STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676337	A. BUILDING _____ B. WING _____	**04/02/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR HOUSTON	**6920 T.C. JESTER BLVD HOUSTON, TX 77091**

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to consult with the physician when there was a need to alter the medical treatment of [REDACTED].#s 70, 14, 73, 15, 59, 100, 72, 65 and 30) reviewed for physician consultations. Resident #70 ' s physician was not consulted when the resident's pain was not effectively controlled. The physician was not consulted prior to the resident running out of a narcotic pain medication that required a triple script perscription from the physician. The resident ran out of Narco on 3/24/15 and the physician was not notified until 3/28/2015. The Narco was not delivered to the facility until 3/30/2015. The resident experienced pain with the intensity of 7-10 on a scale from 1-10 during this time. The physician was not consulted when Resident #70 was found to have new multiple open areas with excoriation to inner thighs and gluteal fold. Resident #70 had nutritional problems and the physician ordered to give her the medication [MEDICATION NAME] to stimulate her appetite. The facility failed to give her this medication and the physician was not notified. Resident #14, who aspirates thin liquids into the lungs, was not compliant with the thicken liquids ordered by the physician, drank thin liquids and the physician was not consulted. The physicians were not consulted when Resident #s 73, 15, 59, 100, 72, and 65 experienced weight loss for two consecutive months. The Registered Dietitian's recommendations for suplements and increasing tube feedings to increase nutritional intake and prevent further weight loss were not communicated to the physicians. Resident # 30's physician was not promptly consulted when she had a low blood pressure for three days with the physician ordered medications being held. Resident #30's physician ordered STAT labs and was not informed of the abnormal results until a day after the facility was notified of the results. An immediate jeopardy (IJ) was identified on 3/26/2015 . While the IJ was removed on 4/2/2015 the facility remained out of compliance at a scope of pattern and a severity level of actual harm because all staff had not been trained on consulting physicians of resident conditions. These failures affected nine residents by causing increased duration of pain, further weight loss, risks of aspiration, and delay in treatments and placed 99 residents at risk of not having their physicians consulted when they experience a change in condition and could require their medical care altered so their medical condition was not negatively impacted. Findings include: Resident # 70 Record review of Resident # 70 face sheet revealed a [AGE] year old female readmitted to facility on 6/27/13 with the following diagnose: hypertension, diabetes mellitus, depression, [MEDICAL CONDITION], muscle weakness, obesity and ends stage kidney disease. Record review of Resident #70 ' s care plan dated 7/13/13 with no update date revealed Resident #70 has impaired comfort related to chronic pain, complaint of pain, [MEDICAL CONDITION]. The care plan goal with target date .Resident will have relief from pain when as needed (PRN) medication is used over 90 days with the target date of 5/14/15 . Approaches .Give PRN pain medication according to physician's order [REDACTED]. observe for effectiveness of PRN pain medications . Record Review of Resident #70's prescription for [MEDICATION NAME] with APAP ([MEDICATION NAME]) 10/325 mg was dated as being ordered by the physician on 11/12/2014. Record review of Resident # 70 ' s MDS dated [DATE] revealed the resident was moderately impaired for cognition and received as needed pain medication. Record review of Resident #70 ' s MAR dated March 2015 revealed [MEDICATION NAME] ([MEDICATION NAME]) 10/325 mg, one by mouth every 6 hours as needed for pain. Further review of the MAR revealed this medication was administered for complaints of pain on: 3/3, 3/5, 3/7, 3/8, 3/10, 3/11, 3/13, 3/18, 3/19, 3/20 the last dose documented as administered was on 3/24/15. Review of the back of the MAR did not document the time that 3/24/15 dose of [MEDICATION NAME] was administered. Record review of Resident #70 ' s MAR dated March 2015 revealed [MEDICATION NAME] HCL 50 mg, by mouth every 6 hours as needed for pain, reordered by the physician on 2/24/2015. Further review of MAR revealed the medication was administered on the following days: 3/2, 3/3, 3 /4, 3/9, 3/10, 3/13, 3/16, 3/19, 3/20, 3/23, 3/24 3/25, 3/26, 3/27 and 3/28/15. Record review of Resident # 70 ' s nurse ' s notes dated 3/3/15 revealed at 9:22 p.m., .resident continued to complain of pain to buttocks areas, resident given pain medication twice, resident continued to be monitored for increased pain. Record review of Resident # 70 ' s nurse ' s notes dated 3/4/15 revealed at 10:07 p.m., .resident was medicated for pain. Observation on 3/10/15 at 12:10 p.m., revealed Resident #70 in bed moaning in pain. The resident verbalized she had generalized pain of 10 on a scale of 0-10. She was medicated for pain following the complaint of pain by staff. Further observation on 3/10/15 at 1:30 pm., revealed Resident # 70 complained of pain being present. Wound care that was scheduled was held due to the resident's pain. Interview on 3/10/15 at 1:35 p.m., LVN # 4 said the resident had not refused wound care due to pain and had not complained of pain during wound care until today . Observation and interview on 3/10/15 about 2:10 p.m., during wound care. Resident # 70 said it was ok to perform wound care. Resident # 70 moaned in pain whenever sacral/buttocks wounds were cleaned or touched by LVN # 4 and when she was repositioned. Further observation revealed LVN # 4 did not acknowledge the resident moaning in pain throughout the wound care. Resident # 70 verbalized her buttock was hurting during the wound care. Resident # 70 was noted with large stage II pressure ulcer from left buttock extending to her right buttock and the sacral area. The wound bed did not show any slough or eschar, but had mild drainage. Resident #70 was found to have multiple open areas to inner thigh and excoriations to the perineal areas. She also had an unstageable wound to her left heel. Interview on 3/10/15 following wound care, Resident # 70 ' s family members said that the resident had never been assessed nor medicated for pain before wound care treatment. They said that Resident #70 would moan in pain during treatment and the nurse would not stop and would continue with the treatment. Resident #70 would just continue to moan. Interview on 3/10/15 following the above observation, Resident # 70 ' s family member reported she notified LVN# 4 of multiple open areas she identified on the resident but LVN # 4 did not follow up and did not assess the resident. Interview on 3/10/15 about 3:00 p.m., LVN # 4 said the resident ' s family notified her of the skin excoriations on Resident # 70's inner thighs. She said staff had been applying barrier cream to the excoriated red area but she had not seen the open areas since it was reported to her by the family. Record review of the Individual Narcotic sign out sheet identified as [MEDICATION NAME] for Resident #70 revealed on 3/20/15 at 10:00 A.M. the remaining [MEDICATION NAME] count was one tablet remained. Continued review revealed the last [MEDICATION

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) NAME] was removed and administered on 3/24/15. Interview on 3/29/15 at 1:46 P.M. the DON stated she did not know why the resident ran out of her [MEDICATION NAME] Record review of the facility Pain Roster dated 3/1/15 thru 3/31/15 revealed the resident reported the following level of pain based on a 1-10 pain scale with 10 being the worst pain ever experienced on the following dates: 3/20/15 resident ' s pain intensity was 10 3/21/15 resident ' s pain intensity was 10 at 10:57 A.M. and 6:11 P.M. 3/22/15 resident ' s pain intensity was 10 at 12:44 P.M. and 7:08 P.M. 3/26/15 resident ' s pain intensity was 5 at 11:29 P.M. 3/28/15 resident ' s pain intensity was 10 at 9:44 P.M. 3/29/15 resident ' s pain intensity was 10 at 1:19 P.M. Observation on 3/29/15 at 12:36 P.M. revealed Resident #70 in bed awake and alert. Interview on 3/29/15 at 12:36 P.M. during the observation Resident #70 stated her pain intensity level was 7. Resident #70 continued and stated she was out of the [MEDICATION NAME] and was getting [MEDICATION NAME] instead. She stated [MEDICATION NAME] did not work like the [MEDICATION NAME] on her pain. Observations on 3/29/15 at 2:00 P.M. with the DON and at 2:11 P.M. with LVN #3 of the medication cart narcotic box revealed a bubble pack for [MEDICATION NAME]. Continued observation revealed no bubble pack for [MEDICATION NAME] for Resident #70. Interview on 3/29/15 at 2:11 P.M. LVN#3 stated Resident #70 was getting [MEDICATION NAME] 50 mg and [MEDICATION NAME] 10/325 mg every six hours as needed for pain. LVN#3 continued and stated when she realized the [MEDICATION NAME] was out on Saturday (March 28, 2015) she called the pharmacy to request a refill but she was told she needed triplicates. She continued and stated she called the physician to notify him that she needed a triplicate prescription. The doctor questioned why he was not notified during the week. LVN#3 stated she only worked on weekends and she did not know. The physician stated the resident would have to wait until Monday. Record review of Resident#70 ' s physician's order [REDACTED].#3 every four hours as needed for pain. Record review of Resident #70 ' s MAR dated March 2015 revealed Tylenol #3 was discontinued on 3/30/15 and the new order for [MEDICATION NAME] 5/325 mg was the resident was to receive it four times a day was started. Observation on 3/30/15 at 8:15 A.M. revealed Resident #70 was in bed grimacing and holding her left arm. Interview on 3/30/15 at 8:15 A.M. Resident #70 stated they let the [MEDICATION NAME] ran out about a week ago and they were giving the [MEDICATION NAME] and Tylenol which did not work. The resident stated she was having overall chronic body pain and reported her pain intensity on a scale of 1-10 was 9 and a half at this time . She continued and stated she did not go to sleep until 4:00 A.M. this morning because of the pain. Resident #70 stated how do you let someone ' s pain medicine run out? Interview on 3/30/15 at 8:25 A.M. LVN #4 said that the physician ordered another pain medication, Tylenol #3, yesterday , but Resident #70 did not want Tylenol #3 because it did not relieve her of pain. She only wanted [MEDICATION NAME] because it was the only pain medication that she had used that helped her with pain. Observation on 3/30/15 at 8:25 A.M. revealed LVN #4 called the physician to reorder [MEDICATION NAME] since Resident #4 had ran out of it. Interview on 3/30/15 at 8:40 A.M. LVN#14 stated when she noticed a resident ' s medicine was about to run out she called the pharmacy for refills and if it cannot be refilled she notifies the physician. She stated she does not notify the DON but will notify the next on coming nurse during report and if she worked the next day she would call the pharmacy and physician again. Interview on 3/30/15 at 9:15 A.M. Resident #70 stated she received [MEDICATION NAME] and Tylenol #3 about 30 minutes earlier and her pain was about the same with no relief. She continued and stated she told her doctor last week she was out of pain medicine. Interview on 3/30/15 at 10:09 A.M. the DON stated she cannot remember any nurse notifying her about Resident #70 ' s [MEDICATION NAME] running out and last night she got an order for [REDACTED]. Interview on 3/30/2015 at 4:45 Resident #70 stated she had just returned from [MEDICAL TREATMENT]. She stated her pain was a 9 on a scale of 1-10 but the nurse just gave her a pain pill. She stated it was not a [MEDICATION NAME] but the nurse stated they had been ordered and should be coming from the pharmacy this evening. She stated the [MEDICATION NAME] was the only drug that was effective for her pain. Further record review of Resident #70 ' s clinical records revealed a physician order [REDACTED]. Record review of Resident #70 ' s MAR dated March 2015 revealed that the staff had initials on the MAR indicating that [MEDICATION NAME] 10 mg was administered to Resident #10 on the following dates: 3/4/, 3/5, 3/7, and 3/8/15. Further record review revealed that the [MEDICATION NAME] was discontinued on 3/9/15. Record review of Resident # 70 ' s Psychiatric Review /Mental Status Exam dated 3/9/15 revealed Primary care physician ordered [MEDICATION NAME] 10 mg every night for appetite but pharmacy has not delivered secondary to no 10 mg pill , will change to [MEDICATION NAME] 15 mg every night so they will send it . Record review of Resident# 70 ' s progress notes revealed that there was no evidence indicating that Resident # 70 ' s physician was notified of the unavailability of the [MEDICATION NAME] 10 mg ordered 3/3/15. Interview on 3/10/15 at 11:34 a.m., LVN # 4 said the medication was supposed to have been delivered by the pharmacy. She said staff should indicate and document the reason on the back of the MAR when medications were not administered. LVN # 4 said the physician should have been notified that the ordered medication was not available in the ordered dose. Record review of the drug reorder book on 3/30/2015 revealed a binder with dividers for 31 days in it. Behind the divider marked 30 there were several copies of phone orders and tear off slips from medication cards that had been attached to blank pages and faxed to the pharmacy. Interview on 3/30/2015 at 5:00 P.M. the Corporate Educator after being asked for the previous days of the month ' s pharmacy orders, stated the notebook was the corporate system which should have been used at the facility but was not. She stated prior to today the nurses had just been shoving the order forms into an accordion binder in the medication room. She stated there was no organization or filing system and there were several folders. She then stated she had started training the nurses to the corporate system. When asked how many nurses she had trained she stated two. When asked to see the in-service form for the two nurses she stated she had not made one out yet. The Corporate Educator was asked to see if she could find the reorder form for Resident #70's [MEDICATION NAME] which ran out on 3/24/2015. She stated she would try to find it. No reorder form was ever provided for review. Record review and interview of the in-service form dated 3/30/2015 concerning the medication reorder system revealed one nurse had signed they had been trained to the corporate medication reorder policy and procedure. Interview on 3/30/2015 at 5:10 P.M. the ADON stated she would order medications when the resident had a seven day supply left. She stated if it was a PRN medication she would use her nursing judgement and assess how many pills a day the resident was taking and then multiply that times 7 to give her a seven day supply. Interview on 3/30/2015 at 5:30 P.M. LVN #20 stated he reordered resident's medications when they had ten pills left. Interview on 3/31/15 at 9:30 A.M. LVN #19 sated she reordered medications on the seventh day before it runs out. She did the ninth day but she would be notified by pharmacy it was too early to refill. Interview on 3/31/15 at 9:36 A.M. LVN #4 stated it depended on the frequency of the medication but she reordered medications 7 days before it runs out. The turnaround time to get the medication depended on if there were any refills left on the medication or if it needed triplicate scripts. Record review of facility ' s policy on treatment of [REDACTED]. Resident #14 Record review of Resident #14 ' s face sheet revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years old. Record review of Resident #14 ' s chart revealed a nurse ' s note dated 11/27/2014 which revealed the family had brought the resident food and drink to eat. The note went on to state the resident was not compliant with diet. There was no documentation of physician notification in the chart at this time. Further review revealed no documentation of any physician notification in [DATE], Jan, Feb or March 2015 concerning the resident ' s diet. Record review of Resident #14 ' s MDS dated [DATE] revealed the resident was dependent on staff for activities of daily living but could feed herself with just the assistance of the staff to set up her tray. The MDS also revealed the resident

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) weighed 240 pounds and was on a mechanically altered diet. Record review of Resident #14 ' s consolidated physician's order [REDACTED]. Observation on 3/11/2015 at 12:30 P.M. revealed Resident #14 eating lunch. On her tray revealed a cup of coffee and a glass of water. Both were thin consistency. Review of the lunch tray meal card at this same time revealed the resident was to have Nectar thickened liquids. Observation on 3/11/2015 at 4:00 P.M. revealed Resident #14 in her bed sitting up. The bedside table was over her lap and contained two large glasses of ice water with straws. Both glasses were half full. The resident was alert but due to her [DIAGNOSES REDACTED]. The resident took three to four drinks of water during this observation. The water was of thin consistency. In the room there were no signs or notifications to staff or visitors that the resident was to have thickened liquids. Observation on 3/11/2015 at 5:35 A.M. the supper trays were being passed by the staff. On Resident #14 ' s tray was a glass of nectar thick water and nectar thick juice that were covered with plastic lids and labeled with an N. Interview on 3/11/2015 at 5:40 P.M. the DON was taken to the resident ' s room and asked to explain the system to notify family or visitors concerning fluid consistencies. She stated the resident should have a sign above her bed with a B which alerts staff the resident is to have thickened liquids. She stated the resident should not have the thin water that was located on her bedside table. At this time LVN #5 entered the room and stated that the resident would not drink thickened liquids and had always been non compliant. He stated the family would also offer her thin liquids because she would refuse the nectar thick ones. When asked if the doctor had been informed LVN #5 stated he did not know. Interview on 3/11/2015 at 6:20 P.M. the DON stated Resident #14 ' s physician had been notified and he had ordered a swallowing test to be performed on the resident which she will make sure gets completed. Record review of Resident #14's record concerning the swallowing exam dated 3/20/2015 revealed recommendations of small bites/sips-crush meds-alternate solids/liquids; position upright and supervised feedings with curing . Results of the test also revealed the resident was a silent aspirator on thin liquids. Further review revealed the resident and family were counseled concerning the test results and the resident chose, even after risks explained, to be non compliant and drink thin liquids. The physician was notified on 3/27/2015 of the family and Resident #14's decision and facility forms concerning the refusal of treatment were signed. Resident #73 Record review of Resident # 73 ' s face sheet revealed he was a [AGE] year old male, admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 73 ' s Minimum Data Set ((MDS) dated [DATE] revealed her Brief Interview for Memory Status (BIMS) score was 4 which indicated he was severely cognitively impaired. Record review of the same MDS revealed the resident ' s weight was 191 pounds. Record review of Resident #73 ' s MDS dated [DATE] revealed his weight was 172 pounds. The weight loss between 10/17/2014 and 1/09/2015 was not identified on the form. Record review of Resident #73 ' s care plan with a problem onset date of 02/10/15 revealed .Potential for unintended wt. loss R/T dysphagia inadequate intake of meal AEB coughing while swallowing. Weight loss of 5% in the last 30 days . Approach listed .Notify MD/RP of wt. loss of additional 2# despite interventions . Record review of Resident # 73 ' s physician's order [REDACTED]. discontinue Nutrien 2.0 cal at 30 ml/hr and change to Nutrien 2.0 cal bolus per GT QID. Resident is NPO . order dated 03/04/15 revealed . change feeding to [MEDICATION NAME] 1.5 one can bolus QID. Record review of Resident #73 ' s care plan with a problem onset date of 03/04/15 update revealed .Resident has feeding tube R/T Dx dysphagia AEB Resident has silent aspiration and alteration in airway clearance. At risk for weight loss . Approach listed .will monitor patients monthly weights .will notify MD/RP of any weight loss . Record review of the facility Weight Change History form dated 03/12/15 revealed Resident #73 ' s weight history as follows: 10/10/14 191.20 pounds 11/10/14 171.20 pounds 12/09/14 171.80 pounds 01/10/15 173.80 pounds 02/10/15 149.20 pounds 03/03/15 151.20 pounds Record review of the following dietary notes for Resident # 73 revealed: 12/10/14 .171.8 pounds wt. stabilized this month . wt. loss 15.5 pounds 8.2% down BW x 3 months . 01/29/15 .173.8 pounds wt. stable trending up + 2 months wt. loss of 17.4 pounds 9.1% over 3 months . 03/05/15 .March wt. 151.2 pounds wt. stable x 1 month Question 24.8 pound wt. loss for 1 month. Wt. loss 20.6 pounds 11.9% x 3 months 36.1 pounds 19.2% On TF [MEDICATION NAME] 1.5 bolus 1 can QID. Flush 150 cc H20 Q4h. Resident NPO .Recommend change from 1.5 formula QID to a 2.0 formula QID. TF to provide 1900 kcal, 79.8g protein and 664 cc fluid/day .recommend weekly wts x 4 weeks . Record review of Resident #73' s physician's order [REDACTED]. Observations of Resident #73 on the following dates and times revealed the resident was unable to communicate. 3/11/15 at 5:45 P.M. 3/12/15 at 8:30 A.M., 8:58 A.M., and 1:47 P.M. Interview on 03/12/15 at 8:30 A.M. ADON-Staffing revealed Resident #73 did not take anything by mouth. She stated even his meds were given by [DEVICE]. She stated his feeding was [MEDICATION NAME] 1.5 bolus QID and she was getting ready to feed him right now. Interview on 3/12/15 at 12:45 P.M. RD/LD (Registered Dietitian/Licensed Dietitian) stated he recommended a tube feeding increase on 03/05/15 from [MEDICATION NAME] 1.5 bolus 1 can QID to 2.0 formula QID to provide 1900 kcal due to Resident #73 ' s 20.6 pound weight loss between 01/29/15 and 03/15/15. He stated the [MEDICATION NAME] 1.5 was only providing 1420 kcal. He continued and stated he did not know if the physician was notified of the recommendations. He stated he made the recommendations and gave them to the Director of Nursing (DON) who then was to notify the physician. He further stated he recommended weekly weights for Resident #73. Resident #15 Record review of Resident # 15 ' s face sheet revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. She was [AGE] years old. Her [DIAGNOSES REDACTED]. Record review of Resident #15 ' s Minimum Data Set ((MDS) dated [DATE] revealed on her Brief Interview for Memory Status (BIMS) the resident ' s cognitive pattern was 3 which indicated she was severely impaired for daily decision making (rarely/never made decisions). The MDS revealed the resident was totally dependent on staff for eating. Record review of the same MDS revealed the resident ' s weight was 126 pounds with 51% or more of her total calories received through a tube feeding and her average fluid intake was 501 cc per day from tube feeding. Record review of Resident#15 ' s care plan dated 6/5/14 with no update revealed the problem related to [MEDICAL CONDITION] . Resident #15 has tube feeding related to impaired swallowing, at risk for weight loss resident was receiving [MEDICATION NAME] 1.2 at 60 ml per hour for 22 hours. Record review of Resident #15 ' s MDS dated [DATE] revealed her weight was 117 pounds. The weight loss was identified and not on a physician prescribed with loss regimen . with 51% or more of her total calories though tube feeding and her average fluid intake was 501 cc per day from the tube feeding. Record review of the facility Weekly Weight Record dated November 2014, December 2014 and January 2015 revealed Resident #15 was not on weekly weights. Record review of the facility Resident Current Weight List dated 11/15/14 revealed Resident #15 ' s weight was 126.4 pounds, new weight undated was 113.4 pounds and weight dated November 15-16, 2014 was 115.2 pounds. Record review of the facility Weight Change History form dated 12/4/14 revealed Resident #15 weight history: 7/11/14- 126.4 pounds 8/10/14- 117.2 pounds Resident in the hospital 10/10/14-126.4 pounds

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) 11/10/14-115.2 pounds Record review of Resident #15 ' s weight history untitled and undated provided by the facility dietician revealed the following weight history: 10/10/14-126.4 pounds 11/10/14-115.2 pounds 12/9/14-115.0 pounds 1/10/15-110.6 pounds 2/10/15- 112.6 pounds Record review of Resident #15 ' s Initial Dietary Assessment undated revealed the resident ' s diet was nothing by mouth NPO Record review of the following dietary notes for Resident #15 revealed: . 8/28/14 August 117.2 pounds weight loss 9.2 pounds 7.2 % per month stage III wound . recommended increase tube feeding [MEDICATION NAME] 1.2 to 65 ml per hour . .11/25/14 November at 115.2 pounds .11.2 pound decrease down 8.8% in 3 months . .1/15/15 January at 110.6 pounds. Weight loss restarted weight down 15.8 pounds 12.5 % in 3 and 6 months recommended [MEDICATION NAME] 1.2 at 65 ml per hour for 22 hours . .2/12/15 dietary notes revealed February weight pending January at 110.6 pounds .recommend increase tube feeding to [MEDICATION NAME] 1.2 at 65 cc per hour. Record review of Resident # 15 ' s consolidated physician's order [REDACTED]. [MEDICATION NAME] 1.2 at 60 ml per hour for 22 hours . order and start date was 9/10/14. Record review of Resident #15' s physician's order [REDACTED]. Observations of Resident #15 on the following dates and times revealed the resident was non-verbal. Her oxygen was per [MEDICAL CONDITION] collar and her tube feeding was running on a pump at 60 ml per hour: 3/10/15 at 10:22 A.M. and 1:10 P.M. 3/11/15 at 10:30 A.M., 11:31 A.M. 12:48 P.M. and 4:00 P.M. 3/12/15 at 8:00 A.M. and 11:00 A.M. Interview on 3/12/15 at 8:35 A.M. RD/LD (Registered Dietitian/Licensed Dietitian) stated he visited the facility four times a month, one time a week. He stated his priority was new and readmitted residents, residents with weight loss and pressure ulcers and then residents with weight gain. The RD/LD stated he recommended a tube feeding increase in August and the resident was on hospice at that time. In September Resident #15 was in the hospital and in February another recommendation to increase her tube feeding to 65 ml per hour was made. He continued and stated he did not know if the physician was notified of the recommendations. He stated he made the recommendation and gave them to the Director of Nursing (DON) who then was to notify the physician. He stated Resident #15 warranted weekly weights when her weight moved from 126 pounds to 115 pounds then 110.6 pounds. He stated he did not know why they were not done. Interview on 3/12/15 at 12:45 P.M. the ADON -skilled stated the DON or Dietician could recommend weekly weights. She stated when the dietician makes a recommendation the quality nurse or the DON notifies the physician. Record review of Resident #15's physician's telephone orders dated 3/12/2015 revealed an order to increase the resident's tube feeding to 65 cc per hour for 22 hours. Observation on 3/25/15 at 3:50 P.M. revealed Resident #15 in the bed receiving O2 [MEDICAL CONDITION] 2 liter per. The feeding tube was dispensing [MEDICATION NAME] 1.2 at 60 cc per hour. Record review of Resident #15's March 2015 MAR revealed the resident was to receive [MEDICATION NAME] 1.2 at 60 cc per hour. The physician's orders [REDACTED]. Interview on 3/25/2015 at 4:05 P.M. the DON stated Resident #15's original dietary recommendation was one of the recommendations that had been overlooked but she had corrected the tube feeding order as of 3/12/2015. After reviewing the order, the March MAR and the resident's tube feeding she stated she remembered talking with the physician, writing the order and giving it to the nurse to transcribe to the MAR. She stated she would make sure it was transcribed now and that the feeding was changed to the correct amount. She also stated she would inservice the nurse on transcribing orders. Continued review revealed no documentation in Resident #15's medical record the physician was notified the resident was and had not received the increase in feeding as ordered on [DATE]. Resident # 59 Record review of Resident # 59 ' s face sheet revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. She was [AGE] years old. Her [DIAGNOSES REDACTED]. Record review of Resident#59 ' s care plan dated 3/5/14 with no update revealed the problem altered nutrition less than body requirements . nutrition altered less than body requirements: receives therapeutic diet at risk for non-compliance with diet and weight loss. Record review of Resident #59 ' s MDS dated [DATE] revealed her BIMS score was 2 which indicated her cognition was severely impaired. The MDS revealed the resident required extensive assistance for eating. Record review of the same MDS revealed the resident ' s weight was 111 pounds. Record review of Resident #59 ' s MDS dated [DATE] revealed her weight was 110 pounds. The weight loss was identified and not on a physician prescribed weight loss regimen Record review of the resident weight change history form revealed the following: 7/11/4- 116.4 pounds 8/10/14-112.2 pounds 9/10/14- 109.2 pounds 10/10/14- 108.4 pounds 11/10/14-111.0 pounds Continued review did not reveal additional weight change history forms or weekly weights. Record review of the resident ' s dietary progress notes revealed: 6/12/14 June w
F 0224 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement policies and procedures that would have prohibited the neglect for one of 19 residents (Resident #70) reviewed for neglect. Resident # 70 was readmitted to the facility on [DATE] with treatment orders to pressure ulcers on the sacral area and left heel that were not implemented. Resident #70's physician ordered [MEDICATION NAME] 10 mg by mouth every night to increase the resident's caloric intake and wound healing on 3/3/15 which were not ordered from pharmacy or administered to the resident. Resident #70's pain was not managed effectively when facility staff allowed her narcotic pain medication to run out and was not available for resident usage for six days. This failure affected one resident, whose skin condition worsened and placed 107 residents at risk of neglect, and delay in receiving treatment and care which could cause increased pain, suffering, or infection. Findings include: Intake # 7 Resident # 70 Record review of Resident # 70's face sheet revealed a [AGE] year old female admitted to the facility on [DATE] and readmitted [DATE] with the following Diagnoses: [REDACTED]. Record review of Resident # 70 ' s MDS dated [DATE] revealed the resident was moderately impaired for cognition and required extensive assistance with ADLs. Resident # 70 had no wounds documented on the MDS. Record review of Resident # 70 ' s physician's re-admission orders [REDACTED]. Record review of Resident #70 ' s treatment administration record dated February 2015 revealed Balsam peru/ castor oil/ trypsin ointment, apply to heel wounds every 12 hours and cadexomer iodine 0.9 topical gel, apply to sacrum every other

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F 0224 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) day. Further review of Resident #70's TAR revealed the above orders were signed and circled on 2/25/15 with instruction that read see treatment book . When LVN #4 was requested to provide any other wound treatment documentationthere was no other wound treatment record provided for the month of February 2015 for review. Record review of Resident # 70 ' s wound assessment report dated 2/24/15 revealed Resident # 70 had pressure ulcer to sacrum upon re-admission, granulation tissue was 30%. The wound had 30 % slough and 40% eschar. The physician and resident ' s responsible party were notified of the wounds on 3/3/15. Further review of the record revealed a wound assessment was completed on 3/4/15. Further review of the record revealed treatment orders were pending. Record review of Resident # 70 ' s treatment administration record dated March 2015 revealed Balsam peru/ castor oil/ trypsin ointment, apply to heel wounds every 12 hours and cadexomer iodine 0.9 topical gel, apply to sacrum every other day. There was no discontinuation date and no documentation that treatments were initiated. Observation on 3/10/15 about 2:10 p.m., during wound care. Resident # 70 was noted with large stage II pressure ulcer from the left buttock extending to her right buttock and the sacral area. The wound was clean, had no slough and no eschar with a mild drainage. Resident # 70 had multiple open areas to the inner thigh and excoriations to the perineal areas. She also had an unstageable pressure sore to her left heel. Further observation on 3/10/15 about 2:10 p.m., revealed LVN # 4 performed wound care to the sacral area and left heel. LVN # 4 said she was not aware of the multiple open areas on the resident ' s inner thigh areas. LVN # 4 said she knew Resident # 70 had some excoriations to the perineal area and gluteal folds. Interview on 3/10/15 following the above observation, Resident # 70 ' s family member reported she notified LVN# 4 of the multiple open areas she identified on the resident but LVN # 4 did not follow up and did not assess the resident. Interview on 3/10/15 about 3:00 p.m., LVN # 4 said the resident ' s family notified her of the skin excoriations on Resident # 70's inner thighs. She said staff had been applying barrier cream to the area but she did not see the open areas. Interview on 3/11/15 at 4:00 p.m. the ADON said she discovered the order was not processed through the pharmacy and the orders were not implemented upon the resident ' s re-admission. She explained she had completed a medication variance (for documentation of medication errors according to the facility protocol) after surveyor intervened. The ADON said she did not know why the above orders were not implemented. Record review of Resident # 70 ' s physician's orders [REDACTED]. Record review of Resident #70 ' s MAR indicated [REDACTED]. Medication had staff initials the medication was administered on 3/4/, 3/5, 3/7, and 3/8/15. Medication was discontinued on MAR indicated [REDACTED] Record review of Resident # 70 ' s psychiatric review /mental status exam dated 3/9/15 revealed Primary care physician ordered [MEDICATION NAME] 10 mg every night for appetite but pharmacy has not delivered secondary to no 10 mg pill , will change to [MEDICATION NAME] 15 mg every night so they will send it . Record review of Resident# 70 ' s progress notes revealed no evidence indicating that Resident # 70 ' s physician was notified of the unavailability of the [MEDICATION NAME] 10 mg ordered 3/3/15. Interview on 3/10/15 at 11:34 a.m., LVN # 4 said the medication was supposed to have been delivered by the pharmacy. She said staff should indicate and document the reason on the back of the MAR indicated [REDACTED]. Interview on 3/11/15 at 3:40 p.m., DON said she was not aware of the above concerns but expected nursing staff to implement physician orders [REDACTED]. Record review of Resident #70 ' s care plan dated 7/13/13 with no update revealed Resident #70 has impaired comfort related to chronic pain, complaint of pain, [MEDICAL CONDITION] . care plan goal with target date .Resident will have relief from pain when as needed (PRN) medication is used over 90 days with the target date of 5/14/15 . Approaches .Give PRN pain medication according to physician's order [REDACTED]. observe for effectiveness of PRN pain medications . Record review of Resident #70 ' s MAR indicated [REDACTED]. Further review of the MAR indicated [REDACTED]. Review of the back of the MAR indicated [REDACTED]. Record review of Resident #70 ' s MAR indicated [REDACTED]. Further review of MAR indicated [REDACTED]. Record review of Resident#70 ' s MAR indicated [REDACTED]. Continued review revealed it was administered at 8:40 A.M. on 3/30/15. Record review of the Individual Narcotic sign out sheet identified as Narco for Resident #70 revealed on 3/20/15 at 10:00 A.M. the remaining Narco count was one tablet l remained. Continued review revealed the last Narco was removed and administered on 3/24/15. Record review of Resident#70 ' s physician's order [REDACTED].#3 every four hours as needed for pain. Record review of Resident #70 ' s MAR indicated [REDACTED]. Record review of the facility Pain Roster dated 3/1/15 thru 3/31/15 revealed the resident reported the following level of pain based on a 1-10 pain scale with 10 being the worst pain ever experienced on the following dates: 3/20/15 resident ' s pain intensity was 10 3/21/15 resident ' s pain intensity was 10 at 10:57 A.M. and 6:11 P.M. 3/22/15 resident ' s pain intensity was 10 at 12:44 P.M. and 7:08 P.M. 3/26/15 resident ' s pain intensity was 5 at 11:29 P.M. 3/28/15 resident ' s pain intensity was 10 at 9:44 P.M. 3/29/15 resident ' s pain intensity was 10 at 1:19 P.M. Observation on 3/29/15 at 12:36 P.M. revealed Resident #70 in bed awake and alert. Interview on 3/29/15 at 12:36 P.M. during the observation Resident #70 stated her pain intensity level was 7. Resident #70 continued and stated she was out of the Narco and was getting [MEDICATION NAME] instead. She stated [MEDICATION NAME] did not work like the [MEDICATION NAME] on her pain. Interview on 3/29/15 at 1:46 P.M. DON stated she did not know why the resident ran out of her Narco. Interview on 3/29/15 at 2:11 P.M. LVN#3 stated Resident #70 was getting [MEDICATION NAME] 50 mg and [MEDICATION NAME] 10/325 every six hours as needed for pain. LVN#3 continued and stated when she realized the [MEDICATION NAME] was out on Saturday (3/28/2015) she called the pharmacy to request a refill but she was told she needed triplicates. She continued and stated she called the physician to notify him that she needed triplicate prescriptions. The doctor questioned why he was not notified during the week.LVN#3 stated she only worked on weekends and she did not know. The physician stated the resident would have to wait until Monday. Interview on 3/30/15 at 8:40 A.M. LVN#14 stated when she noticed that a resident ' s medicine was about to run out she calls the pharmacy for refills and if it cannot be refilled she notifies the physician. She stated she does not notify the DON but will notify the next on coming nurse during report and if she works the next day she would call the pharmacy and physician again. Observation on 3/30/2015 at 8:00 P.M. revealed Resident #70's [MEDICATION NAME] had been reordered by the physician and called to the pharmacy after 1:00 P.M. on 3/30/2015. As of the time of this observation Resident #70's [MEDICATION NAME] had not been delivered to the facility. Interview on 3/31/2015 at 9:00 A.M. per phone the Administrator stated the resident's [MEDICATION NAME] arrived at 11:40 P.M. on 3/30/2015 and Resident #70 was immediately given a dose. Record review of facility policy on abuse prohibition and procedure dated 11/14 did not address above concerns. The facility provided a census which revealed 108 residents.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop, review, and update resident's comprehensive care plans to correctly identify care and services for eight of 22 residents (#73, #30, #25, #47, #70, #106, #9 and #86) reviewed to ensure the care plans met the resident's medical, nursing, mental, and psychosocial needs. Resident #73's care plans were not individualized to his nutritional problems.

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) Resident #30's care plans were not individualized to reflect care needs. Resident #25's care plans were not individualized concerning medication side effects. Resident #47's care plans were not individualized concerning his contractures. Resident #70's care plans were not individualized concerning her activities and [MEDICAL TREATMENT]. Resident #106's care plans were not individualized concerning her medications and the use of wander guard system. Resident #9's care plans were not individualized concerning her medications. Resident #86's care plans were not individualized concerning medications and the use of a [DEVICE]. These failures affected eight residents and placed 100 residents at risk of not receiving the care they need due to their care plans not accurately communicating these needs to the caretakers which could cause a decline in their mental and physical health. Findings include: Intake # 7 Resident #73 Record review of Resident # 73 ' s face sheet revealed he was a [AGE] year old male, admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 73 ' s Minimum Data Set ((MDS) dated [DATE] revealed his Brief Interview for Memory Status (BIMS) was 4 which indicated he was severely cognitively impaired. Record review of the same MDS revealed the resident ' s weight was 191 pounds. Record review of Resident #73 ' s MDS dated [DATE] revealed his weight was 172 pounds. The weight loss not was identified. Record review of Resident # 73 ' s physician's order [REDACTED]. discontinue Nutrien 2.0 cal at 30 ml/hr and change to [MEDICATION NAME] 2.0 cal bolus per GT QID Resident is NPO . Record review of Resident #73 ' s care plans revealed the care plans were not specific and individualized to the resident ' s needs and capabilities (the resident had a [DEVICE] and was NPO as follows: The resident had a care plan for potential for unintended wt. loss dated 02/10/15 and a goal target date of 05/10/15 with an approach that included: escort Resident to dining CNA room for lunch/dinner, no more than 15 minutes prior to meal service, provide high calorie snacks and beverage, preferences at snack times .document meal intake daily, offer sub if meal intake below 50%, then LQD nutritional supplement .currently on a pureed diet; the resident had a care plan for Resident and family having difficulty accepting new peg tube placement dated 03/04/15 with a target & goal date of 06/04/15; the resident had a care plan dated 7/15/13 with a goal and target date of 4/27/15 with an approach of encourage Resident that all meals are given by nurse, gentle exit Resident out of dining room and provide diversional activity. Interview on 3/12/15 at 12:30 P.M. Assessment Nurse #2 stated they attempt to divert Resident #73 away from the dining room during meals because he was NPO and did not understand why he could not eat any longer. She stated he had a problem with aspiration pneumonia and that was the reason for the [DEVICE] placement. Resident #30 Record review of Resident #30 ' s face sheet revealed a [AGE] year old female, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #30 ' s MDS dated [DATE] revealed a BIMS score of 14, which indicated the resident was not cognitively impaired. Continued review of the same MDS revealed the resident required extensive assistance from two plus staff for personal hygiene. Record review of Resident #30 ' s care plans revealed the care plans were not specific and individualized to the resident ' s needs and capabilities as follows: The resident had a care plan which stated Resident requires extensive assist x1 with personal hygiene dated 12/12/14 with approaches which listed staff x1 to assist Resident with oral, hair and nail care daily; the resident had a care plan which stated Resident has Dx [MEDICAL CONDITION] medication risk for S/E of medication risk for hypertensive crisis dated 12/12/14 and the approaches listed give feedings/flushes via g/t per MD orders. Observation and interview on 3/26/15 at 9: 52 a.m., Resident # 30 was in bed. She stated she had an upper respiratory infection and was receiving antibiotic treatment for [REDACTED]. The resident did not have a gastrostomy tube (g/t). Resident #25 Record review of Resident #25 ' s face sheet revealed a [AGE] year old female, admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #25 ' s MDS dated [DATE] revealed the resident had a BIMS score of 13 which indicated the resident was mildly impaired in cognition for daily decision making skills. Continued review revealed the resident required extensive assistance in ADL ' s. Record review of Resident #25 ' s care plans revealed the care plans were not specific and individualized to the resident ' s needs and capabilities as follows: The resident had a care plan dated 06/18/13 which stated has a hx of neurological dysfunction r/t hx of [MEDICAL CONDITION]. At risk for aspiration, injury, pain and adverse reaction with a goal of minimal to no adverse effects to medication (no medication stated) with approaches which listed side effects of a medication. Resident # 47 Record review of Resident #47 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Record review of Resident #47 ' s care plans dated 12/12/14 revealed no care plan that identified the residents bilateral hand contractures. Record review of Resident #47 ' s MDS dated [DATE] revealed his BIMS was 10 which indicated he was cognitively intact. Continued review of the same MDS revealed the resident had bilateral upper extremity contractures. Observation on 3/11/15 at 3:40 P.M. revealed Resident #47 sitting in his room in a wheel chair. The resident was alert and oriented and had bilateral contractures to his hands. Interview on 3/11/15 at 3:40 P.M. the resident stated he was unable to open his hands but he did have splints used at night. Interview on 3/12/15 at 11:50 A.M. Assessment Nurse #2 stated she was surprised Resident #47 did not have a care plan for his contractures. She stated he should and she must have missed that. Interview on 3/12/15 at 12:45 P.M. ADON Skilled stated the care plans indicate the care that was to be provided for the resident. Resident # 70 Record review of Resident # 70 face sheet revealed a [AGE] year old female admitted to facility on 6/27/13 with the following diagnose: hypertension, Diabetes mellitus, depression, [MEDICAL CONDITION], muscle weakness, obesity and ends stage kidney disease. Record review of Resident # 70 ' s MDS dated [DATE] revealed the resident was moderately impaired for cognition and required extensive assistance with ADLs. Record review of Resident # 70 ' s care plan updated 2/24/15 revealed the resident enjoys attending daily activities programming and does need assistance to and with activity. Goal was resident will have no decline in activity participation for 90 days. Further review of Resident # 70 ' s care plan updated 2/24/15 revealed resident had a decline in activity participation related to the start of [MEDICAL TREATMENT] three times a week, activities will continue to invite and encourage to activities of choice. Goal and approach were outline. Record review of Resident # 70 ' s care plan updated 2/27/15 revealed resident was at risk for infection related to end stage [MEDICAL CONDITION], had a graft and decreased kidney function, goal was the resident will maintain current level of physical conditions for 90 days, will maintain current level of activities of daily living function for as long as possible without decline within the next 90 days. The above goals did not correlate with the identified problem, making care plan unrealistic. Record review of resident # 70 ' s care plan updated 2/24/15 revealed resident had a [DIAGNOSES REDACTED]. Approached identified include [MEDICAL TREATMENT] at 5:30 a.m., on Monday, Wednesday, and Friday. Record review of Resident # 70 record revealed her [MEDICAL TREATMENT] chair times was 10:30 a.m. Interview on 3/11/15 at 5:00 p.m., Assessment Nurse # 2 read the identified concerns and said she understood that the goal

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) and approaches should address the identified problem. She reported Resident # 70 ' s [MEDICAL TREATMENT] time was not 5:30 a.m., and will be corrected. Resident #106 Record review of Resident #106 ' s face sheet revealed she was admitted to the facility on [DATE]. She was [AGE] years old. Her [DIAGNOSES REDACTED]. Record review of Resident #106 ' s quarterly MDS dated [DATE] revealed she was assessed as severely impaired in cognition for daily decision making skills. Continued review of the same MDS revealed the resident required extensive assistance with ADL ' s. Record review of Resident #106 ' s care plans revealed the care plans were not specific and individualized to the resident ' s needs and capabilities as follows: The resident had a care plan for activity attendance dated 4/3/14 and a goal target date of 4/27/15 with an approach that included: encourage resident to attend the resident council meeting; the resident had a care plan dated 7/15/13 with a target & goal date of 4/27/15 for the use of medication for [MEDICAL CONDITION] disorder with approaches that listed the side effects of the medication; the resident had a care plan dated 7/15/13 with a goal and target date of 4/27/15 for the use of shortness of breath and cough with a goal of minimal adverse reactions to medications with approaches that included a list of the side effects of the medication; the resident had a care plan for wandering with approaches that included the use of a wander control system (wander guard) and to obtain an order for [REDACTED]. Interview on 3/12/15 at 12:30 P.M. Assessment Nurse #2 stated care plans should be individualized and fit the needs and capabilities of each resident. She further stated the facility did not use a wander control (wander guard) system. Resident #9 Record review of Resident #9 ' s face sheet revealed the resident was admitted to the facility on [DATE]. The resident was [AGE] years old. His [DIAGNOSES REDACTED]. Record review of Resident #9 ' s quarterly MDS dated [DATE] revealed a BIMS score of 7, which indicated the resident was severely impaired in cognition for daily decision making skills. Continued review of the same MDS revealed the resident was dependent on facility staff for all care. Record review of Resident #9 ' s care plans revealed the care plans were not specific and individualized to the resident ' s needs and capabilities as follows: The resident had a care plan for receiving an antidepressant medication dated 10/28/14 ([MEDICATION NAME]) with approaches which listed all of the side effects of the medication; the resident had a care plan for insulin due to diabetes and the approaches included a list of the side effects of insulin; the resident had a care plan for risk of [MEDICAL CONDITION] with an approach that included administer [MEDICATION NAME] as ordered (record review of the resident ' s MAR and physician's order [REDACTED]. Resident #86 Record review of Resident #86 ' s face sheet revealed she was admitted to the facility on [DATE]. She was [AGE] years old. Her [DIAGNOSES REDACTED]. Record review of Resident #86 ' s quarterly MDS dated [DATE] revealed the resident had a BIMS score of 12 which indicated the resident was moderately impaired in cognition for daily decision making skills. Continued review revealed the resident required extensive assistance in ADL ' s. Record review of Resident #86 ' s care plans revealed the care plans were not specific and individualized to the resident ' s needs and capabilities as follows: The resident had a care plan dated 2/6/15 for risk for withdrawal, fear and increased fatigue with a goal of minimal to no adverse effects to medication (no medication stated) with approaches which listed side effects of a medication; the resident had a care plan for risk reflux, heartburn and chest pain due [MEDICAL CONDITION] an approach which included give feedings/flushes via [DEVICE] per MD orders (the resident did not have a [DEVICE]). Record review of the facility ' s policy Care Planning dated December 2005 revealed The Interdisplinary team will coordinate with the patient/representative a care plan appropriate for the patient ' s needs or wishes based on the assessment and reassessment process within the required time frames. Facility's 672 reported a census of 108.
F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide services by a qualified person in accordance with the written plan of care/physician's orders [REDACTED].#72, #62, #65, #97, and #15)whose care plans and physician's orders [REDACTED]. Resident #72's was not provided the Nepro supplement and blood pressure medications as ordered by the physician. The resident experienced weight loss for two consecutive months without the supplements recommended by the Registered Dietitian. The resident's blood pressure medicine ordered four times a day was administered three times per day. Resident #62 was not provided tube feedings as ordered by her physician. The resident, who had contractures and was compromised, was not provided the tube feeding as ordered by the physician. Resident #65 was not provided health shakes with meals as ordered by the physician. The resident experienced weight loss without the supplement being given. Resident #97 was not provided hand rolls and treatments to the insides of her hands as ordered by the physician and documented in the care plan. The resident had orders to have hand rolls in place to prevent injury and contractures which was not provided by staff Resident #15's heels were not floated while in bed as documented in the resident's care plan. The resident had pressure sores on her heels that were not provided the treatment ordered by the physician. Resident #15's tube feeding was not provided as ordered by the physician. The resident experienced weight loss and when the doctor increased her tube feeding on 3/12/2015 the facility staff did not implement the increase until 3/25/2015. An immediate jeopardy (IJ) was identified on 3/26/2015. While the IJ was removed on 4/2/2015 the facility remained out of compliance at a scope of patterned and a severity level of actual harm because all staff had not been trained on the following of physician's orders [REDACTED]. These failures affected six residents with increased weight loss, pressure sores and contractures and placed 102 residents at risk of not receiving the care ordered by their physician's or as planned in their care plans which could cause a decline in their health. Findings include: Resident #72 Record review of Resident #72 ' s face sheet revealed the resident was admitted to the facility on [DATE] and was readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #72 ' s MDS dated [DATE] revealed the resident was cognitively impaired. The MDS revealed the resident required the assistance of staff for all ADLs. Record review of Resident #72 ' s care plan dated 10-22-2014 revealed a problem of the resident was at risk for weight loss with approaches of serving the diet as ordered by the physician and to have dietary consults as needed. Another problem identified was the resident had a [DIAGNOSES REDACTED]. Record review of Resident #72 ' s weight history revealed the following: 1-10-15 wt. 150.60 pounds 2-10-15 wt. 142.60 pounds 3-10-15 wt. 139.00 pounds Record review of Resident #72 ' s dietary notes dated 2-23-15 revealed the dietitian had documented the resident had an eight pound weight loss and recommended the resident receive one can of Nepro every day for 30 days. Record review of Resident #72 ' s physician's order [REDACTED].

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

F 0282

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 7)
Record review of Resident #72 ' s dietary notes dated 3-24-15 revealed the dietitian documented the resident had an additional weight loss of 3.6 pounds. The dietitian at this time recommended the resident was to be provided one can of Nepro two times a day for 30 days.
Review of Resident #72 ' s physician's order [REDACTED].
Record review of Resident #72 ' s MAR dated March 2015 revealed no transcription of the Nepro order and no documentation of the resident receiving the Nepro.
Observation and interview on 3-26-2015 at 8:30 A.M. revealed the resident eating breakfast in the dining room. The resident stated his meal was very good and he ate 90 percent of the meal. There was no Nepro served with the meal.
Interview on 3-26-2015 at 8:30 A.M. LVN #10 stated Resident #72 received the Nepro on [MEDICAL TREATMENT] days. She stated
it was packed by the dietary department.
Interview on 3-26-2015 at 8:40 A.M. the Food Service Supervisor stated the dietary department supplied a sack lunch for the residents when they went to [MEDICAL TREATMENT]. She stated the sack lunch consisted of a sandwich, graham crackers and fruit along with a juice. She stated the dietary department does not dispense the Nepro drinks. She stated that would be supplied by the nurses.
Interview on 3-26-2015 at 10:30 A.M. the DON stated she had spoken to the nursing staff and figured out the system at the facility was that all residents who had [MEDICAL TREATMENT] was given a can of Nepro on their [MEDICAL TREATMENT] days that
was provided by the nurses out of the nourishment room. She stated that Resident #72 went to [MEDICAL TREATMENT] three times a week. She stated she would get the order transcribed to the MAR and in-service the nurses so Resident #72 would receive the Nepro twice a day as ordered.
Record review of Resident #72 ' s physician ' s telephone orders revealed an order dated 3-24-2015 for the blood pressure medication [MEDICATION NAME] 10 mg to be administered every 8 hours. The same order also revealed another blood pressure medication [MEDICATION NAME] 50 mg to be administered every 6 hours PRN (as needed) if the resident ' s systolic blood pressure was above 160.
Record review of Resident #72 ' s MAR dated March 2015 revealed the medication [MEDICATION NAME] 10 mg had been transcribed
to be given every 6 hours and the [MEDICATION NAME] 50 mg to be administered every 8 hours PRN. The medication [MEDICATION
NAME] 10 mg had been documented as administered at 8 AM, 2 PM, 8 PM and 2 AM on 3-25-2015. The medication [MEDICATION NAME]
50 mg had not been administered.
Interview on 3-26-15 at 8:45 AM the DON stated she was the one who had written the order. She stated she remembered the physician giving the order as it was transcribed not as she had written it on the order and that she had written the order wrong. She stated the doctor wanted the resident to receive the [MEDICATION NAME] every 6 hours and the [MEDICATION NAME]
every 8 hours PRN. She stated she would verify and make the corrections.
Interview on 3-26-2015 at 11:45 AM LVN #10 stated she had administered Resident #72 ' s medications to him on 3-25-15. She stated, as she showed the medication card of the [MEDICATION NAME], that the label on the medication read to give every 8 hours but the MAR had directions to give every 6 hours. She stated she administered the medications as it was written on the MAR. She showed the sticker on the package that directed staff there was a direction change and to check the resident ' s order. She stated that sticker was just applied to the card and was not there the previous day. She stated she had been trained that when the medication label did not match the MAR she was to check the physician's order [REDACTED]. She stated she did not do what she had been trained to do.
Resident #62
Record review of Resident #62 ' s face sheet revealed the resident was admitted to the facility on [DATE]. The resident was [AGE] years old. Her [DIAGNOSES REDACTED].
Observation on 3/10/2015 at 1:24 P.M. revealed the resident in bed with O2 being administered at 2 liters per minute. The resident had a tube feeding being administered per a [DEVICE] and feeding pump of Glucerna 60 cc/hr. The tube feeding was dated 3/10/2015.
Record review of Resident #62 ' s MDS dated [DATE] revealed the resident had impairments to both upper and lower extremities. It also revealed the resident was totally dependent on staff for bed mobility and all activities of daily living. The MDS revealed the resident weighed 150 pounds and received her nourishment per a [DEVICE].
Record review of Resident #62 ' s care plan dated 2/14/2015 revealed the resident ate nothing by mouth and obtained all nutrition intake via an external tube. Approaches listed to administer the tube feedings and flushes per physician's order [REDACTED].
Record review of Resident #62 ' s physician's order [REDACTED]. Turn feeding off at 10 A.M. and on at 12:00 P.M.
Observation on 3/11/2015 at 9:33 A.M. the resident was positioned on her back with the tube feeding off. The tube feeding bottle had 700 cc Glucerna 1.2 in the bottle dated 3/12/2015 and was marked to be dispensed at 60 cc per hour. After the provision of incontinent care CNA #17 went into the hall to get RN #6 to turn the resident ' s feeding tube back on.
Interview on 3/11/2015 at 9:35 A.M. RN #6 stated she was still in orientation and it was her second day. She stated the resident ' s tube feedings were to be at 60 cc per hour and the pump was set for this so she just had to turn the pump back on after the aides elevated her head and were through providing the incontinent care. When asked how she knew the feeding was to be 60 cc per hour she stated it was marked on the bottle.
Observation and interview on 3/12/2015 at 1:10 P.M. revealed the resident lying on her back with her knees in the air. Head of bed was elevated 45 degrees. The resident had a tube feeding being administered of Glucerna 1.2 being administered at 60 cc per hour. LVN #4 entered the room and when asked what the resident ' s tube feeding was she stated it was being dispensed at 60 cc per hour for 22 hours and that she had just turned it back on at noon. When asked she stated she would confirm the physician's order [REDACTED]. hour and that she would go adjust the rate. She stated the night nurse always marked the bottles and would set the feeding pump. She stated she would leave a note for the night nurse to make sure the feeding was set at 70 cc per hour.
Interview on 3/11/2015 at 4:00 P.M. the DON stated the tube feedings were set up by the night nurse. She stated she would check with the nurse to see why she had set up the resident ' s feedings for 60 cc per hour instead of the doctor ordered 70 cc per hour and in-service her to make sure she doubled checked orders.
Resident #65
Record review of Resident #65's face sheet revealed he was admitted to the facility on [DATE]. The resident's [DIAGNOSES REDACTED].
Record review of Resident #65's care plan dated 9/8/2014 with no updates noted, revealed no care plan concerning the resident's nutritional status except that the resident was sad concerning his having a [DEVICE]. The care plan revealed the resident would be monitored and referred to counseling and a psychiatric evaluation. No approaches were listed for staff to provide.
Record review of Resident #65's weight change history revealed the resident weighed 177.70 pounds on 1/10/2015 and 162.80 pounds on 2/10/2015. A 14.6 pound weight loss.
Record review of Resident #65's Communication between the Dietitian and the Attending Physician form dated 2/26/2015 revealed the RD/LD recommended a health shake by mouth three times a day with meals for thirty days and weekly weights for four weeks.
Record review revealed the recommendations were not communicated to the physician until 3/24/2015 when a physician's orders [REDACTED].
Record review on 3/26/2015 of the nurse's notes revealed the resident had been transferred to the hospital earlier that morning due to vomiting.
Record review on 3/26/2015 of Resident #65's dietary card printed by the Food Service Supervisor did not have the health shakes added to the diet order.
Interview on 3/26/2015 at 10:30 a.m. the DON stated the health shake order would be carried out by the dietary department due to it being served with meals. She stated the nurses had a form to communicate with the dietary department and would write the orders in the book of the forms and give a copy to dietary. When requested to see the communication form the DON was unable to locate where dietary had been notified to provide the health shakes.
Resident #97
Record review of Resident # 97 ' s face sheet revealed she was admitted to the facility on [DATE]. She was [AGE] years old. Her [DIAGNOSES REDACTED].

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) Record review of Resident #97 ' s MDS dated [DATE] revealed her cognitive status was severely impaired. The same MDS revealed the resident was totally dependent on staff for all mobility and activities of daily living. The MDS documented the resident had impairments to both upper extremities. Observation at 3:30 P.M. on 3-11-2015 revealed the resident alert and able to track with her eyes. The resident was non-verbal and lying in bed. Both of the resident ' s hands were elevated on a pillow lying on her chest. Her upper arms and hands were contracted. Both hands were in fists with the fingers overlapping each other in an unnatural way. The resident was unable to open her hands upon request. There were no hand rolls in her hands. Record review of Resident #97 ' s care plan originally dated 6/4/2013 (no updates listed on care plan) revealed a problem of contractures to upper and lower extremities. Approaches listed keep hands clean and dry, Use hand rolls and pillows as needed. Record review of Resident #97 ' s physician's order [REDACTED]. Interview with Resident #97 ' s family member on 3/11/2015 at 6:00 P.M. he stated that just last night (3/10/2015) he had told the charge nurse (LVN #8 identified by name) about the resident ' s left hand. He stated when he comes, daily, there is never anything in her hands and he would always try to open them up a little to stretch her fingers. He said when he opened the resident ' s left hand he noticed there was a wound and a buildup of skin and dead tissue. He said the odor was awful. He tried putting some scented lotion inside it but that did not help. He went on to state LVN #8 told him she would tell the treatment nurse and they would take care of the wound. He said he then left for the evening and when he came back tonight he found the resident in the exact same condition with nothing in her hands and no treatment being done to the wound. Observation on 3/11/2015 at 6:00 P.M. of the inside of the left hand revealed a very foul odor and a large amount of dead skin. The inside of the hand appeared moist with injury to the tissue noted in the palm of the hand. The resident was unable to open the hand independently but did not show expressions of pain when family member extended the deformed fingers to show the inside of the hand to the surveyor. Interview on 3/11/2015 at 6:10 P.M. the DON discussed with the family member the condition of the resident ' s hand after the family member showed it once more. The DON stated she would follow up with the nurses and make sure the physician was contacted. Interview on 3/11/2015 at 6:15 P.M. the DON stated LVN #8 had reported the condition of Resident #97 ' s hand to the Treatment Nurse. The Treatment Nurse stated she had looked at the hand and the Resident was to have a hand roll (carrot) in her hands to prevent this. Resident # 15 Record review of Resident # 15 ' s face sheet revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. She was [AGE] years old. Her [DIAGNOSES REDACTED]. Record review of Resident #15 ' s MDS dated [DATE] revealed her cognitive pattern was 3 which indicated she was severely impaired for daily decision making (rarely/never made decisions). The MDS revealed the resident was total dependence on staff for personal hygiene. Record review of Resident # 15 ' s care plan dated 6/10/14 revealed the problem .Resident is weak and with contractures to upper extremities and foot drop to left foot . approaches .float heels while in bed . Record review of the following dietary notes for Resident #15 revealed: . 8/28/14 August 117.2 pounds weight loss 9.2 pounds 7.2 % per month stage III wound . recommended increase tube feeding [MEDICATION NAME] 1.2 to 65 ml per hour . .11/25/14 November at 115.2 pounds .11.2 pound decrease down 8.8% in 3 months . .1/15/15 January at 110.6 pounds. Weight loss restarted weight down 15.8 pounds 12.5 % in 3 and 6 months recommended [MEDICATION NAME] 1.2 at 65 ml per hour for 22 hours . .2/12/15 dietary notes revealed February weight pending January at 110.6 pounds .recommend increase tube feeding to [MEDICATION NAME] 1.2 at 65 cc per hour. Observations of Resident #15 on the following dates and times revealed the resident was non-verbal. Her oxygen was per [MEDICAL CONDITION] collar and tube feeding was running on a pump at 60 ml per hour: The resident had heel protectors on bilateral lower extremities with heels on the mattress: 3/10/15 at 10:22 A.M. and 1:10 P.M. 3/11/15 at 10:30 A.M. and 4:00 P.M. Interview on 3/12/15 at 12:45 P.M. ADON skilled stated Resident #15 had an air mattress and heel protectors but if her heels were flat on the bed they were not floated. Record review of Resident #15's physician's telephone orders dated 3/12/2015 revealed an order to increase the resident's tube feeding to 65 cc per hour for 22 hours. Observation on 3/25/15 at 3:50 P.M. revealed Resident #15 in the bed receiving O2 [MEDICAL CONDITION] 2 liter per. The feeding tube was dispensing [MEDICATION NAME] 1.2 at 60 cc per hour. Record review of Resident #15's March 2015 MAR revealed the resident was to receive [MEDICATION NAME] 1.2 at 60 cc per hour. The physician's orders [REDACTED]. Interview on 3/25/2015 at 4:05 P.M. the DON stated Resident #15's original dietary recommendation was one of the recommendations that had been overlooked but she had corrected the tube feeding order as of 3/12/2015. After reviewing the order, the March MAR and the resident's tube feeding she stated she remembered talking with the physician, writing the order and giving it to the nurse to transcribe to the MAR. She stated she would make sure it was transcribed now and that the feeding was changed to the correct amount. She also stated she would inservice the nurse on transcribing orders. Record review of the Comprehensive Care Plan policy for the facility dated 7/13 revealed the services provided or arranged by the facility must meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care. A policy was requested concerning [DEVICE]s but on the policy concerning nasogastric tubes was provided. Record review of the facility's policy concerning receiving/recording physician orders [REDACTED].r.n. (as needed). There should also be orders in place that specify the amount of water used for flushing. An immediate jeopardy (IJ) was identified on 3/26/2015 . A plan to lower the immediate jeopardy was submitted and accepted on 3/29/2015 . The plans included: Immediate interventions implemented to include all residents residing in facility that could be affected by an effective system not being in place and monitored to track residents who could be at risk for weight loss. 1. 100% audit of current census was conducted by Corporate Consultant Nurse to ensure weight variances were addressed, malnutrition assessments were completed for all residents to identify any at risk residents without a current weight loss INITIATED: 3/27/2015 COMPLETED: 3/29/2015 Care plans updated to include interventions to prevent weight loss. Dietician reviewed all residents with a significant weight loss. INITIATED: 3/26/2015 COMPLETED: 3/29/2015 100% audit of tube feeding orders to verify ordered formula was being given as per physician orders. INITIATED: 3/27/2015 COMPLETED: 3/27/2015 Corporate Dietitian audited 100% of dietary orders and supplement orders to verify Dietary Managers diet roster matches physician orders. Any discrepancies were corrected. INITIATED: 3/27/2015 COMPLETED: 3/28/2015 Corporate Dietitian conducted a 100% supplement order and delivery during meal service to verify supplements supplied by the kitchen were delivered as ordered. INITIATED: 3/27/2015 COMPLETED: 3/28/2015 100% audit of all new orders from March 1, 2015 current were checked for accuracy of transcription. INITIATED: 3/29/2015 COMPLETED: 3/30/2015 Interventions Issue #1: 1. Residents at risk and those who had a significant weight loss will be identified by the management nurses to begin on 3/26/15 and complete by 3/27/15. Any resident identified to be at risk were assessed, RD, & MD were notified to determine whether a change in treatment regimen was required. 2. MD/Nurse Practitioner will be contacted by DON or Designee with all dietary recommendations and the DON will monitor MD response/orders and ensure all recommendations have been addressed. If MD does not respond within 24 hours the DON or

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F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 9) designee will make a second attempt to notify of recommendation. If no response at this 2nd attempt, the DON or designee will contact the Medical Director for orders following every scheduled dietary visit. All recommendations will be addressed within 24 hours of DON / designee receiving recommendations from dietician. All current recommendations were communicated to the MD/Nurse Practitioner, have been addressed, agreed with dietician recommendations, order written and noted in the medical records, transcribed onto MAR, communication forms given to dietary department for all diet changes, and supplement orders. New orders are being administered as directed. 3. All Licensed staff in-serviced by nurse management on notifying DON when Dietary Recommendations have been received from the MD or Nurse Practitioner after every scheduled dietary visit. Nurses will not be allowed to work the floor prior to receiving this education beginning on 3/26/15 and will be completed by 3/31/15. DON is responsible for tracking of the dietary recommendations and ensuring they are followed up on within the specified time frame. 4. All Licensed Staff were in-serviced by nurse managers regarding administration of treatments and medications. Nurses will not be allowed to work the floor prior to receiving this education beginning on 3/26/15 and will be completed by 3/31/15. In-service included what the nurse must do when the medication is not received from the pharmacy when ordered. The nurse must notify the MD immediately to make aware of med not available in order to adjust treatment regimen. Nurse must notify MD of med allergies [REDACTED]. When a medication has to be held due to abnormal vital signs the MD must be notified immediately. Interventions Issue #2: 1. All Licensed Staff were in-serviced by management nurses regarding transcribing all MD orders per policy and procedure. POLICY: When an order is received from the MD, it must be transcribed to an order sheet, the order must be transcribed exactly as it is ordered to the MAR. The nurse must implement the order as transcribed. All orders must be documented in the clinical records stating the order was received, the RP was notified and order initiated. The new order will be documented on the 24 hour report for continuum of care. Nurses will not be allowed to work the floor prior to receiving this education beginning on 3/26/15 and will be completed by 3/31/15. 2. All Licensed Staff were in-serviced by management nurses regarding transcription and implementation of all tube feeding changes and supplements as per physician orders. Nurses will not be allowed to work the floor prior to receiving this education beginning on 3/26/15 and will be completed by 3/31/15. Interventions Issue #3: 1. Licensed Staff were in-serviced by nurses managers regarding completing dietary communication form for all new diet orders or changes prior to working the floor beginning on 3/26/15 and will be completed by 3/31/15. Monitoring: 1. Nurse Managers will verify a dietary communication form was complete for all new diet orders or diet changes and supplements in daily start up meeting. Process improvement began: 3/27/2015 2. Nurse Managers will review all new orders in daily start up meeting to ensure transcription to medication administration records is accurate and complete. Process improvement began: 3/27/2015 3. Nurse Managers will review 24 hour report in start- up process to identify any resident who has refused medications or have had to hold medications due to doctor ' s order for parameters. The managers will review documentation to verify notification to the physician. Process improvement began: 3/27/2015 4. Nurse Managers will monitor medication transcription of medications are accurate in daily start up process. Process improvement began: 3/27/2015 5. Nurse Managers will verify all dietary orders and recommendations are transcribed and implemented in daily start up meeting. Process improvement began: 3/27/2015 6. DON will monitor supplements to ensure the process for administration is being followed to ensure that all residents requiring supplements are receiving it as ordered at it specified time, right amount to be consumed. (Health shakes , and magic cups are listed on the resident ' s tray cards to be served from Nutrition Department and ordered (with or between meals.) Med pass, can supplements (Nepro, Glucerna, Ensure, etc)as ordered on the MAR, will be administered by nurse during medication pass. The hydration /snack cart contains among other items, labeled Health shakes, magic cup if ordered between meals. Process improvement began: 3/27/2015 Monitoring of the plan: Record review of the facility inservices revealed 17 out of 20 licensed nursing staff were inserviced for notification to physician, verification of orders and allergies [REDACTED].) form. Record review of the facility inservices revealed 29 out of 37 unlicensed nursing staff were inserviced for notification to the nurse and completion of the stop and watch form. Interviews on 4/2/15 with 11 out of 12 licensed nursing staff on duty identified the need to call the physician for changes in the resident's condition, weight loss, medication or treatment refusal, no relief from pain medication, abnormal lab values, medication not available, abnormal vital signs, verification of orders and allergies [REDACTED]. Interviews on 4/2/15 with 9 out of 10 unlicensed nursing staff and three therapy staff identified the need to complete the stop and watch form and notify the nurse for any complaint of pain or change in the resident. Record review of Resident #'s 62, 15, 30 and 86's clinical record reveal lab results were called to the physicians. Resident #30's blood pressure was low on 4/1/15 which required her blood pressure medication to be held. The physician was notified. Record review of the resident's with weekly weights revealed completed with no changes. The dietician was in the facility on 4/2/15. Observations on 4/1/15 and 4/2/15 revealed Residents #'s 59, 100 and 72 received and completed the dietary recommended supplements. Observation on 4/2/15 revealed Resident #73 received his ordered tube feeding bolus. Observation on 3/28/15, 3/29/15, 3/30/15, 3/31/15, 4/1/15 and 4/2/15 revealed Resident # 15's tube feeding was infusing at 65ml per hour. The resident heels were floated and the catheter was removed as ordered on [DATE]. An immediate jeopardy (IJ) was identified on 3/26/2015 . While the IJ was removed on 4/2/2015 the facility remained out of compliance at a scope of pattern and a severity level of actual harm because all staff had not been trained on the following of physician's orders [REDACTED]. The facility 672 form revealed the census was 108 residents.
F 0309 **Level of harm** - Immediate jeopardy **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, record review and interview the facility failed to provide the necessary pain management and appropriate medication treatments to attain or maintain the highest practicable physical, mental and psychosocial well-being according to the comprehensive assessment for two of 10 residents (Resident #70 and #30) assessed for pain management and quality of care Resident #70 ' s pain was not effectively controlled. The facility failed to assess her pain and medicate her for pain. She ran out of pain medications for 6 days and she experienced severe pain with pain score of 10. During treatment for [REDACTED].#4 failed to assess and medicate her for pain. Resident #70 was grimacing in pain and LVN #4 did not stop and continued with the treatment. Resident #70 was found to have new multiple open areas with excoriation to inner thighs and gluteal fold which were not identified and addressed. Resident #70 had nutritional problems and the physician ordered to give her [MEDICATION NAME] to stimulate her appetite. The facility failed to give her this medication and the physician was not notified. Resident #30 was given antibiotics to which she was allergic. The facility failed to check Resident #30 ' s list of allergies [REDACTED]. This failure affected one resident who suffered with chronic pain and one resident who was at risk of various allergic

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F 0309

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 10)
reactions and placed 39 residents on pain management and 65 residents in the facility at risk of poor care and increased pain which could cause a decline in their medical, physical and mental health.
An IJ was identified on 3/26/2015. While the IJ was removed on 4/2/2015 the facility remained out of compliance at a scope of pattern and a severity level of actual harm because all staff had not been trained on assessing and the management of pain.
Findings include:
Intake # 7
Resident # 70
Record review of Resident # 70 face sheet revealed a [AGE] year old female admitted to facility on 6/27/13 with the following diagnose: hypertension, diabetes mellitus, depression, [MEDICAL CONDITION], muscle weakness, obesity and ends stage kidney disease.
Record review of Resident #70 ' s care plan dated 7/13/13 with no update date revealed Resident #70 has impaired comfort related to chronic pain, complaint of pain, [MEDICAL CONDITION]. The care plan goal with target date .Resident will have relief from pain when as needed (PRN) medication is used over 90 days with the target date of 5/14/15 . Approaches .Give PRN pain medication according to physician ' s orders .Notify physician and responsible party if pain medication is not effective in relieving pain . observe for effectiveness of PRN pain medications .
Record review of Resident # 70 ' s MDS dated [DATE] revealed the resident was moderately impaired for cognition and received as needed pain medication.
Record Review of Resident #70's prescription for [MEDICATION NAME] with APAP ([MEDICATION NAME]) 10/325 mg was dated as
being ordered by the physician on 11/12/2014.
Record review of Resident #70 ' s MAR indicated [REDACTED]. Further review of the MAR indicated [REDACTED]. Review of the
back of the MAR indicated [REDACTED].
Record review of Resident #70 ' s MAR indicated [REDACTED]. Further review of MAR indicated [REDACTED].
Record review of Resident # 70 ' s nurse ' s notes dated 3/3/15 revealed at 9:22 p.m., .resident continued to complain of pain to buttocks areas, resident given pain medication twice, resident continued to be monitored for increased pain.
Record review of Resident # 70 ' s nurse ' s notes dated 3/4/15 revealed at 10:07 p.m., .resident was medicated for pain.
Observation on 3/10/15 at 12:10 p.m., revealed Resident #70 in bed moaning in pain. The resident verbalized she had generalized pain of 10 on a scale of 0-10. She was medicated for pain following the complaint of pain by staff.
Further observation on 3/10/15 at 1:30 pm., revealed Resident # 70 complained of pain being present. Wound care that was scheduled was held due to the resident's pain.
Interview on 3/10/15 at 1:35 p.m., LVN # 4 said the resident had not refused wound care due to pain and had not complained of pain during wound care until today .
Observation and interview on 3/10/15 about 2:10 p.m., during wound care. Resident # 70 said it was ok to perform wound care. Resident # 70 moaned in pain whenever sacral/buttocks wounds were cleaned or touched by LVN # 4 and when she was repositioned. Further observation revealed LVN # 4 did not acknowledge the resident moaning in pain throughout the wound care. Resident # 70 verbalized her buttock was hurting during the wound care. Resident # 70 was noted with large stage II pressure ulcer from left buttock extending to her right buttock and the sacral area. The wound bed did not show any slough or eschar, but had mild drainage. Resident #70 was found to have multiple open areas to inner thigh and excoriations to the perineal areas. She also had an unstageable wound to her left heel.
Interview on 3/10/15 following wound care, Resident # 70 ' s family members said that the resident had never been assessed nor medicated for pain before wound care treatment. They said that Resident #70 would moan in pain during treatment and the nurse would not stop and would continue with the treatment. Resident #70 would just continue to moan.
Interview on 3/10/15 following the above observation, Resident # 70 ' s family member reported she notified LVN# 4 of multiple open areas she identified on the resident but LVN # 4 did not follow up and did not assess the resident.
Interview on 3/10/15 about 3:00 p.m., LVN # 4 said the resident ' s family notified her of the skin excoriations on Resident # 70's inner thighs. She said staff had been applying barrier cream to the excoriated red area but she had not seen the open areas since it was reported to her by the family.
Record review of the Individual Narcotic sign out sheet identified as [MEDICATION NAME] for Resident #70 revealed on 3/20/15 at 10:00 A.M. the remaining [MEDICATION NAME] count was one tablet remained. Continued review revealed the last [MEDICATION
NAME] was removed and administered on 3/24/15.
Interview on 3/29/15 at 1:46 P.M. the DON stated she did not know why the resident ran out of her [MEDICATION NAME]
Record review of the facility Pain Roster dated 3/1/15 thru 3/31/15 revealed the resident reported the following level of pain based on a 1-10 pain scale with 10 being the worst pain ever experienced on the following dates:
3/20/15 resident ' s pain intensity was 10
3/21/15 resident ' s pain intensity was 10 at 10:57 A.M. and 6:11 P.M.
3/22/15 resident ' s pain intensity was 10 at 12:44 P.M. and 7:08 P.M.
3/26/15 resident ' s pain intensity was 5 at 11:29 P.M.
3/28/15 resident ' s pain intensity was 10 at 9:44 P.M.
3/29/15 resident ' s pain intensity was 10 at 1:19 P.M.
Observation on 3/29/15 at 12:36 P.M. revealed Resident #70 in bed awake and alert.
Interview on 3/29/15 at 12:36 P.M. during the observation Resident #70 stated her pain intensity level was 7. Resident #70 continued and stated she was out of the [MEDICATION NAME] and was getting [MEDICATION NAME] instead. She stated [MEDICATION
NAME] did not work like the [MEDICATION NAME] on her pain.
Observations on 3/29/15 at 2:00 P.M. with the DON and at 2:11 P.M. with LVN #3 of the medication cart narcotic box revealed a bubble pack for [MEDICATION NAME]. Continued observation revealed no bubble pack for [MEDICATION NAME] for Resident #70.
Interview on 3/29/15 at 2:11 P.M. LVN#3 stated Resident #70 was getting [MEDICATION NAME] 50 mg and [MEDICATION NAME] 10/325
mg every six hours as needed for pain. LVN#3 continued and stated when she realized the [MEDICATION NAME] was out on Saturday (March 28, 2015) she called the pharmacy to request a refill but she was told she needed triplicates. She continued and stated she called the physician to notify him that she needed a triplicate prescription. The doctor questioned why he was not notified during the week. LVN#3 stated she only worked on weekends and she did not know. The physician stated the resident would have to wait until Monday.
Record review of Resident#70 ' s physician ' s order dated 3/29/15, Sunday revealed discontinue [MEDICATION NAME] 10/325 every six hours as needed for pain start Tylenol with [MEDICATION NAME] #3 every four hours as needed for pain.
Record review of Resident #70 ' s MAR indicated [REDACTED].
Observation on 3/30/15 at 8:15 A.M. revealed Resident #70 was in bed grimacing and holding her left arm.
Interview on 3/30/15 at 8:15 A.M. Resident #70 stated they let the [MEDICATION NAME] ran out about a week ago and they were giving the [MEDICATION NAME] and Tylenol which did not work. The resident stated she was having overall chronic body pain and reported her pain intensity on a scale of 1-10 was 9 and a half at this time . She continued and stated she did not go to sleep until 4:00 A.M. this morning because of the pain. Resident #70 stated how do you let someone ' s pain medicine run out?
Interview on 3/30/15 at 8:25 A.M. LVN #4 said that the physician ordered another pain medication, Tylenol #3, yesterday , but Resident #70 did not want Tylenol #3 because it did not relieve her of pain. She only wanted [MEDICATION NAME] because it was the only pain medication that she had used that helped her with pain.
Observation on 3/30/15 at 8:25 A.M. revealed LVN #4 called the physician to reorder [MEDICATION NAME] since Resident #4 had ran out of it.
Interview on 3/30/15 at 8:40 A.M. LVN#14 stated when she noticed a resident ' s medicine was about to run out she called the pharmacy for refills and if it cannot be refilled she notifies the physician. She stated she does not notify the DON but will notify the next on coming nurse during report and if she worked the next day she would call the pharmacy and physician again.
Interview on 3/30/15 at 9:15 A.M. Resident #70 stated she received [MEDICATION NAME] and Tylenol #3 about 30 minutes earlier and her pain was about the same with no relief. She continued and stated she told her doctor last week she was out of pain medicine.
Interview on 3/30/15 at 10:09 A.M. the DON stated she cannot remember any nurse notifying her about Resident #70 ' s

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	676337	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR HOUSTON	6920 T.C. JESTER BLVD HOUSTON, TX 77091

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) [MEDICATION NAME] running out and last night she got an order for [REDACTED]. Interview on 3/30/2015 at 4:45 Resident #70 stated she had just returned from [MEDICAL TREATMENT]. She stated her pain was a 9 on a scale of 1-10 but the nurse just gave her a pain pill. She stated it was not a [MEDICATION NAME] but the nurse stated they had been ordered and should be coming from the pharmacy this evening. She stated the [MEDICATION NAME] was the only drug that was effective for her pain. Further record review of Resident #70 ' s clinical records revealed a physician order dated 3/3/15 for [MEDICATION NAME] 10 mg 1 tablet every night to stimulate the appetite. Record review of Resident #70 ' s MAR indicated [REDACTED]. Further record review revealed that the [MEDICATION NAME] was discontinued on 3/9/15. Record review of Resident # 70 ' s Psychiatric Review /Mental Status Exam dated 3/9/15 revealed Primary care physician ordered [MEDICATION NAME] 10 mg every night for appetite but pharmacy has not delivered secondary to no 10 mg pill , will change to [MEDICATION NAME] 15 mg every night so they will send it . Record review of Resident# 70 ' s progress notes revealed that there was no evidence indicating that Resident # 70 ' s physician was notified of the unavailability of the [MEDICATION NAME] 10 mg ordered 3/3/15. Interview on 3/10/15 at 11:34 a.m., LVN # 4 said the medication was supposed to have been delivered by the pharmacy. She said staff should indicate and document the reason on the back of the MAR indicated [REDACTED]. Record review of the drug reorder book on 3/30/2015 revealed a binder with dividers for 31 days in it. Behind the divider marked 30 there were several copies of phone orders and tear off slips from medication cards that had been attached to blank pages and faxed to the pharmacy. Interview on 3/30/2015 at 5:00 P.M. the Corporate Educator after being asked for the previous days of the month ' s pharmacy orders, stated the notebook was the corporate system which should have been used at the facility but was not. She stated prior to today the nurses had just been shoving the order forms into an accordion binder in the medication room. She stated there was no organization or filing system and there were several folders. She then stated she had started training the nurses to the corporate system. When asked how many nurses she had trained she stated two. When asked to see the in-service form for the two nurses she stated she had not made one out yet. The Corporate Educator was asked to see if she could find the reorder form for Resident #70's [MEDICATION NAME] which ran out on 3/24/2015. She stated she would try to find it. No reorder form was ever provided for review. Record review and interview of the in-service form dated 3/30/2015 concerning the medication reorder system revealed one nurse had signed they had been trained to the corporate medication reorder policy and procedure. Interview on 3/30/2015 at 5:10 P.M. the ADON stated she would order medications when the resident had a seven day supply left. She stated if it was a PRN medication she would use her nursing judgement and assess how many pills a day the resident was taking and then multiply that times 7 to give her a seven day supply. Interview on 3/30/2015 at 5:30 P.M. LVN #20 stated he reordered resident's medications when they had ten pills left. Interview on 3/31/15 at 9:30 A.M. LVN #19 sated she reordered medications on the seventh day before it runs out. She did the ninth day but she would be notified by pharmacy it was too early to refill. Interview on 3/31/15 at 9:36 A.M. LVN #4 stated it depended on the frequency of the medication but she reordered medications 7 days before it runs out. The turnaround time to get the medication depended on if there were any refills left on the medication or if it needed triplicate scripts. Record review of facility ' s policy on treatment of [REDACTED]. Resident # 30 Record review of Resident #30 ' s face sheet revealed a [AGE] year old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident # 30' s physician's order dated 3/20/15 revealed STAT Chest X-ray and start (antibiotic) [MEDICATION NAME] 500 mg, by mouth daily for 10 days for upper respiratory tract infection. Order was a telephone/verbal order from physician to staff. Record review of Resident # 30 ' s MAR indicated [REDACTED]. Record review of Resident #30 ' s MAR indicated [REDACTED] [MEDICATION NAME] 500 mg PO daily for 10 days. Medication time was 7 a.m. Further review of the March MAR indicated [REDACTED]. Record review of Resident # 30 ' s nurse notes dated 3/23/15 at 2:39 p.m., revealed resident on [MEDICATION NAME] for upper respiratory tract infection, pharmacy notified writer that Resident # 30 was allergic to [MEDICATION NAME]. Day 2 on medication. No adverse reactions noted. Called MD four times , still waiting for return call. Temperature was 98.7, will continue to monitor for status changes . Record review of Resident # 30 ' s nurse ' s notes revealed addendum late entry for 3/21/15: notified MD of allergy to [MEDICATION NAME], initial dose was given, no adverse effects from [MEDICATION NAME] observed . Record review of Resident #30 ' s nurse notes dated 3/23/15 at 2:58 p.m., revealed new order to discontinue [MEDICATION NAME], start [MEDICATION NAME] 500 mg PO today than 250 mg PO Tuesday, Wednesday, Thursday and Friday. Observation and interview on 3/26/15 at 9: 52 a.m., Resident # 30 was in bed. She stated she had an upper respiratory infection and was receiving antibiotic treatment for [REDACTED]. Interview on 3/26/15 at 12:15 p.m., the ADON said she called pharmacy to inquire why the [MEDICATION NAME] for Resident # 30 was not yet supplied and was told it was because Resident # 30 was allergic to [MEDICATION NAME]. She then called the physician to notify him and got new order. The ADON said the resident had no known adverse reactions. Interview on 3/26/15 about 12:00 p.m., LVN# 4 said she said she did not see the resident ' s allergies [REDACTED]. LVN# 4 further said she could have looked up the resident ' s allergies [REDACTED]. She expressed it did not occur to her to check Resident # 30 ' s allergies [REDACTED]. Record review of the facility policy titled Medication Ordering undated revealed . Goal: To ensure all medication, pursuant to a valid physician order, are available in the facility at all times .Nurses should reorder medications when they were down to five to seven day supply. Nursing must identify the refill is in the facility when they were down to three day supply and place the refill card at the medication cart .Nurse manager should verify all nurses have been in service on medication order/reorder system. Re-order book should be audited on a daily basis to verify all med orders can be accounted for. Medication carts should be audited on a weekly basis to verify no less than a three day supply of medications was available. Record review of facility ' s policy on pain assessment and management dated 11/14 revealed that continuing assessment of the pain management program should occur daily and should focus on the effectiveness of the program and the comfort level of the resident. Pain should be assessed and documented at regular intervals, as necessary and in accordance with the pain management program . Evaluation of the effectiveness of the [MEDICATION NAME] medications in relieving pain to a level that is acceptable to the resident should occur. A policy was requested concerning the reviewing of resident information for allergies [REDACTED]. An IJ was identified on 3/26/2015. A plan to remove the IJ was submitted and accepted on 3/29/2015. The Plans of removal included: Immediate interventions implemented for the resident with pain: 1. Resident #70 - Resident was immediately assessed for pain by DON and noted her pain to be rated at a (7). Resident was administered [MEDICATION NAME] 50mg 1 PO and Tylenol 325 mg 2 tabs PO at 8:15 pm. At 9:00 pm resident was asleep and no compliant of pain. Resident ' s [MEDICATION NAME] 5/325 mg P O q 6 hours arrived at facility around 11:40 pm and resident received a dose as it was changed to routine administration. Resident will be assessed also before during and after treatment , as well as before leaving facility for [MEDICAL TREATMENT] and returning. Immediate interventions implemented for resident as it relates to medication and treatment not being administered as ordered: 1. Resident #70 - On 3/9/2015 [MEDICATION NAME] 10mg 1 tab PO QHS ordered on [DATE] was discontinued. Corrected order for [MEDICATION NAME] 15mg 1 tab PO qHS submitted to pharmacy for delivery. Medication was received in facility and initiated on 3/10/2015. Immediate interventions implemented to include all residents residing in facility that could be affected by an effective system not being in place and monitored to identify residents at risk for pain, or who are experiencing actual pain.

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) 1. 100% audit of current census was conducted by Nurse Managers to ensure all residents with pain were addressed, by completing a new pain assessment for all residents and any residents noted to be experiencing any pain were given medication if they were prescribed. Any resident without pain medication orders, MD was notified for an order for [REDACTED].>2. Based on 100% audit of pain assessments all Care plans were updated to include interventions to manage pain and include alternate means of pain relief. INITIATED: 3/31/2015 COMPLETED: 3/31/2015 3. Pain assessment roster was reviewed for 100% of resident to ensure that anyone with documented pain has medications available and given as ordered by the physician. INITIATED: 3/30/2015 COMPLETED 3/31/2015 4. 100% audit of current pain meds on hand by nurse managers, to ensure all residents have at least 5 day supply of current pain medication available. Any residents with less than 5 day supply will have medications reordered. INITIATED: 3/30/2015 COMPLETED: 3/31/2015 5. Residents will be assessed on admission and quarterly for pain management. All nurses were re-educated on doing pain assessments. Residents who have been identified of having pain will have pain per pain monitored per pain roster every shift and as needed. INITIATED: 3/30/2015 COMPLETE 3/31/2015 6. Physician will be notified by the charge nurse of any resident who does not experience relief from pain with current pain regimen within 2 hours of medication administration for further interventions to reduce pain to a level that is tolerable for the resident. INITIATED: 3/30/2015 COMPLETED: 3/31/2015 7. Residents will be assessed by charge nurse for pain each shift, and during and after treatments. Interventions will be implemented per orders, or MD will be notified by charge nurse if current regimen is not effective for new orders. INITIATED: 3/30/2015 COMPLETED: 3/31/2015 8. Charge nurses were in-serviced on the process for reordering medication: The nurse will re-order pain medication when there is a 7 day supply remaining. MD will be contacted for triplicate prescription if required, during business hours prior to 7th day to ensure resident has pain medication available at all times. When the nurse receives the narcotic from the pharmacy delivery, pharmacy reconciliation binder will be updated, medication counted and placed in secured drawer in the medication cart. INITIATED: 3/30/2015 COMPLETED: 3/31/2015 9. Nurse Managers will re-educate and or implement progressive disciplinary actions for any nurse who fails to assess, and manage resident pain or ensure at least a 7 day supply of medication is on hand at all times. Monitoring: 1. Nurse Managers will review pain roster daily in the morning meeting to identify all residents that had documented pain levels to ensure each resident received meds routinely, or prn to manage the pain. Process improvement began: 3/30/2015 2. Nurse Managers will review med carts daily with the start up to ensure the residents have at least a 7 day supply of meds for administration. The meds that are close to 7 day refill are called to the physician for the needed triplicate. Process improvement began; 3/30/2015 3. Nurse Managers will review the pharmacy reconciliation binder daily in start-up to verify pain medications ordered were received. Process improvement began: 3/30/2015 4. Department heads will ask resident daily on their guardian angel rounds if they are experiencing any pain, and if the resident states they are the department head will immediately notify the charge nurse, and complete a Stop & Watch to ensure the pain was addressed. The department head will present a copy of the stop & watch to the DON for assurance of follow up. Process improvement began: 3/31/2015 Immediate interventions implemented for residents as it relates to MD notification of resident allergies [REDACTED]. Resident #30 - On 3/23/2015 [MEDICATION NAME] 500mg PO X 10 days was D/C ' d after two doses were given. [MEDICATION NAME] 250 mg PO QD was ordered and initiated on 3/23/2015. Resident was assessed for any allergic reactions to the medication and none noted. Stop date 3/29/2015. Interventions Issue : All Licensed Staff were in-serviced by nurse managers regarding notification of allergies [REDACTED]. Nurses were in serviced on noting allergies [REDACTED]. Nurses will not be allowed to work the floor prior to receiving this education beginning on 3/26/15 and will be completed by 3/31/15. Monitoring: Nurse Manages will monitor that residents do not have an allergy to new medication orders in start-up meeting. Process improvement began: 3/27/2015. Monitoring of the plan to lower the immediate jeopardy: Record review of the facility in-services revealed 17 out of 20 licensed nursing staff were in-service to assess the resident's pain level every shift and to notify the physician for any pain not relieved ,any changes in the resident's condition, weight loss, medication or treatment refusal, abnormal lab values, medication not available, abnormal vital signs. To complete a stop and watch form and the physician notification form: situation, background, assessment , response (SBAR) form. Record review of the facility in-services revealed 29 out of 37 unlicensed nursing staff were in-serviced for notification to the nurse if the resident complained of pain and completion of the stop and watch form. Interviews on 4/2/15 with 11 out of 12 licensed nursing staff on duty identified the need to assess the resident's pain level every shift, before and after administering pain medications and for any changes in the resident's condition, weight loss, medication or treatment refusal, abnormal lab values, medication not available, abnormal vital signs. Interviews on 4/2/15 with 9 out of 10 unlicensed nursing staff and three therapy staff identified the need to complete the stop and watch form and notify the nurse for any complaint of pain or change in the resident. Record review of Resident #30's Medication Administration Record [REDACTED]. Record review of Resident #70's physician order's and Medication Administration Record [REDACTED]. and topically ointment to heel wound. Record review of Resident #70 physician order and Medication Administration Record [REDACTED]. Record review of Resident #70's pain roster, nurse's notes, pain assessment sheet and Medication Administration Record [REDACTED]. Record review and interviews with three residents on pain management revealed their pain was being assessed each shift. The resident's had no complaints concerning the management of their pain. Observations and interviews with Resident #70 on 3/31/15, 4/1/15 and 4/2/15 revealed the resident was getting her medication for pain and the staff was asking her pain level. The resident continued and stated she was feeling much better, her pain was in control and she was sleeping at night. The Administrator was informed on 4/2/2015 the IJ was lowered after verification of the plan implementation had occurred. While the IJ was lowered on 4/2/2015 the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not an Immediate Jeopardy because all staff had not been trained on the procedure on pain assessment, management of pain, reordering of medications and the procedure of checking resident ' s charts for allergies [REDACTED]. Facility CMS form 672 dated 3/24/14 listed 40 resident were on a pain management program and 18 residents had pressure ulcers. The census of the facility was 108.
F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to maintain personal grooming /hygiene to four of 19 residents (Residents #47, #61 #62 and #70) reviewed for Activities of Daily Living (ADL) needs being provided. Residents #47 , #61, and #62 were not provided nail care.

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F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 13) Resident #70 was left with food particles on her clothing and bed linens after her tray was removed. This failure affected four residents and placed 104 residents who required assistance with ADLs at risk of poor grooming, infection and psychosocial decline. Findings include: Resident #47 Record review of Resident #47 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Record review of Resident #47 ' s MDS dated [DATE] revealed his BIMS was 10 which indicated he was cognitively intact. Continued review of the same MDS revealed the resident had bilateral upper extremity contractures and required extensive assistance with his personal hygiene. Observations on 3/10/15 during initial tour of 300 hall at 9:13 A.M. revealed Resident #47 sitting in his room awake and alert. The resident's fingernails on both his hands extended past the tips of his fingers and had a brown substance caked underneath. Interview on 3/10/15 during the observation Resident #47 stated his nails were very dirty. Resident #61 Record review of Resident #61's face sheet revealed she was admitted to the facility on [DATE] she was [AGE] years old. Her admission [DIAGNOSES REDACTED]. Record review of the resident's MDS dated [DATE] revealed her BIMS was 10 meaning she was moderately connectively impaired and she required extensive assistance with her personal hygiene. Observation on 3/10/15 during initial tour of 300 hall at 9:17 A.M. revealed Resident #61 in her room in bed eating breakfast. The resident's nails were long extending past the tips of her fingers and caked with brown substance underneath. Interview on 3/12/15 at 12:05 P.M. CNA #17 stated she tried to do the resident's who were assigned to her nails once a week but she did not know how often the other CNAs did nail care. Resident #62 Record review of Resident #62 ' s face sheet revealed the resident was admitted to the facility on [DATE]. The resident was [AGE] years old. Her [DIAGNOSES REDACTED]. Record review of Resident #62 ' s MDS dated [DATE] revealed the resident had impairments to both upper and lower extremities. It also revealed the resident was totally dependent on staff for bed mobility and all activities of daily living. Record review of Resident #62 ' s care plan dated 2/14/2015 and 2/17/2015 revealed a problem listed the resident required total assist with personal hygiene. Approach for this problem listed was to have staff provide nail care weekly and as needed. Observation on 3/10/2015 at 1:24 P.M. revealed the resident had contractures of both upper and lower extremities. Her hands were balled into fists. When requested, the resident was unable to follow verbal commands to open her hands. Observation and interview on 3/12/2015 at 3:30 P.M revealed Resident #62 lying on her back with her knees in the air. Head of bed was elevated 45 degrees. Her hands were clinched into fists with no hand rolls in place. Treatment Nurse #1 stated, as she opened the resident ' s fingers to look at the palms of her hands, that the resident ' s nails were to be cut by the aides unless she was diabetic then the nurse would trim them. Observation revealed the resident ' s nails were extending past the tips of the fingers and were rough and jagged in appearance with a brown substance under the tips. When asked how the resident ' s fingernails felt to the nurse, Treatment Nurse #1 said they were rough to touch. Treatment Nurse #1 stated the resident should have hand rolls in place to prevent her fingers from digging into her palms and to extend the fingers. Observation and interview at the same time revealed Resident #62 ' s toenails were long and went past the tips of the toe curving back around and into the skin underneath the toe. Treatment Nurse #1 stated she knew the podiatrist was coming on 3/18/2015 but she was not sure if the resident was on the list to be seen. She stated she would check and if she was not on the list add her to make sure she did get seen. Resident # 70 Record review of Resident # 70's face sheet revealed a [AGE] year old female admitted to facility on 6/27/13 with the following diagnose: hypertension, diabetes mellitus, depression, [MEDICAL CONDITION], muscle weakness, obesity and ends stage kidney disease. Record review of Resident # 70 ' s MDS dated [DATE] revealed the resident required extensive assistance with ADLs. Record review of Resident #70 ' s care plan dated 7/13/13 with no update date revealed Resident #70 required assistance from staff for all ADLs. Observation on 3/10/15 at 10:34 a.m., revealed the resident in bed sleeping. Resident #70 had food particles on her gown, chest area, and on her bed. No food tray was found in her room. Interview on 3/11/15 at 10:40 a.m., Resident # 70 ' s family member said she walked into the resident ' s room to visit her this morning and found food all over her. She said whoever took her tray should have at least helped to pick up and tidy the resident before walking away. A policy concerning staff assisting with resident's ADL care was requested but not provided prior to exit. Facility CMS form 672 dated 3/11/15 listed 103 residents required assistance with ADLS.
F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary treatment and services to prevent the development of and promote the healing of pressure sores for one of six residents (Resident #70) who were reviewed for pressure sore care. Resident # 70 was not promptly provided wound care upon readmission to the facility with a large stage II to the sacral and buttocks areas. Resident #70 had multiple open areas with excoriation to her inner thighs and gluteal folds which were not identified and addressed. Resident #70 was not provided a heel protector for her left heel unstageable wound. This failure affected one resident and placed 17 other residents with pressure sores at risk of worsening of the sores, decrease of new skin growth and infections. Findings included: Intake # 7 Resident # 70 Record review of Resident # 70's face sheet revealed a [AGE] year old female admitted to facility on 6/27/13 with the following Diagnoses: [REDACTED]. Record review of Resident # 70 ' s MDS dated [DATE] revealed the resident was moderately impaired for cognition and required extensive assistance with ADLs. Resident # 70 had no wounds documented on the MDS. Record review of Resident # 70 ' s wound assessment report dated 2/24/15 revealed Resident # 70 had pressure ulcer to her sacrum upon re-admission, granulation tissue was 30%. The wound had 30 % slough and 40% eschar. The physician and resident ' s responsible party were notified of the wounds on 3/3/15. Further review of the record revealed a wound assessment was completed on 3/4/15. Further review of record revealed treatment orders were pending. Record review of Resident # 70 ' s care plan date 3/6/15 revealed the resident had a deep tissue injury to her left heel. The goal was the deep tissue injury would show signs of healing. The approach included offload wound , heel protectors , float heel while in bed etc. Observation on 3/10/15 at 10:34 a.m., revealed Resident # 70 in bed. She had no heel protectors on her left heel. Heel

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 14) protector was at the foot of the bed. Record review of Resident # 70 ' s physician re-admission orders [REDACTED]. Record review of Resident #70 ' s treatment administration record dated February 2015 revealed Balsam peru/ castor oil/ trypsin ointment, apply to heel wounds every 12 hours and cadexomer iodine 0.9 topical gel, apply to sacrum every other day. Further review of the resident's TAR revealed the above orders were signed and circled on 2/25/15 with instruction that read see treatment book . When requested, there was no other wound treatment record provided for the month of February 2015 or evidence of wound care from admission on 2/24/15 to the end of the month. Record review of Resident # 70 ' s treatment administration record dated March 2015 revealed Balsam peru/ castor oil/ trypsin ointment, apply to heel wounds every 12 hours and cadexomer iodine 0.9 topical gel, apply to sacrum every other day. There was no discontinuation date or order on the above treatment and no documentation that treatments were initiated. Observation on 3/10/15 about 2:10 p.m., during wound care. Resident # 70 was noted with large stage II pressure ulcer from left buttock extending to her right buttock and the sacral area. Wound was clean , had no slough and no eschar but with a mild drainage. Resident # 70 had multiple open areas to inner thigh and excoriations to the perineal areas. She also had an unstageable wound to her left heel. Further observation and interview revealed LVN # 4 performed wound care to the sacral area and left heel. LVN # 4 said she was not aware of multiple open areas on the resident ' s inner thigh areas. LVN # 4 said she knew Resident # 70 had some red excoriations to the perineal areas and gluteal folds. Interview on 3/10/15 following the above observation, Resident # 70 ' s family member reported she notified LVN# 4 of multiple open areas she identified on the resident but LVN # 4 did not follow up and did not assess the resident. Interview on 3/10/15 about 3:00 p.m., LVN # 4 said the resident ' s family notified her of the skin excoriations on Resident # 70's inner thighs. She said staff had been applying barrier cream to the area but did not see the open areas. Interview on 3/11/15 about 4:00 p.m. the ADON said she found out the treatments were not ordered from pharmacy and was not implemented upon the resident ' s re-admission. She explained she had completed a medication variance (for medication error according to the facility protocol) after the surveyor intervened. The ADON said she did not know why the above orders were not implemented. Record review of facility ' s policy on treatment of [REDACTED]. further review of policy reealed policy did not address above concerns. Facility CMS form 672 dated 3/24/14 listed 18 residents had pressure ulcers.
F 0353 **Level of harm** - Actual harm **Residents Affected** - Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the facility failed to have sufficient nursing staff trained to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being as determined by resident assessments and individual plans of care for ten of 22 residents (#70, #14, #73, #15, #59, #100, #72, #65, #30, and #97) reviewed for sufficient care being provided by staff. Facility nursing staff failed to notify the physician when : Resident #70 did not receive treatments and medications as ordered. Resident #14 was non compliant with her diet. Residents #s 73, 15, 59, 100, 72, and 65 experienced weight loss. Resident #30's stat lab and x-ray abnormal results. Facility nursing staff failed to follow physician's orders [REDACTED].>Resident #72's nutritional supplement and blood pressure medications. Resident #62's tube feedings. Resident #65's health shakes with meals. Resident #97's hand rolls and treatments to the insides of her hands. Resident #15's heels were not floated while in bed. Resident #15's tube feeding. Facility nursing staff failed to effectively: Assess and manage the pain of Resident #70. Review Resident #30's allergy history prior to administering new medications. These failures affected ten residents and placed 98 residents at risk of not receiving the medical care and treatments required for them to maintain their highest level of health and function. Findings include: Resident # 70 Record review of Resident # 70's face sheet revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Resident #70 did not receive the medication [MEDICATION NAME] for five days because it was unavailable from the pharmacy. (see tag F157 for evidence.) Resident #70's pain was not assessed and managed. Resident #70 was not medicated effectively prior to the treatment for [REDACTED]. (See F309 for evidence). Resident #70's pain was not assessed and managed on a daily basses. Assessments would reflect her pain intensity at a 10 on a scale of 1-10 with 10 being the most severe with no documentation of pain medication or alternate pain management being provided to the resident (See F309 and F425 for evidence). Resident #70 had history of chronic pain which required treatments of narcotic pain medication on a daily basis to control. Facility staff did not reorder the narcotic pain medication timely and the resident was not provided the medication she felt most effective for her pain for six days. (see F309 and F425 for evidence) Resident #14 Record review of Resident #14 ' s face sheet revealed she was admitted [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years old. Resident #14 had a medical condition which resulted in her aspirating thin fluids into her lungs. The physician ordered nectar thickened liquids for the resident. The resident refused the nectar thick liquids and drank thin liquids from November 2014 to March 2015 without the physician being consulted. (See F157, F323, and F365 for evidence). Resident #73 Record review of Resident # 73 ' s face sheet revealed he was a [AGE] year old male, admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident #73 had a weight loss of forty pounds in five months and the dietitian's recommendations to change the resident's tube feeding to increase nutritional intake was not communicated to the physician or implemented. (see F157 and F325 for evidence). Resident #15 Record review of Resident # 15 ' s face sheet revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. She was [AGE] years old. Her [DIAGNOSES REDACTED]. Resident #15 experienced a weight loss of 20 pounds in three months and the dietitian recommended an increase in her tube feeding on 2/12/2015. This was not communicated to the physician until 3/12/2015. The physician ordered the increase on 3/12/2015 which was not implemented by the facility staff until 3/25/2015. (see F157 and F325 for evidence). Resident #15's care plan instructed staff to float her heels while in bed which was not provided. (See F282 for evidence). Resident # 59 Record review of Resident # 59 ' s face sheet revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. She was [AGE] years old. Her [DIAGNOSES REDACTED]. Resident #59 experienced a weight loss of nine pounds in one month and the dietitian recommended med pass supplement which

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	676337	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR HOUSTON	6920 T.C. JESTER BLVD HOUSTON, TX 77091

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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** br>Based on observation, interview and record review the facility failed to store, prepare and distribute food under sanitary conditions. The facility failed: To have a thermometer to register the temperature in the milk cooler, freezer #1 and freezer #2. To maintain and clean the milk cooler to prevent the leaking of milk. To label and date foods stored in the two freezers (#1 and #2), the refrigerator and the pantry. To keep the two door oven, exhaust hood, institutional fryer, and the stove ' s back splash clean. These failures placed 91 residents who eat food prepared by the kitchen at risk of food borne illness or infection. Findings include: Observation in the kitchen on initial tour on 03/10/2015 at 9:20 A.M. revealed there was no thermometer in the milk cooler. Interview on 03/10/2015 at 9:20 A.M. the Food Service Supervisor stated there was a thermometer but she was not able to locate it. Observation on 03/10/2015 at 9:25 A.M. revealed there was a white liquid inside the milk cooler on the bottom. Interview on 03/10/2015 at 9:25 A.M. the Food Service Supervisor stated the milk was delivered on Saturday mornings and it had leaked. Observation on 03/10/2015 at 9:30 A.M. revealed there were no thermometers in the freezers (#1 and #2). Interview on 03/10/2015 at 9:30 A.M. the Food Service Supervisor there were thermometers but she was not able to find them in the freezers. Observation in kitchen freezer # 1 (located near the back door) on 03/10/2015 at 9:35 A.M. revealed food items stored in the freezer were not labeled and dated as follows: Biscuits in an open bag partially used not sealed. Two bags of Okra. One bag of Onion Rings. One Bag of Cauliflower. One bag of Vegetable blend. Two bags of Squash. Six pieces of Tilapia (Fish) in an opened box with no opening date on the box. Diced Chicken in an opened box partially used with no opening date and the bag was not sealed. French Toast in a zip lock bag. Whip topping in an opened box with no opening date. Chicken Breast Strips breaded in an opened box partially used with no opening date. Breaded Chicken Tenders partially used with the bag opened, no opening date. Cat Fish in an opened box partially used with no received and opening date. Observation in kitchen freezer #2 (located next to freezer #1) on 03/10/2015 at 9:50 A.M. revealed food items stored in the freezer were not labeled and dated as follows: One package of Hash Browns partially used. Biscuits in a plastic bag partially used. Two bags of Corn Nuggets not dated when received. One bag of Okra. Fish in a plastic bag. Observation in the refrigerator on 03/10/2015 at 10:00 A.M. revealed Mozzarella Shredded Cheese in a plastic bag no opening

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F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 16) date. Observation in the kitchen pantry on 03/10/2015 at10:10 A.M. revealed the following food items not labeled and dated: Fettuccini (Pasta) not labeled and dated. Rice cereal partially used not labeled and dated. Opened box of Graham Crackers not labeled and dated (no opening date). Sugar Cookies in a box not labeled and dated (no opening date). Two box of Spanish rice not dated when box was opened. Cream Pies in an opened box not labeled and dated (no opening date). Observation in the kitchen on 03/10/ at 10:20 A.M. revealed a two door oven which opened sideways. There was a brown build up on both doors on the inside and along the inside of the oven. Observation in the kitchen on 03/10/2015 at 10:20 A.M. revealed an institutional fryer with crumbs and grease around the outside edges. Interview on 03/10/2015 at 10:20 A.M. the Food Service Supervisor stated the staff used the fryer the previous night and should have wiped it clean after they used it. Observation in the kitchen on 03/10/2015 at 10:25 P.M. revealed the exhaust hood with filters, over the grill and stove, was greasy on the inside of the hood. Record review of the invoice by the contracted company that serviced the exhaust hood, provided by the facility, revealed the last service and cleaning was done on 09/02/14. Interview on 03/10/2015 at 10:25 P.M. the Food Service Supervisor stated she was just recently employed by the facility. Record review of the facility ' s In-Service on labeling and dating revealed it was dated 12/03/14. Record review of the facility ' s policy on Food Receiving and Storage revised 01/13 revealed foods shall be received and stored in a manner that complies with safe food handling. The same policy revealed all foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). The facility 672 form revealed a census of 108 residents with 17 receiving nourishment from a tube feeding and 91 residents eating meals prepared by the kitchen.