STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675249	A. BUILDING ______ B. WING _____	**02/10/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEBELLO WELLNESS CENTER	**12350 WOOD BAYOU DR HOUSTON, TX 77013**

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

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

F 0224

Level of harm - Immediate jeopardy

Residents Affected - Many

Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview, and record review, the facility failed to implement its written abuse /neglect policy and procedures to prohibit neglect, mistreatment and abuse by not protecting five of 10 residents from resident-to-resident physical aggression. (Resident #2, #4, #5, #6 and #7). --The facility failed to develop interventions or intervene for Resident #5, who had a history of [REDACTED]. --On 01/18/14 at 12:46 pm Resident #5 grabbed and scratched Resident #2 ' s arm in the dining room. --On 01/18/14 at 5:23pm in the dining room Resident #5 had an altercation over a cup of coffee with Resident #2, scratched Resident #2's left posterior hand and caused 2 open wounds. --On 01/22/14 Resident #5 was in the dining room behind Resident #4 and was observed to have a butter knife in her hands and made a stabbing motion toward Resident #4. --On 01/28/14 at 4:30 pm Resident #5 was in the dining room screaming at and slapped Resident #7. --On 02/01/14 Resident #5 grabbed Resident # 6 by the arm and said that she would scratch Resident #6 if she touched her again. These failures resulted in Immediate Jeopardy (IJ). The Administrator and the Director of Nurses (DON) were informed of the IJ on 02/06/14 at 4:00 p.m. While the IJ was removed retroactively on 02/06/14 at 4:15 p.m. The facility remained out of compliance at a scope of widespread, no actual harm with potential of more than minimal harm due to the need for ongoing monitoring of staff's response to resident behaviors. These failures affected five residents and placed the other 107 residents at risk for further abuse, injuries and fear, as facility had not identified aggressive residents, did not update, develop and implement plan of actions to prevent abuse and neglect of residents and the staff were not in-serviced. Incidents/Complaint # 5 and 6 Findings include: Record review of the facility's annual (Minimum Data Set) MDS with assessment reference date of 04/30/13 for Resident # 5 revealed she was a [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of the psychiatrist's quarterly reviewed dated 03/19/13 for Resident #5 revealed [DIAGNOSES REDACTED]. The current treatment and behavioral objectives were to continue to support and reinforce positive change behaviors and mood management. The section on current status revealed Resident #5 had a history of [REDACTED]. Record review of the last psychiatric progress notes for Resident #5 were dated 01/15/14 with documentation including current medications of [MEDICATION NAME] and [MEDICATION NAME] and the Resident was assessed as oriented to self,
alert with poor insight and poor judgment and as deteriorating. The comment section revealed refusing blood sugar checks, can sometimes be re-directed. The treatment plan was to continue Resident #5's medication as ordered and staff were to monitor Resident #5 for behaviors and medication side effects. Record review of the facility's nursing notes dated 01/2014 for Resident #5 revealed no documentation related to the physical abuse incident with Resident #2 on 01/18/14. No entry documented for monitoring of Resident #5. Record review of the facility incident/accident report dated 01/18/14 at 12:46 p.m. revealed documentation of incident in the dining room with Resident #5 reaching for a cup of coffee and apparently Resident #2 was in her way. Resident #5 reached out to Resident #2's arm, grabbing it and scratched Resident #2's arm with her fingernails. Further review of the facility's incident/accident report revealed that the section on immediate action taken was the 2 residents were immediately separated and no injuries were observed at the time of the incident. Resident #5 was assessed as oriented to self, situation and place. Licensed Vocational Nurse (LVN) A spoke with resident about the behavior and Resident #5 didn't mean to scratch resident #2 she said that it wouldn ' t happen again. Record review of the incident/accident report dated 01/18/14 at 5:23 p.m. revealed that the nurse for hall 1 and 4 reported an altercation in the dining room. Residents #5 and #2 were yelling and the nurse noted 2 opened cuts on Resident #2's left posterior hand. When asked what happened neither resident could explain the reason for the altercation, Resident #2 said Resident #5 wanted coffee and she went crazy and started to scratch me. Immediate action taken was Resident #2 was assessed, open cuts to hand were cleaned. Injuries observed at time incident was documented as a skin tear on the back of Resident #2's left hand. The section on mental status was checked as resident was oriented to person and situation. Record review of the nurse notes dated 01/2014 for Resident #2 revealed documentation dated 01/18/14 at 5:51p.m. of nurse assessed this resident, complained of mild pain to her hand, .Open cuts to hand were cleaned, applied triple antibiotic .Will notify wound nurse to assess cuts. Notified responsible party (R.P.) will continue to monitor. Record review of the facility's nursing progress notes dated 01/22/14 for Resident #4 revealed Resident #5 attempted to stab Resident #4 with a butter knife . Record review of the incident/accident report dated 01/22/14 at 12:40 p.m. revealed Resident #4 was sitting at a table with Resident #5. Resident #4 was reaching forward towards the middle of the table. Resident #5 picked up a butter knife and was holding it up to stab Resident #4. LVN A immediately intervened and grabbed the butter knife from Resident #5 and explained to resident #5 she could not do that. Resident #5 stated I can do it too and I will . Resident #4 was moved to another table. Further review of the document revealed no injuries were observed and the immediate action was to remove resident #4 from the table. No documentation was present for monitoring, recommendations/measures put in place or plan of action. Record review of the nurse progress notes dated of 01/14 for Resident #5 revealed no documentation related to monitoring, incident or behaviors. Record review of the incident/accident report dated 01/28/14 at 4:30 p.m. revealed LVN B had been called to the dining room. Resident #5 was screaming at and slapped Resident #7. Resident #7 then swung back at Resident #5. Further review of the incident/accident report revealed no obvious injuries, separated residents and notified families. The section on mental status revealed Resident #5 was checked as oriented to person, place, situation and time. Record review of the Resident #5's nursing progress notes dated 01/28/14 revealed documentation of Resident #5 hitting Resident #7 in the dining room. Received new order to send Resident #5 to the emergency room (ER) for refusal of medical management and danger to others. Further review of the nursing progress notes revealed that Resident #5 was not monitored for behaviors. Record review of Resident #5's Care Plan with last review date of 01/31/14 and no updates revealed a problem with initiation date of 04/29/13 for [MEDICAL CONDITION] medications use related to mental changes due to Alzheimer ' s. The goal was documented will be/remain free of drug related complications including cognitive /behavioral impairment. The interventions included; monitor/record occurrence of target behavior symptoms .inappropriate response to verbal communications, violence/aggression towards staff/others etc. Record review of the facility' s nurse progress notes dated 02/01/14 at 3:02 p.m. for Resident #5 revealed ambulating down hall in her wheelchair. Resident #6 reached out and touched Resident #5 ' s arm. Resident #5 grabbed Resident #6 ' s arm and told Resident #6 if she touched her again, she would scratch her face out. Resident #6 reached out for Resident # 5' s jacket a second time and Resident #5 grabbed Resident #6 ' s finger and pulled on it. Resident #5 said I told her if she did it again, I would scratch her face and I will . Resident #6 was assessed and no injuries noted. Further review of the report revealed signed documentation for recommendation dated 02/03/14 to refer Resident #5 for psychiatric evaluation and conduct care plan meeting. Continued review of the notes revealed on 02/04/14 at 4:10pm (Social Service Director) SSD had obtained medical consult for psychological services and referred Resident #5 for services. This evaluation was completed on02/06/14. Observations conducted on 02/06/14 throughout the day revealed that

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675249**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/10/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEBELLO WELLNESS CENTER	**12350 WOOD BAYOU DR HOUSTON, TX 77013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) Resident #5 was unsupervised while in her room, dining room and in the hallways. In an interview on 02/06/14 at 5:45 a.m. with Resident #2 who was positioned in bed with left hand wrapped in gauze and 2 red dried thick linear marks on her left arm she said a lady in the dining room scratched me with her finger nails bad, in 3 places . The resident was asked if she knew the person and Resident #2 said she goes to the dining room in a wheel chair , she ' s a black lady , she yells and hits others lots. She tried to stab a lady . In an interview on 02/06/14 at 5:55 a.m. with Certified Nursing Assistant (CNA) I revealed #5 had frequently yelled and hit other Residents. CNA I continued to say that Resident #5 had recently attacked Resident # 2 in the dining room. CNA I was asked what the facility had been doing about these problem residents and she said she didn ' t' t know. In an interview on 02/06/14 at 5:58 am LVN B said Resident #5 had got at Resident #2 and cut Resident #2 ' s arm and hand with her finger nails and the hand wound was bad . In an observation and interview on 02/06/14 at 6:35a.m. in the unsupervised dining room Resident #2 was sitting in a wheelchair positioned at a table in the dining room and her left hand was wrapped in gauze. Resident #2 was asked what happened to her hand and she said, A black lady cut, scratched me . In an interview on 02/06/14 at 7:08 a.m. with LVN C revealed that Resident #5 had scratched Resident #2 and caused a wound to Resident #2 ' s left hand. In an interview on 02/06/14 at 7:15 a.m. CNA D revealed that Resident #5 was known to have hit and yelled at other Residents and she attacked Resident #2 in the dining room. When asked what did staff do about Resident #5 CNA D said the resident had been reported and she was to be watched and separated from others if any problems. Observation on 02/06/14 at 7:20 a.m. of Resident #5 in the dining room unsupervised at a table with other residents. There was only one CNA (CNA F) present in the room sitting at the table with residents that needed assistance with eating talking with residents and positioned out of view of Resident #5. Observation on 02/06/14 at 8:30 a.m. of Resident #5 in the dining room unsupervised at a table with other residents. Many staff were present in the dining room assisting residents and no staff was sitting near or at the table with Resident #5. In an interview on 02/06/14 at 8:35 a.m. with LVN E said that Resident #5 had hit, yelled at other residents and attacked and scratched Resident #2. LVN E was asked what was the facility doing about Resident #5 and she said to watch the resident and report any problems. Observation on 02/06/14 at 8:50 a.m. of Resident #5 in the hallway self-propelling in her wheel chair. There were no staff in hallway or at nursing station and there were residents in wheelchairs/gerichairs in the hallway. Observation on 02/06/14 at 9:00 a.m. of Resident #5 in wheelchair in hallway unsupervised with residents in Geri chairs/ wheelchairs nearby and the staff were observed going from room to room to assist residents. In an interview on 02/06/14 at 11:00 a.m. with the Director of Nursing (DON) and Administrator about the Resident to Resident altercations involving Resident #5 the DON said the resident was sent to the hospital on [DATE] for psychological evaluation and the [DIAGNOSES REDACTED]. The DON continued to say that she believed some of the problems were due to the UTI. The DON further said she was new to the facility and staff said that Resident #5 was a problem but Resident #5 returned from hospital on [DATE] with new medications and the resident was being monitored. The DON was asked how Resident #5 was being monitored and she said the staff watched the resident and reported any behavior or problems. The DON was asked where was the documentation to support the monitoring of Resident #5 and the DON said the nurse should document in the nurse notes and she continued to say, what else was the facility to do and we had a care plan meeting with the family yesterday . Record review of Resident #5's care plan provided by the DON on 02/06/14 revealed a problem with initiation date of 02/05/14 for Resident #5 exhibiting behavior secondary to Urinary Tract Infection (UTI.) No goal was documented. The interventions were documented as; 1. Resident to be placed on one on one monitoring as an intervention to resident to resident behavior. Care plan updated to reflect new interventions. Physician/family notified. 2. In-service nursing staff on monitoring and interventions for Residents with behaviors related to short-term [MEDICAL CONDITION] secondary to infections-UTI. In service to included abuse/neglect training. Social service designee to follow up with residents for resolution. 3. Director Nursing Service (DNS) or Designee will review residents with [DIAGNOSES REDACTED]. 4. DNS and Abuse coordinator will review resident to resident altercations to ensure interventions in place to maintain safety and follow state reporting guidelines. 5. Summary of self-reports to be reviewed no less than quarterly by Quarterly Assurance (QA) and A committee. In an interview on 02/06/14 at 12:30 p.m. with (Activity Director) AD said during a recent activity with popcorn Resident #7 was asking many times for more popcorn and Resident #5 must have become agitated and swung out to hit Resident #7 in the face but she hit the bag of popcorn that Resident #7 had in front of her face. The nurse was immediately notified and the residents were checked and Resident #5 was removed from the activity and taken to her room. In an interview on 02/06/14 at 12:45 p.m. with Resident #4 she said a black woman tried to hurt her in the dining room and a nurse took a knife away from the resident. In an interview on 02/06/14 at 12:55 p.m. with CNA F revealed awareness that there were problems with Resident #5 being aggressive and hitting Residents. CNA F continued to say that Resident #5 had recently slapped Resident #7 and tried to stab Resident #4 and she said I just saw Resident #5 go off on a man in the dining room and threatened him. She said she would slap him silly if he touched her stuff . In an interview on 02/06/14 at 1:30 p.m. with Regional Corporate Nurse (RCN) said that the plan of action for Resident #5 was for the Resident to be transported by ambulance to the hospital, plans were in place with family and hospital and facility will have a plan in place to monitor Resident with sitter if resident is returned to facility. The RCN further said she had started to conduct In-services with the staff. In an interview on 02/06/14 at 3:10 p.m. with CNA H said that there were problems with Resident #5 and the resident had grabbed at her and had swung to hit her. CNA H was asked what had been done about resident ' s behavior and she said she reported incidents but she just tried to get along with the resident. In an interview on 02/07/14 at 7:55 a.m. with the DON and Administrator revealed that Resident #5 had been discharged from the facility on 02/06/14 at 4:15 p.m. In an interview on 02/07/14 at 9:30 a.m. Resident #2 said she had not seen Resident #5 for a few days. The Resident was asked if any staff or residents were rude or threatening to her and she said No. In an interview on 02/07/14 at 10:15 a.m. LVN B said that Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #2 causing a bad hand injury. LVN B was asked what was the facility had done about Resident #5 and she said Resident #5 had been sent to hospital as she was acting out. In an interview on 02/07/14 at 10:30 a.m. LVN K said that Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #2. LVN K was asked what had the facility done about Resident #5 and she said she was not given any new instructions by the Administrator or DON regarding Resident #5. In an interview on 02/07/14 at 11:45 a.m. LVN L said Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #2. LVN L was asked what had the facility done about Resident #5 and she said there were not any new orders for Resident #5. In an interview on 02/07/14 at 12:00pm with the Assistant Director of Nursing (ADON) at other residents and attacked Resident #2 causing a very bad skin tear to Resident #2 ' s left hand. ADON further said she requested and sent resident to hospital on [DATE] for a psychological evaluation but Resident #5 was diagnosed with [REDACTED]. The ADON said that Resident #5 continued to refuse her medications and to be aggressive. The ADON said the plan was to document behaviors so we could transfer Resident #5 to a Geri-psyche center. In an interview on 02/07/14 at 12:20 p.m. with the SSD about Resident to Resident altercations and role of social services he said that he received reports from staff either in person or by telephone, from the nurse or physician of problems of residents with behaviors and if a physician's order [REDACTED]. SSD was asked if he received any referrals or a list for psychological consult requests related to resident to resident altercation/behaviors from the facility and he said, I don ' t recall. SSD was asked if he kept any documentation of SSD ' s involvement in resident problem behaviors and he said sometimes . SSD was asked if he received any psychological consult requests for Resident #5 and after a long pause he said something, I don ' t remember . SSD was asked to provide any documentation/notes related to involvement with Residents #5. The SSD never provided any documentation per request. In an interview on 02/07/14 at 12:30 p.m. with the DON revealed that the staff received in-service training with orientation, yearly and when necessary. The DON was asked about Resident #5 and she said the resident was not in the facility and had in the past verbal and physical behaviors such as hitting, scratching other residents. The DON was asked if she observed the wound caused by Resident #5 to Resident #2 ' s left hand and DON said yes . The DON was asked what did the facility do to prevent Resident #5 from causing harm to other residents and DON said monitor behavior . The DON was asked how the staff had been instructed to monitor Resident #5 and she said, Staff were to observe Resident #5 in public areas, document any behaviors, notify, and report incidents. The DON was asked who was to monitor Resident #5 and no response was provided. The DON was asked if any staff were assigned to monitor Resident #5 and she said no . The DON was asked who documented the behaviors of Resident #5 and she said the Charge Nurse if noted or reported and documentation was to be done on the progress notes. The DON was asked if the Administrator was aware of Resident #5 ' s increased episodes of behavior problems. She said the incidents were discussed in the morning clinical meetings. The DON continued to say after the incident on 01/28/14 involving Resident #5 and #7 the ADON and I said we needed to get Resident #5 out of the building and Resident was sent to the hospital. The DON was asked what the facility did to protect the Residents upon the return of Resident #5, the staff was verbally told to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675249**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/10/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEBELLO WELLNESS CENTER	**12350 WOOD BAYOU DR HOUSTON, TX 77013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) monitor resident #5 closely and keep her in public areas with staff members and document behaviors. The DON was asked when did she verbally notify the nurses about monitoring resident #5 closely and document behaviors and she said on 01/31/14. In an interview on 02/07/14 at 1:15 p.m. with the Administrator about how he ensured the abuse and neglect policy and procedure are implemented and he said he made rounds at the facility daily and talks with Residents. In-services were frequently conducted on abuse and neglect and reporting. Daily clinical meetings with 24 hour report review which address resident behavior problems or potential abuse problem with discussion on recommendations to prevent and ensure safety of residents and with follow-up. The Administrator was asked if the facility ' s incident /accident logs were reviewed and he said yes, in our interdisciplinary team meeting and he was further asked what does the facility do about residents identified with incidents of behavior and he said the resident has medications that are monitored and the resident is monitored closely and if behavior problems continue, the behavior becomes dangerous then the resident is discharged . The Administrator was asked about the facility ' s response to Resident #5 ' s behavior problem. He said that was why we sent her to the hospital, to protect the other residents. On 02/06/14 when the surveyor identified resident #5 was aggressive again, we put 1 on 1 staff monitor of Resident #5 and we are making arrangements to send resident out of facility. The Administrator said there were some incidents and so we are sending resident #5 out as soon as we can but the family is very difficult would not allow resident to be sent to hospital we requested so we acquired orders to send the resident to the family ' s preferred hospital. The Administrator continued to say, It was a mistake on my part to bring Resident #5 back, it was not the setting to bring her back. The Administrator was asked what facility did to prevent further abuse of Residents upon the return of Resident #5. He said staff were asked to be conscious of Resident #5' s behavior, the staff were to watch Resident #5 and monitor any behavior. The Administrator continued to say then we found other behaviors and we put her on 1 to 1 monitoring. In an interview on 02/10/14 at 9:00 a.m. LVN A said she had witnessed Resident #5 trying to stab Resident # 4 with a butter knife, hit Resident #7 in the face and grab Resident #6. LVN A was asked what did the facility tell the nurse to do and she said document any behaviors and keep an eye on Resident #5. In an interview on 02/10/14 at 9:15 a.m. the Director of Clinical Services (DCS) said if the facility had followed their written policy and procedures they would not have the difficulties as they are having now. There was a new DON and Social worker and things were not done per policy and procedure. Record review of the facility's incident/accident tracking and trending logs dated 12/13 revealed no entry for Resident #5. Record review of the facility's incident/accident tracking and trending logs dated 01/14 revealed entry for Resident #5 dated for 01/18/14, 01/22/14, 01/28/14 for incidents of behavior. No new or updated interventions or approaches were documented. Record review of the facility's incident/accident tracking and trending logs dated 02/14 revealed an entry for Resident #5 dated 02/01/14 for incident of behavior. No new or updated interventions or approaches were documented. Record review of the facility's In-services dated 2013 and 2014 revealed staff signed documentation dated 10/23/13, 10/26/13, 10/28/13 and 11/08/13 for abuse and neglect reporting and changes in condition of residents. Facility provided signed staff in-service conducted on 02/06/14 for managing difficult behaviors with subject of reporting, interventions and monitoring. Record Review of the facility's policy for Agitated & Combative Resident with a revision date of 5/2007 read in part: Policy: .all residents who demonstrate agitated or combative behaviors have prompt intervention to prevent injury to the resident, other residents. in the facility. Purpose: 1. To ensure that all residents who display combative behaviors have prompt and appropriate intervention. 2. To ensure that staff are properly educated and trained to respond to .behaviors. Procedures: Before admission, each resident will be evaluated for potential combative behaviors, based on historical data, [DIAGNOSES REDACTED]. Prevention: Staff will adhere to the following procedures for measures of prevention: 1. Identify and remove source of the problem, if known. 2. Approach resident in calm and reassuring manner. 3. Direct resident to a less stressful area. 5.Maintain one to one staff/resident ratio until resident no longer exhibits problem behavior. 6. Provide distraction or engagement if necessary. 7. Monitor resident's further interactions with peers. 8. Communicate via 24-hour report, resident's behavior trigger. 9. Notify physician. Interventions: Severely Agitated/Combative Resident In the event the above preventions prove unsuccessful. 1. First staff to witness combative behavior calls for additional assistance. 2. Unit staff will respond immediately to remove the resident from area of agitation. 3. Provide safe quiet area, with direct staff supervision (1:1 staff as indicated). Place the resident on checks, to monitor behaviors, at least every hour until behavior subside. Facility will use 1:1 staff when needed and document behaviors. Social Services will assess potential causes of combative behaviors. Discharge Planning: .3. Resident(s) with aggressive behavior that affect other residents and/or endangers the resident will be discharged immediately to an appropriate setting, per physician order, and the family will be notified. Record review of the facility's policy and procedure on abuse prevention program dated 08/13 revealed: It is the policy of this facility that each Resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers . Prevention: Employees of our facility will take action to protect and prevent abuse and neglect from occurring within the facility by; *Assess, care plan and monitor residents with history of aggressive behaviors . Protection: If a resident incident is reported, discovered or suspected , where the health, welfare or safety of residents involved , this facility will take the following steps to prevent further potential abuse while the investigation is in progress; 1) If suspected perpetrator is another resident: a. Separate the residents so they do not interact with each other until circumstances of the reported incident can be determined. These failures resulted in Immediate Jeopardy (IJ). The Director of Nurses and the Administrator were informed of the IJ on 02/06/14 at 3:00 p.m. The following plan of action to remove the IJ was submitted by the Administrator on 02/07/14 at 2:37 p.m. Action Plan: Removal of Immediate Jeopardy: 1)Ensuring Safety of Residents: Upon learning that Resident #5 was in question from regarding behaviors; the resident was put on one sitter for the remainder of the day (11:45am until discharge). MD notified and discharge orders received. Resident #5 was discharged from the facility on 2/6/14 at 4:15pm. The patient was taken to the hospital. Resident #5 will not be admitted back to the facility. 2)Immediate Actions: a. Criteria used to identify residents with combative behaviors: IDT team reviewed each resident's behavior history and documented abnormal behaviors to identify residents with combative behaviors. IDT met and completed list of residents on 2/6/2014 at 8:00pm. b. Identified residents with inappropriate/aggressive behaviors by observation, interview, behavior monitoring, and incident reports completed on 2/6/14. c. All residents with identified inappropriate behaviors will have their care plans reviewed and updated by 2/7/14 at 9:00am. All change of conditions including abnormal behaviors will be documented on the 24 hour report for follow up. Nursing staff will be aware of changes in care plan interventions through shift change report, 24 hour report. d. All residents identified with aggressive behaviors were referred to Senior Psychological Care for assessment and recommendations to be performed on 2/7/14. The MD was notified of aggressive behaviors to obtain referral for psychological services. e. All residents with identified inappropriate behaviors received nursing progress notes to update current behaviors and ensure wellbeing. The nursing progress notes were started on 2/6/14 and completed on 2/7/14 at 10:30am. 3)Training a. All nursing staff and any other direct care staff that are involved with providing care to the resident ' s day in and day out will be in-serviced on Managing Residents with Difficult Behaviors and Abuse/Neglect Prevention and Reporting. In-service started on 2/6/14 and will be completed by 12:00pm on 2/7/14. Training will be provided by Nurse Resource. b. All nursing staff and any other direct care staff not available for live in-service will be contacted by phone and receive training by 2/7/14 by 2:.00pm. c. Staff in-serviced by Clinical Nurse Resource on identification of aggressive combative behaviors and to notify DON and Administrator immediately upon identification. d. All nursing staff and any other direct care staff not available on live or phone in-service will not be permitted to work until in-services are completed. The facility was monitored on 02/08/14, 02/09/14 and 02/10/14 to ensure that all residents with combative behaviors were identified and assessed for inappropriate behavior by observations, interview and record review, with the resident care plans reviewed and updated, nursing progress notes and 24 hour reports including abnormal behaviors developed. Identified residents with aggressive behaviors had notification to physician with referral to senior psychological service for assessments and recommendations. The Staff were In-serviced on managing residents with difficult behaviors and abuse/neglect prevention and reporting and Staff was interviewed on how to implement appropriate interventions for residents with aggressive behaviors per the plan to remove the immediate jeopardy. While the IJ was removed retroactively on 02/06/14 at 4:15 p.m. The facility remained out of compliance at a scope of widespread, no actual harm with potential of more than minimal harm due to need for ongoing monitoring of staff's response to Resident behaviors. The CMS 672 revealed resident census of 112.
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.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675249**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/10/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEBELLO WELLNESS CENTER	**12350 WOOD BAYOU DR HOUSTON, TX 77013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its written abuse /neglect policy and procedures to prohibit neglect, mistreatment and abuse by not protecting five of 10 residents from resident-to-resident physical aggression. (Resident #2, #4, #5, #6 and #7). --The facility failed to develop interventions or intervene for Resident #5, who had a history of [REDACTED]. --On 01/18/14 at 12:46 pm Resident #5 grabbed and scratched Resident #2 ' s arm in the dining room. --On 01/18/14 at 5:23pm in the dining room Resident #5 had an altercation over a cup of coffee with Resident #2, scratched Resident #2's left posterior hand and caused 2 open wounds. --On 01/22/14 Resident #5 was in the dining room behind Resident #4 and was observed to have a butter knife in her hands and made a stabbing motion toward Resident #4. --On 01/28/14 at 4:30 pm Resident #5 was in the dining room screaming at and slapped Resident #7. --On 02/01/14 Resident #5 grabbed Resident # 6 by the arm and said that she would scratch Resident #6 if she touched her again. These failures resulted in Immediate Jeopardy (IJ). The Administrator and the Director of Nurses (DON) were informed of the IJ on 02/06/14 at 4:00 p.m. While the IJ was removed retroactively on 02/06/14 at 4:15 p.m. The facility remained out of compliance at a scope of widespread, no actual harm with potential of more than minimal harm due to the need for ongoing monitoring of staff's response to resident behaviors. These failures affected five residents and placed the other 107 residents at risk for further abuse, injuries and fear, as facility had not identified aggressive residents, did not update, develop and implement plan of actions to prevent abuse and neglect of residents and the staff were not in-serviced. Incidents/Complaint # 5 and 6 Findings include: Record review of the facility's policy and procedure on abuse prevention program dated 08/13 revealed: It is the policy of this facility that each Resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers . Prevention: Employees of our facility will take action to protect and prevent abuse and neglect from occurring within the facility by; *Assess, care plan and monitor residents with history of aggressive behaviors . Protection: If a resident incident is reported, discovered or suspected , where the health, welfare or safety of residents involved , this facility will take the following steps to prevent further potential abuse while the investigation is in progress; 1) If suspected perpetrator is another resident: a. Separate the residents so they do not interact with each other until circumstances of the reported incident can be determined. Record review of the facility's annual (Minimum Data Set) MDS with assessment reference date of 04/30/13 for Resident # 5 revealed she was a [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of the psychiatrist's quarterly reviewed dated 03/19/13 for Resident #5 revealed [DIAGNOSES REDACTED]. The current treatment and behavioral objectives were to continue to support and reinforce positive change behaviors and mood management. The section on current status revealed Resident #5 had a history of [REDACTED]. Record review of the last psychiatric progress notes for Resident #5 were dated 01/15/14 with documentation including current medications of [MEDICATION NAME] and [MEDICATION NAME] and the Resident was assessed as oriented to self, alert with poor insight and poor judgment and as deteriorating. The comment section revealed refusing blood sugar checks, can sometimes be re-directed. The treatment plan was to continue Resident #5's medication as ordered and staff were to monitor Resident #5 for behaviors and medication side effects. Record review of the facility's nursing notes dated 01/2014 for Resident #5 revealed no documentation related to the physical abuse incident with Resident #2 on 01/18/14. No entry documented for monitoring of Resident #5. Record review of the facility incident/accident report dated 01/18/14 at 12:46 p.m. revealed documentation of incident in the dining room with Resident #5 reaching for a cup of coffee and apparently Resident #2 was in her way. Resident #5 reached out to Resident #2's arm, grabbing it and scratched Resident #2's arm with her fingernails. Further review of the facility's incident/accident report revealed that the section on immediate action taken was the 2 residents were immediately separated and no injuries were observed at the time of the incident. Resident #5 was assessed as oriented to self, situation and place. Licensed Vocational Nurse (LVN) A spoke with resident about the behavior and Resident #5 didn't mean to scratch resident #2 she said that it wouldn ' t happen again. Record review of the incident/accident report dated 01/18/14 at 5:23 p.m. revealed that the nurse for hall 1 and 4 reported an altercation in the dining room. Residents #5 and #2 were yelling and the nurse noted 2 opened cuts on Resident #2's left posterior hand. When asked what happened neither resident could explain the reason for the altercation, Resident #2 said Resident #5 wanted coffee and she went crazy and started to scratch me. Immediate action taken was Resident #2 was assessed, open cuts to hand were cleaned. Injuries observed at time incident was documented as a skin tear on the back of Resident #2's left hand. The section on mental status was checked as resident was oriented to person and situation. Record review of the nurse notes dated 01/2014 for Resident #2 revealed documentation dated 01/18/14 at 5:51p.m. of nurse assessed this resident, complained of mild pain to her hand, .Open cuts to hand were cleaned, applied triple antibiotic .Will notify wound nurse to assess cuts. Notified responsible party (R.P.) will continue to monitor. Record review of the facility's nursing progress notes dated 01/22/14 for Resident #4 revealed Resident #5 attempted to stab Resident #4 with a butter knife . Record review of the incident/accident report dated 01/22/14 at 12:40 p.m. revealed Resident #4 was sitting at a table with Resident #5. Resident #4 was reaching forward towards the middle of the table. Resident #5 picked up a butter knife and was holding it up to stab Resident #4. LVN A immediately intervened and grabbed the butter knife from Resident #5 and explained to resident #5 she could not do that. Resident #5 stated I can do it too and I will . Resident #4 was moved to another table. Further review of the document revealed no injuries were observed and the immediate action was to remove resident #4 from the table. No documentation was present for monitoring, recommendations/measures put in place or plan of action. Record review of the nurse progress notes dated of 01/14 for Resident #5 revealed no documentation related to monitoring, incident or behaviors. Record review of the incident/accident report dated 01/28/14 at 4:30 p.m. revealed LVN B had been called to the dining room. Resident #5 was screaming at and slapped Resident #7. Resident #7 then swung back at Resident #5. Further review of the incident/accident report revealed no obvious injuries, separated residents and notified families. The section on mental status revealed Resident #5 was checked as oriented to person, place, situation and time. Record review of the Resident #5's nursing progress notes dated 01/28/14 revealed documentation of Resident #5 hitting Resident #7 in the dining room. Received new order to send Resident #5 to the emergency room (ER) for refusal of medical management and danger to others. Further review of the nursing progress notes revealed that Resident #5 was not monitored for behaviors. Record review of Resident #5's Care Plan with last review date of 01/31/14 and no updates revealed a problem with initiation date of 04/29/13 for [MEDICAL CONDITION] medications use related to mental changes due to Alzheimer ' s. The goal was documented will be/remain free of drug related complications including cognitive /behavioral impairment. The interventions included; monitor/record occurrence of target behavior symptoms .inappropriate response to verbal communications, violence/aggression towards staff/others etc. Record review of the facility' s nurse progress notes dated 02/01/14 at 3:02 p.m. for Resident #5 revealed ambulating down hall in her wheelchair. Resident #6 reached out and touched Resident #5 ' s arm. Resident #5 grabbed Resident #6 ' s arm and told Resident #6 if she touched her again, she would scratch her face out. Resident #6 reached out for Resident # 5' s jacket a second time and Resident #5 grabbed Resident #6 ' s finger and pulled on it. Resident #5 said I told her if she did it again, I would scratch her face and I will . Resident #6 was assessed and no injuries noted. Further review of the report revealed signed documentation for recommendation dated 02/03/14 to refer Resident #5 for psychiatric evaluation and conduct care plan meeting. Continued review of the notes revealed on 02/04/14 at 4:10pm (Social Service Director) SSD had obtained medical consult for psychological services and referred Resident #5 for services. This evaluation was completed on02/06/14. Observations conducted on 02/06/14 throughout the day revealed that Resident #5 was unsupervised while in her room, dining room and in the hallways. In an interview on 02/06/14 at 5:45 a.m. with Resident #2 who was positioned in bed with left hand wrapped in gauze and 2 red dried thick linear marks on her left arm she said a lady in the dining room scratched me with her finger nails bad, in 3 places . The resident was asked if she knew the person and Resident #2 said she goes to the dining room in a wheel chair , she ' s a black lady , she yells and hits others lots. She tried to stab a lady . In an interview on 02/06/14 at 5:55 a.m. with Certified Nursing Assistant (CNA) I revealed #5 had frequently yelled and hit other Residents. CNA I continued to say that Resident #5 had recently attacked Resident # 2 in the dining room. CNA I was asked what the facility had been doing about these problem residents and she said she didn ' t' t know. In an interview on 02/06/14 at 5:58 am LVN B said Resident #5 had got at Resident #2 and cut Resident #2 ' s arm and hand with her finger nails and the hand wound was bad . In an observation and interview on 02/06/14 at 6:35a.m. in the unsupervised dining room Resident #2 was sitting in a wheelchair positioned at a table in the dining room and her left hand was wrapped in gauze. Resident #2 was asked what happened to her hand and she said, A black lady cut, scratched me . In an interview on 02/06/14 at 7:08 a.m. with LVN C revealed that Resident #5 had scratched

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675249**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/10/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEBELLO WELLNESS CENTER	**12350 WOOD BAYOU DR HOUSTON, TX 77013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 4) Resident #2 and caused a wound to Resident #2 ' s left hand. In an interview on 02/06/14 at 7:15 a.m. CNA D revealed that Resident #5 was known to have hit and yelled at other Residents and she attacked Resident #2 in the dining room. When asked what did staff do about Resident #5 CNA D said the resident had been reported and she was to be watched and separated from others if any problems. Observation on 02/06/14 at 7:20 a.m. of Resident #5 in the dining room unsupervised at a table with other residents. There was only one CNA (CNA F) present in the room sitting at the table with residents that needed assistance with eating talking with residents and positioned out of view of Resident #5. Observation on 02/06/14 at 8:30 a.m. of Resident #5 in the dining room unsupervised at a table with other residents. Many staff were present in the dining room assisting residents and no staff was sitting near or at the table with Resident #5. In an interview on 02/06/14 at 8:35 a.m. with LVN E said that Resident #5 had hit, yelled at other residents and attacked and scratched Resident #2. LVN E was asked what was the facility doing about Resident #5 and she said to watch the resident and report any problems. Observation on 02/06/14 at 8:50 a.m. of Resident #5 in the hallway self-propelling in her wheel chair. There were no staff in hallway or at nursing station and there were residents in wheelchairs/gerichairs in the hallway. Observation on 02/06/14 at 9:00 a.m. of Resident #5 in wheelchair in hallway unsupervised with residents in Geri chairs/ wheelchairs nearby and the staff were observed going from room to room to assist residents. In an interview on 02/06/14 at 11:00 a.m. with the Director of Nursing (DON) and Administrator about the Resident to Resident altercations involving Resident #5 the DON said the resident was sent to the hospital on [DATE] for psychological evaluation and the [DIAGNOSES REDACTED]. The DON continued to say that she believed some of the problems were due to the UTI. The DON further said she was new to the facility and staff said that Resident #5 was a problem but Resident #5 returned from hospital on [DATE] with new medications and the resident was being monitored. The DON was asked how Resident #5 was being monitored and she said the staff watched the resident and reported any behavior or problems. The DON was asked where was the documentation to support the monitoring of Resident #5 and the DON said the nurse should document in the nurse notes and she continued to say, what else was the facility to do and we had a care plan meeting with the family yesterday . Record review of Resident #5's care plan provided by the DON on 02/06/14 revealed a problem with initiation date of 02/05/14 for Resident #5 exhibiting behavior secondary to Urinary Tract Infection (UTI.) No goal was documented. The interventions were documented as; 1. Resident to be placed on one on one monitoring as an intervention to resident to resident behavior. Care plan updated to reflect new interventions. Physician/family notified. 2. In-service nursing staff on monitoring and interventions for Residents with behaviors related to short-term [MEDICAL CONDITION] secondary to infections-UTI. In service to included abuse/neglect training. Social service designee to follow up with residents for resolution. 3. Director Nursing Service (DNS) or Designee will review residents with [DIAGNOSES REDACTED]. 4. DNS and Abuse coordinator will review resident to resident altercations to ensure interventions in place to maintain safety and follow state reporting guidelines. 5. Summary of self-reports to be reviewed no less than quarterly by Quarterly Assurance (QA) and A committee. In an interview on 02/06/14 at 12:30 p.m. with (Activity Director) AD said during a recent activity with popcorn Resident #7 was asking many times for more popcorn and Resident #5 must have become agitated and swung out to hit Resident #7 in the face but she hit the bag of popcorn that Resident #7 had in front of her face. The nurse was immediately notified and the residents were checked and Resident #5 was removed from the activity and taken to her room. In an interview on 02/06/14 at 12:45 p.m. with Resident #4 she said a black woman tried to hurt her in the dining room and a nurse took a knife away from the resident. In an interview on 02/06/14 at 12:55 p.m. with CNA F revealed awareness that there were problems with Resident #5 being aggressive and hitting Residents. CNA F continued to say that Resident #5 had recently slapped Resident #7 and tried to stab Resident #4 and she said I just saw Resident #5 go off on a man in the dining room and threatened him. She said she would slap him silly if he touched her stuff . In an interview on 02/06/14 at 1:30 p.m. with Regional Corporate Nurse (RCN) said that the plan of action for Resident #5 was for the Resident to be transported by ambulance to the hospital, plans were in place with family and hospital and facility will have a plan in place to monitor Resident with sitter if resident is returned to facility. The RCN further said she had started to conduct In-services with the staff. In an interview on 02/06/14 at 3:10 p.m. with CNA H said that there were problems with Resident #5 and the resident had grabbed at her and had swung to hit her. CNA H was asked what had been done about resident ' s behavior and she said she reported incidents but she just tried to get along with the resident. In an interview on 02/07/14 at 7:55 a.m. with the DON and Administrator revealed that Resident #5 had been discharged from the facility on 02/06/14 at 4:15 p.m. In an interview on 02/07/14 at 9:30 a.m. Resident #2 said she had not seen Resident #5 for a few days. The Resident was asked if any staff or residents were rude or threatening to her and she said No. In an interview on 02/07/14 at 10:15 a.m. LVN B said that Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #2 causing a bad hand injury. LVN B was asked what was the facility had done about Resident #5 and she said Resident #5 had been sent to hospital as she was acting out. In an interview on 02/07/14 at 10:30 a.m. LVN K said that Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #2. LVN K was asked what had the facility done about Resident #5 and she said she was not given any new instructions by the Administrator or DON regarding Resident #5. In an interview on 02/07/14 at 11:45 a.m. LVN L said Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #2. LVN L was asked what had the facility done about Resident #5 and she said there were not any new orders for Resident #5. In an interview on 02/07/14 at 12:00pm with the Assistant Director of Nursing (ADON) at other residents and attacked Resident #2 causing a very bad skin tear to Resident #2 ' s left hand. ADON further said she requested and sent resident to hospital on [DATE] for a psychological evaluation but Resident #5 was diagnosed with [REDACTED]. The ADON said that Resident #5 continued to refuse her medications and to be aggressive. The ADON said the plan was to document behaviors so we could transfer Resident #5 to a Geri-psyche center. In an interview on 02/07/14 at 12:20 p.m. with the SSD about Resident to Resident altercations and role of social services he said that he received reports from staff either in person or by telephone, from the nurse or physician of problems of residents with behaviors and if a physician's order [REDACTED]. SSD was asked if he received any referrals or a list for psychological consult requests related to resident to resident altercation/behaviors from the facility and he said, I don ' t recall. SSD was asked if he kept any documentation of SSD ' s involvement in resident problem behaviors and he said sometimes . SSD was asked if he received any psychological consult requests for Resident #5 and after a long pause he said something, I don ' t remember . SSD was asked to provide any documentation/notes related to involvement with Residents #5. The SSD never provided any documentation per request. In an interview on 02/07/14 at 12:30 p.m. with the DON revealed that the staff received in-service training with orientation, yearly and when necessary. The DON was asked about Resident #5 and she said the resident was not in the facility and had in the past verbal and physical behaviors such as hitting, scratching other residents. The DON was asked if she observed the wound caused by Resident #5 to Resident #2 ' s left hand and DON said yes . The DON was asked what did the facility do to prevent Resident #5 from causing harm to other residents and DON said monitor behavior . The DON was asked how the staff had been instructed to monitor Resident #5 and she said, Staff were to observe Resident #5 in public areas, document any behaviors, notify, and report incidents. The DON was asked who was to monitor Resident #5 and no response was provided. The DON was asked if any staff were assigned to monitor Resident #5 and she said no . The DON was asked who documented the behaviors of Resident #5 and she said the Charge Nurse if noted or reported and documentation was to be done on the progress notes. The DON was asked if the Administrator was aware of Resident #5 ' s increased episodes of behavior problems. She said the incidents were discussed in the morning clinical meetings. The DON continued to say after the incident on 01/28/14 involving Resident #5 and #7 the ADON and I said we needed to get Resident #5 out of the building and Resident was sent to the hospital. The DON was asked what the facility did to protect the Residents upon the return of Resident #5, the staff was verbally told to monitor resident #5 closely and keep her in public areas with staff members and document behaviors. The DON was asked when did she verbally notify the nurses about monitoring resident #5 closely and document behaviors and she said on 01/31/14. In an interview on 02/07/14 at 1:15 p.m. with the Administrator about how he ensured the abuse and neglect policy and procedure are implemented and he said he made rounds at the facility daily and talks with Residents. In-services were frequently conducted on abuse and neglect and reporting. Daily clinical meetings with 24 hour report review which address resident behavior problems or potential abuse problem with discussion on recommendations to prevent and ensure safety of residents and with follow-up. The Administrator was asked if the facility ' s incident /accident logs were reviewed and he said yes, in our interdisciplinary team meeting and he was further asked what does the facility do about residents identified with incidents of behavior and he said the resident has medications that are monitored and the resident is monitored closely and if behavior problems continue, the behavior becomes dangerous then the resident is discharged . The Administrator was asked about the facility ' s response to Resident #5 ' s behavior problem. He said that was why we sent her to the hospital, to protect the other residents. On 02/06/14 when the surveyor identified resident #5 was aggressive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675249**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/10/2014**
NAME OF PROVIDER OF SUPPLIER **MONTEBELLO WELLNESS CENTER**		STREET ADDRESS, CITY, STATE, ZIP **12350 WOOD BAYOU DR HOUSTON, TX 77013**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) again, we put 1 on 1 staff monitor of Resident #5 and we are making arrangements to send resident out of facility. The Administrator said there were some incidents and so we are sending resident #5 out as soon as we can but the family is very difficult would not allow resident to be sent to hospital we requested so we acquired orders to send the resident to the family ' s preferred hospital. The Administrator continued to say, It was a mistake on my part to bring Resident #5 back, it was not the setting to bring her back. The Administrator was asked what facility did to prevent further abuse of Residents upon the return of Resident #5. He said staff were asked to be conscious of Resident #5' s behavior, the staff were to watch Resident #5 and monitor any behavior. The Administrator continued to say then we found other behaviors and we put her on 1 to 1 monitoring. In an interview on 02/10/14 at 9:00 a.m. LVN A said she had witnessed Resident #5 trying to stab Resident # 4 with a butter knife, hit Resident #7 in the face and grab Resident #6. LVN A was asked what did the facility tell the nurse to do and she said document any behaviors and keep an eye on Resident #5. In an interview on 02/10/14 at 9:15 a.m. the Director of Clinical Services (DCS) said if the facility had followed their written policy and procedures they would not have the difficulties as they are having now. There was a new DON and Social worker and things were not done per policy and procedure. Record review of the facility's incident/accident tracking and trending logs dated 12/13 revealed no entry for Resident #5. Record review of the facility's incident/accident tracking and trending logs dated 01/14 revealed entry for Resident #5 dated for 01/18/14, 01/22/14, 01/28/14 for incidents of behavior. No new or updated interventions or approaches were documented. Record review of the facility's incident/accident tracking and trending logs dated 02/14 revealed an entry for Resident #5 dated 02/01/14 for incident of behavior. No new or updated interventions or approaches were documented. Record review of the facility's In-services dated 2013 and 2014 revealed staff signed documentation dated 10/23/13, 10/26/13, 10/28/13 and 11/08/13 for abuse and neglect reporting and changes in condition of residents. Facility provided signed staff in-service conducted on 02/06/14 for managing difficult behaviors with subject of reporting, interventions and monitoring. Record Review of the facility's policy for Agitated & Combative Resident with a revision date of 5/2007 read in part: Policy: .all residents who demonstrate agitated or combative behaviors have prompt intervention to prevent injury to the resident, other residents. in the facility. Purpose: 1. To ensure that all residents who display combative behaviors have prompt and appropriate intervention. 2. To ensure that staff are properly educated and trained to respond to .behaviors. Procedures: Before admission, each resident will be evaluated for potential combative behaviors, based on historical data, [DIAGNOSES REDACTED]. Prevention: Staff will adhere to the following procedures for measures of prevention: 1. Identify and remove source of the problem, if known. 2. Approach resident in calm and reassuring manner. 3. Direct resident to a less stressful area. 5.Maintain one to one staff/resident ratio until resident no longer exhibits problem behavior. 6. Provide distraction or engagement if necessary. 7. Monitor resident's further interactions with peers. 8. Communicate via 24-hour report, resident's behavior trigger. 9. Notify physician. Interventions: Severely Agitated/Combative Resident In the event the above preventions prove unsuccessful. 1. First staff to witness combative behavior calls for additional assistance. 2. Unit staff will respond immediately to remove the resident from area of agitation. 3. Provide safe quiet area, with direct staff supervision (1:1 staff as indicated). Place the resident on checks, to monitor behaviors, at least every hour until behavior subside. Facility will use 1:1 staff when needed and document behaviors. Social Services will assess potential causes of combative behaviors. Discharge Planning: .3. Resident(s) with aggressive behavior that affect other residents and/or endangers the resident will be discharged immediately to an appropriate setting, per physician order, and the family will be notified. The facility was monitored on 02/08/14, 02/09/14 and 02/10/14 to ensure that all residents with combative behaviors were identified and assessed for inappropriate behavior by observations, interview and record review, with the resident care plans reviewed and updated, nursing progress notes and 24 hour reports including abnormal behaviors developed. Identified residents with aggressive behaviors had notification to physician with referral to senior psychological service for assessments and recommendations. The Staff were In-serviced on managing residents with difficult behaviors and abuse/neglect prevention and reporting and Staff was interviewed on how to implement appropriate interventions for residents with aggressive behaviors per the plan to remove the immediate jeopardy. While the IJ was removed retroactively on 02/06/14 at 4:15 p.m. The facility remained out of compliance at a scope of widespread, no actual harm with potential of more than minimal harm due to need for ongoing monitoring of staff's response to Resident behaviors. The CMS 672 revealed resident census of 112.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 1 of 10 residents reviewed for behavior problems received adequate supervision to prevent resident to resident altercations. (Resident #5) --The facility failed to develop interventions or intervene for Resident #5, who had a history of [REDACTED]. --On 01/18/14 at 12:46 pm Resident #5 grabbed and scratched Resident #2 ' s arm in the dining room. --On 01/18/14 at 5:23pm in the dining room Resident #5 had an altercation over a cup of coffee with Resident #2, scratched Resident #2's left posterior hand and caused 2 open wounds. --On 01/22/14 Resident #5 was in the dining room behind Resident #4 and was observed to have a butter knife in her hands and made a stabbing motion toward Resident #4. --On 01/28/14 at 4:30 pm Resident #5 was in the dining room screaming at and slapped Resident #7. --On 02/01/14 Resident #5 grabbed Resident # 6 by the arm and said that she would scratch Resident #6 if she touched her again. These failures resulted in Immediate Jeopardy (IJ). The Administrator and the Director of Nurses (DON) were informed of the IJ on 02/06/14 at 4:00 p.m. While the IJ was removed retroactively on 02/06/14 at 4:15 p.m. The facility remained out of compliance at a scope of widespread, no actual harm with potential of more than minimal harm due to the need for ongoing monitoring of staff's response to resident behaviors. These failures affected five residents and placed the other 107 residents at risk for further abuse, injuries and fear, as facility had not identified aggressive residents, did not update, develop and implement plan of actions to prevent abuse and neglect of residents and the staff were not in-serviced. Incidents/Complaint # 5 and 6 Findings include: Record review of the facility's annual (Minimum Data Set) MDS with assessment reference date of 04/30/13 for Resident # 5 revealed she was a [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of the psychiatrist's quarterly reviewed dated 03/19/13 for Resident #5 revealed [DIAGNOSES REDACTED]. The current treatment and behavioral objectives were to continue to support and reinforce positive change behaviors and mood management. The section on current status revealed Resident #5 had a history of [REDACTED]. Record review of the last psychiatric progress notes for Resident #5 were dated 01/15/14 with documentation including current medications of Aricept and Haldol and the Resident was assessed as oriented to self, alert with poor insight and poor judgment and as deteriorating. The comment section revealed refusing blood sugar checks, can sometimes be re-directed. The treatment plan was to continue Resident #5's medication as ordered and staff were to monitor Resident #5 for behaviors and medication side effects. Record review of the facility's nursing notes dated 01/2014 for Resident #5 revealed no documentation related to the physical abuse incident with Resident #2 on 01/18/14. No entry documented for monitoring of Resident #5. Record review of the facility incident/accident report dated 01/18/14 at 12:46 p.m. revealed documentation of incident in the dining room with Resident #5 reaching for a cup of coffee and apparently Resident #2 was in her way. Resident #5 reached out to Resident #2's arm, grabbing it and scratched Resident #2's arm with her fingernails. Further review of the facility's incident/accident report revealed that the section on immediate action taken was the 2 residents were immediately separated and no injuries were observed at the time of the incident. Resident #5 was assessed as oriented to self, situation and place. Licensed Vocational Nurse (LVN) A spoke with resident about the behavior and Resident #5 didn't mean to scratch resident #2 she said that it wouldn ' t happen again. Record review of the incident/accident report dated 01/18/14 at 5:23 p.m. revealed that the nurse for hall 1 and 4 reported an altercation in the dining room. Residents #5 and #2 were yelling and the nurse noted 2 opened cuts on Resident #2's left posterior hand. When asked what happened neither resident could explain the reason for the altercation, Resident #2 said Resident #5 wanted coffee and she went crazy and started to scratch me. Immediate action taken was Resident #2 was assessed, open cuts to hand were cleaned. Injuries observed at time incident was documented as a skin tear on the back of Resident #2's left hand. The section on mental status was checked as resident was oriented to person and situation. Record review of the nurse notes dated 01/2014 for Resident #2 revealed documentation dated 01/18/14 at 5:51p.m. of nurse assessed this resident, complained of mild pain to her hand, .Open cuts to hand were cleaned, applied triple antibiotic .Will notify wound nurse to assess cuts. Notified responsible party (R.P.) will continue to monitor. Record review of the facility's nursing progress notes dated 01/22/14 for Resident #4 revealed Resident #5 attempted to stab Resident #4 with a butter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675249**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/10/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEBELLO WELLNESS CENTER	**12350 WOOD BAYOU DR HOUSTON, TX 77013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 6) knife . Record review of the incident/accident report dated 01/22/14 at 12:40 p.m. revealed Resident #4 was sitting at a table with Resident #5. Resident #4 was reaching forward towards the middle of the table. Resident #5 picked up a butter knife and was holding it up to stab Resident #4. LVN A immediately intervened and grabbed the butter knife from Resident #5 and explained to resident #5 she could not do that. Resident #5 stated I can do it too and I will . Resident #4 was moved to another table. Further review of the document revealed no injuries were observed and the immediate action was to remove resident #4 from the table. No documentation was present for monitoring, recommendations/measures put in place or plan of action. Record review of the nurse progress notes dated of 01/14 for Resident #5 revealed no documentation related to monitoring, incident or behaviors. Record review of the incident/accident report dated 01/28/14 at 4:30 p.m. revealed LVN B had been called to the dining room. Resident #5 was screaming at and slapped Resident #7. Resident #7 then swung back at Resident #5. Further review of the incident/accident report revealed no obvious injuries, separated residents and notified families. The section on mental status revealed Resident #5 was checked as oriented to person, place, situation and time. Record review of the Resident #5's nursing progress notes dated 01/28/14 revealed documentation of Resident #5 hitting Resident #7 in the dining room. Received new order to send Resident #5 to the emergency room (ER) for refusal of medical management and danger to others. Further review of the nursing progress notes revealed that Resident #5 was not monitored for behaviors. Record review of Resident #5's Care Plan with last review date of 01/31/14 and no updates revealed a problem with initiation date of 04/29/13 for psychotropic medications use related to mental changes due to Alzheimer ' s. The goal was documented will be/remain free of drug related complications including cognitive /behavioral impairment. The interventions included; monitor/record occurrence of target behavior symptoms .inappropriate response to verbal communications, violence/aggression towards staff/others etc. Record review of the facility' s nurse progress notes dated 02/01/14 at 3:02 p.m. for Resident #5 revealed ambulating down hall in her wheelchair. Resident #6 reached out and touched Resident #5 ' s arm. Resident #5 grabbed Resident #6 ' s arm and told Resident #6 if she touched her again, she would scratch her face out. Resident #6 reached out for Resident # 5' s jacket a second time and Resident #5 grabbed Resident #6 ' s finger and pulled on it. Resident #5 said I told her if she did it again, I would scratch her face and I will . Resident #6 was assessed and no injuries noted. Further review of the report revealed signed documentation for recommendation dated 02/03/14 to refer Resident #5 for psychiatric evaluation and conduct care plan meeting. Continued review of the notes revealed on 02/04/14 at 4:10pm (Social Service Director) SSD had obtained medical consult for psychological services and referred Resident #5 for services. This evaluation was completed on02/06/14. Observations conducted on 02/06/14 throughout the day revealed that Resident #5 was unsupervised while in her room, dining room and in the hallways. In an interview on 02/06/14 at 5:45 a.m. with Resident #2 who was positioned in bed with left hand wrapped in gauze and 2 red dried thick linear marks on her left arm she said a lady in the dining room scratched me with her finger nails bad, in 3 places . The resident was asked if she knew the person and Resident #2 said she goes to the dining room in a wheel chair , she ' s a black lady , she yells and hits others lots. She tried to stab a lady . In an interview on 02/06/14 at 5:55 a.m. with Certified Nursing Assistant (CNA) I revealed #5 had frequently yelled and hit other Residents. CNA I continued to say that Resident #5 had recently attacked Resident # 2 in the dining room. CNA I was asked what the facility had been doing about these problem residents and she said she didn ' t' t know. In an interview on 02/06/14 at 5:58 am LVN B said Resident #5 had got at Resident #2 and cut Resident #2 ' s arm and hand with her finger nails and the hand wound was bad . In an observation and interview on 02/06/14 at 6:35a.m. in the unsupervised dining room Resident #2 was sitting in a wheelchair positioned at a table in the dining room and her left hand was wrapped in gauze. Resident #2 was asked what happened to her hand and she said, A black lady cut, scratched me . In an interview on 02/06/14 at 7:08 a.m. with LVN C revealed that Resident #5 had scratched Resident #2 and caused a wound to Resident #2 ' s left hand. In an interview on 02/06/14 at 7:15 a.m. CNA D revealed that Resident #5 was known to have hit and yelled at other Residents and she attacked Resident #2 in the dining room. When asked what did staff do about Resident #5 CNA D said the resident had been reported and she was to be watched and separated from others if any problems. Observation on 02/06/14 at 7:20 a.m. of Resident #5 in the dining room unsupervised at a table with other residents. There was only one CNA (CNA F) present in the room sitting at the table with residents that needed assistance with eating talking with residents and positioned out of view of Resident #5. Observation on 02/06/14 at 8:30 a.m. of Resident #5 in the dining room unsupervised at a table with other residents. Many staff were present in the dining room assisting residents and no staff was sitting near or at the table with Resident #5. In an interview on 02/06/14 at 8:35 a.m. with LVN E said that Resident #5 had hit, yelled at other residents and attacked and scratched Resident #2. LVN E was asked what was the facility doing about Resident #5 and she said to watch the resident and report any problems. Observation on 02/06/14 at 8:50 a.m. of Resident #5 in the hallway self-propelling in her wheel chair. There were no staff in hallway or at nursing station and there were residents in wheelchairs/gerichairs in the hallway. Observation on 02/06/14 at 9:00 a.m. of Resident #5 in wheelchair in hallway unsupervised with residents in Geri chairs/ wheelchairs nearby and the staff were observed going from room to room to assist residents. In an interview on 02/06/14 at 11:00 a.m. with the Director of Nursing (DON) and Administrator about the Resident to Resident altercations involving Resident #5 the DON said the resident was sent to the hospital on [DATE] for psychological evaluation and the [DIAGNOSES REDACTED]. The DON continued to say that she believed some of the problems were due to the UTI. The DON further said she was new to the facility and staff said that Resident #5 was a problem but Resident #5 returned from hospital on [DATE] with new medications and the resident was being monitored. The DON was asked how Resident #5 was being monitored and she said the staff watched the resident and reported any behavior or problems. The DON was asked where was the documentation to support the monitoring of Resident #5 and the DON said the nurse should document in the nurse notes and she continued to say, what else was the facility to do and we had a care plan meeting with the family yesterday . Record review of Resident #5's care plan provided by the DON on 02/06/14 revealed a problem with initiation date of 02/05/14 for Resident #5 exhibiting behavior secondary to Urinary Tract Infection (UTI.) No goal was documented. The interventions were documented as; 1. Resident to be placed on one on one monitoring as an intervention to resident to resident behavior. Care plan updated to reflect new interventions. Physician/family notified. 2. In-service nursing staff on monitoring and interventions for Residents with behaviors related to short-term delirium secondary to infections-UTI. In service to included abuse/neglect training. Social service designee to follow up with residents for resolution. 3. Director Nursing Service (DNS) or Designee will review residents with [DIAGNOSES REDACTED]. 4. DNS and Abuse coordinator will review resident to resident altercations to ensure interventions in place to maintain safety and follow state reporting guidelines. 5. Summary of self-reports to be reviewed no less than quarterly by Quarterly Assurance (QA) and A committee. In an interview on 02/06/14 at 12:30 p.m. with (Activity Director) AD said during a recent activity with popcorn Resident #7 was asking many times for more popcorn and Resident #5 must have become agitated and swung out to hit Resident #7 in the face but she hit the bag of popcorn that Resident #7 had in front of her face. The nurse was immediately notified and the residents were checked and Resident #5 was removed from the activity and taken to her room. In an interview on 02/06/14 at 12:45 p.m. with Resident #4 she said a black woman tried to hurt her in the dining room and a nurse took a knife away from the resident. In an interview on 02/06/14 at 12:55 p.m. with CNA F revealed awareness that there were problems with Resident #5 being aggressive and hitting Residents. CNA F continued to say that Resident #5 had recently slapped Resident #7 and tried to stab Resident #4 and she said I just saw Resident #5 go off on a man in the dining room and threatened him. She said she would slap him silly if he touched her stuff . In an interview on 02/06/14 at 1:30 p.m. with Regional Corporate Nurse (RCN) said that the plan of action for Resident #5 was for the Resident to be transported by ambulance to the hospital, plans were in place with family and hospital and facility will have a plan in place to monitor Resident with sitter if resident is returned to facility. The RCN further said she had started to conduct In-services with the staff. In an interview on 02/06/14 at 3:10 p.m. with CNA H said that there were problems with Resident #5 and the resident had grabbed at her and had swung to hit her. CNA H was asked what had been done about resident ' s behavior and she said she reported incidents but she just tried to get along with the resident. In an interview on 02/07/14 at 7:55 a.m. with the DON and Administrator revealed that Resident #5 had been discharged from the facility on 02/06/14 at 4:15 p.m. In an interview on 02/07/14 at 9:30 a.m. Resident #2 said she had not seen Resident #5 for a few days. The Resident was asked if any staff or residents were rude or threatening to her and she said No. In an interview on 02/07/14 at 10:15 a.m. LVN B said that Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #2 causing a bad hand injury. LVN B was asked what was the facility had done about Resident #5 and she said Resident #5 had been sent to hospital as she was acting out. In an interview on 02/07/14 at 10:30 a.m. LVN K said that Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #2. LVN K was asked what had the facility done about Resident #5 and she said she was not given any new instructions by the Administrator or DON regarding Resident #5. In an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675249**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/10/2014**

NAME OF PROVIDER OF SUPPLIER **MONTEBELLO WELLNESS CENTER**	STREET ADDRESS, CITY, STATE, ZIP **12350 WOOD BAYOU DR HOUSTON, TX 77013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 7) interview on 02/07/14 at 11:45 a.m. LVN L said Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #2. LVN L was asked what had the facility done about Resident #5 and she said there were not any new orders for Resident #5. In an interview on 02/07/14 at 12:00pm with the Assistant Director of Nursing (ADON) at other residents and attacked Resident #2 causing a very bad skin tear to Resident #2 ' s left hand. ADON further said she requested and sent resident to hospital on [DATE] for a psychological evaluation but Resident #5 was diagnosed with [REDACTED]. The ADON said that Resident #5 continued to refuse her medications and to be aggressive. The ADON said the plan was to document behaviors so we could transfer Resident #5 to a Geri-psyche center. In an interview on 02/07/14 at 12:20 p.m. with the SSD about Resident to Resident altercations and role of social services he said that he received reports from staff either in person or by telephone, from the nurse or physician of problems of residents with behaviors and if a physician's order [REDACTED]. SSD was asked if he received any referrals or a list for psychological consult requests related to resident to resident altercation/behaviors from the facility and he said, I don ' t recall. SSD was asked if he kept any documentation of SSD ' s involvement in resident problem behaviors and he said sometimes . SSD was asked if he received any psychological consult requests for Resident #5 and after a long pause he said something, I don ' t remember . SSD was asked to provide any documentation/notes related to involvement with Residents #5. The SSD never provided any documentation per request. In an interview on 02/07/14 at 12:30 p.m. with the DON revealed that the staff received in-service training with orientation, yearly and when necessary. The DON was asked about Resident #5 and she said the resident was not in the facility and had in the past verbal and physical behaviors such as hitting, scratching other residents. The DON was asked if she observed the wound caused by Resident #5 to Resident #2 ' s left hand and DON said yes . The DON was asked what did the facility do to prevent Resident #5 from causing harm to other residents and DON said monitor behavior . The DON was asked how the staff had been instructed to monitor Resident #5 and she said, Staff were to observe Resident #5 in public areas, document any behaviors, notify, and report incidents. The DON was asked who was to monitor Resident #5 and no response was provided. The DON was asked if any staff were assigned to monitor Resident #5 and she said no . The DON was asked who documented the behaviors of Resident #5 and she said the Charge Nurse if noted or reported and documentation was to be done on the progress notes. The DON was asked if the Administrator was aware of Resident #5 ' s increased episodes of behavior problems. She said the incidents were discussed in the morning clinical meetings. The DON continued to say after the incident on 01/28/14 involving Resident #5 and #7 the ADON and I said we needed to get Resident #5 out of the building and Resident was sent to the hospital. The DON was asked what the facility did to protect the Residents upon the return of Resident #5, the staff was verbally told to monitor resident #5 closely and keep her in public areas with staff members and document behaviors. The DON was asked when did she verbally notify the nurses about monitoring resident #5 closely and document behaviors and she said on 01/31/14. In an interview on 02/07/14 at 1:15 p.m. with the Administrator about how he ensured the abuse and neglect policy and procedure are implemented and he said he made rounds at the facility daily and talks with Residents. In-services were frequently conducted on abuse and neglect and reporting. Daily clinical meetings with 24 hour report review which address resident behavior problems or potential abuse problem with discussion on recommendations to prevent and ensure safety of residents and with follow-up. The Administrator was asked if the facility ' s incident /accident logs were reviewed and he said yes, in our interdisciplinary team meeting and he was further asked what does the facility do about residents identified with incidents of behavior and he said the resident has medications that are monitored and the resident is monitored closely and if behavior problems continue, the behavior becomes dangerous then the resident is discharged . The Administrator was asked about the facility ' s response to Resident #5 ' s behavior problem. He said that was why we sent her to the hospital, to protect the other residents. On 02/06/14 when the surveyor identified resident #5 was aggressive again, we put 1 on 1 staff monitor of Resident #5 and we are making arrangements to send resident out of facility. The Administrator said there were some incidents and so we are sending resident #5 out as soon as we can but the family is very difficult would not allow resident to be sent to hospital we requested so we acquired orders to send the resident to the family ' s preferred hospital. The Administrator continued to say, It was a mistake on my part to bring Resident #5 back, it was not the setting to bring her back. The Administrator was asked what facility did to prevent further abuse of Residents upon the return of Resident #5. He said staff were asked to be conscious of Resident #5' s behavior, the staff were to watch Resident #5 and monitor any behavior. The Administrator continued to say then we found other behaviors and we put her on 1 to 1 monitoring. In an interview on 02/10/14 at 9:00 a.m. LVN A said she had witnessed Resident #5 trying to stab Resident # 4 with a butter knife, hit Resident #7 in the face and grab Resident #6. LVN A was asked what did the facility tell the nurse to do and she said document any behaviors and keep an eye on Resident #5. In an interview on 02/10/14 at 9:15 a.m. the Director of Clinical Services (DCS) said if the facility had followed their written policy and procedures they would not have the difficulties as they are having now. There was a new DON and Social worker and things were not done per policy and procedure. Record review of the facility's incident/accident tracking and trending logs dated 12/13 revealed no entry for Resident #5. Record review of the facility's incident/accident tracking and trending logs dated 01/14 revealed entry for Resident #5 dated for 01/18/14, 01/22/14, 01/28/14 for incidents of behavior. No new or updated interventions or approaches were documented. Record review of the facility's incident/accident tracking and trending logs dated 02/14 revealed an entry for Resident #5 dated 02/01/14 for incident of behavior. No new or updated interventions or approaches were documented. Record review of the facility's In-services dated 2013 and 2014 revealed staff signed documentation dated 10/23/13, 10/26/13, 10/28/13 and 11/08/13 for abuse and neglect reporting and changes in condition of residents. Facility provided signed staff in-service conducted on 02/06/14 for managing difficult behaviors with subject of reporting, interventions and monitoring. Record Review of the facility's policy for Agitated & Combative Resident with a revision date of 5/2007 read in part: Policy: .all residents who demonstrate agitated or combative behaviors have prompt intervention to prevent injury to the resident, other residents. in the facility. Purpose: 1. To ensure that all residents who display combative behaviors have prompt and appropriate intervention. 2. To ensure that staff are properly educated and trained to respond to .behaviors. Procedures: Before admission, each resident will be evaluated for potential combative behaviors, based on historical data, [DIAGNOSES REDACTED]. Prevention: Staff will adhere to the following procedures for measures of prevention: 1. Identify and remove source of the problem, if known. 2. Approach resident in calm and reassuring manner. 3. Direct resident to a less stressful area. 5.Maintain one to one staff/resident ratio until resident no longer exhibits problem behavior. 6. Provide distraction or engagement if necessary. 7. Monitor resident's further interactions with peers. 8. Communicate via 24-hour report, resident's behavior trigger. 9. Notify physician. Interventions: Severely Agitated/Combative Resident In the event the above preventions prove unsuccessful. 1. First staff to witness combative behavior calls for additional assistance. 2. Unit staff will respond immediately to remove the resident from area of agitation. 3. Provide safe quiet area, with direct staff supervision (1:1 staff as indicated). Place the resident on checks, to monitor behaviors, at least every hour until behavior subside. Facility will use 1:1 staff when needed and document behaviors. Social Services will assess potential causes of combative behaviors. Discharge Planning: .3. Resident(s) with aggressive behavior that affect other residents and/or endangers the resident will be discharged immediately to an appropriate setting, per physician order, and the family will be notified. Record review of the facility's policy and procedure on abuse prevention program dated 08/13 revealed: It is the policy of this facility that each Resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers . Prevention: Employees of our facility will take action to protect and prevent abuse and neglect from occurring within the facility by; *Assess, care plan and monitor residents with history of aggressive behaviors . Protection: If a resident incident is reported, discovered or suspected , where the health, welfare or safety of residents involved , this facility will take the following steps to prevent further potential abuse while the investigation is in progress; 1) If suspected perpetrator is another resident: a. Separate the residents so they do not interact with each other until circumstances of the reported incident can be determined. These failures resulted in Immediate Jeopardy (IJ). The Director of Nurses and the Administrator were informed of the IJ on 02/06/14 at 3:00 p.m. The following plan of action to remove the IJ was submitted by the Administrator on 02/07/14 at 2:37 p.m. Action Plan: Removal of Immediate Jeopardy: 1)Ensuring Safety of Residents: Upon learning that Resident #5 was in question from regarding behaviors; the resident was put on one sitter for the remainder of the day (11:45am until discharge). MD notified and discharge orders received. Resident #5 was discharged from the facility on 2/6/14 at 4:15pm. The patient was taken to the hospital. Resident #5 will not be admitted back to the facility. 2)Immediate Actions: a. Criteria used to identify residents with combative behaviors: IDT team reviewed each resident's behavior history and documented abnormal behaviors to identify residents with combative behaviors. IDT met and completed list of residents on 2/6/2014 at 8:00pm. b. Identified residents with inappropriate/aggressive behaviors by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675249**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/10/2014**

NAME OF PROVIDER OF SUPPLIER **MONTEBELLO WELLNESS CENTER**	STREET ADDRESS, CITY, STATE, ZIP **12350 WOOD BAYOU DR HOUSTON, TX 77013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 8) observation, interview, behavior monitoring, and incident reports completed on 2/6/14. c. All residents with identified inappropriate behaviors will have their care plans reviewed and updated by 2/7/14 at 9:00am. All change of conditions including abnormal behaviors will be documented on the 24 hour report for follow up. Nursing staff will be aware of changes in care plan interventions through shift change report, 24 hour report. d. All residents identified with aggressive behaviors were referred to Senior Psychological Care for assessment and recommendations to be performed on 2/7/14. The MD was notified of aggressive behaviors to obtain referral for psychological services. e. All residents with identified inappropriate behaviors received nursing progress notes to update current behaviors and ensure wellbeing. The nursing progress notes were started on 2/6/14 and completed on 2/7/14 at 10:30am. 3)Training a. All nursing staff and any other direct care staff that are involved with providing care to the resident ' s day in and day out will be in-serviced on Managing Residents with Difficult Behaviors and Abuse/Neglect Prevention and Reporting. In-service started on 2/6/14 and will be completed by 12:00pm on 2/7/14. Training will be provided by Nurse Resource. b. All nursing staff and any other direct care staff not available for live in-service will be contacted by phone and receive training by 2/7/14 by 2:.00pm. c. Staff in-serviced by Clinical Nurse Resource on identification of aggressive combative behaviors and to notify DON and Administrator immediately upon identification. d. All nursing staff and any other direct care staff not available on live or phone in-service will not be permitted to work until in-services are completed. The facility was monitored on 02/08/14, 02/09/14 and 02/10/14 to ensure that all residents with combative behaviors were identified and assessed for inappropriate behavior by observations, interview and record review, with the resident care plans reviewed and updated, nursing progress notes and 24 hour reports including abnormal behaviors developed. Identified residents with aggressive behaviors had notification to physician with referral to senior psychological service for assessments and recommendations. The Staff were In-serviced on managing residents with difficult behaviors and abuse/neglect prevention and reporting and Staff was interviewed on how to implement appropriate interventions for residents with aggressive behaviors per the plan to remove the immediate jeopardy. While the IJ was removed retroactively on 02/06/14 at 4:15 p.m. The facility remained out of compliance at a scope of widespread, no actual harm with potential of more than minimal harm due to need for ongoing monitoring of staff's response to Resident behaviors. The CMS 672 revealed resident census of 112.
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 Administrator and the DON failed to administer the facility in a manner that enabled it to use its resources effectively and efficiently for five of 10 residents (Residents #2, #4, #6 and #7) reviewed for resident to resident aggression. The Administrator failed: --To implement appropriate interventions were implemented to deal with aggressive residents, protect all residents from harm, direct the Social Worker to assess and intervene with aggressive residents, have a behavior committee and to immediately have Resident #5 assessed for treatment. --To protect residents to include Resident #2, #4, #6 and #7 after they were hit by Resident #5. --To supervise the Director of Nursing (DON) to ensure that she carried out her responsibility of supervising the nursing staff when they monitored residents with aggressive behaviors. The DON failed: --To monitor and supervise the nursing staff to ensure appropriate interventions were implemented to protect residents from abuse from Resident #5, who had aggressive behaviors. --To ensure that care plans and interventions were implemented for Resident #5. These failures resulted in an immediate Jeopardy (IJ). The Administrator and the Director of Nurses were informed of the IJ on 02/06/14 at 4:00 p.m. While the IJ was retroactively removed on 02/06/14 at 4:15 p.m. the facility remained out of compliance at a scope of widespread, no actual harm with potential of more than minimal harm due to need for ongoing monitoring of Resident #5. These failures affected five residents and placed the other 107 residents at risk for further abuse, injuries and fear, as facility had not identified aggressive residents, did not update, develop and implement plan of actions to prevent abuse and neglect of residents and the staff were not In serviced Incidents/Complaint # 5 and 6 Findings include: Record review of the facility's annual MDS with assessment reference date of 04/30/13 for Resident # 5 revealed she was a [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of the facility incident/accident reports for January 2014 and February 2014 revealed that Resident #5 was in volved in five incdents of Resident-to Resident aggression as follows: --01/18/12 at 12:46 p.m. Resident #5 was reaching for a cup of coffee and apparently, Resident #2 was in her way. Resident #5 reached out to Resident #2' s arm, grabbing it and scratched Resident #2's arm with her fingernails. --01/18/14 at 5:23 p.m. Resident #5 and #2 were in the dining room yelling at one another. The nurse noted 2 opened cuts on Resident #2's left posterior hand. Resident #2 said Resident #5 wanted coffee and she went crazy and started to scratch me. No entry was documented for monitoring of resident #5. --01/22/14 at 12:40 p.m. Resident #5 attempted to stab Resident #4 with a butter knife while both residents were seated at the same table in the dining room. No entry was documented for the monitoring of Resident #5. --01/28/14 at 4:30 p.m. while in the dining room Resident #5 was screaming at Resident #7 and then began to slap Resident #7 who swung back at Resident #5.Documented on the bottom of the report was Resident #5 sent to ER. No entry documented for monitoring of Resident #5. --02/01/14 at 3:02 p.m. while in the hallway of the facility Resident #6 reached out and touched Resident #5's arm. Resident #5 grabbed Resident #6 ' s arm and told Resident #6 if she touched her again, she would scratch her face out. Resident #6 reached out for Resident # 5' s jacket a second time and Resident #5 grabbed Resident #6 ' s finger and pulled on it. Resident #5 said I told her if she did it again, I would scratch her face and I will . Record review of the nurse progress notes dated 01/14 for Resident #5 revealed no documentation related to monitoring, incident, or behaviors. Record review of the facility's In-services dated 2013 and 2014 revealed staff signed documentation dated 10/23/13, 10/26/13, 10/28/13, and 11/08/13 for abuse and neglect reporting and changes in condition of residents. Facility provided signed staff in-service conducted on 02/06/14 for managing difficult behaviors with subject of reporting, interventions and monitoring. Observations and interviews conducted on 02/06/14 revealed that Resident #5 was unsupervised while in her room, dining room and in the hallways. Residents #2 and #4 said that Resident #5 had tried to hit them and other residents. In an interview on 02/06/14 at 7:15 a.m. with CNA D revealed that Resident #5 was known to have hit and yell at other Residents and she attacked Resident #2 in the dining room. The CNA was asked what did staff do about Resident #5 and CNA D said the resident had been reported and she was to be watched and separated from others if any problem. In an interview on 02/06/14 at 11:00 a.m. with the Director of Nursing (DON) and Administrator about the Resident to Resident altercations involving Resident #5 the DON said the resident was sent to the hospital on [DATE] for psychological evaluation and the [DIAGNOSES REDACTED]. The DON continued to say that she believed some of the problems were due to the UTI. The DON further said she was new to the facility and staff said that Resident #5 was a problem but Resident #5 returned from hospital on [DATE] with new medications and the resident was being monitored. The DON was asked how Resident #5 was being monitored and she said the staff watched the resident and reported any behavior or problems. The DON was asked where was the documentation to support the monitoring of Resident #5 and the DON said the nurse should document in the nurse notes and she continued to say, what else was the facility to do and we had a care plan meeting with the family yesterday . In an interview on 02/07/14 at 7:55 a.m. with the DON and Administrator revealed that Resident #5 had been discharged from the facility on 2/6/14 at 4:15p.m. In an interview on 02/07/14 at 12:00pm with the Assistant Director of Nursing (ADON) at other residents and attacked Resident #2 causing a very bad skin tear to Resident #2 ' s left hand. ADON further said she requested and sent resident to hospital on [DATE] for a psychological evaluation but Resident #5 was diagnosed with [REDACTED]. The ADON said that Resident #5 continued to refuse her medications and to be aggressive. The ADON said the plan was to document behaviors so we could transfer Resident #5 to a Geri-psyche center. In an interview on 02/07/14 at 12:20 p.m. with the SSD about Resident to Resident altercations and role of social services he said that he received reports from staff either in person or by telephone, from the nurse or physician of problems of residents with behaviors and if a physician's order [REDACTED]. SSD was asked if he received any referrals or a list for psychological consult requests related to resident to resident altercation/behaviors from the facility and he said, I don ' t recall. SSD was asked if he kept any documentation of SSD ' s involvement in resident problem behaviors and he said sometimes . SSD was asked if he received any psychological consult requests for Resident #5 and after a long pause he said something, I don ' t remember . SSD was asked to provide any documentation/notes related to involvement with Residents #5. The SSD never provided any documentation per request. In an interview on 02/07/14 at 12:30 p.m. with the DON revealed that the staff received in-service training with orientation, yearly and when necessary. The DON was asked about Resident #5 and she said the resident was not in the facility and had in the past verbal and physical behaviors such as hitting, scratching other residents. The DON was asked if she observed the wound caused by Resident #5 to Resident #2 ' s left hand and DON said yes . The DON was asked what did the facility do to prevent Resident #5 from causing

PRINTED:9/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675249**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/10/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEBELLO WELLNESS CENTER	**12350 WOOD BAYOU DR HOUSTON, TX 77013**

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 9) harm to other residents and DON said monitor behavior . The DON was asked how the staff had been instructed to monitor Resident #5 and she said, Staff were to observe Resident #5 in public areas, document any behaviors, notify, and report incidents. The DON was asked who was to monitor Resident #5 and no response was provided. The DON was asked if any staff were assigned to monitor Resident #5 and she said no . The DON was asked who documented the behaviors of Resident #5 and she said the Charge Nurse if noted or reported and documentation was to be done on the progress notes. The DON was asked if the Administrator was aware of Resident #5 ' s increased episodes of behavior problems. She said the incidents were discussed in the morning clinical meetings. The DON continued to say after the incident on 01/28/14 involving Resident #5 and #7 the ADON and I said we needed to get Resident #5 out of the building and Resident was sent to the hospital. The DON was asked what the facility did to protect the Residents upon the return of Resident #5, the staff was verbally told to monitor resident #5 closely and keep her in public areas with staff members and document behaviors. The DON was asked when did she verbally notify the nurses about monitoring resident #5 closely and document behaviors and she said on 01/31/14. In an interview on 02/07/14 at 1:15 p.m. with the Administrator about how he ensured the abuse and neglect policy and procedure are implemented and he said he made rounds at the facility daily and talks with Residents. In-services were frequently conducted on abuse and neglect and reporting. Daily clinical meetings with 24 hour report review which address resident behavior problems or potential abuse problem with discussion on recommendations to prevent and ensure safety of residents and with follow-up. The Administrator was asked if the facility ' s incident /accident logs were reviewed and he said yes, in our interdisciplinary team meeting and he was further asked what does the facility do about residents identified with incidents of behavior and he said the resident has medications that are monitored and the resident is monitored closely and if behavior problems continue, the behavior becomes dangerous then the resident is discharged . The Administrator was asked about the facility ' s response to Resident #5 ' s behavior problem. He said that was why we sent her to the hospital, to protect the other residents. On 02/06/14 when the surveyor identified resident #5 was aggressive again, we put 1 on 1 staff monitor of Resident #5 and we are making arrangements to send resident out of facility. The Administrator said there were some incidents and so we are sending resident #5 out as soon as we can but the family is very difficult would not allow resident to be sent to hospital we requested so we acquired orders to send the resident to the family ' s preferred hospital. The Administrator continued to say, It was a mistake on my part to bring Resident #5 back, it was not the setting to bring her back. The Administrator was asked what facility did to prevent further abuse of Residents upon the return of Resident #5. He said staff were asked to be conscious of Resident #5' s behavior, the staff were to watch Resident #5 and monitor any behavior. The Administrator continued to say then we found other behaviors and we put her on 1 to 1 monitoring. In an interview on 02/10/14 at 9:15 a.m. the Director of Clinical Services (DCS) said if the facility had followed their written policy and procedures they would not have the difficulties as they are having now. There was a new DON and Social worker and things were not done per policy and procedure. Record Review of the facility's policy for Agitated & Combative Resident with a revision date of 5/2007 read in part: Policy: .all residents who demonstrate agitated or combative behaviors have prompt intervention to prevent injury to the resident, other residents. in the facility. Purpose: 1. To ensure that all residents who display combative behaviors have prompt and appropriate intervention. 2. To ensure that staff are properly educated and trained to respond to .behaviors. Procedures: Before admission, each resident will be evaluated for potential combative behaviors, based on historical data, [DIAGNOSES REDACTED]. Prevention: Staff will adhere to the following procedures for measures of prevention: 1. Identify and remove source of the problem, if known. 2. Approach resident in calm and reassuring manner. 3. Direct resident to a less stressful area. 5.Maintain one to one staff/resident ratio until resident no longer exhibits problem behavior. 6. Provide distraction or engagement if necessary. 7. Monitor resident's further interactions with peers. 8. Communicate via 24-hour report, resident's behavior trigger. 9. Notify physician. Interventions: Severely Agitated/Combative Resident In the event the above preventions prove unsuccessful. 1. First staff to witness combative behavior calls for additional assistance. 2. Unit staff will respond immediately to remove the resident from area of agitation. 3. Provide safe quiet area, with direct staff supervision (1:1 staff as indicated). Place the resident on checks, to monitor behaviors, at least every hour until behavior subside. Facility will use 1:1 staff when needed and document behaviors. Social Services will assess potential causes of combative behaviors. Discharge Planning: .3. Resident(s) with aggressive behavior that affect other residents and/or endangers the resident will be discharged immediately to an appropriate setting, per physician order, and the family will be notified. Record review of the facility's policy and procedure on abuse prevention program dated 08/13 revealed: It is the policy of this facility that each Resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers . Prevention: Employees of our facility will take action to protect and prevent abuse and neglect from occurring within the facility by; *Assess, care plan and monitor residents with history of aggressive behaviors . Protection: If a resident incident is reported, discovered or suspected , where the health, welfare or safety of residents involved , this facility will take the following steps to prevent further potential abuse while the investigation is in progress; 1) If suspected perpetrator is another resident: a. Separate the residents so they do not interact with each other until circumstances of the reported incident can be determined. These failures resulted in Immediate Jeopardy (IJ). The Director of Nurses and the Administrator were informed of the IJ on 02/06/14 at 3:00 p.m. The following plan of action to remove the IJ was submitted by the Administrator on 02/07/14 at 2:37 p.m. Action Plan: Removal of Immediate Jeopardy: 1)Ensuring Safety of Residents: Upon learning that Resident #5 was in question from regarding behaviors; the resident was put on one sitter for the remainder of the day (11:45am until discharge). MD notified and discharge orders received. Resident #5 was discharged from the facility on 2/6/14 at 4:15pm. The patient was taken to the hospital. Resident #5 will not be admitted back to the facility. 2)Immediate Actions: a. Criteria used to identify residents with combative behaviors: IDT team reviewed each resident's behavior history and documented abnormal behaviors to identify residents with combative behaviors. IDT met and completed list of residents on 2/6/2014 at 8:00pm. b. Identified residents with inappropriate/aggressive behaviors by observation, interview, behavior monitoring, and incident reports completed on 2/6/14. c. All residents with identified inappropriate behaviors will have their care plans reviewed and updated by 2/7/14 at 9:00am. All change of conditions including abnormal behaviors will be documented on the 24 hour report for follow up. Nursing staff will be aware of changes in care plan interventions through shift change report, 24 hour report. d. All residents identified with aggressive behaviors were referred to Senior Psychological Care for assessment and recommendations to be performed on 2/7/14. The MD was notified of aggressive behaviors to obtain referral for psychological services. e. All residents with identified inappropriate behaviors received nursing progress notes to update current behaviors and ensure wellbeing. The nursing progress notes were started on 2/6/14 and completed on 2/7/14 at 10:30am. 3)Training a. All nursing staff and any other direct care staff that are involved with providing care to the resident ' s day in and day out will be in-serviced on Managing Residents with Difficult Behaviors and Abuse/Neglect Prevention and Reporting. In-service started on 2/6/14 and will be completed by 12:00pm on 2/7/14. Training will be provided by Nurse Resource. b. All nursing staff and any other direct care staff not available for live in-service will be contacted by phone and receive training by 2/7/14 by 2:.00pm. c. Staff in-serviced by Clinical Nurse Resource on identification of aggressive combative behaviors and to notify DON and Administrator immediately upon identification. d. All nursing staff and any other direct care staff not available on live or phone in-service will not be permitted to work until in-services are completed. The facility was monitored on 02/08/14, 02/09/14 and 02/10/14 to ensure that all residents with combative behaviors were identified and assessed for inappropriate behavior by observations, interview and record review, with the resident care plans reviewed and updated, nursing progress notes and 24 hour reports including abnormal behaviors developed. Identified residents with aggressive behaviors had notification to physician with referral to senior psychological service for assessments and recommendations. The Staff were In-serviced on managing residents with difficult behaviors and abuse/neglect prevention and reporting and Staff was interviewed on how to implement appropriate interventions for residents with aggressive behaviors per the plan to remove the immediate jeopardy. While the IJ was removed retroactively on 02/06/14 at 4:15 p.m. The facility remained out of compliance at a scope of widespread, no actual harm with potential of more than minimal harm due to need for ongoing monitoring of staff's response to Resident behaviors. Cross Reference to F225/F226.