STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675958	A. BUILDING _____ B. WING _____	06/10/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRISTIAN CARE CENTER	1008 CITIZENS TRAIL TEXARKANA, TX 75501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to consult with the physician for 1 of 2 residents with [MEDICAL CONDITIONS] who was on contact isolation precautions for 2 ½ months (Resident #5). The facility did not consult with Resident #5's physician when she was asymptomatic for [MEDICAL CONDITION] from March 24, 2015 until surveyor intervention on 6/8/2015. There was no documentation that resident #5 had any signs and symptoms of [MEDICAL CONDITION] infection such as diarrhea, fever, nausea or foul smelling stool requiring medication and confinement to her room to prevent the spread of infection for 2 ½ months. Findings Included: A Consolidated physician's orders [REDACTED].#5 was [AGE] years old. Her [DIAGNOSES REDACTED]. She was readmitted to the facility 1/20/15. A lab result dated 3/3/2015 indicated Resident #5 tested negative for [MEDICAL CONDITION]. A Physician order [REDACTED]. On 3/28/15 a lab result indicated Resident # 5 was positive for [MEDICAL CONDITION]. A Physicians Order dated 3/30/15 indicated Resident #5 was placed on Contact Isolation precautions and confined to her room. An MDS dated [DATE] indicated Resident #5 could make herself understood and understood others. She was independent per wheelchair mobility and required minimal assist of one staff. She was incontinent of bowel and bladder. The resident received an antidepressant A care plan dated 1/24/15 indicated Resident #5 was on antibiotic and Contact Isolation for [MEDICAL CONDITION]. Approaches were to medicate as ordered, reculture after medication regimen is completed. Notify MD if recurrent problem or if further treatment is needed. A care plan dated 4/11/15 indicated Resident #5 had a history of [REDACTED]. and was on medication for both conditions. During an interview on 6/8/15 at 2:30 p.m. the nurse practitioner said she did not know Resident #5 had been on Contact Isolation for the past 2 ½ months. During a telephone interview on 6/8/15 at 4:20 p.m., the physician said he did not know Resident #5 had been on contact isolation so long. He said, Being in isolation that long would depress anyone. He said he would call the DON and find out more information immediately. During an interview on 6/10/15 at 8:40 a.m. the physician said if a person does not have diarrhea, or is asymptomatic, they do not have [MEDICAL CONDITION] and do not need to be isolated. He said he was not informed Resident #5 was asymptomatic until the evening of 6/9/15. His treatment was based on Resident #5 having diarrhea and a watery stool. He said he will consult with the [MEDICATION NAME] before and after Resident #5's visit today, but he thinks the [MEDICAL CONDITION] bacteria may be colonized and giving a false/positive lab result. During an observation on 6/8/15 at 9:10 a.m. Resident #5 was well groomed and friendly and sitting at the threshold of her door looking up and down the hall. A sign on her door instructed to, See nurse before entering, and an isolation cabinet containing gloves, gowns and masks was in the hall beside her door. Resident #5 became tearful and said she wanted to come out of her room because she had been in isolation for a long time. During an interview on 6/8/15 at 9:14 a.m. LVN A said Resident #5 had been on Contact Isolation and confined to her room for about 6 months. LVN A said Resident #5 had [MEDICAL CONDITION] and had been on a lot of antibiotics, and tested at least four times. LVN A said the DON decided whether or not Resident #5 needed to remain on contact isolation. LVN A said she did not think Resident #5 needed contact isolation; but she just does what she is told. During an interview on 6/8/15 at 12:25 p.m. CNA C said she was very close to Resident #5 and visited with her often. CNA C said Resident #5 cried and asked to come out of her room about once a day. She said Resident #5 was very depressed. During an interview on 6/8/15 at 1:40 p.m. LVN B performed a skin assessment on Resident #5. Resident #5 had no wound or excoriation to her buttocks or perineum. LVN B said the resident had excoriation in the past, but has not had a runny stool in several months. LVN B said Resident #5 was depressed and needed to come out of her room because she has been confined to her room too long. LVN B said Resident # 5 was receiving [MEDICATION NAME] 125 mg (milligrams) by mouth every other day. LVN B said this is the second time Resident #5 had received [MEDICATION NAME] to treat [MEDICAL CONDITION]. During an interview on 6/8/15 at 1:54 p.m. the DON said the nurses and CNAs told her Resident #5 still had a watery, runny stool. The DON said she made the decision whether or not to keep a resident on contact isolation. She said that the last lab results indicated Resident #5 was positive for the [MEDICAL CONDITION] infection and as long as she was positive she would stay in isolation no matter how long it had been. She said Resident #5 did not wash her hands and had been known to get feces all over her room and that was part of the reason Resident #5 needed to be in her room. The DON said Resident #5 had poor hygiene prior to acquiring [MEDICAL CONDITION] in January. During an interview on 6/9/15 at 7:56 a.m. Resident #5 cried as she asked LVN A if she could come out of her room. LVN A told resident #5 she could not come out of her room and the results of the lab test would determine if she could come out. During an interview on 6/9/15 at 8:37 a.m. following surveyor intervention, the DON said she spoke with the physician and he ordered lab and a consult with a [MEDICATION NAME]. The DON said she did not know a [MEDICATION NAME] consult was recommended 4/23/15. She did not know why it was not done. The DON said Resident #5 soiled her hands with feces and touched things, and this required her to be in isolation. During an interview on 6/9/15 at 8:40 a.m. the administrator said she was not aware if Resident #5 continued to have loose, watery stool, but her behaviors with her feces was a factor in her remaining on Contact Isolation. The administrator said she agreed confining Resident #5 to her room was necessary. During a telephone interview on 6/9/15 at 10:15 a.m. a nurse with The Centers for Disease Control, said their guidelines for [MEDICAL CONDITION] included, when a resident is asymptomatic; meaning no diarrhea for 24 hours or more; diarrhea being defined as 3 or more watery stools in a 24 hour period; after 24-48 hours of no symptoms, the resident did not need to be on contact isolation, even if they tested positive for [MEDICAL CONDITION]. During a telephone interview on 6/9/15 at 11:00 a.m. CNA C said Resident #5 had not had a watery stool in at least 2-3 weeks. CNA C said on 6/3/15 the stool was soft and had no odor. On 6/4/15 the stool was formed and had no odor, and the resident's stool had been formed ever since. She said she told the nurses Resident #5 did not have a loose stool. During an interview on 6/9/15 at 11:15 a.m., LVN C said she told Resident #5 she could come out of her room because the doctor had removed the contact isolation precautions. LVN C said the physician called 4 times concerning Resident #5. Following surveyor intervention, the physician gave an order to discontinue the contact isolation due to Resident #5 being

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 0157 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 1) asymptomatic. LVN C said Resident #5 cried when she told her she could leave her room. During an interview on 6/9/2015 at 12:13 p.m. CNA D said she did not know how long Resident #5 had been on Contact Isolation, but it had been too long. CNA D said the nurses were aware Resident #5 did not have diarrhea. During an interview on 6/9/15 at 2:10 p.m. CNA E said Resident #5 cried three or four times a week about wanting to come out of her room. Resident #5 told her, I will do better. CNA E said Resident #5 got feces on her hands when she cleaned herself. She would then get it on the wall and furniture without knowing. CNA E said Resident #5 was very social. She loved to visit and help the other residents. CNA E said Resident #5 based her entire day around activities. During an interview on 6/9/15 at 3:35 p.m. the Activity director said Resident #5 was one of the most active residents in the facility. In May, Resident #5 planned to attend an outing to the casino and was not allowed to attend due to the Contact Isolation Precautions. The AD said Resident #5 became very depressed and cried because she could not attend the outing, as that was her favorite activity. During an interview on 6/9/15 at 3:50 p.m. LVN B said Resident #5 had a formed stool without a foul odor for at least two weeks. LVN B said before that, the stool was soft, not loose, and the resident had not had diarrhea for at least a month. During an interview on 6/9/15 at 4:00 p.m. the DON said she had not reviewed the ADL log or the nurses' notes regarding Resident #5. The DON said she was not aware of what the consistency of Resident #5's stool had been. The ADL log dated from January 1, 2015 through June 8, 2015 indicated Resident #5 had not had a loose stool or diarrhea since March 24, 2015. A Care Plan Conference summary dated 4/23/15 indicated the PA recommended a GI consult due to the resident had [MEDICAL CONDITION], was on contact isolation and had a weight loss. The undated policy entitled, [MEDICAL CONDITION] (C. Diff) indicates Residents with diarrhea known or suspected to be infected with [MEDICAL CONDITION] should be placed on Contact isolation. Asymptomatic colonization may occur more commonly that the clinical disease. Stool samples for persons may test positive for the organism. Antibiotic therapy is not recommended, once primary colonization is established: the risk for CDAD is decreased once colonization occurs. Symptoms include: watery diarrhea, fever, loss of appetite, nausea, and abdominal tenderness/pain. The undated policy, Isolation Initiation and Discontinuation states, To provide guidance to licensed nurses regarding the initiation and discontinuation of isolation precautions that follow CDC recommendations. The undated policy, In-House Developed Infections Process: 1) Residents should be observed for signs and symptoms of infection. 2) Signs and symptoms of infection should be reported to the attending physician and noted in the medical record. During an interview on 6/8/15 at 1:54 p.m. the DON said there were 2 residents with [MEDICAL CONDITION].
F 0285 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Coordinate assessments with the pre-admission screening and resident review program for mentally-ill and mentally-retarded patients.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to coordinate services to ensure individuals with IID (individuals with intellectual disabilities) received care and services in the most appropriate setting for 1 of 2 residents reviewed for Pre-Admission Screening and Resident Review (PASRR). (Resident #7) Resident #7 was not provided options of additional services available for residents with IID after his Pre-Admission Screening and Resident Review (PASRR) This failure could place 2 residents with IID at risk for depression, decreased self-esteem, and decreased quality of life. Findings included: Physician orders [REDACTED].#7 was [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. An MDS assessment dated [DATE] indicated Resident #7 had clear comprehension, and made himself understood, he was independent with his ADLs but required supervision with dressing and was continent of bowel and bladder. A care plan updated 6/4/15 indicated Resident #7 had a history of [REDACTED]. Another entry was socially inappropriate behavior which included screaming out at staff about other residents (if they make noises or in his way), refused housekeeping, hoarded items, and refused to shave at times. Psychological counseling progress notes for Resident #7 included the following: * 6/1/15- He complained of feeling confined and needed to get out. He liked to shop and would like female companionship and asked the therapist if diabetics could marry. Therapist said he appeared depressed. * 5/25/15- He said he wanted staff and residents to be more sociable. Resident #7 appeared confined and depressed. * 5/4/15- He said he controls his temper and was aware he stayed in his room alot. Resident #7 was young to be in a nursing home. The resident appeared to be fairly content in the nursing home but felt confined and crowded. During an observation and interview on 6/8/15 at 9:30 a.m. CNA C said Resident #7 was independent and interviewable, had some mental illness and if he did not want to talk he would ignore you. Resident #7 was lying in his bed in the dark. He was friendly and said he wanted to go on outings but did not have enough money to go out to eat when the residents went on activities outside of the building. Resident #7 said he did not like soup for supper. During an observation on 6/8/15 at 12:20 p.m., Resident #7 was sitting at an assisted dining room with 10 residents and ate 100% of his hamburger and French fries. A PASRR dated 10/16/13 indicated Resident #7 was independent with his ADLs, would like to live where there was 24 hour care in a group home. His barrier to return to the community was listed as care needs were greater than support available in community and limited family support. No referrals were listed, for any additional programs. During an interview on 6/9/15 at 8:40 a.m., the SW said Resident #7 was young, received psychological counseling services, slept alot, and was awake at night. She said he did not have a guardian and his mother was in poor health. She said she had not made any referral nor attempted to send him to any services outside the facility. During an interview on 6/9/15 at 8:45 a.m., the QIDP (Qualified Intellectual Disability Professional) said he did not remember Resident #7, but stated he primarily evaluated residents with mental illness. He said the PASRR assessment was changing and now another individual provided services for residents with IID. The QIDP said Resident #7 had a case manager. During an interview on 6/10/15 at 10:10 a.m., Resident #7's Case Manager said she visited him monthly, but if he was asleep or walking around she might not even talk with him. She said after the initial PASRR evaluation, they were not reevaluated. She said she had not asked him if he was interested in additional services, such as a Day Program, stating services were limited and would have to get approval before offering him any other services. During an interview on 6/9/15 at 3:00 p.m., Resident #7 said he liked to go shopping and buy music. He said he wanted to go out to eat with the group from the facility monthly but had not had any money. He said he would be interested in a group activity, where he might visit with people his age, (Day program) but he needed to talk to his mom first. During an interview on 6/8/15 at 10:30 a.m., the Administrator said there were 2 residents who had IID and met the criteria for a Level 2 PASRR evaluation.
F 0309 **Level of harm** - Actual harm **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 of 2 residents reviewed with [MEDICAL CONDITIONS] infection requiring contact isolation. (Resident #5) The facility did not assess Resident #5 for an improvement in her condition and did not alter their plan of care. Resident #5 had one loose stool documented since 3/24/15. There was no documentation of diarrhea, fever, nausea or foul smelling stool, but Resident #5 was kept isolated in her room for 2 1/2 months until surveyor intervention on 6/8/2015. This failure caused Resident #5 emotional distress and a diminished quality of life and placed 1 other resident with [MEDICAL CONDITION] at risk of psychosocial stress. Findings Included: A Consolidated physician's orders [REDACTED].#5 was [AGE] years old. Her [DIAGNOSES REDACTED]. She was readmitted to the facility 1/20/15.

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 2) A lab result dated 3/3/2015 indicated Resident #5 tested negative for [MEDICAL CONDITION]. A Physician order [REDACTED]. On 3/28/15 a lab result indicated Resident # 5 was positive for [MEDICAL CONDITION]. A Physicians Order dated 3/30/15 indicated Resident #5 was placed on Contact Isolation precautions and confined to her room. An MDS dated [DATE] indicated Resident #5 could make herself understood and understood others. She was independent per wheelchair mobility and required minimal assist of one staff. She was incontinent of bowel and bladder. The resident received an antidepressant A care plan dated 1/24/15 indicated Resident #5 was on antibiotic and Contact Isolation for [MEDICAL CONDITION]. Approaches were to medicate as ordered, reculture after medication regimen is completed. Notify MD if recurrent problem or if further treatment is needed. A care plan dated 4/11/15 indicated Resident #5 had a history of [REDACTED]. and was on medication for both conditions. During an interview on 6/8/15 at 2:30 p.m. the nurse practitioner said she did not know Resident #5 had been on Contact Isolation for the past 2 ½ months. During a telephone interview on 6/8/15 at 4:20 p.m., the physician said he did not know Resident #5 had been on contact isolation so long. He said, Being in isolation that long would depress anyone. He said he would call the DON and find out more information immediately. During an interview on 6/10/15 at 8:40 a.m. the physician said if a person does not have diarrhea, or is asymptomatic, they do not have [MEDICAL CONDITION] and do not need to be isolated. He said he was not informed Resident #5 was asymptomatic until the evening of 6/9/15. His treatment was based on Resident #5 having diarrhea and a watery stool. He said he will consult with the [MEDICATION NAME] before and after Resident #5's visit today, but he thinks the [MEDICAL CONDITION] bacteria may be colonized and giving a false/positive lab result. During an observation on 6/8/15 at 9:10 a.m. Resident #5 was well groomed and friendly and sitting at the threshold of her door looking up and down the hall. A sign on her door instructed to, See nurse before entering, and an isolation cabinet containing gloves, gowns and masks was in the hall beside her door. Resident #5 became tearful and said she wanted to come out of her room because she had been in isolation for a long time. During an interview on 6/8/15 at 9:14 a.m. LVN A said Resident #5 had been on Contact Isolation and confined to her room for about 6 months. LVN A said Resident #5 had [MEDICAL CONDITION] and had been on a lot of antibiotics, and tested at least four times. LVN A said the DON decided whether or not Resident #5 needed to remain on contact isolation. LVN A said she did not think Resident #5 needed contact isolation; but she just does what she is told. During an interview on 6/8/15 at 12:25 p.m. CNA C said she was very close to Resident #5 and visited with her often. CNA C said Resident #5 cried and asked to come out of her room about once a day. She said Resident #5 was very depressed. During an interview on 6/8/15 at 1:40 p.m. LVN B performed a skin assessment on Resident #5. Resident #5 had no wound or excoriation to her buttocks or perineum. LVN B said the resident had excoriation in the past, but has not had a runny stool in several months. LVN B said Resident #5 was depressed and needed to come out of her room because she has been confined to her room too long. LVN B said Resident # 5 was receiving [MEDICATION NAME] 125 mg (milligrams) by mouth every other day. LVN B said this is the second time Resident #5 had received [MEDICATION NAME] to treat [MEDICAL CONDITION]. During an interview on 6/8/15 at 1:54 p.m. the DON said the nurses and CNAs told her Resident #5 still had a watery, runny stool. The DON said she made the decision whether or not to keep a resident on contact isolation. She said that the last lab results indicated Resident #5 was positive for the [MEDICAL CONDITION] infection and as long as she was positive she would stay in isolation no matter how long it had been. She said Resident #5 did not wash her hands and had been known to get feces all over her room and that was part of the reason Resident #5 needed to be in her room. The DON said Resident #5 had poor hygiene prior to acquiring [MEDICAL CONDITION] in January. During an interview on 6/9/15 at 7:56 a.m. Resident #5 cried as she asked LVN A if she could come out of her room. LVN A told resident #5 she could not come out of her room and the results of the lab test would determine if she could come out. During an interview on 6/9/15 at 8:37 a.m. following surveyor intervention, the DON said she spoke with the physician and he ordered lab and a consult with a [MEDICATION NAME]. The DON said she did not know a [MEDICATION NAME] consult was recommended 4/23/15. She did not know why it was not done. The DON said Resident #5 soiled her hands with feces and touched things, and this required her to be in isolation. During an interview on 6/9/15 at 8:40 a.m. the administrator said she was not aware if Resident #5 continued to have loose, watery stool, but her behaviors with her feces was a factor in her remaining on Contact Isolation. The administrator said she agreed confining Resident #5 to her room was necessary. During a telephone interview on 6/9/15 at 10:15 a.m. a nurse with The Centers for Disease Control, said their guidelines for [MEDICAL CONDITION] included, when a resident is asymptomatic; meaning no diarrhea for 24 hours or more; diarrhea being defined as 3 or more watery stools in a 24 hour period; after 24-48 hours of no symptoms, the resident did not need to be on contact isolation, even if they tested positive for [MEDICAL CONDITION]. During a telephone interview on 6/9/15 at 11:00 a.m. CNA C said Resident #5 had not had a watery stool in at least 2-3 weeks. CNA C said on 6/3/15 the stool was soft and had no odor. On 6/4/15 the stool was formed and had no odor, and the resident's stool had been formed ever since. She said she told the nurses Resident #5 did not have a loose stool. During an interview on 6/9/15 at 11:15 a.m., LVN C said she told Resident #5 she could come out of her room because the doctor had removed the contact isolation precautions. LVN C said the physician called 4 times concerning Resident #5. Following surveyor intervention, the physician gave an order to discontinue the contact isolation due to Resident #5 being asymptomatic. LVN C said Resident #5 cried when she told her she could leave her room. During an interview on 6/9/2015 at 12:13 p.m. CNA D said she did not know how long Resident #5 had been on Contact Isolation, but it had been too long. CNA D said the nurses were aware Resident #5 did not have diarrhea. During an interview on 6/9/15 at 2:10 p.m. CNA E said Resident #5 cried three or four times a week about wanting to come out of her room. Resident #5 told her, I will do better. CNA E said Resident #5 got feces on her hands when she cleaned herself. She would then get it on the wall and furniture without knowing. CNA E said Resident #5 was very social. She loved to visit and help the other residents. CNA E said Resident #5 based her entire day around activities. During an interview on 6/9/15 at 3:35 p.m. the Activity director said Resident #5 was one of the most active residents in the facility. In May, Resident #5 planned to attend an outing to the casino and was not allowed to attend due to the Contact Isolation Precautions. The AD said Resident #5 became very depressed and cried because she could not attend the outing, as that was her favorite activity. During an interview on 6/9/15 at 3:50 p.m. LVN B said Resident #5 had a formed stool without a foul odor for at least two weeks. LVN B said before that, the stool was soft, not loose, and the resident had not had diarrhea for at least a month. During an interview on 6/9/15 at 4:00 p.m. the DON said she had not reviewed the ADL log or the nurses' notes regarding Resident #5. The DON said she was not aware of what the consistency of Resident #5's stool had been. The ADL log dated from January 1, 2015 through June 8, 2015 indicated Resident #5 had not had a loose stool or diarrhea since March 24, 2015. A Care Plan Conference summary dated 4/23/15 indicated the PA recommended a GI consult due to the resident had [MEDICAL CONDITION], was on contact isolation and had a weight loss. The undated policy entitled, [MEDICAL CONDITION] (C. Diff) indicates Residents with diarrhea known or suspected to be infected with [MEDICAL CONDITION] should be placed on Contact isolation. Asymptomatic colonization may occur more commonly that the clinical disease. Stool samples for persons may test positive for the organism. Antibiotic therapy is not recommended, once primary colonization is established: the risk for CDAD is decreased once colonization occurs. Symptoms include: watery diarrhea, fever, loss of appetite, nausea, and abdominal tenderness/pain. The undated policy, Isolation Initiation and Discontinuation states, To provide guidance to licensed nurses regarding the initiation and discontinuation of isolation precautions that follow CDC recommendations. The undated policy, In-House Developed Infections Process: 1) Residents should be observed for signs and symptoms of infection. 2) Signs and symptoms of infection should be reported to the attending physician and noted in the medical record. During an interview on 6/8/15 at 1:54 p.m. the DON said there were 2 residents with [MEDICAL CONDITION].
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.**

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F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' drug regimen was free from unnecessary medications for 1 of 2 residents reviewed for [MEDICAL CONDITION] medications. (Resident #3) Resident #3 received [MEDICATION NAME] 50 mg daily (antipsychotic) and [MEDICATION NAME] 40 mg (antidepressant) daily for depression. He also received [MEDICATION NAME] 1 mg every evening and [MEDICATION NAME] 0.25 mg twice daily for anxiety. There was no [DIAGNOSES REDACTED]. This failure could place 23 residents receiving antipsychotic medications at risk for unnecessary medications, confusion, over sedation, weight loss, and decreased quality of life. Findings included: Physician orders [REDACTED].#3 was [AGE] years old, readmitted on [DATE] with diagnoses of diabetes, depression, anxiety, and urinary tract infection. His orders included [MEDICATION NAME] 50 mg (antipsychotic) one every evening; [MEDICATION NAME] 40 mg one daily (antidepressant), [MEDICATION NAME] 1 mg every evening and [MEDICATION NAME] 0.25 mg two times a day (anti-anxiety). The most recent MDS dated [DATE] indicated Resident #3 had some hearing difficulty, usually made himself understood and usually understood others. No hallucinations or delusions were noted during the assessment. He was independent for ADLs, needing set up help only. He was continent of bowel and bladder. A care plan updated 5/15/15 indicated Resident #3 was at risk for episodes of [MEDICAL CONDITION] or behavioral outbursts related to history of delusions and [MEDICAL CONDITION]. Interventions included: monitor for early signs of problem behavior, keep resident away from residents that may show agitation or aggression toward resident, approach in a calm manner, medicate as ordered, provide resident opportunity to share feelings, involve in activities, social services to intervene if needed, document behaviors upon occurrence and notify physician if behaviors persist. A care plan entry updated 5/15/15 indicated Resident #3 had agitation and or restlessness related to anxiety. Interventions included to medicate as ordered, one to one visit with resident when attempting to redirect, encourage appropriate behavior, social services to intervene and notify physician if agitation becomes worse or unable to redirect. [MEDICATION NAME] received routinely and PRN as ordered. The Behavior Management Record for behaviors of cussing, fighting, anxiety and agitation for Resident #3 for February 2015 (present date)- June 2015 had no entries for behavior episodes in any category. The Psychoactive Medication Quarterly Evaluations dated 1/20/15 and 4/13/15 for [MEDICATION NAME] 50 mg every evening and [MEDICATION NAME] 0.25 mg two times a day, said behavior warranting use of medications was cussing at staff. The recommendation was no change in plan of care. A hospital assessment dated [DATE] (prior to his admission) indicated the diagnostic impression was [MEDICAL CONDITION], delusions, [MEDICAL CONDITION] and rule out dementia. His medical diagnoses included diabetes, [MEDICAL CONDITION], chronic [MEDICAL CONDITION] and [MEDICAL CONDITION] (kidney infection). Mental Health Progress notes included the following: * 9/10/14- [AGE] year old living alone, was not caring for himself, hospital admission due [MEDICAL CONDITIONS] and several physical problems. He had a [DIAGNOSES REDACTED]. Today he was alert and cognitive, answered all questions . He has a history of combativeness .start [MEDICATION NAME] 20 mg every day and [MEDICATION NAME] 25 mg every evening for delusional activity. * 12/10/14- agitation/aggression and treatment of [REDACTED]. He regretted feeling angry at being at the facility, but did not want to be here. Increase [MEDICATION NAME] to 40 mg daily and increase [MEDICATION NAME] to 50 mg at night. During observation and interview the following was noted: * 6/8/15 at 11:40 a.m.- Lying in bed on left side, cap pulled over his eyes. * 6/8/15 at 2:15 p.m., Resident #3 said he liked sports, could read large print books and liked to fish. He said he had not been attending activities and was unaware of activities. An activity calendar was on his wall but he said the print was too small to read. He said a bath one time a week was enough. Resident #3 was alert, answered questions appropriately, with very few complaints. * 6/9/15 at 8:10 a.m.- asleep in bed, breakfast tray in room, ate 75% of his meal. During an interview on 6/9/15 at 8:50 a.m., the SW said she did not evaluate or assess [MEDICAL CONDITION] medications, they were discussed in quarterly meetings but usually the ADON handled any pharmacy or [MEDICAL CONDITION] medications. A pharmacy recommendation dated 5/20/15 indicated a gradual dose reduction for Resident #3's [MEDICATION NAME]. During an interview on 6/9/15 at 12:40 p.m., the ADON said Resident #3's physician would not change any [MEDICAL CONDITION] medications until the psychologist had seen him and made recommendations. She verified his [MEDICATION NAME] had not been reduced but had been expecting the psychologist to see the resident. During an interview on 6/9/15 at 4:55 p.m., LVN B said she had never seen Resident #3 have delusions or hallucinations. She said he got upset if he ran out of cigarettes. She said he had never been combative, and could usually be redirected or his brother was called if he got upset. During an interview on 6/10/15 at 10:35 a.m., LVN K said Resident #3 was usually a pleasant man, he did not like to be told what to do and sometimes he would cuss you out, she said in the past he had thrown sugar on the floor and poured his milk out. LVN K said Resident #3 wanted to go home. During an interview on 6/10/15 at 11:00 a.m., the psychologist said Resident #3 had a [DIAGNOSES REDACTED]. He said a nurse had told him Resident #3 had been agitated (12/14/14 mental health note). He was asked had he read any documentation regarding behaviors or agitation. He said he had not seen any documentation regarding agitation and verified that nursing had not been documenting him having any behaviors. He was unaware of Resident #3 having any delusions. During an interview on 6/10/15 at 2:30 p.m., the DON reviewed Resident #3's chart and could not find a [DIAGNOSES REDACTED]. During an interview on 6/10/15 at 3:15 p.m., Resident #3's brother said he had not had any behaviors or agitation prior to his hospitalization in August 2014. He said he had been very sick and septic. Resident #3's family said he had asked about the medication he was receiving and what he needed it for, but no one could tell him why he needed it. He said to his knowledge the only time he had become upset in the past was when he ran out of cigarettes. He said he had brought him plenty, but had discovered staff were giving his cigarettes to other residents that smoked. He said that had been resolved. A Mental Health Progress note dated 6/10/15 indicated a recommendation to reduce [MEDICATION NAME] to 25 mg daily. A policy and procedure for Psychoactive Drug Usage undated said [MEDICAL CONDITION] drugs are prescribed for a specific condition or targeted behavior that warrants the use of [MEDICAL CONDITION] medication and shall be documented in the clinical record in the physician's progress notes or history and physical. Therapy with [MEDICAL CONDITION] drugs shall be in the lowest possible dose to control symptoms and for the shortest period necessary. Addendum: www.agingcare.com/Articles/urinary-tract-infections-elderly- 6.htm Urinary tract infection and dementia UTI can cause confusion in older people and people with dementia If the person has a sudden and unexplained change in their behaviour such as increased confusion, agitation, or withdrawal, this may be caused by a UTI. (kidney infection). www.bcmj.org/articles/geriatric-depression-use-antidepressants-elderly: ([MEDICATION NAME]) [MEDICATION NAME] is generally not recommended for use in the elderly because of its long half-life and prolonged side effects. [MEDICATION NAME] is also typically not recommended for use in the elderly as it has the greatest [MEDICATION NAME] effect of all the SSRIs, similar to that of the tricyclics desi¿pramine and [MEDICATION NAME]. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC 09/ : Antipsychotic medications, typically given for psychotic symptoms (e.g., delusions, hallucinations), are also frequently administered to manage disruptive behavior in older adults with cognitive impairment. Antipsychotic medications include both typical (older generation) and atypical (newer generation) drugs. The CMS 672 dated 6/8/15 indicated 23 residents received antipsychotic medications.

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** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the kitchen. *The dry storage room had a blackish-grey thick substance that surrounded the baseboard and extended 6 inches from the wall

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	675958	A. BUILDING _____ B. WING _____	06/10/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRISTIAN CARE CENTER	1008 CITIZENS TRAIL TEXARKANA, TX 75501

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 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) beneath the food racks. * Kitchen floor tiles were cracked and broken. * The walk-in refrigerator temperature was 48- 50 degrees Fahrenheit (F), had food spills, buckling floor surfaces, rusted corners, seams and shelving. * Cookie sheets, frying pan, and muffin tins, had black carbon build-up. * Food debris was on a spoodle and plastic wrap, and paper was wrapped around an ice cream dispenser (uncleanable) found in the utensil drawer. * The dishwasher did not meet minimum 120 degree temperature during the wash/rinse cycle. * The three compartment skin with sanitizer had sanitizer of 100 ppm, not the 200 ppm (parts per million) as directed on the sanitizer tablet bottle. This failure could place residents who ate food from the kitchen at risk for food borne illness. Findings included: 1. During an observation on 6/8/15 the following was noted: * 9:00 a.m. - the kitchen floor throughout was sticky, and shoes were sticking to the floor. * the low temperature dish machine after two cycles was washing at 110 degrees during the wash cycle and 115 degrees during the rinse cycle. * 9:05 a.m., the dry storage room, greyish-black thick glue like substance along the baseboards and 4-6 inches from the walls beneath the food racks. * 9:10 a.m., the walk-in refrigerator did not feel cool and the thermometer had a white haze on it, which was difficult to read. Kitchen staff were noted to walk in and out of the refrigerator leaving the door open for long periods of time. The corners of the refrigerator, food racks and seams in the ceiling were rusted and brown. Dried liquid food spills, crumbs and food debris were noted beneath the food racks in the refrigerator and the vinyl floor was buckling. Several small cartons of milk were not cold to the touch but the FSS said his milk refrigerator had gone out and they had moved the milk to the walk-in. He said the milk man was coming to check the milk and replace it. * 9:15 a.m., the 3 compartment sink was filled with wash, rinse, and sanitizer water. The FSS said they used the sink to wash and sanitize the pans. A sanitizer strip showed 100 ppm., sanitizer should be 200 ppm. The FSS said he would add additional sanitizer. During an observation on 6/9/15 at 10:40 a.m. included the following: * 10:41 a.m.- Dry storage room continued to have greyish black substance along the baseboards extending 4-6 inches from the wall. (Approximately 13 ft on both side walls beneath the food racks.) *10:45 a.m.- Two doors leading to the exterior of the building had missing sections of the rubber door seal and light could be seen under the door. (This could provide an entrance for pests.) * 10:47 a.m.- the kitchen bathroom had 2-3 missing floor tiles around the commode, producing an uncleanable surface. A 4 inch chunk of cracked floor tile was missing off a 12 inch tile. * 10:50 a.m.- a 12 inch skillet, 3 large cookie sheets, and 3 muffin pans had black carbon buildup covering the bottom and sides of the pans. * 10:55 a.m.- food debris, crumbs, and dead bugs were noted beneath food prep tables and along the baseboards of the kitchen. * 10:57 a.m.- 10 floor tiles (12 inch) were discolored with black streaks, chipped and broken beneath the convection oven and on the floor of the kitchen. During an observation and interview on 6/9/15 at 11:00 a.m., Cook H prepared pureed food in a robo type blender. Food began oozing out of the bottom of the blender. Neither Cook H or the FSS knew how long the blender had leaked. The large blender base had dried food in the cracks of the machine. During an observation on 6/9/15 at 11:05 a.m. a spoodle had dried food debris on it and the ice cream scoop had plastic wrap and paper tied around the handle. During an observation and interview on 6/9/15 at 11:10 a.m., the temperature in the walk-in refrigerator was 54 degrees F. The log sheets for April 2015 indicated all but 5 days the temperature had been 50 degrees F. The refrigerator temperatures for May 2015 to June 9, 2015 had been 50 degrees F. Dietary aide A said they reported the temperatures to the FSS. The FSS said he was unaware of the 50 degree temperature. The Maintenance man came in without a hair net, went into the walk-in refrigerator and lowered the thermostat, and said he was going to add freon. During an observation on 6/9/15 at 11:50 a.m., the hydration/snack cart in the kitchen near the walk-in refrigerator had an insulated cooler with a broken lid that fell off when it was touched. The blue mesh surrounding the cart had holes in it and was discolored and ragged. The [MEDICATION NAME] covering the cart had brown stains throughout. During an observation on 6/9/15 at 12:00 p.m., Cook H was plating food on a shelf above the steam table. The shelf tilted from side to side. Cook H said the steam table used to have a glass front but that had broken out. Texas Food Establishment Rules dated September 2006 indicated: .b) §229.167. Physical Facilities. (a) Indoor areas, surface characteristics. Materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: (1) smooth, durable, and easily cleanable for areas where food establishment operations are conducted; . Rule 229.165 Equipment, Utensils, and Linens (1) Characteristics. Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be: (A) safe; (f) Functionality of equipment. Rule 229.164 Food 1) Temperature. (A) Except as specified in subparagraph (B) of this paragraph, refrigerated, potentially hazardous food shall be at a temperature of 5 degrees Celsius (41 degrees Fahrenheit) or below when received. The CMS 672 dated 6/8/15 indicated 10 residents had gastrostomy tube feedings, 80 residents received routine meals served from the kitchen.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain an infection control program to ensure a safe and sanitary environment to prevent the development and transmission of disease for the facility. The facility did not track, trend, and analyze all active infections in the facility. Only residents with new infections included [REDACTED]. Current infections were not included. The program did not accurately track or trend all infections to correctly analyze data to prevent further spread of infections. This failure could place the census of 90 at risk of exposure to infections. Findings included: The 2015 infection control book did not contain information of all infections investigated from January 2015 through June 8, 2015. The monthly infection logs included only tracking and trending of new infections identified in that month and did not contain information of on-going infections identified in prior months. There were two residents in the facility with[DIAGNOSES REDACTED] that were not on the current log because they contracted their infection before June 2015. During an interview on 6/9/15 at 9:07 a.m. the DON said she was responsible for tracking and trending of infections. She said she did not have reports for tracking and trending from month to month. The DON said she only tracked and trended new infections for the current month. The monthly Infection Log used to track and trend did not include all residents with infections. The DON said she understood why this was not an effective method to accurately identify and analyze data to determine cause of infections, preventing the spread of infections, and identify a possible epidemic. The undated policy and procedure, Surveillance for Healthcare-Associated Infections states, The infection Control Coordinator will conduct ongoing surveillance for Healthcare-Associated Infections (HIAs) and epidemiologically significant

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F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to permit interventions, and to prevent future infections. -Compare incidence of current infections to previous data to identify trends and patterns. -Compare subsequent rates to the average rate to identify possible increases in infection rates. The CMS 672 dated 6/8/15 indicated the census was 90.