STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675062	A. BUILDING _____ B. WING _____	10/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARNE HEALTHCARE CENTER	1101 W BROWN ST HEARNE, TX 77859

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promptly notify the Physician of changes in wounds for three (3) of 13 residents (Resident #2, #3 and #4) reviewed for skin assessments and wound treatments. A) The Physician was not promptly notified when Resident #3's wounds declined and additional wounds were observed by multiple staff including the Treatment Nurse. B) The Physician was not promptly notified when Resident #2's had worsening of his coccyx pressure sore and the development of a new pressure sore to his sacrum. C) The Physician was not promptly notified Resident #4's wound to her ankle declined. Resident # 4's pressure sore declined from a Stage II to a Stage III. This deficient practice affected three (3) residents (Resident #2, #3 and #4) and placed an additional 13 residents with wounds and 22 residents at risk for the development of pressure sores at risk for development of infection, pain and worsening of current wounds. Findings Include: A) Review of the Face Sheet reflected Resident #3 was a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] reflected Resident #3's cognitive skills for daily decision making was severely impaired. She had behaviors of scratching others, cursing others and behavior symptoms not directed toward others less than daily. She was totally dependent on others for her bathing needs and required two people for hygiene. Resident #3 was always incontinent of bowel and bladder and was admitted with Moisture Associated Skin Damage and Pressure Sores. Review of the Comprehensive Plan of Care for Resident #3 dated [DATE] and reviewed on [DATE] reflected Resident #3 had Pressure Sores on her back extending down to posterior or upper thighs and the goal was that skin will remain clean and dry and area will decrease in size and or heal within the next three (3) months. Approaches included: Perform treatment per order, if no improvement within two weeks report to Medical Doctor .Keep.Medical Doctor informed of residents progress. Also care planned was the risk for skin breakdown with multiple skin problems and refusal of care and dressing changes. The stated goal was skin will remain clean, dry and intact .over the next three months. Approaches included monitor for incontinence every two hours and as needed, change promptly. Assess skin on a weekly basis and as needed, report any breakdown to Medical Doctor . Review of Resident #3's Consolidated Physicians Orders Dated [DATE] reflected: [DATE] Head to Toe skin assessment every week on Mondays on evening shift . and [DATE] Apply dermaseptin to affected areas of buttocks and bilateral thighs every shift and after each incontinent episode. Review of Resident #3's Weekly Skin Documentation Record reflected on [DATE] Resident #3 had open wounds to the back of the right thigh (3.1 x 1.4 cm), left lower buttock (0.8 x 0.2 cm), and the right thigh above the knee (11.6 x 3.1 cm). Observation on [DATE] at 10:15 AM revealed Resident #3 turned to her left side to reveal multiple wounds without dressings: * Resident #3's posterior right lower thigh had a full thickness wound that measured approximately 13.5 cm by 5.5 cm with notable depth, the wound edges were irregular and beveled, the wound bed was beefy red, bloody granulation tissue. These measurements reflected a decline of the wound. *Resident #3 had a full thickness wound to her right posterior upper thigh that measured 3 cm by 2.5 cm, the wound edges were irregular and beveled, the wound bed was beefy red, bloody granulation tissue. *Resident #3 had partial thickness wound to her posterior lateral upper right thigh that measured approximately 1 cm by 1 cm and the wound bed was beefy red. This wound had not been identified previously. *Resident #3 had a full thickness wound to her posterior upper left thigh which measured approximately 3.5 cm by 4.5 cm with >0.1 cm depth the wound had irregular beveled wound edges, from 9 o'clock to 5 o'clock there was a 2 cm by 2 cm area of yellow slough the wound from 5 o'clock to 9 o'clock was beefy red, bloody granulation tissue. This wound had not been identified previously. * Resident #3's Left buttock revealed a full thickness wound approximately 2 cm by 3 cm with beveled irregular wound edges, the wound bed was beefy red, bloody granulation tissue. The Treatment Nurse was present to see the wounds, studied them for a moment, then went to his cart outside the room. When he returned to the bedside he applied Dermaseptin to all skin around all wounds and attempted to apply the ointment to the wounds. The Dermaseptin would not adhere to the wounds. In an interview on [DATE] at 12:00 PM the Treatment Nurse stated he had not seen Resident #3's wounds since Thursday, [DATE]. He stated she had refused treatment on Friday, Monday and Tuesday so he was not aware that the other areas had opened up. When asked if he approached Resident #3 a second time in a day for treatment, he stated, she refused Friday morning and that afternoon. In an interview on [DATE] at 12:10 PM CNA L stated, Her (Resident #3's) wounds are like that every day. That's what it looked like Sunday when I saw her. In an interview on [DATE] at 12:30 AM with LVN G regarding Resident #3's wounds, the 10:00 PM to 6:00 AM charge nurse stated, Friday night ([DATE]) we gave her a bath. Her wounds were coming back open then. In an interview on [DATE] at 2:30 AM with LVN G regarding Resident #3's wounds the 10:00 PM to 6:00 AM charge nurse stated that he had let the day shift know of the worsening wounds but that he could not remember if it was Friday or Saturday morning ([DATE] or [DATE]). In an interview on [DATE] at 10:30 AM the Treatment Nurse stated he did not have an updated Weekly Skin Documentation record because he did not measure Resident #3's wounds on [DATE]. He stated after the surveyor left the room (on [DATE]) Resident #3 sent him out of the room and would not turn to the other side for him. He further stated he documented the refusal. Upon examining the chart with the surveyor, no documentation for refusal of care of wounds on [DATE] is documented. The Treatment Nurse stated, I didn't document her refusal. When asked if he had went to the room to measure Resident #3's wounds on [DATE] he stated, No I went in there to do a treatment. He further stated, In a week, she got a couple new open areas and the others have gotten a little worse. He stated no staff had notified him of the worsening wounds. The Treatment Nurse further stated the physician had not been notified of the change in the wounds. In an interview on [DATE] at 6:20 PM the DON stated that she expected the staff to notice the change in skin condition on their weekly skin checks. The DON also stated she would expect that the Treatment Nurse would measure the wounds that he was seeing at that opportunity. The DON further stated that she would have expected the Treatment Nurse to notify the Doctor the day he noted the increase in size and number of wounds. She also stated it was reasonable to expect him to do his treatments as ordered. The DON stated the nurse aide staff is not trained to know what a significant change in skin is and that it is up to the Treatment Nurse to know when there is a change. In an interview on [DATE] at 6:45 PM the RNC stated he expected the CNAs to report any change in skin condition to the charge nurse. B) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to require extensive two person assist with bed mobility and personal hygiene. Resident #2 was assessed to be dependent on staff for personal hygiene and bathing. Resident #2 was assessed to require pressure ulcer care. Resident #2 was assessed to have three (3) Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough.) pressure ulcers that were present on admission with at date of [DATE]. The tissue type of the pressure ulcers was assessed to be granulation tissue. Further review of Resident #2's care plan reflected a problem

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

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F 0157 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) with the onset date of [DATE] Category: Pressure Ulcer; I have an open area to back of right thigh. Under approach Keep me clean and dry; provide me with treatments as ordered by my physician; Report any drainage to my physician promptly; Use good infection control when dealing with my ulcer. Remember to wash your hands before and after treatment. Resident #2's care plan further reflected a problem with the onset date of [DATE] Category: Pressure Ulcer; I have an open area to my left thigh. No care plan was noted for a coccyx pressure ulcer. Review of Resident #2's Consolidated Physician orders [REDACTED]. No order was noted for Resident #2's coccyx. Review of Resident #2's Physician Telephone orders reflected an order dated Late entry [DATE] Apply Dermaseptin to Rt. (right) mid thigh , Rt. Lower thigh and coccyx q (every shift) and PRN. Review of Resident #2's Admission assessment dated [DATE] reflected Resident #2 was readmitted from the hospital at 7:00 PM. The assessment further reflected Resident #2 had no pressure areas noted on the assessment. The assessment was signed by RN A. In an interview on [DATE] at 3:00 PM RN A stated she readmitted Resident #2 on [DATE] and stated she did not see any pressure sores. Review of Resident#2's Weekly Skin Documentation reflected an assessment performed on [DATE] which reflected Resident #2 had a Stage II pressure ulcer to his coccyx which measured 2.1 cm by 0.3 cm no depth was indicated tissue type was beefy red. In an interview on [DATE] at 2:15 PM the Treatment Nurse stated there was not an assessment of Resident #2's wounds for [DATE]. The Treatment Nurse stated the first time he looked at the wounds was [DATE]. Review of Resident #2's Weekly Skin Documentation reflected an assessment performed on [DATE] which reflected Resident #2 had a Stage II pressure ulcer to his coccyx which measured 1.6 cm by 0.3 cm. no depth was indicated tissue type was beef red. Observation on [DATE] at 11:00 AM revealed Resident #2 in bed. Resident #2 was turned to his right side by the DON and Treatment Nurse to reveal two (2) pressure ulcers one on his sacrum and one on the coccyx. The pressure ulcers were not covered with a dressing and no cream was noted to the pressure ulcers. The Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) pressure ulcer to Resident #2's sacrum that measured approximately 2 cm by 1 cm by >0.2 cm depth, the pressure ulcer had an irregular beveled wound edges with a white/ gray macerated peri-wound which extended out approximately 0.2 cm. The wound bed was granulation tissue, with active bleeding at 12 o'clock. The Unstageable (Full thickness tissue loss in which the base of the ulcer is covered by slough) pressure ulcer to Resident #2's coccyx measured approximately 1 cm by 0.5 cm, the pressure ulcer had an irregular beveled wound edge with a red to light pink peri-wound that extended out approximately 0.4 cm. The wound bed was covered in a light yellow slough. (Approximation by surveyor) No drainage was noted. The Treatment Nurse used saline gauze and wiped across both pressure ulcers and then applied dermaseptin cream (menthol/zinc oxide). The treatment Nurse did not measure the pressure ulcers or acknowledge the new pressure ulcer on Resident #2's sacrum. Review of Resident #2's Physician order [REDACTED].#2's Physician or Nurse Practitioner (NP) had not been notified in regards to worsening of Resident #2's pressure ulcers or the development of new pressure ulcers. In an interview on [DATE] at 12:00 Noon Resident #2's NP stated she comes to the facility on ce a month to assess the skin issues in the facility. Resident #2's NP stated she could not remember if the facility had called her regarding Resident #2 and further stated she had not seen Resident #2 since he was readmitted to the facility from the hospital. In an interview [DATE] at 2:15 PM the Treatment Nurse stated he had not completed the skin assessment for Resident #2 that was due on [DATE]. The Treatment Nurse stated he documents in the nurses notes when he notifies the NP. The Treatment Nurse stated he does the weekly skin assessments anywhere from Tuesday to Thursday. The Treatment Nurse stated he had not notified Resident #2's NP of any changes in Resident #2's pressure ulcers and further stated the NP would be at the facility next week. In an interview on [DATE] at 5:40 PM the DON, when asked about the skin assessment for Resident #2, she stated He has not done that yet? The DON stated she would check with the Treatment Nurse. In an interview on [DATE] at 5:55 PM the DON stated We can go down there now and assess him referring to Resident #2. Observation on [DATE] at 6:30 PM revealed Resident #2 turned to his left side by the DON. Resident #2 pressure ulcers were not covered with a dressing. The Treatment Nurse measured Resident #2's Coccyx unstageable pressure ulcer stating the measurements were 1.9 cm by 0.3 cm; the Treatment Nurse did not stage the pressure ulcer. The Treatment Nurse measured the pressure ulcer to Resident #2's sacrum and stated it was 2.8 cm by 0.7 cm; the Treatment Nurse did not stage the pressure ulcer. In an interview on [DATE] at 7:01 PM the DON stated she would notify Resident #2's NP of his worsening wounds. The DON stated the NP should be notified of any changes in wounds and any new areas when they found. Review of Resident #2's Physician Telephone orders on [DATE] reflected an order dated [DATE] Duoderm to open coccyx ulcer change every 3 days until healed use wound cleanser to clean areas . C) Review of the Face Sheet for Resident #4 reflected a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of the Quarterly MDS Assessment for Resident #4 dated [DATE] reflected a BIMS score of three (3) indicating severe cognitive impairment. Resident #4 was totally dependent on staff for dressing, hygiene, bed mobility, and bathing. She needed extensive assistance with eating. The Assessment reflected Resident #4 was not transferred for the seven (7) day look back period. Resident #4 was incontinent bowel and bladder. She weighed 104 pounds and was coded for weight loss that was not prescribed. Resident #4 was not coded for dehydration. Resident #4 was also on a mechanically altered diet. The Assessment reflected Resident #4 had two Stage II Pressure Sores and one (1) Stage IV. The date of the oldest Stage II was [DATE]. The Stage IV measurements were 1.7 cm x 1.1 cm x 1.4 cm with granulation tissue. The Assessment indicated all the pressure sores worsened and none had healed since the last assessment. Resident #4's skin treatment included a pressure reducing device for bed, nutrition or hydration intervention to manage skin problems, and pressure ulcer care. Resident #4 was on Hospice care. Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated [DATE] I have a pressure ulcer on my right outer ankle currently a Stage II. 1.3 x 1.2 cm with a Goal for the pressure sore to .heal 1 cm per month . The Care Plan reflected Resident #4's Approaches .Provide me with treatments as ordered .Report any drainage to my physician promptly .Use good infection control when dealing with my ulcer. Remember to wash your hands before and after treatment. Review of Resident #4's Consolidated Physician order [REDACTED]. Chlorine, the active ingredient in Dakin's solution, is a strong antiseptic that kills most forms of bacteria [MEDICAL CONDITION].) apply wet to dry every day. Review of Resident #4's Weekly Skin Documentation reflected an assessment dated [DATE] of Resident #4's Right outer ankle. Resident #4's right ankle was Staged at a II that measured 0.8 cm by 0.6 cm with 0.2 cm depth with granulation tissue. Observation on [DATE] at 11:45 AM revealed Resident #4 lying in the bed on the left side. Treatment Nurse did not wash his hands prior to setting up the wound care supplies on a piece of wax paper on top of the treatment cart. The DON entered Resident #4's room and donned gloves without washing her hands. Resident #4's dressing to the right outer ankle was intact and when removed had a moderate amount of light yellow drainage. The wound bed had slough and depth when observed-indicating a Stage III. The wound was not measured at this time but was approximated as 1 cm x 1 cm x 0.5 cm. The wound had slough from throughout the wound but depth could be determined. The wound edges were macerated and rolled. The Treatment Nurse did not change gloves until he finished with this procedure, therefore he removed the dirty dressing, cleansed the wound, and placed the clean dressing on the wound without changing gloves or hand hygiene. The Treatment Nurse cleansed the wound from the outer edge then towards the center wound bed. In an interview on [DATE] at 11:55 AM the DON stated Resident #4's pressure sore to her right outer ankle was a Stage II. In an interview on [DATE] at 12:05 PM Resident #4's NP stated she could not recall if the facility had notified her of any changes for Resident #4. The NP stated generally for Stage III pressure sores she like to use a calcium alginate type dressing covered with a foam dressing to provided extra protection. It just depends on what the wound looks like. In an interview on [DATE] at 4:40 PM the Treatment Nurse stated he should have washed his hands before gathering his supplies and during the procedure when you get anything on you. He stated the cleansing should start in the middle of the wound bed and then outward to not drag germs inside. The Treatment Nurse stated he was trained for two hours by RNC and VP Clinical Services and had been performing wound care for two months. Review of Resident #4's Medical Record reflected no new orders for Resident #4's right ankle or assessment documentation as of [DATE]. In an interview on [DATE] at 10:30 AM the Treatment Nurse stated Resident #4's right outer ankle pressure sore was a Stage III instead of a Stage II like he had documented. He stated he had not notified the Physician or NP of the right ankle wound changes or the presence of slough. Review of the facility provided policy reflected: General Skin Protocols.You should work with the Resident's attending physician to implement this protocol by obtaining any necessary physician's orders [REDACTED].8. Any change in the Resident's skin condition must be documented, the physician and responsible party notified. The facility provided a list of 22 residents at risk for pressure sores and 13 residents with wounds.
F 0166 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Try to resolve each resident's complaints quickly.**

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F 0166 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure prompt efforts were made by the facility to resolve grievances for two (2) of the 19 Residents (Residents #2 and #14) reviewed for grievances when the facility failed to resolve : A) Resident # 2's grievance regarding his missing clothes and cell phone. B) Resident #14's grievance regarding staff treatment, and missing clothes. This deficient practice placed 66 residents who reside in the facility at risk for decreased self-worth, decline in quality of life and dignity. Findings include: A) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Observation on 10/14/2014 at 9:00 AM revealed Resident #2 in bed. Resident #2 was wearing a open back hospital gown. In an confidential complainant interview on 10/16/2014 at 1:00 PM the Complainant stated she regularly visits Resident #2 and has been since January 2014. The Complainant stated Resident #2 has complained on multiple occasions regarding his missing clothes and has told the Complainant that he has told the Administrator. The Complainant stated he/she had told the Administrator about the missing items and stated the Administrator was a Jerk and So Rude. The Complainant stated no effort has been made to locate Resident #2's missing items. In an interview on 10/16/2014 at 4:15 PM Resident #2 stated My clothes and phone have been missing since I came back from the hospital in September. Resident #2 stated he was missing his robe, shorts, underwear and his cell phone. Resident #2 stated the only thing he had to wear was the hospital gowns. Resident #2 stated he told the Administrator and the Administrator has not followed up with him. Review of the facility's Grievance Log reflected no grievance's listed for Resident #2 from March 2014 to October 2014. In an interview on 10/17/2014 at 11:25 PM the Administrator stated I don't know about his missing clothes or phone. Why don't you call his sister. B) Review of Resident #14's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #14's Admission MDS dated [DATE] reflected Resident #14 was assessed to not have long or short term memory problems and was assessed to require modified independence in decision making. Resident #14 was assessed to have no speech, and usually understood and usually understands. Resident #14 was assessed to not have behavior problems or resist care. Resident #14 was assessed to require limited to extensive assist with ADL's and was assessed to be occasionally incontinent. Review of Resident #14's Comprehensive Care Plan reflected a problem with the start date 09/04/2014 which reflected I have a communication deficit related [MEDICAL CONDITION]. I need to use writing material to be able to communicate at times. Approaches listed included: Reassurance and patience when I attempt to communicate, Use gentle, relaxed tone of voice. Resident #14's care plan did not address a cognitive impairment, or behavior problems. Review of Resident #14's History and Physical dated 09/03/2014 reflected Resident #14 was oriented to person, oriented to place, oriented to time, affect appropriate, mood appropriate, is cooperative with care. Observation on 10/15/2014 at 12:10 PM revealed Resident #14 entering the facility library where the surveyors were working. Resident #14 was visibly upset and wanting to talk with the surveyors. Resident #14 was unable to talk related to [MEDICAL CONDITION] but was able to communicate with slight whispering and by lip reading. In an interview on 10/15/2014 at 12:15 PM Resident #14 stated he had multiple items of clothing missing. Resident #14 stated he told the Administrator about his missing items and that his Wife told the Administrator about his missing items and no effort was made to locate his missing items. In an interview on 10/16/2014 LVN G stated, when asked if Resident #14 had reported any complaints, It is hard to understand what he says, so I don't know what he is saying. Review of the facility's Grievance Log reflected no grievances listed for Resident #2 from August 2014 to October 2014. In an interview on 10/17/2014 at 11:20 PM the Administrator stated he had not talked with Resident #14 and has not had a grievance regarding his missing clothing. Review of a list of missing items dated 10/19/2014 made by Resident #14's wife reflected a list of 11 items that were missing. Review of the facility's policy Grievance Guidelines dated 04/16/2014 reflected 1. The disposition of all written grievances and/or complaints must be recorded on the Grievance and Complaint Log. 2. The Administrator will be responsible for recording and maintaining this log. 3. The following information, as a minimum, must be recorded: a. The date of grievance/complaint was received. b. The name and room number of the resident. c. The name and relationship of the person filing the grievance/complaint.f. The date the resident, or interested party, was informed of the findings. g. The disposition of the grievance (i.e.,resolved, dispute, etc.). The facility provided CMS 672 reflected a census of 66 residents.
F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident had the right to be free from verbal and physical abuse for two (2) of 13 residents (Resident #2 and #14) reviewed for abuse. A) The facility failed to protect Resident #2 from physical abuse when he reported two (2) CNAs (CNA G and CNA K) had abused him by spanking him with their hands and hurt him. The CNAs continued to work with him despite his wishes and they began telling him he was a trouble maker and hard to deal with. Both CNA G and CNA K were at work during the survey until surveyor intervention. B) The facility failed to protect Resident #14 from verbal abuse when he reported that two (2) CNA's (CNA O and CNA P) verbally abused him every time they came to work and would seek him out to call him names and make fun of him. Both CNA O and CNA P were at work during the survey until surveyor intervention. An Immediate Jeopardy (IJ) was identified on 10/17/2014 at 2:15 PM. While the IJ was removed on 10/18/2014, the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure affected Resident #2 and #14 could affect the facility's 66 residents by placing them at risk for abuse and/or mistreatment by staff members or agency staff. Findings included: A) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to require extensive two person assist with bed mobility and personal hygiene. Resident #2 was assessed to be dependent on staff for personal hygiene and bathing. Resident #2 was assessed to not have any psychiatric or mood disorders. Resident #2 was assessed to not have any behavioral symptoms. Review of Resident #2's Comprehensive Care Plan reflected a problem with the onset date of 09/15/2014 I have cognitive loss, which affects my ST/LT (short term and long term) memory and decision making skills. I am at risk for further decline as my disease progresses. Further review of Resident #2's care plan reflected a problem with the onset date of 09/15/2014 I have delusions as evidenced by; Interview on 08/28/2014 by SW (social worker) with mild paranoia and smiling and giggling inappropriately at conversation and secretiveness. Review of Resident #2's physician progress notes [REDACTED]. Review of the list of interviewable Residents in the facility provided by the facility on 10/14/2014 reflected Resident #2 was interviewable. Observation on 10/16/2014 at 4:10 PM revealed Resident #2 was an obese male who was in bed on his back. Resident #2 had oxygen on at 3 liters per nasal canula. Resident #2 was alert. In an interview on 10/16/2014 at 4:15 PM Resident #2 stated CNA G spanked him with her hands a while back. Resident #2 stated there were two (2) CNAs present and did not know the other CNAs name but gave a physical description. Resident #2 stated the event occurred between April and September, before he went to the hospital. Resident #2 stated the aides were rough with me. Resident #2 stated he told the CNAs they were hurting him. Resident #2 stated the aides replied back you are a big man, what do you expect us to do about that. Resident #2 stated when the CNAs spanked him that he asked them to stop and the aides replied He likes it. Resident #2 stated I told the Administrator, the Charge Nurse LVN B, and the Social Worker and they told me I was out of it and did not believe it. They treat me like I am confused. Resident #2 stated the CNAs continue to work with him and they are rough and he does not like it. Resident #2 stated the CNAs have been calling him a trouble maker and hard to deal with. Resident #2 further stated he feels like the CNAs throw him and he is fearful, like he is going to fall out of the bed. Review of Resident #2's Social Service Progress Note dated 05/21/2014 no time reflected reported that he was spanked by CNAs last week and had given the details to the Administrator. Possible delusional thought content. SW (Social Worker) notified DON and Administrator of resident's allegation this AM. In an interview on 10/17/2014 at 5:05 PM the SW stated when Resident #2 is speaking and doesn't seem to be engaged that he is delusional. The SW stated that was the definition of delusional. (The definition of delusional: A false belief or opinion.

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) Psychiatry A false belief strongly held in spite of invalidating evidence, especially as a symptom of mental illness: http://dictionary.reference.com/browse/delusional) Review of Resident #2's Social Service Progress Note dated 06/11/2014 no time reflected Resident continues to talking about delusional thought content about being spanked as well. In an interview on 10/16/2014 at 6:30 PM LVN B stated she was aware of an incident in which Resident #2 stated he was spanked. LVN B stated she reported it to the Administrator. In an interview on 10/17/2014 at 9:20 AM CNA G when asked if she had ever had any problems with Resident #2, stated that Resident #2 did not want her to check on him. CNA G further stated she recalled an incident were Resident #2 accused her of abuse. CNA G stated she was patting Resident #2; CNA G was making repetitive inward motions with her hands; to keep him on his side. CNA G further stated the Administrator talked to her about the incident and told her not to do that anymore. CNA G stated he is trying to get people in trouble referring to Resident #2. CNA G stated she has continued to worked with Resident #2 after the Administrator talked to her. In an interview on 10/17/2014 at 11:07 AM the SW stated that Resident #2 had complained to her about being spanked. SW could not give a date but stated she gave it to the Administrator to follow up on for potential abuse. The SW stated Resident #2 told her he did not want it to happen again. In an interview on 10/17/2014 at 11:20 AM Resident #2 stated he felt abused when CNA G and the other aide were hitting him. Resident #2 stated he told her to stop and he did not want them to take care of him and was fearful they would hurt him. Resident #2 further stated I try to be nice so they won't be mean to me. I laugh and joke, that way they will take care of me. I can't take care of myself. In an interview on 10/17/2014 at 11:25 AM when asked if Resident #2 had advised him of any abuse, the Administrator stated no. When asked if the Charge Nurses had advised him Resident #2 had been abused or spanked, the Administrator stated no. When asked if the Social Worker had advised him Resident #2 had been abused or spanked, the Administrator stated no. Surveyor asked the Administrator if he had talked to a CNA regarding an allegation that Resident #2 stated he was spanked by CNAs, Administrator stated there was a spanking incident but he had not been advised it was abuse. The Administrator stated Resident #2 had told him he wanted to be spanked and the Administrator stated he did not feel it was abuse. In an interview on 10/17/2014 at 11:35 AM the DON, who was with the Administrator during the above interview, stated she recalled hearing about a report that Resident #2 had wanted to be spanked but she could not remember what was done. The DON stated possibly a psych eval. Review of Resident #2's Medical Record reflected no psych evaluation was conducted regarding behaviors. Review of Resident #2's Comprehensive Care Plan did not reflect a care plan for sexually inappropriate behavior. In an interview on 10/17/2014 at 1:00 PM the Administrator stated again that no one had reported any allegation of abuse to him regarding Resident #2. The Administrator stated he might have talked with an aide he could not remember. The Administrator further stated Resident #2 wanted to be spanked. In an interview on 10/17/2014 at 2:00 PM CNA H stated Resident #2 had never been inappropriate with her and stated no he has never asked me to spank him. In an interview on 10/17/2014 at 2:02 PM CNA I stated that Resident #2 had never been inappropriate and further stated he has never asked to be spanked. CNA I stated she was told by Resident #2 that CNAs had spanked him but he would not tell her who. CNA I stated she told him to report the incident and Resident #2 told her he had already reported it. CNA I stated Resident #2 told her that when he reported it they made him feel uncomfortable. In an interview on 10/17/2014 at 2:10 PM CNA J stated Resident #2 had never been inappropriate with her and never asked her to spank him. CNA J asked someone thinks that about him? In an interview on 10/17/2014 at 2:15 PM LVN B stated regarding Resident #2 No he has never asked me to spank him. In an interview on 10/17/2014 at 4:50 PM CNA K stated she was with CNA G providing care for Resident #2 when the incident occurred. CNA K stated CNA G was pushing Resident #2 to his side using both hands. CNA K indicated that CNA G's hands left and regained contact with Resident #2 multiple times. CNA K stated she did not feel like CNA G was spanking Resident #2 but trying to hold him over. CNA K stated he's big and he is hard to take care of. In an interview on 10/17/2014 at 5:30 PM the RNC stated the facility contacted the police department and a officer came to speak with Resident #2. The RNC stated Resident #2 repeated the allegation and named CNA G as the person who assaulted him and another unknown female. Review of the Police Department report dated 10/17/2014 at 4:40 PM reflected Resident #2 advised two b/f (black females) nurses spanked him on his bottom. Resident advised the incident happened two (2) months ago. Resident #2 advised the pain was a 7 or 8 pain ranging from 1-10 with 10 being the highest. Resident #2 advised he felt kind of abused.Resident #2 advised one of the females nurses who assaulted him was named CNA G.Resident #2 did not know the other aide's name. B) Review of Resident #14's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #14's Admission MDS dated [DATE] reflected Resident #14 was assessed to not have long or short term memory problems and was assessed to require modified independence in decision making. Resident #14 was assessed to recall, location of room, staff names and faces, and that he is in a nursing. Resident #14 was assessed to have no speech (absence of spoken words), and usually understood and usually understands. Resident #14 was assessed to not have behavior problems or resist care. Resident #14 was assessed to require limited to extensive assist with ADL's and was assessed to be occasionally incontinent. Review of Resident #14's Comprehensive Care Plan reflected a problem with the start date 09/04/2014 which reflected I have a communication deficit related [MEDICAL CONDITION]. I need to use writing material to be able to communicate at times. Approaches listed included: Reassurance and patience when I attempt to communicate, Use gentle, relaxed tone of voice. Resident #14's care plan did not address a cognitive impairment, or behavior problems. Review of Resident #14's History and Physical dated 09/03/2014 reflected Resident #14 was oriented to person, oriented to place, oriented to time, affect appropriate, mood appropriate, is cooperative with care. Review of Resident #14's Admission assessment dated [DATE] reflected Resident #14 was assessed to be alert without memory problems and exhibited no behavior problems. Review of the list of interviewable Residents in the facility provided by the facility on 10/14/2014 reflected Resident #14 was interviewable. Observation on 10/15/2014 at 12:10 PM revealed Resident #14 self propelled in a wheel chair and entered the facility library where the surveyors were working. Resident #14 was visibly upset and asked to talk with the surveyors. Resident #14 was unable to talk related to [MEDICAL CONDITION] but was able to communicate with slight whispering and by lip reading. Resident #14 was asked if he would like a pen an paper so he could write down what he wanted to tell the surveyors. Resident #14 mouthed, no and pointed to his right hand (which was paralyzed) and mouthed he could not write. Resident #14 stated CNA O and CNA P (Resident #14 gave descriptions of the CNAs and first names) talk bad to him and call him names. Resident #14 stated they call him a motherf****** and call him other names and make fun of him when he can't do things for himself. Resident #14 stated the CNAs seek him out and pick on him calling him names. Resident #14 stated it happens every time the CNAs work. Resident #14 stated it has been going on for two (2) months. Resident #14 stated I tell them to go away and they come back. Resident #14 stated she won't stop. Resident #14 stated he feels threatened when they come to him. Resident #14 stated the CNAs have not hit him but stated I feel like she will hit me. Resident #14 stated he was scared that things were going to get worse. Resident #14 stated he has told several people about the CNAs and they do not listen to him. Resident #14 stated he has told Administrator but he did not listen to him. Resident #14 stated the Administrator acted like he did not understand Resident #14 when he tried to tell he about the CNAs mistreatment. In an interview on 10/15/2014 at 1:00 PM the Administrator stated he was not aware of any verbal abuse toward Resident #14 and nothing had been reported to him. After surveyor informed the Administrator of Resident #14's allegations of verbal abuse from CNA O and CNA P he stated okay. Attempts made to contact CNA O and CNA P were unsuccessful. CNA O and CNA P provided the Administrator written statements which were provided to surveyors at exit. Review of CNA P's written statement dated 10/15/2014 (no time) reflected I have never cursed at Resident #14. The only conflict was in the dining room. Resident #13 gave him his regular tray. I reported to charge nurse.He started cursing at me. Calling me bitc*** and motherf****** and pointing his finger in my face. Review of CNA O's written statement which was dated 10/10/2014 (no time) .today is the first day I have ever heard that Resident #14 has accused me of cussing at or in front of him. If I work on Hall 2, I always have another nurse aide or nurse go with me when I take care of him because staff that have worked here before told me that he will lie on you and get you in trouble. Resident #14 tend to get very upset over little things an then will lie on anyone when he can't get what he wants. Resident #14 always cussing towards me an other staff we are the one being abused by him. Review of an interview conducted by the Social Worker on 10/15/2014 reflected Resident #14 was interviewed in presence of Police.Resident reports these ladies (referring to CNA O and CNA P) have been insulting before today.then elaborated that it was a problem before this month. He later indicated it has been going on for two (2) months. When asked what has been going on, resident stated these aides call me names.all kind of names.and stated he got mad because they were calling him names yesterday. In an interview on 10/15/2014 at 2:00 PM the Police Officer stated Resident # 14 had advised him two aides had called him names including mother******. The Police Officer stated this was not a criminal offense. In an interview on 10/15/2014 at 5:00 PM the Administrator stated he suspended CNA O and CNA P pending results of the investigation he was conducting into Resident #14's allegations. In an interview on 10/16/2014 at 12:30 AM LVN G stated,

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	675062	A. BUILDING _____ B. WING _____	10/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARNE HEALTHCARE CENTER	1101 W BROWN ST HEARNE, TX 77859

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

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 4) when asked if Resident #14 had reported any complaints, It is hard to understand what he says, so I don't know what he is saying. In an interview on 10/16/2014 at 1:30 PM Resident #30 stated he is Resident #14's roommate. Resident #30 stated the aides pull the curtain when they are providing care to Resident #14 but he can hear them arguing with Resident #14. Resident #30 could not identify which aides argue with Resident #14. In an interview on 10/16/2014 at 5:30 PM Resident #13 (who's room is down the hall from Resident #14) stated he hears the aides screaming at people all the time. Resident #13 stated he can't make out what they say. Resident #14 stated the aides scream at him. Resident #13 stated he did not want to pursue it because it will do no good. In an interview on 10/17/2014 at 11:00 AM Resident #14 stated he wanted to know what was going on. Resident #14 wanted to know why CNA O and CNA P were at the facility. Resident #14 stated he saw the CNAs in the building. Resident #14 was visibly upset by seeing the CNAs. In an interview on 10/17/2014 at 11:25 PM the Administrator stated he could not find any evidence to support Resident #14 was abused, verbally so he let the CNAs come back to work. The Administrator stated both CNAs denied verbally abusing or calling Resident #14 names. The surveyor then asked to see the Administrators investigation report. The Administrator stated he was not completed with the investigation report. The surveyor then asked if he was not completed with the investigation then why were the CNAs allowed to come back to work. The Administrator stated he would get all his notes and give them to the surveyor. The facility did not provide a completed investigation report on 10/17/2014. In an interview on 10/17/2014 at 4:55 PM the RNC stated the Administrator had been suspended and Resident #14's investigation was reopened and CNA O and CNA P were suspended until the facility investigation could be completed. In an interview on 10/17/2014 at 6:00 PM the RNC stated all allegations of abuse must be handled seriously and investigated. Review of the facility's policy Abuse Prevention Program dated 05/20/2014 reflected Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion .Abuse Investigation Protocol: All reports of resident abuse, neglect injuries of an unknown source .are promptly and thoroughly investigated by facility management .The individual conducting the investigation will as a minimum: e. Interview the persons reporting the incident; f. Interview any witness to the incident; g. Interview the resident; m. Interview other residents to whom the accused employee provides care and services to determine if they have complaints about the employee; o. Review all events preceding the alleged incident .9. Employees of this facility who have been accused of resident abuse will be suspended until the investigation has been completed. Preventing Resident Abuse: Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse . q. Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately. Reporting Abuse to Facility Management: 2. all reports of abuse, including anonymous reports, are promptly investigated. 7. a. Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being .15. Any person who has knowledge or reason to believe that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense SHALL report, or cause a report to be made of , the mistreatment or offense. Failure to report such an incident may result in legal/ criminal action being filed against the individual(s) withholding such information. The facility Administrator was notified on 10/17/2014 at 2:15 PM that an IJ situation had been identified due to above failures. The first Plan of Removal was submitted by the RNC on 10/17/2014 at 5:20 PM. The final Plan of Removal was accepted by the survey team on 10/17/2014 at 5:34 PM. Immediate Jeopardy Plan of Removal Variance to Standard-Allegation of Abuse Resident Behavior and Administration Corrective Action Steps: 1) Staff member accused of abuse was suspended immediately at 2:40 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible DON. 2) Second staff member accused of abuse was also suspended pending investigation at 5:05 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 3) Resident #2 was interviewed on 10/17/2014 by RNC with (MDS Coordinator) witness. Interview completed by Officer .Hearne Police Department at 2:55 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 4) Allegation of Abuse reported to Department of Aging Disability Services by the Administrator at 4:44 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible Administrator. 5) Facility staff in the building in-serviced on abuse and neglect at 5:10 PM. Staff not currently in facility will be in-serviced before returning to duty. Date started 10/17/2014. Target Date 10/18/2014. Staff Responsible DON. 6) Medical Director .notified of Immediate Jeopardy at 4:12 PM by RNC. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 7) Interviewable Residents will be interviewed regarding allegations of abuse or neglect. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RVP. 8) Administrator is suspended pending investigation as of 4:55 PM. RNC is point of contact for DADS until RVP arrives. RVP will be abuse prevention coordinator until investigation completed. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RVP. 9) QA&A Committee will review abuse allegations quarterly until such time as the Administrator determines that substantial compliance has been met. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible Administrator. Monitoring of the Plan of Removal was conducted by the Survey Team between 10/17/2014 and 10/18/2014. *Resident #2's allegation of abuse was addressed by the Corporate Staff, an investigation was started and it was called to the State certification and survey agency. *Resident #14's allegation of abuse was addressed by the Corporate Staff, an investigation was started and it was called to the State certification and survey agency. *Staff accused were suspended. * In-services had begun with approximately 70 percent of the staff trained by 10/18/2014 and employees not in-serviced will be in-serviced prior to working. *All in-service documentation was reviewed and attendance checked to ensure all licensed nurses were in-serviced. The facility had over 70% of their staff in-serviced on . *Interviews conducted on 10/18/2014 with licensed nursing staff reflected the nurses knew how to identify signs of abuse, were able to identify types of abuse and reporting procedures. *Interviews conducted on 10/18/2014 with certified nursing aides reflected the CNA's knew how to identify signs of abuse, were able to identify types of abuse and reporting procedures. The RNC was notified on 10/18/2014 at 12:15 PM that the IJ was removed, however, the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. The facility provided CMS 672 reflected a census of 66 Residents.
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure all alleged violations involving mistreatment, neglect, abuse or injuries of an unknown source was reported immediately to other officials in accordance with State law through established procedures (including to the State survey and certification agency) and that all alleged violations were investigated to prevent further potential for abuse for four (4) of 13 residents (Resident #2, #14, #18 and #9) reviewed for abuse/neglect. A) The facility failed to protect Resident #2 from physical abuse when he reported two (2) CNAs (CNA G and CNA K) had abused him by spanking him with their hands and hurt him. Resident #2 notified the Social Worker on 05/21/2014 and stated he had also notified the Administrator and Charge Nurse. Resident #2 stated after telling staff about the CNAs, there was nothing accomplished, the CNAs continued to work with him despite his wishes and they began telling him he was a trouble maker and hard to deal with. Both CNA G and CNA K were at work during the survey until surveyor intervention. The facility failed to conduct a thorough investigation, report the incident to the State survey and certification agency and report their findings accurately to the administrator and the State survey and certification agency. B) Resident #14 stated that two (2) CNA's (CNA O and CNA P) verbally abused him every time they came to work and would seek him out to call him names and make fun of him. Resident #14 stated that he attempted to tell multiple facility staff including the Administrator and no one would listen to him. Resident #14 indicated that the CNAs continued to verbally abuse him and he wanted it to stop and was fearful that they would hit him. Resident #14 stated the verbal abuse has been going on for two (2) months. Both CNA O and CNA P were at work during the survey until surveyor intervention. The facility failed to conduct a thorough investigation, report the incident to the State survey and certification agency and report their findings accurately to the administrator and the State survey and certification agency. C) Resident #18 stated when he was in the van to be transferred to the other facility he fell when he was trying to get out of the van to his knees. He stated he was left on his knees for 30 minutes before the BOM and the Medical Records/Van Driver finally assisted

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) him back to his wheelchair. The facility failed to conduct a thorough investigation, report the incident to the State survey and certification agency and report their findings accurately to the the State survey and certification agency. D) Resident #9 made an allegation that a CNA poured urine on him. The facility failed to conduct a thorough investigation into Resident #9's allegation. An Immediate Jeopardy (IJ) was identified on 10/17/2014 at 2:15 PM. While the IJ was removed on 10/18/2014, the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure affected Resident #2 ,#14, #18 and #9 and could affect the facility's 66 residents by placing them at risk for abuse and/or mistreatment by staff members or agency staff. Findings Include: A) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to require extensive two person assist with bed mobility and personal hygiene. Resident #2 was assessed to be dependent on staff for personal hygiene and bathing. Resident #2 was assessed to not have any psychiatric or mood disorders. Resident #2 was assessed to not have any behavioral symptoms. Review of Resident #2's Comprehensive Care Plan reflected a problem with the onset date of 09/15/2014 I have cognitive loss, which affects my ST/LT (short term and long term) memory and decision making skills. I am at risk for further decline as my disease progresses. Further review of Resident #2's care plan reflected a problem with the onset date of 09/15/2014 I have delusions as evidenced by; Interview on 08/28/2014 by SW (social worker) with mild paranoia and smiling and giggling inappropriately at conversation and secretiveness. Review of Resident #2's physician progress notes [REDACTED]. Review of the list of interviewable Residents in the facility provided by the facility on 10/14/2014 reflected Resident #2 was interviewable. Observation on 10/16/2014 at 4:10 PM revealed Resident #2 was an obese male who was in bed on his back. Resident #2 had oxygen on at 3 liters per nasal canula. Resident #2 was alert. In an interview on 10/16/2014 at 4:15 PM Resident #2 stated CNA G spanked him with her hands a while back. Resident #2 stated there were two (2) CNAs present and did not know the other CNAs name but gave a physical description. Resident #2 stated the event occurred between April and September, before he went to the hospital. Resident #2 stated the aides were rough with me. Resident #2 stated he told the CNAs they were hurting him. Resident #2 stated the aides replied back you are a big man, what do you expect us to do about that. Resident #2 stated when the CNAs spanked him that he asked them to stop and the aides replied He likes it. Resident #2 stated I told the Administrator, the Charge Nurse LVN B, and the Social Worker and they told me I was out of it and did not believe it. They treat me like I am confused. Resident #2 stated the CNAs continue to work with him and they are rough and he does not like it. Resident #2 stated the CNAs have been calling him a trouble maker and hard to deal with. Resident #2 further stated he feels like the CNAs throw him and he is fearful, like he is going to fall out of the bed. Review of Resident #2's Social Service Progress Note dated 05/21/2014 no time reflected reported that he was spanked by CNAs last week and had given the details to the Administrator. Possible delusional thought content. SW (Social Worker) notified DON and Administrator of resident's allegation this AM. In an interview on 10/17/2014 at 5:05 PM the SW stated when Resident #2 is speaking and doesn't seem to be engaged that he is delusional. The SW stated that was the definition of delusional. (The definition of delusional: A false belief or opinion. Psychiatry A false belief strongly held in spite of invalidating evidence, especially as a symptom of mental illness:http://dictionary.reference.com/browse/delusional) Review of Resident #2's Social Service Progress Note dated 06/11/2014 no time reflected Resident continues to talking about delusional thought content about being spanked as well. In an interview on 10/16/2014 at 6:30 PM LVN B stated she was aware of an incident in which Resident #2 stated he was spanked. LVN B stated she reported it to the Administrator. In an interview on 10/17/2014 at 9:20 AM CNA G when asked if she had ever had any problems with Resident #2, stated that Resident #2 did not want her to check on him. CNA G further stated she recalled an incident were Resident #2 accused her of abuse. CNA G stated she was patting Resident #2; CNA G was making repetitive inward motions with her hands; to keep him on his side. CNA G further stated the Administrator talked to her about the incident and told her not to do that anymore. CNA G stated he is trying to get people in trouble referring to Resident #2. CNA G stated she has continued to worked with Resident #2 after the Administrator talked to her. In an interview on 10/17/2014 at 11:07 AM the SW stated that Resident #2 had complained to her about being spanked. SW could not give a date but stated she gave it to the Administrator to follow up on for potential abuse. The SW stated Resident #2 told her he did not want it to happen again. 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The Administrator stated he did not investigate the incident. The Administrator stated Resident #2 had told him he wanted to be spanked and the Administrator stated he did not feel it was abuse. In an interview on 10/17/2014 at 11:35 AM the DON, who was with the Administrator during the above interview, stated she recalled hearing about a report that Resident #2 had wanted to be spanked but she could not remember what was done. The DON stated possibly a psych eval. Review of Resident #2's Medical Record reflected no psych evaluation was conducted regarding behaviors. Review of Resident #2's Comprehensive Care Plan did not reflect a care plan for sexually inappropriate behavior. In an interview on 10/17/2014 at 1:00 PM the Administrator stated again that no one had reported any allegation of abuse to him regarding Resident #2. The Administrator stated he might have talked with an aide he could not remember. The Administrator further stated Resident #2 wanted to be spanked. 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In an interview on 10/17/2014 at 4:50 PM CNA K stated she was with CNA G providing care for Resident #2 when the incident occurred. CNA K stated CNA G was pushing Resident #2 to his side using both hands. CNA K indicated that CNA G's hands left and regained contact with Resident #2 multiple times. CNA K stated she did not feel like CNA G was spanking Resident #2 but trying to hold him over. CNA K stated he's big and he is hard to take care of. In an interview on 10/17/2014 at 5:30 PM the RNC stated the facility contacted the police department and a officer came to speck with Resident #2. The RNC stated Resident #2 repeated the allegation and named CNA G as the person who assaulted him and another unknown female. Review of the Police Department report dated 10/17/2014 at 4:40 PM reflected Resident #2 advised two b/f (black females) nurses spanked him on his bottom. Resident advised the incident happened two (2) months ago. Resident #2 advised the pain was a 7 or 8 pain ranging from 1-10 with 10 being the highest. Resident #2 advised he felt kind of abused.Resident #2 advised one of the females nurses who assaulted him was named CNA G.Resident #2 did not know the other aide's name. B) Review of Resident #14's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #14's Admission MDS dated [DATE] reflected Resident #14 was assessed to not have long or short term memory problems and was assessed to require modified independence in decision making. Resident #14 was assessed to recall, location of room, staff names and faces, and that he is in a nursing. Resident #14 was assessed to have no speech (absence of spoken words), and usually understood and usually understands. Resident #14 was assessed to not have behavior problems or resist care. Resident #14 was assessed to require limited to extensive assist with ADL's and was assessed to be occasionally incontinent. Review of Resident #14's Comprehensive Care Plan reflected a problem with the start date 09/04/2014 which reflected I have a communication deficit related [MEDICAL CONDITION]. I need to use writing material to be able to communicate at times. Approaches listed included: Reassurance and patience when I attempt to communicate, Use gentle, relaxed tone of voice. Resident #14's care plan did not address a cognitive impairment, or behavior problems. Review of Resident #14's History and Physical dated 09/03/2014 reflected Resident #14 was oriented to person, oriented to place, oriented to time, affect appropriate, mood appropriate, is cooperative with care. Review of Resident #14's Admission

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	675062	A. BUILDING _____ B. WING _____	10/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARNE HEALTHCARE CENTER	1101 W BROWN ST HEARNE, TX 77859

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 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 6) assessment dated [DATE] reflected Resident #14 was assessed to be alert without memory problems and exhibited no behavior problems. Review of the list of interviewable Residents in the facility provided by the facility on 10/14/2014 reflected Resident #14 was interviewable. Observation on 10/15/2014 at 12:10 PM revealed Resident #14 self propelled in a wheel chair and entered the facility library where the surveyors were working. Resident #14 was visibly upset and asked to talk with the surveyors. Resident #14 was unable to talk related to [MEDICAL CONDITION] but was able to communicate with slight whispering and by lip reading. Resident #14 was asked if he would like a pen an paper so he could write down what he wanted to tell the surveyors. Resident #14 mouthed, no and pointed to his right hand (which was paralyzed) and mouthed he could not write. Resident #14 stated CNA O and CNA P (Resident #14 gave descriptions of the CNAs and first names) talk bad to him and call him names. Resident #14 stated they call him a motherf***** and call him other names and make fun of him when he can't do things for himself. Resident #14 stated the CNAs seek him out and pick on him calling him names. Resident #14 stated it happens every time the CNAs work. Resident #14 stated it has been going on for two (2) months. Resident #14 stated I tell them to go away and they come back. Resident #14 stated she won't stop. Resident #14 stated he feels threatened when they come to him. Resident #14 stated the CNAs have not hit him but stated I feel like she will hit me. Resident #14 stated he was scared that things were going to get worse. Resident #14 stated he has told several people about the CNAs and they do not listen to him. Resident #14 stated he has told Administrator but he did not listen to him. Resident #14 stated the Administrator acted like he did not understand Resident #14 when he tried to tell he about the CNAs mistreatment. In an interview on 10/15/2014 at 1:00 PM the Administrator stated he was not aware of any verbal abuse toward Resident #14 and nothing had been reported to him. After surveyor informed the Administrator of Resident #14's allegations of verbal abuse from CNA O and CNA P he stated okay. Attempts made to contact CNA O and CNA P were unsuccessful. CNA O and CNA P provided the Administrator written statements which were provided to surveyors at exit. Review of CNA P's written statement dated 10/15/2014 (no time) reflected I have never cursed at Resident #14. The only conflict was in the dining room. Resident #13 gave him his regular tray. I reported to charge nurse.He started cursing at me. Calling me bitc*** and motherf****** and pointing his finger in my face. Review of CNA O's written statement which was dated 10/10/2014 (no time) .today is the first day I have ever heard that Resident #14 has accused me of cussing at or in front of him. If I work on Hall 2, I always have another nurse aide or nurse go with me when I take care of him because staff that have worked here before told me that he will lie on you and get you in trouble. Resident #14 tend to get very upset over little things an then will lie on anyone when he can't get what he wants. Resident #14 always cussing towards me an other staff we are the one being abused by him. Review of an interview conducted by the Social Worker on 10/15/2014 reflected Resident #14 was interviewed in presence of Police.Resident reports these ladies (referring to CNA O and CNA P) have been insulting before today.then elaborated that it was a problem before this month. He later indicated it has been going on for two (2) months. When asked what has been going on, resident stated these aides call me names.all kind of names.and stated he got mad because they were calling him names yesterday. In an interview on 10/15/2014 at 2:00 PM the Police Officer stated Resident # 14 had advised him two aides had called him names including mother******. The Police Officer stated this was not a criminal offense. In an interview on 10/15/2014 at 5:00 PM the Administrator stated he suspended CNA O and CNA P pending results of the investigation he was conducting into Resident #14's allegations. In an interview on 10/16/2014 at 12:30 AM LVN G stated, when asked if Resident #14 had reported any complaints, It is hard to understand what he says, so I don't know what he is saying. In an interview on 10/16/2014 at 1:30 PM Resident #30 stated he is Resident #14's roommate. Resident #30 stated the aides pull the curtain when they are providing care to Resident #14 but he can hear them arguing with Resident #14. Resident #30 could not identify which aides argue with Resident #14. In an interview on 10/16/2014 at 5:30 PM Resident #13 (who's room is down the hall from Resident #14) stated he hears the aides screaming at people all the time. Resident #13 stated he can't make out what they say. Resident #14 stated the aides scream at him. Resident #13 stated he did not want to pursue it because it will do no good. In an interview on 10/17/2014 at 11:00 AM Resident #14 stated he wanted to know what was going on. Resident #14 wanted to know why CNA O and CNA P were at the facility. Resident #14 stated he saw the CNAs in the building. Resident #14 was visibly upset by seeing the CNAs. In an interview on 10/17/2014 at 11:25 PM the Administrator stated he could not find any evidence to support Resident #14 was abused, verbally so he let the CNAs come back to work. The Administrator stated both CNAs denied verbally abusing or calling Resident #14 names. The surveyor then asked to see the Administrators investigation report. The Administrator stated he was not completed with the investigation report. The surveyor then asked if he was not completed with the investigation then why were the CNAs allowed to come back to work. The Administrator stated he would get all his notes and give them to the surveyor. The facility did not provide a completed investigation report on 10/17/2014. In an interview on 10/17/2014 at 4:55 PM the RNC stated the Administrator had been suspended and Resident #14's investigation was reopened and CNA O and CNA P were suspended until the facility investigation could be completed. C) Review of the Face Sheet for Resident #18 reflected a [AGE] year old male admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of the Admission MDS assessment dated [DATE] for Resident #18 reflected an entry date of 05/29/2014. Resident #18's BIMS score was 14 indicating cognitively intact. Resident #18 was coded with disorganized thinking, delusions, and that he rejected care four to six days of the assessment period. Resident #18 required extensive assistance with transfers and locomotion off the unit but only supervision for locomotion while on the unit. Resident #18 had no history of falls or any falls since admission. Review of the MDS Assessment-Discharge-return not anticipated for Resident #18 dated 08/29/2014 reflected no BIMS score, but reflected Resident #18 had a memory problem under short term memory. Resident #18 was coded to have severe impairment under cognitive skills for daily decision making. Resident #18 was also coded to have disorganized thinking continuously. Resident #18 was assessed with [REDACTED]. Resident #18 also rejected care one to three days during this assessment period. Resident #18 required extensive assistance for transfers but was independent for locomotion on and off the unit. Resident #18 was coded as having one fall since admission with an injury that was not major. In an interview on 10/20/2014 at 1:28 PM Resident #18 stated when he was in the van to be transferred to the other facility he fell when he was trying to get out of the van to his knees. He stated he was left on his knees for 30 minutes before the BOM and the Medical Records/Van Driver finally assisted him back to his wheelchair. Review of the facility's Incident/Accident binder for the month of September 2014 revealed no incident or accident report for Resident #18's fall. Review of the facility's Progress Notes for Resident #18 dated 08/29/2014 reflected no information about a fall. The Notes reflected Resident #18 said he agreed to get on van to go to (other) facility .Pt. (patient) was transferred safely via van. In an interview on 10/20/2014 at 1:50 PM Medical Records/Van Driver stated she was outside of the van loading his belongings when Resident #18 lunged forward in the van. She stated an Agency Nurse was in the van with Resident #18. She stated she did not remember the name of the nurse. The Medical Records/Van Driver stated Resident #18 had told her he would take the keys away or he would wreck the van along the way so the BOM also rode in the van with them. In an interview on 10/20/2014 at 2:00 PM the BOM stated she saw Resident #18 get up from his wheelchair to transfer to a seat in the van and fell to his knees. She stated she told Resident #18 he needed to stay in his wheelchair seat and belted in with the seatbelt. In an interview on 10/20/2014 at 2:20 PM the RNC stated the Administrator was to call corporate on all incidents/accidents that were reportable. The RNC stated he did not recall this incident being reported to him. In an interview on 10/20/2014 at 4:00 PM the VP Clinical Services stated she does not recall the incident or accident on Resident #18 and she would be the one the Administrator would call to find out if the incident was reportable. The VP Clinical Services stated she could not find the investigation of the incident with Resident #18. Review of the facility's policy entitled Accidents/Incidents System revised 08/23/2010 reflected An Accident/Incident Report must be completed immediately upon Facility Staff becoming aware of the incident involving a Resident.An assessment must be performed at the time of the accident/incident and findings documented.An Accident/Incident Investigation must be completed in addition to the Accident/Incident report when staff discovers.any falls.The Director of Nursing Services completes the Conclusion and Intervention form when the investigation has been completed.Accidents/Incidents must be reported both internally and externally in accordance with the State and Federal Guidelines.The Regional Nurse Consultant and the Regional Vice President must be notified. D) Review of the Face Sheet for Resident #9 reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of Resident #9's Quarterly Minimum Data Set ((MDS) dated [DATE] reflected he had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition. His behavior indicators were daily verbal threatening, screaming and cursing along with behavior symptoms not directed toward others such as throwing food. He was scored as rejecting care daily. Additional [DIAGNOSES REDACTED]. Review of the Provider Investigation Report Intake # 1 reflected the facility reported an incident on 09/21/2014 at 10:40 AM that occurred on 09/21/2014 at 10:10 AM. The provider reported Resident #9 has made many allegations when angry. Resident #9 called 911 to report the incident. Resident #9

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 7) complained that She poured pi** all over him. He further stated it was last night (09/20/2014) and the pi** caused him to have sores on his head. A head to toe skin assessment was performed while the police were at the facility and no sores were found, no injuries. A statement was obtained from the alleged perpetrator. The report stated Resident #9 named his alleged perpetrator by name and the alleged perpetrator denied the event occurred. Resident #9's Responsible Party was contacted and informed and the Responsible Party requested the Resident be sent out for a complete psychological care because he makes these things up all the time and has for years. The report stated the nurse aide was suspended pending Investigation and that the alleged perpetrator did not work the night of the alleged abuse. Review of the statement from the alleged perpetrator reflected that on Thursday, 18, 2014 Resident #9 turned on his call light and said he needed to be cleaned. He insulted CNA and she told him her name and proceeded to care for him. According to CNA N's witness statement, during that interaction between Resident #9 and CNA N, Resident #9 complained that she had poured urine on him. She stated she informed the charge nurse and had a co-worker accompany her to the room. Review of the Incident Investigation of Incident completed and signed by the LVN F reflected nine (9) staff names of employees/caregivers that had worked in the past 24 hours prior to the complaint of abuse to the police department. There were no statements from any of these potential witness employees. LVN F recorded the incident occurred on 09/20/2014 on 10-6 shift the shift prior to Resident #9's allegation of abuse. There were no interviews or statements from other residents. In an interview on 10/16/2014 at approximately 4:00 PM the Administrator stated he had no further written statements to give to this Surveyor other than the statement from the alleged perpetrator. He stated the packet was complete as given to Surveyor. Review of the Provider Investigation Report Intake # 1 reflected the Facility Investigation findings were that the alleged abuse was unconfirmed and the Provider Action Taken Post-Investigation was that Resident #9 was frequently noncompliant with patient care, refuses assessment by mental health professionals. Nurse Aide will not be working with resident, in-service on abuse and neglect complete. No signs of indications that this allegation is founded and no further issues noted at this time. The document was signed by the Administrator. In an interview on 10/17/2014 at 6:00 PM the RNC stated all allegations of abuse must be handled seriously and investigated. Review of the facility's policy Abuse Prevention Program dated 05/20/2014 reflected Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion .Abuse Investigation Protocol: All reports of resident abuse, neglect injuries of an unknown source .are promptly and thoroughly investigated by facility management .The individual conducting the investigation will as a minimum: e. Interview the persons reporting the incident; f. Interview any witness to the incident; g. Interview the resident; m. Interview other residents to whom the accused employee provides care and services to determine if they have complaints about the employee; o. Review all events preceding the alleged incident .9. Employees of this facility who have been accused of resident abuse will be suspended until the investigation has been completed. Preventing Resident Abuse: Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse . q. Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately. Reporting Abuse to Facility Management: 2. all reports of abuse, including anonymous reports, are promptly investigated. 7. a. Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being .15. Any person who has knowledge or reason to believe that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense SHALL report, or cause a report to be made of , the mistreatment or offense. Failure to report such an incident may result in legal/ criminal action being filed against the individual(s) withholding such information. The facility Administrator was notified on 10/17/2014 at 2:15 PM that an IJ situation had been identified due to above failures. The first Plan of Removal was submitted by the RNC on 10/17/2014 at 5:20 PM. The final Plan of Removal was accepted by the survey team on 10/17/2014 at 5:34 PM. Immediate Jeopardy Plan of Removal Variance to Standard-Allegation of Abuse Resident Behavior and Administration Corrective Action Steps: 1) Staff member accused of abuse was suspended immediately at 2:40 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible DON. 2) Second staff member accused of abuse was also suspended pending investigation at 5:05 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 3) Resident #2 was interviewed on 10/17/2014 by RNC with (MDS Coordinator) witness. Interview completed by Officer .Hearne Police Department at 2:55 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 4) Allegation of Abuse reported to Department of Aging Disability Services by the Administrator at 4:44 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible Administrator. 5) Facility staff in the building in-serviced on abuse and neglect at 5:10 PM. Staff not currently in facility will be in-serviced before returning to duty. Date started 10/17/2014. Target Date 10/18/2014. Staff Responsible DON. 6) Medical Director .notified of Immediate Jeopardy at 4:12 PM by RNC. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 7) Interviewable Residents will be interviewed regarding allegations of abuse or neglect. Date started 10/17/2014. Target Date 10/17/2014. Staff
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed implement written policies and procedures that prohibit mistreatment, neglect and abuse (including injuries of unknown origin) for four (4) of 13 residents (Resident #2, #14, #18 and #9) reviewed for abuse/neglect. A) The facility failed to protect Resident #2 from physical abuse when he reported two (2) CNAs (CNA G and CNA K) had abused him by spanking him with their hands and hurt him. The CNAs continued to work with him despite his wishes and they began telling him he was a trouble maker and hard to deal with. Both CNA G and CNA K were at work during the survey until surveyor intervention. The facility failed to conduct a thorough investigation, report the incident to the State survey and certification agency and report their findings accurately to the administrator and the State survey and certification agency. B) The facility failed to protect Resident #14 from verbal abuse when he reported that two (2) CNA's (CNA O and CNA P) verbally abused him every time they came to work and would seek him out to call him names and make fun of him. Both CNA O and CNA P were at work during the survey until surveyor intervention. The facility failed to conduct a thorough investigation, report the incident to the State survey and certification agency and report their findings accurately to the administrator and the State survey and certification agency. C) Resident #18 stated when he was in the van to be transferred to the other facility he fell when he was trying to get out of the van to his knees. He stated he was left on his knees for 30 minutes before the BOM and the Medical Records/Van Driver finally assisted him back to his wheelchair. The facility failed to conduct a thorough investigation, report the incident to the State survey and certification agency and report their findings accurately to the administrator and the State survey and certification agency. D) Resident #9 made an allegation that a CNA poured urine on him. The facility failed to conduct a thorough investigation into Resident #9's allegation. An Immediate Jeopardy (IJ) was identified on 10/17/2014 at 2:15 PM. While the IJ was removed on 10/18/2014, the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure affected Resident #2 ,#14, #18 and #9 and could affect the facility's 66 residents by placing them at risk for abuse and/or mistreatment by staff members or agency staff. Findings Include: Review of the facility's policy Abuse Prevention Program dated 05/20/2014 reflected Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion .Abuse Investigation Protocol: All reports of resident abuse, neglect injuries of an unknown source .are promptly and thoroughly investigated by facility management .The individual conducting the investigation will as a minimum: e. Interview the persons reporting the incident; f. Interview any witness to the incident; g. Interview the resident; m. Interview other residents to whom the accused employee provides care and services to determine if they have complaints about the employee; o. Review all events preceding the alleged incident .9. Employees of this facility who have been accused of resident abuse will be suspended until the investigation has been completed. Preventing Resident Abuse: Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse . q. Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately. Reporting Abuse to Facility Management: 2. all reports of abuse, including anonymous reports, are promptly investigated. 7. a. Abuse is defined as the willful infliction of injury;

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 8) unreasonable confinement; intimidation; punishment with resulting physical harm, pain or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being .15. Any person who has knowledge or reason to believe that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense SHALL report, or cause a report to be made of , the mistreatment or offense. Failure to report such an incident may result in legal/ criminal action being filed against the individual(s) withholding such information. A) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to require extensive two person assist with bed mobility and personal hygiene. Resident #2 was assessed to be dependent on staff for personal hygiene and bathing. Resident #2 was assessed to not have any psychiatric or mood disorders. Resident #2 was assessed to not have any behavioral symptoms. Review of Resident #2's Comprehensive Care Plan reflected a problem with the onset date of 09/15/2014 I have cognitive loss, which affects my ST/LT (short term and long term) memory and decision making skills. I am at risk for further decline as my disease progresses. Further review of Resident #2's care plan reflected a problem with the onset date of 09/15/2014 I have delusions as evidenced by; Interview on 08/28/2014 by SW (social worker) with mild paranoia and smiling and giggling inappropriately at conversation and secretiveness. Review of Resident #2's physician progress notes [REDACTED]. Review of the list of interviewable Residents in the facility provided by the facility on 10/14/2014 reflected Resident #2 was interviewable. Observation on 10/16/2014 at 4:10 PM revealed Resident #2 was an obese male who was in bed on his back. Resident #2 had oxygen on at 3 liters per nasal canula. Resident #2 was alert. In an interview on 10/16/2014 at 4:15 PM Resident #2 stated CNA G spanked him with her hands a while back. Resident #2 stated there were two (2) CNAs present and did not know the other CNAs name but gave a physical description. Resident #2 stated the event occurred between April and September, before he went to the hospital. Resident #2 stated the aides were rough with me. Resident #2 stated he told the CNAs they were hurting him. Resident #2 stated the aides replied back you are a big man, what do you expect us to do about that. Resident #2 stated when the CNAs spanked him that he asked them to stop and the aides replied He likes it. Resident #2 stated I told the Administrator, the Charge Nurse LVN B, and the Social Worker and they told me I was out of it and did not believe it. They treat me like I am confused. Resident #2 stated the CNAs continue to work with him and they are rough and he does not like it. Resident #2 stated the CNAs have been calling him a trouble maker and hard to deal with. Resident #2 further stated he feels like the CNAs throw him and he is fearful, like he is going to fall out of the bed. Review of Resident #2's Social Service Progress Note dated 05/21/2014 no time reflected reported that he was spanked by CNAs last week and had given the details to the Administrator. Possible delusional thought content. SW (Social Worker) notified DON and Administrator of resident's allegation this AM. In an interview on 10/17/2014 at 5:05 PM the SW stated when Resident #2 is speaking and doesn't seem to be engaged that he is delusional. The SW stated that was the definition of delusional. (The definition of delusional: A false belief or opinion. Psychiatry A false belief strongly held in spite of invalidating evidence, especially as a symptom of mental illness:http://dictionary.reference.com/browse/delusional) Review of Resident #2's Social Service Progress Note dated 06/11/2014 no time reflected Resident continues to talking about delusional thought content about being spanked as well. In an interview on 10/16/2014 at 6:30 PM LVN B stated she was aware of an incident in which Resident #2 stated he was spanked. LVN B stated she reported it to the Administrator. In an interview on 10/17/2014 at 9:20 AM CNA G when asked if she had ever had any problems with Resident #2, stated that Resident #2 did not want her to check on him. CNA G further stated she recalled an incident were Resident #2 accused her of abuse. CNA G stated she was patting Resident #2; CNA G was making repetitive inward motions with her hands; to keep him on his side. CNA G further stated the Administrator talked to her about the incident and told her not to do that anymore. CNA G stated he is trying to get people in trouble referring to Resident #2. CNA G stated she has continued to worked with Resident #2 after the Administrator talked to her. In an interview on 10/17/2014 at 11:07 AM the SW stated that Resident #2 had complained to her about being spanked. SW could not give a date but stated she gave it to the Administrator to follow up on for potential abuse. The SW stated Resident #2 told her he did not want it to happen again. In an interview on 10/17/2014 at 11:20 AM Resident #2 stated he felt abused when CNA G and the other aide were hitting him. Resident #2 stated he told her to stop and he did not want them to take care of him and was fearful they would hurt him. Resident #2 further stated I try to be nice so they won't be mean to me. I laugh and joke, that way they will take care of me. I can't take care of myself. In an interview on 10/17/2014 at 11:25 AM when asked if Resident #2 had advised him of any abuse, the Administrator stated no. When asked if the Charge Nurses had advised him Resident #2 had been abused or spanked, the Administrator stated no. When asked if the Social Worker had advised him Resident #2 had been abused or spanked, the Administrator stated no. Surveyor asked the Administrator if he had talked to a CNA regarding an allegation that Resident #2 stated he was spanked by CNAs, Administrator stated there was a spanking incident but he had not been advised it was abuse. The Administrator stated Resident #2 had told him he wanted to be spanked and the Administrator stated he did not feel it was abuse. In an interview on 10/17/2014 at 11:35 AM the DON, who was with the Administrator during the above interview, stated she recalled hearing about a report that Resident #2 had wanted to be spanked but she could not remember what was done. The DON stated possibly a psych eval. Review of Resident #2's Medical Record reflected no psych evaluation was conducted regarding behaviors. Review of Resident #2's Comprehensive Care Plan did not reflect a care plan for sexually inappropriate behavior. In an interview on 10/17/2014 at 1:00 PM the Administrator stated again that no one had reported any allegation of abuse to him regarding Resident #2. The Administrator stated he might have talked with an aide he could not remember. The Administrator further stated Resident #2 wanted to be spanked. In an interview on 10/17/2014 at 2:00 PM CNA H stated Resident #2 had never been inappropriate with her and stated no he has never asked me to spank him. In an interview on 10/17/2014 at 2:02 PM CNA I stated that Resident #2 had never been inappropriate and further stated he has never asked to be spanked. CNA I stated she was told by Resident #2 that CNAs had spanked him but he would not tell her who. CNA I stated she told him to report the incident and Resident #2 told her he had already reported it. CNA I stated Resident #2 told her that when he reported it they made him feel uncomfortable. In an interview on 10/17/2014 at 2:10 PM CNA J stated Resident #2 had never been inappropriate with her and never asked her to spank him. CNA J asked someone thinks that about him? In an interview on 10/17/2014 at 2:15 PM LVN B stated regarding Resident #2 No he has never asked me to spank him. In an interview on 10/17/2014 at 4:50 PM CNA K stated she was with CNA G providing care for Resident #2 when the incident occurred. CNA K stated CNA G was pushing Resident #2 to his side using both hands. CNA K indicated that CNA G's hands left and regained contact with Resident #2 multiple times. CNA K stated she did not feel like CNA G was spanking Resident #2 but trying to hold him over. CNA K stated he's big and he is hard to take care of. In an interview on 10/17/2014 at 5:30 PM the RNC stated the facility contacted the police department and a officer came to speak with Resident #2. The RNC stated Resident #2 repeated the allegation and named CNA G as the person who assaulted him and another unknown female. Review of the Police Department report dated 10/17/2014 at 4:40 PM reflected Resident #2 advised two b/f (black females) nurses spanked him on his bottom. Resident advised the incident happened two (2) months ago. Resident #2 advised the pain was a 7 or 8 pain ranging from 1-10 with 10 being the highest. Resident #2 advised he felt kind of abused.Resident #2 advised one of the females nurses who assaulted him was named CNA G.Resident #2 did not know the other aide's name. B) Review of Resident #14's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #14's Admission MDS dated [DATE] reflected Resident #14 was assessed to not have long or short term memory problems and was assessed to require modified independence in decision making. Resident #14 was assessed to recall, location of room, staff names and faces, and that he is in a nursing. Resident #14 was assessed to have no speech (absence of spoken words), and usually understood and usually understands. Resident #14 was assessed to not have behavior problems or resist care. Resident #14 was assessed to require limited to extensive assist with ADL's and was assessed to be occasionally incontinent. Review of Resident #14's Comprehensive Care Plan reflected a problem with the start date 09/04/2014 which reflected I have a communication deficit related [MEDICAL CONDITION]. I need to use writing material to be able to communicate at times. Approaches listed included: Reassurance and patience when I attempt to communicate, Use gentle, relaxed tone of voice. Resident #14's care plan did not address a cognitive impairment, or behavior problems. Review of Resident #14's History and Physical dated 09/03/2014 reflected Resident #14 was oriented to person, oriented to place, oriented to time, affect appropriate, mood appropriate, is cooperative with care. Review of Resident #14's Admission assessment dated [DATE] reflected Resident #14 was assessed to be alert without memory problems and exhibited no behavior problems. Review of the list of interviewable Residents in the facility provided by the facility on 10/14/2014 reflected Resident #14 was interviewable. Observation on 10/15/2014 at 12:10 PM revealed Resident #14 self

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HEARNE HEALTHCARE CENTER	1101 W BROWN ST HEARNE, TX 77859

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 9) propelled in a wheel chair and entered the facility library where the surveyors were working. Resident #14 was visibly upset and asked to talk with the surveyors. Resident #14 was unable to talk related to [MEDICAL CONDITION] but was able to communicate with slight whispering and by lip reading. Resident #14 was asked if he would like a pen an paper so he could write down what he wanted to tell the surveyors. Resident #14 mouthed, no and pointed to his right hand (which was paralyzed) and mouthed he could not write. Resident #14 stated CNA O and CNA P (Resident #14 gave descriptions of the CNAs and first names) talk bad to him and call him names. Resident #14 stated they call him a motherf***** and call him other names and make fun of him when he can't do things for himself. Resident #14 stated the CNAs seek him out and pick on him calling him names. Resident #14 stated it happens every time the CNAs work. Resident #14 stated it has been going on for two (2) months. Resident #14 stated I tell them to go away and they come back. Resident #14 stated she won't stop. Resident #14 stated he feels threatened when they come to him. Resident #14 stated the CNAs have not hit him but stated I feel like she will hit me. Resident #14 stated he was scared that things were going to get worse. Resident #14 stated he has told several people about the CNAs and they do not listen to him. Resident #14 stated he has told Administrator but he did not listen to him. Resident #14 stated the Administrator acted like he did not understand Resident #14 when he tried to tell he about the CNAs mistreatment. In an interview on 10/15/2014 at 1:00 PM the Administrator stated he was not aware of any verbal abuse toward Resident #14 and nothing had been reported to him. After surveyor informed the Administrator of Resident #14's allegations of verbal abuse from CNA O and CNA P he stated okay. Attempts made to contact CNA O and CNA P were unsuccessful. CNA O and CNA P provided the Administrator written statements which were provided to surveyors at exit. Review of CNA P's written statement dated 10/15/2014 (no time) reflected I have never cursed at Resident #14. The only conflict was in the dining room. Resident #13 gave him his regular tray. I reported to charge nurse.He started cursing at me. Calling me bitc*** and motherf****** and pointing his finger in my face. Review of CNA O's written statement which was dated 10/10/2014 (no time) .today is the first day I have ever heard that Resident #14 has accused me of cussing at or in front of him. If I work on Hall 2, I always have another nurse aide or nurse go with me when I take care of him because staff that have worked here before told me that he will lie on you and get you in trouble. Resident #14 tend to get very upset over little things an then will lie on anyone when he can't get what he wants. Resident #14 always cussing towards me an other staff we are the one being abused by him. Review of an interview conducted by the Social Worker on 10/15/2014 reflected Resident #14 was interviewed in presence of Police.Resident reports these ladies (referring to CNA O and CNA P) have been insulting before today.then elaborated that it was a problem before this month. He later indicated it has been going on for two (2) months. When asked what has been going on, resident stated these aides call me names.all kind of names.and stated he got mad because they were calling him names yesterday. In an interview on 10/15/2014 at 2:00 PM the Police Officer stated Resident # 14 had advised him two aides had called him names including mother******. The Police Officer stated this was not a criminal offense. In an interview on 10/15/2014 at 5:00 PM the Administrator stated he suspended CNA O and CNA P pending results of the investigation he was conducting into Resident #14's allegations. In an interview on 10/16/2014 at 12:30 AM LVN G stated, when asked if Resident #14 had reported any complaints, It is hard to understand what he says, so I don't know what he is saying. In an interview on 10/16/2014 at 1:30 PM Resident #30 stated he is Resident #14's roommate. Resident #30 stated the aides pull the curtain when they are providing care to Resident #14 but he can hear them arguing with Resident #14. Resident #30 could not identify which aides argue with Resident #14. In an interview on 10/16/2014 at 5:30 PM Resident #13 (who's room is down the hall from Resident #14) stated he hears the aides screaming at people all the time. Resident #13 stated he can't make out what they say. Resident #14 stated the aides scream at him. Resident #13 stated he did not want to pursue it because it will do no good. In an interview on 10/17/2014 at 11:00 AM Resident #14 stated he wanted to know what was going on. Resident #14 wanted to know why CNA O and CNA P were at the facility. Resident #14 stated he saw the CNAs in the building. Resident #14 was visibly upset by seeing the CNAs. In an interview on 10/17/2014 at 11:25 PM the Administrator stated he could not find any evidence to support Resident #14 was abused, verbally so he let the CNAs come back to work. The Administrator stated both CNAs denied verbally abusing or calling Resident #14 names. The surveyor then asked to see the Administrators investigation report. The Administrator stated he was not completed with the investigation report. The surveyor then asked if he was not completed with the investigation then why were the CNAs allowed to come back to work. The Administrator stated he would get all his notes and give them to the surveyor. The facility did not provide a completed investigation report on 10/17/2014. In an interview on 10/17/2014 at 4:55 PM the RNC stated the Administrator had been suspended and Resident #14's investigation was reopened and CNA O and CNA P were suspended until the facility investigation could be completed. C) Review of the Face Sheet for Resident #18 reflected a [AGE] year old male admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of the Admission MDS assessment dated [DATE] for Resident #18 reflected an entry date of 05/29/2014. Resident #18's BIMS score was 14 indicating cognitively intact. Resident #18 was coded with disorganized thinking, delusions, and that he rejected care four to six days of the assessment period. Resident #18 required extensive assistance with transfers and locomotion off the unit but only supervision for locomotion while on the unit. Resident #18 had no history of falls or any falls since admission. Review of the MDS Assessment-Discharge-return not anticipated for Resident #18 dated 08/29/2014 reflected no BIMS score, but reflected Resident #18 had a memory problem under short term memory. Resident #18 was coded to have severe impairment under cognitive skills for daily decision making. Resident #18 was also coded to have disorganized thinking continuously. Resident #18 was assessed with [REDACTED]. Resident #18 also rejected care one to three days during this assessment period. Resident #18 required extensive assistance for transfers but was independent for locomotion on and off the unit. Resident #18 was coded as having one fall since admission with an injury that was not major. In an interview on 10/20/2014 at 1:28 PM Resident #18 stated when he was in the van to be transferred to the other facility he fell when he was trying to get out of the van to his knees. He stated he was left on his knees for 30 minutes before the BOM and the Medical Records/Van Driver finally assisted him back to his wheelchair. Review of the facility's Incident/Accident binder for the month of September 2014 revealed no incident or accident report for Resident #18's fall. Review of the facility's Progress Notes for Resident #18 dated 08/29/2014 reflected no information about a fall. The Notes reflected Resident #18 said he agreed to get on van to go to (other) facility .Pt. (patient) was transferred safely via van. In an interview on 10/20/2014 at 1:50 PM Medical Records/Van Driver stated she was outside of the van loading his belongings when Resident #18 lunged forward in the van. She stated an Agency Nurse was in the van with Resident #18. She stated she did not remember the name of the nurse. The Medical Records/Van Driver stated Resident #18 had told her he would take the keys away or he would wreck the van along the way so the BOM also rode in the van with them. In an interview on 10/20/2014 at 2:00 PM the BOM stated she saw Resident #18 get up from his wheelchair to transfer to a seat in the van and fell to his knees. She stated she told Resident #18 he needed to stay in his wheelchair seat and belted in with the seatbelt. In an interview on 10/20/2014 at 2:20 PM the RNC stated the Administrator was to call corporate on all incidents/accidents that were reportable. The RNC stated he did not recall this incident being reported to him. In an interview on 10/20/2014 at 4:00 PM the VP Clinical Services stated she does not recall the incident or accident on Resident #18 and she would be the one the Administrator would call to find out if the incident was reportable. The VP Clinical Services stated she could not find the investigation of the incident with Resident #18. Review of the facility's policy entitled Accidents/Incidents System revised 08/23/2010 reflected An Accident/Incident Report must be completed immediately upon Facility Staff becoming aware of the incident involving a Resident.An assessment must be performed at the time of the accident/incident and findings documented.An Accident/Incident Investigation must be completed in addition to the Accident/Incident report when staff discovers.any falls.The Director of Nursing Services completes the Conclusion and Intervention form when the investigation has been completed.Accidents/Incidents must be reported both internally and externally in accordance with the State and Federal Guidelines.The Regional Nurse Consultant and the Regional Vice President must be notified. D) Review of the Face Sheet for Resident #9 reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of Resident #9's Quarterly Minimum Data Set ((MDS) dated [DATE] reflected he had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition. His behavior indicators were daily verbal threatening, screaming and cursing along with behavior symptoms not directed toward others such as throwing food. He was scored as rejecting care daily. Additional [DIAGNOSES REDACTED]. Review of the Provider Investigation Report Intake # 1 reflected the facility reported an incident on 09/21/2014 at 10:40 AM that occurred on 09/21/2014 at 10:10 AM. The provider reported Resident #9 has made many allegations when angry. Resident #9 called 911 to report the incident. Resident #9 complained that She poured pi** all over him. He further stated it was last night (09/20/2014) and the pi** caused him to have sores on his head. A head to toe skin assessment was performed while the police were at the facility and no sores were found, no injuries. A statement was obtained from the alleged perpetrator. The report stated Resident #9 named his alleged

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 10) perpetrator by name and the alleged perpetrator denied the event occurred. Resident #9's Responsible Party was contacted and informed and the Responsible Party requested the Resident be sent out for a complete psychological care because he makes these things up all the time and has for years. The report stated the nurse aide was suspended pending Investigation and that the alleged perpetrator did not work the night of the alleged abuse. Review of the statement from the alleged perpetrator reflected that on Thursday, 18, 2014 Resident #9 turned on his call light and said he needed to be cleaned. He insulted CNA and she told him her name and proceeded to care for him. According to CNA N's witness statement, during that interaction between Resident #9 and CNA N, Resident #9 complained that she had poured urine on him. She stated she informed the charge nurse and had a co-worker accompany her to the room. Review of the Incident Investigation of Incident completed and signed by the LVN F reflected nine (9) staff names of employees/caregivers that had worked in the past 24 hours prior to the complaint of abuse to the police department. There were no statements from any employees. LVN F recorded the incident occurred on 09/20/2014 on 10-6 shift the shift prior to Resident #9's allegation of abuse. There were no interviews or statements from other residents. In an interview on 10/16/2014 at approximately 4:00 PM the Administrator stated he had no further written statements to give to this Surveyor other than the statement from the alleged perpetrator. He stated the packet was complete as given to Surveyor. Review of the Provider Investigation Report Intake # 1 reflected the Facility Investigation findings were that the alleged abuse was unconfirmed and the Provider Action Taken Post-Investigation was that Resident #9 was frequently noncompliant with patient care, refuses assessment by mental health professionals. Nurse Aide will not be working with resident, in-service on abuse and neglect complete. No signs of indications that this allegation is founded and no further issues noted at this time. The document was signed by the Administrator. In an interview on 10/17/2014 at 6:00 PM the RNC stated all allegations of abuse must be handled seriously and investigated. The facility Administrator was notified on 10/17/2014 at 2:15 PM that an IJ situation had been identified due to above failures. The first Plan of Removal was submitted by the RNC on 10/17/2014 at 5:20 PM. The final Plan of Removal was accepted by the survey team on 10/17/2014 at 5:34 PM. Immediate Jeopardy Plan of Removal Variance to Standard-Allegation of Abuse Resident Behavior and Administration Corrective Action Steps: 1) Staff member accused of abuse was suspended immediately at 2:40 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible DON. 2) Second staff member accused of abuse was also suspended pending investigation at 5:05 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 3) Resident #2 was interviewed on 10/17/2014 by RNC with (MDS Coordinator) witness. Interview completed by Officer .Hearne Police Department at 2:55 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 4) Allegation of Abuse reported to Department of Aging Disability Services by the Administrator at 4:44 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible Administrator. 5) Facility staff in the building in-serviced on abuse and neglect at 5:10 PM. Staff not currently in facility will be in-serviced before returning to duty. Date started 10/17/2014. Target Date 10/18/2014. Staff Responsible DON. 6) Medical Director .notified of Immediate Jeopardy at 4:12 PM by RNC. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 7) Interviewable Residents will be interviewed regarding allegations of abuse or neglect. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RVP. 8) Administrator is suspended pending investigation as of 4:55 PM. RNC is point of contact for DADS until RVP arrives. RVP will be abuse prevention coordinator until investigation completed. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RVP. 9) QA&A Committee will review abuse allegations quarterly until such time as the Administrator determines that substantial compliance has been met. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible Administrator. Monitoring of the Plan of Removal was conducted by the Survey Team between 10/17/2014 and 10/18/2014. *Resident #2's allegation of abuse was addressed by the Corporate Staff, an investigation was started and it was called to the State certification and survey agency. *Reside
F 0241 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each Resident's dignity and respect in full recognition of his or her individuality for two (2) of 13 residents reviewed for abuse. A) Resident #2 indicated that two (2) CNA's (CNA G and CNA K) spanked him with there hands and hurt him. Resident #2 indicated that he notified the Administrator, Charge Nurse, and Social Worker but the CNAs continued to work with him despite Resident #2 not wanting the CNAs to take care of him. Resident #2 stated that after telling staff about the CNAs they began telling him he was a trouble maker and hard to deal with. B) Resident #14 indicated that two (2) CNA's (CNA O and CNA P) verbally abused him every time they came to work and would seek him out to call him names and make fun of him. Resident #14 indicated that he attempted to tell multiple facility staff including the Administrator and no one would listen to him. Resident #14 indicated that the CNAs continued to verbally abuse him and he wanted it to stop. Resident #14 requested assist from CNA L related to a incontinent episode. Resident #14 was not provided assistance and had to go to the dinning room with wet pants. This failure had the potential to place 14 bariatric residents and two (2) residents that communicate with non-oral communication at risk for for loss of dignity and self-worth. Findings include: A) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to require extensive two person assist with bed mobility and personal hygiene. Resident #2 was assessed to be dependent on staff for personal hygiene and bathing. Resident #2 was assessed to not have any psychiatric or mood disorders. Resident #2 was assessed to not have any behavioral symptoms. Review of Resident #2's Comprehensive Care Plan reflected a problem with the onset date of 09/15/2014 I need extensive assist times one to two staff member for bed mobility, toileting, dressing and personal hygiene and total assist times one to two staff member for bathing due to (weakness, obesity and [MEDICAL CONDITION]). I am incontinent of bowel and bladder . Listed under approaches Provide cheerful dialogue with me while cleansing me to encourage maintained self-esteem.' Review of Resident #2's physician progress notes [REDACTED]. Review of the list of interviewable Residents in the facility provided by the facility on 10/14/2014 reflected Resident #2 was interviewable. Observation on 10/14/2014 at 9:00 AM revealed Resident #2 in bed. Resident #2 was wearing a open back hospital gown. Resident #2 was alert. In an interview on 10/16/2014 at 4:15 PM Resident #2 stated CNA G spanked him with her hands a while back. Resident #2 stated there were two (2) CNAs present and did not know the other CNAs name but gave a physical description. Resident #2 stated the event occurred between April and September, before he went to the hospital. Resident #2 stated the aides were rough with me. Resident #2 stated he told the CNAs they were hurting him. Resident #2 stated the aides replied back you are a big man, what do you expect us to do about that. Resident #2 stated when the CNAs spanked him that he asked them to stop and the aides replied He likes it. Resident #2 stated I told the Administrator, the Charge Nurse LVN B, and the Social Worker and they told me I was out of it and did not believe it. They treat me like I am confused. Resident #2 stated the CNAs continue to work with him and they are rough and he does not like it. Resident #2 stated the CNAs have been calling him a trouble maker and hard to deal with. Resident #2 further stated he feels like the CNAs throw him and he is fearful, like he is going to fall out of the bed. In an interview on 10/17/2014 at 9:20 AM CNA G when asked if she had ever had any problems with Resident #2, stated that Resident #2 did not want her to check on him. CNA G further stated she recalled an incident were Resident #2 accused her of abuse. CNA G stated she was patting Resident #2; CNA G was making repetitive inward motions with her hands; to keep him on his side. CNA G further stated the Administrator talked to her about the incident and told her not to do that anymore. CNA G stated he is trying to get people in trouble referring to Resident #2. CNA G stated she has continued to worked with Resident #2 after the Administrator talked to her. In an interview on 10/17/2014 at 11:20 AM Resident #2 stated he felt abused when CNA G and the other aide were hitting him. Resident #2 stated he told her to stop and he did not want them to take care of him and was fearful they would hurt him. Resident #2 further stated I try to be nice so they won't be mean to me. I laugh and joke, that way they will take care of me. I can't take care of myself. In an interview on 10/17/2014 at 4:50 PM CNA K stated she was with CNA G providing care for Resident #2 when the incident occurred. CNA K stated CNA G was pushing Resident #2 to his side using both hands. CNA K indicated that CNA G's hands left and regained contact with Resident #2 multiple times. CNA K stated she did not feel like CNA G was spanking Resident #2 but trying to hold him over. CNA K stated he's big and he is hard to take care of. In an interview on 10/17/2014 at 2:02 PM CNA I stated she was told by Resident #2 that CNAs had spanked him but he would not tell her who. CNA I stated she told him to

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F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) report the incident and Resident #2 told her he had already reported it. CNA I stated Resident #2 told her that when he reported it they made him feel uncomfortable. B) Review of Resident #14's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #14's Admission MDS dated [DATE] reflected Resident #14 was assessed to not have long or short term memory problems and was assessed to require modified independence in decision making. Resident #14 was assessed to have no speech, and usually understood and usually understands. Resident #14 was assessed to not have behavior problems or resist care. Resident #14 was assessed to require limited to extensive assist with ADL's and was assessed to be occasionally incontinent. Review of Resident #14's Comprehensive Care Plan reflected a problem with the start date 09/04/2014 which reflected I have a communication deficit related [MEDICAL CONDITION]. I need to use writing material to be able to communicate at times. Approaches listed included: Reassurance and patience when I attempt to communicate, Use gentle, relaxed tone of voice. Resident #14's care plan did not address a cognitive impairment, or behavior problems. Review of Resident #14's History and Physical dated 09/03/2014 reflected Resident #14 was oriented to person, oriented to place, oriented to time, affect appropriate, mood appropriate, is cooperative with care. Review of Resident #14's Admission assessment dated [DATE] reflected Resident #14 was assessed to be alert without memory problems and exhibited no behavior problems. In an interview on 10/14/2014 at 12:20 PM Resident #14 stated I'm tired of being wet. He also stated I'm tired of them (the staff) walking over me. Resident #14 stated he told the CNA that was assigned to him to clean him before lunch. Observation on 10/14/2014 at 12:20 PM revealed Resident #14 was in the dining room waiting for lunch and he motioned with his arm and hand for the surveyor to come over and pointed to his pants. Resident #14's pants in the groin area was wet looking. Observation on 10/14/2014 at 1:03 PM revealed Resident #14 left the dining room. He first attempted to propel himself, then another resident propelled him to the front lobby entrance area. At 1:06 PM Resident #14 propelled himself to the nurses' station to find a staff member who propelled him to his room. Resident #14's pants were wet looking in the groin area. LVN B met him in his room, then left him in his room. In an interview on 10/14/2014 at 1:08 PM CNA L stated the last time she checked him was at 10:00 AM. She stated she was going to assist him now. Observation on 10/14/2014 at 1:15 PM revealed CNA L entered Resident #14's room with a brief and a pad then exited the room to find help and the hoyer lift. At 1:20 PM CNA L returned with LVN B to assist Resident #14. Observation on 10/15/2014 at 12:10 PM revealed Resident #14 entering the facility library where the surveyors were working. Resident #14 was visibly upset and wanting to talk with the surveyors. Resident #14 was unable to talk related to [MEDICAL CONDITION] but was able to communicate with slight whispering and by lip reading. In an interview on 10/15/2014 at 12:15 PM Resident #14 was asked if he would like a pen an paper so he could write down what he wanted to tell the surveyors. Resident #14 mouthed, no and pointed to his right hand (which was paralyzed) and mouthed he could not write. Resident #14 stated CNA O and CNA P talk bad to him and call him names. Resident #14 stated they call him a motherf***** and call him other names and make fun of him when he can't do things for himself. Resident #14 stated the CNA's seek him out and pick on him calling him names. Resident #14 stated it happens every time the CNA's work. Resident #14 stated it has been going on for two (2) months. Resident #14 stated I tell them to go away and they come back. Resident #14 stated she won't stop. Resident #14 stated he feels threatened when they come to him. Resident #14 stated the CNA's have not hit him but stated I feel like she will hit me. Resident #14 stated he has told several people about the CNA's and they do not listen to him. Resident #14 stated he has told Administrator but he did not listen to him. Resident #14 stated the Administrator acted like he did not understand Resident #14 when he tried to tell he about the CNA's mistreatment. In an interview on 10/16/2014 at 1:30 PM Resident #30 stated he is Resident #14's roommate. Resident #30 stated the aides pull the curtain when they are providing care to Resident #14 but he can hear them arguing with Resident #14. Resident #30 could not identify which aides argue with Resident #14. In an interview on 10/16/2014 LVN G stated, when asked if Resident #14 had reported any complaints, It is hard to understand what he says, so I don't know what he is saying. Review of the facility's Policy Resident Rights Under Federal Law (no date) reflected 1. The Resident has a right to a dignified existence, self-determination, communication with and access to, persons and services inside and outside the Facility. 14. The Resident has a right to voice grievances with respect to treatment or care that fails to be furnished, without discrimination or reprisal for voicing grievances. Resident's Rights under Texas Law 4. to be treated with courtesy, consideration and respect;. The facility provided a list of 14 bariatric residents and two (2) residents that communicate with non-oral communication
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide housekeeping and maintenance services.** Based on observation, interview, and record review the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for three of five halls (100, 200, and 600 Halls) when: A) Resident #5 had a puddle of something liquid (Resident #5 stated it was urine) on the floor under his catheter bag and a strong odor. This deficient practice could affect 2 residents with indwelling or external catheters at risk for a decline in quality of life. B) Resident #9 had a thoroughly dried brown substance resembling chocolate milk twelve (12) inches across and six (6) inches wide, food and trash over the floor throughout his room. This deficient practice could affect 10 residents on 600 hall. C) Resident #13 had a wet brief and clothing on the floor in his room with a strong odor. This deficient practice could affect 47 residents occasionally or frequently were incontinent of bladder and 40 residents occasionally or frequently incontinent of bowel at risk for a decline in quality of life. Findings include: A) Observation on 10/13/2014 at 7:05 PM revealed in Resident #5's room and on the floor under the catheter bag was a puddle of something liquid on the floor. Resident #5 stated the CNA spilled the urine when she emptied the catheter bag. The room had a strong odor. In an interview on 10/13/2014 at 7:07 PM the DON stated the puddle on the floor could possibly be urine. The DON stated she would arrange for the spilled liquid to be cleaned. Review of the facility's policy Housekeeping and Pest Control dated 12/2003 reflected 3. Blood, excretion, and secretion spills should be quickly contained by nursing personnel and disinfected according to the procedure entitled Cleaning Up Spills or Splashes of Blood or Body Fluids. The facility provided a CMS Form 672 reflected 2 residents with indwelling or external catheters. B) Observation on 10/13/2014 at 7:00 PM revealed in Resident #9's room there was a brown stain on the floor, food remnants all along the wall, four napkins under the bed along with a disposable thermometer. There were two gloves in the bathroom floor under the sink and one glove in the corner behind the toilet. The floor was soiled throughout the room. In an interview on 10/13/2014 at 8:39 PM HSKPR stated, He (Resident #9) raises sand about the housekeepers going in the room. He says mopping with plain water is trying to kill him. When I go in there, he is nice if he is having a good day. If he is having a bad day, he is not nice to anyone. In an interview on 10/14/2014 at 10:10 AM the Administrator stated, each day we do what we can. The house keepers go in there just like they do every room. We do what we can if he lets us. There is no special program. Review of the facility provided Infection Control Guidelines dated 05/01/2009 reflected.D. Housekeeping: The facility will be maintained in a clean and sanitary condition.The Housekeeping Department will clean and decontaminate those.environment surfaces and equipment in resident rooms, .on a regularly scheduled basis, based on location,.types of surfaces, soil present and procedure to be performed. This deficient practice could affect 10 residents on 600 hall. C) Observation on 10/13/2014 at 6:40 PM revealed in Resident #13's room there was a wet brief on the floor with the dirty side down on the floor. There was also some wet clothing on the brief and floor. Resident #13 stated the CNA just left the brief and clothing on the floor when he was assisted to bed about an hour ago. The room had an odor. In an interview on 10/13/2014 at 7:02 PM the DON stated the wet brief and clothing should not be left on the floor. Review of the facility provided policy for Incontinent Care reflected steps.4.place soiled items in plastic bag.5. Gather all supplies and remove from room.8. Ensure Resident's safety at all times and use Infection Control Procedures appropriately. Review of the facility provided policy for Laundry/Linen reflected.3. All soiled linen should be considered potentially infectious. The facility provided a CMS Form 672 reflected 47 residents occasionally or frequently were incontinent of bladder and 40 residents occasionally or frequently incontinent of bowel.
F 0256 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide adequate and comfortable lighting levels in all areas.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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	675062	A. BUILDING _____ B. WING _____	10/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARNE HEALTHCARE CENTER	1101 W BROWN ST HEARNE, TX 77859

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

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F 0256 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) Based on observation, interview and record review the facility failed to provide adequate and comfortable lighting levels in one (1) of eight (8) rooms on the locked unit. Resident #8 did not have a working light in her room. Resident #8 had to use the television or closet light to see. This deficient practice placed 14 residents on the locked unit at risk of falls, decline in quality of life. Findings Include: Review of Resident #8's Face Sheet reflected an [AGE] year old female admitted to the facility on [DATE] with the following Diagnosis: [REDACTED]. Review of Resident #8's Admission MDS dated [DATE] reflected Resident #8's BIMS score was a seven (7) indicating she had severe cognitive impairment. Resident #8 was assessed to have impaired vision. Resident #8 was assessed under activity preferences that having books, newspapers, and magazines to read was very important. Resident #8 was assessed to be continent of bowel and bladder and assessed to require supervision for ADLs. Resident #8 was assessed to have two (2) falls with injury. Review of Resident #8's Comprehensive Care Plan reflected a problem with the onset date of 04/22/2014 which reflected I may have a problem adjusting to lifestyle changes resulting form change in environment. Approaches included assist my family in making my room as home like as possible. Further review of Resident #8's comprehensive care plan reflected an problem with onset date of 04/22/2014 which reflected I wear glasses. Observation on 10/13/2014 at 7:25 PM revealed Resident #8 walking around room. No lights were on. Resident #8 had the bathroom door open to the room with the light on. Observation on 10/15/2014 at 4:50 PM revealed lights not working in room. Surveyor attempted to turn lights on but they did not work. In an interview on 10/15/2014 at 4:55 PM Resident #8 stated the lights in her room were not working. Resident #8 stated she has reported it. Resident #8 stated she uses the television or closet light to see. Resident #8 stated she did not remember who she reported the broke light to. Observation on 10/16/2014 at 6:00 PM revealed the light on the other side of Resident #8's room was working. The light above Resident #8's bed was not working. Resident #8 had magazines and newspapers on her bed. In an interview on 10/16/2014 at 6:02 PM Resident #8 stated that sometimes her light works and sometimes it does not. Resident #8 stated when the light does not work she can not see to read her newspapers or magazines. Resident #8 stated I will have to use the light on the other side of the room or open the curtains and use the bathroom light. In an interview on 10/17/2014 at 8:50 AM the Administrator stated he expected all residents to have adequate lighting in their rooms and would turn in a maintenance request. The RNC stated the facility did not have a policy for lighting in resident rooms. The facility provided a list of 14 residents on 400 hall (locked unit).
F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure assessments accurately reflected resident's status for three (3) of 17 residents (Residents #3, #9 and #13) reviewed for assessments. A) Resident #3's assessment failed to accurately reflect Resident #3 did not take oral medications in the observation period. B) Resident #9's assessment failed to accurately reflect Resident #9's bilateral knee contractures. C) Resident #13's assessment failed to accurately reflect Resident #13 had Moisture Associated Skin Damage (MASD). This deficient practice placed 66 residents at risk of having inaccurate and incomplete assessments which could result in health conditions and needs being unrecognized and unmet. Findings Include: A) Review of Resident #3's Face Sheet reflected a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of the Physicians Telephone Orders reflected an order to discontinue routine oral medications on 05/21/14. Review of the Minimum Data Set ((MDS) dated [DATE] reflected Resident #3 took antidepressants and diuretic pills seven (7) of seven (7) days. Review of the Care Plan dated 05/13/14 and updated 08/27/14 reflected Discontinue all oral medications. In an interview on 10/16/2014 at 11:45 AM the MDS Coordinator stated, That is my fault. The MDS should reflect zeros (for diuretics and antidepressants by mouth). In an interview on 10/16/2014 at 6:20 PM the DON stated she would expect the MDS to reflect Resident #3 was not taking diuretics and antidepressants. B) Review of Resident #9's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of Resident #9's Quarterly Minimum Data Set ((MDS) dated [DATE] reflected he had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition. He was scored as no impairment in upper and lower extremities range of motion which indicated no impairment that interfered with daily functions. Review of Resident #9's Care Plan dated 8/26/ through 9/23/2014 reflected there was no Care Plan to address the loss in range of motion or interventions to assist in regaining range of motion in his knees. Observation on 10/13/2014 at 7:00 PM revealed Resident #9 to be at the foot of the bed with his knees approximately three (3) to four (4) inches from the footboard and knees bent at a less than 90 degree angle. Observation on 10/14/2014 at 12:00 PM revealed Resident #9 at the foot of his bed and he demonstrated at surveyor request that his knees were contracted so that he would have had his feet under the chair if he were sitting down. In an interview on 10/15/2014 at 5:00 PM the MDS Coordinator stated she was unaware of Resident #9 having contractures in his knees. She stated, the information has to be in the nursing summary for her to put it on the MDS and that she does not go to the resident rooms except for the pain assessment. In an interview on 10/16/2014 at 6:20 PM the DON stated she would expect Resident #9's MDS to accurately reflect the loss of range of motion of the knees. C) Review of the Face Sheet for Resident #13 reflected a [AGE] year old male admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of the 30 day MDS Assessment (like a Quarterly) dated 10/07/2014 for Resident #13 reflected a BIMS score of 11 indicating moderately impaired cognition. Resident #13 was not checked for Moisture Associated Skin Damage (MASD) under Skin Condition. Review of the Significant Change (SC) MDS assessment dated [DATE] for Resident #13 reflected a BIMS score of 15 indicating cognitively intact. Resident #13 was not checked for Moisture Associated Skin Damage (MASD) under Skin Condition. Review of the Comprehensive Care Plan for Resident #13 dated 08/20/2014 reflected a Problem-I am not as mobile as I used to be, my skin is fragile and may have problems with: Skin tear, Bruising, Pressure ulcers, and Wound. I currently have MASD to my buttocks and groin area. Resident #13's care plan reflected under Goal-- .My MASD will be cleared up within the next 90 days. Observation on 10/17/2014 at 9:35 AM revealed Resident #13 in his bed. The Treatment Nurse was preparing to provide the skin treatment for [REDACTED]. Resident #13 was assisted to turn to his side. Resident #13 had MASD on his buttocks and upper thighs with tiny, multiple open areas. In an interview on 10/20/2014 at 3:00 PM the Treatment Nurse stated Resident #13 had MASD on his buttocks and upper thighs since his admission and should be coded on all MDS Assessments. Review of the facility provided Resident Assessment Instrument Manuel reflected that the assessment accurately reflects the resident's status and requires observation, information and knowledge about a resident from all available sources including medical records, the resident .care planning.moves a resident toward.goals crafting the how of resident care. The care plan becomes each resident's unique path toward achieving or maintaining.highest practical level of well-being. This deficient practice could affect 66 residents who reside at the facility.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop individualized comprehensive care plans to maintain the Residents' highest level of functioning for two (2) of 17 Residents (Resident #6, and #9) reviewed for care planning. A) Resident #6 had a neurotic wound to the bottom of right foot which was not addressed in his plan of care. B) Resident #9 had knee contractures and no care plan to prevent further decline. This deficient practice placed 66 residents at risk for not receiving care and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. Findings include: A) Review of Resident #6's Face Sheet reflected an [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #6's Quarterly MDS dated [DATE] reflected Resident #6 had a BIMS score of 0 indicating he had severe cognitive impairment.

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 13) Resident #6 was assessed to require extensive assist with ADL's. Resident #6 was assessed to have surgical wounds. Review of Resident #6's Consolidated Physician order [REDACTED]. Further review reflected an order dated 09/30/2014 to cleanse area to bottom of right foot with soap and water pat dry apply santyl cover with non adherent pad wrap with kerlix everyday. Review of Resident #6's Comprehensive Care Plan reflected a problem with the onset date 07/15/2014 which reflected Resident #6 had a surgical wound from amputation of right great toe. Approaches included Observe an report signs of localized infection. Resident #6 did not have a care plan for a wound to the bottom of right foot. Observation on 10/15/2014 at 12:10 PM revealed the Treatment Nurse and DON outside Resident #6's room. Resident #6 had a neurotic wound to the bottom of right foot. In an interview on 10/17/2014 at 8:45 AM the MDS Coordinator stated the Treatment Nurse would have the Care Plan for Resident #6's foot wound. In an interview on 10/17/2014 at 9:00 AM the Treatment Nurse stated he did not have a care plan the wound on Resident #6's foot. B) Review of Resident #9's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of Resident #9's Quarterly Minimum Data Set ((MDS) dated [DATE] reflected he had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition. He was scored as no impairment in upper and lower extremities range of motion which indicated no impairment that interfered with daily functions. Review of Resident #9's Care Plan dated 8/26/ through 9/23/2014 reflected there was no Care Plan to address the loss in range of motion or interventions to assist in regaining range of motion in his knees. Observation on 10/13/2014 at 7:00 PM revealed Resident #9 to be at the foot of the bed with his knees approximately three (3) to four (4) inches from the footboard and knees bent at a less than 90 degree angle. Observation on 10/14/2014 at 12:00 PM revealed Resident #9 at the foot of his bed and he demonstrated at surveyor request that his knees were contracted so that he would have had his feet under the chair if he were sitting down. In an interview on 10/15/2014 at 5:00 PM the MDS Coordinator stated she was unaware of Resident #9 having contractures in his knees. She stated, the information has to be in the nursing summary for her to put it on the MDS and that she does not go to the resident rooms except for the pain assessment. In an interview on 10/16/2014 at 6:20 PM the DON stated she would expect Resident #9's MDS to accurately reflect the loss of range of motion of the knees and that his care plan should reflect the loss. Review of the facility provided Resident Assessment Instrument Manuel reflected that the assessment accurately reflects the resident's status and requires observation, information and knowledge about a resident from all available sources including medical records, the resident .care planning .moves a resident toward .goals crafting the how of resident care. The care plan becomes each resident's unique path toward achieving or maintaining .highest practical level of well-being. The facility provided CMS 672 reflected a census of 66 residents.
F 0281 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide services that meet professional standards of quality for one (1) of one (1) Treatment LVN reviewed for skin assessments and wound care for four (4) of four (4) residents (Resident #4,#3, #2 and #11) . Two (2) of (2) Licensed Vocational Nurses (LVN) (LVN C and D) reviewed for glucometer testing, and one (1) of one (1) DON for skin assessment monitoring when: A) A facility Resident had an infectious blood borne pathogen ,[MEDICAL CONDITION]. and received finger stick blood sugar (FSBS) tests four times a day with a glucometer used to test other facility residents. Two (2) of (2) Licensed Vocational Nurses (LVN) (LVN C and D) failed to clean the blood glucose test meter between uses as per manufacturer recommendations An Immediate Jeopardy (IJ) was identified on 10/15/2014 at 9:20 AM. While the IJ was removed on 10/16/2014, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice placed 21 residents receiving Glucometer blood glucose monitoring at risk for infection from blood borne pathogens. Non-Immediate Jeopardy (IJ) B) The Treatment Nurse and DON failed to accurately assess and stage Resident #4's wound to her ankle and failed to notify the physician of a decline in the wound. Resident # 4's wound declined from a Stage II to a Stage III. C) Resident #3 had documented open wounds on her posterior thighs and buttocks some of which had increased in size and an additional opening on her left posterior thigh. The Treatment Nurse, failed to perform a timely physician ordered head to toe assessment and failed to identify the worsening of Resident #3's wound to her right thigh on 10/15/2014 or the development of a new wound to her left thigh, and failed to notify Resident #3's Physician until surveyor intervention on 10/16/2014. D) a) The Treatment Nurse and DON did not identify a Stage II Pressure Sore that declined to a Stage III Pressure Sore on Resident #2's coccyx and did not identify a separate Stage III Pressure Sore on Resident #2's sacrum until Surveyor Intervention. b) Resident #2 had an open wound on his posterior lateral right thigh which had increased in size and a new area to his posterior medial right thigh, not on a bony prominence. The Treatment Nurse, failed to perform a physician ordered head to toe assessment and failed to identify the worsening of Resident #2's wound to his right thigh on 10/14/2014 or the development of a new wound to his right thigh, and failed to notify Resident #2 Physician until surveyor intervention on 10/15/2014. E) Resident #11 Did not routinely receive the physician ordered treatments to heal a skin condition that inflamed the majority of her buttock area. This deficient practice affected four (4) residents (Resident #2, #3, #4,and #11) and placed 16 residents with wounds and four (4) residents with pressure sores at risk for wounds not being assessed, a decline in wounds, infection, and pain. Findings Include: Texas Administrative Code, Title 22, Part 11, Chapter 217, Rule 217.11 Standards of Nursing Practice (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall: (A) Know and conform to the Texas Nursing Practice Act and the board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice; (D) Accurately and completely report and document: (i) the client's status including signs and symptoms; (ii) nursing care rendered; (iii) physician, dentist or podiatrist orders; (iv) administration of medications and treatments; (v) client response(s); and (vi) contacts with other health care team members concerning significant events regarding client's status; (G) Obtain instruction and supervision as necessary when implementing nursing procedures or practices; (M) Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications; (O) Implement measures to prevent exposure to infectious pathogens and communicable conditions; (P) Collaborate with the client, members of the health care team and, when appropriate, the client's significant other(s) in the interest of the client's health care; (Q) Consult with, utilize, and make referrals to appropriate community agencies and health care resources to provide continuity of care; (U) Supervise nursing care provided by others for whom the nurse is professionally responsible; (2) Standards Specific to Vocational Nurses. The licensed vocational nurse practice is a directed scope of nursing practice under the supervision of a registered nurse, advanced practice registered nurse, physician's assistant, physician, podiatrist, or dentist. Supervision is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity. The licensed vocational nurse shall assist in the determination of predictable healthcare needs of clients within healthcare settings and: (A) Shall utilize a systematic approach to provide individualized, goal-directed nursing care by: (i) collecting data and performing focused nursing assessments; (ii) participating in the planning of nursing care needs for clients; (iii) participating in the development and modification of the comprehensive nursing care plan for assigned clients; (iv) implementing appropriate aspects of care within the LVN's scope of practice; and (v) assisting in the evaluation of the client's responses to nursing interventions and the identification of client needs; (B) Shall assign specific tasks, activities and functions to unlicensed personnel commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made and shall maintain appropriate supervision of unlicensed personnel. (C) May perform other acts that require education and training as prescribed by board rules and policies, commensurate with the licensed vocational nurse's experience, continuing education, and demonstrated licensed vocational nurse competencies. A) Review of Resident #5's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnosis: [REDACTED]. Review of Resident #5's Quarterly MDS dated [DATE] reflected Resident #5 was assessed to have a 14 BIMS score indicating Resident #5 was cognitively intact.

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) Review of Resident #5's Consolidated Physician orders [REDACTED]. Review of Resident #5's Comprehensive Care Plan reflected a problem with the onset date of 07/23/2014 I am positive [MEDICAL CONDITION] am at risk for multiple complications such as infections, [MEDICAL CONDITION], depression, fatigue/weakness, social isolation . Under approach Provide for infection control and standard precautions. Observation on 10/15/2014 at 7:30 AM revealed LVN C outside of Resident #21's room. LVN C got a glucometer out of the cart and without cleaning the glucometer placed a testing strip in the glucometer. LVN C without washing her hands applied gloves and entered Resident #21's room. LVN C then placed the glucometer on Resident #21's over bed table, which had a white substance on it and other debris, without a barrier. LVN C then performed Resident #21's finger stick blood sugar (FSBS). LVN C then went to cart, removed the used testing strip from the glucometer, removed her gloves and placed the lancet, test strip and used gloves in the trash. LVN C then took the glucometer and placed it in the cart without cleaning the glucometer. LVN C then proceeded down the hall with her cart. In an interview on 10/15/2014 at 7:32 AM LVN C stated, when asked if she should have cleansed the glucometer, LVN C did not answer the surveyors question. LVN C opened the bottom drawer of her cart and pulled out a container of Super Sani-Cloths wipes and placed them on the cart and proceeded down the hall. Observation on 10/15/2014 at 7:40 AM revealed LVN D outside of Resident #23's room. LVN D collected Resident #22's insulin, syringe and glucometer. LVN D took an alcohol wipe and wiped the front of the glucometer, LVN D did not clean the sides of the glucometer. LVN D then entered Resident #23's room. LVN D placed the items on his dresser without a barrier and placed a testing strip in the glucometer. LVN D completed the FSBS and returned to cart placing the glucometer in the cart in a basket on top of new lancets without cleaning the glucometer. In an interview on 10/15/2014 at 7:45 AM LVN D stated she was not sure what the facility policy on cleaning the glucometers was. LVN D stated she was an agency nurse and if the facility does not tell her what they want her to use to clean the glucometers she uses alcohol wipes. LVN D further stated she was not trained by the facility on how to clean the glucometer. LVN D stated she cleaned the glucometer before use but did not clean the glucometer prior to putting in the cart and should have cleaned it. In an interview on 10/15/2014 at 7:50 AM LVN C stated she did Resident #5's FSBS this morning with the same glucometer that she used on everyone. In an interview on 10/15/2014 at 8:10 AM the DON stated, when asked if the staff are supposed to clean the glucometers between Residents, she stated she would have to check the policy. When asked by surveyor if the staff should clean the glucometers between Residents the DON stated I will have to check the policy. In an interview on 10/15/2014 at 8:29 AM the Medical Director stated in regards to the facility staff cleansing the glucometer between Residents They should clean it up it is a possible infection control issue. I would say they should know to clean it, common sense tells you should clean it. Observation on 10/15/2014 at 8:55 AM revealed the DON handing the surveyor a container of Super Sani-cloth germicidal disposable wipes and two policies. In an interview on 10/15/2014 at 8:56 AM the DON stated the staff should clean the glucometers with the Super Sani-cloth wipes as per manufacture recommendations. The DON was asked if she had in-serviced the staff on cleaning the glucometers and the DON stated someone is going around right now. The DON was asked if she had in-serviced the agency staff, and the DON stated someone is going around now. In an interview on 10/15/2014 at 5:00 PM the DON stated the Agency Nurses were to be oriented per the orientation checklist for glucose machine cleansing. She also stated she had not in-serviced or trained the staff about glucose machine cleansing. In an interview on 10/15/2014 at 5:05 PM the Administrator stated he expected the DON to be hands on with training the staff on glucose machine cleansing. Review of the facility's policy Medication Pass Observation (no date) reflected When observing Blood Glucose Monitoring make sure the Nurse properly sanitizes the unit as recommended by the Manufacturer prior to use and between each resident. Review of the manufacturer recommendations dated 10/14/2010 for Cleaning and Disinfecting Blood Glucose Meters reflected Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. Many wipes act as both a cleaner and disinfectant. If blood is visibly present on the meter, two wipes must be used, one wipe to clean and a second wipe to disinfect. Review of the Website: <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/ucm 5.htm> reflected the FDA, CDC, and CMS issued clinical reminders and public health notifications highlighting the risk of transmission of disease from shared use of finger stick (lancing) devices and point of care blood testing devices. The posting of these notifications was in response to recent outbreaks of [MEDICAL CONDITIONS] patients where these devices were shared between users. The CDC and the FDA currently recommend the following: ? Lancing devices should never be used for more than one person. Only auto-disabling, single use lancing devices should be used for assisted blood glucose monitoring in multiple patients. ? Point of care blood testing devices such as blood glucose meters should be used only on one patient and not shared. If dedicating blood glucose meters to a single patient is not possible, the meters must be properly cleaned and disinfected after every use following the guidelines provided in device labeling. ? Healthcare personnel should change gloves between patients, even if patient dedicated testing devices and single-use, self-disabling lancing devices are used. The facility Administrator was notified on 10/15/2014 at 9:20 AM that an IJ situation had been identified due to above failures. The first Plan of Removal was submitted by the Administrator on 10/15/2014 at 9:46 AM. The final Plan of Removal was accepted by the survey team on 10/15/2014 at 5:17 PM. Immediate Jeopardy Plan of Removal Variance to Standard: Inappropriate cleaning of glucometer-Infection Control Corrective Action Steps: 1) DON in-serviced nursing staff on infection control and glucometer cleaning at 12:30 PM. Any nurses not available to come in for this in-service will be in-serviced before working with residents. See attached in-service. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible DON. 2) DON in-serviced on glucometer cleaning and infection control 10:52 AM 10/15/2014. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible RNC. 3) Agency Nurses will receive orientation prior to working with residents. See attached orientation checklist. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible DON. 4) Bedside tables of residents who receive glucometer checks were cleaned using PDI Super Sani-cloth germicidal wipes. This was completed 10/15/2014 at 5:05 PM. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible ADON. 5) Facility infection control system will be monitored weekly by DON and DON will visually monitor blood glucose checks weekly for no less than 90 days. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible DON. 6) DON or designee will discuss all infection control issues daily in morning standup meeting. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible DON. 7) Residents with known blood borne infectious disease will have their own designated glucometer. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible DON. 8) Medication and treatment carts were disinfected with PDI brand Super Sani-cloth germicidal disposable wipe by 10:50 AM. Contaminated supplies were disposed of in biohazard container in Biohazard room. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible DON. 9) (Medical Director) notified on 10/15/2014 at 10:49 AM of facility in Immediate Jeopardy. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible Administrator. 10) Resident #5 designated glucometer for his sole use at 9:46 AM. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible DON. 11) QA&A Committee will review all infection control issues quarterly until such time as the Administrator determines that substantial compliance has been met. Date Started 10/15/2014. Target Date 10/15/2014. Staff Responsible Administrator. The survey team monitored the current plan of removal as follows: In an interview on 10/15/2014 at 5:25 PM LVN B stated she had already checked Resident #5's blood sugar. She stated she completed all the FSBS checks for her residents. In an interview on 10/15/2014 at 5:30 PM the Administrator stated he was not aware the nurses had completed the FSBS checks and did not tell the surveyors they were performing the FSBS. He also stated he remembered the surveyors had asked to observe the FSBS before dinner. The Administrator stated he would arrange for the surveyors to observe the morning FSBS. In an interview on 10/15/2014 at 5:45 PM the Administrator stated the morning FSBS would start at 7:00 AM and would include Resident #5. In an interview on 10/15/2014 at 5:50 PM the DON stated she was aware the survey team needed to observe the FSBS but did not tell the nursing staff this evening. She stated she would let the morning staff know to perform the FSBS while the surveyors observed. The survey team monitored facility staff on 10/16/2014 from 7:00 AM to 8:00 AM, the nursing staff were performing FSBS tests and were cleansing the glucometers with the Sani-cloth germicidal wipes. The nursing staff were discarding lancets and testing strips in the regular trash. Observation on 10/16/14 at 11:05 AM revealed LVN B outside of Resident #5's room preparing to do a FSBS. LVN B gloved, set up for testing and picked up Resident #5's personal glucometer and was placing a test strip in it. Before she could firmly seat the strip in the glucometer, the Regional Nurse Consultant stated, What are you doing? Throw that strip away and cleanse your glucometer. LVN B did as instructed and then performed the FSBS and cleansed the glucometer. Observation on 10/16/14 at 4:35 PM revealed LVN E outside room [ROOM NUMBER]. LVN E gloved, sanitized the glucometer, removed gloves, donned fresh gloves, performed a FSBS, placed the soiled glucometer on the paper towel on her cart, disposed of lancet and testing strip in the sharps container, removed her gloves, recorded the results, told the Residents goodbye and washed her hands. She then rolled the cart down the hall. When asked if she had been taught to cleanse the glucometer after every fingerstick, LVN E stated, Oh, yes they did. When surveyor alerted LVN E that she had not cleansed the glucometer LVN E stated, OH, I don't know what I'm waiting for. I guess I was going to do it later, I

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 15) don't know. I set up later. I should have washed the glucometer. It is an infection control issue. LVN then donned gloves and cleansed the glucometer, parked her cart at the beginning of the hall and spoke with other staff. No further fingersticks were performed. Observation on 10/17/2014 from 7:00 AM to 8:00 AM revealed two nurses including LVN C were observed performing glucose checks and cleaning the glucometers accordingly from resident to resident. LVN C was observed performing glucose testing with Resident #5, used his personal glucometer and cleansed accordingly. In-services had begun with approximately 70 percent of the staff trained. The Administrator was notified on 10/17/2014 at 12:04 PM that the IJ was removed, however the facility remained out of compliance at a Severity level of Harm at a Scope of Pattern that was not IJ due to the facility's need to evaluate the effectiveness of the corrective systems. The facility provided a list of 21 residents who have glucose testing performed. Non- Immediate Jeopardy (IJ) B) Review of the Face Sheet for Resident #4 reflected a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of the Quarterly MDS Assessment for Resident #4 dated 09/06/2014 reflected a BIMS score of three (3) indicating severe cognitive impairment. Resident #4 was totally dependent on staff for dressing, hygiene, bed mobility, and bathing. She needed extensive assistance with eating. The Assessment reflected Resident #4 was not transferred for the seven (7) day look back period. Resident #4 was incontinent bowel and bladder. She weighed 104 pounds and was coded for weight loss that was not prescribed. Resident #4 was not coded for dehydration. Resident #4 was also on a mechanically altered diet. The Assessment reflected Resident #4 had two Stage II Pressure Sores and one (1) Stage IV. The date of the oldest Stage II was 08/08/2014. The Stage IV measurements were 1.7 cm x 1.1 cm x 1.4 cm with granulation tissue. The Assessment indicated all the pressure sores worsened and none had healed since the last assessment. Resident #4's skin treatment included a pressure reducing device for bed, nutrition or hydration intervention to manage skin problems, and pressure ulcer care. Resident #4 was on Hospice care. Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated 08/28/2014 I have a pressure ulcer on my right outer ankle currently a Stage II. 1.3 x 1.2 cm with a Goal for the pressure sore to .heal 1 cm per month . The Care Plan reflected Resident #4's Approaches .Provide me with treatments as ordered .Report any drainage to my physician promptly .Use good infection control when dealing with my ulcer. Remember to wash your hands before and after treatment. Review of Resident #4's Consolidated Physician order [REDACTED]. Chlorine, the active ingredient in Dakin's solution, is a strong antiseptic that kills most forms of bacteria [MEDICAL CONDITION].) apply wet to dry every day. Review of Resident #4's Weekly Skin Documentation reflected an assessment dated [DATE] of Resident #4's Right outer ankle. Resident #4's right ankle was Staged at a II that measured 0.8 cm by 0.6 cm with 0.2 cm depth with granulation tissue. Observation on 10/14/2014 at 11:45 AM revealed Resident #4 lying in the bed on the left side. Treatment Nurse did not wash his hands prior to setting up the wound care supplies on a piece of wax paper on top of the treatment cart. The DON entered Resident #4's room and donned gloves without washing her hands. Resident #4's dressing to the right outer ankle was intact and when removed had a moderate amount of light yellow drainage. The wound bed had slough and depth when observed-indicating a Stage III. The wound was not measured at this time but was approximated as 1 cm x 1 cm x 0.5 cm. The wound had slough from throughout the wound but depth could be determined. The wound edges were macerated and rolled. The Treatment Nurse did not change gloves until he finished with this procedure, therefore he removed the dirty dressing, cleansed the wound, and placed the clean dressing on the wound without changing gloves or hand hygiene. The Treatment Nurse cleansed the wound from the outer edge then towards the center wound bed. In an interview on 10/14/2014 at 11:55 AM the DON stated Resident #4's pressure sore to her right outer ankle was a Stage II. In an interview on 10/15/2014 at 12:05 PM Resident #4's NP stated she could not recall if the facility had notified her of any changes for Resident #4. The NP stated generally for Stage III pressure sores she like to use a calcium alginate type dressing covered with a foam dressing to provided extra protection. It just depends on what the wound looks like. In an interview on 10/15/2014 at 4:40 PM the Treatment Nurse stated he should have washed his hands before gathering his supplies and during the procedure when you get anything on you. He stated the cleansing should start in the middle of the wound bed and then outward to not drag germs inside. The Treatment Nurse stated he was trained for two hours by RNC and VP Clinical Services and had been performing wound care for two months. Review of Resident #4's Medical Record reflected no new orders for Resident #4's right ankle or assessment documentation as of 10/16/2014. In an interview on 10/16/2014 at 10:30 AM the Treatment Nurse stated Resident #4's right outer ankle pressure sore was a Stage III instead of a Stage II like he had documented. He stated he had not notified the Physician or NP of the right ankle wound changes or the presence of slough. Observation on 10/16/2014 at 12:01 PM revealed Resident #4 was lying in her bed on the right side. The Treatment Nurse entered the room for wound care, and found the right outer ankle pressure sore was not covered by a dressing when he removed her sock and heel protector. He did not know where the dressing for Resident #4 was located and how long it was not on the right outer ankle pressure sore. C) Review of the Face Sheet reflected Resident #3 was a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] reflected Resident #3's cognitive skills for daily decision making was severely impaired. She had behaviors of scratching others, cursing others and behavior symptoms not directed toward others less than daily. She was totally dependent on others for her bathing needs and required two people for hygiene. Resident #3 was always incontinent of bowel and bladder and was admitted with Moisture Associated Skin Damage and Pressure Sores. Review of the Comprehensive Plan of Care for Resident #3 dated 05/13/2014 and reviewed on 08/27/2014 reflected Resident #3 had Pressure Sores on her back extending down to posterior or upper thighs and the goal was that skin will remain clean and dry and area will decrease in size and or heal within the next three (3) months. Approaches included: Perform treatment per order, if no improvement within two weeks report to Medical Doctor .Keep.Medical Doctor informed of residents progress. Also care planned was the risk for skin breakdown with multiple skin problems and refusal of care and dressing changes. The stated goal was skin will remain clean, dry and intact .over the next three months. Approaches included monitor for incontinence every two hours and as needed, change promptly. Assess skin on a weekly basis and as needed, report any breakdown to Medical Doctor . Review of Resident #3's Physicians Order Report Dated 10/01/2014 to 12/31/2014 reflected: 04/09/2014 Head to Toe skin assessment every week on Mondays on evening shift . and 08/31/2014 Apply dermaseptin to affected areas of buttocks and bilateral thighs every shift and after each incontinent episode. Review of Resident #3's Weekly Skin Documentation Record reflected on October 8, 2014 Resident #3 had open wounds to the back of the right thigh (3.1 x 1.4 cm), left lower buttock (0.8 x 0.2 cm), and the right thigh above the knee (11.6 x 3.1 cm). Observation on 10/15/2014 at 8:03 AM revealed Resident #3 to be extremely talkative with laughter and requested surveyor to dry her up and shower her and to help her get up now. The surveyor pushed the call bell and alerted staff to Resident #3's wishes to get cleaned up and get up when the call bell was answered. Observation on 10/15/2014 at 10:15 AM revealed Resident #3 turned to her left side with a disposable brief saturated with urine and feces beneath her. Surveyor noted CNA H cleaning feces from Resident #3's anus with toilet paper. CNA H then placed the toilet paper in the trash bag, did not change gloves and then used disposable peri-wipe to cleanse the wound. CNA H without changing her gloves, which were covered in feces, held Resident #3 over on her left side to reveal multiple wounds without dressings: * Resident #3's posterior right lower thigh and a full thickness wound that measured approximately 13.5 cm by 5.5 cm with notable depth, the wound edges were irregular and beveled, the wound bed was beefy red, bloody granulation tissue. These measurements reflected a decline of the wound. *Resident #3 had a full thickness wound to her right posterior upper thigh that measured approximately 3 cm by 2.5 cm, the wound edges were irregular and beveled, the wound bed was beefy red, bloody granulation tissue. *Resident #3 had partial thickness wound to her posterior lateral upper right thigh that measured approximately 1 cm by 1 cm and the wound bed was beefy red. This wound had not been identified previously. *Resident #3 had a full thickness wound to her posterior upper left thigh which measured approximately 3.5 cm by 4.5 cm with >0.1 cm depth the wound had irregular beveled wound edges, from 9 o'clock to 5 o'clock there was a 2 cm by 2 cm area of yellow slough the wound from 5 o'clock to 9 o'clock was beefy red, bloody granulation tissue. This wound had not been identified previously. * Resident #3's Left buttock revealed a full thickness wound approximately 2 cm by 3 cm with beveled irregular wound edges, the wound bed was beefy, bloody granulation tissue. CNA H then placed the disposable peri-wipe in the trash bag and changed gloves. The Treatment Nurse then dabbed at the right thigh wound with a disposable peri-wipe and when he was asked by Resident #3 how her wounds looked he told Resident #3 her wounds were not bad and looked pretty good comparatively. Resident #3 turned to her right side as requested by staff. The Treatment Nurse did not bring a measuring device into the room and did not measure the wounds. CNA H wiped a wound to the left thigh with disposable peri-wipe. The Treatment Nurse then applied Dermaseptin to all skin around all wounds and to the wounds. The Dermaseptin would not adhere to the wounds. In an interview on 10/15/2014 at 11:15 AM CNA L stated she had not done any care for Resident #3 until 10:05 AM. She stated she didn't do it between 6:00 AM and 7:30 AM and that she passed breakfast trays after that. CNA L stated 10:05 AM was the first time she provided care. When surveyor told CNA L Resident #3 had asked for care at 8:05 AM CNA L

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 16) made no response and again stated this was the first care Resident #3 had received. In an interview on 10/15/2014 at 12:00 PM the Treatment Nurse stated he had not seen Resident #3's wounds since Thursday, 10/09/14. He stated she had refused treatment on Friday, Monday and Tuesday therefore he was not aware that the other areas had opened up. When asked if he approached Resident #3 a second time in a day for treatment, he stated, she refused Friday morning and that afternoon. In an interview on 10/15/2014 at 12:10 PM CNA L stated, Her (Resident #3's) wounds are like that every day. That's what it looked like Sunday when I saw her. In an interview on 10/16/2014 at 12:30 AM with LVN G the 10:00 PM to 6:00 AM charge nurse regarding Resident #3's wounds he stated, Friday night (10/10/2014) we gave her a bath. Her wounds were coming back open then. In an interview on 10/17/2014 at 2:30 AM with LVN G the 10:00 PM to 6:00 AM charge nurse regarding Resident #3's wounds he stated that he had let the day shift know of the worsening wounds but that he could not remember if it was Friday or Saturday morning (10/10/2014 or 10/11/2014). In an interview on 10/16/2014 at 10:30 AM the Treatment Nurse stated he did not have an updated Weekly Skin Documentation record because he did not measure Resident #3's wounds on 10/15/2014. He stated after the surveyor left the room (on 10/15/2014) Resident #3 sent him out of the room and would not turn to the other side for him. He further stated he documented the refusal. Upon examining the chart with the surveyor, no documentation for refusal of care of wounds on 10/15/2014 is documented. The Treatment Nurse stated, I didn't document her refusal. When asked if he had went to the room to measure Resident #3's wounds on 10/15/2014 he stated, No I went in there to do a treatment. He further stated, In a week, she got a couple new open areas and the others have gotten a little wors
F 0309 **Level of harm -** Actual harm **Residents Affected -** Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being for three (3) of 13 residents (Resident #2, #3 and #11) reviewed for skin assessments and wound treatments. A) Resident #3 had documented open wounds on her posterior thighs and buttocks some of which had increased in size and an additional opening on her left posterior thigh, not on a bony prominence. The Treatment Nurse, failed to perform a timely physician ordered head to toe assessment and failed to identify the worsening of Resident #3's wound to her right thigh on 10/15/2014 or the development of a new wound to her left thigh, and failed to notify Resident #3's Physician until surveyor intervention on 10/16/2014. B) Resident #2 had an open wound on his posterior lateral right thigh which had increased in size and a new area to his posterior medial right thigh, not on a bony prominence. The Treatment Nurse, failed to perform a physician ordered head to toe assessment and failed to identify the worsening of Resident #2's wound to his right thigh on 10/14/2014 or the development of a new wound to his right thigh, and failed to notify Resident #2 Physician until surveyor intervention on 10/15/2014. C) Resident #11 did not routinely receive the physician ordered treatments to heal a skin condition that inflamed the majority of her buttock area. This deficient practice affected three (3) residents (Resident #2, #3 and #11) and placed an additional 13 residents with wounds at risk for development of infection, pain and worsening of current wounds. Findings Include: A) Review of the Face Sheet reflected Resident #3 was a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] reflected Resident #3's cognitive skills for daily decision making was severely impaired. She had behaviors of scratching others, cursing others and behavior symptoms not directed toward others less than daily. She was totally dependent on others for her bathing needs and required two people for hygiene. Resident #3 was always incontinent of bowel and bladder and was admitted with Moisture Associated Skin Damage and Pressure Sores. Review of the Comprehensive Plan of Care for Resident #3 dated 05/13/2014 and reviewed on 08/27/2014 reflected Resident #3 had Pressure Sores on her back extending down to posterior or upper thighs and the goal was that skin will remain clean and dry and area will decrease in size and or heal within the next three (3) months. Approaches included: Perform treatment per order, if no improvement within two weeks report to Medical Doctor .Keep.Medical Doctor informed of residents progress. Also care planned was the risk for skin breakdown with multiple skin problems and refusal of care and dressing changes. The stated goal was skin will remain clean, dry and intact .over the next three months. Approaches included monitor for incontinence every two hours and as needed, change promptly. Assess skin on a weekly basis and as needed, report any breakdown to Medical Doctor . Review of Resident #3's Physicians Order Report Dated 10/01/2014 to 12/31/2014 reflected: 04/09/2014 Head to Toe skin assessment every week on Mondays on evening shift . and 08/31/2014 Apply dermaseptin to affected areas of buttocks and bilateral thighs every shift and after each incontinent episode. Review of Resident #3's Weekly Skin Documentation Record reflected on October 8, 2014 Resident #3 had open wounds to the back of the right thigh (3.1 x 1.4 cm), left lower buttock (0.8 x 0.2 cm), and the right thigh above the knee (11.6 x 3.1 cm). Observation on 10/15/2014 at 8:03 AM revealed Resident #3 to be extremely talkative with laughter and requested surveyor to dry her up and shower her and to help her get up now. The surveyor pushed the call bell and alerted staff to Resident #3's wishes to get cleaned up and get up when the call bell was answered. Observation on 10/15/2014 at 10:15 AM revealed Resident #3 turned to her left side with a disposable brief saturated with urine and feces beneath her. Surveyor noted CNA H cleaning feces from Resident #3's anus with toilet paper. CNA H then placed the toilet paper in the trash bag, did not change gloves and then used disposable towels to cleanse the wound. CNA H without changing her gloves, which were covered in feces, held Resident #3 over on her left side to reveal multiple wounds without dressings: * Resident #3's posterior right lower thigh and a full thickness wound that measured approximately 13.5 cm by 5.5 cm with notable depth, the wound edges were irregular and beveled, the wound bed was beefy red, bloody granulation tissue. These measurements reflected a decline of the wound. *Resident #3 had a full thickness wound to her right posterior upper thigh that measured approximately 3 cm by 2.5 cm, the wound edges were irregular and beveled, the wound bed was beefy red, bloody granulation tissue. *Resident #3 had partial thickness wound to her posterior lateral upper right thigh that measured approximately 1 cm by 1 cm and the wound bed was beefy red. This wound had not been identified previously. *Resident #3 had a full thickness wound to her posterior upper left thigh which measured approximately 3.5 cm by 4.5 cm with >0.1 cm depth the wound had irregular beveled wound edges, from 9 o'clock to 5 o'clock there was a 2 cm by 2 cm area of yellow slough the wound from 5 o'clock to 9 o'clock was beefy red, bloody granulation tissue. This wound had not been identified previously. * Resident #3's Left buttock revealed a full thickness wound approximately 2 cm by 3 cm with beveled irregular wound edges, the wound bed was beefy, bloody granulation tissue. CNA H then placed the disposable cleansing towel in the trash bag and changed gloves. The Treatment Nurse then dabbed at the right thigh wound with a disposable peri-wipe and when he was asked by Resident #3 how her wounds looked he told Resident #3 her wounds were not bad and looked pretty good comparatively. Resident #3 turned to her right side as requested by staff. The Treatment Nurse did not bring a measuring device into the room and did not measure the wounds. CNA H wiped a wound to the left thigh with disposable peri-wipe. The Treatment Nurse then applied Dermaseptin to all skin around all wounds and to the wounds. The Dermaseptin would not adhere to the wounds. In an interview on 10/15/2014 at 11:15 AM CNA L stated she had not done any care for Resident #3 until 10:05 AM. She stated she didn't do it between 6:00 AM and 7:30 AM and that she passed breakfast trays after that. CNA L stated 10:05 AM was the first time she provided care. When surveyor told CNA L Resident #3 had asked for care at 8:05 AM CNA L made no response and again stated this was the first care Resident #3 had received. In an interview on 10/15/2014 at 12:00 PM the Treatment Nurse stated he had not seen Resident #3's wounds since Thursday, 10/09/14. He stated she had refused treatment on Friday, Monday and Tuesday so he was not aware that the other areas had opened up. When asked if he approached Resident #3 a second time in a day for treatment, he stated, she refused Friday morning and that afternoon. In an interview on 10/15/2014 at 12:10 PM CNA L stated, Her (Resident #3's) wounds are like that every day. That's what it looked like Sunday when I saw her. In an interview on 10/15/2014 at 12:15 Resident #3's NP stated she could not remember if she saw Resident #3's wounds on her last visit to the facility. Resident #3's NP stated Resident #3's skin stays macerated. Resident #3's NP stated she expected staff to notify her of changes. In an interview on 10/16/2014 at 12:30 AM regarding Resident #3's wounds, LVN G, the 10:00 PM to 6:00 AM charge nurse stated, Friday night (10/10/2014) we gave her a bath. Her wounds were coming back open then. In an interview on 10/17/2014 at 2:30 AM regarding Resident #3's wounds, LVN G, the 10:00 PM to 6:00 AM charge nurse stated that he had let the day shift know of the worsening wounds but that he could not remember if it was Friday or Saturday morning (10/10/2014 or 10/11/2014). In an interview on 10/16/2014 at 10:30 AM the Treatment Nurse stated he did not have an updated Weekly Skin Documentation record because he did not measure Resident #3's wounds on 10/15/2014. He stated after the surveyor left the room (on 10/15/2014) Resident #3 sent him out of the room and would not turn to the other side for him. He further stated he documented the refusal. Upon examining

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F 0309 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 17) the chart with the surveyor, no documentation for refusal of care of wounds on 10/15/2014 is documented. The Treatment Nurse stated, I didn't document her refusal. When asked if he had went to the room to measure Resident #3's wounds on 10/15/2014 he stated, No I went in there to do a treatment. He further stated, In a week, she got a couple new open areas and the others have gotten a little worse. He stated 'no staff had notified him of the worsening wounds. The Treatment Nurse further stated the physician had not been notified of the change in the wounds as of 10/16/2014 at 10:30 AM. In an interview on 10/16/2014 at 6:20 PM the DON stated that she expected the staff to notice the change in skin condition on their weekly skin checks. The DON also stated she would expect that the Treatment Nurse would measure the wounds that he was seeing at that opportunity. The DON further stated that she would have expected the Treatment Nurse to notify the Doctor the day he noted the increase in size and number of wounds. She also stated it was reasonable to expect him to do his treatments as ordered. The DON stated the nurse aide staff is not trained to know what a significant change in skin is and that it is up to the Treatment Nurse to know when there is a change. In an interview on 10/16/2014 at 6:45 PM the RNC stated he expected the CNAs to report any change in skin condition to the charge nurse. B) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to require extensive two person assist with bed mobility and personal hygiene. Resident #2 was assessed to be dependent on staff for personal hygiene and bathing. Resident #2 was assessed to require pressure ulcer care. Resident #2 was assessed to have three (3) Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough.) pressure ulcers that were present on admission with at date of 09/29/2014. The tissue type of the pressure ulcers was assessed to be granulation tissue. Resident #2 was assessed to be frequently incontinent of bladder and always incontinent of bowel. Further review of Resident #2's care plan reflected a problem with the onset date of 08/29/2014 Category: Pressure Ulcer; I have an open area to back of right thigh. Under approach Keep me clean and dry; provide me with treatments as ordered by my physician; Report any drainage to my physician promptly; Use good infection control when dealing with my ulcer. Remember to wash your hands before and after treatment. Review of Resident #2's Consolidated Physician orders [REDACTED]. No order was noted for Resident #2's right thigh. Review of Resident #2's Physician Telephone orders reflected an order dated Late entry 09/29/2014 Apply Dermaseptin to Rt. (right) mid thigh , Rt. Lower thigh and coccyx q (every) shift and PRN. Review of Resident #2's Admission assessment dated [DATE] reflected Resident #2 was readmitted for the hospital at 7:00 PM. The assessment further reflected Resident #2 had no pressure areas or wounds noted on the assessment. The assessment was signed by RN A. In an interview on 10/17/2014 at 3:00 PM RN A stated she readmitted Resident #2 on 09/29/2014 and stated she did not see any pressure sores or wounds. Review of Resident #2's Weekly Skin Documentation dated 10/02/2014 reflected Right mid thigh Stage II sheering, 2.1 cm by 1.7 cm with uneven wound edges, pink tissue. Review of Resident #2's Weekly Skin Documentation on 10/08/2014 reflected Right mid thigh Stage II, 1.6 cm by 1.3 cm with uneven wound edges, pink tissue. In an interview on 10/14/2014 at 10:15 AM Resident #2 stated he had sores on his bottom and back of legs. Resident #2 stated I keep them. Resident #2 stated the staff sometimes does treatments and used to use patches on them but I have not had a patch in awhile. Observation on 10/14/2014 at 11:00 AM revealed Resident #2 in bed. Resident #2 was turned to his right side by the DON and Treatment Nurse to reveal a full thickness wound to his posterior lateral right thigh without a dressing which measured approximately 3 cm x 4 cm with >0.1 cm depth, the wound edges were beveled and irregular, the wound bed was pale granulation tissue. Resident #2's had a full thickness wound to his posterior medial right thigh which measured approximately 1.5 cm by 2.5 cm with .0.1 cm depth, the wound edges were beveled and irregular, the wound bed was red granulation tissue. The Treatment Nurse used saline gauze and wiped across both wounds and then applied dermaseptin cream (menthol/zinc oxide). The treatment Nurse did not measure the wounds or acknowledge the new area to Resident #2's right thigh. The treatment Nurse did not wash his hands or change gloves between sites. Review of Resident #2's Physician order [REDACTED].#2's Physician or Nurse Practitioner (NP) had not been notified in regards to worsening of Resident #2's wounds or the development of new wounds. In an interview on 10/15/2014 at 12:00 Noon Resident #2's NP stated she comes to the facility on ce a month to assess the skin issues in the facility. Resident #2's NP stated she could not remember if the facility had called her regarding Resident #2 and further stated she had not seen Resident #2 since he was readmitted to the facility from the hospital. In an interview 10/15/2014 at 2:15 PM the Treatment Nurse stated he had not completed the skin assessment for Resident #2 that was due on 10/14/2014. The Treatment Nurse stated he documents in the nurses notes when he notifies the NP. The Treatment Nurse stated he does the weekly skin assessments anywhere from Tuesday to Thursday. The Treatment Nurse stated he had not notified Resident #2 of any changes in Resident #2's wounds and further stated the NP would be at the facility next week. In an interview on 10/15/2014 at 5:40 PM the DON, when asked about the skin assessment for Resident #2, she stated He has not done that yet? The DON stated she would check with the Treatment Nurse. In an interview on 10/15/2014 at 5:55 PM the DON stated We can go down there now and assess him referring to Resident #2. Observation on 10/15/2014 at 6:30 PM revealed Resident #2 turned to his left side by the DON to reveal Resident #2 had a large amount of loose stool. Resident #2 wounds were not covered with a dressing or cream. Resident #2's wounds were covered in loose stool. The Treatment Nurse left the room to get a CNA to provide incontinent care. In an interview on 10/15/2014 at 7:01 PM the DON stated she would notify Resident #2's NP of his worsening wounds. The DON stated the NP should be notified of any changes in wounds and any new areas when they found. Review of Resident #2's Physician Telephone orders on 10/16/2014 reflected an order dated 10/15/2014 Duoderm to open coccyx ulcer change every 3 days until healed use wound cleanser to clean areas and use dermaseptin to buttocks and thighs PRN. C) Review of Resident #11's Face Sheet reflected a [AGE] year old female admitted on [DATE] with the [DIAGNOSES REDACTED]. Review of Resident #11's Social Service Progress Notes reflected Resident #11 was readmitted on [DATE] from home where she had stayed home overnight in an unsuccessful attempt at independent living. Review of Resident #11's Annual Minimum (MDS) data set [DATE] reflected a Brief Interview for Mental Status score of fourteen (14) indicating she was cognitively intact. Resident #11 was scored as rejecting care one (1) to three (3) days a week and this behavior had worsened compared to the last assessment period. Her functional status was scored as requiring extensive assistance of two (2) people for toilet use, one person for personal hygiene and bathing. She was independently mobile in her wheelchair and transferred independently. She was scored as totally incontinent and had Moisture Associated Skin Damage with daily applications of ointments or medications. Review of Resident #11's Care Plan dated 08/29/2014 reflected a problem of redness to my buttock area measuring 39.6 cm x 31.2 cm with a goal of the redness resolving within the next 30 days. The listed approaches were: 1. Keep me clean and dry. 2. Provide me with the treatments as ordered by my physician. 3. Use treatment as ordered by my physician. Review of Resident #11's Physician order [REDACTED]. infection WebMD website) topical as needed. Review of Resident #11's Physician Telephone Orders reflected a telephone order dated 9/26/2014 Use Interdry Moisture wicking fabric with antimicrobial silver sheets to folds of Abdomen and Buttocks Twice a Day until healed. Review of the Physician Telephone Orders dated 9/29/2014 reflected a telephone order on 09/29/2014 stating: 1. Discontinue Triple Antibiotic ointment to buttocks .2. Discontinue [MEDICATION NAME] to buttocks .3. Change [MEDICATION NAME] powder to abdominal folds to as needed. Review of Resident #11's Weekly Skin Documentation reflected on 08/28/2014 the redness to the buttocks was 39.6 centimeters (cm) x 31.2 cm and the redness to the mid abdomen was 11.8 cm x 26.3 cm. On 10/16/2014 the area to the buttocks was 33.3 cm x 28.2 cm and 15.4 cm x 28.3 cm to the mid abdominal fold. Observation on 10/13/2014 at 8:05 PM revealed Resident #11 to be in the bed with a facility gown on fully awake and alert. Observation on 10/17/2014 at 2:45 PM revealed Resident #11 to be in the bed with a facility gown on. She independently turned to her side but could not reach to remove the disposable brief from her buttocks. Staff was summoned and staff pulled the brief away from the buttock area. The brief had an approximately 6 cm x 4 cm area of old blood soaked into the top of the brief. The buttock area from the top of the gluteal fold to the perineum and extending out towards both flanks was flaming red with lines of dry crusty flakes of skin as it was dying and flaking off. Inside the gluteal fold the skin was intact and showed no sign of breakdown. There was no evidence of any powder, ointment or wicking fabric on buttock area. The resident had a dry brief on. In an interview on 10/17/2014 at 3:30 PM with Resident #11 who was in the bed, she stated she had not had a treatment to her skin that day. She further stated, I don't think he did it yesterday, it is so busy around her now. It is better now because it was bleeding a lot. Now it only bleeds once in a while when the brief sticks to it. When I pull it off it hurts and bleeds a little. In an interview on 10/17/2014 at 10:15 AM with the Treatment Nurse, he stated, We put the anti-wicking sheets on her and the [MEDICATION NAME] to her Left breast around 8:00 PM (yesterday). I did one treatment yesterday. Two were scheduled. The day before, I know I did the abscess on her breast. I don't think we did the wet to dry sheets. They are scheduled twice a day. Most of the time, I can do it. If she is not already up, I'm able to get it done. It is drying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675062	A. BUILDING _____ B. WING _____	10/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARNE HEALTHCARE CENTER	1101 W BROWN ST HEARNE, TX 77859

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

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 18) it out. It's not so moist. It's peeling. We have discussed her lying on her side. She is up most of the day. In an interview on 10/20/2014 at 2:39 PM Resident #11 was in the bed in a facility gown and stated she had not had a treatment today and that there are no more supplies to do the treatment. In an interview on 10/20/2014 at 2:45 PM the Treatment Nurse stated we are doing the Dermaseptin (a moisture barrier ointment) until more supplies arrive. We ran out on Saturday (10/18/2014). When asked who orders the supplies he stated, We order our own supplies. He stated that he faxed the pharmacy in Austin on Saturday and provided this Surveyor a phone number. In a telephone interview on 10/20/2014 at 2:50 PM with multiple Pharmacy staff it was determined that the pharmacy only sent the oral antibiotics to Resident #11 and that the Pharmacy does not supply the Interdry Moisture Wicking Fabric as it does not carry those supplies. In an interview on 10/20/2014 at 3:00 PM Resident #11 is in the bed in a facility gown and states the Treatment Nurse has not done a treatment (on her buttocks) .as he has not had time. In an interview on 10/16/2014 at 6:20 PM the DON stated she expected the Treatment Nurse to do his treatments. When asked if it was reasonable for the Treatment Nurse to do the treatments twice a day if they are ordered twice a day. The DON stated, He works 8:00 AM to 5:00 PM and it is reasonable to expect him to do the twice a day treatments. Review of the facility provided General Skin Protocol reflected: This General Skin Protocol must be followed for all Residents.3. Turn and reposition as indicated by the Resident's clinical condition.5. Incontinent care as indicated by he resident's condition using a nonrinse/moisturizing/moisture barrier. 6. Complete a Wound Evaluation Flow Sheet weekly.8. Any change in the Resident's skin condition must be documented, the Physician and Responsible Party notified and the (corporate) Skin Treatments initiated. Review of the Website: <http://www.ncbi.nlm.nih.gov/pubmed/ 547>: reflected Moisture-associated skin damage (MASD) is caused by prolonged exposure to various sources of moisture, including urine or stool, perspiration, wound exudate, mucus, saliva, and their contents. MASD is characterized by inflammation of the skin, occurring with or without erosion or secondary cutaneous infection. Multiple conditions may result in MASD; 4 of the most common forms are incontinence-associated [MEDICAL CONDITION], intertriginous [MEDICAL CONDITION], periwound moisture-associated [MEDICAL CONDITION], and [MEDICATION NAME] moisture-associated [MEDICAL CONDITION] .To prevent MASD, clinicians need to be vigilant both in maintaining optimal skin conditions and in diagnosing and treating minor cases of MASD prior to progression and skin breakdown. Review of the Website: <http://www.woundsource.com/patientcondition/moisture-associated-skin-damage-masd> :Incontinence-associated [MEDICAL CONDITION] (IAD) is predominantly a chemical irritation resulting from urine or stool coming in contact with the skin. Ammonia from urine and enzymes from stool can disrupt the acid mantle of the skin and eventually cause the skin to break down. As with the other forms of MASD discussed above, maceration also plays a key role in the formation of IAD, and can makes the skin more susceptible to friction damage. While urinary incontinence may lead to IAD, it is much more common in individuals with fecal incontinence or mixed urinary and fecal incontinence. The affected area will present with [DIAGNOSES REDACTED], as well as maceration. The area may progress to painful partial-thickness erosions with weepy serous exudate. If left untreated, pressure and friction may increase stress on the affected area, leading to skin breakdown. Depending on the areas exposed to urine and stool, IAD is not necessarily limited to the perineal area, and can extend up onto the lower back or down onto the inner thighs. Review of the Facility's Policy Skin System dated 02/15/2012 reflected 6. The Weekly Skin Assessment form is completed weekly for Residents with presence of skin interruptions of any type. If no skin interruption is identified, the nurse assessor will document the assessment performed weekly on the TAR. 7. The facility DON is responsible for assignment of weekly skin assessments . 10. The facility DON should visualize areas related to pressure weekly and be able to report observations to the Standards of Care Team members. The DON is validating the accuracy of the description of the pressure ulcer documentation on the weekly assessment form. Review of the Facility's Policy Pressure Ulcer definition dated 02/15/2012 reflected A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.Stage II.This stage should not be used to describe skin tears, tap burns, perineal [MEDICAL CONDITION], maceration or excoriation. Review of the Facility's Policy General Skin Protocols dated 02/15/2012 reflected Peri-Care Instructions 1B. 6. Complete a Skin Site Identification Form and notify charge nurse of any reddened or broken area(s). The facility provided a list of 13 Residents with wounds.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure two (2) of nine (9) Residents (Resident #4, and #2) reviewed for pressure sores received necessary treatment and services to promote healing and prevent new sores from developing. A) The facility failed to accurately assess and stage Resident #4's wound to her ankle and failed to notify the physician of a decline in the wound. Resident # 4's wound declined from a Stage II to a Stage III. B)The facility did not identify a Stage II Pressure Sore that declined to a Stage III Pressure Sore on Resident #2's coccyx and did not identify a separate Stage III Pressure Sore on Resident #2's sacrum until Surveyor Intervention. This deficient practice affected Resident #4, and #2 and placed 22 additional residents at risk for development of new pressure sores, infection and worsening of current pressure sores. Finding Include: A) Review of the Face Sheet for Resident #4 reflected a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of the Quarterly MDS Assessment for Resident #4 dated 09/06/2014 reflected a BIMS score of three (3) indicating severe cognitive impairment. Resident #4 was totally dependent on staff for dressing, hygiene, bed mobility, and bathing. She needed extensive assistance with eating. The Assessment reflected Resident #4 was not transferred for the seven (7) day look back period. Resident #4 was incontinent bowel and bladder. She weighed 104 pounds and was coded for weight loss that was not prescribed. Resident #4 was not coded for dehydration. Resident #4 was also on a mechanically altered diet. The Assessment reflected Resident #4 had two Stage II Pressure Sores (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough.) and one (1) Stage IV. The date of the oldest Stage II was 08/08/2014. The Stage IV measurements were 1.7 cm x 1.1 cm x 1.4 cm with granulation tissue. The Assessment indicated all the pressure sores worsened and none had healed since the last assessment. Resident #4's skin treatment included a pressure reducing device for bed, nutrition or hydration intervention to manage skin problems, and pressure ulcer care. Resident #4 was on Hospice care. Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated 08/28/2014 I have a pressure ulcer on my right outer ankle currently a Stage II. 1.3 x 1.2 cm with a Goal for the pressure sore to .heal 1 cm per month . The Care Plan reflected Resident #4's Approaches .Provide me with treatments as ordered .Report any drainage to my physician promptly .Use good infection control when dealing with my ulcer. Remember to wash your hands before and after treatment. Review of Resident #4's Consolidated Physician order [REDACTED]. Chlorine, the active ingredient in Dakin's solution, is a strong antiseptic that kills most forms of bacteria [MEDICAL CONDITION].) apply wet to dry every day. Review of Resident #4's Weekly Skin Documentation reflected an assessment dated [DATE] of Resident #4's Right outer ankle. Resident #4's right ankle was Staged at a II that measured 0.8 cm by 0.6 cm with 0.2 cm depth with granulation tissue. Observation on 10/14/2014 at 11:45 AM revealed Resident #4 lying in the bed on the left side. Treatment Nurse did not wash his hands prior to setting up the wound care supplies on a piece of wax paper on top of the treatment cart. The DON entered Resident #4's room and donned gloves without washing her hands. Resident #4's dressing to the right outer ankle was intact and when removed had a moderate amount of light yellow drainage. The wound bed had slough and depth when observed-indicating a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendons or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. It may include undermining and tunneling). The wound was not measured at this time but was approximated as 1 cm x 1 cm x 0.5 cm. The wound had slough from throughout the wound but depth could be determined. The wound edges were macerated and rolled. The Treatment Nurse did not change gloves until he finished with this procedure, therefore he removed the dirty dressing, cleansed the wound, and placed the clean dressing on the wound without changing gloves or hand hygiene. The Treatment Nurse cleansed the wound from the outer edge then towards the center wound bed. In an interview on 10/14/2014 at 11:55 AM the DON stated Resident #4's pressure sore to her right outer ankle was a Stage II. In an interview on 10/15/2014 at 12:05 PM Resident #4's NP stated she could not recall if the facility had notified her of any changes for Resident #4. The NP stated generally for Stage III pressure sores she like to use a calcium alginate type dressing covered with a foam dressing to provided extra protection.

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	675062	A. BUILDING _____ B. WING _____	10/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARNE HEALTHCARE CENTER	1101 W BROWN ST HEARNE, TX 77859

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 19) It just depends on what the wound looks like. In an interview on 10/15/2014 at 4:40 PM the Treatment Nurse stated he should have washed his hands before gathering his supplies and during the procedure when you get anything on you. He stated the cleansing should start in the middle of the wound bed and then outward to not drag germs inside. The Treatment Nurse stated he was trained for two hours by RNC and VP Clinical Services and had been performing wound care for two months. Review of Resident #4's Medical Record reflected no new orders for Resident #4's right ankle or assessment documentation as of 10/16/2014. In an interview on 10/16/2014 at 10:30 AM the Treatment Nurse stated Resident #4's right outer ankle pressure sore was a Stage III instead of a Stage II like he had documented. He stated he had not notified the Physician or NP of the right ankle wound changes or the presence of slough. Observation on 10/16/2014 at 12:01 PM revealed Resident #4 was lying in her bed on the right side. The Treatment Nurse entered the room for wound care, and found the right outer ankle pressure sore was not covered by a dressing when he removed her sock and heel protector. He did not know where the dressing for Resident #4 was located and how long it was not on the right outer ankle pressure sore. B) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to require extensive two person assist with bed mobility and personal hygiene. Resident #2 was assessed to be dependent on staff for personal hygiene and bathing. Resident #2 was assessed to require pressure ulcer care. Resident #2 was assessed to have three (3) Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough.) pressure ulcers that were present on admission with at date of 09/29/2014. The tissue type of the pressure ulcers was assessed to be granulation tissue. Further review of Resident #2's care plan reflected a problem with the onset date of 08/29/2014 Category: Pressure Ulcer; I have an open area to back of right thigh. Under approach Keep me clean and dry; provide me with treatments as ordered by my physician; Report any drainage to my physician promptly; Use good infection control when dealing with my ulcer. Remember to wash your hands before and after treatment. Resident #2's care plan further reflected a problem with the onset date of 08/29/2014 Category: Pressure Ulcer; I have an open area to my left thigh. No care plan was noted for a coccyx pressure ulcer. Review of Resident #2's Consolidated Physician orders [REDACTED]. No order was noted for Resident #2's coccyx. Review of Resident #2's Physician Telephone orders reflected an order dated Late entry 09/29/2014 Apply Dermaseptin to Rt. (right) mid thigh , Rt. Lower thigh and coccyx q (every shift and PRN. Review of Resident #2's Admission assessment dated [DATE] reflected Resident #2 was readmitted from the hospital at 7:00 PM. The assessment further reflected Resident #2 had no pressure areas noted on the assessment. The assessment was signed by RN A. In an interview on 10/17/2014 at 3:00 PM RN A stated she readmitted Resident #2 on 09/29/2014 and stated she did not see any pressure sores. Review of Resident#2's Weekly Skin Documentation reflected an assessment performed on 10/02/2014 which reflected Resident #2 had a Stage II pressure ulcer to his coccyx which measured 2.1 cm by 0.3 cm no depth was indicated tissue type was beefy red. In an interview on 10/15/2014 at 2:15 PM the Treatment Nurse stated there was not an assessment of Resident #2's wounds for 09/29/2014. The Treatment Nurse stated the first time he looked at the wounds was 10/02/2014. Review of Resident #2's Weekly Skin Documentation reflected an assessment performed on 10/8/2014 which reflected Resident #2 had a Stage II pressure ulcer to his coccyx which measured 1.6 cm by 0.3 cm. no depth was indicated tissue type was beef red. Observation on 10/14/2014 at 11:00 AM revealed Resident #2 in bed. Resident #2 was turned to his right side by the DON and Treatment Nurse to reveal two (2) pressure ulcers one on his sacrum and one on the coccyx. The pressure ulcers were not covered with a dressing and no cream was noted to the pressure ulcers. The Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) pressure ulcer to Resident #2's sacrum that measured approximately 2 cm by 1 cm by >0.2 cm depth, the pressure ulcer had an irregular beveled wound edges with a white/ gray macerated peri-wound which extended out approximately 0.2 cm. The wound bed was granulation tissue, with active bleeding at 12 o'clock. The Stage III (Full thickness tissue loss in which the base of the ulcer is covered by slough) pressure ulcer to Resident #2's coccyx measured approximately 1 cm by 0.5 cm, the pressure ulcer had an irregular beveled wound edge with a red to light pink peri-wound that extended out approximately 0.4 cm. The wound bed was covered in a yellow granulation tissue. (Approximation by surveyor) No drainage was noted. The Treatment Nurse used saline gauze and wiped across both pressure ulcers and then applied dermaseptin cream (menthol/zinc oxide). The treatment Nurse did not measure the pressure ulcers or acknowledge the new pressure ulcer on Resident #2's sacrum. The treatment nurse did not wash his hands or change gloves between sites. Review of Resident #2's Physician order [REDACTED].#2's Physician or Nurse Practitioner (NP) had not been notified in regards to worsening of Resident #2's pressure ulcers or the development of new pressure ulcers. In an interview on 10/15/2014 at 12:00 Noon Resident #2's NP stated she comes to the facility on ce a month to assess the skin issues in the facility. Resident #2's NP stated she could not remember if the facility had called her regarding Resident #2 and further stated she had not seen Resident #2 since he was readmitted to the facility from the hospital. In an interview 10/15/2014 at 2:15 PM the Treatment Nurse stated he had not completed the skin assessment for Resident #2 that was due on 10/14/2014. The Treatment Nurse stated he documents in the nurses notes when he notifies the NP. The Treatment Nurse stated he does the weekly skin assessments anywhere from Tuesday to Thursday. The Treatment Nurse stated he had not notified Resident #2's NP of any changes in Resident #2's pressure ulcers and further stated the NP would be at the facility next week. In an interview on 10/15/2014 at 5:40 PM the DON, when asked about the skin assessment for Resident #2, she stated He has not done that yet? The DON stated she would check with the Treatment Nurse. In an interview on 10/15/2014 at 5:55 PM the DON stated We can go down there now and assess him referring to Resident #2. Observation on 10/15/2014 at 6:30 PM revealed Resident #2 turned to his left side by the DON. Resident #2 pressure ulcers were not covered with a dressing. The Treatment Nurse measured Resident #2's Coccyx Stage III pressure ulcer stating the measurements were 1.9 cm by 0.3 cm; the Treatment Nurse did not stage the pressure ulcer. The Treatment Nurse measured the pressure ulcer to Resident #2's sacrum and stated it was 2.8 cm by 0.7 cm; the Treatment Nurse did not stage the pressure ulcer. In an interview on 10/15/2014 at 7:01 PM the DON stated she would notify Resident #2's NP of his worsening wounds. The DON stated the NP should be notified of any changes in wounds and any new areas when they found. Review of Resident #2's Physician Telephone orders on 10/16/2014 reflected an order dated 10/15/2014 Duoderm to open coccyx ulcer change every 3 days until healed use wound cleanser to clean areas . Review of the website <http://www.kinnser.com/home-healthcare-blog/oasis-c-tip-m1320-and-stage-ii-pressure-ulcers/> reflected A Stage II pressure ulcer, by definition, is partial thickness loss of dermis presenting as a shallow ulcer. It may also appear as a blister, either intact or ruptured. Because Stage II pressure ulcers do not involve damage to the underlying tissues, they do not heal by formation of granulation tissue. Stage II ulcers heal by [MEDICATION NAME] or regeneration of the epidermis across the wound surface. Review of the <<http://www.woundsource.com/article/identifying-types-tissues-found-pressure-ulcers>> website reflected Granulation tissue- The formation of granulation tissue is thought to be an intermediate step in the healing process of full-thickness wounds. Review of the <http://www.medleague.com/blog/2013/11/14/key-points-for-pressure-ulcer-staging-and-documentation/> website reflected Slough and eschar (types of dead tissue) will only form in full thickness wounds, not partial thickness wounds. If the wound was a Stage 2 and had slough or eschar present, it was inappropriately assessed as a Stage 2. It should have been staged as a Stage 3 or 4. Review of the Facility's Policy Skin System dated 02/15/2012 reflected 6. The Weekly Skin Assessment form is completed weekly for Residents with presence of skin interruptions of any type. If no skin interruption is identified, the nurse assessor will document the assessment performed weekly on the TAR. 7. The facility DON is responsible for assignment of weekly skin assessments . 10. The facility DON should visualize areas related to pressure weekly and be able to report observations to the Standards of Care Team members. The DON is validating the accuracy of the description of the pressure ulcer documentation on the weekly assessment form. 15. The General Skin Protocol should be followed for all pressure ulcers and other skin conditions. Review of the Facility's General Skin Protocols (no date) reflected 6. Complete a Wound Evaluation Flow sheet weekly. 8. Any change in the Residents skin condition must be documented, the physician and responsible party notified and the SLP Skin Treatments initiated. The facility provided a list of 22 residents at risk for development of new pressure sores.
F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**<b>Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and**

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	675062	A. BUILDING _____ B. WING _____	10/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARNE HEALTHCARE CENTER	1101 W BROWN ST HEARNE, TX 77859

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F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 20) **restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide appropriate treatment and services to prevent urinary tract infections for one (1) of one (1) resident (Resident #5) reviewed for catheters when: Resident #5's Indwelling urinary catheter was not secured during repositioning to prevent removal or pulling of the catheter and the Resident's urinary catheter was not maintained in a sanitary manner when his catheter bag was placed on the floor and his tubing was dragged on the floor while he was up in his wheelchair. This deficient practice placed two (2) residents with catheters at risk for the development of/or worsening of urinary tract infection,[MEDICAL CONDITION], undue pain and discomfort and possible trauma such as bleeding or accidental removal of the catheters. Findings include: Review of Resident #5's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnosis: [REDACTED]. Review of Resident #5's Quarterly MDS dated [DATE] reflected Resident #5 was assessed to have a 14 BIMS score indicating Resident #5 was cognitively intact. Review of Resident #5's Consolidated Physician orders [REDACTED]. Review of Resident #5's Comprehensive Care Plan reflected a problem with the onset date of 07/23/2014 I am positive [MEDICAL CONDITION] am at risk for multiple complications such as infections, [MEDICAL CONDITION], depression, fatigue/weakness, social isolation . Under approach Provide for infection control and standard precautions. Further review reflected I am at risk for urinary tract infection due to my permanent indwelling suprapubic Catheter. Under approaches Observe my indwelling catheter, provide catheter care every shift. Observation on 10/15/2014 at 9:00 AM revealed Resident #5 in room. Resident #5's catheter bag was on the floor. Resident #5 was provided peri care by CNA I and rolled over in bed multiple times. No strap was noted to secure Resident #5's catheter. CNA I then transferred Resident #5 with his catheter bag on the floor. CNA I then placed Resident #5's catheter bag into a privacy bag. The catheter tubing was on the floor. CNA I then wheeled Resident #5 out of his room. Resident #5's catheter tubing was dragging on the floor. In an interview on 10/15/2014 at 9:10 AM CNA I stated the catheter bags should not be placed on the floor. In an observation on 10/16/2014 at 9:50 AM the Treatment Nurse provided appropriate Suprapubic catheter care for Resident #5 and when the Treatment Nurse was finished he did not apply a Cath Secure to the abdominal wall and secure the catheter from being pulled or dislodged from the bladder. There was no Cath Secure in place when he set up to perform the care. In an interview on 10/16/2014 at 9:55 AM Resident #5 states he has never been offered a Cath Secure and that his catheter did fall out about two (2) years ago. In an interview on 10/16/2015 at 10:05 AM the Treatment Nurse stated that he doesn't believe it is facility policy to have a catheter securing device and that he doesn't know if it would truly benefit the Resident. Review of The Lippincott Manual of Nursing Practice, 7th Edition, page 694, Care of the Indwelling Catheter reflected Properly securing the catheter prevents catheter movement and traction on the urethra.Pulling on the catheter may be painful. Backward and forward displacement of the catheter introduces contaminants into the urinary tract. Review of the facility's policy Catheter Care, Urinary dated 12/2003 reflected The purpose of this procedure is to prevent infection of the resident's urinary tract.11. Be sure the catheter tubing and drainage bag are kept off the floor.15. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion sit. (Note: Catheter tubing should be strapped to the resident's inner thigh.) 16. Report unsecured catheters to the supervisor. The facility provided CMS 672 reflected two (2) residents with indwelling urinary catheters.
F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility, based on a Resident's comprehensive assessment, failed to ensure each resident maintained acceptable parameters of nutritional status and received a therapeutic diet when there was a nutritional problem for two (2) of four (4) residents (Resident #4 and #7) reviewed for unplanned weight loss or gain. A) Resident #4 had a dietary recommendation on 12/10/2013 to try a mechanical soft diet related to Resident #4 poor intake on the puree diet. This dietary recommendation was not carried out. Resident #4 had a 8.4% weight loss in three (3) months. B) Resident #7 had a Physician order [REDACTED].#7 had a 11.8 % loss of weight in one (1) month. This deficient practice placed 19 residents on supplements and 13 residents on therapeutic diets at risk of further weight loss or gain, increased risk of pressure ulcers and an overall decline in their physical and psychosocial condition. Findings Include: A) Review of the Face Sheet for Resident #4 reflected a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of the Quarterly MDS Assessment for Resident #4 dated 09/06/2014 reflected a BIMS score of three (3) indicating severe cognitive impairment. Resident #4 was totally dependent on staff for dressing, hygiene, bed mobility, and bathing. She needed extensive assistance with eating. The Assessment reflected Resident #4 was not transferred for the seven (7) day look back period. Resident #4 was incontinent bowel and bladder. She weighed 104 pounds and was coded for weight loss that was not prescribed. Resident #4 was not coded for dehydration. Resident #4 was also on a mechanically altered diet. The Assessment reflected Resident #4 had two Stage II Pressure Sores and one Stage IV. The Assessment indicated all the pressure sores worsened and none had healed since the last assessment. Resident #4's skin treatment included a pressure reducing device for bed, nutrition or hydration intervention to manage skin problems, and pressure ulcer care. Resident #4 was on Hospice care. Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated 09/24/2014 I need Hospice care due to my terminal condition with a Goal to .be kept comfortable . Resident #4's Approaches reflected .Observe me for abnormal weight loss and/or appetite and skin breakdown, even though these conditions may become unavoidable, report all changes to my MD (Medical Doctor) and Hospice Services . Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated 09/24/2014 I am bedfast; I do not desire to get out of bed often. I am at risk for skin breakdown and weight loss due to my decreased mobility. Resident #4's Goal was I will have no further skin breakdown or weight loss with nursing intervention . The Care Plan for Resident #4 reflected Approaches .Monitor my weight .Observe my skin with care for redness to pressure areas; report promptly . Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated 09/24/2014 My diet ordered is Pureed NAS (No Added Salt) diet with the option to ask for a regular diet . Resident #4's Goal .be offered an appetizing meal and an alternative meal to help me keep my weight at an acceptable range . Resident #4's Approaches .Let Dietary know if there is a change in my abilities or any special requests I might have so that they can help to provide meals and foods that I like .Let my doctor know if there is a major change in my abilities .Offer me fluids with meals and between meals .Provide me the food I can and like to eat in a way that I can eat it .Weigh me at least once a month and WEEKLY if I show a significant weight loss. Review of Resident #4's weights for the past three (3) months reflected: 08/07/2014: 104 pounds, 09/16/2014: 92 pounds, 10/06/2014: 95.2 pounds a 8.4% weight loss in three (3) months. Review of Resident #4's Consolidated Physician orders [REDACTED].*per son's request* further review reflected an order dated 11/01/2013 May have regular diet. and a order dated 06/24/2014 Magic cup twice daily with lunch and dinner due to recent weight loss. Review of Resident #4's Face Sheet reflected her responsible party (RP) was her daughter. Observation on 10/14/2014 at 12:30 PM revealed Resident #4 in bed being fed by CNA J. Resident #4 lunch was pureed chicken, bread, pinto beans, green peas and carrots. Resident #4 had a magic cup. CNA J stated Resident #4 usually eats well for breakfast then about 25 % at lunch. CNA J stated she does not get the magic cup every meal and sometimes, she does not get it at all. CNA J stated Resident #4 likes the magic cup, but she does not always eat all of it. In an interview on 10/14/2014 at 5:25 PM Resident #4 RP stated Resident #4 does not like the pureed food and does not eat it well. Resident #4's RP stated Resident #4 ask for pinto beans, greens, sweet potatoes. Resident #4's RP stated she eats the soft food she brings her with no problem. Review of Resident #4's Annual Dietary assessment dated [DATE] reflected Observed at lunch, fed by staff not eating much, dislikes puree diet. May want to change to some mechanical soft foods if possible. In an interview on 10/15/2014 at 11:40 AM the Registered Dietician (RD) stated the CNAs, and family members have reported that she does not like the pureed diet and it may have something to do with her weight loss in the past three (3) months. The RD stated that she recommended in December of 2013 that if possible to change to mechanical soft diet. The RD stated that it does not appear that staff have followed through or that there has been any attempt to go back to a mechanical soft diet. Review of Resident #4's Nutritional Progress Notes reflected: -12/10/2013

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F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 21) Weight 113 pounds talked with patient to update food preference. -03/19/2014 on puree diet. Observed in room at lunch, did not like meal. -08/14/2014 Weight 104 pounds Stage II to sacrum.On puree diet.Resident refused to eat. -09/17/2014 Weight 92 pounds (11.5% weight loss) Has stage IV wound coccyx and Stage II to right ankle. Resident admitted to hospice on 09/05/2014.On puree diet.Observed at lunch, ate very little. -10/15/2014 May want to try on soft food such as sandwich to see if resident may take. B) Review of Resident #7's Face Sheet reflected an [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #7 Significant Change MDS dated [DATE] reflected Resident #7 was assessed to have BIMS score of 14 indicating he was cognitively intact. Resident #7 was assessed to require extensive assist with ADLs and was assessed to require extensive one per assist with eating. Resident #7 was assessed to not have weight loss. Review of Resident #7's Comprehensive Care Plan reflected a problem with the onset date 07/31/2014 diet ordered is Pureed with Nectar Thickened Liquids with a goal to be offered an appetizing meal and an alternative meal to help me keep my weight at an acceptable range. Under approaches: Make sure I receive any supplements ordered by my physician. Review of Resident #7's Consolidated Physician order [REDACTED]. Review of Resident #7's Weight Record reflected Resident #7 weight on 09/16/2014 was 153 pounds. Resident #7's weight for 10/06/2014 reflected a weight of 135 pounds a 11.8 % loss of weight in one (1) month. Review of the Dietary Supplement list provided by the facility dated 10/14/2014 reflected Resident #7 was not listed to receive a dietary supplement. In an interview on 10/13/2014 at 6:52 PM with the Dish Aide she stated ,There are no milkshakes. I came in Saturday and there weren't any. The truck comes in on Tuesday and Friday. No one is getting them by an order. The card just says they prefer milkshakes. In an observation on 10/13/2014 at 7:15 PM Resident #7 was in his wheelchair and there was no supplement drink in the room. Observation on 10/14/2014 at 10:18 AM Resident #7 was up in his wheelchair and the Occupational Therapist came to get him for therapy. There was no supplement drink in his room. Observation on 10/14/2014 at 12:30 PM Resident #7 was drinking juice in the dining room. There was no supplement on his tray. He took several bites only. A CNA removed him from the dining room (per his request) without offering him a supplemental drink. Observation on 10/15/2014 from 12:00 to 1:00 PM Resident #7 was not offered a Boost. Review of Resident #7's MARs and TARs reflected no entry for a Boost to be given to Resident #7. In an interview on 10/16/2014 at 10:34 AM LVN B stated there was no entry for Resident #7 on the MAR indicated [REDACTED]. LVN B stated Resident #7 may get a milkshake if he does not eat but she was not aware of Resident #7 having a physician order [REDACTED]. In an interview on 10/16/2014 at 11:25 AM Resident #7 stated he has not had a shake or Boost for over a month to a month and a half ago. Resident #7 stated if he was offered a Boost he would drink it. Resident #7 stated he did not like puree diet. Resident #7 further stated he was hungry and would like something to eat. In an interview on 10/16/2014 at 3:55 PM the DON stated that dietary is responsible for Boost. The DON stated If it is with meals, comes out with the trays and if at bedtime comes out with snacks. The DON further stated she was aware Resident #7 had a physician order [REDACTED]. In an interview on 10/16/2014 at 10:15 AM with the Dietary Department Manager, she stated the facility did not run out of healthshakes until Monday morning and the truck ran on Tuesday and they received two (2) cases of healthshakes. She further stated there are three (3) residents with orders for healthshakes and Resident #7 was not on the list. Review of Resident #7's Daily Skilled Nursing Notes dated 10/18/2014 at 10:30 AM reflected a notification to Resident #7's weight loss. Review of Resident #7's Physician Telephone order dated 10/18/2014 reflected an order for [REDACTED]. Review of the facility's policy Weight Documentation dated 05/21/2014 reflected 8. Physician, Consultant Dietitian, and resident/family (or responsible party) will be notified of significant weight loss/ gain. Implement additional interventions or recommendations as made by notification. Review of the facility's Nourishments and Supplement dated 05/01/2014 reflected 4. Nursing service will deliver the snack or supplement to the designated resident. Supplements are delivered no more than 15 minutes prior to scheduled delivery time. The facility provided a list of 19 residents on supplements and 13 residents on therapeutic diets.
F 0327 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give each resident enough fluids to keep them healthy and prevent dehydration.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, interview and record review, the facility failed to provide sufficient fluids to maintain proper hydration and health to one (1) of five (5) residents (Resident #4) reviewed or hydration, who was dependent on staff for hydration and nutrition needs being met and who had been identified at a risk of dehydration. Resident #4 who had documented weight loss, decrease in intake, and was totally dependent on staff for was not consistently offered fluids for hydration. This deficient practice placed 47 residents who need assistance to eat or drink at risk of dehydration and associated symptoms and complications including skin breakdown, urinary tract infections, kidney failure and a general health decline. Findings include: Review of the Face Sheet for Resident #4 reflected a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of the Quarterly MDS Assessment for Resident #4 dated 09/06/2014 reflected a BIMS score of three (3) indicating severe cognitive impairment. Resident #4 was totally dependent on staff for dressing, hygiene, bed mobility, and bathing. She needed extensive assistance with eating. The Assessment reflected Resident #4 was not transferred for the seven (7) day look back period. Resident #4 was incontinent bowel and bladder. She weighed 104 pounds and was coded for weight loss that was not prescribed. Resident #4 was not coded for dehydration. Resident #4 was also on a mechanically altered diet. The Assessment reflected Resident #4 had two Stage II Pressure Sores and one Stage IV. The Assessment indicated all the pressure sores worsened and none had healed since the last assessment. Resident #4's skin treatment included a pressure reducing device for bed, nutrition or hydration intervention to manage skin problems, and pressure ulcer care. Resident #4 was on Hospice care. Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated 09/24/2014 I am at risk for dehydration . Resident #4's Approaches .Encourage my fluid intake .Monitor my skin turgor .Provide my diet as ordered . Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated 09/24/2014 I need Hospice care due to my terminal condition with a Goal to .be kept comfortable . Resident #4's Approaches reflected .Observe me for abnormal weight loss and/or appetite and skin breakdown, even though these conditions may become unavoidable, report all changes to my MD (Medical Doctor) and Hospice Services . Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated 09/24/2014 I am bedfast; I do not desire to get out of bed often. I am at risk for skin breakdown and weight loss due to my decreased mobility. Resident #4's Goal was I will have no further skin breakdown or weight loss with nursing intervention . The Care Plan for Resident #4 reflected Approaches .Monitor my weight .Observe my skin with care for redness to pressure areas; report promptly . Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated 09/24/2014 My diet ordered is Pureed NAS (No Added Salt) diet with the option to ask for a regular diet . Resident #4's Goal .be offered an appetizing meal and an alternative meal to help me keep my weight at an acceptable range . Resident #4's Approaches .Let Dietary know if there is a change in my abilities or any special requests I might have so that they can help to provide meals and foods that I like .Let my doctor know if there is a major change in my abilities .Offer me fluids with meals and between meals .Provide me the food I can and like to eat in a way that I can eat it .Weigh me at least once a month and WEEKLY if I show a significant weight loss. Review of Resident #4's weights for the past three (3) months reflected: 08/07/2014: 104 pounds, 09/16/2014: 92 pounds, 10/06/2014: 95.2 pounds a 8.4% weight loss in three (3) months. Observation on 10/13/2014 at 6:30 PM revealed Resident #4 lying in bed with eyes closed. No water was noted at bedside. Observation on 10/14/2014 at 10:00 AM revealed Resident #4 in bed on right side with eyes closed. No water was noted at bedside. Observation on 10/14/2014 at 11:45 AM revealed Resident #4 lying in the bed on the left side. Resident #4's dressing to the right outer ankle was intact and when removed had a moderate amount of light yellow drainage. The wound bed had slough and depth when observed-indicating a Stage III pressure sore (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendons or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. It may include undermining and tunneling). Resident #4's skin was shriveled and dry looking. Resident #4's mouth appeared dry and her lips were cracked. Observation on 10/14/2014 at 12:30 PM reveled CNA J assisting Resident #4 with her lunch. Resident #4 had Kool-aide to drink. CNA J asked Resident #4 if she wanted some Kool-aide and Resident #4 stated Just give me anything to drink. CNA J got a straw and placed it to Resident #4's lips. Resident #4 gulped 2/3 of the 10-12 oz glass. In an interview on 10/14/2014 at 5:25 PM Resident #4's RP stated She doesn't have a water pitcher and I don't think they give her water. I can tell the way she drinks that she be thirsty. She likes Kool-aide better than water. In an interview on 10/15/2014 at 9:42 PM CNA Q was asked why Resident #4 did not have a water pitcher in her room and what was Resident #4's hydration plan. CNA Q stated she gives Resident #4 drinks with her meals. In an interview on 10/15/2014 at 11:40 PM the Registered Dietician (RD) stated there was no reason for fluid restrictions on Resident #4 and that she should be offered

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F 0327 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 22) fluids regularly. The RD stated she was not aware the CNAs only offer liquids with meals. In an interview on 10/15/2014 at 5:18 PM the DON stated that water and ice should be available in all rooms at all times. The DON further stated Residents who can not get water on their own should be offered water every hour by CNAs. Review of Resident #4's Medical record reflected no lab work had been drawn since 07/24/2014. Review of the facility's policy Hydration dated 05/01/2014 reflected Residents should be provided sufficient fluid intake to maintain hydration and nutritional needs.4. Hydration carts.are recommended between meals. The facility provided a list of 47 residents who need assistance to eat or drink.
F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents received proper treatment and care for special services for one (1) of one (1) Resident (Resident #2) reviewed for [MEDICAL CONDITION] care when: Resident #2's [MEDICAL CONDITION] (bilevel positive airway pressure) machine was not maintained in a sanitary manner. Resident #2's [MEDICAL CONDITION] had debris floating in the humidification reservoir and Resident #2's [MEDICAL CONDITION] mask had debris in the mask and a thick film on the mask. This deficient practice placed five (5) residents that received [MEDICAL CONDITION] therapy at increased risk of respiratory infection and difficulty breathing. Findings Include: Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to have oxygen therapy. Resident #2 was assessed to have shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. Review of Resident #2's Comprehensive Care Plan reflected a problem with the start date of 09/15/2014 I am at risk for shortness of breath and decreased oxygen saturation level and require continuous oxygen therapy at 3 liters. The care plan did not address Resident #2's [MEDICAL CONDITION].(bilevel positive airway pressure) (is used when positive airway pressure is needed with the addition of pressure support. Common situations where positive airway pressure is indicated are those where taking a breath is difficult.) Review of Resident #2's Consolidated Physician order [REDACTED]. Review of Resident #2's Physician ordered Discharge instructions dated 09/29/2014 at 4:47 PM reflected use of nighttime [MEDICAL CONDITION]. Review of Resident #2's Medical Record reflected Resident #2 was discharged to the hospital on [DATE] for Altered Mental Status (AMS) and was admitted to the hospital for [MEDICAL CONDITION] and placed on a ventilator. Resident #2 was discharged back to the facility on [DATE]. Review of Resident #2's Admission assessment dated [DATE] reflected resident was readmitted to the facility at 7:00 PM. Review of Resident #2's Physician Telephone orders dated 09/30/2014 (no time) reflected to send to hospital to evaluate and treat for possible [MEDICAL CONDITION]. Review of Resident #2's Emergency Record dated 09/30/2014 at 7:34 PM reflected Triage Notes: discharged from hospital last night to Hearne Health Care. Reports dyspnea since last night and left sided weakness since last month. Per EMS, patient I is on [MEDICAL CONDITION] every night and machine was very dirty, mold was on top of water. EMS will file APS report. Handwritten in the margin of this note was This was pt's (patients) personal [MEDICAL CONDITION] from home. Facility [MEDICAL CONDITION] is rented. Review of the APS report dated 09/30/2014 which was referred to DADS reflected EMS was returning the patient to nursing home after being treated at hospital for [MEDICAL CONDITION] physician order [REDACTED]. Upon EMS arrival to patient room, EMS notes yellow, purulent, cloudy, obviously infected water in the humidifying chamber of patients [MEDICAL CONDITION]/ [MEDICAL CONDITION] device. Typically, only distilled water is used in humidifying chambers to prevent infection and to prevent machine malfunction. Nursing staff is notified about the obviously contaminated water and does not seem concerned.EMS informed nurses that the [MEDICAL CONDITION]/ [MEDICAL CONDITION] humidifier needed to be cleansed before it is used by the patient. Nursing staff appeared unconcerned and generally did not act like they cared. Observation on 10/14/2014 at 10:15 AM revealed Resident #2 in bed with oxygen on. Resident #2 had a [MEDICAL CONDITION] machine at his bedside. The [MEDICAL CONDITION] machine had a masked attached to it which was in an undated Ziploc bag. The water in the [MEDICAL CONDITION] humidification reservoir was cloudy and particles were noted floating in the water. In an interview on 10/15/2014 at 11:49 PM the Confidential EMS stated when he brought Resident #2 back to the facility, Resident #2 only had one [MEDICAL CONDITION] machine in the room and it was on his bed side table. The Confidential EMS stated the machine was nasty and disgusting. I took pictures of the machine. Observation of the pictures revealed a blue [MEDICAL CONDITION] machine with the serial number S 6368. The [MEDICAL CONDITION]'s humidification chamber was filled with a yellow, purulent, cloudy substance and clear tape was present at the intake valve where the [MEDICAL CONDITION] machine connected to the humidification chamber. In an interview on 10/16/2014 at 2:00 PM the Administrator stated Resident #2 had an old [MEDICAL CONDITION] from home in his room that was nasty and it was thrown away (the Administrator handed surveyor a ticket from the agency that the facility rented Resident #2's [MEDICAL CONDITION]). The Administrator stated the [MEDICAL CONDITION] Resident #2 was using was picked up by the agency and a [MEDICAL CONDITION] was delivered. The Administrator pointed at the delivery ticket and stated this was the machine he was using. Review of the delivery ticket dated 10/01/2014 reflected pick up for [MEDICAL CONDITION] with the serial #S . The same one in the picture the EMS sent to the state. In an interview on 10/15/2014 at 1:20 PM LVN B stated she did not recall what Resident #2's [MEDICAL CONDITION] looked like when she had him on 09/30/2014. In an interview on 10/17/2014 at 3:00 PM RN A stated she did not remember what Resident #2's [MEDICAL CONDITION] looked like when she readmitted him on 09/29/2014. In an interview on 10/16/2014 at 5:00 PM the DON stated the nurses are supposed to clean the [MEDICAL CONDITION]/[MEDICAL CONDITION] machines weekly or if they are dirty. The DON stated the bags the mask are placed in should be labeled with a date. Review of the facility's policy Nursing Guideline for [MEDICAL CONDITION] and/ or [MEDICAL CONDITION] no date reflected 3. the oxygen tubing and humidifier reservoir will be changed weekly according to facility schedule. 4. The mask will be wiped with a germicidal wipe weekly and as needed to clean any residue on mask. The facility provided a list of five (5) residents on a [MEDICAL CONDITION].

F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection when: A) A facility Resident had an infectious blood borne pathogen (HIV) and received finger stick blood sugar (FSBS) tests four times a day with a glucometer used to test other facility residents. Two (2) of (2) Licensed Vocational Nurses (LVN) (LVN C and D) failed to clean the blood glucose test meter between uses as per manufacturer recommendations. This deficient practice placed 21 residents receiving Glucometer blood glucose monitoring at risk for infection from blood borne pathogens. B) One (1) of one (1) LVN Treatment Nurse provided improper wound care for four (4) of four (4) residents reviewed for wound care (Resident #2, #3, #4 and #6). a) Resident #2 was administered wound treatment that did not incorporate infection control practices of cleaning the wound from inside/center towards the outside of the wound. The Treatment Nurse wiped across two (2) pressure ulcers. The treatment nurse did not wash his hands or change gloves between sites. b) Resident # 3 was administered wound treatment that did not incorporate infection control practices of prevention of fecal contamination of the wounds and appropriate cleansing and administering treatment of [REDACTED]. c) Resident #4 was administered wound treatment that did not incorporate infection control practices of cleaning the wound from inside/center towards the outside of the wound. d) Resident#6 was administered wound treatment to his right third toe amputation site and a pressure sore on the bottom of his foot that did not incorporate infection control practices of hand washing, cleaning the wound from inside/ center towards the outside of the wound, or washing hands and changing gloves between sites. This deficient practice had the potential to place 13 residents with wounds at risk for wound infection, worsening of wounds and sepsis. C) Three (3) of five (5) residents (Resident #1, #3, and #9) when three (3) of five (5) CNAs (CNA M, CNA L, and CNA H) failed to wash hands and/or change gloves, during incontinent care. This deficient practice affected four residents and could affect 47 residents who were occasionally or frequently incontinent of bladder and/or 40 residents who were occasionally or frequently incontinent of bowel at risk for infections to the wounds, the bladder, or the kidneys and a decline in quality of life. D) Three (3) of three (3) residents (Resident #21, #32, and #33) reviewed for

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARNE HEALTHCARE CENTER	**1101 W BROWN ST HEARNE, TX 77859**

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F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 23) respiratory care when the facility failed to change out dated oxygen, and failed to keep oxygen concentrators clean and free of dust and debris. This deficient practice placed residents that received oxygen at increased risk of respiratory infection and difficulty breathing. E) Biohazard room with boxes filled beyond capacity and one resident known to be HIV positive. This deficient practice placed 66 residents at risk for potentially acquiring infectious diseases from within the facility. F) Resident #5 had urine on the floor from the catheter bag and Resident #13 had a wet brief and clothing on the floor in his room at the foot of the bed. This deficient practice could affect 47 residents occasionally or frequently were incontinent of bladder and 40 residents occasionally or frequently incontinent of bowel and could affect 2 residents with indwelling or external catheters at risk for a decline in quality of life. An Immediate Jeopardy (IJ) was identified on 10/15/2014 at 9:20 AM. While the IJ was removed on 10/17/2014, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. Findings include: A) Review of Resident #5's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnosis: [REDACTED]. Review of Resident #5's Quarterly MDS dated [DATE] reflected Resident #5 was assessed to have a 14 BIMS score indicating Resident #5 was cognitively intact. Review of Resident #5's Consolidated Physician orders dated 10/01/2014 reflected an order to Check Blood Sugar at AC and HS (before Meals and at Bedtime) at 6:30 AM, 11:00 AM, 4:00 PM and 8:00 PM. Review of Resident #5's Comprehensive Care Plan reflected a problem with the onset date of 07/23/2014 I am positive for HIV and am at risk for multiple complications such as infections, skin lesions, depression, fatigue/weakness, social isolation . Under approach Provide for infection control and standard precautions. Observation on 10/15/2014 at 7:30 AM revealed LVN C outside of Resident #21's room. LVN C got a glucometer out of the cart and without cleaning the glucometer placed a testing strip in the glucometer. LVN C without washing her hands applied gloves and entered Resident #21's room. LVN C then placed the glucometer on Resident #21's over bed table, which had a white substance on it and other debris, without a barrier. LVN C then performed Resident #21's finger stick blood sugar (FSBS). LVN C then went to cart, removed the used testing strip from the glucometer, removed her gloves and placed the lancet, test strip and used gloves in the trash. LVN C then took the glucometer and placed it in the cart without cleaning the glucometer. LVN C then proceeded down the hall with her cart. In an interview on 10/15/2014 at 7:32 AM LVN C stated, when asked if she should have cleansed the glucometer, LVN C did not answer the surveyors question. LVN C opened the bottom drawer of her cart and pulled out a container of Super Sani-Cloths wipes and placed them on the cart and proceeded down the hall. Observation on 10/15/2014 at 7:40 AM revealed LVN D outside of Resident #23's room. LVN D collected Resident #22's insulin, syringe and glucometer. LVN D took an alcohol wipe and wiped the front of the glucometer, LVN D did not clean the sides of the glucometer. LVN D then entered Resident #23's room. LVN D placed the items on his dresser without a barrier and placed a testing strip in the glucometer. LVN D completed the FSBS and returned to cart placing the glucometer in the cart in a basket on top of new lancets without cleaning the glucometer. In an interview on 10/15/2014 at 7:45 AM LVN D stated she was not sure what the facility policy on cleaning the glucometers was. LVN D stated she was an agency nurse and if the facility does not tell her what they want her to use to clean the glucometers she uses alcohol wipes. LVN D further stated she was not trained by the facility on how to clean the glucometer. LVN D stated she cleaned the glucometer before use but did not clean the glucometer prior to putting in the cart and should have cleaned it. In an interview on 10/15/2014 at 7:50 AM LVN C stated she did Resident #5's FSBS this morning with the same glucometer that she used on everyone. In an interview on 10/15/2014 at 8:10 AM the DON stated, when asked if the staff are supposed to clean the glucometers between Residents, she stated she would have to check the policy. When asked by surveyor if the staff should clean the glucometers between Residents the DON stated I will have to check the policy. In an interview on 10/15/2014 at 8:29 AM the Medical Director stated in regards to the facility staff cleansing the glucometer between Residents They should clean it up it is a possible infection control issue. I would say they should know to clean it, common sense tells you should clean it. Observation on 10/15/2014 at 8:55 AM revealed the DON handing the surveyor a container of Super Sani-cloth germicidal disposable wipes. In an interview on 10/15/2014 at 8:56 AM the DON stated the staff should clean the glucometers with the Super Sani-cloth wipes as per manufacture recommendations. The DON was asked if she had in-serviced the staff on cleaning the glucometers and the DON stated someone is going around right now. The DON was asked if she had in-serviced the agency staff, and the DON stated someone is going around now. In an interview on 10/15/2014 at 5:00 PM the DON stated the Agency Nurses were to be oriented per the orientation checklist for glucose machine cleansing. She also stated she had not in-serviced or trained the staff about glucose machine cleansing. In an interview on 10/15/2014 at 5:05 PM the Administrator stated he expected the DON to be hands on with training the staff on glucose machine cleansing. Review of the facility's policy Medication Pass Observation (no date) reflected When observing Blood Glucose Monitoring make sure the Nurse properly sanitizes the unit as recommended by the Manufacturer prior to use and between each resident. Review of the manufacturer recommendations dated 10/14/2010 for Cleaning and Disinfecting Blood Glucose Meters reflected Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. Many wipes act as both a cleaner and disinfectant. If blood is visibly present on the meter, two wipes must be used, one wipe to clean and a second wipe to disinfect. Review of the Website: <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/ucm 5.htm> reflected the FDA, CDC, and CMS issued clinical reminders and public health notifications highlighting the risk of transmission of disease from shared use of finger stick (lancing) devices and point of care blood testing devices. The posting of these notifications was in response to recent outbreaks of viral hepatitis among patients where these devices were shared between users. The CDC and the FDA currently recommend the following: ?Point of care blood testing devices such as blood glucose meters should be used only on one patient and not shared. If dedicating blood glucose meters to a single patient is not possible, the meters must be properly cleaned and disinfected after every use following the guidelines provided in device labeling. ?Healthcare personnel should change gloves between patients, even if patient dedicated testing devices and single-use, self-disabling lancing devices are used. The facility provided a list of 21 residents who have glucose testing performed. B) a.) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to require pressure ulcer care. Further review of Resident #2's care plan reflected a problem with the onset date of 08/29/2014 Category: Pressure Ulcer; I have an open area. Under approach Keep me clean and dry; provide me with treatments as ordered by my physician; Report any drainage to my physician promptly; Use good infection control when dealing with my ulcer. Remember to wash your hands before and after treatment. Review of Resident #2's Consolidated Physician orders dated 10/01/2014 reflected an order to perform a head to toes skin assessment every week on Tuesday and an order to Cleanse back of left thigh with WC (wound cleanser), pat dry, apply [MEDICATION NAME] q (every) 3 days and PRN (as needed). No order was noted for Resident #2's coccyx. Review of Resident #2's Physician Telephone orders reflected an order dated Late entry 09/29/2014 Apply Dermaseptin to Rt. (right) mid thigh , Rt. Lower thigh and coccyx q (every shift and PRN. Observation on 10/14/2014 at 11:00 AM revealed Resident #2 in bed. Resident #2 was turned to his right side by the DON and Treatment Nurse to reveal two (2) pressure ulcers one on his sacrum and one on the coccyx. The Treatment Nurse used saline gauze and wiped across both pressure ulcers and then applied dermaseptin cream (menthol/zinc oxide). The treatment Nurse did measure the pressure ulcers or address the new pressure ulcer on Resident #2's sacrum. The treatment nurse did not wash his hands or change gloves between sites. In an interview on 10/14/2014 at 1:00 PM the Treatment Nurse stated he should have washed hands and changed gloves between wounds, and cleaned one wound at a time. In an interview on 10/16/2014 at 6:20 PM the DON stated, Yes, I would expect staff to wash their hands when they remove gloves. b.) Review of the Face Sheet reflected Resident #3 was a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] reflected Resident #3's cognitive skills for daily decision making was severely impaired. Resident #3 was always incontinent of bowel and bladder and was admitted with Moisture Associated Skin Damage and Pressure Sores. Review of the Comprehensive Plan of Care for Resident #3 dated 05/13/2014 and reviewed on 08/27/2014 reflected Resident #3 had Pressure Sores on her back extending down to posterior or upper thighs and the goal was that skin will remain clean and dry and area will decrease in size and or heal within the next three (3) months. Approaches included: Perform treatment per order, if no improvement within two weeks report to Medical Doctor .Keep.Medical Doctor informed of residents progress. Also care planned was the risk for skin breakdown with multiple skin problems and refusal of care and dressing changes. The stated goal was skin will remain clean, dry and intact .over the next three months. Approaches included monitor for incontinence every two hours and as needed, change promptly. Review of Resident #3's Physicians Order Report Dated

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F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 24) 10/01/2014 to 12/31/2014 reflected: 04/09/2014 Head to Toe skin assessment every week on Mondays on evening shift . and 08/31/2014 Apply dermaseptin to affected areas of buttocks and bilateral thighs every shift and after each incontinent episode. Observation on 10/15/2014 at 10:15 AM revealed Resident #3 turned to her left side with a disposable brief saturated with urine and feces beneath her. Resident #3 had multiple open wounds without dressings.the Treatment Nurse then dabbed at the right thigh wound with a disposable peri-wipe. CNA H wiped a wound to the left thigh with disposable peri-wipe.The Treatment Nurse then applied Dermaseptin to all skin around all wounds and to the wounds. The Dermaseptin would not adhere to the wounds. The Treatment Nurse did not cleanse the wounds properly prior to attempting to apply ointment. c.) Review of the Face Sheet for Resident #4 reflected a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of the Quarterly MDS Assessment for Resident #4 dated 09/06/2014 reflected a BIMS score of three (3) indicating severe cognitive impairment. The Assessment reflected Resident #4 had two Stage II Pressure Sores and one (1) Stage IV. Resident #4's skin treatment included a pressure reducing device for bed, nutrition or hydration intervention to manage skin problems, and pressure ulcer care. Review of the Comprehensive Care Plan for Resident #4 reflected a Problem dated 08/28/2014 I have a pressure ulcer on my right outer ankle currently a Stage II. 1.3 x 1.2 cm with a Goal for the pressure sore to .heal 1 cm per month . The Care Plan reflected Resident #4's Approaches .Provide me with treatments as ordered .Report any drainage to my physician promptly .Use good infection control when dealing with my ulcer. Remember to wash your hands before and after treatment. Review of Resident #4's Consolidated Physician Orders dated 10/01/2014 reflected an order with the start date 09/17/2014 to cleanse right outer ankle with Dakins (made from bleach that has been diluted and treated to decrease irritation. Chlorine, the active ingredient in Dakin's solution, is a strong antiseptic that kills most forms of bacteria and viruses.) apply wet to dry every day. Observation on 10/14/2014 at 11:45 AM revealed Resident #4 lying in the bed on the left side. Treatment Nurse did not wash his hands prior to setting up the wound care supplies on a piece of wax paper on top of the treatment cart. The DON entered Resident #4's room and donned gloves without washing her hands. The Treatment Nurse did not change gloves until he finished with this procedure, therefore he removed the dirty dressing, cleansed the wound, and placed the clean dressing on the wound without changing gloves or hand hygiene. The Treatment Nurse cleansed the wound from the outer edge then towards the center wound bed. In an interview on 10/15/2014 at 4:40 PM the Treatment Nurse stated he should have washed his hands before gathering his supplies and during the procedure when you get anything on you. He stated the cleansing should start in the middle of the wound bed and then outward to not drag germs inside. The Treatment Nurse stated he was trained for two hours by RNC and VP Clinical Services and had been performing wound care for two months. d.) Review of Resident #6's Face Sheet reflected an [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #6's Quarterly MDS dated [DATE] reflected Resident #6 had a BIMS score of 0 indicating he had severe cognitive impairment. Resident #6 was assessed to require extensive assist with ADL's. Resident #6 was assessed to have surgical wounds. Review of Resident #6's Comprehensive Care Plan reflected a problem with the onset date 07/15/2014 which reflected Resident #6 had a surgical wound from amputation of right great toe. Approaches included Observe an report signs of localized infection. Review of Resident #6's Consolidated Physician Orders dated 10/01/2014 reflected an order dated 09/12/2014 to Cleanse right third toe amputation with wound cleanser and apply dry dressing with dakins everyday. Further review reflected an order dated 09/30/2014 to cleanse area to bottom of right foot with soap and water pat dry apply santyl cover with non adherent pad wrap with kerlix everyday. Observation on 10/15/2014 at 12:10 PM revealed the Treatment Nurse and DON outside Resident #6's room. The Treatment Nurse set up his supplies on wax paper without washing his hands. The Treatment Nurse and DON entered Resident #6's room and did not wash hands prior to donning gloves and performing Resident #6's Treatment to his right toe amputation site. The Treatment Nurse changed gloves without washing hands and treated Resident #6's wound on the bottom of his right foot. In an interview on 10/15/2014 at 4:40 PM the Treatment Nurse stated he should have washed his hands before gathering his supplies and during the procedure when you get anything on you. C) Observation on 10/14/2014 at 5:24 PM revealed CNA M getting prepared to provide incontinent care for Resident #1. Resident #1 was lying in his low bed. CNA M entered the room, did not wash her hands prior to donning gloves. During the procedure CNA M left the dirty brief under the right side of Resident #1, changed gloves, placed the clean brief under the left side of Resident #1, turned Resident #1 back on his left side to finish cleaning, removed the dirty brief, and adjusted the clean brief under Resident #1 prior to changing her gloves. CNA M left Resident #1's room with the trash and did not wash her hands. She entered the shower room, placed the trash in the can, then washed her hands. In an interview on 10/14/2014 at 5:37 PM CNA M stated she should have washed her hands when she entered the room prior to donning gloves. CNA M stated she should have completed the incontinent care and removed the dirty brief, changed gloves, then placed the clean brief on Resident #1. Observation on 10/15/2014 at 8:30 AM revealed CNA L to perform incontinent care and a bed bath for Resident #9. CNA L Entered room after asking a co-worker to get her a plastic bag and did not wash her hands before donning gloves. She washed across the anterior perineal area and then had Resident #9 turn over. She removed feces with toilet paper and changed her gloves without washing her hands. She continued the care and then removed her gloves donned new gloves without washing her hands and applied ointment to his upper body and back. CNA L then removed her gloves and washed her hands. When she finished care she gathered her trash removed her gloves and exited the room without washing her hands. In an interview on 10/15/2014 at 9:00 AM CNA L stated she had been trained to wash hands when going from dirty to clean. When asked, What happened today? She stated, Oh, s*** I messed up. Observation on 10/15/2014 at 10:15 AM revealed Resident #3 turned to her left side with a disposable brief saturated with urine and feces beneath her. Surveyor noted CNA H cleaning feces from Resident #3's anus with toilet paper. CNA H then placed the toilet paper in the trash bag, did not change gloves and then used disposable towels to cleanse the wound. CNA H without changing her gloves, which were covered in feces, held Resident #3 over on her left side to reveal multiple wounds without dressings (see pictures). CNA H then placed a disposable cleansing towel in the trash bag and changed gloves without washing or sanitizing her hands. In an interview on 10/20/2014 at 1:10 PM with CNA H when asked by surveyor what are you supposed to do when you are doing incontinent care and you are going from dirty to clean? I think you are supposed to change gloves. With further questioning CNA H stated, As far as I know you don't have to wash your hands when going from dirty to clean, you only have to change gloves. CNA H further stated she trained with CNA L when she was hired. In an interview on 10/16/2014 at 6:20 PM the DON stated she would expect her staff to wash their hands when they remove their gloves. Review of the facility provided Incontinent Care for the Male Resident reflected: 1. Gather all supplies-towels, disposable wipes, toilet tissue, plastic bags, gloves, place a towel or paper towels over the bedside table for supplies. 2 .Pull curtains, wash/dry hands-apply gloves. 3 .if gloves get soiled-remove them and place in plastic bag-wash hands and re-apply gloves. 4 .cleanse perineal area-wiping front to back-using a clean area of the wipe for each stroke .grasp the penis-clean the tip using a circular motion, starting at the urethral opening and work outward .using a different part of the disposable wipe.cleanse the shaft.Clean the scrotum from clean to dirty .remove and dispose of gloves-wash/dry hands-reapply gloves .cleanse buttocks.place soiled items in a plastic bag .wash hands reapply gloves place call light in reach, open curtains. Gather all supplies and remove .clean bedside table .avoid unnecessary exposure of the resident throughout the procedure . Review of the undated facility Infection Control guidelines for glove use reflected 1. All employees must wear gloves when touching.body fluids, secretions, excretions.non-intact skin.8. Handwashing is necessary when gloves are removed. Review of the facility policy for Handwashing/Hand hygiene dated December 2003 reflected To prevent and to control the spread of infectious diseases. General Guidelines 1. Appropriate.hand washing.must be performed under the following conditions: a. when hands are visibly soiled.b. after contact with blood, body secretions,.non-intact skin; c. After handling items potentially contaminated with blood, body fluids or secretions.3. The use of gloves does not replace handwashing. 4. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: e. Before handling clean or soiled dressings, gauze pads, etc.; f. Before moving from a contaminated body site to a clean body site during resident care; j. After removing gloves. The facility provided a CMS Form 672 that reflected 47 residents who were occasionally or frequently incontinent of bladder and/or 40 residents who were occasionally or frequently incontinent of bowel. D) Review of Resident #21's Face Sheet reflected an [AGE] year old female admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #21's Consolidated Physician Orders reflected an order dated 08/07/2014 for oxygen at 2 liters per nasal canula continuous. Observation on 10/13/2014 at 6:24 PM revealed Resident #21 in bed with oxygen on. Resident #21's oxygen concentrator did not have a filter on the intake vent. Resident #21's concentrator was covered in a gray substance. In an interview on 10/13/2014 at 6:26 PM LVN F stated the oxygen concentrator should have a filter and the concentrator should be cleaned. LVN F stated she thought night shift did that. Review of Resident #32's Face Sheet reflected an [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following

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F 0441 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 25) [DIAGNOSES REDACTED]. Review of Resident #32's Consolidated Physician Orders dated 10/01/2014 reflected an order dated 09/04/2013 for oxygen at 2 liters per nasal canula to maintain oxygen saturation above 90%. Observation on 10/13/2014 at 6:40 PM revealed Resident #32 in bed with oxygen on. Resident #32's oxygen concentrators filter was covered in a gray substance. Resident #32's oxygen concentrator was covered with a gray substance and other debris coated the machine. Resident #32 oxygen tubing was not labeled or dated and she had a neb mask lying on her bedside table that was not in a bag and was not labeled or dated. In an interview on 10/13/2014 at 6:45 PM LVN F stated Resident #32's oxygen concentrator was dirty and the filter needed to be cleansed. LVN F stated her oxygen tubing and neb mask should be labeled and dated. Review of Resident #33's Face Sheet reflected an [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #33's Consolidated Physician Orders dated 10/01/2014 reflected an order 02/06/2014 for oxygen at 2 liters as needed for shortness of breath. Observation on 10/13/2014 at 6:35 PM revealed Resident #33 in bed with oxygen on. Resident #32's oxygen concentrator did not have a filter on the intake vent and the machine was covered in a gray substance. In an interview on 10/13/2014 at 6:40 PM LVN F stated Ya that needs a filter too. Review of the Facility's policy for Oxygen Administration (no date) reflected 7. Change oxygen canula and tubing every seven days and as necessary. 8. Keep oxygen canula and tubing used. in a plastic bag when not in use. 9. Wash filters from oxygen concentrators every (the policy reflected a blank to be filled in which was not) in soapy water. E) Observation on 10/18/2014 at 2:30 PM revealed the biohazard room to have two (2) boxes filled and overflowing with red biohazard bags. The box in the back of the closet had red biohazard bags up over the top of the open box with a full sharps container perched on the top bag having only the back ledge of the sharps container within the extended flaps of the box. The box closest to the door was full beyond the top of the extended box flaps with red bags. In an interview on 10/18/2014 at 2:35 PM with RN B, weekend charge nurse, she stated the boxes are not supposed to be overflowing and that she does not know who is responsible for the biohazard room. In an interview on 10/18/2014 at 2:38 PM with the Maintenance Director, he stated the nurses are supposed to let me know when the boxes need taking out. He further stated he does not look into the room routinely. In an interview on 10/18/2014 at 2:40 PM the RNC stated he expected the boxes not to be over-filled, for them to be closed when they are full and for the nurses to let the maintenance man know when the boxes need to be removed from the building. Review of the Infection Control Guidelines: Infectious Waste, Storage dated 05/01/2009 reflected .11. It is the responsibility of the infection control coordinator to monitor the medical wastes storage to assure that medical wastes are treated, disposed of, or picked up by the authorized vendor on a timely basis. Review of the facility provided Regulated Waste Policy reflected .place in containers which are.constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping.closed prior to removal to prevent spillage or protrusion of contents during handling, storage. F) Review of Resident #5's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnosis: [REDACTED]. Review of Resident #5's Quarterly MDS dated [DATE] reflected Resident #5 was assessed to have a 14 BIMS score indicating Resident #5 was cognitively intact. Review of Resident #5's Comprehensive Care Plan reflected a problem with the onset date of 07/23/2014 I am positive for HIV and am at risk for multiple complications such as infections, skin lesions, depression, fatigue/weakness, social isolation . Under approach Provide for infection control and standard precautions. Observation on 10/13/2014 at 7:05 PM revealed in Resident #5's room and on the floor under the catheter bag was a puddle of something liquid on the floor. Resident #5 stated the CNA spilled the urine when she emptied the catheter bag. The room had a strong odor. In an interview on 10/13/2014 at 7:07 PM the DON stated the puddle on the floor could possibly be urine. The DON stated she would arrange for the spill to be cleaned. Observation on 10/13/2014 at 6:40 PM revealed in Resident #13's room there was a wet brief on the floor with the dirty side down on the floor. There was also some wet clothing on the brief and floor. Resident #13 stated the CNA just left the brief and clothing on the floor when he was assisted to bed about an hour ago. The room had an odor. The items were on the floor at the foot of the bed. In an interview on 10/13/2014 at 7:02 PM the DON stated the wet brief and clothing should not be left on the floor. Review of the facility's policy Housekeeping and Pest Control dated 12/2003 reflected 3. Blood, excretion, and secretion spills should be quickly contained by nursing personnel and disinfected according to the procedure entitled Cleaning Up Spills or Splashes of Blood or Body Fluids. The facility Administrator was notified on 10/15/2014 at 9:20 AM that an IJ situ
F 0456 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep all essential equipment working safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain all patient care equipment in safe operating condition for three (3) of nine (9) oxygen concentrators (Resident #21, #32 and #33); and one (1) of five (5) [MEDICAL CONDITION] machines (Resident #2.) A) Three (3) of three (3) residents (Resident #21, #32, and #33) reviewed for respiratory care when the facility failed to keep oxygen concentrators clean and free of dust and debris. This deficient practice placed residents that received oxygen at increased risk of respiratory infection and difficulty breathing. B) Resident #2's [MEDICAL CONDITION] (bilevel positive airway pressure) machine was not maintained in a sanitary manner. Resident #2's [MEDICAL CONDITION] had debris floating in the humidification reservoir and Resident #2's [MEDICAL CONDITION] mask had debris in the mask and a thick film on the mask. This deficient practice had the potential to affect nine (9) residents using oxygen concentrator and five (5) Residents using [MEDICAL CONDITION] machines by placing them at risk for upper airway discomfort from dirty filters and introduction of bacteria resulting in damage to the resident airway which could lead to bleeding and upper airway infections. Findings Include: A) Review of Resident #21's Face Sheet reflected an [AGE] year old female admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #21's Consolidated Physician order [REDACTED]. Observation on 10/13/2014 at 6:24 PM revealed Resident #21 in bed with oxygen on. Resident #21's oxygen concentrator did not have a filter on the intake vent. Resident #21's concentrator was covered in a gray substance. In an interview on 10/13/2014 at 6:26 PM LVN F stated the oxygen concentrator should have a filter and the concentrator should be cleaned. LVN F stated she thought night shift did that. Review of Resident #32's Face Sheet reflected an [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #32's Consolidated Physician order [REDACTED]. Observation on 10/13/2014 at 6:40 PM revealed Resident #32 in bed with oxygen on. Resident #32's oxygen concentrators filter was covered in a gray substance. Resident #32's oxygen concentrator was covered with a gray substance and other debris coated the machine. In an interview on 10/13/2014 at 6:45 PM LVN F stated Resident #32's oxygen concentrator was dirty and the filter needed to be cleansed. Review of Resident #33's Face Sheet reflected an [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #33's Consolidated Physician order [REDACTED]. Observation on 10/13/2014 at 6:35 PM revealed Resident #33 in bed with oxygen on. Resident #32's oxygen concentrator did not have a filter on the intake vent and the machine was covered in a gray substance. In an interview on 10/13/2014 at 6:40 PM LVN F stated Ya that needs a filter too. Review of the Facility's policy for Oxygen Administration (no date) reflected 7. Change oxygen cannulae and tubing every seven days and as necessary. 8. Keep oxygen cannulae and tubing used. in a plastic bag when not in use. 9. Wash filters from oxygen concentrators every (the policy reflected a blank to be filled in which was not) in soapy water. B) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to have oxygen therapy. Resident #2 was assessed to have shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. Review of Resident #2's Comprehensive Care Plan reflected a problem with the start date of 09/15/2014 I am at risk for shortness of breath and decreased oxygen saturation level and require continuous oxygen therapy at 3 liters. The care plan did not address Resident #2's [MEDICAL CONDITION].(bilevel positive airway pressure) (is used when positive airway pressure is needed with the addition of pressure support. Common situations where positive airway pressure is indicated are those where taking a breath is difficult.) Review of Resident #2's Consolidated Physician order [REDACTED]. Review of Resident #2's Physician ordered Discharge instructions dated 09/29/2014 at 4:47 PM reflected use of nighttime [MEDICAL CONDITION]. Review of Resident #2's Medical Record reflected Resident #2 was discharged to the hospital on [DATE] for Altered Mental Status (AMS) and was admitted to the hospital for [MEDICAL CONDITION] and placed on a ventilator. Resident #2 was discharged back to the facility on [DATE]. Review of Resident #2's Admission assessment dated [DATE] reflected resident was readmitted to the facility at 7:00 PM. Review of Resident #2's Physician Telephone orders dated 09/30/2014 (no time) reflected to send to hospital to evaluate and treat for possible [MEDICAL CONDITION]. Review of Resident #2's Emergency Record dated 09/30/2014 at 7:34 PM reflected Triage Notes: discharged from hospital last night to Hearne Health Care. Reports dyspnea since last

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	675062	A. BUILDING _____ B. WING _____	**10/20/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARNE HEALTHCARE CENTER	**1101 W BROWN ST HEARNE, TX 77859**

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

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F 0456 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 26) night and left sided weakness since last month. Per EMS, patient Is on [MEDICAL CONDITION] every night and machine was very dirty, mold was on top of water. EMS will file APS report. Handwritten in the margin of this note was This was pt's (patients) personal [MEDICAL CONDITION] from home. Facility [MEDICAL CONDITION] is rented. Review of the APS report dated 09/30/2014 which was referred to DADS reflected EMS was returning the patient to nursing home after being treated at hospital for [MEDICAL CONDITION] physician order [REDACTED]. Upon EMS arrival to patient room, EMS notes yellow, purulent, cloudy, obviously infected water in the humidifying chamber of patients [MEDICAL CONDITION]/ [MEDICAL CONDITION] device. Typically, only distilled water is used in humidifying chambers to prevent infection and to prevent machine malfunction. Nursing staff is notified about the obviously contaminated water and does not seem concerned.EMS informed nurses that the [MEDICAL CONDITION]/ [MEDICAL CONDITION] humidifier needed to be cleansed before it is used by the patient. Nursing staff appeared unconcerned and generally did not act like they cared. Observation on 10/14/2014 at 10:15 AM revealed Resident #2 in bed with oxygen on. Resident #3 had a [MEDICAL CONDITION] machine at his bedside. The [MEDICAL CONDITION] machine had a masked attached to it which was in an undated Ziploc bag. The water in the [MEDICAL CONDITION] humidification reservoir was cloudy and particles were noted floating in the water. In an interview on 10/15/2014 at 11:49 PM the Confidential EMS stated when he brought Resident #2 back to the facility, Resident #2 only had one [MEDICAL CONDITION] machine in the room and it was on his bed side table. The Confidential EMS stated the machine was nasty and disgusting. I took pictures of the machine. Observation of the pictures revealed a blue [MEDICAL CONDITION] machine with the serial number S 6368. The [MEDICAL CONDITION]'s humidification chamber was filled with a yellow, purulent, cloudy substance and clear tape was present at the intake value where the [MEDICAL CONDITION] machine connected to the humidification chamber. In an interview on 10/16/2014 at 2:00 PM the Administrator stated Resident #2 had an old [MEDICAL CONDITION] from home in his room that was nasty and it was thrown away (the Administrator handed surveyor a ticket from the agency that the facility rented Resident #2's [MEDICAL CONDITION]). The Administrator stated the [MEDICAL CONDITION] Resident #2 was using was picked up by the agency and a [MEDICAL CONDITION] was delivered. The Administrator pointed at the delivery ticket and stated this was the machine he was using. Review of the delivery ticket dated 10/01/2014 reflected pick up for [MEDICAL CONDITION] with the serial #S . The same one in the picture the EMS sent to the state. In an interview on 10/15/2014 at 1:20 PM LVN B stated she did not recall what Resident #2's [MEDICAL CONDITION] looked like when she had him on 09/30/2014. In an interview on 10/17/2014 at 3:00 PM RN A stated she did not remember what Resident #2's [MEDICAL CONDITION] looked like when she readmitted him on 09/29/2014. In an interview on 10/16/2014 at 5:00 PM the DON stated the nurses are supposed to clean the [MEDICAL CONDITION]/[MEDICAL CONDITION] machines weekly or if they are dirty. The DON stated the bags the mask are placed in should be labeled with a date. Review of the facility's policy Nursing Guideline for [MEDICAL CONDITION] and/ or [MEDICAL CONDITION] no date reflected 3. the oxygen tubing and humidifier reservoir will be changed weekly according to facility schedule. 4. The mask will be wiped with a germicidal wipe weekly and as needed to clean any residue on mask. The facility provided a list of five (5) residents on a [MEDICAL CONDITION] and (9) residents using oxygen concentrators.

F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility Administrator, and the DON failed to administer in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Administrator failed to protect residents in the facility from physical and verbal abuse, and failed to ensure all alleged violations were investigated to prevent further potential for abuse. The Administrator also failed to,implement written policies and procedures that prohibit abuse and the spread of infection. The DON failed to ensure staff were competent to assess and treat pressure sores and wounds. The DON lacked knowledge of staging and treatment of [REDACTED]. The DON failed to ensure staff were trained and competent to perform glucometer testing. An Immediate Jeopardy (IJ) was identified on 10/15/2014 at 9:20 AM. While the IJ was removed on 10/18/2014, the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure affected Resident #2 and #14 could affect the facility's 66 residents by placing them at risk for abuse and/or mistreatment by staff members or agency staff. This deficient practice also placed 21 residents receiving Glucometer blood glucose monitoring at risk for infection from blood borne pathogens. This deficient practice affected four (4) residents (Resident #2, #3, #4,and #11) and placed 16 residents with wounds and four (4) residents with pressure sores at risk for wounds not being assessed, a decline in wounds, infection, and pain. Findings include: A) Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #2's most recent Quarterly MDS dated [DATE] reflected Resident #2 had a Brief Interview of Mental Status (BIMS) score of 13 indicating Resident #2 was cognitively intact. Resident #2 was assessed to require extensive two person assist with bed mobility and personal hygiene. Resident #2 was assessed to be dependent on staff for personal hygiene and bathing. Resident #2 was assessed to not have any psychiatric or mood disorders. Resident #2 was assessed to not have any behavioral symptoms. Review of Resident #2's Comprehensive Care Plan reflected a problem with the onset date of 09/15/2014 I have cognitive loss, which affects my ST/LT (short term and long term) memory and decision making skills. I am at risk for further decline as my disease progresses. Further review of Resident #2's care plan reflected a problem with the onset date of 09/15/2014 I have delusions as evidenced by; Interview on 08/28/2014 by SW (social worker) with mild paranoia and smiling and giggling inappropriately at conversation and secretiveness. Review of Resident #2's physician progress notes [REDACTED]. Review of the list of interviewable Residents in the facility provided by the facility on 10/14/2014 reflected Resident #2 was interviewable. Observation on 10/16/2014 at 4:10 PM revealed Resident #2 was an obese male who was in bed on his back. Resident #2 had oxygen on at 3 liters per nasal canula. Resident #2 was alert. In an interview on 10/16/2014 at 4:15 PM Resident #2 stated CNA G spanked him with her hands a while back. Resident #2 stated there were two (2) CNAs present and did not know the other CNAs name but gave a physical description. Resident #2 stated the event occurred between April and September, before he went to the hospital. Resident #2 stated the aides were rough with me. Resident #2 stated he told the CNAs they were hurting him. Resident #2 stated the aides replied back you are a big man, what do you expect us to do about that. Resident #2 stated when the CNAs spanked him that he asked them to stop and the aides replied He likes it. Resident #2 stated I told the Administrator, the Charge Nurse LVN B, and the Social Worker and they told me I was out of it and did not believe it. They treat me like I am confused. Resident #2 stated the CNAs continue to work with him and they are rough and he does not like it. Resident #2 stated the CNAs have been calling him a trouble maker and hard to deal with. Resident #2 further stated he feels like the CNAs throw him and he is fearful, like he is going to fall out of the bed. Review of Resident #2's Social Service Progress Note dated 05/21/2014 no time reflected reported that he was spanked by CNAs last week and had given the details to the Administrator. Possible delusional thought content. SW (Social Worker) notified DON and Administrator of resident's allegation this AM. In an interview on 10/17/2014 at 5:05 PM the SW stated when Resident #2 is speaking and doesn't seem to be engaged that he is delusional. The SW stated that was the definition of delusional. (The definition of delusional: A false belief or opinion. Psychiatry A false belief strongly held in spite of invalidating evidence, especially as a symptom of mental illness:http://dictionary.reference.com/browse/delusional) Review of Resident #2's Social Service Progress Note dated 06/11/2014 no time reflected Resident continues to talking about delusional thought content about being spanked as well. In an interview on 10/16/2014 at 6:30 PM LVN B stated she was aware of an incident in which Resident #2 stated he was spanked. LVN B stated she reported it to the Administrator. In an interview on 10/17/2014 at 9:20 AM CNA G when asked if she had ever had any problems with Resident #2, stated that Resident #2 did not want her to check on him. CNA G further stated she recalled an incident were Resident #2 accused her of abuse. CNA G stated she was patting Resident #2; CNA G was making repetitive inward motions with her hands; to keep him on his side. CNA G further stated the Administrator talked to her about the incident and told her not to do that anymore. CNA G stated he is trying to get people in trouble referring to Resident #2. CNA G stated she has continued to worked with Resident #2 after the Administrator talked to her. In an interview on 10/17/2014 at 11:07 AM the SW stated that Resident #2 had complained to her about being spanked. SW could not give a date but stated she gave it to the Administrator to follow up on for potential abuse. The SW stated Resident #2 told her he did not want it to happen again. In an interview on 10/17/2014 at 11:20 AM Resident #2 stated he felt abused when CNA G and the other aide were hitting him. Resident #2 stated he told her to stop and he did not want them to take care of him and was fearful they would hurt him. Resident #2 further

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 27) stated I try to be nice so they won't be mean to me. I laugh and joke, that way they will take care of me. I can't take care of myself. In an interview on 10/17/2014 at 11:25 AM when asked if Resident #2 had advised him of any abuse, the Administrator stated no. When asked if the Charge Nurses had advised him Resident #2 had been abused or spanked, the Administrator stated no. When asked if the Social Worker had advised him Resident #2 had been abused or spanked, the Administrator stated no. Surveyor asked the Administrator if he had talked to a CNA regarding an allegation that Resident #2 stated he was spanked by CNAs, Administrator stated there was a spanking incident but he had not been advised it was abuse. The Administrator stated he did not investigate the incident. The Administrator stated Resident #2 had told him he wanted to be spanked and the Administrator stated he did not feel it was abuse. In an interview on 10/17/2014 at 11:35 AM the DON, who was with the Administrator during the above interview, stated she recalled hearing about a report that Resident #2 had wanted to be spanked but she could not remember what was done. The DON stated possibly a psych eval. Review of Resident #2's Medical Record reflected no psych evaluation was conducted regarding behaviors. Review of Resident #2's Comprehensive Care Plan did not reflect a care plan for sexually inappropriate behavior. In an interview on 10/17/2014 at 1:00 PM the Administrator stated again that no one had reported any allegation of abuse to him regarding Resident #2. The Administrator stated he might have talked with an aide he could not remember. The Administrator further stated Resident #2 wanted to be spanked. In an interview on 10/17/2014 at 2:00 PM CNA H stated Resident #2 had never been inappropriate with her and stated no he has never asked me to spank him. In an interview on 10/17/2014 at 2:02 PM CNA I stated that Resident #2 had never been inappropriate and further stated he has never asked to be spanked. CNA I stated she was told by Resident #2 that CNAs had spanked him but he would not tell her who. CNA I stated she told him to report the incident and Resident #2 told her he had already reported it. CNA I stated Resident #2 told her that when he reported it they made him feel uncomfortable. In an interview on 10/17/2014 at 2:10 PM CNA J stated Resident #2 had never been inappropriate with her and never asked her to spank him. CNA J asked someone thinks that about him? In an interview on 10/17/2014 at 2:15 PM LVN B stated regarding Resident #2 No he has never asked me to spank him. In an interview on 10/17/2014 at 4:50 PM CNA K stated she was with CNA G providing care for Resident #2 when the incident occurred. CNA K stated CNA G was pushing Resident #2 to his side using both hands. CNA K indicated that CNA G's hands left and regained contact with Resident #2 multiple times. CNA K stated she did not feel like CNA G was spanking Resident #2 but trying to hold him over. CNA K stated he's big and he is hard to take care of. In an interview on 10/17/2014 at 5:30 PM the RNC stated the facility contacted the police department and a officer came to speck with Resident #2. The RNC stated Resident #2 repeated the allegation and named CNA G as the person who assaulted him and another unknown female. Review of the Police Department report dated 10/17/2014 at 4:40 PM reflected Resident #2 advised two b/f (black females) nurses spanked him on his bottom. Resident advised the incident happened two (2) months ago. Resident #2 advised the pain was a 7 or 8 pain ranging from 1-10 with 10 being the highest. Resident #2 advised he felt kind of abused.Resident #2 advised one of the females nurses who assaulted him was named CNA G.Resident #2 did not know the other aide's name. B) Review of Resident #14's Face Sheet reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #14's Admission MDS dated [DATE] reflected Resident #14 was assessed to not have long or short term memory problems and was assessed to require modified independence in decision making. Resident #14 was assessed to recall, location of room, staff names and faces, and that he is in a nursing. Resident #14 was assessed to have no speech (absence of spoken words), and usually understood and usually understands. Resident #14 was assessed to not have behavior problems or resist care. Resident #14 was assessed to require limited to extensive assist with ADL's and was assessed to be occasionally incontinent. Review of Resident #14's Comprehensive Care Plan reflected a problem with the start date 09/04/2014 which reflected I have a communication deficit related [MEDICAL CONDITION]. I need to use writing material to be able to communicate at times. Approaches listed included: Reassurance and patience when I attempt to communicate, Use gentle, relaxed tone of voice. Resident #14's care plan did not address a cognitive impairment, or behavior problems. Review of Resident #14's History and Physical dated 09/03/2014 reflected Resident #14 was oriented to person, oriented to place, oriented to time, affect appropriate, mood appropriate, is cooperative with care. Review of Resident #14's Admission assessment dated [DATE] reflected Resident #14 was assessed to be alert without memory problems and exhibited no behavior problems. Review of the list of interviewable Residents in the facility provided by the facility on 10/14/2014 reflected Resident #14 was interviewable. Observation on 10/15/2014 at 12:10 PM revealed Resident #14 self propelled in a wheel chair and entered the facility library where the surveyors were working. Resident #14 was visibly upset and asked to talk with the surveyors. Resident #14 was unable to talk related to [MEDICAL CONDITION] but was able to communicate with slight whispering and by lip reading. Resident #14 was asked if he would like a pen an paper so he could write down what he wanted to tell the surveyors. Resident #14 mouthed, no and pointed to his right hand (which was paralyzed) and mouthed he could not write. Resident #14 stated CNA O and CNA P (Resident #14 gave descriptions of the CNAs and first names) talk bad to him and call him names. Resident #14 stated they call him a motherf***** and call him other names and make fun of him when he can't do things for himself. Resident #14 stated the CNAs seek him out and pick on him calling him names. Resident #14 stated it happens every time the CNAs work. Resident #14 stated it has been going on for two (2) months. Resident #14 stated I tell them to go away and they come back. Resident #14 stated she won't stop. Resident #14 stated he feels threatened when they come to him. Resident #14 stated the CNAs have not hit him but stated I feel like she will hit me. Resident #14 stated he was scared that things were going to get worse. Resident #14 stated he has told several people about the CNAs and they do not listen to him. Resident #14 stated he has told Administrator but he did not listen to him. Resident #14 stated the Administrator acted like he did not understand Resident #14 when he tried to tell he about the CNAs mistreatment. In an interview on 10/15/2014 at 1:00 PM the Administrator stated he was not aware of any verbal abuse toward Resident #14 and nothing had been reported to him. After surveyor informed the Administrator of Resident #14's allegations of verbal abuse from CNA O and CNA P he stated okay. Attempts made to contact CNA O and CNA P were unsuccessful. CNA O and CNA P provided the Administrator written statements which were provided to surveyors at exit. Review of CNA P's written statement dated 10/15/2014 (no time) reflected I have never cursed at Resident #14. The only conflict was in the dining room. Resident #13 gave him his regular tray. I reported to charge nurse.He started cursing at me. Calling me bitc*** and motherf****** and pointing his finger in my face. Review of CNA O's written statement which was dated 10/10/2014 (no time) .today is the first day I have ever heard that Resident #14 has accused me of cussing at or in front of him. If I work on Hall 2, I always have another nurse aide or nurse go with me when I take care of him because staff that have worked here before told me that he will lie on you and get you in trouble. Resident #14 tend to get very upset over little things an then will lie on anyone when he can't get what he wants. Resident #14 always cussing towards me an other staff we are the one being abused by him. Review of an interview conducted by the Social Worker on 10/15/2014 reflected Resident #14 was interviewed in presence of Police.Resident reports these ladies (referring to CNA O and CNA P) have been insulting before today.then elaborated that it was a problem before this month. He later indicated it has been going on for two (2) months. When asked what has been going on, resident stated these aides call me names.all kind of names.and stated he got mad because they were calling him names yesterday. In an interview on 10/15/2014 at 2:00 PM the Police Officer stated Resident # 14 had advised him two aides had called him names including mother******. The Police Officer stated this was not a criminal offense. In an interview on 10/15/2014 at 5:00 PM the Administrator stated he suspended CNA O and CNA P pending results of the investigation he was conducting into Resident #14's allegations. In an interview on 10/16/2014 at 12:30 AM LVN G stated, when asked if Resident #14 had reported any complaints, It is hard to understand what he says, so I don't know what he is saying. In an interview on 10/16/2014 at 1:30 PM Resident #30 stated he is Resident #14's roommate. Resident #30 stated the aides pull the curtain when they are providing care to Resident #14 but he can hear them arguing with Resident #14. Resident #30 could not identify which aides argue with Resident #14. In an interview on 10/16/2014 at 5:30 PM Resident #13 (who's room is down the hall from Resident #14) stated he hears the aides screaming at people all the time. Resident #13 stated he can't make out what they say. Resident #14 stated the aides scream at him. Resident #13 stated he did not want to pursue it because it will do no good. In an interview on 10/17/2014 at 11:00 AM Resident #14 stated he wanted to know what was going on. Resident #14 wanted to know why CNA O and CNA P were at the facility. Resident #14 stated he saw the CNAs in the building. Resident #14 was visibly upset by seeing the CNAs. In an interview on 10/17/2014 at 11:25 PM the Administrator stated he could not find any evidence to support Resident #14 was abused, verbally so he let the CNAs come back to work. The Administrator stated both CNAs denied verbally abusing or calling Resident #14 names. The surveyor then asked to see the Administrators investigation report. The Administrator stated he was not completed with the investigation report. The surveyor then asked if he was not completed with the investigation then why were the CNAs allowed to come back to work. The Administrator stated he would get all his notes and give them to the surveyor. The facility did

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 28) not provide a completed investigation report on 10/17/2014. In an interview on 10/17/2014 at 4:55 PM the RNC stated the Administrator had been suspended and Resident #14's investigation was reopened and CNA O and CNA P were suspended until the facility investigation could be completed. C) Review of the Face Sheet for Resident #18 reflected a [AGE] year old male admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of the Admission MDS assessment dated [DATE] for Resident #18 reflected an entry date of 05/29/2014. Resident #18's BIMS score was 14 indicating cognitively intact. Resident #18 was coded with disorganized thinking, delusions, and that he rejected care four to six days of the assessment period. Resident #18 required extensive assistance with transfers and locomotion off the unit but only supervision for locomotion while on the unit. Resident #18 had no history of falls or any falls since admission. Review of the MDS Assessment-Discharge-return not anticipated for Resident #18 dated 08/29/2014 reflected no BIMS score, but reflected Resident #18 had a memory problem under short term memory. Resident #18 was coded to have severe impairment under cognitive skills for daily decision making. Resident #18 was also coded to have disorganized thinking continuously. Resident #18 was assessed with [REDACTED]. Resident #18 also rejected care one to three days during this assessment period. Resident #18 required extensive assistance for transfers but was independent for locomotion on and off the unit. Resident #18 was coded as having one fall since admission with an injury that was not major. In an interview on 10/20/2014 at 1:28 PM Resident #18 stated when he was in the van to be transferred to the other facility he fell when he was trying to get out of the van to his knees. He stated he was left on his knees for 30 minutes before the BOM and the Medical Records/Van Driver finally assisted him back to his wheelchair. Review of the facility's Incident/Accident binder for the month of September 2014 revealed no incident or accident report for Resident #18's fall. Review of the facility's Progress Notes for Resident #18 dated 08/29/2014 reflected no information about a fall. The Notes reflected Resident #18 said he agreed to get on van to go to (other) facility .Pt. (patient) was transferred safely via van. In an interview on 10/20/2014 at 1:50 PM Medical Records/Van Driver stated she was outside of the van loading his belongings when Resident #18 lunged forward in the van. She stated an Agency Nurse was in the van with Resident #18. She stated she did not remember the name of the nurse. The Medical Records/Van Driver stated Resident #18 had told her he would take the keys away or he would wreck the van along the way so the BOM also rode in the van with them. In an interview on 10/20/2014 at 2:00 PM the BOM stated she saw Resident #18 get up from his wheelchair to transfer to a seat in the van and fell to his knees. She stated she told Resident #18 he needed to stay in his wheelchair seat and belted in with the seatbelt. In an interview on 10/20/2014 at 2:20 PM the RNC stated the Administrator was to call corporate on all incidents/accidents that were reportable. The RNC stated he did not recall this incident being reported to him. In an interview on 10/20/2014 at 4:00 PM the VP Clinical Services stated she does not recall the incident or accident on Resident #18 and she would be the one the Administrator would call to find out if the incident was reportable. The VP Clinical Services stated she could not find the investigation of the incident with Resident #18. Review of the facility's policy entitled Accidents/Incidents System revised 08/23/2010 reflected An Accident/Incident Report must be completed immediately upon Facility Staff becoming aware of the incident involving a Resident.An assessment must be performed at the time of the accident/incident and findings documented.An Accident/Incident Investigation must be completed in addition to the Accident/Incident report when staff discovers.any falls.The Director of Nursing Services completes the Conclusion and Intervention form when the investigation has been completed.Accidents/Incidents must be reported both internally and externally in accordance with the State and Federal Guidelines.The Regional Nurse Consultant and the Regional Vice President must be notified. D) Review of the Face Sheet for Resident #9 reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of Resident #9's Quarterly Minimum Data Set ((MDS) dated [DATE] reflected he had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition. His behavior indicators were daily verbal threatening, screaming and cursing along with behavior symptoms not directed toward others such as throwing food. He was scored as rejecting care daily. Additional [DIAGNOSES REDACTED]. Review of the Provider Investigation Report Intake # 1 reflected the facility reported an incident on 09/21/2014 at 10:40 AM that occurred on 09/21/2014 at 10:10 AM. The provider reported Resident #9 has made many allegations when angry. Resident #9 called 911 to report the incident. Resident #9 complained that She poured pi** all over him. He further stated it was last night (09/20/2014) and the pi** caused him to have sores on his head. A head to toe skin assessment was performed while the police were at the facility and no sores were found, no injuries. A statement was obtained from the alleged perpetrator. The report stated Resident #9 named his alleged perpetrator by name and the alleged perpetrator denied the event occurred. Resident #9's Responsible Party was contacted and informed and the Responsible Party requested the Resident be sent out for a complete psychological care because he makes these things up all the time and has for years. The report stated the nurse aide was suspended pending Investigation and that the alleged perpetrator did not work the night of the alleged abuse. Review of the statement from the alleged perpetrator reflected that on Thursday, 18, 2014 Resident #9 turned on his call light and said he needed to be cleaned. He insulted CNA and she told him her name and proceeded to care for him. According to CNA N's witness statement, during that interaction between Resident #9 and CNA N, Resident #9 complained that she had poured urine on him. She stated she informed the charge nurse and had a co-worker accompany her to the room. Review of the Incident Investigation of Incident completed and signed by the LVN F reflected nine (9) staff names of employees/caregivers that had worked in the past 24 hours prior to the complaint of abuse to the police department. There were no statements from any employees. LVN F recorded the incident occurred on 09/20/2014 on 10-6 shift the shift prior to Resident #9's allegation of abuse. There were no interviews or statements from other residents. In an interview on 10/16/2014 at approximately 4:00 PM the Administrator stated he had no further written statements to give to this Surveyor other than the statement from the alleged perpetrator. He stated the packet was complete as given to Surveyor. Review of the Provider Investigation Report Intake # 1 reflected the Facility Investigation findings were that the alleged abuse was unconfirmed and the Provider Action Taken Post-Investigation was that Resident #9 was frequently noncompliant with patient care, refuses assessment by mental health professionals. Nurse Aide will not be working with resident, in-service on abuse and neglect complete. No signs of indications that this allegation is founded and no further issues noted at this time. The document was signed by the Administrator. In an interview on 10/17/2014 at 6:00 PM the RNC stated all allegations of abuse must be handled seriously and investigated. Review of the facility's policy Abuse Prevention Program dated 05/20/2014 reflected Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion .Abuse Investigation Protocol: All reports of resident abuse, neglect injuries of an unknown source .are promptly and thoroughly investigated by facility management .The individual conducting the investigation will as a minimum: e. Interview the persons reporting the incident; f. Interview any witness to the incident; g. Interview the resident; m. Interview other residents to whom the accused employee provides care and services to determine if they have complaints about the employee; o. Review all events preceding the alleged incident .9. Employees of this facility who have been accused of resident abuse will be suspended until the investigation has been completed. Preventing Resident Abuse: Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse . q. Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately. Reporting Abuse to Facility Management: 2. all reports of abuse, including anonymous reports, are promptly investigated. 7. a. Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being .15. Any person who has knowledge or reason to believe that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense SHALL report, or cause a report to be made of , the mistreatment or offense. Failure to report such an incident may result in legal/ criminal action being filed against the individual(s) withholding such information. The facility Administrator was notified on 10/17/2014 at 2:15 PM that an IJ situation had been identified due to above failures. The first Plan of Removal was submitted by the RNC on 10/17/2014 at 5:20 PM. The final Plan of Removal was accepted by the survey team on 10/17/2014 at 5:34 PM. Immediate Jeopardy Plan of Removal Variance to Standard-Allegation of Abuse Resident Behavior and Administration Corrective Action Steps: 1) Staff member accused of abuse was suspended immediately at 2:40 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible DON. 2) Second staff member accused of abuse was also suspended pending investigation at 5:05 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 3) Resident #2 was interviewed on 10/17/2014 by RNC with (MDS Coordinator) witness. Interview completed by Officer .Hearne Police Department at 2:55 PM. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 4) Allegation of Abuse reported to Department of Aging Disability Services by the Administrator at 4:44 PM. Date started 10/17/2014. Target Date 10/17/2014.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675062	A. BUILDING _____ B. WING _____	10/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARNE HEALTHCARE CENTER	1101 W BROWN ST HEARNE, TX 77859

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 29) Staff Responsible Administrator. 5) Facility staff in the building in-serviced on abuse and neglect at 5:10 PM. Staff not currently in facility will be in-serviced before returning to duty. Date started 10/17/2014. Target Date 10/18/2014. Staff Responsible DON. 6) Medical Director .notified of Immediate Jeopardy at 4:12 PM by RNC. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RNC. 7) Interviewable Residents will be interviewed regarding allegations of abuse or neglect. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RVP. 8) Administrator is suspended pending investigation as of 4:55 PM. RNC is point of contact for DADS until RVP arrives. RVP will be abuse prevention coordinator until investigation completed. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible RVP. 9) QA&A Committee will review abuse allegations quarterly until such time as the Administrator determines that substantial compliance has been met. Date started 10/17/2014. Target Date 10/17/2014. Staff Responsible Administrator. Monitoring of the Plan of Removal was conducted by the Survey Team between 10/17/2014 and 10/18/2014. *Resident #2's allegation of abuse was addressed by the Corporate Staff, an investigation was started and it was called to the State certification and survey agency. *Resident #14's allegation of abuse was addressed by the Corporate Staff, an investigation was started and it was called to the State certification and survey agency. *Staff accused were suspended. * In-services had begun with approximately 70 percent of the staff trained by 10/18/2014 and employees not in-serviced will be in-serviced prior to working. *All in-service documentation was reviewed and attendance checked to ensure all licensed nurses were in-serviced. The facility had over 70% of their staff in-serviced on . *Interviews conducted on 10/18/2014 with licensed nursing staff reflected the nurses knew how to identify signs of abuse, were able to identify types of abuse and reporting procedures. *Interviews conducted on 10/18/2014 with certified nur
F 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** Based on observation, interview, and record review the facility failed to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for: A) Three (3) of five (5) residents (Resident #1, #3, and #9) when three (3) of five (5) CNAs (CNA M, CNA L, and CNA H) failed to wash hands and/or change gloves, during incontinent care. This deficient practice affected four residents and could affect 47 residents who were occasionally or frequently incontinent of bladder and/or 40 residents who were occasionally or frequently incontinent of bowel at risk for infections to the wounds, the bladder, or the kidneys and a decline in quality of life. B) One (1) of two (2) Residents (Resident #14) when CNA N and the Treatment Nurse assisted Resident #14 with a two-person transfer by grabbing Resident #14 under both arms to lift him instead of using a gait belt. This deficient practice could affect 41 residents who needed assistance with transfers at risk for potential discomfort and injury. Findings include: A) Observation on 10/14/2014 at 5:24 PM revealed CNA M getting prepared to provide incontinent care for Resident #1. Resident #1 was lying in his low bed. CNA M entered the room, did not wash her hands prior to donning gloves. During the procedure CNA M left the dirty brief under the right side of Resident #1, changed gloves, placed the clean brief under the left side of Resident #1, turned Resident #1 back on his left side to finish cleaning, removed the dirty brief, and adjusted the clean brief under Resident #1 prior to changing her gloves. CNA M left Resident #1's room with the trash and did not wash her hands. She entered the shower room, placed the trash in the can, then washed her hands. In an interview on 10/14/2014 at 5:37 PM CNA M stated she should have washed her hands when she entered the room prior to donning gloves. CNA M stated she should have completed the incontinent care and removed the dirty brief, changed gloves, then placed the clean brief on Resident #1. Observation on 10/15/2014 at 8:30 AM revealed CNA L to perform incontinent care and a bed bath for Resident #9. CNA L Entered room after asking a co-worker to get her a plastic bag and did not wash her hands before donning gloves. She washed across the anterior perineal area and then had Resident #9 turn over. She removed feces with toilet paper and changed her gloves without washing her hands. She continued the care and then removed her gloves donned new gloves without washing her hands and applied ointment to his upper body and back. CNA L then removed her gloves and washed her hands. When she finished care she gathered her trash removed her gloves and exited the room without washing her hands. In an interview on 10/15/2014 at 9:00 AM CNA L stated she had been trained to wash hands when going from dirty to clean. When asked, What happened today? She stated, Oh, s*** I messed up. Observation on 10/15/2014 at 10:15 AM revealed Resident #3 turned to her left side with a disposable brief saturated with urine and feces beneath her. Surveyor noted CNA H cleaning feces from Resident #3's anus with toilet paper. CNA H then placed the toilet paper in the trash bag, did not change gloves and then used disposable towels to cleanse the wound. CNA H without changing her gloves, which were covered in feces, held Resident #3 over on her left side to reveal multiple wounds without dressings (see pictures). CNA H then placed a disposable cleansing towel in the trash bag and changed gloves without washing or sanitizing her hands. In an interview on 10/20/2014 at 1:10 PM with CNA H when asked by surveyor what are you supposed to do when you are doing incontinent care and you are going from dirty to clean? I think you are supposed to change gloves. With further questioning CNA H stated, As far as I know you don't have to wash your hands when going from dirty to clean, you only have to change gloves. CNA H further stated she trained with CNA L when she was hired. In an interview on 10/16/2014 at 6:20 PM the DON stated she would expect her staff to wash their hands when they remove their gloves. Review of the facility provided Incontinent Care for the Male Resident reflected: 1. Gather all supplies-towels, disposable wipes, toilet tissue, plastic bags, gloves, place a towel or paper towels over the bedside table for supplies. 2 .Pull curtains, wash/dry hands-apply gloves. 3 .if gloves get soiled-remove them and place in plastic bag-wash hands and re-apply gloves. 4 .cleanse perineal area-wiping front to back-using a clean area of the wipe for each stroke .grasp the penis-clean the tip using a circular motion, starting at the urethral opening and work outward .using a different part of the disposable wipe.cleanse the shaft.Clean the scrotum from clean to dirty .remove and dispose of gloves-wash/dry hands-reapply gloves .cleanse buttocks.place soiled items in a plastic bag .wash hands reapply gloves place call light in reach, open curtains. Gather all supplies and remove .clean bedside table .avoid unnecessary exposure of the resident throughout the procedure . Review of the undated facility Infection Control guidelines for glove use reflected 1. All employees must wear gloves when touching.body fluids, secretions, excretions.non-intact skin.8. Handwashing is necessary when gloves are removed. Review of the facility policy for Handwashing/Hand hygiene dated December 2003 reflected To prevent and to control the spread of infectious diseases. General Guidelines 1. Appropriate.hand washing.must be performed under the following conditions: a. when hands are visibly soiled.b. after contact with blood, body secretions,.non-intact skin; c. After handling items potentially contaminated with blood, body fluids or secretions.3. The use of gloves does not replace handwashing. 4. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: e. Before handling clean or soiled dressings, gauze pads, etc.; f. Before moving from a contaminated body site to a clean body site during resident care; j. After removing gloves. The facility provided a CMS Form 672 that reflected 47 residents who were occasionally or frequently incontinent of bladder and/or 40 residents who were occasionally or frequently incontinent of bowel. B) Observation on 10/15/2014 at 2:55 PM revealed Resident #14 in his room with CNA N and the Treatment Nurse preparing to provide a two-person transfer for him from his bed to his wheelchair. CNA N and the Treatment Nurse stood on each side of Resident #14 and grabbed under each arm while facing Resident #14 to lift him, pulled up his pants, then sat him back on the bed. CNA N and the Treatment Nurse lifted Resident #14 in the same manner and he was pivoted on his left leg. Resident #14's shoulders and arms were lifted up and out while he was transferred. Resident #14 also had a hoyer lift pad in his wheelchair. In an interview on 10/15/2014 at 4:00 PM the Treatment Nurse stated Resident #14 was sometimes transferred per hoyer lift when staff felt they could not lift him. The Treatment Nurse also stated he felt like he and CNA N could lift him today and did so. The Treatment Nurse stated they should have used a gait belt instead of lifting him under the arms per the facility policy. CNA N nodded her head in agreement. Review of the Facility's policy Safe Resident Handling & Movement Policy (no date) reflected Provide safe resident care and maintain a safe work environment.The facility will assess residents to determine the safest way to accomplish lifting and transferring. Mechanical lifting equipment and/or other handling aides will be used as indicated by assessment. Resident handling tasks that have a high risk of musculoskeletal injury, it. transfer tasks. The facility provided a CMS Form 672 that reflected 41 residents who needed assistance with transfers.

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HEARNE HEALTHCARE CENTER	**1101 W BROWN ST HEARNE, TX 77859**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 30)