STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455745	A. BUILDING _____ B. WING _____	09/16/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TIMBERWOOD NURSING AND REHABILITATION CENTER	4001 HWY 59 NORTH LIVINGSTON, TX 77351

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 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an accurate MDS assessment to reflect the resident status for 1 of 18 residents reviewed for assessments. (Resident #26) Resident #26's MDS was inaccurate. This failure could place the census of 105 at risk for unmet care needs. Findings included: Physician orders [REDACTED].#26, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. A history and physical dated 2/6/15 indicated Resident #26 had a history of [REDACTED]. The most recent MDS dated [DATE] indicated Resident #26 indicated the following: *had no Impairment in range of motion; and *had no falls with or without injury. During observation and interview on 9/14/15 at 10:50 a.m., Resident #26 had left [MEDICAL CONDITION] and was unable to use her left arm or leg. Resident #26 said she had fallen in the facility, fractured her left hip and went to the hospital in February. During an interview on 9/15/15 at 10:53 a.m., LVN D acknowledged the MDS assessment for Resident #26 was inaccurate. She said the resident had impairment in her range of motion due to [MEDICAL CONDITION]. During an interview on 9/15/15 at 2:40 p.m., LVN D acknowledged Resident #26 had experienced a fall with fracture in the facility and the MDS did not accurately reflect her fall. The CMS 672 dated 9/14/15 indicated a census of 105.
F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing services met professional standards of quality for 1 of 2 residents reviewed for intravenous central catheter care and services (Resident #106) Resident #106 died after his central venous catheter (CVC) (a catheter placed into a large vein in the internal jugular vein for medication administration) was removed. The facility did not ensure nursing staff were trained on proper procedures for removing a CVC. The facility did not ensure Resident #106 was positioned correctly to prevent the possibility of an air embolism when his CVC was removed. This failure may have contributed to the death of Resident #106. An Immediate Jeopardy situation existed on [DATE]. The Immediate Jeopardy was removed on [DATE] because there was no current resident with a CVC. However, the facility remained out of compliance at isolated actual harm. There were no current residents with a CVC. Findings included: Physician orders [REDACTED].#106, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. He received intravenous antibiotic therapy. He was admitted with a CVC on the right side of his neck. A physician's order [REDACTED]. The care plan dated [DATE] for Resident #106 did not address interventions for a CVC. Daily skilled nursing notes dated [DATE] through [DATE] for Resident #106 indicated an uneventful stay until he prepared to be discharged home. He was alert and oriented to person, place, and time. He was ambulatory and independent with activities of daily living. Nursing notes dated [DATE] entered by RN C (DON at the time of the incident) for Resident #106 indicated he was upset and wanted the CVC out of his neck. A physician order [REDACTED]. The notes indicated the resident ambulated to his room with no assistance. The resident requested to sit in the wheelchair and had no signs and symptoms of distress. The notes indicated at 10:10 a.m. Resident #106 was alert and oriented. RN C documented she walked the resident through the procedure verbally. The notes indicated the nurse returned the vital sign (V/S) machine to the nurse's station and retrieved a suture removal kit. The nurse removed the sutures and the resident turned his head to the left, (line inserted to right side of neck) and held his breath while she pulled out the CVC. The nurse documented she applied moderate pressure to site for 1 minute with no bleeding noted and a pressure dressing was applied. The notes indicated at 10:15 a.m. Resident #106 began to cough excessively and said this was common for his fibrosis and asked for a breathing treatment. RN C documented she left the room to retrieve the V/S machine and asked the floor nurse if it was time for a breathing treatment. The notes indicated she returned to the resident's room at 10:20 a.m. and the resident was continuously coughing and stated I feel like I am going to faint. RN C documented Resident #106 became unresponsive with faint palpable pulses. She then called for help and after additional staff came into the room to assist, she attained the resident's blood pressure to be ,[DATE]. The resident was transferred to his bed and oxygen was administered at 4 liters. The nurse indicated she started an IV (intravenous) and administered a normal saline bolus. The notes indicated Resident #106's pulse was no longer palpable and a Code was in progress. During an interview on [DATE] at 9:45 a.m., LVN A said she went into the room to help with the Code. LVN A said Resident #106 was sitting up in a wheelchair, unresponsive, moaning with slow shallow breathing. She said he quit breathing and there was no pulse so they began CPR. She said EMS arrived and transported the resident to the hospital where he was pronounced dead. During an interview on [DATE] at 10:07 a.m., RN H said she would be uncomfortable removing a CVC since she had never removed one. She said RN C said she was uncomfortable about removing the CVC. RN H said she offered to go with her to assist, but RN C went alone. RN H acknowledged all staff wear phone communication devices to contact each other and she could have called for help without leaving the room. During an interview on [DATE] at 2:20 p.m., RN G (clinical nurse consultant) said RN C was the acting DON from [DATE] to [DATE]. She acknowledged RN C did not contact her for any guidance on removing a CVC. RN G said she checked RN C off for proficiency on IV therapy, but not a CVC. She said none of the nurses had training on CVC care when Resident #106 was admitted with it or after he was discharged to the hospital.

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.

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) During an interview on [DATE] at 3:45 p.m., RN J said she had never removed a CVC. She said she would not want to unless she had an experienced person with her. She acknowledged they (other licensed staff) talked about CVC removal before RN C removed the resident's CVC and after, but no in-services or educational training were conducted. During an interview on [DATE] at 10:00 a.m., the current DON acknowledged RN C was uncomfortable removing Resident #106's CVC. She said RN C did not have experience with CVCs. The DON said RN C reported she read the policy and watched a video at home on how to remove a CVC. The DON did not know which video she watched. The DON said there were 5 RN's employed by the facility (including the herself) and none had documentation of experience with removal of a CVC. Attempts to contact RN C by telephone on [DATE] at 2:32 p.m. and [DATE] at 8:06 a.m. were unsuccessful. The undated policy and procedures for Central Venous Catheters: Removal: d. Registered Nurses who have the knowledge, education and validated skills to do so may perform this procedure. 4. b. Prepare a sterile field . k. Immediately place the bolus of gauze sponges over the exit site and apply direct, firm pressure for five minutes. The policy did not address positioning of the resident as being a critical factor in preventing complications such as an air-embolism. There was no evidence in the clinical record from [DATE] to [DATE] to indicate RN C followed the facility policy and procedure during removal of Resident #106's CVC on [DATE] by RN C. She failed to use sterile technique and did not hold pressure for 5 minutes per facility policy. There was no evidence in her personnel record to indicate RN C was experienced in removal of CVCs and did not have validated skills. An article from Nursing Times dated [DATE] indicated: 5 Keys points. 1. Inform the patient. 2. Place the patient supine (they should not be sitting or upright). 5. Cover the insertion site immediately with a sterile gauze, maintain firm manual pressure until haemostasis (bleeding) is achieved. Then cover the site with an air-occlusive dressing which should remain in place for ,[DATE] hours. Positioning during central line removal is a critical intervention to prevent air embolism. {www.nursingtimes.net} Preventing Central Line Air Embolism article from the AJN (American Journal of Nurses ajnonline.com) dated [DATE] vol.115, No. 6 page 68 indicated: Removal of central lines. * Place the patient in the Trendelenburg (patient lying flat, head tilted downward with feet higher than the head) position when possible. If it's not possible, the supine position is sufficient. Put pressure on the site until hemostasis is achieved; one to five minutes is suggested. Apply a sterile occlusive dressing, such as gauze impregnated with petroleum jelly and covered with a transparent film dressing. According to the website, http://resusreview.com/2013/removing-central-lines, accessed [DATE], a Resus Review article dated 2013 on removing CVC lines indicated: Patients need to be in a position below the level of the heart (i.e. HOB (head of bed) flat) during catheter removal to prevent air embolism. An IJ was determined to have existed from [DATE] through [DATE]. The IJ was removed on [DATE] because there was no current resident with a CVC. The facility remained out of compliance at isolated actual harm. The CMS 672 dated [DATE] indicated there was 1 resident with IV therapy; however, there were no current residents with a CVC.
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**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 or arrange for services by a qualified person in accordance with each resident's written plan of care for 1 of 2 residents reviewed for intravenous central catheter care and services (Resident #106) Resident #106 died after his central venous catheter (CVC) (a catheter placed into a large vein in the internal jugular vein for medication administration) was removed. The facility did not ensure nursing staff were trained on proper procedures for removing a CVC. The facility did not ensure Resident #106 was positioned correctly to prevent the possibility of an air embolism when his CVC was removed. This failure may have contributed to the death of Resident #106. An Immediate Jeopardy situation existed on [DATE]. The Immediate Jeopardy was removed on [DATE] because there was no current resident with a CVC. However, the facility remained out of compliance at isolated actual harm. There were no current residents with a CVC. Findings included: Physician orders [REDACTED].#106, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. He received intravenous antibiotic therapy. He was admitted with a CVC on the right side of his neck. A physician's order [REDACTED]. The care plan dated [DATE] for Resident #106 did not address interventions for a CVC. Daily skilled nursing notes dated [DATE] through [DATE] for Resident #106 indicated an uneventful stay until he prepared to be discharged home. He was alert and oriented to person, place, and time. He was ambulatory and independent with activities of daily living. Nursing notes dated [DATE] entered by RN C (DON at the time of the incident) for Resident #106 indicated he was upset and wanted the CVC out of his neck. A physician order [REDACTED]. The notes indicated the resident ambulated to his room with no assistance. The resident requested to sit in the wheelchair and had no signs and symptoms of distress. The notes indicated at 10:10 a.m. Resident #106 was alert and oriented. RN C documented she walked the resident through the procedure verbally. The notes indicated the nurse returned the vital sign (V/S) machine to the nurse's station and retrieved a suture removal kit. The nurse removed the sutures and the resident turned his head to the left, (line inserted to right side of neck) and held his breath while she pulled out the CVC. The nurse documented she applied moderate pressure to site for 1 minute with no bleeding noted and a pressure dressing was applied. The notes indicated at 10:15 a.m. Resident #106 began to cough excessively and said this was common for his fibrosis and asked for a breathing treatment. RN C documented she left the room to retrieve the V/S machine and asked the floor nurse if it was time for a breathing treatment. The notes indicated she returned to the resident's room at 10:20 a.m. and the resident was continuously coughing and stated I feel like I am going to faint. RN C documented Resident #106 became unresponsive with faint palpable pulses. She then called for help and after additional staff came into the room to assist, she attained the resident ' s blood pressure to be ,[DATE]. The resident was transferred to his bed and oxygen was administered at 4 liters. The nurse indicated she started an IV (intravenous) and administered a normal saline bolus. The notes indicated Resident #106's pulse was no longer palpable and a Code was in progress. During an interview on [DATE] at 9:45 a.m., LVN A said she went into the room to help with the Code. LVN A said Resident #106 was sitting up in a wheelchair, unresponsive, moaning with slow shallow breathing. She said he quit breathing and there was no pulse so they began CPR. She said EMS arrived and transported the resident to the hospital where he was pronounced dead. During an interview on [DATE] at 10:07 a.m., RN H said she would be uncomfortable removing a CVC since she had never removed one. She said RN C said she was uncomfortable about removing the CVC. RN H said she offered to go with her to assist, but RN C went alone. RN H acknowledged all staff wear phone communication devices to contact each other and she could have called for help without leaving the room. During an interview on [DATE] at 2:20 p.m., RN G (clinical nurse consultant) said RN C was the acting DON from [DATE] to [DATE]. She acknowledged RN C did not contact her for any guidance on removing a CVC. RN G said she checked RN C off for proficiency on IV therapy, but not a CVC. She said none of the nurses had training on CVC care when Resident #106 was admitted with it or after he was discharged to the hospital. During an interview on [DATE] at 3:45 p.m., RN J said she had never removed a CVC. She said she would not want to unless she had an experienced person with her. She acknowledged they (other licensed staff) talked about CVC removal before RN C removed the resident's CVC catheter and after, but no in-services or educational training were conducted. During an interview on [DATE] at 10:00 a.m., the current DON acknowledged RN C was uncomfortable removing Resident #106's CVC. She said RN C did not have experience with CVC. The DON said RN C reported she read the policy and watched a video at home on how to remove a CVC. The DON did not know which video she watched. The DON said there were 5 RN's employed by the facility (including the herself) and none had documentation of experience with removal of a CVC. Attempts to contact RN C by telephone on [DATE] at 2:32 p.m. and [DATE] at 8:06 a.m. were unsuccessful. The undated policy and procedures for Central Venous Catheters: Removal: d. Registered Nurses who have the knowledge, education and validated skills to do so may perform this procedure. 4. b.

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F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) Prepare a sterile field . k. Immediately place the bolus of gauze sponges over the exit site and apply direct, firm pressure for five minutes. The policy did not address positioning of the resident as being a critical factor in preventing complications such as an air-embolism. There was no evidence in the clinical record from [DATE] to [DATE] to indicate RN C followed the facility policy and procedure during removal of Resident #106's CVC on [DATE] by RN C. She failed to use sterile technique and did not hold pressure for 5 minutes per facility policy. There was no evidence in her personnel record to indicate RN C was experienced in removal of CVC and did not have validated skills. An article from Nursing Times 01.11.11 indicated: 5 Keys points. 1. Inform the patient. 2. Place the patient supine (they should not be sitting or upright). 5. Cover the insertion site immediately with a sterile gauze, maintain firm manual pressure until haemostasis (bleeding) is achieved. Then cover the site with an air-occlusive dressing which should remain in place for ,[DATE] hours. Positioning during central line removal is a critical intervention to prevent air embolism. {www.nursingtimes.net} Preventing Central Line Air Embolism article from the AJN (American Journal of Nurses ajnonline.com) dated [DATE] vol.115, No. 6 page 68 indicated: Removal of central lines. * Place the patient in the Trendelenburg (patient lying flat, head tilted downward with feet higher than the head) position when possible. If it's not possible, the supine position is sufficient. Put pressure on the site until hemostasis is achieved; one to five minutes is suggested. Apply a sterile occlusive dressing, such as gauze impregnated with petroleum jelly and covered with a transparent film dressing. According to the website, http://resusreview.com/2013/removing-central-lines, accessed [DATE], Resus Review article dated 2013 on removing CVC lines indicated: Patients need to be in a position below the level of the heart (i.e. HOB (head of bed) flat) during catheter removal to prevent air embolism. An IJ was determined to have existed from [DATE] through [DATE]. The IJ was removed on [DATE] because there was no current resident with a CVC. The facility remained out of compliance at isolated actual harm. The CMS 672 dated [DATE] indicated there was 1 resident with IV therapy; however, there were no current residents with a CVC.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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 interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 of 2 residents reviewed for intravenous catheters. (Resident #106) Resident #106 died after his central venous catheter (CVC) (a catheter placed into a large vein in the internal jugular vein for medication administration) was removed. The facility did not ensure nursing staff were trained on proper procedures for removing a CVC. The facility did not ensure Resident #106 was positioned correctly to prevent the possibility of an air embolism when his CVC was removed. This failure may have contributed to the death of Resident #106. An Immediate Jeopardy situation existed on [DATE]. The Immediate Jeopardy was removed on [DATE] because there was no current resident with a CVC. However, the facility remained out of compliance at isolated actual harm. There were no current residents with a CVC. Findings included: Physician orders [REDACTED].#106, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. He received intravenous antibiotic therapy. He was admitted with a CVC on the right side of his neck. A physician's orders [REDACTED]. The care plan dated [DATE] for Resident #106 did not address interventions for a CVC. Daily skilled nursing notes dated [DATE] through [DATE] for Resident #106 indicated an uneventful stay until he prepared to be discharged home. He was alert and oriented to person, place, and time. He was ambulatory and independent with activities of daily living. Nursing notes dated [DATE] entered by RN C (DON at the time of the incident) for Resident #106 indicated he was upset and wanted the CVC out of his neck. A physician order [REDACTED]. The notes indicated the resident ambulated to his room with no assistance. The resident requested to sit in the wheelchair and had no signs and symptoms of distress. The notes indicated at 10:10 a.m. Resident #106 was alert and oriented. RN C documented she walked the resident through the procedure verbally. The notes indicated the nurse returned the vital sign (V/S) machine to the nurse's station and retrieved a suture removal kit. The nurse removed the sutures and the resident turned his head to the left, (line inserted to right side of neck) and held his breath while she pulled out the CVC. The nurse documented she applied moderate pressure to site for 1 minute with no bleeding noted and a pressure dressing was applied. The notes indicated at 10:15 a.m. Resident #106 began to cough excessively and said this was common for his fibrosis and asked for a breathing treatment. RN C documented she left the room to retrieve the V/S machine and asked the floor nurse if it was time for a breathing treatment. The notes indicated she returned to the resident's room at 10:20 a.m. and the resident was continuously coughing and stated I feel like I am going to faint. RN C documented Resident #106 became unresponsive with faint palpable pulses. She then called for help and after additional staff came into the room to assist, she attained the resident's blood pressure to be ,[DATE]. The resident was transferred to his bed and oxygen was administered at 4 liters. The nurse indicated she started an IV (intravenous) and administered a normal saline bolus. The notes indicated Resident #106's pulse was no longer palpable and a Code was in progress. During an interview on [DATE] at 9:45 a.m., LVN A said she went into the room to help with the Code. LVN A said Resident #106 was sitting up in a wheelchair, unresponsive, moaning with slow shallow breathing. She said he quit breathing and there was no pulse so they began CPR. She said EMS arrived and transported the resident to the hospital where he was pronounced dead. During an interview on [DATE] at 10:07 a.m., RN H said she would be uncomfortable removing a CVC since she had never removed one. She said RN C said she was uncomfortable about removing the CVC. RN H said she offered to go with her to assist, but RN C went alone. RN H acknowledged all staff wear phone communication devices to contact each other and she could have called for help without leaving the room. During an interview on [DATE] at 2:20 p.m., RN G (clinical nurse consultant) said RN C was the acting DON from [DATE] to [DATE]. She acknowledged RN C did not contact her for any guidance on removing a CVC. RN G said she checked RN C off for proficiency on IV therapy, but not a CVC. She said none of the nurses had training on CVC care when Resident #106 was admitted with it or after he was discharged to the hospital. During an interview on [DATE] at 3:45 p.m., RN J said she had never removed a CVC. She said she would not want to unless she had an experienced person with her. She acknowledged they (other licensed staff) talked about CVC removal before RN C removed the resident's CVC and after, but no in-services or educational training were conducted. During an interview on [DATE] at 10:00 a.m., the current DON acknowledged RN C was uncomfortable removing Resident #106's CVC. She said RN C did not have experience with CVC. The DON said RN C reported she read the policy and watched a video at home on how to remove a CVC. The DON did not know which video she watched. The DON said there were 5 RN's employed by the facility (including the herself) and none had documentation of experience with removal of a CVC. Attempts to contact RN C by telephone on [DATE] at 2:32 p.m. and [DATE] at 8:06 a.m. were unsuccessful. The undated policy and procedures for Central Venous Catheters: Removal: d. Registered Nurses who have the knowledge, education and validated skills to do so may perform this procedure. 4. b. Prepare a sterile field . k. Immediately place the bolus of gauze sponges over the exit site and apply direct, firm pressure for five minutes. The policy did not address positioning of the resident as being a critical factor in preventing complications such as an air-embolism. There was no evidence in the clinical record from [DATE] to [DATE] to indicate RN C followed the facility policy and procedure during removal of Resident #106's CVC line on [DATE] by RN C. She failed to use sterile technique and did not hold pressure for 5 minutes per facility policy. There was no evidence in her personnel record to indicate RN C was experienced in removal of CVC lines and did not have validated skills. An article from Nursing Times dated [DATE] indicated: 5 Keys points. 1. Inform the patient. 2. Place the patient supine (they should not be sitting or upright). 5. Cover the insertion site immediately with a sterile gauze, maintain firm manual pressure until haemostasis (bleeding) is achieved. Then cover the site with an air-occlusive dressing which should remain

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) in place for ,[DATE] hours. Positioning during central line removal is a critical intervention to prevent air embolism. {www.nursingtimes.net} Preventing Central Line Air Embolism article from the AJN (American Journal of Nurses ajnonline.com) dated [DATE] vol.115, No. 6 page 68 indicated: Removal of central lines. * Place the patient in the Trendelenburg (patient lying flat, head tilted downward with feet higher than the head) position when possible. If it's not possible, the supine position is sufficient. Put pressure on the site until hemostasis is achieved; one to five minutes is suggested. Apply a sterile occlusive dressing, such as gauze impregnated with petroleum jelly and covered with a transparent film dressing. According to the website, http://resusreview.com/2013/removing-central-lines, accessed [DATE], a Resus Review article dated 2013 on removing CVC lines indicated: Patients need to be in a position below the level of the heart (i.e. HOB (head of bed) flat) during catheter removal to prevent air embolism. Accessed from internet [DATE]. {http://resusreview.com/2013/removing-central-lines} An IJ was determined to have existed from [DATE] through [DATE]. The IJ was removed on [DATE] because there was no current resident with a CVC. The facility remained out of compliance at isolated actual harm. The CMS 672 dated [DATE] indicated there was 1 resident with IV therapy; however, there were no current residents with a CVC.
F 0318 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that residents with reduced range of motion get propertreatment and services to increase range of motion.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident with a limited range of motion received treatment and services to prevent further decrease in range of motion for 1 of 18 residents reviewed for range of motion. (Resident #26) Resident #26 had limited range of motion to her left upper and lower extremities. The facility did not address the need for contracture prevention measures for the left hand. This failure affected 1 resident and could place the additional 34 residents with contractures at risk for a decline in range of motion, discomfort and decreased level of functioning. Findings included: Physician orders [REDACTED].#26, admitted on [DATE], was [AGE] years old, with [DIAGNOSES REDACTED]. The admission MDS assessment dated [DATE] indicated Resident #26 was alert and oriented with mild cognitive deficits. She had limited range of motion of both extremities on 1 side. She required extensive assistance of 1 staff member for transfers, dressing using the wheelchair and bathing. The care plan updated 3/28/15 did not address Resident #26's limited range of motion or the need for contracture prevention. An occupational therapy progress note dated 3/5/15 indicated Resident #26 had flaccid (relaxed, flabby, having deective or absent muscle tone) paralysis of the left arm. During observations on the following dates/times, Resident #26's fingers on the left had were contracted and she did not have any device in place to prevent the worsening of contractures: *on 9/14/15 at 10:50 a.m., and 12:30 p.m.; and *on 9/15/15 at 8:10 a.m. During an interview on 9/15/15 at 8:10 a.m., Resident #26 said her daughter brought her a foam heart to keep in her left hand to help prevent the fingers from curling. She said the foam heart kept falling out so sometimes she would put her salt shaker inside her hand. Resident #26 said the facility had never provided anything for her to put inside her hand to help prevent the contracture. During an interview on 9/16/15 at 2:15 p.m., COTA B said she did an evaluation on Resident #26 in June, 2105 and at that time her left hand was flaccid and had no contractures. She said she did not make any recommendations for contracture prevention due to the resident's hand being flaccid. During an interview on 9/16/15 at 2:23 p.m., LVN A said she was Resident #26's charge nurse. She said she was not aware of any device in use to help prevent contractures of the resident's hand. A facility policy dated 5/07 titled Contracture Documentation indicated the following: It is the policy of this facility that: .2. A resident with a limited range of motion or contracture shall receive appropriate treatment and services, based on the comprehensive assessment of the resident, to increase range of motion and/or prevent further decrease. The CMS 672 dated 9/14/15 indicated 35 residents with contractures.
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services to ensure the amount of insulin given was documented on the MAR for 1 of 5 residents reviewed for insulin injections. (Resident #20) There was no documentation to indicate the amount of insulin given according to the sliding scale for Resident #20. This failure could place the 9 residents receiving insulin injections at risk of not receiving the intended therapeutic benefit of their medications. Findings included: Physician orders [REDACTED].#26 was to receive NovoLOG insulin (quick acting insulin) per sliding scale (amount of insulin given dependent on the resident's blood sugar) before meals and at HS. The MAR dated September 2015 indicated Resident #20 received NovoLOG insulin 38 times before meals and 12 times at HS from 9/1/15 through 9/14/15. There was no documentation on the MARs or in the nurse's notes to indicate the amount of NovoLOG insulin given. During an interview on 9/15/15 at 9:42 a.m., the DON acknowledged there was no documentation in Resident #20's clinical record to indicate the amount of sliding scale NovoLOG administered. She said the amount given should be documented. During an interview on 9/15/15 at 10:38 a.m., LVN E, charge nurse for Resident #20, said she did not document the amount of insulin given per sliding scale to Resident #20. During an interview on 9/16/15 at 4:10 p.m., the pharmacist for the facility said the amount of insulin given should be documented on the MAR. An undated medication administration policy (page 57) indicated: . When PRN medications are administered, the following documentation is provided: 1) Date and time of administration, dose, route of administration (if other that oral), and, if applicable, the injection site. A list provided by the facility indicated 9 residents had physician orders [REDACTED].
F 0465 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interview and record review, the facility failed to maintain a functional and safe environment for residents, staff and the public. The water temperature on 2 of 6 halls were above the 115 degrees F range. (Halls 300 and 600) This failure could place the 38 residents residing on Halls 300 and 600 at risk of exposure to uncomfortable or unsafe water temperatures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455745	A. BUILDING _____ B. WING _____	09/16/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TIMBERWOOD NURSING AND REHABILITATION CENTER	4001 HWY 59 NORTH LIVINGSTON, TX 77351

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 0465 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) Findings included: During observations on 9/14/15 the following water temperatures were noted in resident hand sinks: Hall 600: *at 10:55 a.m., Room 630 was 119.6 degrees F. Hall 300: *at 2:03 p.m., Room 351 was 118.2 degrees F; and *at 2:12 p.m., Room 355 was 119.4 degrees F. During observations on 9/15/15 the following water temperatures were noted in resident hand sinks: Hall 300: *at 10:03 a.m., Room 351 was 118 degrees F; *at 3:00 p.m., Room 351 was 118.6 degrees F; and *at 3:10 p.m., Room 355 was 118 degrees F. Hall 600: *at 3:30 p.m., Room 630 was 114 degrees F; and *at 3:40 p.m., Room 620 was 119.8 degress F. During an interview on 9/15/15 at 3:50 p.m., the maintenance supervisor acknowledged the water temperature in Room #351 was 119.9 degrees F. During an interview on 9/15/15 at 4:00 p.m., the maintenance supervisor acknowledged the water temperature in Room #630 was 116 degrees F. During an interview on 9/15/15 at 4:15 p.m., the maintenance supervisor acknowledged the water temperature in Room #620 was 118 degrees F. During an interview on 9/16/15 at 10:00 a.m., the administrator said they follow the state and federal requirements for their policy on the water temperatures. The facility resident roster dated 9/14/15 indicated 38 residents resided on Halls 300 and 600.
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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 enabled it to use its resources effectively and efficiently to maintain the residents' highest physical well-being for 1 of 2 residents reviewed for care and services for IV Intravenous catheters (a catheter inserted for medication administration or hydration). (Resident #106) The administrator, RN C (DON at the time of the incident) and the current DON (who was the ADON at the time of the incident) failed to ensure licensed nurses were: *trained to remove CVCs; *given a competency check prior to removing a CVC; *knowledgeable in the care and services during an emergency situation; and The administrator and DON did not ensure the central venous catheter policy and procedures contained detailed instructions for removal of a CVC (central venous catheter) Resident #106 died after his central venous catheter (CVC) (a catheter placed into a large vein in the internal jugular vein for medication administration) was removed. The facility did not ensure nursing staff were trained on proper procedures for removing a CVC line. The facility did not ensure Resident #106 was positioned correctly to prevent the possibility of an air embolism when his CVC line was removed. This failure may have contributed to the death of Resident #106. An Immediate Jeopardy was determined to have existed from [DATE] through [DATE]. The Immediate Jeopardy was removed on [DATE] because there was no current resident with a CVC line. However, the facility remained out of compliance at isolated actual harm. This failure could place future residents with CVCs at risk for complications. There were not any current residents with a CVC. Findings included: During an interview on [DATE] at 10:00 a.m., the current DON acknowledged RN C was uncomfortable removing Resident #106's CVC. The DON said RN C reported she watched a video from home (not sure which video) on how to remove a CVC and read the policy. She said there were 5 RNs employed by the facility (including herself) and none had documentation of experience with removal of a CVC. She said the facility did not conduct any in-services or educational training on removal of CVC, even after Resident #106's death. During an interview on [DATE] at 10:18 a.m., the administrator said he was aware of the incident with Resident #106. He acknowledged there had been no inservices or educational training on central lines or the removal of a central line when Resident #106 was admitted with it. He said the policy and procedure for central venous catheters was incomplete. Physician orders [REDACTED].#106, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. He received Medicare skilled services for intravenous antibiotic therapy. He was admitted with a CVC inserted in the right side of his neck. Nursing notes dated [DATE] indicated the physician gave an order to remove the CVC prior to discharging Resident #106 home. According to the notes, RN C removed the CVC, not adhering to the standard of practice for removal of a CVC resulting in an emergency situation and death of the resident. RN C did not use sterile procedures, position the resident lying down, or hold pressure for 5 minutes. She left the resident sitting up in the wheelchair while removing the CVC. She left Resident #106 without medical assistance after he started coughing while she went to get a blood pressure machine and a breathing treatment. When she went back into the room, RN C called for help when Resident #106 felt faint and became unresponsive. He had to be moved to the bed to begin CPR (cardio-pulmonary resuscitation). There was no documentation in Resident #106's clinical record on [DATE] that RN C followed professional standards and/or policy when she removed the CVC. There was no documentation in RN C's personnel file to verify she had validated skills training for a CVC including removal of the catheter and emergency procedures. During an interview on [DATE] at 2:20 p.m., RN G (clinical nurse consultant) said RN C was the acting DON from [DATE] to [DATE]. She acknowledged RN C did not contact her for any guidance on removing a CVC. RN G said she checked RN C off for proficiency on IV therapy, which did not include CVC. She said the nurses were not educated on CVC when Resident #106 was admitted with it. During an interview on [DATE] at 3:45 p.m., RN J said she had never removed a CVC. She said she would not want to unless she had an experienced person with her. She acknowledged the staff talked about CVC removal, but no educational in-services were conducted. The undated policy and procedure for CVC removal indicated: Registered nurses who have the knowledge, education and validated skills to do so may perform this procedure.This procedure is performed using sterile technique .Immedicately place the bolus of gauze sponges over the exit site and apply direct, firm pressure for five (5) minutes. The policy did not address positioning of a resident or any emergency procedures. An article from Nursing Times dated [DATE] indicated: 5 Keys points. 1. Inform the patient. 2. Place the patient supine (they should not be sitting or upright). 5. Cover the insertion site immediately with a sterile gauze, maintain firm manual pressure until haemostasis (bleeding) is achieved. Then cover the site with an air-occlusive dressing which should remain in place for ,[DATE] hours. Positioning during central line removal is a critical intervention to prevent air embolism. {www.nursingtimes.net} An IJ was determined to have existed on [DATE]. The IJ was removed on [DATE] because there was no current resident with a CVC. The facility remained out of compliance at isolated actual harm. The CMS 672 dated [DATE] indicated there was 1 resident with IV therapy; however, there were no current residents with a CVC.

F 0494 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure that all full-time nurse aids employed for more than 4 months are fully trained**

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	455745	A. BUILDING _____ B. WING _____	**09/16/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TIMBERWOOD NURSING AND REHABILITATION CENTER	**4001 HWY 59 NORTH LIVINGSTON, TX 77351**

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

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F 0494 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) **and competent to provide nursing and nursing-related services, as defined by Federal requirements.** Based on interview and record review, the facility failed to ensure 1 of 8 nurse aides, for which employee records were reviewed, was not working at the facility longer than 4 months full time and was certified according to the requirements. NA F was hired on 3/19/15 and was still working in this capacity at the time of survey exit (9/16/15). This failure could place all 105 residents at risk of receiving care from an individual whose skill level is not known. Findings included: The personnel file for NA F indicated she was hired 3/19/15. There was no documentation of NA F receiving the required certification within the required 4 month time frame for full time employment. During an interview on 9/16/15 at 9:50 a.m., the HR director and unit manager, LVN K said NA F was not a certified nurse aide but had worked full time as a nurse aide on the 10 p.m. to 6 a.m. shift since hire on 3/19/15 to the present. They said she had completed her training but had not tested for her certification. During an interview on 9/16/15 at 10:27 a.m., the DON acknowledged NA F was not certified and worked full time as a nurse aide on the night shift. A New Hire Form dated 3/19/15 and signed by the DON indicated NA F was hired full time as a nurse aide. The Texas Department of Aging and Disability Services Nurse Aide Registry, verified by the facility on 3/13/15 indicated no records found for NA F. The CMS 672 dated 9/14/15 indicated a census of 105.