STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHOLLOW HEIIGHTS TRANSITIONAL CARE CENTER	**1737 N LOOP W HOUSTON, TX 77008**

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 0156 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give each resident a notice of rights, rules, services and charges. Tell each resident who can get Medicaid benefits about 1) which items and services Medicaid covers and which the resident must pay for.** Based on interview and record review, the facility failed to ensure residents were notified in writing regarding changes in services for 3 of 5 residents reviewed for notification of Medicare non-coverage. (Resident #s 7, 32 and 33) Resident #'s 7, 32 and 33 were discharged from Medicare services without prior written notification. This failure affected 3 residents and placed the other 15 residents on Medicare at risk of not being informed of their rights to appeal. Findings include: Record review of the facility Notice of Medicare Non-Coverage revealed: Please sign below to indicate you received and understood this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision Signature of Patient or Representative and Date. Record review of the Notices of Medicare Non-Coverage letters revealed 1 of the 5 letters were unsigned and undated (Resident #7). - Resident #7 service end date: 10/06/14, Additional information: To Resident #7's family member. (Please sign and return. This letter is to inform you that Resident #7 had reached his maximum potential with therapy treatment and will be discharged from Medicare benefits as of 10/06/14. Please feel free to call me for any questions. This documentation was signed by MDS Coordinator. Further review revealed no date on the letter indicating when it was sent out. The section with Patient/Representative signature was not signed or dated. Record review of 2 notices of Medicare Non-Coverage letters revealed 2 of the 5 letters were signed on the day the Medicare coverage ended for the following residents: - Resident #32 service end date was: 01/19/15, the notice of Medicare Non- Coverage was signed on 01/19/15 by the patient/Representative. - Resident #33 service end date was: 03/05/15, the notice of Medicare Non- Coverage was signed on 03/05/15 by the patient/Representative. During an interview on 03/30/15 at 3:03 p.m., the MDS Coordinator said the letters were sent out to the families to inform them of the Notice of Medicare Non-coverage. He said he called the families to notify them of the non-coverage dates. He said he sent the families a letter to explain the changes in their Medicare coverage. He said they were to sign and return the letters to him. He said he had some return mail but did not produce any records of the letters that were mailed to the families of Resident #7, 32 and 33. He further stated that that sending a letter was just a matter of courtesy. Record Review of the Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS- revealed in part: .A Medicare health provider must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to enrollees receiving skilled nursing, home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services, no later than two days before the termination of services . The facility ' s CMS-672 form revealed 18 resident's receiving Medicare services.
F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to consult with the resident's physician of elevated blood sugar levels for 1 of 27 residents reviewed for care (Resident's #21) - Resident #21's physician was not informed when blood sugar reading were over 351. This failure affected 1 residents and placed an additional 119 residents at risk of not receiving the care and services ordered by the physician and a decline in health status. Findings include: Resident #21: Record review of Resident #21's face sheet revealed an [AGE] year old female that was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of physician's orders [REDACTED]. Record review of Resident #21's MAR for March 2015 revealed that insulin was administered and blood sugar readings at 6:00 a.m. on the following dates were: 03/18/15 was 384 mg/dl, 03/19/15 was 406 mg/dl, 03/20/15 was 390 mg/dl, Further review of the MAR indicated [REDACTED]. There was no documentation on the backside of the MAR indicated [REDACTED]. Record review of Resident #21's nurse's notes revealed no documentation that the physician was notified concerning the elevated blood sugar elevated levels. During an interview on 03/26/15 at 5:45 p.m. with Administrator regarding the nurse's notes for Resident #21 he said he was going to look in it. No further documentation was presented to the survey team for review prior to the survey exit. The facility's CMS 672 listed a census of 122 resident.
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 their written policies and procedures that prohibit neglect for 7 of 10 residents reviewed for pressure sores. (Residents # 1, 11, 14, 5, 3, 26 and #25) -The Wound Treatment Nurse was unable to accurately describe, stage and measure pressure sores for Residents # 1, 11, 14,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**

NAME OF PROVIDER OF SUPPLIER **BROOKHOLLOW HEIIGHTS TRANSITIONAL CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP **1737 N LOOP W** **HOUSTON, TX 77008**

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 1)
26, 5, 3, and 25.
- Resident #1 ' s Stage IV sacral pressure ulcer was not staged and measured correctly by the Wound Treatment Nurse. The resident received the incorrect treatment for [REDACTED]. The pressure ulcer increased in size on 03/11/15 and again on 03/18/15.
- Resident #1 developed a Stage II pressure ulcer on his left ankle that was not identified by the facility until 03/26/15. The wound was covered with a dry dressing dated 3/24/15. The physician was not notified until 3/26/15 of the new Stage II on the left ankle.
- Resident #1 unstageable wound to the left hip was not documented on the wound reports and there was no physician order for [REDACTED].>-The Wound care nurse applied the incorrect treatment to Resident #1 ' s left shoulder wound.
- Resident #11, who entered the facility without pressure sores on 2/18/15, developed multiple unstageable wounds on 3/9/15. On 03/23/15 he developed a Stage II pressure ulcer to left buttock. Pressure relieving devices for the wheelchair were not applied. Resident #11 was not being repositioned, heels were not being offloaded and Prevalon boots were not applied as per plan of care. The depth of the wound was not measured.
- Resident #14 developed a Stage II right buttock pressure ulcer on 1/20/2015. The pressure ulcer increased in size and worsened to a Stage III by 2/18/2015. The depth of the wound was not measured.
-Resident # 14 was not being turned and repositioned as per care plan.
-Resident # 14 did not have pressure relieving devices in her bed or chair for a Stage III wound on her buttock.
-Resident #5 who had a Stage IV pressure sore to his bilateral buttocks and multiple wounds on his right leg, was not turned and repositioned as per care plan.
-Resident #3 developed pressure sores on the left ankle. Orders to float his feet were not being followed. The wounds increased in size. The depth of the wound was not measured.
-Resident # 26 wounds were not measured correctly by the Wound Treatment Nurse. Resident #26 ' s sacral wound deteriorated to a Stage IV with tunneling by 03/16/15.
- Resident #25 who was assessed by the facility to be at low risk for developing pressure ulcers and entered the facility with no pressure ulcers on 12/2/14, developed multiple avoidable wounds to include a Stage IV to the sacrum, a Stage III to right malleolus, unstageable wounds to bilateral feet and other wounds on her hips and back. Skin assessments did not accurately reflect her skin breakdown. The depth of the wounds was not measured.
An IJ was identified on 3/26/15. While the IJ was lowered on 3/31/15, the facility remained out of compliance at a pattern level and a severity of actual harm that is not immediate jeopardy due to facility needing more time to monitor the plan of removal for effectiveness.
These failures affected 7 residents and placed the other 10 residents with pressure sores at risk of further neglect, deterioration of ulcers, pain, infection, developing more ulcers and a decline in their quality of life.
Findings include:
Resident #1
Record review of Resident #1 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #1 ' s initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, transfers. Resident #1 had range of motion issues and was continent of bladder with indwelling catheter and incontinent of bowel. Further review of the MDS section for skin conditions revealed that he was at high risk for pressure ulcers, and had a pressure ulcer stage II to sacrum. The section titled skin and ulcer treatment was checked for pressure reducing device for bed, pressure ulcer care, nutrition or hydration intervention to manage skin problems and application of ointments.
Record review of Care plan dated 01/19/15 and last revised on 02/24/15 did address Stage II sacral pressure ulcer. Goal included showing signs of healing and decreased risk of infection. Approaches included in part: treatment as needed, assess and document progress of wound every week and as needed, use of air mattress and notify MD of wound progress weekly.
Record review of the Braden scales for Resident #1 revealed that he was assesse4d as being at high risk for pressure sores (9 of 23) on 01/19/15. The resident was reassessed by a different nurse on 02/11/15 as being at low risk for pressure sores (23 of 23) score. He was again assessed as being at high risk for pressure sores on 02/24/15.
Record review of the facility admission report revealed that Resident #1 was readmitted on [DATE] from the hospital.
Record review of the weekly wound healing progress report revealed that it was not completed until 02/25/15. Further review revealed that the resident was readmitted to the facility with a Stage IV pressure ulcer to the sacral area measuring 6.00 cm x 5.50 cm , depth not measured.
Further review of the report revealed that the wound increased in size on:
3/11/15 the wound increased in size to 7.00 cm x 6.00 cm, depth not measured.
3/18/15 measured 8.50 cm x 5.00 cm, depth not measured.
Record review of the weekly wound healing progress report dated 03/24/15 revealed a new for Stage II pressure ulcer to the right heel, right inner ankle measuring: 1.50 cm x 2.00 cm, depth not measured.
3/26/15 wound observation revealed 3.00 cm (L) by 1.00 cm (W) by 0.00 (D).
Interview during initial rounds with unit manager LVN C on 3/24/15 at 8:45 a.m. LVN C said Resident #1 was admitted with a Stage II sacral pressure ulcer. She said that Resident #1 had developed other pressure ulcers in house, but she was not sure of the pressure sore location.
Observation on 03/24/15 at 12:35 p.m. and 12:55 p.m. revealed that Resident #1 was in bed on an air mattress. He was positioned on his right side. The resident had a feeding tube and a Foley catheter in place. He had a [MEDICAL CONDITION] and was awake, but was unable to verbalize.
Observation of incontinent care on 3/24/15 at 2:50 p.m. performed by CNA KK and CNA II revealed that Resident #1 did not have a dressing on the wound on his Stage IV sacral area wound. The sacral wound was large with granulation tissue.
Interview at the time of the observation with CNA KK and CNA II both confirmed that the dressing was not on and they were not aware how long ago the dressing came off.
During an interview with unit manager LVN A on 3/24/15 at 4:30 p.m. regarding Resident #1's sacral wound with no dressing on, she said she was not aware that the dressing was not on. The Unit Manager said she was calling the treatment nurse.
Interview with the Wound Treatment Nurse on 3/24/15 at 5:20 p.m. she said she was not informed that the dressing came off and that she was just getting ready to change the dressing. The Wound Treatment Nurse said she would have to wait after the dinner trays were taken off the unit to place a dressing on his wound.
Observation of wound treatment to Resident #1 on 3/25/15 at 11:15 am by the Wound Treatment Nurse , she removed the old dressing to Resident #1's left hip revealing an unstageable pressure ulcer with slough, she cleaned with normal saline, and she applied Santyl ointment. The nurse measured the pressure left hip pressure ulcer as 3.00 cm length (L) by 1 cm width (W).
Record review of the weekly wound healing progress report of the wound care doctor reports did not have documentation that the resident had an unstageable pressure ulcer with slough to the left hip. The onset of the wound was not documented.
Record review of Resident #1 ' s TAR or the physician orders revealed no treatment orders for the left hip unsteagable wound.
Record review of physician ' s telephone order dated 2/25/15 had cleanse sacral with normal saline, pat dry, apply Santyl cover with dry dressing daily. No other orders found on the chart.
Further observation and interview on 03/25/15 at 11:20 am revealed the Wound Treatment nurse then removed the old dressing to Resident #1 ' s sacral wound. The wound was large with granulation tissue, tunneling noticed on all sides and some of the bone was exposed (Stage IV). The Wound Treatment Nurse said it was an unstageable wound with slough. She cleaned it with normal saline then pat dry with 4 x4 gauze. The nurse applied Santyl ointment. The nurse proceeded to measure the sacral wound pressure as 7 cm x 5 cm and said it was an unstageable wound. The Wound Treatment Nurse did not measure the depth or tunneling of the wound. The Wound Treatment Nurse kept saying it was unstageable because the wound doctor said it was.
Record review of telephone physician order dated 03/18/15 revealed to apply triple antibiotic ointment to left shoulder once per day.
Record review of the TAR revealed that the order was transcribed as cleanse left shoulder with normal saline and apply

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2)

silverdane, cover with dry dressing.
Further observation and interview at this time revealed that the Treatment nurse removed the old dressing to Resident #1 ' s upper back left shoulder. The Wound Treatment Nurse cleaned the area with normal saline and pat and dry with 4x4 gauze and applied Silver [MEDICATION NAME] cream and taped. She measured the area as 0.5 cm (L) by 0.5 cm (W).Treatment nurse said it was an abrasion acquired in house and that those were the only wounds Resident #1 had.
Interview and observation of head to toe assessment done with Wound Treatment Nurse on 3/26/15 at 11:50 am revealed that the nurse surveyor discovered a dressing dated 3/24/15 on Resident #1 ' s left outer ankle. The Wound Treatment Nurse said at 11:55 a.m., that she was not sure about the left ankle wound and that she was going to check her treatment book outside Resident #1 ' s room. At 11:58 a.m., the Wound Treatment Nurse came in Resident #1 ' s room stated I do not have that wound in the book . The Wound Treatment Nurse measured the left outer ankle wound and it was 1 cm (L) by 1.5 cm (W) with slough. The Wound Treatment Nurse said she was going to call the doctor and obtain an order.
In a phone interview on 03/26/15 at 1:24 pm with a family member for Resident #1 he said that he was concern about all the wounds that the resident developed in the facility.
Observation and interview on 03/26/15 at 3:15 pm was conducted with the DON in the presence of the Wound Treatment Nurse. The DON was informed that the Wound Treatment Nurse said Resident #1 ' s wound to the sacral area was unsteageable. The DON opened the dressing to Resident #1 ' s sacral wound and said: it is a Stage IV with about 35 % slough with pink surrounding and tunneling on all sides . The DON further stated that the Wound Care doctor and the Wound Treatment Nurse did not make a good assessment of the wound.
During an interview and observation with the wound care doctor on 3/26/15 at 6:17 p.m. regarding pressure ulcer staging and depth not documented in the assessments, the doctor checked Resident #1 ' s chart for his wound progress report, but did not find any report. The Wound Treatment Nurse was present during this interview and said she had the wound progress report in her office. The doctor reviewed his notes and said at one point the pressure was unstageable but after debridement the bone was exposed, so I staged it at a 4.
Record review of the doctor ' s wound care progress note dated 3/18/15 revealed that the depth was not documented. Further review of the report revealed:
.Sacral: 8.5 x 5 cm, bone exposed, [MEDICATION NAME] exudate seen in wound bed. Wound is abrasively debrided. Tunnel noted at 6 to 12 o ' clock. (No depth documented) .Right elbow healed.
Right hip: 3.5 x3.5 cm, dry eschar, abrasively I &D using 4x4 gauze .
Left shoulder: 2 x 2 cm, stage abrasion. No depth .
Record review of the Regional Wound Treatment Nurse (RNC) dated 3/27/15 had the following staging, sites and measurements of the pressure ulcers for resident #1:
1. Right buttock with slough was 4 cm (L) x 3 cm (W) x 1cm (D), tunneling at 6 o ' clock 0.5 cm.
2. Left hip with Stage II was 1 cm (L) x 1.5 cm (W).
3. Left ankle with Stage II was 0.5 cm (L) x 1.0 cm (W) x 0.00 (D).
4. Sacrum with Stage IV was 7 cm x 6 cm, tunneling at 12 o ' clock was 2 cm (D), 6 o ' clock was 1 cm (D), 3 o ' clock 2.5 cm (D) and 9 o ' clock 1 cm.
During an interview with regional wound care nurse (RNC) on 3/30/15 at 3:26 p.m. she confirmed that the wounds were not measured correctly by the wound care nurse. She said Resident# 1 had tunneling all over the sacral pressure ulcer and the treatment for [REDACTED].
Record review of Santyl indication and usage revealed: .ointment is indicated for [MEDICATION NAME] chronic dermal ulcers and severely burned areas . Discontinue when debridement of necrotic tissue is complete and granulation tissue is well established
Resident #11:
Record review of Resident #11's face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #11's initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, and transfers. Resident #11 had no range of motion issues and was frequently continent of bladder and bowel. Further review of the MDS section for skin conditions revealed that he was at risk for pressure ulcers, but he do not have any pressure ulcers. The section titled skin and ulcer treatment was checked for pressure reducing device for bed, pressure ulcer care and application of ointments.
Record review of the admission Braden scale dated 01/29/15 revealed a score of 10 of 23 or high risk for the developing of pressure sores. From 02/01/2015 until 02/26/15 the resident ' s Braden scale fluctuated from moderate to mild risk.
Record review of Resident #11 ' s skin inspection report from 01/29/15 until 03/05/15 revealed that his skin was intact. Further review revealed that the skin inspection report was documented as skin not intact on 03/07/15.
Record review of physician's telephone order dated 3/7/15 revealed float heels while in bed and wound doctor consult. Further review of physician orders dated 03/10/15 revealed to add an air mattress and Prevalon boots to left and right foot. Further review revealed that treatment orders were dated 03/09/15.
Record review of Resident #11 ' s weekly wound healing progress report revealed that the onset date for the wounds was documented as 3/9/15 and not 03/07/15. The wound evaluation measurement revealed Resident #11 developed the following wounds:
1. Pressure ulcer to left 5th toe (unstageable due to suspected deep tissue) was 2cm x 1cm. Then on 3/11/15 was 3 cm x 2.50 cm and 3/18/15 was 2.50 cm x 2.00 cm.
2. Pressure ulcer to left bottom of foot with (unstageable due to suspected deep tissue) was 9.50 cm x 1.00 cm. Then on 3/11/15 was 9.50 cm x 1.00 cm and 3/18/15 was 2.00 cm x 1.0 cm.
3. Pressure ulcer to left heel (unstageable due to suspected deep tissue) was 5 cm x 4 cm. Then on 3/11/15 was 4 cm x 3 cm and 3/18/15 was 5 cm x 3 cm.
4. Open blister to right buttock was 0.00 (L) x 0.00 (W). Then on 3/10/15 the wound had increased in size to 2.50 cm x 4.00 cm, on 3/11/15 was 4 cm x 4 cm. The wound increased again on 3/18/15 to 5.50 cm x 4.50 cm.
5. Pressure ulcer to right foot arch (unstageable due to suspected deep tissue) was 2.00 cm x 0.70 cm.
6. Pressure ulcer to right great toe (unstageable due to suspected deep tissue) was 2.50 cm x 2.00 cm.
7. Pressure ulcer to right heel (unstageable due to suspected deep tissue) was 5 cm x 2.50 cm.
8. Pressure ulcer to right medial malleolus (unstageable due to suspected deep tissue) was 2.50 cm x 1.50 cm. The wound increased in size on 3/18/15 to 2.80 cm x 2.00 cm.
9. On 3/23/2015 pressure ulcer to left buttock, left hip Stage II with 0.00 cm (L) x 0.00 cm (W) (depth not measured).
Observation on 03/24/15 at 8:35 a.m. revealed that Resident #11 was in bed on an air mattress. He was positioned on his right side. Resident #11 ' s heels were not floated.
Further observation on 03/24/15 at 12:25 p.m. revealed that Resident #11 was sitting in a wheel chair (w/c) by the nurses ' station. The resident did have pressure reliving cushion on the w/c and the resident did not have his Prevalon boots on his feet. Further observation on 3/24/15 at 2:00 p.m., 3:30 p.m. and 5:00 p.m. revealed that Resident #11 was lying in bed asleep with his heels not floated.
Observation on 3/25/15 at 8:40 a.m., 9:30 a.m. and 12:25 pm revealed Resident #11 sitting in w/c at the nurses ' station. The resident remained on the same position and did not have a pressure relieving cushion on the w/c. Resident #11 did not have his Prevalon boots on his feet. Resident #11 had non-skid socks on. Further observation at 12:30 p.m. revealed Resident #11 was still sitting in w/c at the nurses ' station. Resident 11 did not have his Prevalon boots on his feet. Further observation on 3/25/15 at 1:30 p.m., 3:30 p.m. and 5:30 p.m. revealed that Resident #11 was lying in bed asleep with his heels not floated.
Observation on 3/26/15 at 8:45 a.m., 9:00 a.m., 10:30 a.m., 11:15 a.m. and 12:30 p.m. Resident #11 revealed sitting in w/c at the nurses ' station. The resident remained on the same position and did not have a pressure relieving cushion on the w/c. Resident 11 did not have his Prevalon boots on his feet. Resident #11 had non-skid socks on and his feet were resting directly on the floor. Further observation on 3/26/15 at 1:00 p.m. revealed Resident #11 was lying in the bed with Prevalon boots on.
During an interview on 3/26/15 at 2:10 p.m. CNA CC said she worked with Resident #11 and that she was told not to put on the Prevalon boots while he was on the wheel chair. CNA CC said she was just told to put the Prevalon boots while he was in bed.

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 3)
Record review of the TAR for Resident #11 revealed to apply wound gel to the right and left hips ' wounds.
Observation and interview during wound treatment to Resident #11 on 3/26/15 at 2:35 p.m., revealed that the Wound Treatment Nurse cleaned, measured and applied [MEDICATION NAME] gel to the following pressure ulcers:
1. Left hip Stage II measuring 2 cm (L) x 1.5 cm (W)
2. Right hip Stage II measuring 4.5 cm (L) x 4 cm (W) x 0.00 (D)
3. Right lower hip Stage II measuring 5.5 cm (L) x1.5 cm (W) x 0.00 (D)
Further observation at the time revealed that the Wound treatment nurse measured, cleaned the eschar and applied skin prep on the following wounds:
1. Right foot ankle 2.5 cm x 1 cm x0.00 (D)
2. Right foot lateral 3 cm x 2.5 cm
3. Right inner ankle 5 cm x 1 cm
4. Left foot outer ankle 3 cm x 1.5 cm
5. Left lateral foot 1.5 cm x1.5 cm
6. Outer great toe 2.5 cm x 2 cm
7. Left heel 4 cm x4.5 cm
Interview at this time the Wound Treatment Nurse said that Resident #11 developed all the wounds in the facility.
Record review of the doctor ' s wound care progress note dated 3/18/15 revealed that the depth of the wounds was not being documented. The wounds measured:
1. Left foot 1st metatarsal: 2 x 3 cm, soft black eschar.
2. Left outer foot: 2 x 1 cm, soft black eschar covering.
3. Left lateral malleolus: 4 x 2.5 cm, soft eschar.
4. Left 5th metatarsal: 2.5 x2 cm, soft eschar.
5. Left heel: 5 x3 cm, soft eschar.
6. Right lateral malleolus: 2.5 x 2 cm, soft eschar.
7. Right first toe: 1.5 x 0.7 cm, soft eschar.
8. Right medial malleolus: 1 x1 cm soft black eschar covering.
9. Right 5th metatarsal: 1 x 1 cm, soft eschar covering.
10. Right heel: 0.8 x 1cm, soft eschar.
11. Right buttock: Pressure wound, Stage III, 5.5 x 4.5 cm, wound was abrasively debrided.
During an interview with unit manager LVN C on 3/27/15 at 3:00 p.m. she said she had not been monitoring the pressure ulcers weekly but sometimes she does look at them when the treatment nurse was changing the old dressing. Unit manager LVN C said, any nurse admitting residents with pressure ulcer would do the assessment.
Resident # 14:
Record review of Resident #14 ' s face sheet revealed that she is a [AGE] years old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED].
Record review of Resident #14' s initial MDS assessment dated [DATE] revealed that she had moderately impaired cognitively skilld, required extensive assistance for bed mobility and transfers, and was always incontinent of bowel and bladder. Further review of the MDS under the section for skin conditions revealed that she was at risk of developing pressure ulcer and was admitted with intact skin. The section for skin and ulcer treatment was checked for pressure reducing device for bed and application of ointments/medications.
Record review of skin check records for Resident #14 revealed that the skin check done on 9/5/2014 documented skin intact .
Record review of Braden risk score history for Resident #23 revealed she was coded as being a 23 or low risk for developing pressure sores on 09/05/14.
Record review of Resident # 14 ' s care plan dated 9/25/2014, updated 1/7/2015 revealed that she was at risk for skin integrity related to decreased mobility, poor nutrition and incontinence. Approaches include pressure redistribution mattress and/or wheel chair cushioning, weekly skin checks and turn and reposition every 2 hours and as needed.
Record review of Resident #14 ' s Braden Risk Assessment report dated 1/10/2015 reveals, her risk score of 12 and risk level high for development of wounds, her activity level chair fast with severely limited or non-existent ability to walk.
Record review of Resident # 14 ' s skin check report and the wound assessment report dated 1/21/2015 signed by Wound Treatment Nurse revealed that the resident developed new pressure ulcers on rear of left thigh (1 cm x 2 cm) and on the right buttock (4 cm x3 cm) Stage II, first identified on 1/20/2015.
Record review of weekly wound care progress notes by wound care doctor and wound assessment report by Wound Treatment Nurse revealed that the ulcer on the back of left thigh resolved on 2/11/2015 but the one on right buttock increased in size to 5cm x 4 cm on 2/18/2015 and worsened to a Stage III. The current size of the pressure ulcer on right buttock as per the wound care physician ' s progress notes dated 3/23/2015 and the measurements done by Wound Treatment Nurse on 2/24/2015 by the Wound Treatment Nurse were, 3 cm x 3 cm, with tunneling at 9 and 3 o clock. The wound was still a Stage III, with necrotic skin and foul odor. None of the notes from the wound care physician or the Wound Treatment Nurse documents the depth of the wound.
Observation of Resident # 14 on 3/24/2015 at 1:15 pm during wound care observation revealed that she was lying in supine position on her bed with a regular scoop mattress. The wheel chair lying next to her bed had a Pommel cushion on it.
Observations of Resident # 14 on 3/25/2015 revealed:
At 8:30 am, she was lying supine in bed on the scoop mattress, no pillows or any other device on bed to support her in turned position.
At 9:00 am resident was on wheel chair with pummel cushion in place, sitting in the dining room. Resident observed sitting on the same spot in the same position at 10:00 am, 11:00 am, 12:00 Noon. At 1:00 pm Resident #14 was observed sitting next to the table where she had lunch.
At 2:00 pm resident observed lying in bed in supine position on scoop air mattress.
At 4:00 pm she was lying on her bed in supine position, no positioning device or pillows on the bed.
Observation of Resident #14 on 3/26/2015 revealed:
At 8:30 am she was lying supine in bed, no positioning device or pillows on bed, scoop mattress in place.
At 9:00 am, 10:00 am, 11:00 am, and 12:00 noon Resident #14 was observed sitting in the dining room on her wheel chair, with Pommel cushion in place, on the same spot.
At 1:45 pm resident was sitting on her wheel chair in front of nurse station.
At 2:00 pm resident was transferred to bed in a supine position, no positioning device or pillows were placed on the bed.
At 4:30 pm the resident was still lying in bed in supine position.
Interview with LVN Unit Manager A on 3/24/2015 at 12:30 pm she said that Resident # 14 was unable to turn and reposition herself in bed or chair and was totally dependent on staff. She said that the resident had a Pommel cushion on her chair to prevent her from sliding and falling. She further said that the staff got the resident out of bed in the morning after breakfast and she stays up in chair in the dining room until around 1:00 pm or so when she was put back to bed. When asked about Resident #14 ' s in house acquired wounds, LVN Unit Manager A said it was probably due to her nutritional status.
Record review of Resident # 14 's weight report revealed that she had no significant weight loss from September 2014 until March 2015. She was consuming 75 percent or more of her meals and her 76-100% of estimated nutritional needs were being met. In addition she had been getting therapeutic nutritional supplement.
Observation and interview during wound care with the Wound Treatment Nurse on 3/24/2015 at 1:30 pm she said that the resident has the Pommel cushion on chair to prevent her from falling. When asked to stage the pressure ulcer for Resident # 14 she said that the one on the right buttock, was a Stage II. The Wound Treatment Nurse said that the whole skin thickness was lost and sub cutaneous tissue was visible. She further said that she was saying that it was a Stage II wound because the wound care doctor had staged it as a Stage II and it is the doctor who stages the wound and not her.
Record review of the Wound Care Doctor progress notes documenting the right buttock wound on the resident as Stage III on 2/11/2015, unstageable on 2/18/2015, and 2/23/2015, and a Stage III on all of his notes from 2/25/2015 until 3/23/2015.
Record Review of the weekly wound care assessment reports by the Wound Treatment Nurse documents the wound as a Stage II on 1/21/2015 and as unstageable from 1/28/2015 until 3/25/2015.
In an interview with the DON on 3/24/2015 at 2:45 pm he said that his opinion was that Resident # 14 developed new pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**
NAME OF PROVIDER OF SUPPLIER **BROOKHOLLOW HEIGHTS TRANSITIONAL CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1737 N LOOP W HOUSTON, TX 77008**	

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

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

F 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 4)
sore because of her many comorbid illnesses. He said he knew that she had not lost any weight and had been eating and drinking well.
Interview with the DON on 3/27/2015 at 10:30 am revealed that all the facility mattresses with the blue tops were pressure relieving mattresses and those were given to all residents who were at risk of pressure ulcers. He said that air mattresses or other specialty mattresses were given to the residents with pressure sores that were Stage III or IV because they needed that. He said he knew that Resident # 14 had a regular scoop mattress on her bed until 3/25/2015, once it was pointed out by the surveyor despite the resident having a pressure ulcer Stage III.
Further interview with the DON he said that Pommel cushions were of two types, one was just foam which was good for pressure relief for residents at risk of developing pressure ulcer, and the one with gel which was recommended for residents with pressure ulcers on the buttocks.
Interview with the Rehab manager on 3/27/2015 at 10:15 am he said that Pommel cushions were used for positioning and prevent residents from falls and sliding out of chair, sometimes we recommend it and sometimes they are ordered by physicians. The Rehab Manager said gel or foam/ gel were usually recommended for residents who were at fall risk and had pressure sores on buttocks.
Observation and interview of Resident ' s #14 cushion on 3/27/2015 at 10:25 am the rehab manager said that the cushion on her chair was a foam cushion. The Rehab manager said that he did not know Resident # 14 had a Stage III pressure sore on the buttocks and now he was going to order a gel /foam cushion for her.
Resident #5:
Record review of Resident #5's admission face sheet revealed that he was admitted to the facility on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED].
Record review of the Annual MDS assessment dated [DATE] revealed that Resident #5 had severely impaired cognitive skills. He required extensive assistance of two people for bed mobility, was unable to walk and had not been transfer during the assessment period. He had an indwelling catheter and was incontinent of bowel. Skin condition section was marked yes for pressure sores. The wound was documented as a Stage IV measuring 5.0 cm x 5.0 cm. Depth was not documented. Skin treatment included in the assessment included pressure relieving devices for bed, chair, and pressure ulcer treatment.
Record review of the facility Braden Scale report for Resident #5 revealed that from 10/2012 until 2/2014 his risk for developing pressure sores was marked as mild to moderate. The score was documented as high risk from 02/2015 until 03/24/15.
Record review of Resident #5's care plan dated 2/28/15 revealed that the goal of the facility was for Resident #5 not to have any additional skin breakdown. The approach was to turn and reposition every two hours and as needed to promote circulation and relieve pressure while in bed.
Observation on 3/24/15 at 10:15 a.m., 12:30 p.m., and 3:00 p.m., on 3/25/15 at 8:35 a.m., 10:55 a.m., 12:00 p.m. 3:00 p.m. 5:45 p.m. and on 3/26/15 at 8:40 a.m. 10:30 a.m., 1:00 p.m. and 3:30 p.m. revealed that the resident was observed in bed lying on his back and his legs and feet were not elevated and they were resting directly on the mattress. He had a bandage to his right lower posterior leg, close to the ankle.
Observation of wound care on 3/26/15 at 10:30 a.m. with the Wound Nurse revealed Resident #5 had multiple open areas to the back of his lower right leg. Prior to the treatment and after the treatment the legs were not elevated by the nurse before she exited the room.
Record review of physician's notes dated 3/11/15 revealed Sacral /buttock: 4x5 cm wound bed is covered with granulating tissue, no drainage seen, and 3 [MEDICAL CONDITION] (B/L buttock & sacral combined, Stage 4. Apply wound vac.
Record review of nurse's notes dated 03/11/15 and completed by the Wound Treatment Nurse revealed she incorrectly documented the Stage and measurements of the sacral wound: 8:15 a.m. round with wound care doctor assessed sacral wound 5 cm X 4 cm continue with wound vac. Stage III. Right lower

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 their written policies and procedures that prohibit neglect for 7 of 10 residents reviewed for pressure sores. (Residents # 1, 11, 14, 26, 5, 3, and #25)
-The Wound Treatment Nurse was unable to accurately describe, stage and measure pressure sores for Residents # 1, 11, 14, 26, 5, 3, and 25.
- Resident #1 ' s Stage IV sacral pressure ulcer was not staged and measured correctly by the Wound Treatment Nurse. The resident received the incorrect treatment for [REDACTED]. The pressure ulcer increased in size on 03/11/15 and again on 03/18/15.
- Resident #1 developed a Stage II pressure ulcer on his left ankle that was not identified by the facility until 03/26/15. The wound was covered with a dry dressing dated 3/24/15. The physician was not notified until 3/26/15 of the new Stage II on the left ankle.
- Resident #1 unstageable wound to the left hip was not documented on the wound reports and there was no physician order for [REDACTED].>-The Wound care nurse applied the incorrect treatment to Resident #1 ' s left shoulder wound.
- Resident #11, who entered the facility without pressure sores on 2/18/15, developed multiple unstageable wounds on 3/9/15. On 03/23/15 he developed a Stage II pressure ulcer to left buttock. Pressure relieving devices for the wheelchair were not applied. Resident #11 was not being repositioned, heels were not being offloaded and Prevalon boots were not applied as per plan of care. The depth of the wound was not measured.
- Resident #14 developed a Stage II right buttock pressure ulcer on 1/20/2015. The pressure ulcer increased in size and worsened to a Stage III by 2/18/2015. The depth of the wound was not measured.
-Resident # 14 was not being turned and repositioned as per care plan.
-Resident # 14 did not have pressure relieving devices in her bed or chair for a Stage III wound on her buttock.
-Resident #5 who had a Stage IV pressure sore to his bilateral buttocks and multiple wounds on his right leg, was not turned and repositioned as per care plan.
-Resident #3 developed pressure sores on the left ankle. Orders to float his feet were not being followed. The wounds increased in size. The depth of the wound was not measured.
-Resident # 26 wounds were not measured correctly by the Wound Treatment Nurse. Resident #26 ' s sacral wound deteriorated to a Stage IV with tunneling by 03/16/15.
- Resident #25 who was assessed by the facility to be at low risk for developing pressure ulcers and entered the facility with no pressure ulcers on 12/2/14, developed multiple avoidable wounds to include a Stage IV to the sacrum, a Stage III to right malleolus, unstageable wounds to bilateral feet and other wounds on her hips and back. Skin assessments did not accurately reflect her skin breakdown. The depth of the wounds was not measured.
An IJ was identified on 3/26/15. While the IJ was lowered on 3/31/15, the facility remained out of compliance at a pattern level and a severity of actual harm that is not immediate jeopardy due to facility needing more time to monitor the plan of removal for effectiveness.
These failures affected 7 residents and placed the other 10 residents with pressure sores at risk of further neglect, deterioration of ulcers, pain, infection, developing more ulcers and a decline in their quality of life.
Findings include:
Record review of the facility policy and procedure titled Preventing resident abuse and dated 12/2006 revealed in part: .our facility will not condone any form of resident abuse and will continually monitor our facility policies, procedures, training programs, systems, etc .neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness .
Resident #1:
Record review of Resident #1 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #1 ' s initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, transfers. Resident #1 had range of motion issues and was continent of bladder with indwelling catheter and incontinent of bowel. Further review of the MDS section for skin

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHOLLOW HEIIGHTS TRANSITIONAL CARE CENTER	**1737 N LOOP W HOUSTON, TX 77008**

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 5)

conditions revealed that he was at high risk for pressure ulcers, and had a pressure ulcer stage II to sacrum. The section titled skin and ulcer treatment was checked for pressure reducing device for bed, pressure ulcer care, nutrition or hydration intervention to manage skin problems and application of ointments.
Record review of Care plan dated 01/19/15 and last revised on 02/24/15 did address Stage II sacral pressure ulcer. Goal included showing signs of healing and decreased risk of infection. Approaches included in part: treatment as needed, assess and document progress of wound every week and as needed, use of air mattress and notify MD of wound progress weekly.
Record review of the Braden scales for Resident #1 revealed that he was assesse4d as being at high risk for pressure sores (9 of 23) on 01/19/15. The resident was reassessed by a different nurse on 02/11/15 as being at low risk for pressure sores (23 of 23) score. He was again assessed as being at high risk for pressure sores on 02/24/15.
Record review of the facility admission report revealed that Resident #1 was readmitted on [DATE] from the hospital.
Record review of the weekly wound healing progress report revealed that it was not completed until 02/25/15. Further review revealed that the resident was readmitted to the facility with a Stage IV pressure ulcer to the sacral area measuring 6.00 cm x 5.50 cm , depth not measured.
Further review of the report revealed that the wound increased in size on:
3/11/15 the wound increased in size to 7.00 cm x 6.00 cm, depth not measured.
3/18/15 measured 8.50 cm x 5.00 cm, depth not measured.
Record review of the weekly wound healing progress report dated 03/24/15 revealed a new for Stage II pressure ulcer to the right heel, right inner ankle measuring: 1.50 cm x 2.00 cm, depth not measured.
3/26/15 wound observation revealed 3.00 cm (L) by 1.00 cm (W) by 0.00 (D).
Interview during initial rounds with unit manager LVN C on 3/24/15 at 8:45 a.m. LVN C said Resident #1 was admitted with a Stage II sacral pressure ulcer. She said that Resident #1 had developed other pressure ulcers in house, but she was not sure of the pressure sore location.
Observation on 03/24/15 at 12:35 p.m. and 12:55 p.m. revealed that Resident #1 was in bed on an air mattress. He was positioned on his right side. The resident had a feeding tube and a Foley catheter in place. He had a [MEDICAL CONDITION] and was awake, but was unable to verbalize.
Observation of incontinent care on 3/24/15 at 2:50 p.m. performed by CNA KK and CNA II revealed that Resident #1 did not have a dressing on the wound on his Stage IV sacral area wound. The sacral wound was large with granulation tissue.
Interview at the time of the observation with CNA KK and CNA II both confirmed that the dressing was not on and they were not aware how long ago the dressing came off.
During an interview with unit manager LVN A on 3/24/15 at 4:30 p.m. regarding Resident #1's sacral wound with no dressing on, she said she was not aware that the dressing was not on. The Unit Manager said she was calling the treatment nurse.
Interview with the Wound Treatment Nurse on 3/24/15 at 5:20 p.m. she said she was not informed that the dressing came off and that she was just getting ready to change the dressing. The Wound Treatment Nurse said she would have to wait after the dinner trays were taken off the unit to place a dressing on his wound.
Observation of wound treatment to Resident #1 on 3/25/15 at 11:15 am by the Wound Treatment Nurse , she removed the old dressing to Resident #1's left hip revealing an unstageable pressure ulcer with slough, she cleaned with normal saline, and she applied Santyl ointment. The nurse measured the pressure left hip pressure ulcer as 3.00 cm length (L) by 1 cm width (W).
Record review of the weekly wound healing progress report of the wound care doctor reports did not have documentation that the resident had an unstageable pressure ulcer with slough to the left hip. The onset of the wound was not documented.
Record review of Resident #1 ' s TAR or the physician orders revealed no treatment orders for the left hip unsteagable wound.
Record review of physician ' s telephone order dated 2/25/15 had cleanse sacral with normal saline, pat dry, apply Santyl cover with dry dressing daily. No other orders found on the chart.
Further observation and interview on 03/25/15 at 11:20 am revealed the Wound Treatment nurse then removed the old dressing to Resident #1 ' s sacral wound. The wound was large with granulation tissue, tunneling noticed on all sides and some of the bone was exposed (Stage IV). The Wound Treatment Nurse said it was an unstageable wound with slough. She cleaned it with normal saline then pat dry with 4 x4 gauze. The nurse applied Santyl ointment. The nurse proceeded to measure the sacral wound pressure as 7 cm x 5 cm and said it was an unstageable wound. The Wound Treatment Nurse did not measure the depth or tunneling of the wound. The Wound Treatment Nurse kept saying it was unstageable because the wound doctor said it was.
Record review of telephone physician order dated 03/18/15 revealed to apply triple antibiotic ointment to left shoulder once per day.
Record review of the TAR revealed that the order was transcribed as cleanse left shoulder with normal saline and apply silverdane, cover with dry dressing.
Further observation and interview at this time revealed that the Treatment nurse removed the old dressing to Resident #1 ' s upper back left shoulder. The Wound Treatment Nurse cleaned the area with normal saline and pat and dry with 4x4 gauze and applied Silver [MEDICATION NAME] cream and taped. She measured the area as 0.5 cm (L) by 0.5 cm (W).Treatment nurse said it was an abrasion acquired in house and that those were the only wounds Resident #1 had.
Interview and observation of head to toe assessment done with Wound Treatment Nurse on 3/26/15 at 11:50 am revealed that the nurse surveyor discovered a dressing dated 3/24/15 on Resident #1 ' s left outer ankle. The Wound Treatment Nurse said at 11:55 a.m., that she was not sure about the left ankle wound and that she was going to check her treatment book outside Resident #1 ' s room. At 11:58 a.m., the Wound Treatment Nurse came in Resident #1 ' s room stated I do not have that wound in the book . The Wound Treatment Nurse measured the left outer ankle wound and it was 1 cm (L) by 1.5 cm (W) with slough. The Wound Treatment Nurse said she was going to call the doctor and obtain an order.
In a phone interview on 03/26/15 at 1:24 pm with a family member for Resident #1 he said that he was concern about all the wounds that the resident developed in the facility.
Observation and interview on 03/26/15 at 3:15 pm was conducted with the DON in the presence of the Wound Treatment Nurse. The DON was informed that the Wound Treatment Nurse said Resident #1 ' s wound to the sacral area was unsteageable. The DON opened the dressing to Resident #1 ' s sacral wound and said: it is a Stage IV with about 35 % slough with pink surrounding and tunneling on all sides . The DON further stated that the Wound Care doctor and the Wound Treatment Nurse did not make a good assessment of the wound.
During an interview and observation with the wound care doctor on 3/26/15 at 6:17 p.m. regarding pressure ulcer staging and depth not documented in the assessments, the doctor checked Resident #1 ' s chart for his wound progress report, but did not find any report. The Wound Treatment Nurse was present during this interview and said she had the wound progress report in her office. The doctor reviewed his notes and said at one point the pressure was unstageable but after debridement the bone was exposed, so I staged it at a 4.
Record review of the doctor ' s wound care progress note dated 3/18/15 revealed that the depth was not documented. Further review of the report revealed:
.Sacral: 8.5 x 5 cm, bone exposed, [MEDICATION NAME] exudate seen in wound bed. Wound is abrasively debrided. Tunnel noted at 6 to 12 o ' clock. (No depth documented) .Right elbow healed.
Right hip: 3.5 x3.5 cm, dry eschar, abrasively I &D using 4x4 gauze .
Left shoulder: 2 x 2 cm, stage abrasion. No depth .
Record review of the Regional Wound Treatment Nurse (RNC) dated 3/27/15 had the following staging, sites and measurements of the pressure ulcers for resident #1:
1. Right buttock with slough was 4 cm (L) x 3 cm (W) x 1cm (D), tunneling at 6 o ' clock 0.5 cm.
2. Left hip with Stage II was 1 cm (L) x 1.5 cm (W).
3. Left ankle with Stage II was 0.5 cm (L) x 1.0 cm (W) x 0.00 (D).
4. Sacrum with Stage IV was 7 cm x 6 cm, tunneling at 12 o ' clock was 2 cm (D), 6 o ' clock was 1 cm (D), 3 o ' clock 2.5 cm (D) and 9 o ' clock 1 cm.
During an interview with regional wound care nurse (RNC) on 3/30/15 at 3:26 p.m. she confirmed that the wounds were not measured correctly by the wound care nurse. She said Resident# 1 had tunneling all over the sacral pressure ulcer and the treatment for [REDACTED].

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F 0226

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 6)
Record review of Santyl indication and usage revealed: .ointment is indicated for [MEDICATION NAME] chronic dermal ulcers and severely burned areas . Discontinue when debridement of necrotic tissue is complete and granulation tissue is well established
Resident #11:
Record review of Resident #11's face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #11's initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, and transfers. Resident #11 had no range of motion issues and was frequently continent of bladder and bowel. Further review of the MDS section for skin conditions revealed that he was at risk for pressure ulcers, but he do not have any pressure ulcers. The section titled skin and ulcer treatment was checked for pressure reducing device for bed, pressure ulcer care and application of ointments.
Record review of the admission Braden scale dated 01/29/15 revealed a score of 10 of 23 or high risk for the developing of pressure sores. From 02/01/2015 until 02/26/15 the resident ' s Braden scale fluctuated from moderate to mild risk.
Record review of Resident #11 ' s skin inspection report from 01/29/15 until 03/05/15 revealed that his skin was intact. Further review revealed that the skin inspection report was documented as skin not intact on 03/07/15.
Record review of physician's telephone order dated 3/7/15 revealed float heels while in bed and wound doctor consult. Further review of physician orders dated 03/10/15 revealed to add an air mattress and Prevalon boots to left and right foot. Further review revealed that treatment orders were dated 03/09/15.
Record review of Resident #11 ' s weekly wound healing progress report revealed that the onset date for the wounds was documented as 3/9/15 and not 03/07/15. The wound evaluation measurement revealed Resident #11 developed the following wounds:
1. Pressure ulcer to left 5th toe (unstageable due to suspected deep tissue) was 2cm x 1cm. Then on 3/11/15 was 3 cm x 2.50 cm and 3/18/15 was 2.50 cm x 2.00 cm.
2. Pressure ulcer to left bottom of foot with (unstageable due to suspected deep tissue) was 9.50 cm x 1.00 cm. Then on 3/11/15 was 9.50 cm x 1.00 cm and 3/18/15 was 2.00 cm x 1.0 cm.
3. Pressure ulcer to left heel (unstageable due to suspected deep tissue) was 5 cm x 4 cm. Then on 3/11/15 was 4 cm x 3 cm and 3/18/15 was 5 cm x 3 cm.
4. Open blister to right buttock was 0.00 (L) x 0.00 (W). Then on 3/10/15 the wound had increased in size to 2.50 cm x 4.00 cm, on 3/11/15 was 4 cm x 4 cm. The wound increased again on 3/18/15 to 5.50 cm x 4.50 cm.
5. Pressure ulcer to right foot arch (unstageable due to suspected deep tissue) was 2.00 cm x 0.70 cm.
6. Pressure ulcer to right great toe (unstageable due to suspected deep tissue) was 2.50 cm x 2.00 cm.
7. Pressure ulcer to right heel (unstageable due to suspected deep tissue) was 5 cm x 2.50 cm.
8. Pressure ulcer to right medial malleolus (unstageable due to suspected deep tissue) was 2.50 cm x 1.50 cm. The wound increased in size on 3/18/15 to 2.80 cm x 2.00 cm.
9. On 3/23/2015 pressure ulcer to left buttock, left hip Stage II with 0.00 cm (L) x 0.00 cm (W) (depth not measured).
Observation on 03/24/15 at 8:35 a.m. revealed that Resident #11 was in bed on an air mattress. He was positioned on his right side. Resident #11 ' s heels were not floated.
Further observation on 03/24/15 at 12:25 p.m. revealed that Resident #11 was sitting in a wheel chair (w/c) by the nurses ' station. The resident did have pressure reliving cushion on the w/c and the resident did not have his Prevalon boots on his feet. Further observation on 3/24/15 at 2:00 p.m., 3:30 p.m. and 5:00 p.m. revealed that Resident #11 was lying in bed asleep with his heels not floated.
Observation on 3/25/15 at 8:40 a.m., 9:30 a.m. and 12:25 pm revealed Resident #11 sitting in w/c at the nurses ' station. The resident remained on the same position and did not have a pressure relieving cushion on the w/c. Resident #11 did not have his Prevalon boots on his feet. Resident #11 had non-skid socks on. Further observation at 12:30 p.m. revealed Resident #11 was still sitting in w/c at the nurses ' station. Resident 11 did not have his Prevalon boots on his feet. Further observation on 3/25/15 at 1:30 p.m., 3:30 p.m. and 5:30 p.m. revealed that Resident #11 was lying in bed asleep with his heels not floated.
Observation on 3/26/15 at 8:45 a.m., 9:00 a.m., 10:30 a.m., 11:15 a.m. and 12:30 p.m. Resident #11 revealed sitting in w/c at the nurses ' station. The resident remained on the same position and did not have a pressure relieving cushion on the w/c. Resident 11 did not have his Prevalon boots on his feet. Resident #11 had non-skid socks on and his feet were resting directly on the floor. Further observation on 3/26/15 at 1:00 p.m. revealed Resident #11 was lying in the bed with Prevalon boots on.
During an interview on 3/26/15 at 2:10 p.m. CNA CC said she worked with Resident #11 and that she was told not to put on the Prevalon boots while he was on the wheel chair. CNA CC said she was just told to put the Prevalon boots while he was in bed.
Record review of the TAR for Resident #11 revealed to apply wound gel to the right and left hips ' wounds.
Observation and interview during wound treatment to Resident #11 on 3/26/15 at 2:35 p.m., revealed that the Wound Treatment Nurse cleaned, measured and applied [MEDICATION NAME] gel to the following pressure ulcers:
1. Left hip Stage II measuring 2 cm (L) x 1.5 cm (W)
2. Right hip Stage II measuring 4.5 cm (L) x 4 cm (W) x 0.00 (D)
3. Right lower hip Stage II measuring 5.5 cm (L) x1.5 cm (W) x 0.00 (D)
Further observation at the time revealed that the Wound treatment nurse measured, cleaned the eschar and applied skin prep on the following wounds:
1. Right foot ankle 2.5 cm x 1 cm x0.00 (D)
2. Right foot lateral 3 cm x 2.5 cm
3. Right inner ankle 5 cm x 1 cm
4. Left foot outer ankle 3 cm x 1.5 cm
5. Left lateral foot 1.5 cm x1.5 cm
6. Outer great toe 2.5 cm x 2 cm
7. Left heel 4 cm x4.5 cm
Interview at this time the Wound Treatment Nurse said that Resident #11 developed all the wounds in the facility.
Record review of the doctor ' s wound care progress note dated 3/18/15 revealed that the depth of the wounds was not being documented. The wounds measured:
1. Left foot 1st metatarsal: 2 x 3 cm, soft black eschar.
2. Left outer foot: 2 x 1 cm, soft black eschar covering.
3. Left lateral malleolus: 4 x 2.5 cm, soft eschar.
4. Left 5th metatarsal: 2.5 x2 cm, soft eschar.
5. Left heel: 5 x3 cm, soft eschar.
6. Right lateral malleolus: 2.5 x 2 cm, soft eschar.
7. Right first toe: 1.5 x 0.7 cm, soft eschar.
8. Right medial malleolus: 1 x1 cm soft black eschar covering.
9. Right 5th metatarsal: 1 x 1 cm, soft eschar covering.
10. Right heel: 0.8 x 1cm, soft eschar.
11. Right buttock: Pressure wound, Stage III, 5.5 x 4.5 cm, wound was abrasively debrided.
During an interview with unit manager LVN C on 3/27/15 at 3:00 p.m. she said she had not been monitoring the pressure ulcers weekly but sometimes she does look at them when the treatment nurse was changing the old dressing. Unit manager LVN C said, any nurse admitting residents with pressure ulcer would do the assessment.
Resident # 14:
Record review of Resident #14 ' s face sheet revealed that she is a [AGE] years old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED].
Record review of Resident #14' s initial MDS assessment dated [DATE] revealed that she had moderately impaired cognitively skilld, required extensive assistance for bed mobility and transfers, and was always incontinent of bowel and bladder. Further review of the MDS under the section for skin conditions revealed that she was at risk of developing pressure ulcer and was admitted with intact skin. The section for skin and ulcer treatment was checked for pressure reducing device for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**

NAME OF PROVIDER OF SUPPLIER **BROOKHOLLOW HEIGHTS TRANSITIONAL CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP **1737 N LOOP W** **HOUSTON, TX 77008**

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 7)
bed and application of ointments/medications.
Record review of skin check records for Resident #14 revealed that the skin check done on 9/5/2014 documented skin intact .
Record review of Braden risk score history for Resident #23 revealed she was coded as being a 23 or low risk for developing pressure sores on 09/05/14.
Record review of Resident # 14 ' s care plan dated 9/25/2014, updated 1/7/2015 revealed that she was at risk for skin integrity related to decreased mobility, poor nutrition and incontinence. Approaches include pressure redistribution mattress and/or wheel chair cushioning, weekly skin checks and turn and reposition every 2 hours and as needed.
Record review of Resident #14 ' s Braden Risk Assessment report dated 1/10/2015 reveals, her risk score of 12 and risk level high for development of wounds, her activity level chair fast with severely limited or non-existent ability to walk.
Record review of Resident # 14 ' s skin check report and the wound assessment report dated 1/21/2015 signed by Wound Treatment Nurse revealed that the resident developed new pressure ulcers on rear of left thigh (1 cm x 2 cm) and on the right buttock (4 cm x3 cm) Stage II, first identified on 1/20/2015.
Record review of weekly wound care progress notes by wound care doctor and wound assessment report by Wound Treatment Nurse revealed that the ulcer on the back of left thigh resolved on 2/11/2015 but the one on right buttock increased in size to 5cm x 4 cm on 2/18/2015 and worsened to a Stage III. The current size of the pressure ulcer on right buttock as per the wound care physician ' s progress notes dated 3/23/2015 and the measurements done by Wound Treatment Nurse on 2/24/2015 by the Wound Treatment Nurse were, 3 cm x 3 cm, with tunneling at 9 and 3 o clock. The wound was still a Stage III, with necrotic skin and foul odor. None of the notes from the wound care physician or the Wound Treatment Nurse documents the depth of the wound.
Observation of Resident # 14 on 3/24/2015 at 1:15 pm during wound care observation revealed that she was lying in supine position on her bed with a regular scoop mattress. The wheel chair lying next to her bed had a Pommel cushion on it.
Observations of Resident # 14 on 3/25/2015 revealed:
At 8:30 am, she was lying supine in bed on the scoop mattress, no pillows or any other device on bed to support her in turned position.
At 9:00 am resident was on wheel chair with pummel cushion in place, sitting in the dining room. Resident observed sitting on the same spot in the same position at 10:00 am, 11:00 am, 12:00 Noon. At 1:00 pm Resident #14 was observed sitting next to the table where she had lunch.
At 2:00 pm resident observed lying in bed in supine position on scoop air mattress.
At 4:00 pm she was lying on her bed in supine position, no positioning device or pillows on the bed.
Observation of Resident #14 on 3/26/2015 revealed:
At 8:30 am she was lying supine in bed, no positioning device or pillows on bed, scoop mattress in place.
At 9:00 am, 10:00 am, 11:00 am, and 12:00 noon Resident #14 was observed sitting in the dining room on her wheel chair, with Pommel cushion in place, on the same spot.
At 1:45 pm resident was sitting on her wheel chair in front of nurse station.
At 2:00 pm resident was transferred to bed in a supine position, no positioning device or pillows were placed on the bed.
At 4:30 pm the resident was still lying in bed in supine position.
Interview with LVN Unit Manager A on 3/24/2015 at 12:30 pm she said that Resident # 14 was unable to turn and reposition herself in bed or chair and was totally dependent on staff. She said that the resident had a Pommel cushion on her chair to prevent her from sliding and falling. She further said that the staff got the resident out of bed in the morning after breakfast and she stays up in chair in the dining room until around 1:00 pm or so when she was put back to bed. When asked about Resident #14 ' s in house acquired wounds, LVN Unit Manager A said it was probably due to her nutritional status.
Record review of Resident # 14 's weight report revealed that she had no significant weight loss from September 2014 until March 2015. She was consuming 75 percent or more of her meals and her 76-100% of estimated nutritional needs were being met. In addition she had been getting therapeutic nutritional supplement.
Observation and interview during wound care with the Wound Treatment Nurse on 3/24/2015 at 1:30 pm she said that the resident has the Pommel cushion on chair to prevent her from falling. When asked to stage the pressure ulcer for Resident # 14 she said that the one on the right buttock, was a Stage II. The Wound Treatment Nurse said that the whole skin thickness was lost and sub cutaneous tissue was visible. She further said that she was saying that it was a Stage II wound because the wound care doctor had staged it as a Stage II and it is the doctor who stages the wound and not her.
Record review of the Wound Care Doctor progress notes documenting the right buttock wound on the resident as Stage III on 2/11/2015, unstageable on 2/18/2015, and 2/23/2015, and a Stage III on all of his notes from 2/25/2015 until 3/23/2015.
Record Review of the weekly wound care assessment reports by the Wound Treatment Nurse documents the wound as a Stage II on 1/21/2015 and as unstageable from 1/28/2015 until 3/25/2015.
In an interview with the DON on 3/24/2015 at 2:45 pm he said that his opinion was that Resident # 14 developed new pressure sore because of her many comorbid illnesses. He said he knew that she had not lost any weight and had been eating and drinking well.
Interview with the DON on 3/27/2015 at 10:30 am revealed that all the facility mattresses with the blue tops were pressure relieving mattresses and those were given to all residents who were at risk of pressure ulcers. He said that air mattresses or other specialty mattresses were given to the residents with pressure sores that were Stage III or IV because they needed that. He said he knew that Resident # 14 had a regular scoop mattress on her bed until 3/25/2015, once it was pointed out by the surveyor despite the resident having a pressure ulcer Stage III.
Further interview with the DON he said that Pommel cushions were of two types, one was just foam which was good for pressure relief for residents at risk of developing pressure ulcer, and the one with gel which was recommended for residents with pressure ulcers on the buttocks.
Interview with the Rehab manager on 3/27/2015 at 10:15 am he said that Pommel cushions were used for positioning and prevent residents from falls and sliding out of chair, sometimes we recommend it and sometimes they are ordered by physicians. The Rehab Manager said gel or foam/ gel were usually recommended for residents who were at fall risk and had pressure sores on buttocks.
Observation and interview of Resident ' s #14 cushion on 3/27/2015 at 10:25 am the rehab manager said that the cushion on her chair was a foam cushion. The Rehab manager said that he did not know Resident # 14 had a Stage III pressure sore on the buttocks and now he was going to order a gel /foam cushion for her.
Resident #5:
Record review of Resident #5's admission face sheet revealed that he was admitted to the facility on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED].
Record review of the Annual MDS assessment dated [DATE] revealed that Resident #5 had severely impaired cognitive skills. He required extensive assistance of two people for bed mobility, was unable to walk and had not been transfer during the assessment period. He had an indwelling catheter and was incontinent of bowel. Skin condition section was marked yes for pressure sores. The wound was documented as a Stage IV measuring 5.0 cm x 5.0 cm. Depth was not documented. Skin treatment included in the assessment included pressure relieving devices for bed, chair, and pressure ulcer treatment.
Record review of the facility Braden Scale report for Resident #5 revealed that from 10/2012 until 2/2014 his risk for developing pressure sores was marked as mild to moderate. The score was documented as high risk from 02/2015 until 03/24/15.
Record review of Resident #5's care plan dated 2/28/15 revealed that the goal of the facility was for Resident #5 not to have any additional skin breakdown. The approach was to turn and reposition every two hours and as needed to promote circulation and relieve pressure while in bed.
Observation on 3/24/15 at 10:15 a.m., 12:30 p.m., and 3:00 p.m., on 3/25/15 at 8:35 a.m., 10:55 a.m., 12:00 p.m. 3:00 p.m. 5:45 p.m. and on 3/26/15 at 8:40 a.m. 10:30 a.m., 1:00 p.m. and 3:30 p.m. revealed that the resident was observed in bed lying on his back and his legs and feet were not elevated and they were resting directly on the mattress. He had a bandage to his right lower posterior leg, close to the ankle.
Observation of wound care on 3/26/15 at 10:30 a.m. with the Wound Nurse revealed Resident #5 had multiple open areas to the back of his lower right leg. Prior to the treatment and after the treatment the legs were not elevated by the nurse before she exited the room.
Record review of physician's notes dated 3/11/15 revealed Sacral /buttock: 4x5 cm wound bed is

F 0241

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care for residents in a way that keeps or builds each resident's dignity and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**
NAME OF PROVIDER OF SUPPLIER **BROOKHOLLOW HEIIGHTS TRANSITIONAL CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1737 N LOOP W** **HOUSTON, TX 77008**	

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 0241

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 8)
respect of individuality.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview and record review the facility failed to promote care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for 1 of 25 residents reviewed for dignity. (Resident #1)
CNA KK and CNA II failed to pull privacy curtain while providing care to Resident #1.
This failure affected 1 resident and placed 121 residents at risk of a loss of self-worth and a decline in their psychosocial well-being.
Findings include:
Resident #1:
Record review of Resident #1 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #1 ' s initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, transfers. Resident #1 had range of motion issues and was frequently incontinent of bladder with indwelling catheter and bowel. Required extensive assistance with personal hygiene and was totally dependent on staff for bathing.
Observation on 3/24/15 at 2:50 p.m., CNA KK entered Resident #1's room to perform incontinent care.Without pulling the privacy curtain, she removed Resident #1's brief. CNA KK said There is no wipes. CNA KK then covered the resident with the bedsheet, left Resident #1's room to the supply room on station 1. At 3:00 p.m. CNA KK came back with a box of wipes and entered Resident #1's and again did not pull the privacy curtain. The CNA then uncovered Resident #1 which exposed his penis and perineal area. At 3:10 p.m.CNA II came in to assist CNA KK, CNA II then pulled the privacy curtain and assisted in repositioning Resident #1.
During an interview on 3/24/15 at 4:35 p.m. CNA KK said she thought she did a good job but she forgot to pull the privacy curtain.
On 3/27/15 at 3:00 p.m. Resident #1's door was closed with Resident #1. Upon entering the room CNA II and CNA T were observed repositiong the resident who was undressed. CNA II then pulled the privacy curtain.
During an interview with CNA II at the same the time regarding not pulling the privacy curtain, she said I forgot.

Record review of Statement of Right of a Resident revealed the following:
Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States .
You the resident do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law .
1. All care necessary for you to have the highest possible level of care .
4. Be treated with courtesy, consideration, and respect .
The facility's CMS 672 revealed that the census was 122 residents.

F 0279

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 use the result of the comprehensive assessment to develop a comprehensive care plan for 3 of 27 Residents (Resident #'s 16, 30 and 10) reviewed for care plans.
- Resident #16 ' s care plan did not address Cognitive loss/Dementia and Psychological well-being.
- Resident #30's care plan did not address the use of [MEDICATION NAME] Sodium (a blood thinner).
-Resident #10's care plan did not address ambulation, dressing and range of motion issues.
This failure affected 3 resident and placed 119 residents at risk for receiving inadequate care and failure to maintain their highest practicable physical, mental, and psychosocial well-being.
Findings include:
Resident #16:
Record Review of Resident #16's face sheet revealed a [AGE] year old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED].
Record review of Resident #16's Annual MDS assessment dated [DATE] revealed that she was understood and understands. She required extensive assistance with bed mobility, extensive assistance with transfers and extensive assistance with dressing and hygiene.
Further record review of the Annual MDS assessment dated [DATE] revealed that Resident #16's care area assessment triggered cognitive loss/Dementia and psychological well-being.
Record review of the care plans revealed that the care plan did not address cognitive loss/Dementia and psychological well-being.
In an interview on 03/30/15 at 9:55am with RN B, said that he was not sure how they missed those two care plans.

Resident #30:
Record review of Resident # 30's face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and was readmitted on [DATE], with [DIAGNOSES REDACTED].
Record review of the Physician order [REDACTED].
Record review of the care plans section did not address the use of [MEDICATION NAME] Sodium 2.5 mg one tablet daily.
During an interview with Unit manager LVN C on 3/26/15 at 1:10 p.m. she said she did not know Resident #30 was on [MEDICATION NAME] Sodium 2.5 mg until it was brought to her attention. LVN C said the facility should have had a baseline for PT/INR and she was calling the NP to obtain an order. LVN C proceeded to do a care plan for the use of [MEDICATION NAME] Sodium.

Resident #10:
Record review of Resident #10's face sheet revealed an admitted [DATE]. His [DIAGNOSES REDACTED]. Resident #10 was [AGE]
years old.
Record review of Resident #10's Annual MDS assessment dated [DATE] revealed that Resident #10's CAA triggered ADL's which included dressing, ambulation and range of motion. Further review revealed that Resident #10 was totally dependent on one staff in the areas of dressing and ambulation. He had decline in range of motion to one side of the upper extremities and impairment on both sides of the lower extremities and no care plan was done to address the above mentioned areas.
In an interview on 3/26/15 at 8:35 a.m. with Resident #10 he said he can reposition himself with help. He said he does not get out of bed, he preferred to stay in bed because he was more comfortable lying on his back.
Record review of the updated care plan dated 12/14/14 revealed that ADL's were addressed but it did not include required assistance with dressing and ambulation. Contractures were mentioned in the problem onset but there were no goals or approaches listed.
In an interview on 3/26/15 at 2:00 p.m. the MDS Coordinator confirmed that the areas were not addressed on the care plan and he was going to look at it. No other documentation was presented to the survey team for review prior to exit.
Record review of the facility's policy for Care planning-Interdisciplinary Team stated, An individualized comprehensive care plan that includes measureable objectives and timetables to meet the resident ' s medical, nursing, mental and psychological needs is developed for each resident.
The facility ' s 672 resident census and condition listed a census of 122 residents.

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NAME OF PROVIDER OF SUPPLIER **BROOKHOLLOW HEIIGHTS TRANSITIONAL CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1737 N LOOP W HOUSTON, TX 77008**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 9)
F 0282 **Level of harm -** Minimal harm or potential for actual harm **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 interview and record review the facility failed to provide services in accordance with the written Plan of Care for 2 of 27 residents (Resident's #21 and #19) reviewed for compliance with physician's orders [REDACTED]. - Resident #21's physician was not informed when blood sugar reading were over 351. - Resident # 19 recieved an extra dose [MEDICATION NAME] mg tablet. This failure affected 2 residents and placed an additional 120 residents at risk of not receiving the care and services ordered by the physician and a decline in health status. Findings include: Resident #21: Record review of Resident #21's face sheet revealed an [AGE] year old female that was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of physician's orders [REDACTED]. Record review of Resident #21's MAR for March 2015 revealed that insulin was administered and blood sugar readings at 6:00 a.m. on the following dates were: 03/18/15 was 384 mg/dl, 03/19/15 was 406 mg/dl, 03/20/15 was 390 mg/dl, Further review of the MAR indicated [REDACTED]. There was no documentation on the backside of the MAR indicated [REDACTED]. Record review of Resident #21's nurse's notes revealed no documentation that the physician was notified concerning the elevated blood sugar elevated levels. During an interview on 03/26/15 at 5:45 p.m. with Administrator regarding the nurse's notes for Resident #21 he said he was going to look in it. No further documentation was presented to the survey team for review prior to the survey exit. Resident #19: Record review of Resident ' s # 19 face sheet revealed a [AGE] year old male admitted on [DATE] with the [DIAGNOSES REDACTED]. Record review of Resident #19's Physician order [REDACTED]. Record review of gastrostomy tube MAR indicated [REDACTED]. (11 days) Interview on 3/26/15 at 1:00 pm with LVN manager A stated that Nurse Practioner informed her that it was ok for resident to get an extra dose of medication it would not harm him . The facility's CMS 672 listed a census of 122 resident.
F 0309 **Level of harm -** Minimal harm or potential for 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 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 1 of 35 residents reviewed for care (Resident #29) - The facility did not obtain PT/INR testing for Resident #29 who recieved [MEDICATION NAME] Sodium, a blood thinner. This failure affected 1 resident and placed 7 residents receiving blood thinners at risk of of not receiving the therapeutic dose of blood thinners that could cause medical complications [REDACTED]. Findings include: Resident #29: Record review of Resident # 29's face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and was readmitted on [DATE], with [DIAGNOSES REDACTED]. Record review of the Physician order [REDACTED]. Observation of medication administration on 03/24/15 at 5:10 p.m. revealed that LVN W poured [MEDICATION NAME] Sodium 2.5 mg one tablet into a medication cup with other medications and administered to Resident #29. Record review of the care plans revealed that the care plan for Resident #29 did not address the use of [MEDICATION NAME] Sodium 2.5 mg one tablet daily. Record review of the MAR for March 2015 revealed that Resident #29 received [MEDICATION NAME] Sodium daily starting on 03/12/15. During an interview on 3/25/15 at 10:42 a.m. the DON said he had a list with all the residents on [MEDICATION NAME] Sodium in the facility. The DON said when a resident starts [MEDICATION NAME] Sodium or any blood thinner, they always have a baseline PT/INR drawn and then do weekly PT/INR per doctor's order. The DON then presented the list of all residents on [MEDICATION NAME] Sodium and Resident #29 was not on the list. Record review of Resident #29 ' s laboratory results for PT/INR dated 3/25/15 revealed a high PT value of 17.2 (normal Reference 10.4 - 13.8) and a critical INR value of 2.09 (INR Therapeutic range for residents on anticoagulation therapy: Standard dose therapeutic range: 2.0 - 3.0; Higher intensity therapeutic range: 2.5 - 3.5). During an interview with Unit manager LVN C on 3/26/15 at 1:10 p.m. she said she did not know Resident #29 was on [MEDICATION NAME] Sodium 2.5 mg until it was brought to her attention. LVN C said the facility should have had a baseline for PT/INR and she was calling the NP to obtain an order. On 3/26/15, LVN C obtained a stat order for PT/INR and an order for [REDACTED]. Record review of the facility clinical protocol on Anticoagulation dated revised October 2010, page 1 . Treatment/Management: 2 (a) The physician should stop, taper, or change medications that interact with [MEDICATION NAME], or monitor the PT/INR very closely while the individual is receiving [MEDICATION NAME], to ensure that PT/INR stabilizes. Monitoring and Follow-up : 1. The physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications, for example, periodically checking hemoglobin/Hematocrit, platelet, PT/INR, and stool for occult blood. According to the list provided by the DON, 7 residents were on blood thinners.

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 residents who entered the facility without pressure ulcers did not develop pressure ulcers and residents with pressure ulcers received treatment and services to promote healing for 7 of 10 residents reviewed for pressure sores. (Residents # 1, 11, 14, 26, 5, 3, and #25) -The Wound Treatment Nurse was unable to accurately describe, stage and measure pressure sores for Residents # 1, 11, 14, 26, 5, 3, and 25. - Resident #1 ' s Stage IV sacral pressure ulcer was not staged and measured correctly by the Wound Treatment Nurse. The resident received the incorrect treatment for [REDACTED]. The pressure ulcer increased in size on 03/11/15 and again on 03/18/15. - Resident #1 developed a Stage II pressure ulcer on his left ankle that was not identified by the facility until 03/26/15. The wound was covered with a dry dressing dated 3/24/15. The physician was not notified until 3/26/15 of the new Stage II on the left ankle. - Resident #1 unstageable wound to the left hip was not documented on the wound reports and there was no physician order for [REDACTED].>-The Wound care nurse applied the incorrect treatment to Resident #1 ' s left shoulder wound. - Resident #11, who entered the facility without pressure sores on 2/18/15, developed multiple unstageable wounds on 3/9/15. On 03/23/15 he developed a Stage II pressure ulcer to left buttock. Pressure relieving devices for the wheelchair were not applied. Resident #11 was not being repositioned, heels were not being offloaded and Prevalon boots were not applied as per plan of care. The depth of the wound was not measured.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHOLLOW HEIGHTS TRANSITIONAL CARE CENTER	**1737 N LOOP W HOUSTON, TX 77008**

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 0314

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 10)
- Resident #14 developed a Stage II right buttock pressure ulcer on 1/20/2015. The pressure ulcer increased in size and worsened to a Stage III by 2/18/2015. The depth of the wound was not measured.
-Resident # 14 was not being turned and repositioned as per care plan.
-Resident # 14 did not have pressure relieving devices in her bed or chair for a Stage III wound on her buttock.
-Resident #5 who had a Stage IV pressure sore to his bilateral buttocks and multiple wounds on his right leg, was not turned and repositioned as per care plan.
-Resident #3 developed pressure sores on the left ankle. Orders to float his feet were not being followed. The wounds increased in size. The depth of the wound was not measured.
-Resident # 26 wounds were not measured correctly by the Wound Treatment Nurse. Resident #26 ' s sacral wound deteriorated to a Stage IV with tunneling by 03/16/15.
- Resident #25 who was assessed by the facility to be at low risk for developing pressure ulcers and entered the facility with no pressure ulcers on 12/2/14, developed multiple avoidable wounds to include a Stage IV to the sacrum, a Stage III to right malleolus, unstageable wounds to bilateral feet and other wounds on her hips and back. Skin assessments did not accurately reflect her skin breakdown. The depth of the wounds was not measured.
An IJ was identified on 3/26/15. While the IJ was lowered on 3/31/15, the facility remained out of compliance at a pattern level and a severity of actual harm that is not immediate jeopardy due to facility needing more time to monitor the plan of removal for effectiveness.
These failures affected 7 residents and placed the other 10 residents with pressure sores at risk of further neglect, deterioration of ulcers, pain, infection, developing more ulcers and a decline in their quality of life.
Findings include:
Resident #1:
Record review of Resident #1 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #1 ' s initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, transfers. Resident #1 had range of motion issues and was continent of bladder with indwelling catheter and incontinent of bowel. Further review of the MDS section for skin conditions revealed that he was at high risk for pressure ulcers, and had a pressure ulcer stage II to sacrum. The section titled skin and ulcer treatment was checked for pressure reducing device for bed, pressure ulcer care, nutrition or hydration intervention to manage skin problems and application of ointments.
Record review of Care plan dated 01/19/15 and last revised on 02/24/15 did address Stage II sacral pressure ulcer. Goal included showing signs of healing and decreased risk of infection. Approaches included in part: treatment as needed, assess and document progress of wound every week and as needed, use of air mattress and notify MD of wound progress weekly.
Record review of the Braden scales for Resident #1 revealed that he was assesse4d as being at high risk for pressure sores (9 of 23) on 01/19/15. The resident was reassessed by a different nurse on 02/11/15 as being at low risk for pressure sores (23 of 23) score. He was again assessed as being at high risk for pressure sores on 02/24/15.
Record review of the facility admission report revealed that Resident #1 was readmitted on [DATE] from the hospital.
Record review of the weekly wound healing progress report revealed that it was not completed until 02/25/15. Further review revealed that the resident was readmitted to the facility with a Stage IV pressure ulcer to the sacral area measuring 6.00 cm x 5.50 cm , depth not measured.
Further review of the report revealed that the wound increased in size on:
3/11/15 the wound increased in size to 7.00 cm x 6.00 cm, depth not measured.
3/18/15 measured 8.50 cm x 5.00 cm, depth not measured.
Record review of the weekly wound healing progress report dated 03/24/15 revealed a new for Stage II pressure ulcer to the right heel, right inner ankle measuring: 1.50 cm x 2.00 cm, depth not measured.
3/26/15 wound observation revealed 3.00 cm (L) by 1.00 cm (W) by 0.00 (D).
Interview during initial rounds with unit manager LVN C on 3/24/15 at 8:45 a.m. LVN C said Resident #1 was admitted with a Stage II sacral pressure ulcer. She said that Resident #1 had developed other pressure ulcers in house, but she was not sure of the pressure sore location.
Observation on 03/24/15 at 12:35 p.m. and 12:55 p.m. revealed that Resident #1 was in bed on an air mattress. He was positioned on his right side. The resident had a feeding tube and a Foley catheter in place. He had a [MEDICAL CONDITION] and was awake, but was unable to verbalize.
Observation of incontinent care on 3/24/15 at 2:50 p.m. performed by CNA KK and CNA II revealed that Resident #1 did not have a dressing on the wound on his Stage IV sacral area wound. The sacral wound was large with granulation tissue.
Interview at the time of the observation with CNA KK and CNA II both confirmed that the dressing was not on and they were not aware how long ago the dressing came off.
During an interview with unit manager LVN A on 3/24/15 at 4:30 p.m. regarding Resident #1's sacral wound with no dressing on, she said she was not aware that the dressing was not on. The Unit Manager said she was calling the treatment nurse.
Interview with the Wound Treatment Nurse on 3/24/15 at 5:20 p.m. she said she was not informed that the dressing came off and that she was just getting ready to change the dressing. The Wound Treatment Nurse said she would have to wait after the dinner trays were taken off the unit to place a dressing on his wound.
Observation of wound treatment to Resident #1 on 3/25/15 at 11:15 am by the Wound Treatment Nurse , she removed the old dressing to Resident #1's left hip revealing an unstageable pressure ulcer with slough, she cleaned with normal saline, and she applied Santyl ointment. The nurse measured the pressure left hip pressure ulcer as 3.00 cm length (L) by 1 cm width (W).
Record review of the weekly wound healing progress report of the wound care doctor reports did not have documentation that the resident had an unstageable pressure ulcer with slough to the left hip. The onset of the wound was not documented.
Record review of Resident #1 ' s TAR or the physician orders revealed no treatment orders for the left hip unsteagable wound.
Record review of physician ' s telephone order dated 2/25/15 had cleanse sacral with normal saline, pat dry, apply Santyl cover with dry dressing daily. No other orders found on the chart.
Further observation and interview on 03/25/15 at 11:20 am revealed the Wound Treatment nurse then removed the old dressing to Resident #1 ' s sacral wound. The wound was large with granulation tissue, tunneling noticed on all sides and some of the bone was exposed (Stage IV). The Wound Treatment Nurse said it was an unstageable wound with slough. She cleaned it with normal saline then pat dry with 4 x4 gauze. The nurse applied Santyl ointment. The nurse proceeded to measure the sacral wound pressure as 7 cm x 5 cm and said it was an unstageable wound. The Wound Treatment Nurse did not measure the depth or tunneling of the wound. The Wound Treatment Nurse kept saying it was unstageable because the wound doctor said it was.
Record review of telephone physician order dated 03/18/15 revealed to apply triple antibiotic ointment to left shoulder once per day.
Record review of the TAR revealed that the order was transcribed as cleanse left shoulder with normal saline and apply silverdane, cover with dry dressing.
Further observation and interview at this time revealed that the Treatment nurse removed the old dressing to Resident #1 ' s upper back left shoulder. The Wound Treatment Nurse cleaned the area with normal saline and pat and dry with 4x4 gauze and applied Silver [MEDICATION NAME] cream and taped. She measured the area as 0.5 cm (L) by 0.5 cm (W).Treatment nurse said it was an abrasion acquired in house and that those were the only wounds Resident #1 had.
Interview and observation of head to toe assessment done with Wound Treatment Nurse on 3/26/15 at 11:50 am revealed that the nurse surveyor discovered a dressing dated 3/24/15 on Resident #1 ' s left outer ankle. The Wound Treatment Nurse said at 11:55 a.m., that she was not sure about the left ankle wound and that she was going to check her treatment book outside Resident #1 ' s room. At 11:58 a.m., the Wound Treatment Nurse came in Resident #1 ' s room stated I do not have that wound in the book . The Wound Treatment Nurse measured the left outer ankle wound and it was 1 cm (L) by 1.5 cm (W) with slough. The Wound Treatment Nurse said she was going to call the doctor and obtain an order.
In a phone interview on 03/26/15 at 1:24 pm with a family member for Resident #1 he said that he was concern about all the wounds that the resident developed in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHOLLOW HEIIGHTS TRANSITIONAL CARE CENTER	**1737 N LOOP W HOUSTON, TX 77008**

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 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	

(continued... from page 11)
Observation and interview on 03/26/15 at 3:15 pm was conducted with the DON in the presence of the Wound Treatment Nurse. The DON was informed that the Wound Treatment Nurse said Resident #1 ' s wound to the sacral area was unsteageable. The DON opened the dressing to Resident #1 ' s sacral wound and said: it is a Stage IV with about 35 % slough with pink surrounding and tunneling on all sides . The DON further stated that the Wound Care doctor and the Wound Treatment Nurse did not make a good assessment of the wound.
During an interview and observation with the wound care doctor on 3/26/15 at 6:17 p.m. regarding pressure ulcer staging and depth not documented in the assessments, the doctor checked Resident #1 ' s chart for his wound progress report, but did not find any report. The Wound Treatment Nurse was present during this interview and said she had the wound progress report in her office. The doctor reviewed his notes and said at one point the pressure was unstageable but after debridement the bone was exposed, so I staged it at a 4.
Record review of the doctor ' s wound care progress note dated 3/18/15 revealed that the depth was not documented. Further review of the report revealed:
.Sacral: 8.5 x 5 cm, bone exposed, [MEDICATION NAME] exudate seen in wound bed. Wound is abrasively debrided. Tunnel noted at 6 to 12 o ' clock. (No depth documented) .Right elbow healed.
Right hip: 3.5 x3.5 cm, dry eschar, abrasively I &D using 4x4 gauze .
Left shoulder: 2 x 2 cm, stage abrasion. No depth .
Record review of the Regional Wound Treatment Nurse (RNC) dated 3/27/15 had the following staging, sites and measurements of the pressure ulcers for resident #1:
1. Right buttock with slough was 4 cm (L) x 3 cm (W) x 1cm (D), tunneling at 6 o ' clock 0.5 cm.
2. Left hip with Stage II was 1 cm (L) x 1.5 cm (W).
3. Left ankle with Stage II was 0.5 cm (L) x 1.0 cm (W) x 0.00 (D).
4. Sacrum with Stage IV was 7 cm x 6 cm, tunneling at 12 o ' clock was 2 cm (D), 6 o ' clock was 1 cm (D), 3 o ' clock 2.5 cm (D) and 9 o ' clock 1 cm.
During an interview with regional wound care nurse (RNC) on 3/30/15 at 3:26 p.m. she confirmed that the wounds were not measured correctly by the wound care nurse. She said Resident# 1 had tunneling all over the sacral pressure ulcer and the treatment for [REDACTED].
Record review of Santyl indication and usage revealed: .ointment is indicated for [MEDICATION NAME] chronic dermal ulcers and severely burned areas . Discontinue when debridement of necrotic tissue is complete and granulation tissue is well established
Resident #11:
Record review of Resident #11's face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #11's initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, and transfers. Resident #11 had no range of motion issues and was frequently continent of bladder and bowel. Further review of the MDS section for skin conditions revealed that he was at risk for pressure ulcers, but he do not have any pressure ulcers. The section titled skin and ulcer treatment was checked for pressure reducing device for bed, pressure ulcer care and application of ointments.
Record review of the admission Braden scale dated 01/29/15 revealed a score of 10 of 23 or high risk for the developing of pressure sores. From 02/01/2015 until 02/26/15 the resident ' s Braden scale fluctuated from moderate to mild risk.
Record review of Resident #11 ' s skin inspection report from 01/29/15 until 03/05/15 revealed that his skin was intact. Further review revealed that the skin inspection report was documented as skin not intact on 03/07/15.
Record review of physician's telephone order dated 3/7/15 revealed float heels while in bed and wound doctor consult. Further review of physician orders dated 03/10/15 revealed to add an air mattress and Prevalon boots to left and right foot. Further review revealed that treatment orders were dated 03/09/15.
Record review of Resident #11 ' s weekly wound healing progress report revealed that the onset date for the wounds was documented as 3/9/15 and not 03/07/15. The wound evaluation measurement revealed Resident #11 developed the following wounds:
1. Pressure ulcer to left 5th toe (unstageable due to suspected deep tissue) was 2cm x 1cm. Then on 3/11/15 was 3 cm x 2.50 cm and 3/18/15 was 2.50 cm x 2.00 cm.
2. Pressure ulcer to left bottom of foot with (unstageable due to suspected deep tissue) was 9.50 cm x 1.00 cm. Then on 3/11/15 was 9.50 cm x 1.00 cm and 3/18/15 was 2.00 cm x 1.0 cm.
3. Pressure ulcer to left heel (unstageable due to suspected deep tissue) was 5 cm x 4 cm. Then on 3/11/15 was 4 cm x 3 cm and 3/18/15 was 5 cm x 3 cm.
4. Open blister to right buttock was 0.00 (L) x 0.00 (W). Then on 3/10/15 the wound had increased in size to 2.50 cm x 4.00 cm, on 3/11/15 was 4 cm x 4 cm. The wound increased again on 3/18/15 to 5.50 cm x 4.50 cm.
5. Pressure ulcer to right foot arch (unstageable due to suspected deep tissue) was 2.00 cm x 0.70 cm.
6. Pressure ulcer to right great toe (unstageable due to suspected deep tissue) was 2.50 cm x 2.00 cm.
7. Pressure ulcer to right heel (unstageable due to suspected deep tissue) was 5 cm x 2.50 cm.
8. Pressure ulcer to right medial malleolus (unstageable due to suspected deep tissue) was 2.50 cm x 1.50 cm. The wound increased in size on 3/18/15 to 2.80 cm x 2.00 cm.
9. On 3/23/2015 pressure ulcer to left buttock, left hip Stage II with 0.00 cm (L) x 0.00 cm (W) (depth not measured).
Observation on 03/24/15 at 8:35 a.m. revealed that Resident #11 was in bed on an air mattress. He was positioned on his right side. Resident #11 ' s heels were not floated.
Further observation on 03/24/15 at 12:25 p.m. revealed that Resident #11 was sitting in a wheel chair (w/c) by the nurses ' station. The resident did have pressure reliving cushion on the w/c and the resident did not have his Prevalon boots on his feet. Further observation on 3/24/15 at 2:00 p.m., 3:30 p.m. and 5:00 p.m. revealed that Resident #11 was lying in bed asleep with his heels not floated.
Observation on 3/25/15 at 8:40 a.m., 9:30 a.m. and 12:25 pm revealed Resident #11 sitting in w/c at the nurses ' station. The resident remained on the same position and did not have a pressure relieving cushion on the w/c. Resident #11 did not have his Prevalon boots on his feet. Resident #11 had non-skid socks on. Further observation at 12:30 p.m. revealed Resident #11 was still sitting in w/c at the nurses ' station. Resident 11 did not have his Prevalon boots on his feet. Further observation on 3/25/15 at 1:30 p.m., 3:30 p.m. and 5:30 p.m. revealed that Resident #11 was lying in bed asleep with his heels not floated.
Observation on 3/26/15 at 8:45 a.m., 9:00 a.m., 10:30 a.m., 11:15 a.m. and 12:30 p.m. Resident #11 revealed sitting in w/c at the nurses ' station. The resident remained on the same position and did not have a pressure relieving cushion on the w/c. Resident 11 did not have his Prevalon boots on his feet. Resident #11 had non-skid socks on and his feet were resting directly on the floor. Further observation on 3/26/15 at 1:00 p.m. revealed Resident #11 was lying in the bed with Prevalon boots on.
During an interview on 3/26/15 at 2:10 p.m. CNA CC said she worked with Resident #11 and that she was told not to put on the Prevalon boots while he was on the wheel chair. CNA CC said she was just told to put the Prevalon boots while he was in bed.
Record review of the TAR for Resident #11 revealed to apply wound gel to the right and left hips ' wounds.
Observation and interview during wound treatment to Resident #11 on 3/26/15 at 2:35 p.m., revealed that the Wound Treatment Nurse cleaned, measured and applied [MEDICATION NAME] gel to the following pressure ulcers:
1. Left hip Stage II measuring 2 cm (L) x 1.5 cm (W)
2. Right hip Stage II measuring 4.5 cm (L) x 4 cm (W) x 0.00 (D)
3. Right lower hip Stage II measuring 5.5 cm (L) x1.5 cm (W) x 0.00 (D)
Further observation at the time revealed that the Wound treatment nurse measured, cleaned the eschar and applied skin prep on the following wounds:
1. Right foot ankle 2.5 cm x 1 cm x0.00 (D)
2. Right foot lateral 3 cm x 2.5 cm
3. Right inner ankle 5 cm x 1 cm
4. Left foot outer ankle 3 cm x 1.5 cm
5. Left lateral foot 1.5 cm x1.5 cm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHOLLOW HEIGHTS TRANSITIONAL CARE CENTER	**1737 N LOOP W HOUSTON, TX 77008**

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 0314

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 12)
6. Outer great toe 2.5 cm x 2 cm
7. Left heel 4 cm x4.5 cm
Interview at this time the Wound Treatment Nurse said that Resident #11 developed all the wounds in the facility.
Record review of the doctor ' s wound care progress note dated 3/18/15 revealed that the depth of the wounds was not being documented. The wounds measured:
1. Left foot 1st metatarsal: 2 x 3 cm, soft black eschar.
2. Left outer foot: 2 x 1 cm, soft black eschar covering.
3. Left lateral malleolus: 4 x 2.5 cm, soft eschar.
4. Left 5th metatarsal: 2.5 x2 cm, soft eschar.
5. Left heel: 5 x3 cm, soft eschar.
6. Right lateral malleolus: 2.5 x 2 cm, soft eschar.
7. Right first toe: 1.5 x 0.7 cm, soft eschar.
8. Right medial malleolus: 1 x1 cm soft black eschar covering.
9. Right 5th metatarsal: 1 x 1 cm, soft eschar covering.
10. Right heel: 0.8 x 1cm, soft eschar.
11. Right buttock: Pressure wound, Stage III, 5.5 x 4.5 cm, wound was abrasively debrided.
During an interview with unit manager LVN C on 3/27/15 at 3:00 p.m. she said she had not been monitoring the pressure ulcers weekly but sometimes she does look at them when the treatment nurse was changing the old dressing. Unit manager LVN C said, any nurse admitting residents with pressure ulcer would do the assessment.

Resident # 14:
Record review of Resident #14 ' s face sheet revealed that she is a [AGE] years old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED].
Record review of Resident #14' s initial MDS assessment dated [DATE] revealed that she had moderately impaired cognitively skilld, required extensive assistance for bed mobility and transfers, and was always incontinent of bowel and bladder.
Further review of the MDS under the section for skin conditions revealed that she was at risk of developing pressure ulcer and was admitted with intact skin. The section for skin and ulcer treatment was checked for pressure reducing device for bed and application of ointments/medications.
Record review of skin check records for Resident #14 revealed that the skin check done on 9/5/2014 documented skin intact .
Record review of Braden risk score history for Resident #23 revealed she was coded as being a 23 or low risk for developing pressure sores on 09/05/14.
Record review of Resident # 14 ' s care plan dated 9/25/2014, updated 1/7/2015 revealed that she was at risk for skin integrity related to decreased mobility, poor nutrition and incontinence. Approaches include pressure redistribution mattress and/or wheel chair cushioning, weekly skin checks and turn and reposition every 2 hours and as needed.
Record review of Resident #14 ' s Braden Risk Assessment report dated 1/10/2015 reveals, her risk score of 12 and risk level high for development of wounds, her activity level chair fast with severely limited or non-existent ability to walk.
Record review of Resident # 14 ' s skin check report and the wound assessment report dated 1/21/2015 signed by Wound Treatment Nurse revealed that the resident developed new pressure ulcers on rear of left thigh (1 cm x 2 cm) and on the right buttock (4 cm x3 cm) Stage II, first identified on 1/20/2015.
Record review of weekly wound care progress notes by wound care doctor and wound assessment report by Wound Treatment Nurse revealed that the ulcer on the back of left thigh resolved on 2/11/2015 but the one on right buttock increased in size to 5cm x 4 cm on 2/18/2015 and worsened to a Stage III. The current size of the pressure ulcer on right buttock as per the wound care physician ' s progress notes dated 3/23/2015 and the measurements done by Wound Treatment Nurse on 2/24/2015 by the Wound Treatment Nurse were, 3 cm x 3 cm, with tunneling at 9 and 3 o clock. The wound was still a Stage III, with necrotic skin and foul odor. None of the notes from the wound care physician or the Wound Treatment Nurse documents the depth of the wound.
Observation of Resident # 14 on 3/24/2015 at 1:15 pm during wound care observation revealed that she was lying in supine position on her bed with a regular scoop mattress. The wheel chair lying next to her bed had a Pommel cushion on it.
Observations of Resident # 14 on 3/25/2015 revealed:
At 8:30 am, she was lying supine in bed on the scoop mattress, no pillows or any other device on bed to support her in turned position.
At 9:00 am resident was on wheel chair with pummel cushion in place, sitting in the dining room. Resident observed sitting on the same spot in the same position at 10:00 am, 11:00 am, 12:00 Noon. At 1:00 pm Resident #14 was observed sitting next to the table where she had lunch.
At 2:00 pm resident observed lying in bed in supine position on scoop air mattress.
At 4:00 pm she was lying on her bed in supine position, no positioning device or pillows on the bed.
Observation of Resident #14 on 3/26/2015 revealed:
At 8:30 am she was lying supine in bed, no positioning device or pillows on bed, scoop mattress in place.
At 9:00 am, 10:00 am, 11:00 am, and 12:00 noon Resident #14 was observed sitting in the dining room on her wheel chair, with Pommel cushion in place, on the same spot.
At 1:45 pm resident was sitting on her wheel chair in front of nurse station.
At 2:00 pm resident was transferred to bed in a supine position, no positioning device or pillows were placed on the bed.
At 4:30 pm the resident was still lying in bed in supine position.
Interview with LVN Unit Manager A on 3/24/2015 at 12:30 pm she said that Resident # 14 was unable to turn and reposition herself in bed or chair and was totally dependent on staff. She said that the resident had a Pommel cushion on her chair to prevent her from sliding and falling. She further said that the staff got the resident out of bed in the morning after breakfast and she stays up in chair in the dining room until around 1:00 pm or so when she was put back to bed. When asked about Resident #14 ' s in house acquired wounds, LVN Unit Manager A said it was probably due to her nutritional status.
Record review of Resident # 14 's weight report revealed that she had no significant weight loss from September 2014 until March 2015. She was consuming 75 percent or more of her meals and her 76-100% of estimated nutritional needs were being met. In addition she had been getting therapeutic nutritional supplement.
Observation and interview during wound care with the Wound Treatment Nurse on 3/24/2015 at 1:30 pm she said that the resident has the Pommel cushion on chair to prevent her from falling. When asked to stage the pressure ulcer for Resident # 14 she said that the one on the right buttock, was a Stage II. The Wound Treatment Nurse said that the whole skin thickness was lost and sub cutaneous tissue was visible. She further said that she was saying that it was a Stage II wound because the wound care doctor had staged it as a Stage II and it is the doctor who stages the wound and not her.
Record review of the Wound Care Doctor progress notes documenting the right buttock wound on the resident as Stage III on 2/11/2015, unstageable on 2/18/2015, and 2/23/2015, and a Stage III on all of his notes from 2/25/2015 until 3/23/2015.
Record Review of the weekly wound care assessment reports by the Wound Treatment Nurse documents the wound as a Stage II on 1/21/2015 and as unstageable from 1/28/2015 until 3/25/2015.
In an interview with the DON on 3/24/2015 at 2:45 pm he said that his opinion was that Resident # 14 developed new pressure sore because of her many comorbid illnesses. He said he knew that she had not lost any weight and had been eating and drinking well.
Interview with the DON on 3/27/2015 at 10:30 am revealed that all the facility mattresses with the blue tops were pressure relieving mattresses and those were given to all residents who were at risk of pressure ulcers. He said that air mattresses or other specialty mattresses were given to the residents with pressure sores that were Stage III or IV because they needed that. He said he knew that Resident # 14 had a regular scoop mattress on her bed until 3/25/2015, once it was pointed out by the surveyor despite the resident having a pressure ulcer Stage III.
Further interview with the DON he said that Pommel cushions were of two types, one was just foam which was good for pressure relief for residents at risk of developing pressure ulcer, and the one with gel which was recommended for residents with pressure ulcers on the buttocks.
Interview with the Rehab manager on 3/27/2015 at 10:15 am he said that Pommel cushions were used for positioning and prevent residents from falls and sliding out of chair, sometimes we recommend it and sometimes they are ordered by physicians. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHOLLOW HEIIGHTS TRANSITIONAL CARE CENTER	**1737 N LOOP W HOUSTON, TX 77008**

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 0314

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 13)
Rehab Manager said gel or foam/ gel were usually recommended for residents who were at fall risk and had pressure sores on buttocks.
Observation and interview of Resident ' s #14 cushion on 3/27/2015 at 10:25 am the rehab manager said that the cushion on her chair was a foam cushion. The Rehab manager said that he did not know Resident # 14 had a Stage III pressure sore on the buttocks and now he was going to order a gel /foam cushion for her.
Resident #26:
Record review of Resident # 26 ' face sheet revealed that she is an [AGE] years old female admitted to the facility on ,[DATE]/ 2012 and readmitted on [DATE]. Her [DIAGNOSES REDACTED].
Record review of Resident #26 ' s Braden scale dated 10/22/14 revealed that she was assessed at a score of 16 out of 23 to indicate that she was at low risk for developing pressure ulcers. Further review revealed that she was assessed to have moderate risk of developing pressure ulcers on 1/30/15 and at low risk for developing pressure ulcers on 03/17/15 (score of 16 out of 23).
Record review of Resident #26 annual MDS assessment dated [DATE] revealed that she had moderate impaired cognitive skills and required extensive assistance for bed mobility and transfers. Further review of the skin condition section revealed that she had a Stage II pressure ulcer that was not present in the previous assessment. Skin and ulcer treatments were marked as use of pressure relieving devices for bed and chair, nutrition and wound care.
Record review of Resident #26 quarterly MDS assessment dated [DATE] revealed that she required extensive assistance with bed mobility, was not able to walk and was incontinent of bladder and bowel. Further review of the MDS section for skin conditions revealed that she did not have any unhealed pressure ulcer and her skin was intact at that time.
Record review of Resident #26 ' s care plan dated 11/10/2014 revealed that she was at risk for impaired skin integrity related to immobility, [MEDICAL CONDITION], needing staff to assist with bed mobility and bladder incontinence. The approaches included turning and repositioning every 2 hours and as needed, incontinent care and barrier cream as needed, pressure redistributing mattress and encouraging resident to get out of bed. The updated care plan dated 2/11/2015 revealed the resident has impaired skin integrity as evidenced by presence of vascular or pressure ulcer.
Record review of the wound care physician ' s progress notes and wound treatment nurse ' s notes dated 1/14/2015 revealed that the sacral pressure ulcer she had resolved on that day.
Record review of the wound treatment nurses notes dated 2/10/2015 revealed that the resident again developed a sacral wound measuring 6 cm x 9 cm. The depth was not measured and

F 0315

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview and record review, the facility failed to ensure 2 of 27 residents (Resident #4 and #1), observed for catheter and incontinent care received care in a manner to maintain proper infection control techniques to help prevent the development and transmission of disease and infection.
- Resident #4 did not receive proper catheter care to prevent the spread of infection.
Resident #1 did not receive proper catheter care to prevent the spread of infection and his catheter was not secured.
This failure affected 2 residents and placed an additional 5 residents with catheters at risk of developing urinary tract infection and injuries.
Findings include:
Resident #4:
Record review of Resident #4 ' s face sheet revealed a [AGE] year old female admitted on [DATE] with the [DIAGNOSES REDACTED].
Observation on 3/25/15 at 3:01 pm with CNA F during incontinent care provided after Resident # 4 had a bowel movement CNA F turned and cleaned Resident #4's sacral area, but failed to separate labia and cleanse Foley catheter.
Observation on 3/25/15 at 3: 27 pm the Wound Treatment Nurse came into room and informed CNA F to stop the Foley catheter care and to return once she finished wound care for the resident.
Observation on 3/25/15 at 3:47 pm CNA F returned to Resident ' s # 4 room. She did not separate the labia or provide catheter care and proceeded to place a brief on the resident.
Interview with CNA F on 3/25/15 at 4:20 pm stated I had already cleaned her only thing had to do is put a diaper on her . I normally clean her, but I just did it so Treatment Nurse could change wound vac. CNA F reported she thought the wound care nurse would have cleaned her.

Resident #1
Record review of Resident #1 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #1 ' s initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, transfers. Resident #1 had range of motion issues and was frequently continent of bladder with indwelling catheter. He required extensive assistance with personal hygiene and was totally dependent on staff for bathing.
Observation on 3/24/15 at 2:50 p.m., CNA KK entered Resident #1's to perform incontinent care. CNA KK removed Resident #1's brief. Resident's indwelling catheter was not secured. CNA KK using the same glove, pulled the drawer to look for wipes. CNA KK said There is no wipes. CNA KK then covered the resident with the bedsheet, took off her gloves and without washing her hands, left Resident #1's room to the supply room on station 1. At 3:00 p.m. CNA KK came back with a box of wipes. Without washing her hands, she put on gloves, entered Resident #1's room. CNA KK uncovered Resident #1 and provided incontinent/indwelling catheter care to Resident #1. CNA KK started cleaning the penis and the perineal area. While trying to clean the catheter, CNA KK was pulling on the catheter that was tuck under Resident #1's right thigh towards the buttocks. Resident #1 had about a 3 cm long indented mark on his skin from the indwelling catheter. Resident #1 was bleeding from the insertion site of the indwelling catheter. CNA KK then kept using the wipes to clean the bleeding. At 3:10 p.m., CNA II came in to assist CNA KK, CNA II then assisted in repositioning Resident #1 to his left side, cleaned the buttocks. Resident #1 had stage IV to sacral area with no dressing on. CNA KK used the same gloves throughout the procedure. CNA KK picked up a clean brief and placed it under the resident and taped it.
During an interview on 3/24/15 at 4:35 p.m CNA KK said she thought she did a good job. CNA KK confirmed that the indwelling catheter was not secured.
During an interview with unit manager LVN C on 3/24/15 at 4:40 p.m. LVN C enter Resident #1's room and said that the indwelling catheter was not secured and it should.
Record review of facility pocicy dated 2001 for Catheter Care, Urinary
Infection Control
2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.
a. do not clean the periurethral area with antiseptics to prevent catheter-associated UTI while the catheter is in place.
Routine hygiene (e.g., cleansing of the meatal surfaces during daily bathing or showering) is appropriate.
Steps in the procedure
7. Wash the resident ' s genitalia and perineum thoroughly with soap and water. rinse the area well and towel dry.
15. For the female: Use a washcloth with warm water and soap to cleanse the labia
16. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.
According to CMS form 672 the facility had 7 residents with urinary catheters.

F 0332

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**
NAME OF PROVIDER OF SUPPLIER **BROOKHOLLOW HEIGHTS TRANSITIONAL CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1737 N LOOP W HOUSTON, TX 77008**	

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 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 14) Based on observation and record review, it was determined the facility failed to ensure that they were free of medication error rate of less than 5%. The medication error rate for the facility was 7% with two errors observed in 28 opportunities, involving two staffs (LVN M and LVN W) members and two residents (Resident # 29 and Resident #30). LVN M failed to administer Pantoprazole according to physician's orders [REDACTED]. LVN W failed to administer [MEDICATION NAME] as ordered by the physician to Resident #30. These failures affected two residents and placed the other 120 residents who resided in the facility and received medications from facility staff at risk for not receiving their medications in the correct dosage and not receiving their medications as ordered by the physician. Findings Include: Resident #29: Record review of Resident # 29's face sheet revealed a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Record review of the Physician order [REDACTED]. Observation of medication administration on 03/24/15 at 9:09 a.m. revealed that LVN M poured NAME] 40 DR 40 mg one tablet into medication cup with other medications and administered to Resident #29. Record review of the Medication Administration Record [REDACTED] Record review of Café meal hours for breakfast had station 4 breakfast was served at 7:25 a.m. During an interview with Resident #29 on 3/24/15 at 9:10 a.m. in her room. Resident #29 said she ate breakfast earlier that morning. During an interview with LVN M on 3/25/15 at 2:35 p.m. regarding Pantoprazole not administered before meal, LVN M said the night nurses gave breakfast medication before meals. LVN M said NAME] DR 40 mg was on MAR indicated [REDACTED] During an interview on 3/25/15 at 2:45 p.m. with unit manager LVN C, regarding clarification order of Pantoprazole, the unit manager said she did clarify the order but forgot to transcribe it on current MAR. Resident #30: Record review of Resident # 30's face sheet revealed a [AGE] year old male admitted to the facility on 10//17/14 and was readmitted on [DATE], with [DIAGNOSES REDACTED]. Observation of medication administration on 03/24/15 at 5:10 p.m. revealed that LVN W punch [MEDICATION NAME] 20 mg one tablet out of a blister pack into medication cup with other medications and administered to Resident #30. Resident #30 had finished eating diner and the empty tray was at the bedside tablet. Record review of [MEDICATION NAME] 20 mg blister packet document Do not chew or crush. May open & sprinkle contents on applesauce. Do not chew. Take before a meal. Record review of the Physician order [REDACTED]. Record review of the Medication Administration Record [REDACTED] Record review of Café meal hours for diner had station 4 was served dinner at 4:45 p.m. A record review of the facilities Administering medications policy, revised October 2010, documented (in part): The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving medications. The facility's CMS 672 revealed that the census was 122 residents.
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 and distribute food under sanitary conditions as evidence by: -Utensils with food particles on them. - Chipped plates and bowls. -Dented cans in the dry storage room and open juice not refrigerated. - Kitchen equipment was not clean These failures affected 104 residents who ate food prepared in the kitchen by placing them at risk of food borne illness or disease. Findings include: Observation of the kitchen on 03/24/15 at 9:25 a.m., revealed clean serving utensils with food particles and grease on them. Cups and plates had dried food particles and food stains in them. Further observation revealed chipped bowls and plates in the stack of clean plates. Observation of the kitchen on 3/24/15 at 9:30 a.m. revealed the stove vent had yellow greasy substance on it. The microwave had dry food particles in it. The Dietary Manager at that point removed the serving utensils and sent them to the dish room to be rewashed. The chipped plates and bowls were discarded Further observation on 3/24/15 at 9:45 a.m. of the kitchen's dry storage room revealed: 2 Dented cans of 6 lbs. 11 oz. Aged Cheddar Cheese Sauce 2- Open boxes of thickened water with use by date of 6/11/15. 2- Open boxes of thickened cranberry juice with use by date of 6/6/15. Record review of the instruction labeled for usage on the thickened water and cranberry juice revealed refrigerated when open. During an interview with the Dietary Manager on 3/24/15 at 10:55 a.m. she said that the thickened water and cranberry juice did not need to be refrigerated when they were opened. She further stated that they took up a lot of space in the cooler. At that point the instructions were pointed out to the Dietary Manager and she immediately discarded the thickened water and the cranberry juice. She also said she was going to in-service the staff. The facility 672 form revealed a census of 58 residents and they all eat food prepared by the kitchen.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 4 of 27 residents (Resident #4, #10 & #1 and 11), observed for catheter, incontinent care, and dressing change received care in a manner to maintain proper infection control techniques to help prevent the development and transmission of disease and infection. - CNA F failed to separate Resident #4's labia and clean Foley catheter after resident had an bowel movement. - -CNA KK failed to perform appropriate hand hygiene and glove changes during incontinent care on Resident #1. - CNA F failed to place soiled linen in appropriate container, but placed it on the floor. -CNA F did not maintain a clean field and she touched a clean brief, privacy curtain with dirty gloves while providing incontinent care for Resident #10. -CNA T failed to clean Resident 11 in a manner to prevent infection. -Wound Care Nurse took items from the treatment cart without properly sanitizing hands after biohazard bag fell on floor and she picked it up to place in trash. This failure affected 4 residents and placed the remaining 118 residents at risk of infections. Findings include: Resident #4: Record review of Resident #4 ' s face sheet revealed an [AGE] year old female admitted on [DATE] with the [DIAGNOSES REDACTED]. Observation on 3/25/15 at 3:01 pm with CNA F during incontinent care provided after Resident # 4 had a bowel movement CNA F turned and cleaned Resident #4's sacral area, but failed to separate labia and cleanse Foley catheter. Observation on 3/25/15 at 3: 27 pm the Wound Treatment Nurse came into room and informed CNA F to stop the Foley catheter care and to return once she finished wound care for the resident. Observation on 3/25/15 at 3:47 pm CNA F returned to Resident ' s # 4 room. She did not separate the labia or provide catheter care and proceeded to place a brief on the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHOLLOW HEIGHTS TRANSITIONAL CARE CENTER	**1737 N LOOP W HOUSTON, TX 77008**

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 0441

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 15)
Observation on 3/25/15 at 3:27 pm during changing of Resident # 4's wound vac, the Wound Nurse picked up the biohazard bag after it fell on the floor then left room to place it on the trash on cart. Without changing gloves or washing her hands, she placed it in the trash that was on the cart and went directly into the treatment cart to get supplies then returned to resident ' s # 4 ' s room.
Observation on 3/25/15 at 3:47 pm CNA F returned to resident ' s # 4 ' s room to place a clean brief on her. She did not separate labia or provide catheter care to the resident.
Interview with CNA F on 3/25/15 at 4:20 pm stated I had already cleaned her only thing had to do is put a diaper on her . I normally clean her, but I just did it so Treatment Nurse could change wound vac. CNA F reported she thought the wound care nurse would have cleaned her.
Interview on 3/25/15 at 4:12 pm the Wound Care Nurse stated I should have put the bag into trash can and sanitize hands then proceeded to the cart to get supplies .
Observation on 3/26/15 at 6: 17 pm inside resident ' s # 4 ' s room revealed dirty linen was left on the floor inside room after care was provided.
Interview on 3/26/1 at 5: 55 pm CNA F reported she forgot that linen should not be on floor.

Resident #10
Record review of Resident #10 ' s face sheet revealed an admitted [DATE]. His [DIAGNOSES REDACTED]. Resident #10 was [AGE]
years old.
Record review of Resident #10 ' s Annual MDS assessment dated [DATE] revealed that Resident #10 was totally dependent on staff on areas of transfer, eating, hygiene and bathing. Further record review of the MDS Assessment revealed that Resident #10 was incontinent of bladder and bowel.
Observation on 3/25/15 at 11:00 am revealed that CNA F was doing incontinent care for Resident #10. She had prepared a clean field using Resident #10 ' s over bed table. She placed a towel on top of the tray table. After CNA F cleaned Resident #10, she touched the clean brief with her soiled gloves and placed it on the bottom of Resident #10 , touched the privacy curtain and then she changed her gloves.
Interview on 03/25/15 at 11:05 a.m. CNA F said that no one told her that when she finished wiping the back area and have your brief you have to change gloves to put the clean brief on .

Resident #1
Record review of Resident #1 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #1 ' s initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, transfers. Resident #1 had range of motion issues and was frequently continent of bladder with indwelling catheter. He required extensive assistance with personal hygiene and was totally dependent on staff for bathing.
Observation on 3/24/15 at 2:50 p.m., CNA KK entered Resident #1's to perform incontinent care. CNA KK removed Resident #1's brief. Resident's indwelling catheter was not secured. CNA KK using the same glove, pulled the drawer to look for wipes. CNA KK said There is no wipes. CNA KK then covered the resident with the bedsheet, took off her gloves and without washing her hands, left Resident #1's room to the supply room on station 1. At 3:00 p.m. CNA KK came back with a box of wipes. Without washing her hands, she put on gloves, entered Resident #1's room. CNA KK uncovered Resident #1 and provided incontinent/indwelling catheter care to Resident #1. CNA KK started cleaning the penis and the perineal area. While trying to clean the catheter, CNA KK was pulling on the catheter that was tuck under Resident #1's right thigh towards the buttocks. Resident #1 had about a 3 cm long indented mark on his skin from the indwelling catheter. Resident #1 was bleeding from the insertion site of the indwelling catheter. CNA KK then kept using the wipes to clean the bleeding. At 3:10 p.m., CNA II came in to assist CNA KK, CNA II then assisted in repositioning Resident #1 to his left side, cleaned the buttocks. Resident #1 had stage IV to sacral area with no dressing on. CNA KK used the same gloves throughout the procedure. CNA KK picked up a clean brief and placed it under the resident and taped it.
During an interview on 3/24/15 at 4:35 p.m CNA KK said she thought she did a good job.
Resident #11:
Record review of Resident #11 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #11 ' s initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, transfers. Resident #11 had no range of motion issues and was frequently incontinent of bladder and bowel.
Observation on 3/24/15 at 3:30 p.m., CNA II entered Resident #11's room to perform incontinent care with CNA T. CNA II gloved, and clean Resident #11's in-between buttocks, but did not clean around the buttocks. CNA II then picked up a clean brief , placed it under Resident #11. CNA II and CNA T then repositioned Resident #11 on his back. CNA II cleaned Resident #11's perineal area and the penis which had lots of creamy dry flaky substances that fell on the clean brief. CNA II then fasten the brief on Resident #11.
During an interview on 3/24/15 at 4:10 p.m CNA II said I did something wrong refering to the way she cleaned the resident.
Record review of the June 2001 MED-PASS,INC (Revised October2010) Infection Control Guidelines for All nursing Procedures. General Guidelines 3. Employees must wash their for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: e. after handling items potentially contaminated with blood, body fluids, or secretions. 4. In most situations, the preferred method of hand hygiene is with a alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] for
all the following situations: H. After handling used dressings, contaminated equipment, etc.; J. After removing gloves.
Record review 2001 Med-Pass Catheter Care, Urinary
Infection Control
2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.
a. do not clean the peri urethral area with antiseptics to prevent catheter-associated UTI while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surfaces during daily bathing or showering) is appropriate.
Steps in the procedure
7. Wash the resident ' s genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry.
15. For the female: Use a washcloth with warm water and soap to cleanse the labia
16. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.
Review of CMS 672 revealed a facility census of 88 incontinent residents.

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 interview and record review the Administrator and DON failed to administer the facility in a manner that enables it to use its resources effectively and efficiently to ensure that residents who entered the facility without pressure ulcers did not develop pressure ulcers and residents with pressure ulcers received treatment and services to promote healing for 7 of 10 residents reviewed for pressure sores. (Residents # 1, 11, 14, 26, 5, 3, and #25)
The Administrator failed to:
--supervise the DON to ensure the wound treatment nurse was adequately trained to provide wound care to include assessment and measurement of wounds.
--supervise the DON to ensure that nursing staff completed accurate pressure sore assessments and nursing staff was monitored to ensure preventive care was provided to residents at risk for skin breakdown.
The DON failed to:
--monitor and supervise the nursing staff on accurate pressure sore assessment, use of pressure relieving devices, and that preventive care was provided to residents at risk of skin breakdown.
-- train staff to include the Wound Treatment Nurse to be able to identify, measure and stage pressure sore accurately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHOLLOW HEIGHTS TRANSITIONAL CARE CENTER	**1737 N LOOP W HOUSTON, TX 77008**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 16) --monitor nurses and CNAs on following physician orders [REDACTED]. -- develop system to track facility acquired or community acquired pressure ulcers. An IJ was identified on 3/26/15. While the IJ was lowered on 3/31/15, the facility remained out of compliance at a pattern level and a severity of actual harm that is not immediate jeopardy due to facility needing more time to monitor the plan of removal for effectiveness. This failure affected 7 residents and could place 10 current residents with pressure sores at risk of developing additional pressure ulcers, deterioration of existing ones, pain, infection and hospitalization . Findings include: Record Review of the POS [REDACTED]. The Administrator's essential functions of position are: Ensure excellent care for residents is maintained by overseeing and monitoring patient care services. Record Review of the POS [REDACTED]. The DON's essential function of the position is assist in the completion of the care plans (acute and long term) and is involved in the care conference as deemed necessary .assures documentation is accurately completed for admission, discharge and transfer. In an interview on 3/30/15 at 9:15 a.m. the Interim Administrator said he was not sure why they had an IJ related to pressure sores because he had just started to work in the facility two weeks ago. He stated that he had identified other issues but not those. He said they were putting measures in place to correct the issue. In an interview on 3/30/15 at 2:50 pm, the DON said the facility was having the identified issues with pressure sores because the Wound Treatment nurse failed to accurately assessed and identify residents with pressure sores. He further stated that the Wound Treatment nurse was staging or measuring pressure sores incorrectly. Observation and interview on 03/26/15 at 3:15 pm was conducted with the DON in the presence of the Wound Treatment Nurse. The DON was informed that the Wound Treatment Nurse said Resident #1 ' s wound to the sacral area was unsteageable. The DON opened the dressing to Resident #1 ' s sacral wound and said: it is a Stage IV with about 35 % slough with pink surrounding and tunneling on all sides . The DON further stated that the Wound Care doctor and the Wound Treatment Nurse did not make a good assessment of the wound. Further interview with the DON on 03/26/15 at 3:40 pm, the DON said that he had educated the Wound Treatment Nurse on wound care. He said the Wound Treatment Nurse was send to a wound care seminar and she had the certification for it. He said she had not informed him of any issues with her job. The DON said the unit managers were supposed to monitor the treatment nurse and residents with pressure ulcers. Record review of the certificate presented by the DON for the Wound Treatment Nurse revealed a continuing education certificate- skin & wound conference date of attendance was 9/9/14. Record review of individual education form dated 1/27/15 for the Wound Treatment nurse, revealed that the DON had provided 1:1 education to her for: 1. Wound consult: Head toe documented and get order to treat any findings. Items Reviewed: 2. Interpret wound care consult as directive to provide a complete skin check to include head to toe assessment and documentation. Record review of individual education form dated 1/28/15 Wound Treatment nurse, revealed that the DON had provided 1:1 education to her for: 1. List of residents with risk for developing pressure ulcers will be compiled by the unit manager and Wound Treatment Nurse every week. 2. Wound Treatment Nurse must report those on the list who are not up for the day to the DON. Items Reviewed: 3. Wound Treatment Nurse must perform weekly skin rounds every week (Friday). 4. Skin assessment and report by the Wound Treatment Nurse is due within 24 hours of admission to be submitted to the DON. The form was signed by the Wound Treatment Nurse indicating that she had been educated on the above items. During an interview with unit manager LVN C on 3/27/15 at 3:00 p.m. she said she had not been monitoring the pressure ulcers weekly but sometimes she does look at them when the treatment nurse was changing the old dressing. Unit manager LVN C said, any nurse admitting residents with pressure ulcer would do the assessment. Interview with the DON on 3/27/2015 at 10:30 am revealed that all the facility mattresses with the blue tops were pressure relieving mattresses and those were given to all residents who were at risk of pressure ulcers. He said that air mattresses or other specialty mattresses were given to the residents with pressure sores that were Stage III or IV because they needed that. The DON said that he knew that Resident # 14 had a regular scoop mattress on her bed until 3/25/2015 even though she had a pressure ulcer Stage III. Further interview with the DON he said that Pommel cushions were of two types, one was just foam which was good for pressure relief for residents at risk of developing pressure ulcer, and the one with gel which was recommended for residents with pressure ulcers on the buttocks. In an interview with the Wound Treatment Nurse on 3/27/15 at 4:00 p.m. regarding the measurement of pressure sores she stated that the doctor does the measurements and she writes the information down. When asked why there was no depth to the pressure sores measurement she said she was not the one who did the measurement. She said she really did not ask the doctor why he did not measure the depth. Further interview revealed no reason was given for the difference in notes from her and the doctor. Record review of the facility job specific duties of the treatment nurse revealed in part: .Ensure all residents are assessed weekly to evaluate the condition of their skin, identify risks and develop appropriate interventions and required documentation .Measure all skin areas weekly and document . In an interview on 03/27/15 at 2:00 pm the Corporate Nurse said that the Wound Treatment Nurse was supposed to measure the wounds while doing skin assessments. A copy of a skin assessment was presented to the Regional Nurse showing that the depth for pressure sores Stage II, III and IV were documented as 0. The Regional Nurse said that it was incorrect as any wound stages at II, III or IV should have depth documented. She said I see the problem. In an interview with the Wound Treatment Nurse on 3/27/15 at 3:45 pm she aknowledge that she had difficulty completing all her skin assessments weekly because she needed help doing the rounds as a lot or residents needed to be turned with assistance of another staff. She said that she had reported to the DON her concerns and that some residentswere developing new blisters. The Wound Treatment Nurses said that she completed rounds with the Wound Care Doctor weekly and she documented while the doctor performed his assessment. When asked how she measured the depth of a wound that had tunneling, she said that she was not sure because the facility had no residents with wounds that have tunneling. During an interview with regional wound care nurse (RNC) on 3/30/15 at 3:26 p.m. she confirmed that the wounds were not measured correctly by the wound care nurse. She said Resident# 1 had tunneling all over the sacral pressure ulcer and the treatment for [REDACTED]. The facility had no documentation that wounds were being tracked to determine if they were acquired in house or if the residents were admitted with the wounds. Documentation was requested from the DON and the Regional Nurse on 03/26/15 and 03/27/15, but it was not presented before exit. The Wound Treatment Nurse and the Wound Care Doctor failed to measure the depth of Stage II, III or IV wounds for Resident # 1, 11, 14, 26, 5, 3 and 25. The Wound Treatment Nurse was unable to accurately describe, stage, and measure pressure sores for Resident #1, 11, and 14. Facility documentation regarding wound description and stage was inaccurate for Resident #1, 11, 14, 26, 5 and 25. The Wound Treatment Nurse did not conduct weekly skin assessments consistently for residents with pressure sores. Residents #1, 11, 14, 26, 3 and 25 acquired multiple pressure sores in the facility. The wounds for Residents # 1, 14, 26, 3 and 25 increased in size or deteriorated. Observations on different times and dated during the survey from 03/24/15 thru 03/31/15 revealed that Resident #14, #5 and #3 were not repositioned and turned as per their plan of care. Pressure relieving devices such as booties, cushions and air mattresses were not used as ordered for Resident #3 and 14. An IJ was identified on 03/26/15 at 4:00 pm and the Interim Administrator, the DON and the ADON were informed at that time. A Plan of Removal (POR) for the IJ was initially submitted on 03/26/15 at 12:00 am. Several revisions were required and the plan was accepted on 03/27/15 at 4:00pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**

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

F 0490

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 17)
The POR included in part:
1. The four residents: were reassessed per (Corporate Nurses). The treatment orders, the care plans and the adaptive equipment, i.e., wedges, pillows, boots, low air loss mattresses, etc., are current and appropriate for each resident.Completion Date: 3/27/15 by 12 pm
2. The licensed nursing staff will continue to perform weekly skin assessments. In the event a new wound is identified, as part of the revised wound program, we will begin physician and responsible party notification, the care plan updated, and staff educated with new interventions. The licensed nursing staff will be made aware via the 24 hour report, the shift report and nurses notes. The licensed nurses completed a 100% skin audit for all residents in the facility to identify any new skin issues. The physicians and Responsible Parties of the residents who had skin issues identified were notified, physician orders [REDACTED].If the date of admission coincides with the date of the wound identification, the wound is deemed as Community Acquired. If the date of the wound identification is post admitted , the wound is deemed as in-house acquired. Completion Date: 3/27/15 by 12pm
3. (Corporate Nurse), or designee will in-service the licensed nurses on notifying the physician when new skin issues are identified, transcribing physician orders [REDACTED]. Completion Date: 3/27/15 by 12pm
4. (Wound Care Doctor) will provide 1:1 wound staging and wound assessment education to the wound treatment nurse. Completion Date: 3/27/15 by 12pm
5. An in-service will also be provided to CNAs and licensed nurses on repositioning frequency for residents, and the reporting of new skin issues by the CNAs to the Charge Nurse via the Unit Communication Book. The CNA will document in the book that a new skin area was discovered and will verbally tell the Charge Nurse. The Charge Nurse reviews the Communication Book throughout the shift and is made aware of skin issues. If, after assessment, a resident is deemed to be at a higher risk for the development of pressure ulcers, additional interventions, including wedges, pillows, boots, low air loss mattresses, etc., will be put in to place .Completion Date: 3/27/15 by 12pm
6. The DON or designee will re-educate the CNAs and licensed nurses on the rounding frequency of residents. The rounding responsibilities will include visualizing the turning and repositioning of residents and the presence of assistive devices. Each Charge Nurse will monitor that the CNAs are completing their assigned rounds each shift.Completion Date: 3/27/15 by 12p
7. The Unit Managers or designees will audit, each shift, the adaptive equipment, i.e. wedges, pillows, boots, low air loss mattresses, etc. for availability and usage. The Charge Nurses will monitor placement of the devices daily. Completion Date: 3/27/15 by 12pm
8. The Regional Quality Manager will review . job specific duties with the treatment nurse and perform a comprehensive skill assessment:
· Ensure all residents are assessed weekly to evaluate the condition of their skin, identify risks and develop appropriate interventions and required documentation.
· Measure all skin areas weekly and document.
· Initiate and update all care plan information regarding skin.
· Follow up with physician to report any resident skin problems that arise, and transcribe and follow up with any new orders Completion Date: 3/27/15 by 12pm
9. Part time treatment nurse (RN) has been hired for weekend duties beginning next week .Permanent FT Certified Wound nurse is being recruited .That will give us two treatment nurses plus a weekend treatment nurse to collaborate for effective skin care facility wide .
The surveyors confirmed the POR had been implemented sufficiently to remove the IJ by:
Record Review of the In-Service sign-in sheet revealed that staff from the nursing department representing all three shifts had been in-serviced from 03/26/15 until 03/30/15. The topics included in part: repositioning frequency for residents, reporting of new skin issues, use of pressure relieve devices, notification to physician, documentation of skin issues, wound measurements, description.
Interviews conducted from 03/28/15 until 03/31/15 with 15 CNAs and 14 nurses on various shifts revealed staff was able to verbalize the information from the recent in-services.
Record review of skin assessment revealed that the facility completed 100% skin checks for all residents.
The Interim Administrator and DON were informed on 03/31/15 at 2:10 pm that the IJ was lowered; however the facility remained out of compliance at a pattern level and a severity of actual harm that is not immediate jeopardy due to facility needing more time to monitor the plan of removal for effectiveness.
According to CMS 672 form, the facility census was 122.
Refer to F314 and F224 for additional information.

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 2 of 4 staff observed (CNA KK and CNA II) were proficient in competency skills and techniques to care for residents. (Resident #1 and #11)
-CNA KK failed to perform appropriate hand hygiene and glove changes during incontinent care and indwelling catheter on Resident # 1.
-CNA II failed to perform incontinent care properly and she touched the clean brief with dirty gloves during incontinent care for Resident #11.
This failure affected 2 residents and placed 86 that were identified as incontinent of bladder additional resident that were incontinent at increased risk of infections.
Findings include:
Resident #1
Record review of Resident #1 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].
Record review of Resident #1 ' s initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, transfers. Resident #1 had range of motion issues and was frequently continent of bladder with indwelling catheter. He required extensive assistance with personal hygiene and was totally dependent on staff for bathing.
Observation on 3/24/15 at 2:50 p.m., CNA KK entered Resident #1's to perform incontinent care. CNA KK removed Resident #1's brief. Resident's indwelling catheter was not secured. CNA KK using the same glove, pulled the drawer to look for wipes. CNA KK said There is no wipes. CNA KK then covered the resident with the bedsheet, took off her gloves and without washing her hands, left Resident #1's room to the supply room on station 1. At 3:00 p.m. CNA KK came back with a box of wipes. Without washing her hands, she put on gloves, entered Resident #1's room. CNA KK uncovered Resident #1 and provided incontinent/indwelling catheter care to Resident #1. CNA KK started cleaning the penis and the perineal area. While trying to clean the catheter, CNA KK was pulling on the catheter that was tuck under Resident #1's right thigh towards the buttocks. Resident #1 had about a 3 cm long indented mark on his skin from the indwelling catheter. Resident #1 was bleeding from the insertion site of the indwelling catheter. CNA KK then kept using the wipes to clean the bleeding. At 3:10 p.m., CNA II came in to assist CNA KK, CNA II then assisted in repositioning Resident #1 to his left side, cleaned the buttocks. Resident #1 had stage IV to sacral area with no dressing on. CNA KK used the same gloves throughout the procedure. CNA KK picked up a clean brief and placed it under the resident and taped it.
During an interview on 3/24/15 at 4:35 p.m CNA KK said she thought she did a good job. CNA KK confirmed that the indwelling catheter was not secured.
Record review of CNA KK's employee file revealed a date of hire of 3/17/15. She had received a skills competency check for handwashing and was documented as having met the requirements.
Resident #11
Record review of Resident #11 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. His [DIAGNOSES REDACTED].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675793**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/31/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHOLLOW HEIIGHTS TRANSITIONAL CARE CENTER	**1737 N LOOP W HOUSTON, TX 77008**

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 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 18) Record review of Resident #11 ' s initial MDS assessment dated [DATE] revealed that he was severely cognitively impaired and required total assistance of two person for bed mobility, transfers. Resident #11 had no range of motion issues and was frequently incontinent of bladder and bowel. Observation on 3/24/15 at 3:30 p.m., CNA II entered Resident #11's room to perform incontinent care with CNA T. CNA II gloved, and clean Resident #11's in-between buttocks, but did not clean around the buttocks. CNA II then picked up a clean brief , placed it under Resident #11. CNA II and CNA T then repositioned Resident #11 on his back. CNA II cleaned Resident #11's perineal area and the penis which had lots of creamy dry flaky substances that fell on the clean brief. CNA II then fasten the brief on Resident #11. During an interview on 3/24/15 at 4:10 p.m CNA II said I did something wrong refering to the way she cleaned the resident. Record review of CNA II's employee file revealed a date of hire of 4/20/10. She had received a skills competency check for handwashing and was documented as having met the requirements. Record review of the facility ' s policy and procedures on Catheter Care, Urinary dated October 2010, revealed, read in parts, .15. For the male: Use a washcloth with warm water and soap to cleanse around meatus. Cleanse the glans using circular [MEDICAL CONDITION] from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique . Return foreskin to normal position. 19. Discard disposable items into designated containers. Remove gloves and discard into designated container. Wash your hands thoroughly. 24. Wash and dry your hands thoroughly. Record review of facility's Hand Washing Requirements policy, revised 10/2010, revealed staff was required to wash hands before having direct contact with residents and after removing gloves. Record review of there facility Infection Control policy, revised 6/12, read in part: .II. Scope of Infection Control Program . B. Implementation of control measure. Prevention of spread of infection is accomplished by use of universal precautions . Review of the facility's CMS 672 identified 88 residents that were incontinent of bladder.
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete and accurately documented for 2 of 27 residents (Resident #3, # 4) reviewed for clinical records. -Resident #3 ' s MAR was signed off by staff prior to administering the medication. - Resident # 4's [MEDICATION NAME] pain medication not correctly documentated on medication Administration Record. This failure affected 2 resident and placed 120 residents at risk of having medical decisions based on inaccurate medical records. Findings include: Resident #3 Record review of Resident #3 ' s face sheet revealed she was [AGE] years old. She was admitted to the facility on [DATE] and Readmitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #3's Physicians orders for March 2015, stated provide an extra 120 ML of fluids TID between meals order date 04/12/13. Also, Hi Cal 120 ML PO TID after meals order date 02/20/15. Record review of the MAR for March 2015 revealed: - HI CAL 120 ML PO TID after meals given at 10:00am, 2:00pm and 7:00pm. -Provide an extra 120 ML of fluids TID between meals at 10:00am, 2:00pm and 7:00pm. Record review of Resident #3 ' s MAR on 03/24/15 at 1:00pm, revealed that for 03/24/15, HI CAL 120 ML was already signed off by staff for 2:00pm and an extra 120 ML of fluids TID between meals was signed off by staff for 2:00pm. In an interview with MA C on 03/27/15 at 9:51a.m., she confirmed that it was her signature on the MAR for 03/24/15. She explained that she did sign off on the MAR before administering because she was rushing. Record review of the facility policy for Documentation of Medication Administration read, Administration of medication must be documented immediately after (never before) it is given. Record review of Resident #4 ' s face sheet revealed an [AGE] year old female admitted on [DATE] with the [DIAGNOSES REDACTED]. Record review of Physicians Orders dated 12/13/14 revealed [MEDICATION NAME] 7.5-325 milligram (mg) tablet one Tablet via peg tube every (Q) 8 hours as needed (prn) pain and [MEDICATION NAME] 7.5-325 tablet one Tablet via Peg tube before negative pressure dressing change. Record review of Gastrostomy tube MAR for the month of March 2015 indicates that Resident # 7 [MEDICATION NAME] 7.5- 325 tablet was only documented as given on 3/2/15. Further review revealed that prn [MEDICATION NAME] 7.5- 325 tablet was only documented as given on 3/1/15 and 3/25/15. [MEDICATION NAME] given on 3/1/15 had no reassessment for pain medication. There were only 3 entries documented on Nurse ' s Medication Notes but entries were incomplete with no reassessment after medication was given. Record review Controlled Drug Record indicates that narcotic [MEDICATION NAME] for Resident #7 was signed as given on the following days 3/2/15, 3/3/15, 3/6- 3/8/15 , 3/10/15, 3/21/15, 3/23/15, 3/24/15 and 3/25/15. Interview on 3/25/15 4:35 pm with LVN D manager she said that staff was supposed to sign MAR and document on the back of record. Record review of facility policy dated (revised October 2005)for pain Clinical protocol revealed in part: Document the following in the resident ' s record: 1. Results of pain assessment 2. Medication 3. Dose 4. Route of administration and 5. Results of medication (adverse or desired).Reporting : 1. Notify the supervisor if resident refuses the procedure. @. Report other information in accordance with facility policy and professional standards of practice. The facility's CMS resident census listed a census of 122 residents.