for approximately an hour to an hour and a half because her bed, which had a new mattress, was not ready. The CI stated Resident #1 was then moved to another unit. The CI stated he/she went to check on the resident and she was wrapped in a sheet and when he/she removed the sheet from the resident, he/she observed three to four ants. The CI stated he/she knew the sheets and the mattress were clean and free of ants, so he/she checked Resident #1's wheelchair. The CI stated he/she discovered the pad in the seat of the wheelchair had a hole with food in it as well as food under the pad. The CI shook the pad and approximately eight to nine ants came out of the pad. The CI stated this incident was reported to the DON and Administrator. On 09/16/13 at approximately 11:15 AM, during an interview with LVN F, she confirmed she worked on 09/01/13, and her shift was 6:00 AM to 2:00 PM. She stated she had been the charge nurse for the 200 and 300 halls, which included Resident #1. She stated the night nurse told her ants had been found in Resident #1's room and the resident was moved to a new room. She stated she did a quick check of Resident #1 during walking rounds at approximately 6:00 AM, and then did a complete check of Resident #1 at approximately 8:30 AM. She stated the complete check included pulling back Resident #1's covers and checking her body for ant bites and did not find any. During the interview with LVN F, she further stated that at approximately 9:20 AM, she was called by a nurse aide to Resident #1's room. She stated she did not see a great deal of ants; no more than 30 ants. LVN F stated she observed ant bites around Resident #1's collarbone and the front of her chest. She stated she did not observe any ant bites on Resident #1's trunk or vaginal area. She stated the bites did not have blisters and Resident #1 did not have any facial expression indicating she was in pain. (Note: CNA E and the CI both stated they saw hundreds of ants, and MA G stated he saw too many (ants) to count.) LVN F further stated she contacted Resident #1's physician's answering service and then spoke with the physician's NP regarding the incident. She stated the NP who prescribed Resident #1 [MEDICATION NAME] and Loritab, said if Resident #1's family member wanted her sent to the hospital to go ahead and send her. Resident #1's family member requested the resident be sent to the hospital so she contacted a non-emergency transport company and was told that due to Resident #1 being total care, they would be unable to transport the resident. She stated she then contacted an ambulance service for a non-emergency transport. LVN F stated she was not sure if she had notified Resident #1's physician about Resident #1 being sent to the hospital, but did notify the physician upon the resident's return to the facility. (Note: LVN F's nurse's notes for 09/01/13, provided no evidence the physician or his NP were consulted prior to the resident being transferred to a local hospital or upon the resident's return to the facility.) On 09/17/13 at 3:30 PM, during an interview with the DON, she stated that on 09/01/13, between 9:30 AM to 10:00 AM, she was notified of the incident involving Resident #1 and the ants. She recalled that Resident #1 was sent out to the hospital due to the family member's request. The DON stated she

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 16) arrived at the facility shortly after she was notified of the incident but she did not observe Resident #1 until she had returned from the hospital. The DON stated she conducted the investigation of the incident. she could ot explain why LVN F's nurse's notes did not provide and accurate assessment of the number of Resident #1's number of ant bites. She stated she did not interview LVN F regarding her statement that Resident #1 only received 30 ant bites. She stated she was not aware LVN F had not disclosed the severity of Resident #1's ant bites when she consulted with the physician's NP. She was not aware that neither the physician nor the physician's NP had been consulted regarding Resident #1's transfer to the hospital. She was not aware that neither the physician nor his NP were notified when Resident #1 returned to the facility from the hospital. Nurse's notes, dated 09/01/13 at 4:00 PM, reflected the hospital's physician gave orders for the resident to receive 500 mg of Keflex four times a day for seven days, 4 mg of [MEDICATION NAME][MEDICATION NAME] to take as directed on the package, and [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) 2.5 mg/167 mg per 5 ml solution, take 10 ml (two teasponns) every 6 hours as needed for pain. The nurses' notes provided no documented evidence the resident's physician or the physician's PA were notified of the request to transfer the resident to the hospital or of the resident's return from the hospital with new orders. On 09/13/13 at 10:15 AM, during an interview with the physician's NP, she stated she was first notified around midnight (12:00 AM) on 09/01/13, of the ants in Resident #1's room. She stated she received another telephone call later that morning, but was uncertain of the time, and was told the resident had been moved to another room. She stated a third telephone call was received from the facility on 09/01/13, saying Resident #1's family member was worried about Resident #1 being in pain from some ant bites. She stated she prescribed a topical cream, pain medication, and [MEDICATION NAME]. She stated she was not informed of the number of ant bites or seriousness of the incident. The NP stated she received another telephone call from the facility on 09/02/13 at around midnight to inform her that Resident #1's family member did not want Resident #1 to take the steroids prescribed by the emergency room physician. The NP stated she had been unaware Resident #1 had transferred to a hospital emergency room or of Resident #1's return to the facility. The NP stated she did not see Resident #1 until Tuesday (09/03/13), but could tell that she would have sent Resident #1 to the hospital at the time of the incident if the seriousness of the incident had been conveyed. The NP stated she had recently had problems getting accurate reports from staff at the facility. She stated staff were not reporting the full extent of situations and were not prepared with information. On 09/12/13 at 12:30 PM, during an interview with Resident #1's physician, he stated the red welts observed by the surveyors were ant bites. He stated if he had seen the ant bites immediately after the incident, he would have sent her to the hospital. The physician stated he did not initially handle the incident, but the information his office received about the incident did not relay the seriousness of the incident. The physician stated the worst case scenario would have been Resident #1 experiencing anaphylactic shock. A secondary concern was a massive infection. The physician stated Resident #1 could experience scarring in the areas of the ant bites, and added that it could take up to another month for the bites to heal, and stated, There had to be hundreds of ants to have caused the extent of (Resident #1's) injuries. Resident #1's nurse's notes reflected the following entries regarding her ant bites: Entry dated 09/03/13 on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected Resident #1 was small and frail in stature and unable to make needs known. The resident had contractures to knees, hips, and elbows bilaterally. Ant bites are noted to Resident #1's entire body from dense to sparse concentrations. The densest concentrations of ant bites are in the following areas: the base of the back of the neck, the right posterior flank area, left posterior thigh, and left posterior lateral calf. The ants bites are cluster of fluid filled pustules, too numerous to count. Entry dated 09/06/13 (5 days after the incident) on the 6:00 AM to 2:00 PM shift (no specific time provided), reflected a skin assessment was performed due to the incident of multiple ant bites. The densest concentrations of ant bites are the left posterior thigh and left posterior lateral calf. The ant bites in these areas are very red and irritated with a decrease in the fluid filled pustules. The ant bites to the neck, bilateral arms, and right flack are red and angry, but the concentration of redness has decreased. Observation on 09/13/13 at 12:29 PM, of Resident #1 in her room, revealed she was in bed with socks on her hand. Resident #1's family member was present and stated the socks were used to prevent Resident #1 from scratching herself. Ant bites were observed on all of Resident #1's limbs, neck, shoulders, back, right rib cage, and left inner thigh. Several of the ant bites were observed to have pustules. The family member removed the socks and Resident #1 immediately began scratching her neck and shoulder area. Resident #1 had several dark red scratch marks on both her upper arms and shoulder area. Resident #1's facial expression indicated she was distressed. Resident #1 made slight groaning noises and continued to attempt to scratch at areas with ant bites. Review of the Provider Investigation Report, signed by the DON and dated 09/06/13, identified the category of the incident involving Resident #1 as Other: Ant Bites. It reflected the incident occurred on 09/01/13, and was reported to the State Agency on 09/01/13. The summary of the investigation reflected: A nurse observed ants on the resident's dresser and on her bed on 08/31/13 at approximately 11:40 PM. The resident and her roommate were moved to another room and both residents were assessed and no observations of ants were noted on either resident. Staff continued to monitor throughout the shift. On 09/01/13 at 9:30 AM, the resident's mother observed ants on the resident. A nurse assessed Resident #1 and observed multiple ant bits on Resident #1 and the areas were closed and slightly swollen. The Post-Investigation action section reflected facility staff had been monitoring for ants in the facility since 08/28/13, due to ants found in two rooms. Resident #1 was moved to another room, and her previous room was deep cleaned, and she was provided with a new wheelchair cushion. A head-to-toe assessment was conducted every shift. A pest control provider treated the interior and exterior of the facility. (The copies of billing from the pest control provider were for 08/09/13, 08/13/13, 08/16/13, 08/20/13, 08/21/13, 08/26/13, 08/27/13, and 09/06/13.) Staff, including nursing staff, maintenance, housekeeping and administration, were educated on monitoring rooms for ant activity, implementing safety checks for ants, who to notify in the event of finding ants, and how to respond if ants were observed on residents or beds/linens. Daily monitoring continued for observation of ants. The plan did not address ensuring nurses conduct accurate assessments of residents and ensuring nurses provide complete and accurate information when consulting with a resident's physician. It furthermore did not provide information regarding how they addressed ensuring nurses consult/notify a physician when a resident is being transferred to a hospital and again when they return with an order to review the treatment orders from the hospital to allow the attending physician to determine if he wants to approve the new treatment plan or change it. Review of the facility's Patient/Resident Incident/Accident Investigation Worksheets revealed on 08/31/13 at 11:49 PM, Resident #3 was found in her room with ants on her dresser. The nurse conducted a head-to-toe assessment of the resident and found no ant bites. (Note: This incident occurred the day before Resident #1 was found in the same room covered with ants.) Review of the facility's Service Request Log for the contract exterminator revealed the following: 08/20/13 at 2:30 p.m. - Entire unit needs to be sprayed. Bugs and ants in every room. On 08/21/13 (no time) - Entire room [ROOM NUMBER] and bed B have ants. On 08/21/13 (no time) - Ants in closet in room [ROOM NUMBER] on clothes. On 09/01/13 (no time) - Ants in resident room [ROOM NUMBER] and restroom. On 09/03/13 (no time) - Ants at nurses' station (station not specified). Review of the pest control service provider's receipts for treatment revealed the following: 08/13/13: room [ROOM NUMBER] was treated. The facility's exterior was treated. Ants were the targeted pest. Ants were noted during service. A Fire Ant mound was noted near an exit door. Ants were noted in room [ROOM NUMBER]. 08/16/13: this visit was in regard to cockroaches in the kitchen and the treatment of [REDACTED]. 08/20/13: The facility's exterior area was treated. Ants were noted during service. The courtyard of the secured unit, 200 hall, was treated. rooms [ROOM NUMBERS] were treated for [REDACTED]. 08/21/13: Patient/guest rooms were treated. The targeted pest was ants. rooms [ROOM NUMBERS] were treated. Ants were noted during service under cold base in rooms [ROOM NUMBERS]. 08/25/13: The facility's exterior area and patient/guest rooms were treated. The targeted pest was ants. The areas were inspected and treated and rooms were serviced. room [ROOM NUMBER], baseboards, was treated. Ants were noted during services; baseboards around bed. 08/27/13: The facility's perimeter was treated and ants were the target. Ants were noted during service; several ants near building on exterior of building. Trees/shrubs were contacting the facility creating a path for pests to enter. The service provider suggested the facility trim back vegetation to eliminate contact. 09/06/13: The exterior of the widnoew and ground near room [ROOM NUMBER]. On 09/13/13 at 3:20 PM, interview with the Pest Control Service Provider revealed only one fire ant mound was found after the incident that occurred on 09/01/13. The service provider completed a power spray approximately two weeks ago. It will sometimes drive the insects into the facility where they will ingest the poison and then die. The service provider and the facility are working on controlling the issue. On 09/13/13 at 2:28 PM, interview with the Administrator revealed the facility did not have a specific policy regarding ants, just the statement written for the in-service conducted after the incident on 09/01/13. On 09/13/13 at 2:50 PM, interview with the Maintenance Director revealed prior to the incident on 09/01/13, the facility had been calling the exterminator when ants were found in the facility. The Maintenance Director identified the undated handwritten document as a list

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455416	A. BUILDING _____ B. WING _____	09/30/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE COURTYARDS AT FORT WORTH	8001 WESTERN HILLS BLVD FORT WORTH, TX 76108

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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 17) compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The identified repairs were completed following the compilation of the list of repairs needed, however completion dates were not provided at that time. Any ants seen in the facility are logged by staff in a maintenance log book located at each nurses' station. The log books are check twice a day. Insect sightings are also logged in a pest control book located at the nurses' station that is monitored by the pest control service provider on a monthly basis. If only a couple of ants are sighted the maintenance staff will treat the area himself. If it is a resident room he will also treat outside near the exterior wall of the room. Maintenance staff also monitor outside for ant mounds on a daily basis. Review of an undated, untitled document attached to the Facility's Provider Investigation Report involving Resident #1 revealed a list of resident rooms in the facility with environmental issues. On 09/13/13 at 2:50 PM, the Maintenance Director identified the undated handwritten document as a list compiled by staff members after the incident on 09/01/13, of areas in the facility where repairs were needed to address ants in the building. The list included a total of 82 resident rooms that needed caulk around the windows. The following are the rooms identified: 1, 3, 11, 18, 20-22, 24-25, 28-30, 33-34, 38-39, 41-42, 45, 59-60, 200-213, 215-226, 228, 301-309, 311-313, 315, 401-408, 412-415, 418-420, 422-424, 426-427, and 429. The list also included 20 rooms that needed caulk around the windows and in the bathroom. The identified rooms were: 4, 23, 26, 31-32, 35-36, 40, 44, 48-49, 51-58, and 310. Also identified on the list were the following five rooms that needed caulking in the bathroom only: 9, 10, 12, 19, and 411. The list identified seven rooms where ants were found, the rooms were: 5, 9, 11, 20, 53, 55, and 406. The list also identified other environmental issues in resident rooms. In room [ROOM NUMBER] a hole in the widow screen was identified. In room [ROOM NUMBER] the window doesn't shut all the way, and the frame was rotten. In room [ROOM NUMBER] the window was still broken, and room [ROOM NUMBER] had broken window trim. The window in room [ROOM NUMBER] was described as being in bad shape. room [ROOM NUMBER] had a hole by the bathroom door, and room [ROOM NUMBER] had a broken baseboard. A total of 107 resident rooms of the 120 resident rooms in the facility were identified as needing some type of repair. On 09/13/13 at approximately 4:00 PM, the Administrator and Assistant Administrator revealed the plan to address the ants in the facility included the following: One hour checks of total care residents by direct care staff, daily checks on residents' rooms by clinical staff and housekeeping, and daily checks by maintenance outside the facility for ant mounds. Logs of the resident and room checks were kept at each nurses' station, one for direct care staff and one for housekeeping. Staff documents any sightings of ants in the maintenance log as well as the other identified logs. The Assistant Administrator stated he has begun marking rooms where ants were sited on a floor plan so he can monitor which rooms are impacted. The Administrator stated the monitoring began on 08/28/13, but some of the nurses' stations did not begin their logs until 09/02/13. Maintenance staff is monitoring the maintenance logs kept at the nursing stations at least once a day. Maintenance treats any sightings of insects immediately and coordinates further treatments with the pest control service providers. Review of the facility's Daily Ant Inspection logs revealed rooms on the 200 Hall, 300 Hall, 400 Hall, The Terrace, and The Verandah were monitored once a day for ants from 08/28/13 to 09/14/13. Ants were noted on 09/01/13 in Rooms 211, 213, 310, and the 300 Hall Shower Room. Ants were noted on 09/01/13 in room [ROOM NUMBER], and the 300 Hall. Ants were noted on 09/04/13 in rooms [ROOM NUMBERS]. Ants were noted on 09/04/13 in Rooms 310, and 417, and 400 Hall Shower Room. Ants were noted on 09/05/13 in room [ROOM NUMBER]. Ants were noted on 09/06/13 in room [ROOM NUMBER]. Ants were noted on 09/10/13 in room [ROOM NUMBER]. Ants were noted on 09/12/13 in room [ROOM NUMBER]. Ants were noted on 09/14/13 in rooms [ROOM NUMBERS]. Review of the in-service regarding ants/residents, conducted on 09/04/13, revealed the following: If a resident is found to have ants in the room the following should be done; head-to-toe assessment done on the resident, shower the resident, change gown and linens. If the resident is needed to change rooms the bed must be changed as well. One hour ant round logs are to be completed by each shift. The facility's current Nursing Policies and Procedures included: Physician Communication/Change in Condition, revised September 2011 and reflected the following: POLICY: 1. To improve communication between physicians and nursing staff in order to promote optimal patient/resident care. 2. To provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition. PROCEDURES: 1. Complete assessment of the patient/resident which may include but is not limited to: .B. Current physical condition C. Patient's/resident's previous condition (declining, improving, stable) .E. Vital signs, TPR (temperature), BP (blood pressure).Lung Sounds, N/V Abdominal Assessment, Pain. .H. allergies [REDACTED]. .L. Any interventions/first aide (sic) provided to the patient/resident. 2. Notify the physician of the change in medical condition. (The physician notification grid may be used as a reference tool regarding acceptable notification timeframes.) The nurse will document all assessments and changes in the patient's/resident's condition in the medical record. 3. If the physician does not respond within an acceptable time frame, the Medical Director and Director of Nursing will be notified. 4. The patient's/resident's family member/legal representative will be notified of any change in condition requiring an emergent transfer to the hospital. A Physician Communication Grid was provided as guidelines for notifying the physician and reflected: These guidelines are not intended to substitute for good nursing judgment. If the nurse feels uncomfortable with a situation he/she should not delay contacting the physician or call 911 if it appears to be a life-threatening event. Review of the facility's current Abuse, Neglect and Misappropriation of Property policy, revised on February 2008, revealed the following: 1. The facility's Leadership prohibits neglect, mental or physical abuse, including involuntary seclusion and misappropriation of a patient's/resident's property and/or funds. 2. The facility's Leadership will conduct a prompt investigation of any allegation received of suspected abuse, neglect or misappropriation of property and/or funds. 3. The facility's Leadership will provide notification to the proper authorities, and, when requ