DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				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 CONSTRUCT A. BUILDING B. WING	FION	(X3) DATE SURVEY COMPLETED 02/10/2014
NAME OF PROVIDER OF SU MONTEBELLO WELLNESS			STREET ADDRESS, CITY, ST. 12350 WOOD BAYOU DR	ATE, ZIP
			HOUSTON, TX 77013	
<u> </u>	home's plan to correct this deficient	7/1	, , ,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	MATION)		Y FULL REGULATORY
F 0224	<b>Write and use policies that f theft of residents' property.</b>		d abuse of residents and	
Level of harm - Immediate jeopardy	**NOTE- TERMS IN BRACKET Based on observation, interview,	IS HAVE BEEN EDITED TO PR and record review, the facility fai	iled to implement its written abuse	e /neglect policy and
Residents Affected - Many	physical aggression. (Resident #2 Resident #5, who had a history of arm in the dining roomOn 01/1 Resident #2, scratched Resident #4 dining room behind Resident #4 at 302/01/14 Resident #4On 01/28/14 at 4:302/01/14 Resident #5 grabbed Re These failures resulted in Immedi IJ on 02/06/14 at 4:00 p.m. While compliance at a scope of widesprimonitoring of staff's response to residents at risk for further abuse, update, develop and implement placidents/Complaint #5 and 6 Fii assessment reference date of 04/3 [DATE] with [DIAGNOSES REDACT positive change behaviors and mc [REDACTED]. Record review of including current medications of self, alert with poor insight and poor ju can sometimes be re-directed. The monitor Resident #5 for behavior for Resident #5 revealed no docur documented for monitoring of Re p.m. revealed documentation of in Resident #2 was in her way. Resiher fingernails. Further review of taken was the 2 residents were im was assessed as oriented to self, s behavior and Resident #5 didn't in incident/accident report dated 01/the dining room. Residents #5 and When asked what happened neith coffee and she went crazy and stawere cleaned. Injuries observed a section on mental status was chec dated 01/2014 for Resident #2 rev for mild pain to her hand, Open cruts. Notified responsible party (I dated 01/22/14 for Resident #2 rev for mild pain to her hand, Open cruts. Notified responsible party (I dated 01/22/14 for Resident #4 was reaching forward up to stab Resident #4. LVN A in resident #5 she could not do that. Further review of the document review of the nurse progress note or behaviors. Record review of the mirs review of Resident #5's care Plan for O4/29/13 for [MEDICAL CON will be/remain free of drug relater monitor/record occurrence of targ towards staff/others etc. Record reviewed Resident #5's nursing progress note or behaviors. Record review of the nurs review of Resident #5's ram and treached out for Resident #5's ram and treached out for Resident #5's ram and treached out for Resident #5's	2, #4, #5, #6 and #7),The facility of [REDACTED]On 01/18/14 at 18/14 at 5:23pm in the dining roo f2's left posterior hand and caused and was observed to have a butter 10 pm Resident #5 was in the dini sident #6 by the arm and said the late Jeopardy (IJ). The Administrate Leopardy (IJ). The Administrate the Juster was removed retroactively ead, no actual harm with potentia resident behaviors. These failures, injuries and fear, as facility had lan of actions to prevent abuse an andings include: Record review of 10/13 for Resident #5 revealed should have a should ha	ecting five of 10 residents from revealed to develop interventions of t 12:46 pm Resident #5 grabbed a m Resident #5 pm Resident #5 grabbed a m Resident #5 had an altercation of 12 open woundsOn 01/22/14 R r knife in her hands and made a stang room screaming at and slapped at she would scratch Resident #6 is ator and the Director of Nurses (D on 02/06/14 at 4:15 p.m. The facil of more than minimal harm due affected five residents and placed not identified aggressive residents and reglect of residents and the staff the facility's annual (Minimum D be was a [AGE] year old female ad psychiatrist's quarterly reviewed on the properties were to concurrent status revealed Resident #2 of acility incident/accident #2 of acility incident/accident report dat esident #5's medication as order cord review of the facility's nursin abuse incident with Resident #2 of acility incident/accident report dat esident #5 reaching for a cup of ct2's arm, grabbing it and scratched a tesident #5 reaching for a cup of ct2's arm, grabbing it and scratched in the series of th	or intervene for indiverse in the series of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 675249
Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2014
	675249		
NAME OF PROVIDER OF SUPPLIER		STREET ADDRESS, CIT	Y. 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. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG

F 0224

Level of harm - Immediate jeopardy

MONTEBELLO WELLNESS CENTER

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' 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 7:02 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 t 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 are problem but Resident #5 returned from bospital on [DATE] with new 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 (DIS) of Designee will review resident swint [DIAGNOSES REDACTED]. 4. DIS and Aduse coordination will review resident 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 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 hit, yelled at other residents and attacked, and scratched Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #5 had hit, yelled at other residents and attacked, and scratched Resident #5. In an interview on 02/07/14 at 11:45 a.m. LVN L said 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 dif he received any referrals or a list for psychological consult requests related to resident altercation/behaviors from the 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 or 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 prequest. 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

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NAME OF PROVIDER OF SU MONTEBELLO WELLNESS	PPLIER	STREET ADDRESS, CITY 12350 WOOD BAYOU DR HOUSTON, TX 77013	
For information on the nursing (X4) ID PREFIX TAG	1 .	cy, please contact the nursing home or the state survey agency. DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE	D BY FULL REGULATORY
	OR LSC IDENTIFYING INFOR		
F 0224  Level of harm - Immediate jeopardy  Residents Affected - Many	(continued from page 2) monitor resident #5 closely and k did she verbally notify the nurses an interview on 02/07/14 at 1:15 procedure are implemented and h frequently conducted on abuse ar resident behavior problems or po residents and with follow-up. The said yes, in our interdisciplinary t identified with incidents of behav monitored closely and if behavior Administrator was asked about th her to the hospital, to protect the again, we put 1 on 1 staff monito Administrator said there were sor difficult would not allow resident family 's preferred hospital. The it was not the setting to bring her Residents upon the return of Resi were to watch Resident #5 and m put her on 1 to 1 monitoring. In a stab Resident #4 with a butter kn facility tell the nurse to do and sh 02/10/14 at 9:15 a.m. the Directo procedures they would not have t were not done per policy and pro 12/13 revealed no entry for Resident interventions or approaches were dated 02/14 revealed an entry for approaches were documented. Re documentation dated 10/23/13, It residents. Facility provided signe reporting, interventions and moni revision date of 5/2007 read in pa intervention to prevent injury to t who display combative behaviors behaviors, based on historical dat measures of prevention: 1. Identi manner. 3. Direct resident to a lee exhibits problem behaviors of the who display combative behaviors sheavior calls for additional assis agitation. 3. Provide safe quiet ar checks, to monitor behaviors, at 1 document behaviors work and procedure on each Resident has the right to be subjected to abuse by anyone, inc Prevention: Employees of our fat facility by; *Assess, care plan an incident is reported, discovered o will take the following steps to p perpetrator is another resident: a. the reported incident can be deter Administrator were informed of t by the Administrator on 02/07/14 Upon learning that Resident #5 vermainder of the day (11:45am u the facility on 2/6/14 at 4:15pm. facility. 2)Immediate Actions: a. resident's behaviors received p	eep her in public areas with staff members and document beha about monitoring resident #\$ closely and document behaviors p.m. with the Administrator about how he ensured the abuse are said he made rounds at the facility daily and talks with Resid neglect and reporting. Daily clinical meetings with 24 hour retential abuse problem with discussion on recommendations to administrator was asked if the facility 's incident /accident le eam meeting and he was further asked what does the facility of or and he said the resident has medications that are monitored problems continue, the behavior becomes dangerous then the facility 's response to Resident #\$ 's behavior problem. He is facility 's response to Resident #\$ 's behavior problem. He is facility is response to Resident #\$ 's behavior problem. He is facility is response to Resident #\$ shad we are making arrangements to send reside in incidents and so we are sending resident #\$ on the soon as to be sent to hospital we requested so we acquired orders to set to be sent to hospital we requested so we acquired orders to set to be sent to hospital we requested to be conscious of Resident #6. He said staff were asked to be conscious of Resident of continued to say them on interview on 02/10/14 at 9:00 a.m. LVN A said she had with in its, hit Resident #\$ 1 he face and grab Resident #\$ LVN A ve said document any behaviors and keep an eye on Resident #6 coldinous to the difficulties as they are having now. There was a new DON. cedure. Record review of the facility's incident/accident trackinent #\$ dated 01/18/14, 01/12/14, 01/12/14, do rincidents of behoumented. Record review of the facility's incident/accident trackinent #\$ dated 01/18/14, 01/12/14, 01/12/14, do rincidents of behoumented. Record review of the facility's incident/accident trackinent #\$ dated 01/18/14, 01/12/14, 01/12/14, do rincidents of behoumented. Record review of the facility's incident/accident trackinent #\$ dated 01/18/14, 01/12/14, do rincidents of behoumented. Record review of the facility is incide	and she said on 01/31/14. In did neglect policy and ents. In-services were eport review which address prevent and ensure safety of ggs were reviewed and he to about residents and the resident is resident is discharged. The said that was why we sent ent out of facility. The we can but the family is very end the resident to the bring Resident #5 back, to further abuse of \$65 s behavior, the staff we found other behaviors and we sessed Resident #5 trying to was asked what did the 5. In an interview on eir written policy and and Social worker and things gand trending logs dated avior. No new or updated tracking and trending logs dated avior. No new or updated tracking and trending logs or updated interventions or evealed staff signed and changes in condition of behaviors with subject of formbative Resident with a behaviors have prompt re that all residents aff are properly educated and for potential combative to the following procedures for sident in calm and reassuring resident no longer mit's further interactions Interventions: Severely ff to witness combative ident from area of the resident on folger mit's further interactions Interventions: Severely ff to witness combative ident from area of the resident on folger mit's further interactions Interventions: Severely ff to witness combative ident from area of the resident on fit when needed and arge Planning: 3.  Il be discharged dreview of the yof this facility that have not the said that the tother interactions in the property of the subject of the interventions in the property of the subject of the intervention of the property of the subject of the intervention of the property of the subject of the intervention of the property of t
F 0226	<b>Develop policies that preven</b>	Resident behaviors. The CMS 672 revealed resident census of at mistreatment, neglect, or abuse of residents or theft of	11 <i>2</i> .
Level of harm - Immediate jeopardy	resident property.		
Residents Affected - Many			

		OMB NO. 0938-039
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ENTERS FOR MEDICARE &	MEDICAID SERVICES	FORM APPROVED
DEPARTMENT OF HEALTH A	ND HUMAN SERVICES	PRINTED:9/17/2014

DEFICIENCIES AND PLAN OF	CLIA IDENNTIFICATION	A. BUILDING	(X3) DATE SURVEY COMPLETED 02/10/2014
	NUMBER 675249		

NAME OF PROVIDER OF SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP

/2014

MONTERELLO 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.

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

F 0226

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 3)
\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*

\*\*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 is the 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 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 effects are idents consultants or voluntary. Prevention: Employees of our facility table corporal punishment and involuntary sectission. 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 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 for behaviors and indication state 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 prace. Electrical vocational rivins (EVA) A spoke with 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 coriented to person and situation. Percord review of the nurse prace dated 01/20/14 for Percident #2 revealed. 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 #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. Resident was the property of the resident property of the resid 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 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, violence/ageression towards 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 the 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 protect. Further review of the preport revealed signed documentation for recommendation dated 02/03/14 to refer. Resident #3 said 1 fold field it she tild it againt, I would scratch fiel face and I will. Resident #6 was assessed and I of 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 on 02/06/14. Observations conducted on 02/06/14 throughout the day revealed that 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:9/17/2014 FORM APPROVED

	675249		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2014
			OMB NO. 0938-0391

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

jeopardy

Level of harm - Immediate

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 #3 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 8:30 a.m. of Resident #5 and hit, yelled at other residents and native and on 2/06/14 at 8:30 a.m. of 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 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 in near 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 to DON said the resident was being monitored and sh (DIS) of Designee will review resident swint [DIAGNOSES REDACTED]. 4. DIS and Aduse coordination will review resident 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 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 swing 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 valled at other residents and streked and scratched Peridant #2 causing had bond injury. LVN B was saked what was were fude of interacting to the fails site said No. In all interview on 02/07/14 at 10:30 a.m. EVN B said that Resident #3 fail this, 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 scratched Resident #2. LVN K was asked what niad the facility dole about Resident #3 and site said site 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 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 what did the facility do to prevent Resident #5 from causing harm to other residents 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 narm to other residents and DON said monitor behavior. The DON was asked now 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 to pool to the propriet of the provision of the propriet of the provision of 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 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

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				OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	TION	(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		
CORRECTION	NUMBER	В. WING		02/10/2014
	675249			
NAME OF PROVIDER OF SU			STREET ADDRESS, CITY, ST.	ATE, ZIP
MONTEBELLO WELLNESS	CENTER		12350 WOOD BAYOU DR	
			HOUSTON, TX 77013	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing ho	me or the state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		ENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0226	(continued from page 5)	r of Pacidant #5 and wa are maki	ng arrangements to send resident	out of facility. The
<b>Level of harm -</b> Immediate jeopardy	Administrator said there were so difficult would not allow residen	me incidents and so we are sending to be sent to hospital we request	ng resident #5 out as soon as we ca ed so we acquired orders to send t	an but the family is very he resident to the
Residents Affected - Many	it was not the setting to bring her Residents upon the return of Res	back. The Administrator was askident #5. He said staff were asked	It was a mistake on my part to bring sed what facility did to prevent fur I to be conscious of Resident #5' s	ther abuse of behavior, the staff
	put her on 1 to 1 monitoring. In a stab Resident # 4 with a butter kracility tell the nurse to do and st 02/10/14 at 9:15 a.m. the Director procedures they would not have were not done per policy and pro 12/13 revealed no entry for Residen interventions or approaches were dated 02/14 revealed an entry for approaches were dated 02/14 revealed an entry for approaches were documentation dated 10/23/13, 1 residents. Facility provided signe reporting, interventions and mon revision date of 5/2007 read in printervention to prevent injury to who display combative behaviors trained to respond to behaviors. behaviors, based on historical da measures of prevention: 1. Identification of the display combative behavior. Agitated/Combative Resident to a le exhibits problem behavior. 6. Prowith peers. 8. Communicate via Agitated/Combative Resident In behavior calls for additional assis agitation. 3. Provide safe quiet at checks, to monitor behaviors, at document behaviors. Social Serv Resident(s) with aggressive behavior by observ nursing progress notes and 24 ho behaviors had notification to phy The Staff were In-serviced on most Staff was interviewed on how to remove the immediate jeopardy.	un interview on 02/10/14 at 9:00 a tife, hit Resident #7 in the face at the said document any behaviors a or of Clinical Services (DCS) said the difficulties as they are having ocedure. Record review of the facility is 18. Resident #5 dated for 01/18/14, 01/22/14, documented. Record review of the facility is 18. Resident #5 dated 02/01/14 for it is 20/26/13, 10/28/13 and 11/08/13 fixed staff in-service conducted on 0 ditoring. Record Review of the facility is 18. Record Re	strator continued to say then we fear. LVN A said she had witnesse and grab Resident #6. LVN A was and keep an eye on Resident #5. In if the facility had followed their v now. There was a new DON and ility's incident/accident tracking ar lity's incident/accident tracking ar ervices dated 2013 and 2014 reveator abuse and neglect reporting and 2006/14 for managing difficult between the compart of the properties of the properties of the experiment of the properties of the pr	d Resident #5 trying to tasked what did the an interview on written policy and Social worker and things and trending logs dated and trending logs dated and trending logs dated are. No new or updated timing and trending logs dated interventions or led staff signed I changes in condition of taviors with subject of bative Resident with a haviors have prompt at all residents are properly educated and oriential combative ne following procedures for ent in calm and reassuring dent no longer further interactions reventions: Severely witness combative at from area of estident on hen needed and Planning: 3. It discharged the was monitored on day and assessed for viewed and updated, lents with aggressive and recommendations. It is needed for ongoing and behaviors per the plan to hee facility remained out of to need for ongoing
	monitoring of staff's response to	Resident behaviors. The CMS 67	2 revealed resident census of 112.	0 0
F 0323	 b>Make sure that the nursing provides supervision to preven		t hazards and risks and	
Level of harm - Immediate jeopardy	**NOTE- TÊRMS IN BRÂCKE	IS HAVE BEEN EDITED TO P	ROTECT CONFIDENTIALITY** iled to ensure that 1 of 10 resident	
Residents Affected - Many	failed to develop interventions of Resident #5 grabbed and scratch Resident #5 had an altercation of caused 2 open wounds. —On 01/2 knife in her hands and made a stroom screaming at and slapped F would scratch Resident #6 if she and the Director of Nurses (DON 02/06/14 at 4:15 p.m. The facility more than minimal harm due to affected five residents and placet	intervene for Resident #5, who led Resident #2's arm in the dinir yer a cup of coffee with Resident 22/14 Resident #5 was in the dini labing motion toward Resident #4 kesident #7. —On 02/01/14 Resident touched her again. These failures by were informed of the IJ on 02/0 y remained out of compliance at a he need for ongoing monitoring of the other 107 residents at risk for the other 107 residents at risk for the distribution of the other 107 residents at risk for the other 107 residents at risk	ent to resident altercations. (Residate a history of [REDACTED]4 ag roomOn 01/18/14 at 5:23pm #2, scratched Resident #2's left poing room behind Resident #4 and vOn 01/28/14 at 4:30 pm Resident #5 grabbed Resident #6 by the resulted in Immediate Jeopardy (06/14 at 4:00 p.m. While the IJ was a scope of widespread, no actual his fataff's response to resident behavir further abuse, injuries and fear, applement plan of actions to prevent	On 01/18/14 at 12:46 pm in the dining room sterior hand and vas observed to have a butter ent #5 was in the dining arm and said that she IJ). The Administrator s removed retroactively on arm with potential of viors. These failures as facility had
	facility's annual (Minimum Data [AGE] year old female admitted quarterly reviewed dated 03/19/1 objectives were to continue to su status revealed Resident #5 had a #5 were dated 01/15/14 with doc as oriented to self, alert with poo blood sugar checks, can sometim and staff were to monitor Residen tots dated 01/2014 for Resident 01/18/14. No entry documented 01/18/14 at 12:46 p.m. revealed and apparently Resident #2 was i #2's arm with her fingernails. Fu immediate action taken was the 2 incident. Resident #5 was assesser resident about the behavior and F Record review of the incident/ac an altercation in the dining room posterior hand. When asked wha Resident #5 wanted coffee and slassessed, open cuts to hand were Resident #2's left hand. The sectireview of the nurse notes dated 0 this resident, complained of mild wound nurse to assess cuts. Noti	Set) MDS with assessment refere to the facility on [DATE] with [I 3 for Resident #5 revealed [DIAC] pport and reinforce positive chan thistory of [REDACTED]. Record unentation including current meer insight and poor judgment and a less be re-directed. The treatment pint #5 for behaviors and medication #5 revealed no documentation reformonitoring of Resident #5. Redocumentation of incident in the on her way. Resident #5 reached or their review of the facility's incide 2 residents were immediately septed as oriented to self, situation an Resident #5 didn't mean to scratched the report dated 01/18/14 at 5. Residents #5 and #2 were yelling thappened neither resident could be went crazy and started to scratched in the self process of the resident way as the self process of the pro	f 5 and 6 Findings include: Record ence date of 04/30/13 for Resident DIAGNOSES REDACTED]. RecognOSES REDACTED]. The currege behaviors and mood management review of the last psychiatric productions of Aricept and Haldol and the deteriorating. The comment secolan was to continue Resident #5's on side effects. Record review of the lated to the physical abuse incided in the deteriorating above the deficient for the deteriorating for the deteriorating the deteriorating for the deficient for the de	# 5 revealed she was a rd review of the psychiatrist's ent treatment and behavioral ent. The section on current ogress notes for Resident d the Resident was assessed tion revealed refusing medication as ordered the facility's nursing the with Resident #2 on t/accident report dated hing for a cup of coffee it and scratched Resident the section on ed at the time of the the (LVN) A spoke with n't happen again. hall I and 4 reported ts on Resident #2's left ion, Resident #2 was tin tear on the back of and situation. Record is Ip.m. of nurse assessed mitbiotic. Will notify w of the facility's

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 675249
Previous Versions Obsolete

PRINTED:9/17/2014 FORM APPROVED

CORRECTION	NUMBER 675249		02/10/2014
STATEMENT OF DEFICIENCIES AND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
			OMB NO. 0938-0391

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)

(continued... from page 0)
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 table with Resident #5. Resident #4 was reaching forward towards the middle of the table. Resident #5 picked up a butter table with Resident #5. She could not of that Resident #5 is table of the other to the other was noved 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 incident was present for monitoring, incident or behaviors. Record review of the incident/accident report revealed no obvious injuries, separated residents and notified families. The section on mental status revealed Resident #5 was screaming at and slapped Resident #7. Resident #7 then swung back at Resident #5. Turther 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's through the properties of the review of the Resident #5's unsident #5's unsident #5's unsident #5's through the properties of the review of the Resident #5's and not incident #6's and the review of th

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's shibiting 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 #5 must have become agitated and swung out to hit Resident #7 in the face but she hit the bag of popcorn that 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 #5 must have become agitated and swung out to hit Resident #7 in the face but she hit the bag of popcorn that Resident #5 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 #4 she said a black woman tried to hurt her in the dining room and a nurse took a knife away from the resident #5 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 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 h

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	675249		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2014
			OMB NO. 0938-0391

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

F 0323

Level of harm - Immediate jeopardy

Residents Affected - Many

OR LSC IDENTIFYING INFORMATION)

(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 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 his he observed the
wound caused by Resident #5 to Resident #2' 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. TON 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 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 is incident 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 Identified resident #5 was aggressive again, we put 1 on 1 staff monitor of Resident #3 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 07/01/14 for incident of behavior. No new or updated interventions or approaches were documented. Record review of the facility's incident/accident tracking and trending logs dated 01/14 revealed entry. For Resident #5 dated 00/01/14 for incident of behavior. No new or updat 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 resident's further interactions with peers. 8. Communicate via 24-hour report, resident's behavior title and 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 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

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CENTERS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	/ CLÍA	A. BUILDING		(X3) DATE SURVEY COMPLETED 02/10/2014
	675249			
NAME OF PROVIDER OF SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP
MONTEDELLO WELLNESS CENTED			12250 WOOD PAVOU DD	

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.

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG 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 a 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

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 IO7 residents at risk for further abuse, injuries and fear, as facility had 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's arm. Resident #5 grabbed Resident #6 reached out and touched Resident #5's arm. Resident #6 reached out for Resident #6 is he touched her again, she would scratch her fac 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 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 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, 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 lef

PRINTED:9/17/2014 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

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

F 0490

Level of harm - Immediate jeopardy

Residents Affected - Many

harm to other residents and DON said monitor behavior. The DON was asked how the staff had been instructed to monitor

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 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 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, taminy's preferred nospital. 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 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 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 behavior subside. Facility will use 1:1 start 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 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 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 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

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