STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676174	A. BUILDING _____ B. WING _____	06/27/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMERON NURSING AND REHAB	2202 N TRAVIS ST CAMERON, TX 76520

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** 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 immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when a need to alter treatment significantly for three (3) of nine (9) residents (Residents #3, #7, and #2) reviewed for notifying the physician and/or interested family member when: A) The facility failed to notify Resident # 3's Physician or Responsible Party of a decline in condition which resulted in the pressure sore declining to a Stage IV with infection. B) The facility failed to notify Resident # 7's Physician or Responsible Party of a decline in his pressure sore. Resident # 7's pressure sore declined from a Stage II to a Stage III. This failure resulted in an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. Non-Immediate Jeopardy C) Resident #2 experienced pain during wound care treatment and the physician was not immediately notified. These deficient practices affected three (3) residents and could affect 65 residents by placing them at risk for delay in appropriate medical treatment, the development of new or worsening medical conditions, and diminished quality of life for any resident who may have a new clinical condition. Findings include: A) Review of Resident #3's Face Sheet reflected an [AGE] year old female readmitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3's Significant Change MDS assessment dated [DATE] reflected Resident #3's BIMS score was a five (5) (severe cognitive impairment), she required extensive assistance of two persons to turn, she had an indwelling Foley Catheter, and was frequently incontinent of bowel. Resident #3 was coded as having three (3) Stage I (Intact skin with non-blanchable redness of a localized area usually over a boney prominence) pressure sores and no pressure reduction devices in place. Review of Resident #3's Comprehensive Plan of Care revised on [DATE] reflected The resident has some skin breakdown with interventions of has a pressure relieving mattress.and the resident has a Foley Catheter. Observation on [DATE] at 4:25 PM revealed Resident #3 on her right side receiving peri-care during which time the dressing fell off the sacrum revealing a Stage IV (Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunneling) pressure sore. The pressure sore was approximately 3 cm round and 0.3 cm deep with yellow slough attached to the tendon and muscle in the very center of the wound bed with red wound edges. Periwound edges were reddened, [MEDICAL CONDITION] and not adhered to wound bed thereby indicated tunneling was present. Resident # 3 had a standard green plastic mattress on her bed, a mattress with no pressure reducing qualities. There was no Foley Catheter was in place to prevent contamination of the wound. Observation on [DATE] at 10:50 AM revealed Resident #3 in bed sleeping on her back with a strong odor of urine in her room. No pressure relieving device was on the mattress and no Foley Catheter was in place. Review of the Weekly Skin Monitoring for Resident #3 reflected zero (0) decubitus (pressure sore) on [DATE], [DATE], [DATE], and [DATE]. On [DATE] a Stage II pressure sore (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) to coccyx was documented. Review of the Wound Assessment for Resident #3 by RN A (nurse in charge of assessing and staging wounds) dated [DATE] reflected: Coccyx Stage II, 1.75 centimeters long and 1.5 cm wide, two (2) millimeters deep, slough; yes. The definition located on the Wound Assessment reflected a Stage II pressure sore does not have slough and a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) pressure sore may have slough present but does not obscure the depth of tissue loss. Resident # 3's Stage III Coccyx wound was misstaged at a Stage II. On the same sheet there was an additional wound documented as #2 wound superficial 0.5 cm wide and 0.5 cm long, .0 deep. Wound edges were described as macerated (moisture associated skin damage). Review of Resident #3's Nurses' Notes dated [DATE] reflected the physician was notified of a Stage II on [DATE] and the orders were obtained. No responsible party notification was documented. Review of Resident # 3's Physician order [REDACTED]. Review of the next recorded Wound Assessment for Resident #3 was l4 days later by RN A dated [DATE] and reflected: Coccyx Stage II 2.0 cm long and 1.75 cm wide, one (1) mm deep with some slough. Scattered areas of white slough to wound bed. Again, the wound with slough was staged at a Stage II instead of a Stage III. Review of Resident # 3's Physician order [REDACTED].) to decubitus (pressure sore) on shower days (3 times weekly) and as needed. Review of the Nurse's Notes dated [DATE] reflected no responsible party notification was made. Review of Resident #3's [DATE] TAR reflected an order for [REDACTED]. The order written by Resident # 3's physician on [DATE] was not placed on the TAR and there was no indication this treatment had started. The [DATE] TAR reflected there were no nurse signatures for the dates ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], or [DATE] and indicated no treatment was performed for Resident # 3 on those dates. Observation on [DATE] at 4:35 PM revealed Resident # 3 was provided the treatment ordered [DATE] where the wound was cleansed with wound cleanser, the nurse patted dry and applied Wound Be Gone and added a padded dressing. The physician order [REDACTED]. In an interview on [DATE] at 12:30 PM the DON stated, I knew she (Resident # 3) had the order for Santyl, I just didn't know they weren't carrying it out. It might have helped. Review of the next recorded Wound Assessment for Resident #3 was 14 days later by RN A dated [DATE] reflected: Coccyx Stage IV pressure sore 3.0 cm long and 3.0 cm wide, tunneling around wound ranges from 0.5 cm deep to 1.25 cm deep. [DIAGNOSES REDACTED] and purple tissue around edges. Very [DIAGNOSES REDACTED]tous to wound margins. (Tunneling was drawn around one half of the wound). Yellow slough present on wound base in center. Review of the Nurse's Notes from [DATE] through [DATE] reflected no further physician notification was documented until [DATE] when resident was sent to the physician and was prescribed an antibiotic for treatment of [REDACTED]. Review of the Physician order [REDACTED]. Notify if worsens. Review of Resident #3's [DATE] MAR indicated [REDACTED]. In an interview on [DATE] at 11:56 PM the DON stated it looked like no treatment was performed from [DATE] through [DATE] on paper. The DON also stated she would expect that the nurse to sign the treatment sheet when the treatment was performed. Regarding the catheter that was no longer in place, The DON stated she did not think they would get anywhere with the healing of the pressure sore unless the Foley catheter was put back in place. The DON stated we didn't have a [DIAGNOSES REDACTED]. The DON stated she expected the nursing staff to use the Santyl now. In an interview on [DATE] at 12:15 PM RN A, nurse in charge of measuring, staging and documenting pressure sore progress, stated [DATE] was when she was first alerted there was an issue with the coccyx. RN A further stated she (Resident #3) has had a long standing issue with the coccyx. She will get a little pink then heal up. It's not a Stage I, it's a pre-Stage I. RN A stated Resident #3 was really at risk for pressure sores since she was admitted because she was so emaciated. Immediately after we discontinued the Foley Catheter it started getting worse. RN A further stated Resident #3 refused the air mattress on admission and has refused it periodically in the past. She stated she was unable to find any documentation regarding the refusals and stated,

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

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) on [DATE], I mentioned to her trying to get her on an air mattress and she just wouldn't answer me. RN A further stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In an interview on [DATE] at 3:45 PM Resident #3 was asked if she would like an air mattress overlay placed on her bed while she was up for supper when she stated yes, it's worse than it's ever been. In an interview on [DATE] at 9:00 AM Resident #3, who was up in her wheelchair and had slept on the air overlay mattress, stated I like my bed more and I ate 100% (of her breakfast meal). Resident #3 appeared more comfortable than previous observations. In an interview on [DATE] at 3:45 PM CNA H stated Resident #3 required incontinent care due to bladder incontinence a minimum of two (2) or three (3) times a shift on the evening shifts that she worked. In a telephone interview on [DATE] at 6:15 PM Resident #3's primary Physician stated a Foley Catheter possibly could assist in wound healing and that it should have been a suggestion. Resident # 3's Physician stated that it would be reasonable to believe that an air mattress or pressure relieving mattress would be beneficial. He further stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. Resident # 3's Physician also stated weekly wound measurements may have helped the wound from getting so bad and stated the Santyl order would have possibly helped in wound healing if the order had been followed. In an interview on [DATE] at 12:40 PM the facility's Medical Director stated when Santyl wound ointment is used correctly you can at least see a difference in the wound progress. If it's not done, sometimes the progress is not as obvious as it should be. I would expect the nurses to use it like it's ordered. He also stated, I would expect that a resident should be encouraged to use the air mattress or what is available to prevent or improve the wound. If the resident has dementia (he) expects that the family should be encouraged to assist in those interventions. Regarding improper staging of wounds, he replied, if the wound is not healing or progressing then there are different principles to follow for wound care. B) Review of the face sheet reflected Resident #7 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the Nurses' Notes for [DATE] reflected Resident #7 was admitted with a Stage II pressure sore to the coccyx. Review of the initial MDS assessment dated [DATE] reflected Resident #7 to be moderately impaired in thinking, required two persons and a hydraulic lift to transfer, frequently incontinent of bowel and bladder and had one Stage II pressure sore to coccyx. Additional [DIAGNOSES REDACTED]. Review of the Plan of Care dated [DATE] reflected Resident #7 had breaks in his skin integrity related to pressure ulcer, moisture associated skin damage and stasis ulcers/blisters. Interventions included: monitor treatments for effectiveness and notify physician of any concerns.Report improvements and declines to the MD. Review of the Wound Assessment Sheet for Resident #7 dated [DATE] reflected the pressure sore to the coccyx was 2.5 cm long by .75 cm wide with no slough and staged as Stage II documented and signed by RN A. Observation on [DATE] at 4:53 of Resident #7's wound care and measurement by RN A (nurse in charge of assessing and staging wounds) revealed the pressure ulcer on the coccyx to be 3.5 cm long by 1.25 cm wide. The pressure ulcer was 80% covered in yellow slough and was a Stage III pressure ulcer as defined on the Wound Assessment System document RN A was documenting on. In an interview on [DATE] at 4:53 RN A stated the wound bed was 80% covered with yellow slough. She stated It is a Stage II because there is no depth. I don't really agree with that slough only being a Stage III. RN A underlined slough in the description of a Stage III ulcer. During the measurement of the wound, RN A assured Resident #7 that his pressure sore was looking and getting much better. Review of the Wound Assessment Sheet dated [DATE] reflected RN A had staged the pressure sore a Stage II. In the narrative she documented wound continues to improve. Has shallow bed of whitish slough to top of wound with approx. (approximately) 20% clean non-granulating tissue to edges. Will continue treatment as ordered. RN A documented some slough and the wound base as pink, yellow and white. Review of the Nurses' Notes for Resident #7 dated [DATE] reflected there had been no notification to the family or the physician of the increase in size and the worsening of the appearance of the pressure ulcer. In an interview on [DATE] at 4:30 PM when asked who should notify the family and physician of pressure sores and changes for Resident #7 the DON stated, Charge nurses. Skin nurse when she sees it, she should let the charge nurse know. The LVN should realize to notify. In an interview on [DATE] at 12:15 PM with RN A she stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In a telephone interview on [DATE] at 6:15 PM Resident #7's primary Physician stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. He also stated weekly wound measurements may have helped the wound from getting so bad. Review of the facility's undated policy for PRESSURE ULCER PREVENTION AND MONITORING reflected: .h. any resident with a pressure ulcer which fails to improve or worsens, will have the physician notified promptly. Review of the undated facility's Pressure Ulcer Management Sheet reflected: 4. Promptly inform the physician (and responsible party, as appropriate) of new pressure ulcers. In an interview on [DATE] at 4:30 PM the DON stated the skin nurse should let the charge nurse know when she sees a wo0rsening of condition of wounds. The DON stated the LVN should realize to notify the family and physician. The DON stated she and the ADON were responsible for making sure staff followed facility policy. The DON stated it was her and the ADON's responsibility to ensure staff knew what the facility policies and procedures were. In an interview on [DATE] at 6:05 PM the facility Administrator stated the DON, ADON and charge nurses are responsible for notifying the physician and family. The Administrator stated the he and the Nursing Department are responsible for making sure staff followed procedures. The Administrator further stated it was ultimately his responsibility to make sure staff followed procedures. The Administrator stated the DON should definitely know what wounds were in the building. He was aware his policy stated pressure sores were to be measured weekly. The facility Administrator was notified on [DATE] at 6:20 PM that an IJ situation had been identified due to the above failures. The following Plan of Removal was first submitted by the Administrator on [DATE] at 9:04 AM. The final Plan of Removal was accepted by the survey team on [DATE] at 7:30 PM. Cameron Nursing and Rehab Plan of Removal of Immediate Jeopardy In responses Wound Issues, Cameron Nursing and Rehab will do the following: 1. An RN from (Hospice) to in-service nursing staff on the care and treatment of [REDACTED]. DON, ADON, RN, Medicare Coordinator, and MDS Nurse and charge nurses LVN's will attend. In-service will be at 10:00 on Friday [DATE]. 2. Two Staff Registered Nurses will assess and measure all wounds on a weekly basis. All current wounds will be reassessed after training on [DATE]. 3. Facility will identify all At Risk residents for Skin Breakdown by using the Braden Scale. After in-service, all At Risk residents will be assessed by a RN and LVN to identify any possible pressure issues [DATE]. 4. All Physician orders [REDACTED]. A pink copy of all telephone order forms will be given to the ADON when completed. The ADON will monitor the order and follow through to make sure all meds are ordered and orders entered on treatment sheet and or MARs. This process was started on [DATE]. 5. DON and ADON will do in-service with all charge nurses regarding proper documentation of resident's change of condition, pressure sores, treatments, Physician Orders, and notifying family members and Physician. This will be complete during the in-service on [DATE]. 6. ADON and DON will report to Administrator any new skin issues and update of treatments in progress on Friday of each week with a copy of the weekly decubitus skin assessment log and non-decubitus log. First meeting will be on [DATE] and then weekly. 7. All pressure wounds will be reviewed and discussed at weekly staff meeting, including DON, ADON, MDS Nurse, Medicaid Coordinator, Registered Nurse on Staff, and Administrator on [DATE]. 8. Medical Director was notified of this at 9:30 am on Thursday [DATE]. Resident #3 Facility will: 1. Ensure air mattress is on Resident #3's bed, [DATE]. 2. Will follow physician orders [REDACTED]. (The new order: Cleanse wound on coccyx with Normal Saline, pat dry-Apply Normal saline packing to wound bandage BID (twice daily)-Will consult wound care at Scott & White (Temple)-Insert indwelling catheter.-change q (every) month & PRN (as needed)-Record I&O (input and output) q shift-Catheter care q shift.) 3. Registered Nurse will accompany resident to Doctor's appointment on [DATE] to discuss proper treatment and procedure to be used, and request the use of a Catheter, this will be done on [DATE]. ADON or DON will monitor resident treatment with charge nurse for a period of two weeks to assure proper procedure is followed. If there is no improvement or wound worsens, Physician will be notified. 4. Two Registered Nurses will assess and measure wounds on a weekly basis. 5. Have Staff to continue to encourage resident to stay off of her back side and have staff continue to encourage and assist her to turn when in bed. 6. Nursing staff will encourage Resident to take in proper nourishment to help the healing process and have a Care Plan meeting with Son to encourage compliance with treatment plan. Administrator, DON, ADON will meet with son. 7. Have Dietary Consultant review Resident #3's chart and condition and make recommendations for nutrition on her next visit to the facility. Resident #7 1. Make sure resident maintains a pressure relieving mattress on his bed, [DATE]. 2. Nursing staff will encourage resident to try to stay off of his back side as much as possible, offering repositioning and reminded to use overhead bar. 3. Resident #7 request to be up for all three meals each day and remain in his wheelchair. DON, ADON, Administrator will have a care plan meeting will be held with Resident and Responsible Party regarding the benefits of shorter periods of time sitting in the wheelchair. 4. ADON or DON will monitor resident treatment for [REDACTED]. If there is no improvement or wound worsens, Physician will be notified. 5.

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) Confirm with Physician when Heel Protectors should be worn, requested clarification [DATE]. 6. Notify Physician of change of condition [DATE]. 7. Two Registered Nurses will assess and measure resident's wounds on a weekly basis. The survey team monitored the plan of removal as follows: Reviewed was completed of new treatments as per physician order [REDACTED].#3 as shown in the plan of removal. All treatments and interventions were initiated and carried out. Resident #3's Responsible Party was notified. Resident # 7 had a re-assessment of his wounds and physician and responsible party were notified of the decline in the coccyx pressure sore. Observation of the facility in-service on [DATE] at 10:00 AM revealed the in-service was conducted by a RN from a local Hospice agency. The in-service provided information regarding pressure sores, care for pressure sores, assessments including staging and measuring, as well as interventions to prevent pressure sores. The in-service had four (4) RNs and 11 LVNs in attendance. The Medical Director and the Administrator were also present. The facility had over 70% of their licensed nursing staff in-serviced on [DATE]. The Hospice RN gave a competency test after the in-service in which all nursing staff in attendance passed per the Administrator. The facility provided a list of 25 residents who were at risk for pressure sores after completion of a 100% audit using the Braden Scale to identify residents at risk. Observations were made on [DATE] of four (4) of the 25 residents at risk for pressure sores. These Residents were assessed and staged properly and interventions and treatments were in place. The facility notified the Resident's Physicians and Responsible Parties. Observation on [DATE] at 2:40 PM revealed the DON entered a resident room to assess and measure pressure sores. The DON did not bring a cart or any sanitizing agents to the room. She did not prepare a clean surface for her supplies. She placed supplies for wound measurement under the shoes on Resident #14's gerichair pressure reduction pad of the incontinent resident. She then laid a pair of gloves up against the heels of the shoes and went to the bathroom to wash her hands. She returned from the bathroom and began donning gloves. She approached the resident to explain the process to the resident when the surveyor stopped the DON and instructed her to start over and explained that her articles were contaminated. Later, when the DON began assessing the heel of the resident that had a Deep Tissue Injury (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceeded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue) she proceeded to dismiss the area and pronounced it was blanching after she placed pressure on the heel and released it multiple times. The heel was not blanching. Surveyor stepped forward and asked to see the heel turn white and then return to red. The DON applied pressure once again and admitted the heel was not changing color at all and was actually purple. The DON and ADON then tried to decide if the heel sore was a Stage I or not since it wasn't red. The Surveyor handed the DON the inservice Wound Staging Guide as received in the training inservice and asked her to read the description of a Deep Tissue Injury. The DON then correctly identified the heel as having a deep tissue injury. DON then observed the Stage II that was approx. one (1) cm in size with a pinpoint opening on the sacrum. The DON placed the measuring device on the opening and removed it repeatedly. She finally traced the one (1) cm circle and then marked the pinpoint opening. She then placed the device back on the wound and studied it and then asked the ADON to come and see if she had marked her device correctly. The DON then began studying the raised skin edges on the bilateral buttocks and decided that those impaired skin issues needed measuring. After DON applied the graph several times, the Surveyor asked the ADON if she had told the DON that the resident had a rash over her entire perineum? The ADON said she had not informed the DON and then parted the patients legs so that she could see the raised skin was related to a rash and was not at all pressure sores. When the DON submitted the wound assessment to the surveyor, she had left the entire wound description area of the form blank. The Surveyor returned the form to the DON to complete it. The DON submitted it to the Surveyor the second time. The Surveyor returned the form to the DON and asked her to complete the periwound skin assessment line on the form. In an interview on [DATE] at 2:43 PM the Surveyor asked the DON as she donned gloves if she realized that she had her wound care items under a pair of shoes in the seat of a chair, she stated that she was so nervous that she did not realize what she had done. In a meeting on [DATE] at 3:15 PM the facility Administrator was made aware of the DON's actions during the assessment of Resident # 14's wound. The Administrator stated the DON needed more training and decided to have the two RNs performing skin assessments and not include the DON until she was further trained. Observations were made of a LVN and RN performing a skin assessment and identifying a problem on an at risk resident. Then two RNs returned and performed an assessment on the at risk resident and identified an area of concern on her left great toe. The area was identified as a Suspected Deep Tissue Injury. The two RNs correctly assessed, measured, identified prevention interventions, and notified the physician and the responsible party. The facility provided an attendance signature sheet for the Staff Meeting held on [DATE] after the skin audit was completed with the Administrator, DON, ADON, RN A, MDS Coordinator, and one LVN-Medicaid Coordinator in attendance. On [DATE] at 8:00 PM the facility Administrator was informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. The facility provided a list of 25 residents who were at risk for pressure sores. Non-Immediate Jeopardy C) Review of the Consolidated Physician order [REDACTED].#2 reflected an [AGE] year old male who was admitted on [DATE] with the following Diagnoses: [REDACTED]. Resident #2 did not have an order for [REDACTED]. Observation on [DATE] at 3:00 PM revealed LVN B provided wound care treatment on the coccyx area of Resident #2. Resident #2 was in bed on his left side, LVN B cleaned the area and Resident #2 flinched, grimaced, yell out and complained of pain. In an interview on [DATE] at 5:50 PM LVN C stated Yes, all the time to the question does Resident #2 complain of pain during the wound care. LVN C also stated sometimes up to two to three times a day when we have to change his dressing if it's soiled. In a subsequent interview on [DATE] at 6:00 PM LVN B (who had changed Resident #2's dressing earlier) stated when asked if Resident #2 ever complained of pain before or during wound care Oh yes. LVN B also stated I probably should call the physician and get something for pain prior to Resident #2's wound care. In an interview on [DATE] at 3:40 PM LVN E stated she performed wound care on Resident #2 on Sunday [DATE] and remembered Resident #2 flinching and grimacing during wound care and that he was on hospice and they would take care of his pain. In an interview on [DATE] at 3:15 PM Resident #2's attending physician stated his expectations when a resident experienced pain at levels higher than normal or during wound care that was painful, especially if happening two (2) or more times a day, he expected to be notified by phone or facsimile, so he could give an order for [REDACTED]. In an interview on [DATE] at 3:50 PM the physician's office nurse stated the office did not receive a fax on the date of [DATE]-when Resident #2 experienced pain during treatment. The physician's nurse stated the facility requested pain medicine on [DATE] at 6:00 AM via facsimile. In an interview on [DATE] at 9:30 AM Resident #2 stated he still had not received pain medicine prior to or during dressing changes to his bottom area. Review of the current telephone orders available dated [DATE] reflected no new phone orders for pain medication prior to wound care. Review of the current 24 hour report documentation dated [DATE] and [DATE] did not reflect a physician notification for or of pain during the provision of wound care . Review of the most current Nurses' Notes dated [DATE] and [DATE] did not reflect physician notification requesting new orders for pain medication prior to wound care. Review of the facility's undated Pain Policy reflected a pain evaluation will be completed with each OBRA (Omnibus Budget Reconciliation Act) assessment. (Last OBRA assessment dated [DATE].) The facility provided a CMS Form 672 that reflected 34 residents were on pain management.
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement written policies and procedures that prohibit neglect for two (2) of nine (9) residents reviewed for neglect when: A) The facility failed to ensure Resident # 3, a resident with a history of developing pressure sores, had a care planned pressure relieving device on her bed. The facility failed to accurately assess and stage Resident # 3's wound to her coccyx. The facility failed to implement a physician ordered treatment change on [DATE] and failed to provide a wound treatment at all from [DATE] through [DATE]. The facility failed to notify the physician of a decline in the wound and failed to ensure pressure sores were assessed every seven (7) days as stated in their policy. Resident # 3's pressure sore declined to a Stage IV with infection. B) The facility failed to accurately assess and stage Resident #7's wound to his coccyx and failed to notify the physician of a decline in the wound. Resident # 7's wound declined from a Stage II to a Stage III. This failure resulted in an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practice affected Resident #3 and Resident #7 and placed an additional 23 resident at risk for developing new or worsening pressure sores, [MEDICAL CONDITION] (skin infection), [DIAGNOSES REDACTED] (infection of the bone),[MEDICAL CONDITION] (infection of the blood), pain and death. Findings include: A) Review of Resident #3's Face Sheet reflected an [AGE] year old female readmitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3's Significant Change MDS assessment dated [DATE] reflected Resident #3's BIMS score was a five (5) (severe cognitive impairment), she required extensive assistance of two persons to turn, she had an indwelling Foley Catheter, and was frequently incontinent of bowel. Resident #3 was coded as having three (3) Stage I (Intact skin with non-blanchable redness of a localized area usually over a boney prominence) pressure sores and no pressure reduction devices in place. Review of Resident #3's Comprehensive Plan of Care revised on [DATE] reflected The resident has some skin breakdown with interventions of has a pressure relieving mattress.and the resident has a Foley Catheter. Observation on [DATE] at 4:25 PM revealed Resident #3 on her right side receiving peri-care during which time the dressing fell off the sacrum revealing a Stage IV (Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunneling) pressure sore. The pressure sore was approximately 3 cm round and 0.3 cm deep with yellow slough attached to the tendon and muscle in the very center of the wound bed with red wound edges. Periwound edges were reddened, [MEDICAL CONDITION] and not adhered to wound bed thereby indicated tunneling was present. Resident # 3 had a standard green plastic mattress on her bed, a mattress with no pressure reducing qualities. There was no Foley Catheter was in place to prevent contamination of the wound. Observation on [DATE] at 10:50 AM revealed Resident #3 in bed sleeping on her back with a strong odor of urine in her room. No pressure relieving device was on the mattress and no Foley Catheter was in place. Review of the Weekly Skin Monitoring for Resident #3 reflected zero (0) decubitus (pressure sore) on [DATE], [DATE], [DATE], and [DATE]. On [DATE] a Stage II pressure sore (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) to coccyx was documented. Review of the Wound Assessment for Resident #3 by RN A (the nurse in charge of assessing and staging wounds) dated [DATE] reflected: Coccyx Stage II, 1.75 centimeters long and 1.5 cm wide, two (2) millimeters deep, slough; yes. The definition located on the Wound Assessment reflected a Stage II pressure sore does not have slough and a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) pressure sore may have slough present but does not obscure the depth of tissue loss. Resident # 3's Stage III Coccyx wound was misstaged at a Stage II. On the same sheet there was an additional wound documented as #2 wound superficial 0.5 cm wide and 0.5 cm long, .0 deep. Wound edges were described as macerated (moisture associated skin damage). Review of Resident #3's Nurses' Notes dated [DATE] reflected the physician was notified of a Stage II on [DATE] and the orders were obtained. No responsible party notification was documented. Review of Resident # 3's Physician order [REDACTED]. Review of the next recorded Wound Assessment for Resident #3 was l4 days later by RN A dated [DATE] and reflected: Coccyx Stage II 2.0 cm long and 1.75 cm wide, one (1) mm deep with some slough. Scattered areas of white slough to wound bed. Again, the wound with slough was staged at a Stage II instead of a Stage III. Review of Resident # 3's Physician order [REDACTED].) to decubitus (pressure sore) on shower days (3 times weekly) and as needed. Review of Resident #3's [DATE] TAR reflected an order for [REDACTED]. The order written by Resident # 3's physician on [DATE] was not placed on the TAR and there was no indication this treatment had started. The [DATE] TAR reflected there were no nurse signatures for the dates ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], or [DATE] and indicated no treatment was performed for Resident # 3 on those dates. Observation on [DATE] at 4:35 PM revealed Resident # 3 was provided the treatment ordered [DATE] where the wound was cleansed with wound cleanser, the nurse patted dry and applied Wound Be Gone and added a padded dressing. The physician order [REDACTED]. In an interview on [DATE] at 12:30 PM the DON stated, I knew she (Resident # 3) had the order for Santyl, I just didn't know they weren't carrying it out. It might have helped. Review of the next recorded Wound Assessment for Resident #3 was 14 days later by RN A dated [DATE] reflected: Coccyx Stage IV pressure sore 3.0 cm long and 3.0 cm wide, tunneling around wound ranges from 0.5 cm deep to 1.25 cm deep. [DIAGNOSES REDACTED] and purple tissue around edges. Very [DIAGNOSES REDACTED]tous to wound margins. (Tunneling was drawn around one half of the wound). Yellow slough present on wound base in center. Review of the Nurse's Notes from [DATE] through [DATE] reflected no further physician notification was documented until [DATE] when resident was sent to the physician and was prescribed an antibiotic for treatment of [REDACTED]. Review of the Physician order [REDACTED]. Notify if worsens. Review of Resident #3's [DATE] MAR indicated [REDACTED]. In an interview on [DATE] at 11:56 PM the DON stated it looked like no treatment was performed from [DATE] through [DATE] on paper. The DON also stated she would expect that the nurse to sign the treatment sheet when the treatment was performed. Regarding the catheter that was no longer in place, The DON stated she did not think they would get anywhere with the healing of the pressure sore unless the Foley catheter was put back in place. The DON stated we didn't have a [DIAGNOSES REDACTED]. The DON stated she expected the nursing staff to use the Santyl now. In an interview on [DATE] at 12:15 PM RN A, nurse in charge of measuring, staging and documenting pressure sore progress, stated [DATE] was when she was first alerted there was an issue with the coccyx. RN A further stated she (Resident #3) has had a long standing issue with the coccyx. She will get a little pink then heal up. It's not a Stage I, it's a pre-Stage I. RN A stated Resident #3 was really at risk for pressure sores since she was admitted because she was so emaciated. Immediately after we discontinued the Foley Catheter it started getting worse. RN A further stated Resident #3 refused the air mattress on admission and has refused it periodically in the past. She stated she was unable to find any documentation regarding the refusals and stated, on [DATE], I mentioned to her trying to get her on an air mattress and she just wouldn't answer me. RN A further stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In an interview on [DATE] at 3:45 PM Resident #3 was asked if she would like an air mattress overlay placed on her bed while she was up for supper when she stated yes, it's worse than it's ever been. In an interview on [DATE] at 9:00 AM Resident #3, who was up in her wheelchair and had slept on the air overlay mattress, stated I like my bed more and I ate 100% (of her breakfast meal). Resident #3 appeared more comfortable than previous observations. In an interview on [DATE] at 3:45 PM CNA H stated Resident #3 required incontinent care due to bladder incontinence a minimum of two (2) or three (3) times a shift on the evening shifts that she worked. In a telephone interview on [DATE] at 6:15 PM Resident #3's primary Physician stated a Foley Catheter possibly could assist in wound healing and that it should have been a suggestion. Resident # 3's Physician stated that it would be reasonable to believe that an air mattress or pressure relieving mattress would be beneficial. He further stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. Resident # 3's Physician also stated weekly wound measurements may have helped the wound from getting so bad and stated the Santyl order would have possibly helped in wound healing if the order had been followed. In an interview on [DATE] at 12:40 PM the facility's Medical Director stated when Santyl wound ointment is used correctly you can at least see a difference in the wound progress. If it's not done, sometimes the progress is not as obvious as it should be. I would expect the nurses to use it like it's ordered. He also stated, I would expect that a resident should be encouraged to use the air mattress or what is available to prevent or improve the wound. If the resident has dementia (he) expects that the family should be encouraged to assist in those interventions. Regarding improper staging of wounds, he replied, if the wound is not healing or progressing then there are different principles to follow for wound care. B) Review of the face sheet reflected Resident #7 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the Nurses' Notes for [DATE] reflected Resident #7 was admitted with a Stage II pressure sore to the coccyx. Review of the initial MDS assessment dated [DATE] reflected Resident #7 to be moderately impaired in thinking, required two persons and a hydraulic lift to transfer, frequently incontinent of bowel and bladder and had one Stage II pressure sore to coccyx. Additional [DIAGNOSES REDACTED]. Review of the Plan of Care dated [DATE] reflected Resident #7 had breaks in his skin integrity related to pressure ulcer, moisture associated skin damage and stasis ulcers/blisters. Interventions included: Assist Resident #7 to reposition frequently, monitor treatments for effectiveness and notify physician of any concerns. Try to encourage ventilation to perineum area as much as is possible. This may be more realistic in bed. Review of the TAR for [DATE] for Resident #7 reflected an order placed on the TAR dated [DATE] for Inflatable foot/heel protectors with all three shifts ,[DATE], ,[DATE], ,[DATE] signing the TAR. Review of the Wound Assessment Sheet for Resident #7 dated [DATE] reflected the pressure sore to the coccyx was 2.5 cm long by .75 cm wide with no slough and staged as Stage II documented and signed by RN A. Observation on [DATE] revealed Resident #7 to be up in the wheelchair from 9 AM until 6 PM with no inflatable foot/heel protectors in place. Observation on [DATE] at 4:53 of Resident #7's wound

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) care and measurement by RN A (nurse in charge of assessing and staging wounds) revealed the pressure ulcer on the coccyx to be 3.5 cm long by 1.25 cm wide. The pressure ulcer was 80% covered in yellow slough and was a Stage III pressure ulcer as defined on the Wound Assessment System document RN A was documenting on. In an interview on [DATE] at 4:53 RN A stated the wound bed was 80% covered with yellow slough. She stated It is a Stage II because there is no depth. I don't really agree with that slough only being a Stage III. RN A underlined slough in the description of a Stage III ulcer. During the measurement of the wound, RN A assured Resident #7 that his pressure sore was looking and getting much better. Review of the Wound Assessment Sheet dated [DATE] reflected RN A had staged the pressure sore a Stage II. In the narrative she documented wound continues to improve. Has shallow bed of whitish slough to top of wound with approx. (approximately) 20% clean non-granulating tissue to edges. Will continue treatment as ordered. RN A documented some slough and the wound base as pink, yellow and white. Review of Wound Assessment Sheets for Resident #7 reflected his wounds were measured every 14 days. Review of the Nurses' Notes for Resident #7 dated [DATE] reflected there had been no notification to the physician of the increase in size and the worsening of the appearance of the pressure ulcer. In an interview on [DATE] at 4:30 PM when asked who should notify the family and physician of pressure sores and changes for Resident #7 the DON stated, Charge nurses/ Skin nurse when she sees it, she should let the charge nurse know. The LVN should realize to notify. In an interview on [DATE] at 12:15 PM with RN A she stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In a telephone interview on [DATE] at 6:15 PM Resident #7's primary Physician stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. He also stated weekly wound measurements may have helped the wound from getting so bad. In an interview on [DATE] at 12:40 PM with the facility's Medical Director, he stated regarding improper staging of wounds, if the wound is not healing or progressing then there are different principles to follow for wound care. Review of the facility's undated policy for PRESSURE ULCER PREVENTION AND MONITORING reflected: l. All residents admitted at risk for pressure ulcers will be placed on a pressure ulcer prevention program which includes: b. Pressure reducing devices such as special mattresses as needed.e. Intense skin monitoring. 2. Residents with pressure ulcers will have: a. Treatments as ordered.c. Pressure reducing devices such as special mattresses and or/heel protectors as needed.g. At least weekly written assessments including location, stage, odor, color, size, drainage, response to treatment.h. any resident with a pressure ulcer which fails to improve or worsens, will have the physician notified promptly. Review of the undated facility's Pressure Ulcer Management Sheet reflected: 3. Reassess and measure at least weekly or sooner if deterioration of the ulcer is noted. Always document your findings in detail. 4. Promptly inform the physician (and responsible party, as appropriate) of new pressure ulcers. Obtain and initiate treatment orders. In an interview on [DATE] at 4:30 PM the DON stated the skin nurse should let the charge nurse know when she sees worsening of condition of wounds. The DON stated the LVN should realize to notify the family and physician. When asked who was responsible for making sure orders are carried out the DON stated, the charge nurses are responsible to make sure they are carried out. The DON stated she and the ADON were responsible for making sure staff followed facility policy. The DON stated it was her and the ADON's responsibility to ensure staff knew what the facility policies and procedures were. In an interview on [DATE] at 6:05 PM the facility Administrator stated the DON, ADON and charge nurses are responsible for notifying the physician and family. The ADON was responsible for making sure orders were carried out. The Administrator stated the he and the Nursing Department are responsible for making sure staff followed procedures. The Administrator further stated it was ultimately his responsibility to make sure staff followed procedures. The Administrator stated the DON should definitely know what wounds were in the building. He was aware his policy stated pressure sores were to be measured weekly. Regarding whether he and his staff had neglected the care of the residents he stated, It was not correct (the care of the residents). I do not appreciate professional people that I trust not doing what I expect. The facility Administrator was notified on [DATE] at 6:20 PM that an IJ situation had been identified due to the above failures. The following Plan of Removal was first submitted by the Administrator on [DATE] at 9:04 AM. The final Plan of Removal was accepted by the survey team on [DATE] at 7:30 PM. Cameron Nursing and Rehab Plan of Removal of Immediate Jeopardy In responses Wound Issues, Cameron Nursing and Rehab will do the following: 1. An RN from (Hospice) to in-service nursing staff on the care and treatment of [REDACTED]. DON, ADON, RN, Medicare Coordinator, and MDS Nurse and charge nurses LVN's will attend. In-service will be at 10:00 on Friday [DATE]. 2. Two Staff Registered Nurses will assess and measure all wounds on a weekly basis. All current wounds will be reassessed after training on [DATE]. 3. Facility will identify all At Risk residents for Skin Breakdown by using the Braden Scale. After in-service, all At Risk residents will be assessed by a RN and LVN to identify any possible pressure issues [DATE]. 4. All Physician orders [REDACTED]. A pink copy of all telephone order forms will be given to the ADON when completed. The ADON will monitor the order and follow through to make sure all meds are ordered and orders entered on treatment sheet and or MARs. This process was started on [DATE]. 5. DON and ADON will do in-service with all charge nurses regarding proper documentation of resident's change of condition, pressure sores, treatments, Physician Orders, and notifying family members and Physician. This will be complete during the in-service on [DATE]. 6. ADON and DON will report to Administrator any new skin issues and update of treatments in progress on Friday of each week with a copy of the weekly decubitus skin assessment log and non-decubitus log. First meeting will be on [DATE] and then weekly. 7. All pressure wounds will be reviewed and discussed at weekly staff meeting, including DON, ADON, MDS Nurse, Medicaid Coordinator, Registered Nurse on Staff, and Administrator on [DATE]. 8. Medical Director was notified of this at 9:30 am on Thursday [DATE]. Resident #3 Facility will: 1. Ensure air mattress is on Resident #3's bed, [DATE]. 2. Will follow physician orders [REDACTED]. (The new order: Cleanse wound on coccyx with Normal Saline, pat dry-Apply Normal saline packing to wound bandage BID (twice daily)-Will consult wound care at Scott & White (Temple)-Insert indwelling catheter.-change q (every) month & PRN (as needed)-Record I&O (input and output) q shift-Catheter care q shift.) 3. Registered Nurse will accompany resident to Doctor's appointment on [DATE] to discuss proper treatment and procedure to be used, and request the use of a Catheter, this will be done on [DATE]. ADON or DON will monitor resident treatment with charge nurse for a period of two weeks to assure proper procedure is followed. If there is no improvement or wound worsens, Physician will be notified. 4. Two Registered Nurses will assess and measure wounds on a weekly basis. 5. Have Staff to continue to encourage resident to stay off of her back side and have staff continue to encourage and assist her to turn when in bed. 6. Nursing staff will encourage Resident to take in proper nourishment to help the healing process and have a Care Plan meeting with Son to encourage compliance with treatment plan. Administrator, DON, ADON will meet with son. 7. Have Dietary Consultant review Resident #3's chart and condition and make recommendations for nutrition on her next visit to the facility. Resident #7 1. Make sure resident maintains a pressure relieving mattress on his bed, [DATE]. 2. Nursing staff will encourage resident to try to stay off of his back side as much as possible, offering repositioning and reminded to use overhead bar. 3. Resident #7 request to be up for all three meals each day and remain in his wheelchair. DON, ADON, Administrator will have a care plan meeting will be held with Resident and Responsible Party regarding the benefits of shorter periods of time sitting in the wheelchair. 4. ADON or DON will monitor resident treatment for [REDACTED]. If there is no improvement or wound worsens, Physician will be notified. 5. Confirm with Physician when Heel Protectors should be worn, requested clarification [DATE]. 6. Notify Physician of change of condition [DATE]. 7. Two Registered Nurses will assess and measure resident's wounds on a weekly basis. The survey team monitored the plan of removal as follows: Review was completed of new treatments as per physician order [REDACTED].#3 as shown in the plan of removal. All treatments and interventions were initiated and carried out. Resident #3's Responsible Party was notified. Resident # 7 had a re-assessment of his wounds and physician and responsible party were notified of the decline in the coccyx pressure sore. Observation of the facility in-service on [DATE] at 10:00 AM revealed the in-service was conducted by a RN from a local Hospice agency. The in-service provided information regarding pressure sores, care for pressure sores, assessments including staging and measuring, as well as interventions to prevent pressure sores. The in-service had four (4) RNs and 11 LVNs in attendance. The Medical Director and the Administrator were also present. The facility had over 70% of their licensed nursing staff in-serviced on [DATE]. The Hospice RN gave a competency test after the in-service in which all nursing staff in attendance passed per the Administrator. The facility provided a list of 25 residents who were at risk for pressure sores. The facility completed a 100% audit using the Braden Scale to identify residents at risk for pressure sores. Twenty-five (25) residents were identified at risk for pressure sores. Observations were made on [DATE] of four (4) of the 25 residents at risk for pressure sores. These Residents were assessed and staged properly and interventions and treatments were in place. The facility notified the Resident's Physicians and Responsible Parties. Observation on [DATE] at 2:40 PM revealed the DON entered a resident room to assess and measure pressure sores. The DON did not bring a cart or any sanitizing agents to the room. She did not prepare a clean surface for her supplies. She placed supplies for wound

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) measurement under the shoes on Resident #14's Geri chair pressure reduction pad of the incontinent resident. She then laid a pair of gloves up against the heels of the shoes and went to the bathroom to wash her hands. She returned from the bathroom and began donning gloves. She approached the resident to explain the process to the resident when the surveyor stopped the DON and instructed her to start over and explained that her articles were contaminated. Later, when the DON began assessing the heel of the resident that had a Deep Tissue Injury (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue) she proceeded to dismiss the area and pronounced it was blanching after she placed pressure on the heel and released it multiple times. The heel was not blanching. Surveyor stepped forward and asked to see the heel turn white and then return to red. The DON applied pressure once again and admitted the heel was not changing color at all and was actually purple. The DON and ADON then tried to decide if the heel sore was a Stage I or not since it wasn't red. The Surveyor handed the DON the in-service Wound Staging Guide as received in the training in-service and asked her to read the description of a Deep Tissue Injury. The DON then correctly identified the heel as having a deep tissue injury. DON then observed the Stage II that was approximately one (1) cm in size with a pinpoint opening on the sacrum. The DON placed the measuring device on the opening and removed it repeatedly. She finally traced the one (1) cm circle and then marked the pinpoint opening. She then placed the device back on the wound and studied it and then asked the ADON to come and see if she had marked her device correctly. The DON then began studying the raised skin edges on the bilateral buttocks and decided that those impaired skin issues needed measuring. After DON applied the graph several times, the Surveyor asked the ADON if she had told the DON that the resident had a rash over her entire perineum. The ADON said she had not informed the DON and then parted the resident's legs so that she could see the raised skin was related to a rash and was not at all pressure sores. When the DON submitted the wound assessment to the surveyor, she had left the entire wound description area of the form blank. The Surveyor returned the form to the DON to complete it. The DON submitted it to the Surveyor the second time. The Surveyor returned the form to the DON and asked her to complete the periwound skin assessment line on the form. In an interview on [DATE] at 2:43 PM the Surveyor asked the DON as she donned gloves if she realized that she had her wound care items under a pair of shoes in the seat of a chair, she stated that she was so nervous that she did not realize what she had done. In a meeting on [DATE] at 3:15 PM the facility Administrator was made aware of the DON's actions during the assessment of Resident # 14's wound. The Administrator stated the DON needed more training and decided to have the two RNs performing skin assessments and not include the DON until she was further trained. Observations were made of a LVN and RN performing a skin assessment and identifying a problem on an at risk resident. Then two RNs returned and performed an assessment on the at risk resident and identified an area of concern on her left great toe. The area was identified as a Suspected Deep Tissue Injury. The two RNs correctly assessed, measured, identified prevention interventions, and notified the Physician and the Responsible Party. The facility provided an attendance signature sheet for the Staff Meeting held on [DATE] after the skin audit was completed with the Administrator, DON, ADON, RN A, MDS Coordinator, and one LVN-Medicaid Coordinator in attendance. On [DATE] at 8:00 PM the facility Administrator was informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. The facility provided a list of 25 residents at risk for pressure sores.
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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 to implement written policies and procedures that prohibit neglect for two (2) of nine (9) residents (Resident #3 and #7) reviewed for neglect when: A) The facility failed to ensure Resident # 3, a resident with a history of developing pressure sores, had a care planned pressure relieving device on her bed. The facility failed to accurately assess and stage Resident # 3's wound to her coccyx. The facility failed to implement a physician ordered treatment change on [DATE] and failed to provide a wound treatment at all from [DATE] through [DATE]. The facility failed to notify the physician of a decline in the wound and failed to ensure pressure sores were assessed every seven (7) days as stated in their policy. Resident # 3's pressure sore declined to a Stage IV with infection. B) The facility failed to accurately assess and stage Resident #7's wound to his coccyx and failed to notify the physician of a decline in the wound. Resident # 7's wound declined from a Stage II to a Stage III. This failure resulted in an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practice affected Resident #3 and Resident #7 and placed an additional 23 resident at risk for developing new or worsening pressure sores, [MEDICAL CONDITION] (skin infection), [DIAGNOSES REDACTED] (infection of the bone),[MEDICAL CONDITION] (infection of the blood), pain and death. Findings include: Review of the facility's policy revised ,[DATE] entitled Recognizing Signs and Symptoms of Abuse/Neglect reflected under statement Our facility will not condone any form of resident neglect. The Policy also reflected Neglect is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. Under Signs of Actual Physical Neglect: .(6) Inadequate provision of care; (7) Caregiver indifference to resident's personal care and needs. Review of the facility's undated policy for PRESSURE ULCER PREVENTION AND MONITORING reflected: l. All residents admitted at risk for pressure ulcers will be placed on a pressure ulcer prevention program which includes: b. Pressure reducing devices such as special mattresses as needed.e. Intense skin monitoring. 2. Residents with pressure ulcers will have: a. Treatments as ordered.c. Pressure reducing devices such as special mattresses and or/heel protectors as needed.g. At least weekly written assessments including location, stage, odor, color, size, drainage, response to treatment.h. any resident with a pressure ulcer which fails to improve or worsens, will have the physician notified promptly. Review of the undated facility's Pressure Ulcer Management Sheet reflected: 3. Reassess and measure at least weekly or sooner if deterioration of the ulcer is noted. Always document your findings in detail. 4. Promptly inform the physician (and responsible party, as appropriate) of new pressure ulcers. Obtain and initiate treatment orders. A) Review of Resident #3's Face Sheet reflected an [AGE] year old female readmitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3's Significant Change MDS assessment dated [DATE] reflected Resident #3's BIMS score was a five (5) (severe cognitive impairment), she required extensive assistance of two persons to turn, she had an indwelling Foley Catheter, and was frequently incontinent of bowel. Resident #3 was coded as having three (3) Stage I (Intact skin with non-blanchable redness of a localized area usually over a boney prominence) pressure sores and no pressure reduction devices in place. Review of Resident #3's Comprehensive Plan of Care revised on [DATE] reflected The resident has some skin breakdown with interventions of has a pressure relieving mattress.and the resident has a Foley Catheter. Observation on [DATE] at 4:25 PM revealed Resident #3 on her right side receiving peri-care during which time the dressing fell off the sacrum revealing a Stage IV (Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunneling) pressure sore. The pressure sore was approximately 3 cm round and 0.3 cm deep with yellow slough attached to the tendon and muscle in the very center of the wound bed with red wound edges. Periwound edges were reddened, [MEDICAL CONDITION] and not adhered to wound bed thereby indicated tunneling was present. Resident # 3 had a standard green plastic mattress on her bed, a mattress with no pressure reducing qualities. There was no Foley Catheter was in place to prevent contamination of the wound. Observation on [DATE] at 10:50 AM revealed Resident #3 in bed sleeping on her back with a strong odor of urine in her room. No pressure relieving device was on the mattress and no Foley Catheter was in place. Review of the Weekly Skin Monitoring for Resident #3 reflected zero (0) decubitus (pressure sore) on [DATE], [DATE], [DATE], and [DATE]. On [DATE] a Stage II pressure sore (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) to coccyx was documented. Review of the Wound Assessment for Resident #3 by RN A (the nurse in charge of assessing and staging wounds) dated [DATE] reflected: Coccyx Stage II, 1.75 centimeters long and 1.5 cm wide, two (2) millimeters deep, slough; yes. The definition located on the Wound Assessment reflected a Stage II pressure sore does not have slough and a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. 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CAMERON NURSING AND REHAB	2202 N TRAVIS ST CAMERON, TX 76520

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 -** Some	(continued... from page 6) tissue loss. Resident # 3's Stage III Coccyx wound was misstaged at a Stage II. On the same sheet there was an additional wound documented as #2 wound superficial 0.5 cm wide and 0.5 cm long, .0 deep. Wound edges were described as macerated (moisture associated skin damage). Review of Resident #3's Nurses' Notes dated [DATE] reflected the physician was notified of a Stage II on [DATE] and the orders were obtained. No responsible party notification was documented. Review of Resident # 3's Physician order [REDACTED]. Review of the next recorded Wound Assessment for Resident #3 was l4 days later by RN A dated [DATE] and reflected: Coccyx Stage II 2.0 cm long and 1.75 cm wide, one (1) mm deep with some slough. Scattered areas of white slough to wound bed. Again, the wound with slough was staged at a Stage II instead of a Stage III. Review of Resident # 3's Physician order [REDACTED].) to decubitus (pressure sore) on shower days (3 times weekly) and as needed. Review of Resident #3's [DATE] TAR reflected an order for [REDACTED]. The order written by Resident # 3's physician on [DATE] was not placed on the TAR and there was no indication this treatment had started. The [DATE] TAR reflected there were no nurse signatures for the dates ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], or [DATE] and indicated no treatment was performed for Resident # 3 on those dates. Observation on [DATE] at 4:35 PM revealed Resident # 3 was provided the treatment ordered [DATE] where the wound was cleansed with wound cleanser, the nurse patted dry and applied Wound Be Gone and added a padded dressing. The physician order [REDACTED]. In an interview on [DATE] at 12:30 PM the DON stated, I knew she (Resident # 3) had the order for Santyl, I just didn't know they weren't carrying it out. It might have helped. Review of the next recorded Wound Assessment for Resident #3 was 14 days later by RN A dated [DATE] reflected: Coccyx Stage IV pressure sore 3.0 cm long and 3.0 cm wide, tunneling around wound ranges from 0.5 cm deep to 1.25 cm deep. [DIAGNOSES REDACTED] and purple tissue around edges. Very [DIAGNOSES REDACTED]tous to wound margins. (Tunneling was drawn around one half of the wound). Yellow slough present on wound base in center. Review of the Nurse's Notes from [DATE] through [DATE] reflected no further physician notification was documented until [DATE] when resident was sent to the physician and was prescribed an antibiotic for treatment of [REDACTED]. Review of the Physician order [REDACTED]. Notify if worsens. Review of Resident #3's [DATE] MAR indicated [REDACTED]. In an interview on [DATE] at 11:56 PM the DON stated it looked like no treatment was performed from [DATE] through [DATE] on paper. The DON also stated she would expect that the nurse to sign the treatment sheet when the treatment was performed. Regarding the catheter that was no longer in place, The DON stated she did not think they would get anywhere with the healing of the pressure sore unless the Foley catheter was put back in place. The DON stated we didn't have a [DIAGNOSES REDACTED]. The DON stated she expected the nursing staff to use the Santyl now. In an interview on [DATE] at 12:15 PM RN A, nurse in charge of measuring, staging and documenting pressure sore progress, stated [DATE] was when she was first alerted there was an issue with the coccyx. RN A further stated she (Resident #3) has had a long standing issue with the coccyx. She will get a little pink then heal up. It's not a Stage I, it's a pre-Stage I. RN A stated Resident #3 was really at risk for pressure sores since she was admitted because she was so emaciated. Immediately after we discontinued the Foley Catheter it started getting worse. RN A further stated Resident #3 refused the air mattress on admission and has refused it periodically in the past. She stated she was unable to find any documentation regarding the refusals and stated, on [DATE], I mentioned to her trying to get her on an air mattress and she just wouldn't answer me. RN A further stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In an interview on [DATE] at 3:45 PM Resident #3 was asked if she would like an air mattress overlay placed on her bed while she was up for supper when she stated yes, it's worse than it's ever been. In an interview on [DATE] at 9:00 AM Resident #3, who was up in her wheelchair and had slept on the air overlay mattress, stated I like my bed more and I ate 100% (of her breakfast meal). Resident #3 appeared more comfortable than previous observations. In an interview on [DATE] at 3:45 PM CNA H stated Resident #3 required incontinent care due to bladder incontinence a minimum of two (2) or three (3) times a shift on the evening shifts that she worked. In a telephone interview on [DATE] at 6:15 PM Resident #3's primary Physician stated a Foley Catheter possibly could assist in wound healing and that it should have been a suggestion. Resident # 3's Physician stated that it would be reasonable to believe that an air mattress or pressure relieving mattress would be beneficial. He further stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. Resident # 3's Physician also stated weekly wound measurements may have helped the wound from getting so bad and stated the Santyl order would have possibly helped in wound healing if the order had been followed. In an interview on [DATE] at 12:40 PM the facility's Medical Director stated when Santyl wound ointment is used correctly you can at least see a difference in the wound progress. If it's not done, sometimes the progress is not as obvious as it should be. I would expect the nurses to use it like it's ordered. He also stated, I would expect that a resident should be encouraged to use the air mattress or what is available to prevent or improve the wound. If the resident has dementia (he) expects that the family should be encouraged to assist in those interventions. Regarding improper staging of wounds, he replied, if the wound is not healing or progressing then there are different principles to follow for wound care. B) Review of the face sheet reflected Resident #7 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the Nurses' Notes for [DATE] reflected Resident #7 was admitted with a Stage II pressure sore to the coccyx. Review of the initial MDS assessment dated [DATE] reflected Resident #7 to be moderately impaired in thinking, required two persons and a hydraulic lift to transfer, frequently incontinent of bowel and bladder and had one Stage II pressure sore to coccyx. Additional [DIAGNOSES REDACTED]. Review of the Plan of Care dated [DATE] reflected Resident #7 had breaks in his skin integrity related to pressure ulcer, moisture associated skin damage and stasis ulcers/blisters. Interventions included: Assist Resident #7 to reposition frequently, monitor treatments for effectiveness and notify physician of any concerns. Try to encourage ventilation to perineum area as much as is possible. This may be more realistic in bed. Review of the TAR for [DATE] for Resident #7 reflected an order placed on the TAR dated [DATE] for Inflatable foot/heel protectors with all three shifts ,[DATE], ,[DATE], ,[DATE] signing the TAR. Review of the Wound Assessment Sheet for Resident #7 dated [DATE] reflected the pressure sore to the coccyx was 2.5 cm long by .75 cm wide with no slough and staged as Stage II documented and signed by RN A. Observation on [DATE] revealed Resident #7 to be up in the wheelchair from 9 AM until 6 PM with no inflatable foot/heel protectors in place. Observation on [DATE] at 4:53 of Resident #7's wound care and measurement by RN A (nurse in charge of assessing and staging wounds) revealed the pressure ulcer on the coccyx to be 3.5 cm long by 1.25 cm wide. The pressure ulcer was 80% covered in yellow slough and was a Stage III pressure ulcer as defined on the Wound Assessment System document RN A was documenting on. In an interview on [DATE] at 4:53 RN A stated the wound bed was 80% covered with yellow slough. She stated It is a Stage II because there is no depth. I don't really agree with that slough only being a Stage III. RN A underlined slough in the description of a Stage III ulcer. During the measurement of the wound, RN A assured Resident #7 that his pressure sore was looking and getting much better. Review of the Wound Assessment Sheet dated [DATE] reflected RN A had staged the pressure sore a Stage II. In the narrative she documented wound continues to improve. Has shallow bed of whitish slough to top of wound with approx. (approximately) 20% clean non-granulating tissue to edges. Will continue treatment as ordered. RN A documented some slough and the wound base as pink, yellow and white. Review of Wound Assessment Sheets for Resident #7 reflected his wounds were measured every 14 days. Review of the Nurses' Notes for Resident #7 dated [DATE] reflected there had been no notification to the physician of the increase in size and the worsening of the appearance of the pressure ulcer. In an interview on [DATE] at 12:15 PM with RN A she stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In a telephone interview on [DATE] at 6:15 PM Resident #7's primary Physician stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. He also stated weekly wound measurements may have helped the wound from getting so bad. In an interview on [DATE] at 12:40 PM with the facility's Medical Director, he stated regarding improper staging of wounds, if the wound is not healing or progressing then there are different principles to follow for wound care. In an interview on [DATE] at 4:30 PM the DON stated the skin nurse should let the charge nurse know when she sees worsening of condition of wounds. The DON stated the LVN should realize to notify the family and physician. When asked who was responsible for making sure orders are carried out the DON stated, the charge nurses are responsible to make sure they are carried out. The DON stated she and the ADON were responsible for making sure staff followed facility policy. The DON stated it was her and the ADON's responsibility to ensure staff knew what the facility policies and procedures were. In an interview on [DATE] at 6:05 PM the facility Administrator stated the DON, ADON and charge nurses are responsible for notifying the physician and family. The ADON was responsible for making sure orders were carried out. The Administrator stated the he and the Nursing Department are responsible for making sure staff followed procedures. The Administrator further stated it was ultimately his responsibility to make sure staff followed procedures. The Administrator stated the DON should definitely know what wounds were in the building. He was aware his policy stated pressure sores were

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F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 7) to be measured weekly. Regarding whether he and his staff had neglected the care of the residents he stated, It was not correct (the care of the residents). I do not appreciate professional people that I trust not doing what I expect. The facility Administrator was notified on [DATE] at 6:20 PM that an IJ situation had been identified due to the above failures. The following Plan of Removal was first submitted by the Administrator on [DATE] at 9:04 AM. The final Plan of Removal was accepted by the survey team on [DATE] at 7:30 PM. Cameron Nursing and Rehab Plan of Removal of Immediate Jeopardy In responses Wound Issues, Cameron Nursing and Rehab will do the following: 1. An RN from (Hospice) to in-service nursing staff on the care and treatment of [REDACTED]. DON, ADON, RN, Medicare Coordinator, and MDS Nurse and charge nurses LVN's will attend. In-service will be at 10:00 on Friday [DATE]. 2. Two Staff Registered Nurses will assess and measure all wounds on a weekly basis. All current wounds will be reassessed after training on [DATE]. 3. Facility will identify all At Risk residents for Skin Breakdown by using the Braden Scale. After in-service, all At Risk residents will be assessed by a RN and LVN to identify any possible pressure issues [DATE]. 4. All Physician orders [REDACTED]. A pink copy of all telephone order forms will be given to the ADON when completed. The ADON will monitor the order and follow through to make sure all meds are ordered and orders entered on treatment sheet and or MARs. This process was started on [DATE]. 5. DON and ADON will do in-service with all charge nurses regarding proper documentation of resident's change of condition, pressure sores, treatments, Physician Orders, and notifying family members and Physician. This will be complete during the in-service on [DATE]. 6. ADON and DON will report to Administrator any new skin issues and update of treatments in progress on Friday of each week with a copy of the weekly decubitus skin assessment log and non-decubitus log. First meeting will be on [DATE] and then weekly. 7. All pressure wounds will be reviewed and discussed at weekly staff meeting, including DON, ADON, MDS Nurse, Medicaid Coordinator, Registered Nurse on Staff, and Administrator on [DATE]. 8. Medical Director was notified of this at 9:30 am on Thursday [DATE]. Resident #3 Facility will: 1. Ensure air mattress is on Resident #3's bed, [DATE]. 2. Will follow physician orders [REDACTED]. (The new order: Cleanse wound on coccyx with Normal Saline, pat dry-Apply Normal saline packing to wound bandage BID (twice daily)-Will consult wound care at Scott & White (Temple)-Insert indwelling catheter.-change q (every) month & PRN (as needed)-Record I&O (input and output) q shift-Catheter care q shift.) 3. Registered Nurse will accompany resident to Doctor's appointment on [DATE] to discuss proper treatment and procedure to be used, and request the use of a Catheter, this will be done on [DATE]. ADON or DON will monitor resident treatment with charge nurse for a period of two weeks to assure proper procedure is followed. If there is no improvement or wound worsens, Physician will be notified. 4. Two Registered Nurses will assess and measure wounds on a weekly basis. 5. Have Staff to continue to encourage resident to stay off of her back side and have staff continue to encourage and assist her to turn when in bed. 6. Nursing staff will encourage Resident to take in proper nourishment to help the healing process and have a Care Plan meeting with Son to encourage compliance with treatment plan. Administrator, DON, ADON will meet with son. 7. Have Dietary Consultant review Resident #3's chart and condition and make recommendations for nutrition on her next visit to the facility. Resident #7 1. Make sure resident maintains a pressure relieving mattress on his bed, [DATE]. 2. Nursing staff will encourage resident to try to stay off of his back side as much as possible, offering repositioning and reminded to use overhead bar. 3. Resident #7 request to be up for all three meals each day and remain in his wheelchair. DON, ADON, Administrator will have a care plan meeting will be held with Resident and Responsible Party regarding the benefits of shorter periods of time sitting in the wheelchair. 4. ADON or DON will monitor resident treatment for [REDACTED]. If there is no improvement or wound worsens, Physician will be notified. 5. Confirm with Physician when Heel Protectors should be worn, requested clarification [DATE]. 6. Notify Physician of change of condition [DATE]. 7. Two Registered Nurses will assess and measure resident's wounds on a weekly basis. The survey team monitored the plan of removal as follows: Review was completed of new treatments as per physician order [REDACTED].#3 as shown in the plan of removal. All treatments and interventions were initiated and carried out. Resident #3's Responsible Party was notified. Resident # 7 had a re-assessment of his wounds and physician and responsible party were notified of the decline in the coccyx pressure sore. Observation of the facility in-service on [DATE] at 10:00 AM revealed the in-service was conducted by a RN from a local Hospice agency. The in-service provided information regarding pressure sores, care for pressure sores, assessments including staging and measuring, as well as interventions to prevent pressure sores. The in-service had four (4) RNs and 11 LVNs in attendance. The Medical Director and the Administrator were also present. The facility had over 70% of their licensed nursing staff in-serviced on [DATE]. The Hospice RN gave a competency test after the in-service in which all nursing staff in attendance passed per the Administrator. The facility provided a list of 25 residents who were at risk for pressure sores. The facility completed a 100% audit using the Braden Scale to identify residents at risk for pressure sores. Twenty-five (25) residents were identified at risk for pressure sores. Observations were made on [DATE] of four (4) of the 25 residents at risk for pressure sores. These Residents were assessed and staged properly and interventions and treatments were in place. The facility notified the Resident's Physicians and Responsible Parties. Observation on [DATE] at 2:40 PM revealed the DON entered a resident room to assess and measure pressure sores. The DON did not bring a cart or any sanitizing agents to the room. She did not prepare a clean surface for her supplies. She placed supplies for wound measurement under the shoes on Resident #14's Geri chair pressure reduction pad of the incontinent resident. She then laid a pair of gloves up against the heels of the shoes and went to the bathroom to wash her hands. She returned from the bathroom and began donning gloves. She approached the resident to explain the process to the resident when the surveyor stopped the DON and instructed her to start over and explained that her articles were contaminated. Later, when the DON began assessing the heel of the resident that had a Deep Tissue Injury (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue) she proceeded to dismiss the area and pronounced it was blanching after she placed pressure on the heel and released it multiple times. The heel was not blanching. Surveyor stepped forward and asked to see the heel turn white and then return to red. The DON applied pressure once again and admitted the heel was not changing color at all and was actually purple. The DON and ADON then tried to decide if the heel sore was a Stage I or not since it wasn't red. The Surveyor handed the DON the in-service Wound Staging Guide as received in the training in-service and asked her to read the description of a Deep Tissue Injury. The DON then correctly identified the heel as having a deep tissue injury. DON then observed the Stage II that was approximately one (1) cm in size with a pinpoint opening on the sacrum. The DON placed the measuring device on the opening and removed it repeatedly. She finally traced the one (1) cm circle and then marked the pinpoint opening. She then placed the device back on the wound and studied it and then asked the ADON to come and see if she had marked her device correctly. The DON then began studying the raised skin edges on the bilateral buttocks and decided that those impaired skin issues needed measuring. After DON applied the graph several times, the Surveyor asked the ADON if she had told the DON that the resident had a rash over her entire perineum. The ADON said she had not informed the DON and then parted the resident's legs so that she could see the raised skin was related to a rash and was not at all pressure sores. When the DON submitted the wound assessment to the surveyor, she had left the entire wound description area of the form blank. The Surveyor returned the form to the DON to complete it. The DON submitted it to the Surveyor the second time. The Surveyor returned the form to the DON and asked her to complete the periwound skin assessment line on the form. In an interview on [DATE] at 2:43 PM the Surveyor asked the DON as she donned gloves if she realized that she had her wound care items under a pair of shoes in the seat of a chair, she stated that she was so nervous that she did not realize what she had done. In a meeting on [DATE] at 3:15 PM the facility Administrator was made aware of the DON's actions during the assessment of Resident # 14's wound. The Administrator stated the DON needed more training and decided to have the two RNs performing skin assessments and not include the DON until she was further trained. Observations were made of a LVN and RN performing a skin assessment and identifying a problem on an at risk resident. Then two RNs returned and performed an assessment on the at risk resident and identified an area of concern on her left great toe. The area was identified as a Suspected Deep Tissue Injury. The two RNs correctly assessed, measured, identified prevention interventions, and notified the Physician and the Responsible Party. The facility provided an attendance signature sheet for the Staff Meeting held on [DATE] after the skin audit was completed with the Administrator, DON, ADON, RN A, MDS Coordinator, and one LVN-Medicaid Coordinator in attendance. On [DATE] at 8:00 PM the facility Administrator was informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. The facility provided a list of 25 residents at risk for pressure sores.
F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) Based on observation, interview, and record review the facility failed to provide services with reasonable accommodations of individual needs and preferences for one (1) of nine (9) residents (Resident #9) reviewed for non-oral communication when Resident #9 could not reach her communication board to communicate her needs with the staff. This deficient practice placed one (1) resident (Resident #9) who used a non-oral communication deviceat risk for not having her needs met in a timely manner, a decline in quality of life, loneliness, depression and physical pain. Findings include: Review of the Face Sheet for Resident #9 reflected a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of the Admission MDS assessment dated [DATE] for Resident #9 reflected she had moderate difficulty hearing with no aid, unclear speech, sometimes understood, sometimes understands, and had highly impaired vision with no corrective lenses. Resident #9 had a BIMS score of nine (9) which indicated she was moderately cognitively impaired. Resident #9 had the following symptoms for 12-14 days of this assessment: Feeling down, depressed, or hopeless; Trouble falling or staying asleep, or sleeping too much; and Feeling tired or having little energy. Resident #9 required extensive to being totally dependent on one staff for Activities of Daily Living (ADLs). Resident #9 had impairment on both sides for both the upper and lower extremities in range of motion. Resident #9 had no therapy performed during this assessment. The MDS reflected the area of communication was triggered under the Care Area Assessment (CAA) Summary and the facility made the decision to care plan. Review of the Comprehensive Care Plan dated 02/12/2014 for Resident #9 reflected a Focus: The resident has a communication problem r/t (related to) cognitive deficit (Dementia) and Dysarthria ([MEDICAL CONDITION]). Note: (Resident #9) is deaf in her right ear. The Care Plan reflected under Goal: The resident will be able to make basic needs known on a daily basis. The Interventions listed for Resident #9 included Anticipate and meet needs.Use alternative communication tools as needed.Monitor effectiveness of communication strategies.can write on a dry erase marker some. Cue her to print.The resident is able to communicate some by communication board. Observation on 06/24/2014 at 12:30 PM revealed Resident #9 attempted to communicate with the surveyor and had a dry erase board (communication board) in her room that was out of her reach on the bedside table. The board had tape around the frame. When the surveyor asked if she needed to go to the bathroom she was able to nod her head Yes. Resident #9 was sitting in her gerichair. In an interview on 06/24/2014 at 12:35 PM LVN E stated Resident #9 was unable to use the call light. LVN E also stated Resident #9 was incontinent. In an interview on 06/24/2014 at 12:45 PM LVN E stated She points, but can't really use the (communication) board. Observation on 06/24/2014 at 12:45 PM revealed Resident #9 still sitting in her gerichair, The surveyor handed the communication board to Resident #9 and she wrote I have to take a[***] on the communication board. The marker did not write dark enough to read all the letters but it was legible. Observation on 06/24/2014 at 2:15 PM revealed Resident #9 was asleep in her bed. The communication board was again out of her reach on the far end of the bedside table. In an interview on 06/24/2014 at 2:16 PM LVN E stated Resident #9 had an incontinent episode during the hoyer lift transfer to her bed. Observation on 06/25/2014 at 4:15 PM revealed Resident #9 attempting to communicate with the surveyor. The surveyor handed Resident #9 the communication board and was able to write on the board to communicate with the surveyor. Resident #9 wrote I am lonely and need someone to talk to. In an interview on 06/25/2014 at 4:25 PM CNA I stated Resident #9 was her mother and she had a new communication board at home for Resident #9 and would try to remember to bring it to her. Observation on 06/26/2014 at 10:05 to 10:20 AM revealed Resident #9 was in her bed, the communication board was by the foot of the bed on the air conditioner ledge and out of her reach. The surveyor handed Resident #9 the board and she wrote diaper is soiled and that she was in pain. The surveyor told LVN D about Resident #9's requests. Observation on 06/27/2014 at 8:53 AM revealed Resident #9 was asleep in her bed. The same taped frame communication board was on a small dresser beside the left side of the head of the bed about 2.5 feet away. Due to Resident #9's [DIAGNOSES REDACTED]. In an interview on 06/27/2014 at 9:45 AM the Social Worker stated she would send Resident #9 to therapy for special needs. The Social Worker stated when she noticed a need she referred the problem to the appropriate sources. The Social Worker stated she thought the daughter brought the communication board that Resident #9 had in her room from another facility. The Social Worker also stated Resident #9 needed to be reminded to print and be asked simple yes/no questions. In an interview on 06/27/2014 at 10:10 AM the Activity Director stated Resident #9 was alert and knew what was going on around her. The Activity Director stated she was not aware of the communication board or of any policies related to accommodation of needs. Review of the facility's policy not dated entitled Care of the Resident with [MEDICAL CONDITION] reflected the purpose was To promote communication. The policy also reflected .14. Use adaptive devices, such as picture boards, if available. Review of the facility's policy not dated entitled Communication reflected Many of our residents have difficulty communicating R/T (related to) being hard of hearing, having poor cognition or an inability to express their needs. Communication information is located on the Care Plan.An alternative way to communicate with a resident is to write down communication, if the resident is still able to process language. Review of the facility's policy not dated entitled Care of the Deaf or Hard of Hearing Resident reflected the purpose was To assure that residents.experience positive communication.5. If the resident prefers written communication, write down all communication. The facility provided a CMS Form 672 that reflected one (1) resident who use non-oral communication devices.
F 0275 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Completely assess the resident at least every twelve months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct a comprehensive assessment of a resident not less than once every 12 months for one (1) of nine (9) residents (Resident #5) reviewed for assessments when Resident #5's Annual MDS was not completed and pending with a date of 04/24/2014. This deficient practice could affect all 65 residents by placing them at risk of having their plan of care developed based on inaccurate or incomplete information. Findings include: Review of the Face Sheet for Resident #5 reflected a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of the Significant Change (SC) MDS Assessment for Resident #5 dated 05/27/2013 reflected she was severely cognitively impaired, dependent on one (1) staff for ADLs, incontinent of bladder and bowel, tube fed, and on Hospice. Review of the Annual MDS Assessment for Resident #5 dated 04/24/2014 reflected in the computer the MDS was a pending status, meaning not complete. The MDS reflected some of the sections were not complete, including the Care Area Assessment (CAA) (Section V). (The MDS CAA section indicates what areas need care plans.) Review of the To Do List for the MDS Coordinator with a handwritten date of 06/23/2014 reflected Resident #5 was listed under Annual MDS with a date of 05/07/2014. In an interview on 06/24/2014 at 11:25 AM the MDS Coordinator stated We are behind on the MDSs due to staffing issues. The MDS Coordinator stated she was two (2) to three (3) months behind on the MDSs. Review of the facility's policy entitled Resident Assessment Instrument (RAI) Completion MDS not dated reflected the purpose was for .this facility to complete an RAI (MDS) on each resident as required by regulations.in a timely manner. The facility provided a CMS Form 672 with a census of 65 residents.
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 a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for three (3) of nine (9) residents (Resident #4, #8, and #1) reviewed for plan of care when: A) Resident #4 was prescribed an antipsychotic medication for Depression and Anxiety. Resident # 4's antipsychotic medication was not care planned. B) Resident #8 had range of motion impairment to both sides of her lower extremities. There was no plan of care for Resident # 8's range of motion impairment. C) Resident #1 had no plan of care for activities. These deficient practices placed 65 residents at risk for not receiving care and services to attain and/or maintain their highest practicable physical, mental and psychosocial well-being. Findings include: A) Review of Resident # 4's Face Sheet reflected a [AGE] year old male who entered the facility on 02/21/2014 and was re-admitted on [DATE]. Resident # 4's [DIAGNOSES REDACTED]. Review of Resident # 4's latest Admission MDS assessment dated [DATE] reflected the Resident had moderate cognitive impairment, had other behavioral symptoms not directed toward others that occurred daily and received antianxiety and antidepressant medications seven (7) out of seven (7) days. Review of Resident # 4's Physician Orders reflected an order for [REDACTED]. Review of Resident # 4's Comprehensive Care Plan dated 05/19/2014 reflected no plan of care for psychoactive medications. In an interview on 06/25/2014 at 3:30 PM the MDS Coordinator stated Resident # 4's psychoactive medications were not care planned

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 9) but should be. In an interview on 06/25/2014 at 4:00 PM the DON stated Resident # 4's psychoactive medications should be care planned. B) Review of Resident # 8's Face Sheet reflected an [AGE] year old female who entered the facility on 10/31/2016 and re-admitted on [DATE]. Resident # 8's [DIAGNOSES REDACTED]. Generalized [MEDICAL CONDITION], Nonunion of Fracture, [MEDICAL CONDITION] Disorders, [MEDICAL CONDITIONS] Disease, [MEDICAL CONDITION] Reflex and [MEDICAL CONDITION]. Review of Resident # 8's Quarterly MDS assessment dated [DATE] reflected the Resident had severe cognitive impairment, required extensive assistance of one (1) person for most ADLs and had range of motion impairment on both sides of her lower extremities. Review of Resident # 8's Care Plan Dated 04/27/2014 reflected no plan of care for range of motion for the Resident. In an interview on 06/25/2014 at 4:45 PM the MDS Coordinator agreed Resident # 8 had no plan of care for range of motion and stated she never care planned range of motion problems. In an interview on 06/25/2014 at 5:15 PM the DON stated Resident # 8 should have been care planned for range of motion. C) Review of the Face Sheet for Resident #1 reflected a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with the following Diagnoses: [REDACTED]. Review of the Significant Change MDS Assessment for Resident #1 dated 05/09/2014 reflected a BIMS score of one (1) which indicated severe cognitive impairment. The MDS reflected the Activity section had dashes (-) in every box. Review of the Comprehensive Care Plan for Resident #1 reflected no plan of care for the activities. In an interview on 06/25/2014 at 12:40 PM the Activity Director stated I did not know to write a care plan. The Activity Director stated she does not have a care plan for the activities for Resident #1. Review of the facility's policy Resident Assessment Instrument (RAI) Completion MDS not dated reflected .completes the Comprehensive Care Plan in a timely manner, working the . (Care Area Assessment-CAA) .as triggered. Review of the facility undated policy regarding Care Plans reflected: Purpose: 1. To assure that all disciplines coordinate the care of each resident. Procedure: .The (name of nursing facility) care plan protocols appropriate for the resident will be designated in the resident's care plan. Review of the facility policy for Care Plan Protocols, undated, reflected: It is the policy of the (Name of Nursing Facility) that a resident specific, comprehensive plan of care be developed for each resident. Some care plan protocols, however, are applicable for every resident. The protocols listed below will be considered to be part of the plan of care for each resident.ROM (range of motion) is to be given with daily care. This should be performed to the resident's level of comfort and not beyond. Be sure to report joint pain to the Charge Nurse for assessment. The facility provided a CMS Form 672 with a census of 65 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 meet professional standards of quality for the DON when she did not follow facility policy regarding weekly pressure sore assessments, measuring and staging. The DON failed to assume accountability of the staff for the weekly assessment, measuring and correct staging of pressure sores for two (2) of nine (9) residents (Resident #3 and #7) reviewed for pressure sores. The DON also failed to provide standard infection control practices while measuring a pressure sore, failed to assume accountability of the staff to determine physician orders [REDACTED]. This failure resulted in an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practices affected Resident #3 and Resident #7 and placed an additional 63 residents at risk of not receiving timely medical assessments and services as needed due to facility staff incorrectly assessing, failing to notify the Physician and Family of condition changes, and failing to implement physician orders. Findings include: The Texas Board of Nursing is responsible for regulating the practice of nursing within the State of Texas for Vocational Nurses, Registered Nurses. The standards of practice establish a minimum acceptable level of nursing practice in any setting for each level of nursing licensure. Failure to meet these standards may result in action against the nurse's license even if no actual patient injury resulted. (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses.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; (B) Implement measures to promote a safe environment for clients and others; (C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same; (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; (E) Respect the client's right to privacy by protecting confidential information unless required or allowed by law to disclose the information; (F) Promote and participate in education and counseling to a client(s) and, where applicable, the family/significant other(s) based on health needs; (H) Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations; (O) Implement measures to prevent exposure to infectious pathogens and communicable conditions; (R) Be responsible for one's own continuing competence in nursing practice and individual professional growth. Review of the facility's undated policy for PRESSURE ULCER PREVENTION AND MONITORING reflected: l. All residents admitted at risk for pressure ulcers will be placed on a pressure ulcer prevention program which includes: b. Pressure reducing devices such as special mattresses as needed.e. Intense skin monitoring. 2. Residents with pressure ulcers will have: a. Treatments as ordered.c. Pressure reducing devices such as special mattresses and or/heel protectors as needed.g. At least weekly written assessments including location, stage, odor, color, size, drainage, response to treatment.h. any resident with a pressure ulcer which fails to improve or worsens, will have the physician notified promptly. Review of the undated facility's Pressure Ulcer Management Sheet reflected: 3. Reassess and measure at least weekly or sooner if deterioration of the ulcer is noted. Always document your findings in detail. 4. Promptly inform the physician (and responsible party, as appropriate) of new pressure ulcers. Obtain and initiate treatment orders. A) Review of Resident #3's Face Sheet reflected an [AGE] year old female readmitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3's Significant Change MDS assessment dated [DATE] reflected Resident #3's BIMS score was a five (5) (severe cognitive impairment), she required extensive assistance of two persons to turn, she had an indwelling Foley Catheter, and was frequently incontinent of bowel. Resident #3 was coded as having three (3) Stage I (Intact skin with non-blanchable redness of a localized area usually over a boney prominence) pressure sores and no pressure reduction devices in place. Review of Resident #3's Comprehensive Plan of Care revised on [DATE] reflected The resident has some skin breakdown with interventions of has a pressure relieving mattress.and the resident has a Foley Catheter. Observation on [DATE] at 4:25 PM revealed Resident #3 on her right side receiving peri-care during which time the dressing fell off the sacrum revealing a Stage IV (Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunneling) pressure sore. The pressure sore was approximately 3 cm round and 0.3 cm deep with yellow slough attached to the tendon and muscle in the very center of the wound bed with red wound edges. Periwound edges were reddened, [MEDICAL CONDITION] and not adhered to wound bed thereby indicated tunneling was present. Resident # 3 had a standard green plastic mattress on her bed, a mattress with no pressure reducing qualities. There was no Foley Catheter was in place to prevent contamination of the wound. Observation on [DATE] at 10:50 AM revealed Resident #3 in bed sleeping on her back with a strong odor of urine in her room. No pressure relieving device was on the mattress and no Foley Catheter was in place. Review of the Weekly Skin Monitoring for Resident #3 reflected zero (0) decubitus (pressure sore) on [DATE], [DATE], [DATE], and [DATE]. On [DATE] a Stage II pressure sore (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) to coccyx was documented. Review of the Wound Assessment for Resident #3 by RN A (the nurse in charge of assessing and staging wounds) dated [DATE] reflected: Coccyx Stage II, 1.75 centimeters long and 1.5 cm wide, two (2) millimeters deep, slough; yes. The definition located on the Wound Assessment reflected a Stage II pressure sore does not have slough and a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) pressure sore may have slough present but does not obscure the depth of tissue loss. Resident # 3's Stage III Coccyx wound was misstaged at a Stage II. On the same sheet there was an additional wound documented as #2 wound superficial 0.5 cm wide and 0.5 cm long,

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) .0 deep. Wound edges were described as macerated (moisture associated skin damage). Review of Resident #3's Nurses' Notes dated [DATE] reflected the physician was notified of a Stage II on [DATE] and the orders were obtained. No responsible party notification was documented. Review of Resident # 3's Physician order [REDACTED]. Review of the next recorded Wound Assessment for Resident #3 was l4 days later by RN A dated [DATE] and reflected: Coccyx Stage II 2.0 cm long and 1.75 cm wide, one (1) mm deep with some slough. Scattered areas of white slough to wound bed. Again, the wound with slough was staged at a Stage II instead of a Stage III. Review of Resident # 3's Physician order [REDACTED].) to decubitus (pressure sore) on shower days (3 times weekly) and as needed. Review of Resident #3's [DATE] TAR reflected an order for [REDACTED]. The order written by Resident # 3's physician on [DATE] was not placed on the TAR and there was no indication this treatment had started. The [DATE] TAR reflected there were no nurse signatures for the dates ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], or [DATE] and indicated no treatment was performed for Resident # 3 on those dates. Observation on [DATE] at 4:35 PM revealed Resident # 3 was provided the treatment ordered [DATE] where the wound was cleansed with wound cleanser, the nurse patted dry and applied Wound Be Gone and added a padded dressing. The physician order [REDACTED]. In an interview on [DATE] at 12:30 PM the DON stated, I knew she (Resident # 3) had the order for Santyl, I just didn't know they weren't carrying it out. It might have helped. Review of the next recorded Wound Assessment for Resident #3 was 14 days later by RN A dated [DATE] reflected: Coccyx Stage IV pressure sore 3.0 cm long and 3.0 cm wide, tunneling around wound ranges from 0.5 cm deep to 1.25 cm deep. [DIAGNOSES REDACTED] and purple tissue around edges. Very [DIAGNOSES REDACTED]tous to wound margins. (Tunneling was drawn around one half of the wound). Yellow slough present on wound base in center. Review of the Nurse's Notes from [DATE] through [DATE] reflected no further physician notification was documented until [DATE] when resident was sent to the physician and was prescribed an antibiotic for treatment of [REDACTED]. Review of the Physician order [REDACTED]. Notify if worsens. Review of Resident #3's [DATE] MAR indicated [REDACTED]. In an interview on [DATE] at 11:56 PM the DON stated it looked like no treatment was performed from [DATE] through [DATE] on paper. The DON also stated she would expect that the nurse to sign the treatment sheet when the treatment was performed. Regarding the catheter that was no longer in place, The DON stated she did not think they would get anywhere with the healing of the pressure sore unless the Foley catheter was put back in place. The DON stated we didn't have a [DIAGNOSES REDACTED]. The DON stated she expected the nursing staff to use the Santyl now. In an interview on [DATE] at 12:15 PM RN A, nurse in charge of measuring, staging and documenting pressure sore progress, stated [DATE] was when she was first alerted there was an issue with the coccyx. RN A further stated she (Resident #3) has had a long standing issue with the coccyx. She will get a little pink then heal up. It's not a Stage I, it's a pre-Stage I. RN A stated Resident #3 was really at risk for pressure sores since she was admitted because she was so emaciated. Immediately after we discontinued the Foley Catheter it started getting worse. RN A further stated Resident #3 refused the air mattress on admission and has refused it periodically in the past. She stated she was unable to find any documentation regarding the refusals and stated, on [DATE], I mentioned to her trying to get her on an air mattress and she just wouldn't answer me. RN A further stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In an interview on [DATE] at 3:45 PM Resident #3 was asked if she would like an air mattress overlay placed on her bed while she was up for supper when she stated yes, it's worse than it's ever been. In an interview on [DATE] at 9:00 AM Resident #3, who was up in her wheelchair and had slept on the air overlay mattress, stated I like my bed more and I ate 100% (of her breakfast meal). Resident #3 appeared more comfortable than previous observations. In an interview on [DATE] at 3:45 PM CNA H stated Resident #3 required incontinent care due to bladder incontinence a minimum of two (2) or three (3) times a shift on the evening shifts that she worked. In a telephone interview on [DATE] at 6:15 PM Resident #3's primary Physician stated a Foley Catheter possibly could assist in wound healing and that it should have been a suggestion. Resident # 3's Physician stated that it would be reasonable to believe that an air mattress or pressure relieving mattress would be beneficial. He further stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. Resident # 3's Physician also stated weekly wound measurements may have helped the wound from getting so bad and stated the Santyl order would have possibly helped in wound healing if the order had been followed. In an interview on [DATE] at 12:40 PM the facility's Medical Director stated when Santyl wound ointment is used correctly you can at least see a difference in the wound progress. If it's not done, sometimes the progress is not as obvious as it should be. I would expect the nurses to use it like it's ordered. He also stated, I would expect that a resident should be encouraged to use the air mattress or what is available to prevent or improve the wound. If the resident has dementia (he) expects that the family should be encouraged to assist in those interventions. Regarding improper staging of wounds, he replied, if the wound is not healing or progressing then there are different principles to follow for wound care. B) Review of the face sheet reflected Resident #7 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the Nurses' Notes for [DATE] reflected Resident #7 was admitted with a Stage II pressure sore to the coccyx. Review of the initial MDS assessment dated [DATE] reflected Resident #7 to be moderately impaired in thinking, required two persons and a hydraulic lift to transfer, frequently incontinent of bowel and bladder and had one Stage II pressure sore to coccyx. Additional [DIAGNOSES REDACTED]. Review of the Plan of Care dated [DATE] reflected Resident #7 had breaks in his skin integrity related to pressure ulcer, moisture associated skin damage and stasis ulcers/blisters. Interventions included: Assist Resident #7 to reposition frequently, monitor treatments for effectiveness and notify physician of any concerns. Try to encourage ventilation to perineum area as much as is possible. This may be more realistic in bed. Review of the TAR for [DATE] for Resident #7 reflected an order placed on the TAR dated [DATE] for Inflatable foot/heel protectors with all three shifts ,[DATE], ,[DATE], ,[DATE] signing the TAR. Review of the Wound Assessment Sheet for Resident #7 dated [DATE] reflected the pressure sore to the coccyx was 2.5 cm long by .75 cm wide with no slough and staged as Stage II documented and signed by RN A. Observation on [DATE] revealed Resident #7 to be up in the wheelchair from 9 AM until 6 PM with no inflatable foot/heel protectors in place. Observation on [DATE] at 4:53 of Resident #7's wound care and measurement by RN A (nurse in charge of assessing and staging wounds) revealed the pressure ulcer on the coccyx to be 3.5 cm long by 1.25 cm wide. The pressure ulcer was 80% covered in yellow slough and was a Stage III pressure ulcer as defined on the Wound Assessment System document RN A was documenting on. In an interview on [DATE] at 4:53 RN A stated the wound bed was 80% covered with yellow slough. She stated It is a Stage II because there is no depth. I don't really agree with that slough only being a Stage III. RN A underlined slough in the description of a Stage III ulcer. During the measurement of the wound, RN A assured Resident #7 that his pressure sore was looking and getting much better. Review of the Wound Assessment Sheet dated [DATE] reflected RN A had staged the pressure sore a Stage II. In the narrative she documented wound continues to improve. Has shallow bed of whitish slough to top of wound with approx. (approximately) 20% clean non-granulating tissue to edges. Will continue treatment as ordered. RN A documented some slough and the wound base as pink, yellow and white. Review of Wound Assessment Sheets for Resident #7 reflected his wounds were measured every 14 days. Review of the Nurses' Notes for Resident #7 dated [DATE] reflected there had been no notification to the physician of the increase in size and the worsening of the appearance of the pressure ulcer. In an interview on [DATE] at 12:15 PM with RN A she stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In a telephone interview on [DATE] at 6:15 PM Resident #7's primary Physician stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. He also stated weekly wound measurements may have helped the wound from getting so bad. In an interview on [DATE] at 12:40 PM with the facility's Medical Director, he stated regarding improper staging of wounds, if the wound is not healing or progressing then there are different principles to follow for wound care. In an interview on [DATE] at 4:30 PM the DON stated the skin nurse should let the charge nurse know when she sees worsening of condition of wounds. The DON stated the LVN should realize to notify the family and physician. When asked who was responsible for making sure orders are carried out the DON stated, the charge nurses are responsible to make sure they are carried out. The DON stated she and the ADON were responsible for making sure staff followed facility policy. The DON stated it was her and the ADON's responsibility to ensure staff knew what the facility policies and procedures were. In an interview on [DATE] at 6:05 PM the facility Administrator stated the DON, ADON and charge nurses are responsible for notifying the physician and family. The ADON was responsible for making sure orders were carried out. The Administrator stated the he and the Nursing Department are responsible for making sure staff followed procedures. The Administrator further stated it was ultimately his responsibility to make sure staff followed procedures. The Administrator stated the DON should definitely know what wounds were in the building. He was aware his policy stated pressure sores were to be measured weekly. Regarding whether he and his staff had neglected the care of the residents he stated, It was not correct

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) (the care of the residents). I do not appreciate professional people that I trust not doing what I expect. The facility Administrator was notified on [DATE] at 6:20 PM that an IJ situation had been identified due to the above failures. The following Plan of Removal was first submitted by the Administrator on [DATE] at 9:04 AM. The final Plan of Removal was accepted by the survey team on [DATE] at 7:30 PM. Cameron Nursing and Rehab Plan of Removal of Immediate Jeopardy In responses Wound Issues, Cameron Nursing and Rehab will do the following: 1. An RN from (Hospice) to in-service nursing staff on the care and treatment of [REDACTED]. DON, ADON, RN, Medicare Coordinator, and MDS Nurse and charge nurses LVN's will attend. In-service will be at 10:00 on Friday [DATE]. 2. Two Staff Registered Nurses will assess and measure all wounds on a weekly basis. All current wounds will be reassessed after training on [DATE]. 3. Facility will identify all At Risk residents for Skin Breakdown by using the Braden Scale. After in-service, all At Risk residents will be assessed by a RN and LVN to identify any possible pressure issues [DATE]. 4. All Physician orders [REDACTED]. A pink copy of all telephone order forms will be given to the ADON when completed. The ADON will monitor the order and follow through to make sure all meds are ordered and orders entered on treatment sheet and or MARs. This process was started on [DATE]. 5. DON and ADON will do in-service with all charge nurses regarding proper documentation of resident's change of condition, pressure sores, treatments, Physician Orders, and notifying family members and Physician. This will be complete during the in-service on [DATE]. 6. ADON and DON will report to Administrator any new skin issues and update of treatments in progress on Friday of each week with a copy of the weekly decubitus skin assessment log and non-decubitus log. First meeting will be on [DATE] and then weekly. 7. All pressure wounds will be reviewed and discussed at weekly staff meeting, including DON, ADON, MDS Nurse, Medicaid Coordinator, Registered Nurse on Staff, and Administrator on [DATE]. 8. Medical Director was notified of this at 9:30 am on Thursday [DATE]. Resident #3 Facility will: 1. Ensure air mattress is on Resident #3's bed, [DATE]. 2. Will follow physician orders [REDACTED]. (The new order: Cleanse wound on coccyx with Normal Saline, pat dry-Apply Normal saline packing to wound bandage BID (twice daily)-Will consult wound care at Scott & White (Temple)-Insert indwelling catheter.-change q (every) month & PRN (as needed)-Record I&O (input and output) q shift-Catheter care q shift.) 3. Registered Nurse will accompany resident to Doctor's appointment on [DATE] to discuss proper treatment and procedure to be used, and request the use of a Catheter, this will be done on [DATE]. ADON or DON will monitor resident treatment with charge nurse for a period of two weeks to assure proper procedure is followed. If there is no improvement or wound worsens, Physician will be notified. 4. Two Registered Nurses will assess and measure wounds on a weekly basis. 5. Have Staff to continue to encourage resident to stay off of her back side and have staff continue to encourage and assist her to turn when in bed. 6. Nursing staff will encourage Resident to take in proper nourishment to help the healing process and have a Care Plan meeting with Son to encourage compliance with treatment plan. Administrator, DON, ADON will meet with son. 7. Have Dietary Consultant review Resident #3's chart and condition and make recommendations for nutrition on her next visit to the facility. Resident #7 1. Make sure resident maintains a pressure relieving mattress on his bed, [DATE]. 2. Nursing staff will encourage resident to try to stay off of his back side as much as possible, offering repositioning and reminded to use overhead bar. 3. Resident #7 request to be up for all three meals each day and remain in his wheelchair. DON, ADON, Administrator will have a care plan meeting will be held with Resident and Responsible Party regarding the benefits of shorter periods of time sitting in the wheelchair. 4. ADON or DON will monitor resident treatment for [REDACTED]. If there is no improvement or wound worsens, Physician will be notified. 5. Confirm with Physician when Heel Protectors should be worn, requested clarification [DATE]. 6. Notify Physician of change of condition [DATE]. 7. Two Registered Nurses will assess and measure resident's wounds on a weekly basis. The survey team monitored the plan of removal as follows: Review was completed of new treatments as per physician order [REDACTED].#3 as shown in the plan of removal. All treatments and interventions were initiated and carried out. Resident #3's Responsible Party was notified. Resident # 7 had a re-assessment of his wounds and physician and responsible party were notified of the decline in the coccyx pressure sore. Observation of the facility in-service on [DATE] at 10:00 AM revealed the in-service was conducted by a RN from a local Hospice agency. The in-service provided information regarding pressure sores, care for pressure sores, assessments including staging and measuring, as well as interventions to prevent pressure sores. The in-service had four (4) RNs and 11 LVNs in attendance. The Medical Director and the Administrator were also present. The facility had over 70% of their licensed nursing staff in-serviced on [DATE]. The Hospice RN gave a competency test after the in-service in which all nursing staff in attendance passed per the Administrator. The facility provided a list of 25 residents who were at risk for pressure sores. The facility completed a 100% audit using the Braden Scale to identify residents at risk for pressure sores. Twenty-five (25) residents were identified at risk for pressure sores. Observations were made on [DATE] of four (4) of the 25 residents at risk for pressure sores. These Residents were assessed and staged properly and interventions and treatments were in place. The facility notified the Resident's Physicians and Responsible Parties. Observation on [DATE] at 2:40 PM revealed the DON entered a resident room to assess and measure pressure sores. The DON did not bring a cart or any sanitizing agents to the room. She did not prepare a clean surface for her supplies. She placed supplies for wound measurement under the shoes on Resident #14's Geri chair pressure reduction pad of the incontinent resident. She then laid a pair of gloves up against the heels of the shoes and went to the bathroom to wash her hands. She returned from the bathroom and began donning gloves. She approached the resident to explain the process to the resident when the surveyor stopped the DON and instructed her to start over and explained that her articles were contaminated. Later, when the DON began assessing the heel of the resident that had a Deep Tissue Injury (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue) she proceeded to dismiss the area and pronounced it was blanching after she placed pressure on the heel and released it multiple times. The heel was not blanching. Surveyor stepped forward and asked to see the heel turn white and then return to red. The DON applied pressure once again and admitted the heel was not changing color at all and was actually purple. The DON and ADON then tried to decide if the heel sore was a Stage I or not since it wasn't red. The Surveyor handed the DON the in-service Wound Staging Guide as received in the training in-service and asked her to read the description of a Deep Tissue Injury. The DON then correctly identified the heel as having a deep tissue injury. DON then observed the Stage II that was approximately one (1) cm in size with a pinpoint opening on the sacrum. The DON placed the measuring device on the opening and removed it repeatedly. She finally traced the one (1) cm circle and then marked the pinpoint opening. She then placed the device back on the wound and studied it and then asked the ADON to come and see if she had marked her device correctly. The DON then began studying the raised skin edges on the bilateral buttocks and decided that those impaired skin issues needed measuring. After DON applied the graph several times, the Surveyor asked the ADON if she had told the DON that the resident had a rash over her entire perineum. The ADON said she had not informed the DON and then parted the resident's legs so that she could see the raised skin was related to a rash and was not at all pressure sores. When the DON submitted the wound assessment to the surveyor, she had left the entire wound description area of the form blank. The Surveyor returned the form to the DON to complete it. The DON submitted it to the Surveyor the second time. The Surveyor returned the form to the DON and asked her to complete the periwound skin assessment line on the form. In an interview on [DATE] at 2:43 PM the Surveyor asked the DON as she donned gloves if she realized that she had her wound care items under a pair of shoes in the seat of a chair, she stated that she was so nervous that she did not realize what she had done. In a meeting on [DATE] at 3:15 PM the facility Administrator was made aware of the DON's actions during the assessment of Resident # 14's wound. The Administrator stated the DON needed more training and decided to have the two RNs performing skin assessments and not include the DON until she was further trained. Observations were made of a LVN and RN performing a skin assessment and identifying a problem on an at risk resident. Then two RNs returned and performed an assessment on the at risk resident and identified an area of concern on her left great toe. The area was identified as a Suspected Deep Tissue Injury. The two RNs correctly assessed, measured, identified prevention interventions, and notified the Physician and the Responsible Party. The facility provided an attendance signature sheet for the Staff Meeting held on [DATE] after the skin audit was completed with the Administrator, DON, ADON, RN A, MDS Coordinator, and one LVN-Medicaid Coordinator in attendance. On [DATE] at 8:00 PM the facility Administrator was informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. The facility provided a list of 25 residents at risk for pressure sores.
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide services by qualified persons in

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) accordance with each resident's written plan of care for two (2) of nine (9) residents (Resident #3 and #8) reviewed for following physician orders [REDACTED]. A) On [DATE] the physician changed Resident # 3's treatment for [REDACTED]. The physician ordered treatment never was initiated and there was no wound treatment at all from [DATE] through [DATE]. On [DATE] Resident # 3's pressure sore was assessed at a Stage IV and on [DATE] the physician began antibiotics to treat an infection in the wound. This failure resulted in an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice affected Resident #3 and placed an additional 24 resident at risk for developing new or worsening pressure sores, [MEDICAL CONDITION] (skin infection), [DIAGNOSES REDACTED] (infection of the bone),[MEDICAL CONDITION] (infection of the blood), pain and death. Non-Immediate Jeopardy B) Resident # 8 had a physician order [REDACTED].# 8 did not receive milk at each meal. This deficient practice placed seven (7) residents who received the Fortified Meal Plan with milk at each meal at risk for weight loss and malnutrition. Findings include: A) Review of Resident #3's Face Sheet reflected an [AGE] year old female readmitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3's Significant Change MDS assessment dated [DATE] reflected Resident #3's BIMS score was a five (5) (severe cognitive impairment), she required extensive assistance of two persons to turn, she had an indwelling Foley Catheter, and was frequently incontinent of bowel. Resident #3 was coded as having three (3) Stage I (Intact skin with non-blanchable redness of a localized area usually over a boney prominence) pressure sores and no pressure reduction devices in place. Review of Resident #3's Comprehensive Plan of Care revised on [DATE] reflected The resident has some skin breakdown with interventions of has a pressure relieving mattress.and the resident has a Foley Catheter. Observation on [DATE] at 4:25 PM revealed Resident #3 on her right side receiving peri-care during which time the dressing fell off the sacrum revealing a Stage IV (Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunneling) pressure sore. The pressure sore was approximately 3 cm round and 0.3 cm deep with yellow slough attached to the tendon and muscle in the very center of the wound bed with red wound edges. Periwound edges were reddened, [MEDICAL CONDITION] and not adhered to wound bed thereby indicated tunneling was present. Resident # 3 had a standard green plastic mattress on her bed, a mattress with no pressure reducing qualities. There was no Foley Catheter was in place to prevent contamination of the wound. Observation on [DATE] at 10:50 AM revealed Resident #3 in bed sleeping on her back with a strong odor of urine in her room. No pressure relieving device was on the mattress and no Foley Catheter was in place. Review of the Weekly Skin Monitoring for Resident #3 reflected zero (0) decubitus (pressure sore) on [DATE], [DATE], [DATE], and [DATE]. On [DATE] a Stage II pressure sore (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) to coccyx was documented. Review of the Wound Assessment for Resident #3 by RN A (the nurse in charge of assessing and staging wounds) dated [DATE] reflected: Coccyx Stage II, 1.75 centimeters long and 1.5 cm wide, two (2) millimeters deep, slough; yes. The definition located on the Wound Assessment reflected a Stage II pressure sore does not have slough and a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) pressure sore may have slough present but does not obscure the depth of tissue loss. Resident # 3's Stage III Coccyx wound was misstaged at a Stage II. On the same sheet there was an additional wound documented as #2 wound superficial 0.5 cm wide and 0.5 cm long, .0 deep. Wound edges were described as macerated (moisture associated skin damage). Review of Resident #3's Nurses' Notes dated [DATE] reflected the physician was notified of a Stage II on [DATE] and the orders were obtained. No responsible party notification was documented. Review of Resident # 3's Physician order [REDACTED]. Review of the next recorded Wound Assessment for Resident #3 was l4 days later by RN A dated [DATE] and reflected: Coccyx Stage II 2.0 cm long and 1.75 cm wide, one (1) mm deep with some slough. Scattered areas of white slough to wound bed. Again, the wound with slough was staged at a Stage II instead of a Stage III. Review of Resident # 3's Physician order [REDACTED].) to decubitus (pressure sore) on shower days (3 times weekly) and as needed. Review of Resident #3's [DATE] TAR reflected an order for [REDACTED]. The order written by Resident # 3's physician on [DATE] was not placed on the TAR and there was no indication this treatment had started. The [DATE] TAR reflected there were no nurse signatures for the dates ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], or [DATE] and indicated no treatment was performed for Resident # 3 on those dates. Observation on [DATE] at 4:35 PM revealed Resident # 3 was provided the treatment ordered [DATE] where the wound was cleansed with wound cleanser, the nurse patted dry and applied Wound Be Gone and added a padded dressing. The physician order [REDACTED]. In an interview on [DATE] at 12:30 PM the DON stated, I knew she (Resident # 3) had the order for Santyl, I just didn't know they weren't carrying it out. It might have helped. Review of the next recorded Wound Assessment for Resident #3 was 14 days later by RN A dated [DATE] reflected: Coccyx Stage IV pressure sore 3.0 cm long and 3.0 cm wide, tunneling around wound ranges from 0.5 cm deep to 1.25 cm deep. [DIAGNOSES REDACTED] and purple tissue around edges. Very [DIAGNOSES REDACTED]tous to wound margins. (Tunneling was drawn around one half of the wound). Yellow slough present on wound base in center. Review of the Nurse's Notes from [DATE] through [DATE] reflected no further physician notification was documented until [DATE] when resident was sent to the physician and was prescribed an antibiotic for treatment of [REDACTED]. Review of the Physician order [REDACTED]. Notify if worsens. Review of Resident #3's [DATE] MAR indicated [REDACTED]. In an interview on [DATE] at 11:56 PM the DON stated it looked like no treatment was performed from [DATE] through [DATE] on paper. The DON also stated she would expect that the nurse to sign the treatment sheet when the treatment was performed. Regarding the catheter that was no longer in place, The DON stated she did not think they would get anywhere with the healing of the pressure sore unless the Foley catheter was put back in place. The DON stated we didn't have a [DIAGNOSES REDACTED]. The DON stated she expected the nursing staff to use the Santyl now. In an interview on [DATE] at 12:15 PM RN A, nurse in charge of measuring, staging and documenting pressure sore progress, stated [DATE] was when she was first alerted there was an issue with the coccyx. RN A further stated she (Resident #3) has had a long standing issue with the coccyx. She will get a little pink then heal up. It's not a Stage I, it's a pre-Stage I. RN A stated Resident #3 was really at risk for pressure sores since she was admitted because she was so emaciated. Immediately after we discontinued the Foley Catheter it started getting worse. RN A further stated Resident #3 refused the air mattress on admission and has refused it periodically in the past. She stated she was unable to find any documentation regarding the refusals and stated, on [DATE], I mentioned to her trying to get her on an air mattress and she just wouldn't answer me. RN A further stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In an interview on [DATE] at 3:45 PM Resident #3 was asked if she would like an air mattress overlay placed on her bed while she was up for supper when she stated yes, it's worse than it's ever been. In an interview on [DATE] at 9:00 AM Resident #3, who was up in her wheelchair and had slept on the air overlay mattress, stated I like my bed more and I ate 100% (of her breakfast meal). Resident #3 appeared more comfortable than previous observations. In an interview on [DATE] at 3:45 PM CNA H stated Resident #3 required incontinent care due to bladder incontinence a minimum of two (2) or three (3) times a shift on the evening shifts that she worked. In a telephone interview on [DATE] at 6:15 PM Resident #3's primary Physician stated a Foley Catheter possibly could assist in wound healing and that it should have been a suggestion. Resident # 3's Physician stated that it would be reasonable to believe that an air mattress or pressure relieving mattress would be beneficial. He further stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. Resident # 3's Physician also stated weekly wound measurements may have helped the wound from getting so bad and stated the Santyl order would have possibly helped in wound healing if the order had been followed. In an interview on [DATE] at 12:40 PM the facility's Medical Director stated when Santyl wound ointment is used correctly you can at least see a difference in the wound progress. If it's not done, sometimes the progress is not as obvious as it should be. I would expect the nurses to use it like it's ordered. He also stated, I would expect that a resident should be encouraged to use the air mattress or what is available to prevent or improve the wound. If the resident has dementia (he) expects that the family should be encouraged to assist in those interventions. Regarding improper staging of wounds, he replied, if the wound is not healing or progressing then there are different principles to follow for wound care. Review of the facility's undated policy for PRESSURE ULCER PREVENTION AND MONITORING reflected: 2. Residents with pressure ulcers will have: a. Treatments as ordered. Review of the undated facility's Pressure Ulcer Management Sheet reflected: Promptly inform the physician (and responsible party, as appropriate) of new pressure ulcers. Obtain and initiate treatment orders. In an interview on [DATE] at 4:30 PM the DON stated the skin nurse should let the charge nurse know when she sees worsening of condition of wounds. The DON stated the LVN should realize to notify the family and physician. When asked who was responsible for making sure orders are

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) carried out the DON stated, the charge nurses are responsible to make sure they are carried out. The DON stated she and the ADON were responsible for making sure staff followed facility policy. The DON stated it was her and the ADON's responsibility to ensure staff knew what the facility policies and procedures were. In an interview on [DATE] at 6:05 PM the facility Administrator stated the DON, ADON and charge nurses are responsible for notifying the physician and family. The ADON was responsible for making sure orders were carried out. The Administrator stated the he and the Nursing Department are responsible for making sure staff followed procedures. The Administrator further stated it was ultimately his responsibility to make sure staff followed procedures. The Administrator stated the DON should definitely know what wounds were in the building. He was aware his policy stated pressure sores were to be measured weekly. Regarding whether he and his staff had neglected the care of the residents he stated, It was not correct (the care of the residents). I do not appreciate professional people that I trust not doing what I expect. The facility Administrator was notified on [DATE] at 6:20 PM that an IJ situation had been identified due to the above failures. The following Plan of Removal was first submitted by the Administrator on [DATE] at 9:04 AM. The final Plan of Removal was accepted by the survey team on [DATE] at 7:30 PM. Cameron Nursing and Rehab Plan of Removal of Immediate Jeopardy In responses Wound Issues, Cameron Nursing and Rehab will do the following: 1. An RN from (Hospice) to in-service nursing staff on the care and treatment of [REDACTED]. DON, ADON, RN, Medicare Coordinator, and MDS Nurse and charge nurses LVN's will attend. In-service will be at 10:00 on Friday [DATE]. 2. Two Staff Registered Nurses will assess and measure all wounds on a weekly basis. All current wounds will be reassessed after training on [DATE]. 3. Facility will identify all At Risk residents for Skin Breakdown by using the Braden Scale. After in-service, all At Risk residents will be assessed by a RN and LVN to identify any possible pressure issues [DATE]. 4. All Physician orders [REDACTED]. A pink copy of all telephone order forms will be given to the ADON when completed. The ADON will monitor the order and follow through to make sure all meds are ordered and orders entered on treatment sheet and or MARs. This process was started on [DATE]. 5. DON and ADON will do in-service with all charge nurses regarding proper documentation of resident's change of condition, pressure sores, treatments, Physician Orders, and notifying family members and Physician. This will be complete during the in-service on [DATE]. 6. ADON and DON will report to Administrator any new skin issues and update of treatments in progress on Friday of each week with a copy of the weekly decubitus skin assessment log and non-decubitus log. First meeting will be on [DATE] and then weekly. 7. All pressure wounds will be reviewed and discussed at weekly staff meeting, including DON, ADON, MDS Nurse, Medicaid Coordinator, Registered Nurse on Staff, and Administrator on [DATE]. 8. Medical Director was notified of this at 9:30 am on Thursday [DATE]. Resident #3 Facility will: 1. Ensure air mattress is on Resident #3's bed, [DATE]. 2. Will follow physician orders [REDACTED]. (The new order: Cleanse wound on coccyx with Normal Saline, pat dry-Apply Normal saline packing to wound bandage BID (twice daily)-Will consult wound care at Scott & White (Temple)-Insert indwelling catheter.-change q (every) month & PRN (as needed)-Record I&O (input and output) q shift-Catheter care q shift.) 3. Registered Nurse will accompany resident to Doctor's appointment on [DATE] to discuss proper treatment and procedure to be used, and request the use of a Catheter, this will be done on [DATE]. ADON or DON will monitor resident treatment with charge nurse for a period of two weeks to assure proper procedure is followed. If there is no improvement or wound worsens, Physician will be notified. 4. Two Registered Nurses will assess and measure wounds on a weekly basis. 5. Have Staff to continue to encourage resident to stay off of her back side and have staff continue to encourage and assist her to turn when in bed. 6. Nursing staff will encourage Resident to take in proper nourishment to help the healing process and have a Care Plan meeting with Son to encourage compliance with treatment plan. Administrator, DON, ADON will meet with son. 7. Have Dietary Consultant review Resident #3's chart and condition and make recommendations for nutrition on her next visit to the facility. Resident #7 1. Make sure resident maintains a pressure relieving mattress on his bed, [DATE]. 2. Nursing staff will encourage resident to try to stay off of his back side as much as possible, offering repositioning and reminded to use overhead bar. 3. Resident #7 request to be up for all three meals each day and remain in his wheelchair. DON, ADON, Administrator will have a care plan meeting will be held with Resident and Responsible Party regarding the benefits of shorter periods of time sitting in the wheelchair. 4. ADON or DON will monitor resident treatment for [REDACTED]. If there is no improvement or wound worsens, Physician will be notified. 5. Confirm with Physician when Heel Protectors should be worn, requested clarification [DATE]. 6. Notify Physician of change of condition [DATE]. 7. Two Registered Nurses will assess and measure resident's wounds on a weekly basis. The survey team monitored the plan of removal as follows: Review was completed of new treatments as per physician order [REDACTED].#3 as shown in the plan of removal. All treatments and interventions were initiated and carried out. Resident #3's Responsible Party was notified. Resident # 7 had a re-assessment of his wounds and physician and responsible party were notified of the decline in the coccyx pressure sore. Observation of the facility in-service on [DATE] at 10:00 AM revealed the in-service was conducted by a RN from a local Hospice agency. The in-service provided information regarding pressure sores, care for pressure sores, assessments including staging and measuring, as well as interventions to prevent pressure sores. The in-service had four (4) RNs and 11 LVNs in attendance. The Medical Director and the Administrator were also present. The facility had over 70% of their licensed nursing staff in-serviced on [DATE]. The Hospice RN gave a competency test after the in-service in which all nursing staff in attendance passed per the Administrator. The facility provided a list of 25 residents who were at risk for pressure sores after completion of a 100% audit using the Braden Scale to identify residents at risk. Observations were made on [DATE] of four (4) of the 25 residents at risk for pressure sores. These Residents were assessed and staged properly and interventions and treatments were in place. The facility notified the Resident's Physicians and Responsible Parties. Observation on [DATE] at 2:40 PM revealed the DON entered a resident room to assess and measure pressure sores. The DON did not bring a cart or any sanitizing agents to the room. She did not prepare a clean surface for her supplies. She placed supplies for wound measurement under the shoes on Resident #14's Geri chair pressure reduction pad of the incontinent resident. She then laid a pair of gloves up against the heels of the shoes and went to the bathroom to wash her hands. She returned from the bathroom and began donning gloves. She approached the resident to explain the process to the resident when the surveyor stopped the DON and instructed her to start over and explained that her articles were contaminated. Later, when the DON began assessing the heel of the resident that had a Deep Tissue Injury (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue) she proceeded to dismiss the area and pronounced it was blanching after she placed pressure on the heel and released it multiple times. The heel was not blanching. Surveyor stepped forward and asked to see the heel turn white and then return to red. The DON applied pressure once again and admitted the heel was not changing color at all and was actually purple. The DON and ADON then tried to decide if the heel sore was a Stage I or not since it wasn't red. The Surveyor handed the DON the in-service Wound Staging Guide as received in the training in-service and asked her to read the description of a Deep Tissue Injury. The DON then correctly identified the heel as having a deep tissue injury. DON then observed the Stage II that was approximately one (1) cm in size with a pinpoint opening on the sacrum. The DON placed the measuring device on the opening and removed it repeatedly. She finally traced the one (1) cm circle and then marked the pinpoint opening. She then placed the device back on the wound and studied it and then asked the ADON to come and see if she had marked her device correctly. The DON then began studying the raised skin edges on the bilateral buttocks and decided that those impaired skin issues needed measuring. After DON applied the graph several times, the Surveyor asked the ADON if she had told the DON that the resident had a rash over her entire perineum. The ADON said she had not informed the DON and then parted the resident's legs so that she could see the raised skin was related to a rash and was not at all pressure sores. When the DON submitted the wound assessment to the surveyor, she had left the entire wound description area of the form blank. The Surveyor returned the form to the DON to complete it. The DON submitted it to the Surveyor the second time. The Surveyor returned the form to the DON and asked her to complete the periwound skin assessment line on the form. In an interview on [DATE] at 2:43 PM the Surveyor asked the DON as she donned gloves if she realized that she had her wound care items under a pair of shoes in the seat of a chair, she stated that she was so nervous that she did not realize what she had done. In a meeting on [DATE] at 3:15 PM the facility Administrator was made aware of the DON's actions during the assessment of Resident # 14's wound. The Administrator stated the DON needed more training and decided to have the two RNs performing skin assessments and not include the DON until she was further trained. Observations were made of a LVN and RN performing a skin assessment and identifying a problem on an at risk resident. Then two RNs returned and performed an assessment on the at risk resident and identified an area of concern on her left great toe. The area was identified as a Suspected Deep Tissue Injury. The two RNs correctly assessed, measured, identified prevention interventions, and notified the Physician and the Responsible Party. The facility provided an attendance signature sheet for the Staff Meeting held on [DATE] after the skin

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) audit was completed with the Administrator, DON, ADON, RN A, MDS Coordinator, and one LVN-Medicaid Coordinator in attendance. On [DATE] at 8:00 PM the facility Administrator was informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. The facility provided a list of 25 residents at risk for pressure sores. Non-Immediate Jeopardy B. Review of Resident # 8's Face Sheet reflected an [AGE] year old female who entered the facility on [DATE] and re-admitted on [DATE]. Resident # 8's [DIAGNOSES REDACTED]. Generalized [MEDICAL CONDITION], Nonunion of Fracture, [MEDICAL CONDITION] Disorders, [MEDICAL CONDITIONS] Disease, [MEDICAL CONDITION] Reflex and [MEDICAL CONDITION]. Review of Resident # 8's Quarterly MDS assessment dated [DATE] reflected the Resident had severely cognitive impairment, required limited assistance of one (1) person for eating. The assessment reflected Resident # 8 was on a mechanically altered diet and had not had significant weight loss. Review of Resident # 8's Care Plan Dated [DATE] reflected a plan of care for the Resident has a potential nutritional problem r/t (due to) Adult Failure to Thrive. Interventions included to .provide, serve diet as ordered.and RD (Registered Dietician) to evaluate and make diet change recommendations, PRN (as needed). Review of Resident # 8's Physician order [REDACTED]. milk each meal. Observation on [DATE] at 12:05 PM through 1:00 PM revealed Resident # 8 received no milk during her meal. Observation on [DATE] at 12:01 PM through 1:00 PM revealed Resident # 8 did not receive milk during her meal. In an interview on [DATE] at 12:15 PM Hospice Aide (HA) X stated she fed Resident # 8 during lunch and the Resident never received milk at lunch. In an interview on [DATE] at 10:30 AM the Dietary Manager (DM) stated the fortified food is sprinkled on and added to the milk during meals. The DM stated Resident # 8 should have milk provided with each meal. The facility provided a list of seven (7) residents who receive the fortified meal plan and included milk as the fortified food is added to the milk.
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 attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for two (2) of nine (9) residents (Resident #2 and #3) reviewed for pain when: A) The facility failed to evaluate and assess interventions to ensure pain management and control when Resident # 2 experienced pain during wound care. B) During the month of June, 2014, Resident #3 experienced pain at levels of eight (8) to ten (10) on a scale of ten (10) (where 10 is excruciating pain) almost on a daily basis after readmission following a [MEDICAL CONDITION] and repair. The facility failed to assess, evaluate and revise pain relief interventions to ensure consistent pain management and control. These deficient practices placed 34 residents on scheduled pain management at risk for unrelieved or increased pain and poor quality of life that could lead to decreased oral intake, weight loss, dehydration, mood and behavior problems. Findings include: A) Review of the Consolidated Physician order [REDACTED].#2 reflected an [AGE] year old male who was admitted on [DATE] with the following Diagnoses: [REDACTED]. Resident #2 did not have an order for [REDACTED]. Review of the Significant Change (SC) MDS assessment dated [DATE] reflected Resident #2 required extensive assistance with bed mobility and total assistance for transfers. Resident #2 did not interfere with care, and was able to make himself understood. Resident #2's BIMS score was a seven (7) which indicated he was severely cognitively impaired. Resident #2 received scheduled pain medication but indicated he did not have pain for the past five days. The SC MDS reflected Resident #2 had one Stage 2 with an onset date of 12/22/2013. The Stage 2 had [MEDICATION NAME] tissue (new skin growing in superficial ulcer). The SC MDS reflected Resident #2 had a pressure reducing divide for the chair, care, and application of ointment/medications under Skin Conditions. Review of the Care Plan dated 01/17/2014 reflected Resident #2 had the following interventions for generalized pain: administer [MEDICATION NAME] as ordered by physician, assess and chart pain, factors that aggravate pain and pain control regimen. Review of the Care Plan dated 06/26/2014 for Resident #2 reflected .pressure ulcer or potential for pressure ulcer development r/t (related to).Hx of ulcers. The Care Plan reflected under Interventions .Administer medications as ordered. Monitor/document for side effects and effectiveness. The Care Plan did not address for staff to assess for pain. Review of the Pain Evaluation for Resident #2 dated 05/03/2013 reflected the following [DIAGNOSES REDACTED]. The Evaluation reflected no complaint of pain, but to continue to assess for complaints of pain. Observation on 06/25/2014 at 3:00 PM revealed LVN B provided wound care treatment to Resident #2's coccyx area. Resident #2 was on his left side in bed; he flinched, yelled out, and complained of pain. In an interview on 06/25/2014 at 4:40 PM Resident #2 stated Yes when asked if he had pain during the wound care treatment and he responded yes again when asked if he would like pain medication prior to the wound care. Review of the Nurses' Notes for Resident #2 reflected the following documentation: *06/22/2014 at 12:45 PM dressing to coccyx changed, resident tolerated well. *06/25/2014 at 3:00 PM no documented evidence that Resident #2 experienced pain during wound care. Review of the Hospice Nurse Notes dated 06/23/2014 reflected Breakthrough Pain Medication available and the notes dated 06/25/2014 reflected no medication administered for pain before or after wound care. Review of the June 2014 MAR reflected the following information: *04/27/2014(initial order date)-an order for [REDACTED]. There was no evidence of pain medicine prior to wound care. Review of the physician's orders [REDACTED]. Review of the 24 Hour Report dated 06/25/2014 reflected dressing was done 7-3 (shift)- c/d/I (clean, dry and intact). There was no indication the resident experienced pain during the wound care or a facsimile to the physician for pain medication intervention. Review of the Quarterly Nursing Pain Evaluation dated 05/03/2013 reflected no complaint of pain, but continue to assess for complaints of pain. In an interview on 06/25/2014 at 5:50 PM when asked if Resident # 2 complained of pain during wound care, LVN C stated Yes, all the time. LVN C also stated sometimes up to two (2) to three (3) times a day when we have to change his dressing if it's soiled. In an interview on 06/25/2014 at 6:00 PM LVN B, who had changed Resident #2's dressing earlier, when asked if Resident #2 ever complained of pain before or during wound care stated Oh yes, I probably should call the physician and get something for pain prior to Resident #2's wound care. In an interview on 06/27/2014 at 3:40 PM LVN E stated she performed wound care on Resident #2 on Sunday 06/22/2014 and remembered Resident #2 flinching and grimacing during wound care and that he was on hospice and they would take care of his pain. In an interview on 06/27/2014 at 3:15 PM Resident #2's Attending Physician stated he expected to be notified by phone or fax when a resident experienced pain at levels higher than eight(8)-nine(9) or during wound care that was painful, especially if it was happening two (2) or more times a day. Resident # 2's Attending Physician stated he could give an order for [REDACTED]. In an interview on 06/27/2014 at 3:50 PM Resident #2's Physician's Office Nurse stated the office did not receive a facsimile on the date of 06/25/2014 (when Resident #2 experienced pain during the treatment) to request pain medicine. The Physician's Office Nurse stated they received a facsimile on 06/27/2014 at 6:00 AM. In an interview on 06/27/2014 at 9:30 AM Resident #2 stated he still had not received pain medicine prior to or during dressing changes to his bottom area. B) Review of Resident #3's Face Sheet reflected an [AGE] year old female readmitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3's Significant Change MDS assessment dated [DATE] reflected Resident #3 had severe cognitive impairment. Resident # 3 was assessed as having pain frequently making it hard to sleep at night and limiting her day to day activities. Review of Resident #3's Care Plan dated 05/21/2014 reflected a care plan for pain due to her recent [MEDICAL CONDITION] with a goal of resident will voice a level of comfort to her desired level through the review date. Interventions included: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Review of Resident #3's May 2014 MAR reflected orders for [MEDICATION NAME] and [MEDICATION NAME] tablets (narcotic pain pills) 5-325 mg one (1) or two (2) tablets by mouth every six (6) hours as needed beginning 05/10/2014, aspirin 81 mg once daily, and [MEDICATION NAME] 325 mg two tablets by mouth every six (6) hours as needed. Review of Resident #3's May 2014 MAR reflected she received 27 PRN (as needed) doses of [MEDICATION NAME] and [MEDICATION NAME] tablets 5/325 one or two tablets within a 20 day time 05/11/2014 to 05/31/2014. Resident Behaviors documented on the MAR are: crying seven (7) times, grimacing four (4) times and pain all over four (4) times. Documentation of effectiveness of intervention reveals the pain was relieved down to a four (4) or below after administration of prn pain medication. Record review of Resident # 3's Daily Pain Assessments from 05/09/2014 through 05/31/2014 reflected: *05/11/2014 9:00 AM pain rating eight (8) behavior: grimacing, [MEDICATION NAME] 5/325 mg one tablet given. Pain after intervention seven (7) still complaining. *05/11/2014 3:00 PM pain rating eight (8) behavior: grimacing, [MEDICATION NAME] 5/325 mg two (2) tablets given. Pain after intervention: blank. *05/12/2014 9:00 pain rating ten (10) behavior: crying, [MEDICATION NAME] 5/325 mg two (2) tablets given. Pain after intervention four (4). *05/13/2014 9:30 pain rating ten (10) behavior: crying, [MEDICATION NAME] 5/325 mg two (2) tablets given. Pain after intervention: four (4). *05/14/2014 9:30 pain rating ten (10) behavior: crying, [MEDICATION NAME] 5/325 mg two (2) tablets given. Pain after intervention: four (4).

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CAMERON NURSING AND REHAB	2202 N TRAVIS ST CAMERON, TX 76520

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 15) *05/14/2014 at an unspecified time pain rating eight (8) behavior verbal, grimacing, [MEDICATION NAME] 5/325 mg two (2) tablets given. Pain rating after intervention: not indicated, resting in bed. *05/15/2014 1:20 AM pain rating nine (9) behavior: grimacing complains of pain, [MEDICATION NAME] 5/325 mg two (2) tablets given. Pain after intervention: zero, asleep. *05/15/2014 9:00 pain rating ten (10) behavior: crying, [MEDICATION NAME] 5/325 mg two (2) tablets given. Pain after intervention: four (4). *05/16/2014 2:30 pain rating not legible, [MEDICATION NAME] 5/325 mg for pain all over. Pain after intervention: not recorded. (No pain pill interventions recorded for 05/17/2014 thru 05/18/2014). *05/19/2014 9:30 pain rating nine (9) behavior grimacing, [MEDICATION NAME] 5/325 mg one (1) given. Pain after intervention: two (2) resting. *05/20/2014 9:30 pain rating nine (9) behavior: crying, [MEDICATION NAME] 5/325 mg unknown number given. Pain after intervention two (2) resting.almost daily pain medication dosage given until 05/28/2014 10:00 pain rating eight (8) behavior: verbal complaint [MEDICATION NAME] 5/325 mg unknown amount tablets given. Pain after intervention: two (2). *05/29/2014 7:35 PM pain rating eight (8) behavior verbal complaint, [MEDICATION NAME] 5/325 mg one (1) tablet given. Pain after intervention: two (2) resting in bed. *05/30/2014 9:00 pain rating eight (8) behavior: verbal consent, [MEDICATION NAME] 5/325 mg unknown amount given. Pain after intervention: none, resting in bed. *05/31/2014 11:20 PM pain rating eight (8) behavior: complains of pain/refused repositioning, [MEDICATION NAME] 5/325 mg two (2) tablets given. Pain after intervention: none, asleep (effective). Review of the Nurses Notes from 05/11/2014 through 06/23/2014 reflected Resident # 3's Physician was not notified of significant frequent pain and a request for a routine order of pain medication was not initiated. In an interview on 06/25/2014 at 3:45 PM Resident #3 was asked if she would like an air mattress overlay placed on her bed while she was up for supper when she stated yes, it's worse than it's ever been referring to her pain. Resident # 3 stated she had just received pain medication. In an interview on 06/27/2014 at 3:15 PM Resident #3's Attending Physician stated he expected to be notified by phone or fax when a resident experienced pain at levels higher than eight (8)-nine (9), especially if was happening two (2) or more times a day. Review of the facility's undated Pain Policy reflected a pain evaluation will be completed with each OBRA (Omnibus Budget Reconciliation Act) assessment. (Last OBRA assessment was dated 05/08/2014.) The facility provided a CMS Form 672 with 34 residents who were on a pain management program.
F 0314 **Level of harm** - Immediate jeopardy **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 that a resident who enters the facility without pressure sores does not develop pressure sores and ensure residents having pressure sores received the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for two (2) of nine (9) residents (Resident #3 and #7) reviewed for pressure sores when: A) The facility failed to ensure Resident # 3, a resident with a history of developing pressure sores, had a care planned pressure relieving device on her bed. The facility failed to accurately assess and stage Resident # 3's wound to her coccyx. The facility failed to implement a physician ordered treatment change on [DATE] and failed to provide a wound treatment at all from [DATE] through [DATE]. The facility failed to notify the physician of a decline in the wound and failed to ensure pressure sores were assessed every seven (7) days as stated in their policy. Resident # 3's pressure sore declined to a Stage IV with infection. B) The facility failed to accurately assess and stage Resident #7's wound to his coccyx and failed to notify the physician of a decline in the wound. Resident # 7's wound declined from a Stage II to a Stage III. This failure resulted in an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practice affected Resident #3 and Resident #7 and placed an additional 23 resident at risk for developing new or worsening pressure sores, [MEDICAL CONDITION] (skin infection), [DIAGNOSES REDACTED] (infection of the bone),[MEDICAL CONDITION] (infection of the blood), pain and death. Findings include: A) Review of Resident #3's Face Sheet reflected an [AGE] year old female readmitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3's Significant Change MDS assessment dated [DATE] reflected Resident #3's BIMS score was a five (5) (severe cognitive impairment), she required extensive assistance of two persons to turn, she had an indwelling Foley Catheter, and was frequently incontinent of bowel. Resident #3 was coded as having three (3) Stage I (Intact skin with non-blanchable redness of a localized area usually over a boney prominence) pressure sores and no pressure reduction devices in place. Review of Resident #3's Comprehensive Plan of Care revised on [DATE] reflected The resident has some skin breakdown with interventions of has a pressure relieving mattress.and the resident has a Foley Catheter. Observation on [DATE] at 4:25 PM revealed Resident #3 on her right side receiving peri-care during which time the dressing fell off the sacrum revealing a Stage IV (Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunneling) pressure sore. The pressure sore was approximately 3 cm round and 0.3 cm deep with yellow slough attached to the tendon and muscle in the very center of the wound bed with red wound edges. Periwound edges were reddened, [MEDICAL CONDITION] and not adhered to wound bed thereby indicated tunneling was present. Resident # 3 had a standard green plastic mattress on her bed, a mattress with no pressure reducing qualities. There was no Foley Catheter was in place to prevent contamination of the wound. Observation on [DATE] at 10:50 AM revealed Resident #3 in bed sleeping on her back with a strong odor of urine in her room. No pressure relieving device was on the mattress and no Foley Catheter was in place. Review of the Weekly Skin Monitoring for Resident #3 reflected zero (0) decubitus (pressure sore) on [DATE], [DATE], [DATE], and [DATE]. On [DATE] a Stage II pressure sore (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) to coccyx was documented. Review of the Wound Assessment for Resident #3 by RN A (the nurse in charge of assessing and staging wounds) dated [DATE] reflected: Coccyx Stage II, 1.75 centimeters long and 1.5 cm wide, two (2) millimeters deep, slough; yes. The definition located on the Wound Assessment reflected a Stage II pressure sore does not have slough and a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) pressure sore may have slough present but does not obscure the depth of tissue loss. Resident # 3's Stage III Coccyx wound was misstaged at a Stage II. On the same sheet there was an additional wound documented as #2 wound superficial 0.5 cm wide and 0.5 cm long, .0 deep. Wound edges were described as macerated (moisture associated skin damage). Review of Resident #3's Nurses' Notes dated [DATE] reflected the physician was notified of a Stage II on [DATE] and the orders were obtained. No responsible party notification was documented. Review of Resident # 3's Physician order [REDACTED]. Review of the next recorded Wound Assessment for Resident #3 was l4 days later by RN A dated [DATE] and reflected: Coccyx Stage II 2.0 cm long and 1.75 cm wide, one (1) mm deep with some slough. Scattered areas of white slough to wound bed. Again, the wound with slough was staged at a Stage II instead of a Stage III. Review of Resident # 3's Physician order [REDACTED].) to decubitus (pressure sore) on shower days (3 times weekly) and as needed. Review of Resident #3's [DATE] TAR reflected an order for [REDACTED]. The order written by Resident # 3's physician on [DATE] was not placed on the TAR and there was no indication this treatment had started. The [DATE] TAR reflected there were no nurse signatures for the dates ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], or [DATE] and indicated no treatment was performed for Resident # 3 on those dates. Observation on [DATE] at 4:35 PM revealed Resident # 3 was provided the treatment ordered [DATE] where the wound was cleansed with wound cleanser, the nurse patted dry and applied Wound Be Gone and added a padded dressing. The physician order [REDACTED]. In an interview on [DATE] at 12:30 PM the DON stated, I knew she (Resident # 3) had the order for Santyl, I just didn't know they weren't carrying it out. It might have helped. Review of the next recorded Wound Assessment for Resident #3 was 14 days later by RN A dated [DATE] reflected: Coccyx Stage IV pressure sore 3.0 cm long and 3.0 cm wide, tunneling around wound ranges from 0.5 cm deep to 1.25 cm deep. [DIAGNOSES REDACTED] and purple tissue around edges. Very [DIAGNOSES REDACTED]tous to wound margins. (Tunneling was drawn around one half of the wound). Yellow slough present on wound base in center. Review of the Nurse's Notes from [DATE] through [DATE] reflected no further physician notification was documented until [DATE] when resident was sent to the physician and was prescribed an antibiotic for treatment of [REDACTED]. Review of the Physician order [REDACTED]. Notify if worsens. Review of Resident #3's [DATE] MAR indicated [REDACTED]. In an interview on [DATE] at 11:56 PM the DON stated it looked like no treatment was performed from

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 16) [DATE] through [DATE] on paper. The DON also stated she would expect that the nurse to sign the treatment sheet when the treatment was performed. Regarding the catheter that was no longer in place, The DON stated she did not think they would get anywhere with the healing of the pressure sore unless the Foley catheter was put back in place. The DON stated we didn't have a [DIAGNOSES REDACTED]. The DON stated she expected the nursing staff to use the Santyl now. In an interview on [DATE] at 12:15 PM RN A, nurse in charge of measuring, staging and documenting pressure sore progress, stated [DATE] was when she was first alerted there was an issue with the coccyx. RN A further stated she (Resident #3) has had a long standing issue with the coccyx. She will get a little pink then heal up. It's not a Stage I, it's a pre-Stage I. RN A stated Resident #3 was really at risk for pressure sores since she was admitted because she was so emaciated. Immediately after we discontinued the Foley Catheter it started getting worse. RN A further stated Resident #3 refused the air mattress on admission and has refused it periodically in the past. She stated she was unable to find any documentation regarding the refusals and stated, on [DATE], I mentioned to her trying to get her on an air mattress and she just wouldn't answer me. RN A further stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In an interview on [DATE] at 3:45 PM Resident #3 was asked if she would like an air mattress overlay placed on her bed while she was up for supper when she stated yes, it's worse than it's ever been. In an interview on [DATE] at 9:00 AM Resident #3, who was up in her wheelchair and had slept on the air overlay mattress, stated I like my bed more and I ate 100% (of her breakfast meal). Resident #3 appeared more comfortable than previous observations. In an interview on [DATE] at 3:45 PM CNA H stated Resident #3 required incontinent care due to bladder incontinence a minimum of two (2) or three (3) times a shift on the evening shifts that she worked. In a telephone interview on [DATE] at 6:15 PM Resident #3's primary Physician stated a Foley Catheter possibly could assist in wound healing and that it should have been a suggestion. Resident # 3's Physician stated that it would be reasonable to believe that an air mattress or pressure relieving mattress would be beneficial. He further stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. Resident # 3's Physician also stated weekly wound measurements may have helped the wound from getting so bad and stated the Santyl order would have possibly helped in wound healing if the order had been followed. In an interview on [DATE] at 12:40 PM the facility's Medical Director stated when Santyl wound ointment is used correctly you can at least see a difference in the wound progress. If it's not done, sometimes the progress is not as obvious as it should be. I would expect the nurses to use it like it's ordered. He also stated, I would expect that a resident should be encouraged to use the air mattress or what is available to prevent or improve the wound. If the resident has dementia (he) expects that the family should be encouraged to assist in those interventions. Regarding improper staging of wounds, he replied, if the wound is not healing or progressing then there are different principles to follow for wound care. B) Review of the face sheet reflected Resident #7 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the Nurses' Notes for [DATE] reflected Resident #7 was admitted with a Stage II pressure sore to the coccyx. Review of the initial MDS assessment dated [DATE] reflected Resident #7 to be moderately impaired in thinking, required two persons and a hydraulic lift to transfer, frequently incontinent of bowel and bladder and had one Stage II pressure sore to coccyx. Additional [DIAGNOSES REDACTED]. Review of the Plan of Care dated [DATE] reflected Resident #7 had breaks in his skin integrity related to pressure ulcer, moisture associated skin damage and stasis ulcers/blisters. Interventions included: Assist Resident #7 to reposition frequently, monitor treatments for effectiveness and notify physician of any concerns. Try to encourage ventilation to perineum area as much as is possible. This may be more realistic in bed. Review of the TAR for [DATE] for Resident #7 reflected an order placed on the TAR dated [DATE] for Inflatable foot/heel protectors with all three shifts ,[DATE], ,[DATE], ,[DATE] signing the TAR. Review of the Wound Assessment Sheet for Resident #7 dated [DATE] reflected the pressure sore to the coccyx was 2.5 cm long by .75 cm wide with no slough and staged as Stage II documented and signed by RN A. Observation on [DATE] revealed Resident #7 to be up in the wheelchair from 9 AM until 6 PM with no inflatable foot/heel protectors in place. Observation on [DATE] at 4:53 of Resident #7's wound care and measurement by RN A (nurse in charge of assessing and staging wounds) revealed the pressure ulcer on the coccyx to be 3.5 cm long by 1.25 cm wide. The pressure ulcer was 80% covered in yellow slough and was a Stage III pressure ulcer as defined on the Wound Assessment System document RN A was documenting on. In an interview on [DATE] at 4:53 RN A stated the wound bed was 80% covered with yellow slough. She stated It is a Stage II because there is no depth. I don't really agree with that slough only being a Stage III. RN A underlined slough in the description of a Stage III ulcer. During the measurement of the wound, RN A assured Resident #7 that his pressure sore was looking and getting much better. Review of the Wound Assessment Sheet dated [DATE] reflected RN A had staged the pressure sore a Stage II. In the narrative she documented wound continues to improve. Has shallow bed of whitish slough to top of wound with approx. (approximately) 20% clean non-granulating tissue to edges. Will continue treatment as ordered. RN A documented some slough and the wound base as pink, yellow and white. Review of Wound Assessment Sheets for Resident #7 reflected his wounds were measured every 14 days. Review of the Nurses' Notes for Resident #7 dated [DATE] reflected there had been no notification to the physician of the increase in size and the worsening of the appearance of the pressure ulcer. In an interview on [DATE] at 4:30 PM when asked who should notify the family and physician of pressure sores and changes for Resident #7 the DON stated, Charge nurses/ Skin nurse when she sees it, she should let the charge nurse know. The LVN should realize to notify. In an interview on [DATE] at 12:15 PM with RN A she stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In a telephone interview on [DATE] at 6:15 PM Resident #7's primary Physician stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. He also stated weekly wound measurements may have helped the wound from getting so bad. In an interview on [DATE] at 12:40 PM with the facility's Medical Director, he stated regarding improper staging of wounds, if the wound is not healing or progressing then there are different principles to follow for wound care. Review of the facility's undated policy for PRESSURE ULCER PREVENTION AND MONITORING reflected: l. All residents admitted at risk for pressure ulcers will be placed on a pressure ulcer prevention program which includes: b. Pressure reducing devices such as special mattresses as needed.e. Intense skin monitoring. 2. Residents with pressure ulcers will have: a. Treatments as ordered.c. Pressure reducing devices such as special mattresses and or/heel protectors as needed.g. At least weekly written assessments including location, stage, odor, color, size, drainage, response to treatment.h. any resident with a pressure ulcer which fails to improve or worsens, will have the physician notified promptly. Review of the undated facility's Pressure Ulcer Management Sheet reflected: 3. Reassess and measure at least weekly or sooner if deterioration of the ulcer is noted. Always document your findings in detail. 4. Promptly inform the physician (and responsible party, as appropriate) of new pressure ulcers. Obtain and initiate treatment orders. In an interview on [DATE] at 4:30 PM the DON stated the skin nurse should let the charge nurse know when she sees worsening of condition of wounds. The DON stated the LVN should realize to notify the family and physician. When asked who was responsible for making sure orders are carried out the DON stated, the charge nurses are responsible to make sure they are carried out. The DON stated she and the ADON were responsible for making sure staff followed facility policy. The DON stated it was her and the ADON's responsibility to ensure staff knew what the facility policies and procedures were. In an interview on [DATE] at 6:05 PM the facility Administrator stated the DON, ADON and charge nurses are responsible for notifying the physician and family. The ADON was responsible for making sure orders were carried out. The Administrator stated the he and the Nursing Department are responsible for making sure staff followed procedures. The Administrator further stated it was ultimately his responsibility to make sure staff followed procedures. The Administrator stated the DON should definitely know what wounds were in the building. He was aware his policy stated pressure sores were to be measured weekly. Regarding whether he and his staff had neglected the care of the residents he stated, It was not correct (the care of the residents). I do not appreciate professional people that I trust not doing what I expect. The facility Administrator was notified on [DATE] at 6:20 PM that an IJ situation had been identified due to the above failures. The following Plan of Removal was first submitted by the Administrator on [DATE] at 9:04 AM. The final Plan of Removal was accepted by the survey team on [DATE] at 7:30 PM. Cameron Nursing and Rehab Plan of Removal of Immediate Jeopardy In responses Wound Issues, Cameron Nursing and Rehab will do the following: 1. An RN from (Hospice) to in-service nursing staff on the care and treatment of [REDACTED]. DON, ADON, RN, Medicare Coordinator, and MDS Nurse and charge nurses LVN's will attend. In-service will be at 10:00 on Friday [DATE]. 2. Two Staff Registered Nurses will assess and measure all wounds on a weekly basis. All current wounds will be reassessed after training on [DATE]. 3. Facility will identify all At Risk residents for Skin Breakdown by using the Braden Scale. After in-service, all At Risk residents will be assessed by a RN and LVN to identify any possible pressure issues [DATE]. 4. All Physician orders [REDACTED]. A pink copy of all

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F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 17) telephone order forms will be given to the ADON when completed. The ADON will monitor the order and follow through to make sure all meds are ordered and orders entered on treatment sheet and or MARs. This process was started on [DATE]. 5. DON and ADON will do in-service with all charge nurses regarding proper documentation of resident's change of condition, pressure sores, treatments, Physician Orders, and notifying family members and Physician. This will be complete during the in-service on [DATE]. 6. ADON and DON will report to Administrator any new skin issues and update of treatments in progress on Friday of each week with a copy of the weekly decubitus skin assessment log and non-decubitus log. First meeting will be on [DATE] and then weekly. 7. All pressure wounds will be reviewed and discussed at weekly staff meeting, including DON, ADON, MDS Nurse, Medicaid Coordinator, Registered Nurse on Staff, and Administrator on [DATE]. 8. Medical Director was notified of this at 9:30 am on Thursday [DATE]. Resident #3 Facility will: 1. Ensure air mattress is on Resident #3's bed, [DATE]. 2. Will follow physician orders [REDACTED]. (The new order: Cleanse wound on coccyx with Normal Saline, pat dry-Apply Normal saline packing to wound bandage BID (twice daily)-Will consult wound care at Scott & White (Temple)-Insert indwelling catheter.-change q (every) month & PRN (as needed)-Record I&O (input and output) q shift-Catheter care q shift.) 3. Registered Nurse will accompany resident to Doctor's appointment on [DATE] to discuss proper treatment and procedure to be used, and request the use of a Catheter, this will be done on [DATE]. ADON or DON will monitor resident treatment with charge nurse for a period of two weeks to assure proper procedure is followed. If there is no improvement or wound worsens, Physician will be notified. 4. Two Registered Nurses will assess and measure wounds on a weekly basis. 5. Have Staff to continue to encourage resident to stay off of her back side and have staff continue to encourage and assist her to turn when in bed. 6. Nursing staff will encourage Resident to take in proper nourishment to help the healing process and have a Care Plan meeting with Son to encourage compliance with treatment plan. Administrator, DON, ADON will meet with son. 7. Have Dietary Consultant review Resident #3's chart and condition and make recommendations for nutrition on her next visit to the facility. Resident #7 1. Make sure resident maintains a pressure relieving mattress on his bed, [DATE]. 2. Nursing staff will encourage resident to try to stay off of his back side as much as possible, offering repositioning and reminded to use overhead bar. 3. Resident #7 request to be up for all three meals each day and remain in his wheelchair. DON, ADON, Administrator will have a care plan meeting will be held with Resident and Responsible Party regarding the benefits of shorter periods of time sitting in the wheelchair. 4. ADON or DON will monitor resident treatment for [REDACTED]. If there is no improvement or wound worsens, Physician will be notified. 5. Confirm with Physician when Heel Protectors should be worn, requested clarification [DATE]. 6. Notify Physician of change of condition [DATE]. 7. Two Registered Nurses will assess and measure resident's wounds on a weekly basis. The survey team monitored the plan of removal as follows: Reviewed was completed of new treatments as per physician order [REDACTED].#3 as shown in the plan of removal. All treatments and interventions were initiated and carried out. Resident #3's Responsible Party was notified. Resident # 7 had a re-assessment of his wounds and physician and responsible party were notified of the decline in the coccyx pressure sore. Observation of the facility in-service on [DATE] at 10:00 AM revealed the in-service was conducted by a RN from a local Hospice agency. The in-service provided information regarding pressure sores, care for pressure sores, assessments including staging and measuring, as well as interventions to prevent pressure sores. The in-service had four (4) RNs and 11 LVNs in attendance. The Medical Director and the Administrator were also present. The facility had over 70% of their licensed nursing staff in-serviced on [DATE]. The Hospice RN gave a competency test after the in-service in which all nursing staff in attendance passed per the Administrator. The facility provided a list of 25 residents who were at risk for pressure sores. The facility completed a 100% audit using the Braden Scale to identify residents at risk for pressure sores. Twenty-five (25) residents were identified at risk for pressure sores. Observations were made on [DATE] of four (4) of the 25 residents at risk for pressure sores. These Residents were assessed and staged properly and interventions and treatments were in place. The facility notified the Resident's Physicians and Responsible Parties. Observation on [DATE] at 2:40 PM revealed the DON entered a resident room to assess and measure pressure sores. The DON did not bring a cart or any sanitizing agents to the room. She did not prepare a clean surface for her supplies. She placed supplies for wound measurement under the shoes on Resident #14's Geri chair pressure reduction pad of the incontinent resident. She then laid a pair of gloves up against the heels of the shoes and went to the bathroom to wash her hands. She returned from the bathroom and began donning gloves. She approached the resident to explain the process to the resident when the surveyor stopped the DON and instructed her to start over and explained that her articles were contaminated. Later, when the DON began assessing the heel of the resident that had a Deep Tissue Injury (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue) she proceeded to dismiss the area and pronounced it was blanching after she placed pressure on the heel and released it multiple times. The heel was not blanching. Surveyor stepped forward and asked to see the heel turn white and then return to red. The DON applied pressure once again and admitted the heel was not changing color at all and was actually purple. The DON and ADON then tried to decide if the heel sore was a Stage I or not since it wasn't red. The Surveyor handed the DON the in-service Wound Staging Guide as received in the training in-service and asked her to read the description of a Deep Tissue Injury. The DON then correctly identified the heel as having a deep tissue injury. DON then observed the Stage II that was approximately one (1) cm in size with a pinpoint opening on the sacrum. The DON placed the measuring device on the opening and removed it repeatedly. She finally traced the one (1) cm circle and then marked the pinpoint opening. She then placed the device back on the wound and studied it and then asked the ADON to come and see if she had marked her device correctly. The DON then began studying the raised skin edges on the bilateral buttocks and decided that those impaired skin issues needed measuring. After DON applied the graph several times, the Surveyor asked the ADON if she had told the DON that the resident had a rash over her entire perineum. The ADON said she had not informed the DON and then parted the resident's legs so that she could see the raised skin was related to a rash and was not at all pressure sores. When the DON submitted the wound assessment to the surveyor, she had left the entire wound description area of the form blank. The Surveyor returned the form to the DON to complete it. The DON submitted it to the Surveyor the second time. The Surveyor returned the form to the DON and asked her to complete the periwound skin assessment line on the form. In an interview on [DATE] at 2:43 PM the Surveyor asked the DON as she donned gloves if she realized that she had her wound care items under a pair of shoes in the seat of a chair, she stated that she was so nervous that she did not realize what she had done. In a meeting on [DATE] at 3:15 PM the facility Administrator was made aware of the DON's actions during the assessment of Resident # 14's wound. The Administrator stated the DON needed more training and decided to have the two RNs performing skin assessments and not include the DON until she was further trained. Observations were made of a LVN and RN performing a skin assessment and identifying a problem on an at risk resident. Then two RNs returned and performed an assessment on the at risk resident and identified an area of concern on her left great toe. The area was identified as a Suspected Deep Tissue Injury. The two RNs correctly assessed, measured, identified prevention interventions, and notified the Physician and the Responsible Party. The facility provided an attendance signature sheet for the Staff Meeting held on [DATE] after the skin audit was completed with the Administrator, DON, ADON, RN A, MDS Coordinator, and one LVN-Medicaid Coordinator in attendance. On [DATE] at 8:00 PM the facility Administrator was informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. The facility provided a list of 25 residents at risk for pressure sores.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** Based on observation, interview, and record review the facility failed to ensure that the resident environment remains as free of accident hazards as is possible to prevent accidents for two (2) of three (3) Halls (South Side Hall and Hall connecting North and South Wings) reviewed for accidents and hazards when chemicals and razors were found in multiple areas within access of cognitively impaired residents. This deficient practice placed 54 residents at risk for possible ingestion of dangerous chemicals, nausea, vomiting, gastrointestinal issues, burns, abrasions, cuts, and other injuries. Findings include: Observation on 06/23/2014 at 6:54 PM revealed the door to the Physician's Exam Room was unlocked. This Exam Room was located on the main hall connecting the North and South wings of the facility. The Room had supplies including hydrogen peroxide and four (4) bottles of hand sanitizer out on the counters. These supplies all had the warning to keep out of

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	676174	A. BUILDING _____ B. WING _____	06/27/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMERON NURSING AND REHAB	2202 N TRAVIS ST CAMERON, TX 76520

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F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 18) reach of children on them. The Room also had many drawers that were unlocked, in the top drawer was a box of disposable scalpels. In an interview on 06/23/2014 at 6:55 PM LVN C stated the Physician's Exam Room should be locked because a cognitively impaired resident could open the door, enter the room and find the items listed above. Observation on 06/23/2014 at 6:58 PM revealed the South Side nurses' station with a chart rack behind it with sanitizing wipes on the top shelf. The medication cart was also behind the desk with a bottle of sanitizing hand gel. Both of these items had the warning to keep out of reach of children on the label. Observation on 06/23/2014 at 7:00 PM revealed one (1) can of shaving cream and one (1) bottle of shower gel in Resident Room 211. The shaving cream and shower gel had a warning label of keep out of reach of children. Observation on 06/23/2014 at 7:30 PM revelaed four (4) boxes of denture adhesive located in the bathroom of Resident Room 135. The denture adhesive had a warning label of keep out of reach of children. Observation on 06/23/2014 at 8:11 PM revealed in Resident Room 225 a container of sanitizing wipes was located on her dresser near the door with the warning label to keep out of the reach of children. LVN F removed the wipes from the room and stated she did not know why the sanitizing wipes were in the room. Observation on 06/23/204 at 8:17 PM revealed the shower room on the South Side had an unlocked cabinet with one disposable razor on the shelf a and nd two (2) packages of razors on the shelf. There was also a can of shaving cream with the warning label to keep out of reach of children. The top shelf of the unlocked cabinet had a spray bottle with handwritten bleach and water. In an interview on 06/23/2014 at 8:20 PM LVN F stated the cabinet with the above contents should be locked to prevent cognitively impaired residents from getting into the items. In an interview on 06/23/2014 at 8:00 PM LVN G stated chemicals and razors should be locked up and not within access of cognitively impaired residents. In an interview on 06/25/2014 at 5:45 PM the DON stated chemicals and razors are not supposed to be in view or access of residents, they are supposed to be locked up. In an interview on 06/25/2014 at 6:00 PM the Administrator stated anything with keep out of reach of children warning label on it should be locked up and should not be in resident rooms or out where residents can get them. Review of the facility General Restrictions in the (Name of the Nursing Home), undated reflected: .Safety Hazards: The following items, as a general rule are not allowed to be kept in a resident's room to prevent injury to themselves or others in accordance with state regulations and nursing home policy.Scissors, knives and other sharp objects. The policy did not address chemicals or items with a warning label of keep out of reach of children . The facility provided a CMS Form 672 with 54 residents listed with Dementia.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Store, cook, and serve food in a safe and clean way** Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food under sanitary conditions for one (1 of one (1) facility kitchen when: A) Dietary Staff failed to ensure dishes were properly washed and sanitized when the dish machine did not reach the proper temperature to sanitize the dishes. B) Dietary Staff failed to ensure all left over foods were stored properly in sealed containers, dated and labeled when stored and failed to ensure expired food items were discarded for one (1) of two (20 refrigerator (Refrigerator # 1), one (1) of one (1) freezer (the walk in freezer), one (1) of one (1) dry storage area and one (1) of one (1) kitchen preparation area. C) Dietary staff failed to ensure all equipment was maintained in a clean and sanitary manner. D) Dietary staff failed to ensure all dishes were free from cracked or chipped areas. These deficient practices placed 63 residents who ate from the facility kitchen at risk for reaction to food borne illness including nausea, vomiting, pain and diarrhea. Findings include: A) Observation on 06/23/2014 at 6:47 revealed the wash temperature for the facility dish washing machine reached only 100 degrees Fahrenheit (F). The permanent label on the front of the dish washing machine revealed specifications where the temperature had to reach 125 degrees F and the chemicals must be at 50 parts per million (ppm) for proper sanitization of the dishes. Observation on 06/24/2014 at 9:30 AM revealed the dishwashing machine wash temperature was 115 degrees F. The rinse cycle reached 121 degrees F. In an interview on 06/24/2014 at 9:35 AM DA W stated the facility took temperatures and wrote on a log after the dishes were washed, not before. DA W stated dishes are never run through the machine more than one time and the machine is not run a few times to prime it before washing a load of dishes. Observation on 06/24/2014 at 5:50 PM revealed the dishwasher wash cycle reached 90 degrees F and the rinse was 110 degrees F. Interview on 06/25/2014 at 10:45 AM the DM stated the dish washer temperature was too low and she would serve lunch on paper products. In an interview on 06/25/2014 at 1:00 PM the Dish Machine Representative stated he ran the machine a couple of times before washing dishes and the temperature reached 140 degrees F. The Dish Machine Representative stated the dishes were not properly sanitized with the low temperature readings. The Dish Machine Representative stated the facility staff needs to prime the machine before washing dishes, which means, run the dish washer a few times until the temperature gets up to the required limit, then wash the dishes. Review of the facility Dietary Policies, undated, reflected: Cleaning and Sanitizing. 3. Equipment is available for proper cleaning and sanitizing of dishes. Wash temperatures - 140 degrees F for a mechanical cleaning. Review of the Dish Machine Manufacturer's Specifications, undated, reflected Installation Specifications as 45 gallons per hour @ 140 degrees F (recommended water temperature). B) Observation on 06/23/2014 between 6:55 PM and 7:30 PM revealed the following: Two large bags of prepared cornbread squares on top shelf in Refrigerator # 1. One of the bags had a label and date of 06/09/2014. Within that bag of cornbread there were two cornbread squares that had black particles on them. The second bag of cornbread squares had no label or date on it. In an interview on 06/24/2014 at 8:55 AM the DM stated the staff was going to use the cornbread this week. When asked to look at the black spots on the top of some of the cornbread the DM stated it looks green; looks like mold; going to throw it away. Two cream pies on a tray located in the Refrigerator # 1. One of the pies had a date of 06/07/2014 and the other had no date or label on it. One bag of French toast that had no date or label stored in the Walk-In Freezer. Scoops were left in the bins of flour, sugar and cornmeal in the dry storage area. One (1) plastic bag of prepared fried chicken sitting out on the counter. There was no label or date on this bag of chicken. Two bowls of soup, one chicken noodle and one tomato soup, were left sitting on the counter by the steam table. Neither bowl of soup had a label or date on it. One (1) jar of peanut butter was located next to the microwave. The peanut butter had a cracked lid with dried, old peanut butter on the outside of the lid. The label was marked 03/06/2014. Roast was left in a pan on the stove, sitting at room temperature. The roast was not covered and was open to air. In an interview on 06/23/2014 at 7:05 PM Dietary Aide (DA) U stated the cook food that was left out was cooling. Observation on 06/23/2014 at 7:55 PM revealed a plate of food covered with aluminum foil sitting in the reach-in refrigerator with no label or date. Also in this refrigerator was a cop of a white liquid with plastic wrap on the top. There was a name written on the top (first name only) but no date or label. In an interview on 06/24/2014 at 8:45 AM the Dietary Manager (DM) stated left over food should be put in a storage container, label with the date and placed in Refrigerator # 1. The DM stated left over food should be discarded after 72 hours. The DM stated all refrigerated food must be dated and labeled and properly sealed. Review of the facility Food Preparation Policy, undated, reflected: .K. Leftovers 1. All leftover cold foods for storage in the refrigerator are put in storage containers and completely covered with a lid, plastic or foil wrap. These are marked with the name of the item and date. Review of the facility Food Service Hygiene Policy, undated, reflected: .5. Storage. G. Prepared left-over foods are covered before storage, stored at 35-40 degrees F, containers will be labeled indicating contents and date stored. Leftovers are not to be held more than 48 hours. C) Observation on 06/23/2014 at 7:00 PM revealed electric food slicer located in the kitchen preparation area, had food particles and dried food on and around the slicer. There were empty bags that once contained food on the floor by the trash, not in the trash can. The trash can was located by the hand washing sink in the kitchen did not have a lid on it covering the trash. Observation on 06/23/2014 at 7:09 PM revealed the microwave in the facility kitchen had brown particles inside and on the outside of the oven. The mixer on a stand had brown particles on and dried food particles underneath the equipment. Observation on 06/23/2014 at 7:17 PM revealed a milk dispenser in the kitchen with dried white liquid and a blackish grayish substance in areas one (1) to three (3) inches underneath the handles of the dispenser. In an interview on 06/24/2014 at 9:03 the DM stated the blackish grayish substance on the milk dispenser looked like mildew and further stated the Dietary Staff was supposed to have cleaned that. In an interview on 06/24/2014 at 11:25 the DM stated the DM stated staff is to clean the equipment weekly and document. The DM stated she just takes their word for it that it was done. The DM further stated she needed to check to see if it was done. Review of the Daily Dietary Cleaning Assignments Sheet reflected the Microwave was to be cleaned daily. Review of the facility Weekly Cleaning Schedule reflected the milk dispenser was to be cleaned weekly. D) Observation on 06/24/2014 at 9:10 PM revealed 12 cups that were chipped. In an interview on 06/24/2014 at 9:11 PM the DM stated staff should throw away dishes that were chipped or broken. Review of the facility policy regarding Cleaning of Water Pitchers and Glasses, updated 02/98, and reflected: Purpose: To ensure a safe, clean, sanitized container for drinking water for the

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F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 19) resident. Procedure:.At any time the pitcher or glass is damaged, it shall be replaced with a new one. Per interview with the DM on 06/24/2014 at 4:30 PM the facility does not have another policy regarding chipped dishes. The facility provided CMS Form 672 that reflected a census of 65 with two (2) residents who receive nutrition through tube feeding.
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have a program that investigates, controls and keeps infection from spreading.** Based on observation, interview, and record review the facility failed to establish and maintain an effective infection control program to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease or infection when: A) During wound care LVN D did not change gloves. B) During wound measurement the DON placed supplies under a pair of worn shoes on Resident #14's gerichair pressure reduction pad for the incontinent resident. This deficient practice placed five (5) residents who had pressure sores at risk for an infected wound or sepsis. C) LVN C discarded soiled glucose strips in the regular trash instead of the biohazard sharps container. This deficient practice placed 21 residents who needed glucose monitoring at risk for infection or a blood-borne disease. D) Two (2) of six (6) CNAs (CNA I AND H) did not change gloves during the performance of incontinent care and did not sanitize hands or change gloves before touching clean items. This deficient practice placed 43 residents who required incontinent care at risk for developing Urinary Tract Infections and sepsis. Findings include: A) Observation on 06/25/2014 at 11:45 AM revealed LVN D provided wound care for Resident #1. LVN D did not change gloves after cleansing the wound to Resident #1's left great toe and placed the clean dressing on the wound with the same pair of gloves on she had used to clean the wound. In an interview on 06/25/2014 at 11:55 AM LVN D stated she should have changed her gloves after cleansing the wound and performed hand hygiene before she placed the clean dressing on Resident #1's wound to her left great toe. LVN D also stated she forgot to bring the hand sanitizing gel in the room with the other supplies and so she decided to skip that step in the wound care procedure. LVN D stated she should have taken off the gloves and washed her hands since she forgot the hand sanitizer. B) Observation on 06/27/2014 at 2:40 PM revealed the DON placed supplies for wound measurement under the shoes on Resident #14's gerichair pressure reduction pad of the incontinent resident. The DON moved her papers around underneath the shoes, placed a pair of gloves up against the shoes, and went to the bathroom to wash her hands. In an interview on 06/27/2014 at 2:43 PM the Surveyor asked the DON, as she donned gloves, if she realized that she had her wound care items under a pair of shoes in the seat of a chair The DON stated that she was so nervous that she did not realize what she had done. In an interview on 06/27/2014 at 3:15 PM the facility Administrator (after he heard and understood the events that transpired during wound measurement skill check off) stated the DON needed more training. Review of the Infection Control Policy with no date reflected, Use clean nonsterile gloves when touching.nonintact skin. The facility provided a handwritten list of five (5) residents who had pressure sores. C) Observation on 06/24/2014 at 4:35 PM revealed LVN C performed glucose fingersticks. As she read each fingerstick result LVN C removed the blood filled test strip with her gloved fingers, rolled the glove over the test strip and discarded it in the regular trash sack on the cart. In an interview on 06/24/2014 at approximately 4:50 PM LVN C stated she had placed three test strips in the trash with her gloves and further stated but all the blood products need to go in here and pointed to her sharps container. LVN C then placed the next glucose test strip in the sharps container. Review of the facility's policy entitled Glucose Monitoring, not dated, reflected no information on how to dispose of the glucose testing strips. Review of the facility's policy entitled Infection Control, not dated, reflected under Standard Precautions .are used on every resident. It includes the following: Hand Hygiene, Personal Protective equipment, Safe Work Practices. The policy did not reflect specifically how to discard the glucose testing strips. D) Observation on 06/24/2014 at 4:30 PM revealed CNA I cleaned urine and feces from an un-sampled Resident. Wearing the same gloves, CNA I placed a clean brief on the Resident. CNA I did not perform hand hygiene or change gloves during the incontinent care going from soiled to clean items. In an interview on 06/24/2014 at 4:40 PM CNA I stated she did not change gloves and further stated I forgot, I should have changed gloves and washed my hands after I removed the dirty pad . Observation on 06/24/2014 at 4:25 PM revealed CNA H performed incontinent care for Resident #3. CNA H did not change her gloves or wash her hands after completing pericare and covered the patient up CNA H then raised the siderails, picked up her water basin and left the room with her basin of water with her soiled gloves on. CNA H went to a utility room in the hall and disposed of the water, removed her gloves and washed her hands in the utility room. In an interview on 06/24/2014 at 4:30 PM CNA H stated, You have to wash your hands after you finish before you get started with cleansing stuff. When I got through, I should have washed my hands before I poured out the water. I don't know why I brought the water out to the utility room. I should have done it in her room. In an interview on 06/27/2014 at 5 PM LVN D stated she would expect staff to remove gloves, wash their hands and then take care of items in the room. Review of the facility's policy entitled Perineal Care/Incontinent Care Female With or Without Catheter not dated reflected 1. Perform hand hygiene. Follow Standard Precautions. Review of the facility's policy entitled Infection Control not dated reflected under Standard Precautions .are used on every resident. It includes the following: Hand Hygiene, Personal Protective equipment. The policy reflected under Personal Protective Equipment .Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces.and clean hands immediately to avoid transfer of other microorganisms. The facility provided a CMS Form 672 with 43 residents who were dependent and received incontinent care. The facility provided a handwritten list of 21 residents who needed glucose monitoring.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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 the facility in a manner that enabled them to use their resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for two (2) of nine (9) residents (Resident #3 and #7) reviewed for pressure sores when: The Administrator failed to supervise staff, consult with the DON and ensure the facility policy was implemented for pressure sores. The DON failed to supervise staff and ensure the facility policy was implemented for pressure sores. The Administrator and DON failure resulted in worsening of pressure sores for Resident # 3 and Resident # 7 when: A) The facility failed to ensure Resident # 3, a resident with a history of developing pressure sores, had a care planned pressure relieving device on her bed. The facility failed to accurately assess and stage Resident # 3's wound to her coccyx. The facility failed to implement a physician ordered treatment change on [DATE] and failed to provide a wound treatment at all from [DATE] through [DATE]. The facility failed to notify the physician of a decline in the wound and failed to ensure pressure sores were assessed every seven (7) days as stated in their policy. Resident # 3's pressure sore declined to a Stage IV with infection. B) The facility failed to accurately assess and stage Resident #7's wound to his coccyx and failed to notify the physician of a decline in the wound. Resident # 7's wound declined from a Stage II to a Stage III. This failure resulted in an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practice affected Resident #3 and Resident #7 and placed an additional 23 resident at risk for developing new or worsening pressure sores, [MEDICAL CONDITION] (skin infection), [DIAGNOSES REDACTED] (infection of the bone),[MEDICAL CONDITION] (infection of the blood), pain and death. Findings include: A) Review of Resident #3's Face Sheet reflected an [AGE] year old female readmitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3's Significant Change MDS assessment dated [DATE] reflected Resident #3's BIMS score was a five (5) (severe cognitive impairment), she required extensive assistance of two persons to turn, she had an indwelling Foley Catheter, and was frequently incontinent of bowel. Resident #3 was coded as having three (3) Stage I (Intact skin with non-blanchable redness of a localized area usually over a boney prominence) pressure sores and no pressure reduction devices in place. Review of Resident #3's Comprehensive Plan of Care revised on [DATE] reflected The resident has some skin breakdown with interventions of has a pressure relieving mattress.and the resident has a Foley Catheter. Observation on [DATE] at 4:25 PM revealed Resident #3 on her right side receiving peri-care during which time the dressing fell off the sacrum revealing a Stage IV (Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunneling) pressure sore. The pressure sore was approximately 3 cm round and 0.3 cm deep with yellow slough attached to

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 20) the tendon and muscle in the very center of the wound bed with red wound edges. Periwound edges were reddened, [MEDICAL CONDITION] and not adhered to wound bed thereby indicated tunneling was present. Resident # 3 had a standard green plastic mattress on her bed, a mattress with no pressure reducing qualities. There was no Foley Catheter was in place to prevent contamination of the wound. Observation on [DATE] at 10:50 AM revealed Resident #3 in bed sleeping on her back with a strong odor of urine in her room. No pressure relieving device was on the mattress and no Foley Catheter was in place. Review of the Weekly Skin Monitoring for Resident #3 reflected zero (0) decubitus (pressure sore) on [DATE], [DATE], [DATE], and [DATE]. On [DATE] a Stage II pressure sore (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) to coccyx was documented. Review of the Wound Assessment for Resident #3 by RN A (the nurse in charge of assessing and staging wounds) dated [DATE] reflected: Coccyx Stage II, 1.75 centimeters long and 1.5 cm wide, two (2) millimeters deep, slough; yes. The definition located on the Wound Assessment reflected a Stage II pressure sore does not have slough and a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) pressure sore may have slough present but does not obscure the depth of tissue loss. Resident # 3's Stage III Coccyx wound was misstaged at a Stage II. On the same sheet there was an additional wound documented as #2 wound superficial 0.5 cm wide and 0.5 cm long, .0 deep. Wound edges were described as macerated (moisture associated skin damage). Review of Resident #3's Nurses' Notes dated [DATE] reflected the physician was notified of a Stage II on [DATE] and the orders were obtained. No responsible party notification was documented. Review of Resident # 3's Physician order [REDACTED]. Review of the next recorded Wound Assessment for Resident #3 was l4 days later by RN A dated [DATE] and reflected: Coccyx Stage II 2.0 cm long and 1.75 cm wide, one (1) mm deep with some slough. Scattered areas of white slough to wound bed. Again, the wound with slough was staged at a Stage II instead of a Stage III. Review of Resident # 3's Physician order [REDACTED].) to decubitus (pressure sore) on shower days (3 times weekly) and as needed. Review of Resident #3's [DATE] TAR reflected an order for [REDACTED]. The order written by Resident # 3's physician on [DATE] was not placed on the TAR and there was no indication this treatment had started. The [DATE] TAR reflected there were no nurse signatures for the dates ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], or [DATE] and indicated no treatment was performed for Resident # 3 on those dates. Observation on [DATE] at 4:35 PM revealed Resident # 3 was provided the treatment ordered [DATE] where the wound was cleansed with wound cleanser, the nurse patted dry and applied Wound Be Gone and added a padded dressing. The physician order [REDACTED]. In an interview on [DATE] at 12:30 PM the DON stated, I knew she (Resident # 3) had the order for Santyl, I just didn't know they weren't carrying it out. It might have helped. Review of the next recorded Wound Assessment for Resident #3 was 14 days later by RN A dated [DATE] reflected: Coccyx Stage IV pressure sore 3.0 cm long and 3.0 cm wide, tunneling around wound ranges from 0.5 cm deep to 1.25 cm deep. [DIAGNOSES REDACTED] and purple tissue around edges. Very [DIAGNOSES REDACTED]tous to wound margins. (Tunneling was drawn around one half of the wound). Yellow slough present on wound base in center. Review of the Nurse's Notes from [DATE] through [DATE] reflected no further physician notification was documented until [DATE] when resident was sent to the physician and was prescribed an antibiotic for treatment of [REDACTED]. Review of the Physician order [REDACTED]. Notify if worsens. Review of Resident #3's [DATE] MAR indicated [REDACTED]. In an interview on [DATE] at 11:56 PM the DON stated it looked like no treatment was performed from [DATE] through [DATE] on paper. The DON also stated she would expect that the nurse to sign the treatment sheet when the treatment was performed. Regarding the catheter that was no longer in place, The DON stated she did not think they would get anywhere with the healing of the pressure sore unless the Foley catheter was put back in place. The DON stated we didn't have a [DIAGNOSES REDACTED]. The DON stated she expected the nursing staff to use the Santyl now. In an interview on [DATE] at 12:15 PM RN A, nurse in charge of measuring, staging and documenting pressure sore progress, stated [DATE] was when she was first alerted there was an issue with the coccyx. RN A further stated she (Resident #3) has had a long standing issue with the coccyx. She will get a little pink then heal up. It's not a Stage I, it's a pre-Stage I. RN A stated Resident #3 was really at risk for pressure sores since she was admitted because she was so emaciated. Immediately after we discontinued the Foley Catheter it started getting worse. RN A further stated Resident #3 refused the air mattress on admission and has refused it periodically in the past. She stated she was unable to find any documentation regarding the refusals and stated, on [DATE], I mentioned to her trying to get her on an air mattress and she just wouldn't answer me. RN A further stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In an interview on [DATE] at 3:45 PM Resident #3 was asked if she would like an air mattress overlay placed on her bed while she was up for supper when she stated yes, it's worse than it's ever been. In an interview on [DATE] at 9:00 AM Resident #3, who was up in her wheelchair and had slept on the air overlay mattress, stated I like my bed more and I ate 100% (of her breakfast meal). Resident #3 appeared more comfortable than previous observations. In an interview on [DATE] at 3:45 PM CNA H stated Resident #3 required incontinent care due to bladder incontinence a minimum of two (2) or three (3) times a shift on the evening shifts that she worked. In a telephone interview on [DATE] at 6:15 PM Resident #3's primary Physician stated a Foley Catheter possibly could assist in wound healing and that it should have been a suggestion. Resident # 3's Physician stated that it would be reasonable to believe that an air mattress or pressure relieving mattress would be beneficial. He further stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. Resident # 3's Physician also stated weekly wound measurements may have helped the wound from getting so bad and stated the Santyl order would have possibly helped in wound healing if the order had been followed. In an interview on [DATE] at 12:40 PM the facility's Medical Director stated when Santyl wound ointment is used correctly you can at least see a difference in the wound progress. If it's not done, sometimes the progress is not as obvious as it should be. I would expect the nurses to use it like it's ordered. He also stated, I would expect that a resident should be encouraged to use the air mattress or what is available to prevent or improve the wound. If the resident has dementia (he) expects that the family should be encouraged to assist in those interventions. Regarding improper staging of wounds, he replied, if the wound is not healing or progressing then there are different principles to follow for wound care. B) Review of the face sheet reflected Resident #7 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the Nurses' Notes for [DATE] reflected Resident #7 was admitted with a Stage II pressure sore to the coccyx. Review of the initial MDS assessment dated [DATE] reflected Resident #7 to be moderately impaired in thinking, required two persons and a hydraulic lift to transfer, frequently incontinent of bowel and bladder and had one Stage II pressure sore to coccyx. Additional [DIAGNOSES REDACTED]. Review of the Plan of Care dated [DATE] reflected Resident #7 had breaks in his skin integrity related to pressure ulcer, moisture associated skin damage and stasis ulcers/blisters. Interventions included: Assist Resident #7 to reposition frequently, monitor treatments for effectiveness and notify physician of any concerns. Try to encourage ventilation to perineum area as much as is possible. This may be more realistic in bed. Review of the TAR for [DATE] for Resident #7 reflected an order placed on the TAR dated [DATE] for Inflatable foot/heel protectors with all three shifts ,[DATE], ,[DATE], ,[DATE] signing the TAR. Review of the Wound Assessment Sheet for Resident #7 dated [DATE] reflected the pressure sore to the coccyx was 2.5 cm long by .75 cm wide with no slough and staged as Stage II documented and signed by RN A. Observation on [DATE] revealed Resident #7 to be up in the wheelchair from 9 AM until 6 PM with no inflatable foot/heel protectors in place. Observation on [DATE] at 4:53 of Resident #7's wound care and measurement by RN A (nurse in charge of assessing and staging wounds) revealed the pressure ulcer on the coccyx to be 3.5 cm long by 1.25 cm wide. The pressure ulcer was 80% covered in yellow slough and was a Stage III pressure ulcer as defined on the Wound Assessment System document RN A was documenting on. In an interview on [DATE] at 4:53 RN A stated the wound bed was 80% covered with yellow slough. She stated It is a Stage II because there is no depth. I don't really agree with that slough only being a Stage III. RN A underlined slough in the description of a Stage III ulcer. During the measurement of the wound, RN A assured Resident #7 that his pressure sore was looking and getting much better. Review of the Wound Assessment Sheet dated [DATE] reflected RN A had staged the pressure sore a Stage II. In the narrative she documented wound continues to improve. Has shallow bed of whitish slough to top of wound with approx. (approximately) 20% clean non-granulating tissue to edges. Will continue treatment as ordered. RN A documented some slough and the wound base as pink, yellow and white. Review of Wound Assessment Sheets for Resident #7 reflected his wounds were measured every 14 days. Review of the Nurses' Notes for Resident #7 dated [DATE] reflected there had been no notification to the physician of the increase in size and the worsening of the appearance of the pressure ulcer. In an interview on [DATE] at 4:30 PM when asked who should notify the family and physician of pressure sores and changes for Resident #7 the DON stated, Charge nurses/ Skin nurse when she sees it, she should let the charge nurse know. The LVN should realize to notify. In an interview on [DATE] at 12:15 PM with RN A

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	676174	A. BUILDING _____ B. WING _____	06/27/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMERON NURSING AND REHAB	2202 N TRAVIS ST CAMERON, TX 76520

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 21) she stated, As far as documenting or measuring changes in wounds, I don't know what the policy says honestly. I don't know. The nurses can notify the doctor, I am not the only one that can measure. In a telephone interview on [DATE] at 6:15 PM Resident #7's primary Physician stated he would want to know right away if there was a significant change in a wound such as signs of infection and that he would want it to be measured. He also stated weekly wound measurements may have helped the wound from getting so bad. In an interview on [DATE] at 12:40 PM with the facility's Medical Director, he stated regarding improper staging of wounds, if the wound is not healing or progressing then there are different principles to follow for wound care. Review of the facility's undated policy for PRESSURE ULCER PREVENTION AND MONITORING reflected: l. All residents admitted at risk for pressure ulcers will be placed on a pressure ulcer prevention program which includes: b. Pressure reducing devices such as special mattresses as needed.e. Intense skin monitoring. 2. Residents with pressure ulcers will have: a. Treatments as ordered.c. Pressure reducing devices such as special mattresses and or/heel protectors as needed.g. At least weekly written assessments including location, stage, odor, color, size, drainage, response to treatment.h. any resident with a pressure ulcer which fails to improve or worsens, will have the physician notified promptly. Review of the undated facility's Pressure Ulcer Management Sheet reflected: 3. Reassess and measure at least weekly or sooner if deterioration of the ulcer is noted. Always document your findings in detail. 4. Promptly inform the physician (and responsible party, as appropriate) of new pressure ulcers. Obtain and initiate treatment orders. In an interview on [DATE] at 4:30 PM the DON stated the skin nurse should let the charge nurse know when she sees worsening of condition of wounds. The DON stated the LVN should realize to notify the family and physician. When asked who was responsible for making sure orders are carried out the DON stated, the charge nurses are responsible to make sure they are carried out. The DON stated she and the ADON were responsible for making sure staff followed facility policy. The DON stated it was her and the ADON's responsibility to ensure staff knew what the facility policies and procedures were. In an interview on [DATE] at 6:05 PM the facility Administrator stated the DON, ADON and charge nurses are responsible for notifying the physician and family. The ADON was responsible for making sure orders were carried out. The Administrator stated the he and the Nursing Department are responsible for making sure staff followed procedures. The Administrator further stated it was ultimately his responsibility to make sure staff followed procedures. The Administrator stated the DON should definitely know what wounds were in the building. He was aware his policy stated pressure sores were to be measured weekly. Regarding whether he and his staff had neglected the care of the residents he stated, It was not correct (the care of the residents). I do not appreciate professional people that I trust not doing what I expect. The facility Administrator was notified on [DATE] at 6:20 PM that an IJ situation had been identified due to the above failures. The following Plan of Removal was first submitted by the Administrator on [DATE] at 9:04 AM. The final Plan of Removal was accepted by the survey team on [DATE] at 7:30 PM. Cameron Nursing and Rehab Plan of Removal of Immediate Jeopardy In responses Wound Issues, Cameron Nursing and Rehab will do the following: 1. An RN from (Hospice) to in-service nursing staff on the care and treatment of [REDACTED]. DON, ADON, RN, Medicare Coordinator, and MDS Nurse and charge nurses LVN's will attend. In-service will be at 10:00 on Friday [DATE]. 2. Two Staff Registered Nurses will assess and measure all wounds on a weekly basis. All current wounds will be reassessed after training on [DATE]. 3. Facility will identify all At Risk residents for Skin Breakdown by using the Braden Scale. After in-service, all At Risk residents will be assessed by a RN and LVN to identify any possible pressure issues [DATE]. 4. All Physician orders [REDACTED]. A pink copy of all telephone order forms will be given to the ADON when completed. The ADON will monitor the order and follow through to make sure all meds are ordered and orders entered on treatment sheet and or MARs. This process was started on [DATE]. 5. DON and ADON will do in-service with all charge nurses regarding proper documentation of resident's change of condition, pressure sores, treatments, Physician Orders, and notifying family members and Physician. This will be complete during the in-service on [DATE]. 6. ADON and DON will report to Administrator any new skin issues and update of treatments in progress on Friday of each week with a copy of the weekly decubitus skin assessment log and non-decubitus log. First meeting will be on [DATE] and then weekly. 7. All pressure wounds will be reviewed and discussed at weekly staff meeting, including DON, ADON, MDS Nurse, Medicaid Coordinator, Registered Nurse on Staff, and Administrator on [DATE]. 8. Medical Director was notified of this at 9:30 am on Thursday [DATE]. Resident #3 Facility will: 1. Ensure air mattress is on Resident #3's bed, [DATE]. 2. Will follow physician orders [REDACTED]. (The new order: Cleanse wound on coccyx with Normal Saline, pat dry-Apply Normal saline packing to wound bandage BID (twice daily)-Will consult wound care at Scott & White (Temple)-Insert indwelling catheter.-change q (every) month & PRN (as needed)-Record I&O (input and output) q shift-Catheter care q shift.) 3. Registered Nurse will accompany resident to Doctor's appointment on [DATE] to discuss proper treatment and procedure to be used, and request the use of a Catheter, this will be done on [DATE]. ADON or DON will monitor resident treatment with charge nurse for a period of two weeks to assure proper procedure is followed. If there is no improvement or wound worsens, Physician will be notified. 4. Two Registered Nurses will assess and measure wounds on a weekly basis. 5. Have Staff to continue to encourage resident to stay off of her back side and have staff continue to encourage and assist her to turn when in bed. 6. Nursing staff will encourage Resident to take in proper nourishment to help the healing process and have a Care Plan meeting with Son to encourage compliance with treatment plan. Administrator, DON, ADON will meet with son. 7. Have Dietary Consultant review Resident #3's chart and condition and make recommendations for nutrition on her next visit to the facility. Resident #7 1. Make sure resident maintains a pressure relieving mattress on his bed, [DATE]. 2. Nursing staff will encourage resident to try to stay off of his back side as much as possible, offering repositioning and reminded to use overhead bar. 3. Resident #7 request to be up for all three meals each day and remain in his wheelchair. DON, ADON, Administrator will have a care plan meeting will be held with Resident and Responsible Party regarding the benefits of shorter periods of time sitting in the wheelchair. 4. ADON or DON will monitor resident treatment for [REDACTED]. If there is no improvement or wound worsens, Physician will be notified. 5. Confirm with Physician when Heel Protectors should be worn, requested clarification [DATE]. 6. Notify Physician of change of condition [DATE]. 7. Two Registered Nurses will assess and measure resident's wounds on a weekly basis. The survey team monitored the plan of removal as follows: Reviewed was completed of new treatments as per physician order [REDACTED].#3 as shown in the plan of removal. All treatments and interventions were initiated and carried out. Resident #3's Responsible Party was notified. Resident # 7 had a re-assessment of his wounds and physician and responsible party were notified of the decline in the coccyx pressure sore. Observation of the facility in-service on [DATE] at 10:00 AM revealed the in-service was conducted by a RN from a local Hospice agency. The in-service provided information regarding pressure sores, care for pressure sores, assessments including staging and measuring, as well as interventions to prevent pressure sores. The in-service had four (4) RNs and 11 LVNs in attendance. The Medical Director and the Administrator were also present. The facility had over 70% of their licensed nursing staff in-serviced on [DATE]. The Hospice RN gave a competency test after the in-service in which all nursing staff in attendance passed per the Administrator. The facility provided a list of 25 residents who were at risk for pressure sores. The facility completed a 100% audit using the Braden Scale to identify residents at risk for pressure sores. Twenty-five (25) residents were identified at risk for pressure sores. Observations were made on [DATE] of four (4) of the 25 residents at risk for pressure sores. These Residents were assessed and staged properly and interventions and treatments were in place. The facility notified the Resident's Physicians and Responsible Parties. Observation on [DATE] at 2:40 PM revealed the DON entered a resident room to assess and measure pressure sores. The DON did not bring a cart or any sanitizing agents to the room. She did not prepare a clean surface for her supplies. She placed supplies for wound measurement under the shoes on Resident #14's Geri chair pressure reduction pad of the incontinent resident. She then laid a pair of gloves up against the heels of the shoes and went to the bathroom to wash her hands. She returned from the bathroom and began donning gloves. She approached the resident to explain the process to the resident when the surveyor stopped the DON and instructed her to start over and explained that her articles were contaminated. Later, when the DON began assessing the heel of the resident that had a Deep Tissue Injury (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue) she proceeded to dismiss the area and pronounced it was blanching after she placed pressure on the heel and released it multiple times. The heel was not blanching. Surveyor stepped forward and asked to see the heel turn white and then return to red. The DON applied pressure once again and admitted the heel was not changing color at all and was actually purple. The DON and ADON then tried to decide if the heel sore was a Stage I or not since it wasn't red. The Surveyor handed the DON the in-service Wound Staging Guide as received in the training in-service and asked her to read the description of a Deep Tissue Injury. The DON then correctly identified the heel as having a deep tissue injury. DON then observed the Stage II that was approximately one (1) cm in size with a pinpoint opening on the sacrum. The DON placed the measuring device on the opening

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F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 22) and removed it repeatedly. She finally traced the one (1) cm circle and then marked the pinpoint opening. She then placed the device back on the wound and studied it and then asked the ADON to come and see if she had marked her device correctly. The DON then began studying the raised skin edges on the bilateral buttocks and decided that those impaired skin issues needed measuring. After DON applied the graph several times, the Surveyor asked the ADON if she had told the DON that the resident had a rash over her entire perineum. The ADON said she had not informed the DON and then parted the resident's legs so that she could see the raised skin was related to a rash and was not at all pressure sores. When the DON submitted the wound assessment to the surveyor, she had left the entire wound description area of the form blank. The Surveyor returned the form to the DON to complete it. The DON submitted it to the Surveyor the second time. The Surveyor returned the form to the DON and asked her to complete the periwound skin assessment line on the form. In an interview on [DATE] at 2:43 PM the Surveyor asked the DON as she donned gloves if she realized that she had her wound care items under a pair of shoes in the seat of a chair, she stated that she was so nervous that she did not realize what she had done. In a meeting on [DATE] at 3:15 PM the facility Administrator was made aware of the DON's actions during the assessment of Resident # 14's wound. The Administrator stated the DON needed more training and decided to have the two RNs performing skin assessments and not include the DON until she was further trained. Observations were made of a LVN and RN performing a skin assessment and identifying a problem on an at risk resident. Then two RNs returned and performed an assessment on the at risk resident and identified an area of concern on her left great toe. The area was identified as a Suspected Deep Tissue Injury. The two RNs correctly assessed, measured, identified prevention interventions, and notified the Physician and the Responsible Party. The facility provided an attendance signature sheet for the Staff Meeting held on [DATE] after the skin audit was completed with the Administrator, DON, ADON, RN A, MDS Coordinator, and one LVN-Medicaid Coordinator in attendance. On [DATE] at 8:00 PM the facility Administrator was informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. The facility provided a list of 25 residents at risk for pressure sores.
F 0498 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that nurse aides were 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 two (2) of six (6) CNAs (CNA I and H) who did not change gloves during the performance of incontinent care and did not sanitize hands or change gloves before touching clean items. This deficient practice placed 43 residents who received incontinent care at risk for developing Urinary Tract Infections [MEDICAL CONDITION]. Findings include: Observation on 06/24/2014 at 4:30 PM revealed CNA I cleaned urine and feces from an un-sampled Resident. Wearing the same gloves, CNA I placed a clean brief on the Resident. CNA I did not perform hand hygiene or change gloves during the incontinent care going from soiled to clean items. In an interview on 06/24/2014 at 4:40 PM CNA I stated she did not change gloves and further stated I forgot, I should have changed gloves and washed my hands after I removed the dirty pad . Observation on 06/24/2014 at 4:25 PM revealed CNA H performed incontinent care for Resident #3. CNA H did not change her gloves or wash her hands after completing pericare and covered the patient up CNA H then raised the siderails, picked up her water basin and left the room with her basin of water with her soiled gloves on. CNA H went to a utility room in the hall and disposed of the water, removed her gloves and washed her hands in the utility room. In an interview on 06/24/2014 at 4:30 PM CNA H stated, You have to wash your hands after you finish before you get started with cleansing stuff. When I got through, I should have washed my hands before I poured out the water. I don't know why I brought the water out to the utility room. I should have done it in her room. In an interview on 06/27/2014 at 5 PM LVN D stated she would expect staff to remove gloves, wash their hands and then take care of items in the room. Review of the facility's policy entitled Perineal Care/Incontinent Care Female With or Without Catheter not dated reflected 1. Perform hand hygiene. Follow Standard Precautions. Review of the facility's policy entitled Infection Control not dated reflected under Standard Precautions .are used on every resident. It includes the following: Hand Hygiene, Personal Protective equipment. The policy reflected under Personal Protective Equipment .Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces.and clean hands immediately to avoid transfer of other microorganisms. The facility provided a CMS Form 672 with 43 residents who were dependent and received incontinent care.